Effects of Group Treatment on Sexually Abused Young Children

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EFFECTS OF GROUP TREATMENT ON SEXUALLY ABUSED YOUNG CHILDREN

BY

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MASTER OF SOCIAL WORK

"Your hearts know in silence
the secrets of the days and
nights."

Kalil Gibran

To my mother, Lydia Kendall, for her love and support throughout the years and my husband, Jim, who has stood patiently by throughout my studies, always assisting where he could and gently nudging me on.

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CHAPTER 1

Introduction

I became interested in the field of child sexual abuse quite by accident. While working as a behavioral consultant to a day program for mentally handicapped children, I learned of an instance of sexual abuse involving a child attending our program. It greatly disturbed me that an individual could take advantage of a child in this manner, particularly a child with even fewer defenses than most children. My concern intensified as it became apparent how few resources were actually available to protect this child. Her stepfather was the suspected offender, so the victim was placed in a foster home for a brief period of time; eventually, however, she was returned home because there was not sufficient evidence to lay charges. Although there was physical substantiation of abuse, this child could not speak and therefore could not tell her story. I suspect that she went home to further victimization.

This series of events prompted me to look further into the subject of child sexual abuse. I found a dearth of literature prior to the late 1970's when, with the advent of the women's movement, child sexual abuse was acknowledged as a widespread problem and became a popular area of study. Since it is still a relatively new subject of psychological, sociological, medical, and legal interest, there is still comparatively little written about the sexual abuse of children. As well, resources within community social service systems are sparse and those few which do exist are barely past the developmental stages. In 1985, child protection agencies in Winnipeg were only beginning to develop specific protocols for crisis intervention in cases of child sexual abuse and to implement treatment groups for child victims. Today, in 1988, in British Columbia, the Ministry of Social Services and Housing (M.S.S.H.) is only authorized to offer crisis intervention as short-term resolution of a specific crisis situation, not any type of treatment. That is left to the private sector.

This lack of intervention programs and of experienced professionals to organize and maintain them, combined with the profound helplessness of the child victims made me want to become further involved. The first step was to volunteer at the Child Development Clinic at Children's Hospital in Winnipeg. Under the supervision of Dr. Laura Mills, a child psychologist who specialized in treating child victims of sexual abuse, another social worker and I conducted two short-term treatment groups for latency-aged female victims. The proposal for this practicum developed out of that experience.

CHAPTER II

Literature Review

Child Sexual Abuse: An Overview

Introduction. Rush, in her book The Best Kept Secret: Sexual Abuse of Children (1980), traces the history of child sexual abuse through the centuries and across cultures. She begins five thousand years ago with writings inscribed on clay tablets consisting of a message from a young child asserting that she was too "little" for intercourse. From there, she goes on to cite historical accounts of "sex between men and very little girls in marriage, concubinage, and slavery" in the Bible and the Talmud (p. 17), the "boy love" philosophy of Greece's Golden Age, sexual violation of young girls suspected of involvement with witchcraft in the fifteenth through eighteenth centuries, the practice in the United States of intercourse between female child slaves and their masters which lasted until the late 1800's, and so on.

Then, in 1896, Sigmund Freud presented his seduction theory which stated that there may be a correlation between the hysteria for which he was treating a number of middle class women and their accounts of childhood instances of sexual molestation, particularly by their fathers. Freud later retracted this theory, reportedly because he was uneasy about its implications regarding the behavior of the fathers of his clients, and attributed the hysterical symptoms to fantasies of sexual involvement and not real occurrences (Rush, 1980). Until very recently, this second theory was quite universally accepted.

Rush goes on to say that she feels men do not generally take sex with children very seriously. There still exists a demand for "kiddie porn", child prostitutes still manage to make their living on the streets, and instances of child sexual abuse in general are being reported in ever-increasing numbers each day. The evidence, however, suggests that occurrences are not becoming more frequent, but reporting them is. Rush (1980) has supported that notion in her historical account of the phenomenon. As Well, more and more women tell of

their painful experiences (Bass & Thornton, 1983; Brady, 1979; Butler, 1978; Forward & Buck, 1978; MacFarlane, 1978; Myers, 1979; Rush, 1980).

Incidence. At present, there is generally widespread agreement on the prevalence and scope of child sexual abuse in North America. Still, recent statistics on reported cases are thought to grossly underestimate actual figures (Finklehor, 1984; Herman, 1981). Researchers believe that between one in three and one in six women are sexually assaulted by an adult before the age of 18 (Cantwell, 1981; Finklehor, 1983; Mrazek, 1981; Russell, 1983; Sarafino, 1979). The figures for male victims are thought to be much the same.

Between 1940 and 1978, five surveys addressed the subject of sexual encounters between female children and adults. Cumulatively, these studies recorded information from over 5,000 women from many different geographic areas but primarily from middle to upper socio-economic classes. The results from these five studies were remarkably consistent. One fifth to one third of all women surveyed reported some sort of childhood sexual experience with an adult male (Finklehor, 1978; Gagnon, 1965; Kinsey et al., 1953; C. Landis, 1940; J. Landis, 1956).

In a Denver study of all reported cases of sexual abuse to children under the age of 18 years, the reported incidence rate was one in every thousand of the total population within that age range (Cantwell, 1981). Of these children, 45% were under 12 years of age and 16% were under 6. When the perpetrator was a stranger, the average age of the victims was about 12. The average age of onset of all forms of intrafamilial sexual abuse is estimated by Kempe and Kempe (1984) to be 8-9 years and its duration, about five years. A great deal of abuse occurs at the hands of close family members, particularly fathers and stepfathers. Finklehor and Hotaling (1984) concluded that men are the perpetrators 95% of the time when victims are female and 80% of the time when victims are male.

The Child Protection Center of the Children's Hospital in Winnipeg began keeping statistics on child sexual abuse in 1977. In that year, there were eleven investigations and since then reports have been rapidly increasing. In the annual report for 1986, a total of 477 children were referred to the center for sexual abuse assessments. This was a 13% increase over the 1985 figure.

Age and sex patterns of victims have remained relatively constant over the years, the age range being between 2 and 16+ years, peaking at the 14-16 year level. Approximately 88% of sexual abuse victims were reported, as in previous years, to be female.

Definition. In order to study any type of phenomenon, one must define it. Child sexual abuse has been defined by Schecter and Roberge (1976) as:

> ...the involvement of dependent, developmentally immature children and adolescents in sexual activities which they do not fully comprehend and to which they are unable to give informed consent or that violate the social taboo of family rules (p.8).

The Child Protection Center (1984) prefers: "...the use of a child for any sexual activity by someone older and more powerful." Manitoba Community Services (1984) uses the following definition:

> ...any exploitation of a child whether consensual or not for the sexual gratification of a parent or person in charge of a child and includes, but is not necessarily restricted to:

> sexual molestation, sexual assault, and the exploitation of the child for the purposes of pornography or prostitution. Sexual abuse includes 'incest'...and sexual activity between children may constitute sexual abuse if the difference in ages between the children is so significant that the older is clearly taking sexual advantage of the younger (p.4).

No matter which of the many definitions one selects, two of the most common elements involved in defining child sexual abuse are the sexual activity involved and the imbalance of power between the victim and the perpetrator (Finklehor, 1979; Herman, 1981; Sgroi, 1982).

Kempe and Kempe (1984) list several categories of child sexual abuse including: incest, pedophilia, molestation, statutory rape and rape, child prostitution and child pornography. Alternatively, Berliner and Stevens (1982) suggest only three groupings, based on the degree of coercion used and the relationship between the child and the offender. They are: a) Rape: usually a single violent act by a stranger or acquaintance

where the sexual acts are usually forced intercourse (oral, vaginal, or anal) frequently resulting in physical injury, b) Sexual exploitation: a situation where the child believes he or she is an accomplice and where the perpetrator uses age or experience as leverage to sexually exploit the child, and c) Child sexual abuse: when a perpetrator, who is related or known to the victim, uses his position of power over the child to engage him or her in a sexual relationship. A variety of sexual acts can be included in this last category including touching the genitals, forced masturbation, digital penetration, oral-genital contact, intracrural intercourse, vaginal penetration, voyeurism, and exhibitionism, among others.

Child sexual abuse can be further divided into family and non-family child sexual abuse, the latter sometimes being referred to as third-party child sexual abuse. Even though the composition of these two groups may seem quite evident at first glance, there is widespread disagreement as to the réspective populations each term encompasses. For example, Kempe and Kempe (1984) see family abuse as "any physical sexual activity

between family members" (p. 10). Blood relationship is considered here, but not required; the term "family" is used in its broad social context so as to include aunts, uncles, grandparents, and so on, as well as to describe the actual living arrangement of involved persons. This means that nonrelated siblings and stepparents also fit into this category. The definition of family child sexual abuse, or incest, used by the Child Protection Center in Winnipeg refers only to offenders who reside with the victim. All other cases are considered third-party abuse or non-familial child sexual abuse. This can mean that a child's natural father, if living apart from the victim, could be considered a third-party offender.

Browne and Finklehor (1986) in reviewing the research on the impact of childhood sexual abuse, found that their work was made more difficult owing to the differences in definitions by different researchers. More consensus is needed regarding exactly what parameters define this phenomenon.

Etiology. In a recent book, Child Sexual Abuse: New Theory and Research, David Finklehor summarizes those factors which may, in combination, put a child at higher risk of being abused. In brief they are: having a stepfather (most strongly correlated factor), having a mother who is punitive about sexual matters (second strongest correlate), having a socially isolated family, having a mother absent from the home for a period of time, having a mother with a virtually powerless position in the home, having a mother who is much less educated than the father, and having a lower than average family income. The quality of the child's relationship with her natural father may also have a bearing in determining whether or not a child has a higher risk of being abused.

Speculation as to the etiology of child sexual abuse abounds. The child abuse movement and the women's movement have tended to focus on different aspects of the abuse and have put the problem into somewhat different theoretical perspectives. Child protectors tend to look at child sexual abuse in the context of physical abuse and neglect or family dysfunction. However, this fails to

explain the widespread occurrence of extrafamilial sexual abuse. Feminists, on the other hand, tend to blame "patriarchal social structure and male socialization" (Herman, p. 201). In short, men are socialized to view women and children as property with which to do as they like, implying that they may physically or sexually abuse their wives and offspring should they so choose. Involving another man's wife or offspring (property), however, is another matter and becomes less acceptable (Herman, 1981; Rush, 1980).

Melanie Grace (1984) has combined the above postulates, resulting in a feminist-child protection perspective. She proposes that, as in child protection theory, child sexual abuse be regarded as a family problem and that, as the feminist viewpoint suggests, the offender be held totally responsible for his actions.

Finklehor (1984) takes the theory one step further: He proposes a model of sexual abuse "at a level of generality capable of accommodating many different types of sexual abuse from father-daughter incest to compulsive and fixated molesting" (p. 53). He has, fittingly enough, called the model the Four-Preconditions Model of Sexual

Abuse and submits that all four preconditions must be met before sexual abuse can occur. The preconditions state that a potential offender: 1) must be motivated to have sexual contact with a child, 2) overcomes internal inhibitions against acting on that sexual inclination, 3) overcomes external impediments (e.g. adult supervision of a child), and 4) overcomes resistance on the part of the child (e.g. bribes, threats, physical coercion). Finklehor emphatically states that the presence of only one condition is not sufficient in and of itself to explain the abuse.

This model also suggests a direction for interventive action by manipulating the preconditions. Some are easier to manipulate that others, however. Preconditions 1) and 2), for example, imply that treatment of an offender may necessitate behavioral manipulation of sexual proclivities to decrease his motivation for sexual contact with children. As well, to assess the likelihood that the offender will abuse again and his motivation to participate in therapy, the strength and quality of his internal inhibitions must be evaluated. Neither is an easy task.

Manipulation of Preconditions 3) and 4) may prove to be a bit less difficult. Preventive action can be taken by care providers to ensure that their children are adequately and continually attended. From a judicial viewpoint, threat of criminal action may be another type of external inhibitor which will deter the perpetrator. Schools are using educational programs such as the kit developed by the Child Abuse Research and Education (C.A.R.E.) Productions Association of British Columbia and Feeling Yes, Feeling No (Green Thumb Theater, Vancouver, B.C.) to teach children to protect themselves. Some treatment programs find it very valuable to teach abuse prevention skills to children who have already been victimized since the probability of revictimization is quite high (Berliner & Stevens, 1982; Butler, 1980; Finklehor, 1984; Herman, 1981; Kempe & Kempe, 1984; MacFarlane, et al., 1986). Unfortunately, supervising and educating children are not, in themselves, sufficient precautions. Until Preconditions 1) ana 2) are dealt with, child sexual abuse will continue to occur.

Dynamics. Sgroi, Porter, and Blick (1982) suggest that the dynamics of sexual encounters between adults and children usually fall within a predictable pattern, particularly so in cases of intrafamilial abuse. They reason that the activity usually occurs in five separate phases: 1) the engagement phase, 2) the sexual interaction phase, 3) the secrecy phase, 4) the disclosure phase, and often, 5) a suppression phase following disclosure.

In the engagement phase, the perpetrator begins to watch for or to create opportunities for him and the child to be alone. When this is achieved, he will need to find a way to present the activity to the child, usually in a low-key non-forcible fashion such as introducing it as a game or something that is "special and fun." Perhaps rewards or bribes will be offered; the more adept the perpetrator at subtle coercion, the less the likelihood that threats will be used to induce compliance. Although physical force is rarely used to engage a child in an intrafamily situation, it may be used if other approaches fail or if the family interaction mode is based on violence.

The second phase, the sexual interaction phase, marks the initiation of sexual activity; the perpetrator may have exposed himself and/or persuaded the child to undress. The sexual activity may not progress beyond this point and there may not even be another encounter. More often, however, the occurrences increase in frequency and come to involve a wider range of sexual behavior (e.g. masturbation, fondling, vaginal/oral/anal penetration).

Initiating the secrecy phase eliminates accountability for the offender and also allows repetition of the behavior. The child must now be persuaded or pressured to keep the activity secret over time, and the child usually does keep the secret, at least for awhile. Some never tell, and others remain silent until well into adulthood. There are several reasons for the child to keep this secret: First of all, the child may genuinely like the offender, enjoy the sexual activity, and even wish the encounters to continue. Unfortunately, more often the child keeps the secret because the perpetrator has threatened him or her with extreme consequences. They might include the threat of anger by a third party, separation of the child or other family members from the

family, harm to significant others, harm to the perpetrator himself, or even harm to the child. Sometimes threats are implied. In a family where the use of force or threats is an integral part of daily interaction, a child may keep the secret because he or she is aware of usual consequences for noncompliance. Finally, the child may not reveal the abusive relationship because it may be the only nonviolent form of interaction, indeed the only form of affection, that he or she receives.

The disclosure phase may consist of either of two types of disclosure of the sexual activity. In accidental disclosure the participant does not decide to tell the secret; rather, it comes to light in one of the following ways: observation by a third party, physical injury to the child, pregnancy, or precocious sexual activity initiated by the child.

A participant consciously decides to tell a third party about the sexual activity in a purposeful disclosure, and that participant is most often the child. A young child may reveal the secret simply to share it, but an older child usually tells for a very different reason. Often it precipitates a change in the

relationship between the child and the perpetrator. For example, an adolescent girl may find peer relationships becoming increasingly important to her but her father (the offender) forbids her to engage in social activities with friends, particularly boyfriends. Other reasons for disclosure may include mounting fear of pregnancy or protecting younger siblings from similar abuse.

A wide range and combination of reactions can be anticipated from family members when the sexual abuse of a child residing within the family circle is disclosed. Parents are likely to react in a more protective manner toward the victim if the abuse has been at the hands of someone other than a parent. If, however, the offender is a family member, conflicting loyalties may exist (Burgess & Holmstrom, 1979). Parents may also fear the publicity and exposure and feel guilty about their failure to adequately protect their child. They may also be reluctant to address the issues of the child's premature introduction to sexuality and the negative impact of the abuse upon him or her. Many parents prefer to deny the problem rather than to deal with the consequences.

In intrafamilial child sexual abuse, not only do the above difficulties apply, but a whole new set of problems arises. The offender may first react with alarm since his social status, employment, freedom, and even his family are at stake. He can then be expected to react defensively and with hostility towards the child and his or her advocates. He will try to undermine the child's credibility and to use his position of power to control the child and other family members. Mothers may react to a disclosure by coming to the aid of their child, lending support, and cooperating fully in the child protection process. Or they may respond in a much different manner. Since a mother must often choose between the perpetrator (who may provide the woman with economic and/or emotional support and social status) and her child, she may choose to deny the child's allegations and side with her mate. She may also react with anger if she sees her child as a rival for her husband's affections (Kempe & Kempe, 1984; Sgroi, 1982) and in the same vein, blame her daughter for the "promiscuous behavior" which lured her husband into the sexual relationship (Butler, 1980). Siblings might respond with a combination of fear and anger: fear of the

disruption of family life and anger at the perpetrator or sometimes the victim for disclosing, thereby causing the disruption. In some cases, siblings may have also been victims.

In the suppression phase, after the crisis, the family may react by trying to suppress publicity, information and intervention. To discourage further investigation, they may deny the significance of the disturbances suffered by the child as a result of the sexual abuse. Suppression is likely to be intense if the perpetrator is a family member. He may pressure the child and other family members by trying to induce feelings of guilt for their parts in the disclosure, he may reiterate threats similar to those described in the secrecy phase, or he may use physical force, all in an attempt to undermine the child's credibility and, thereby, the allegation of sexual abuse. The results, he hopes, will be that the child will withdraw the complaint or at least stop cooperating with those who are trying to help.

Effects. James Ramey, a sociologist who defends the pro-incest school of thought, equates the existing incest taboo with the public's abhorence of masturbation 100

years ago (1979). He feels that children involved in sexual relations within the family are often happy, well-adjusted individuals and furthermore, "that whatever damage occurs as a result of incest is mainly attributable to social intervention..." (Herman, p. 23). Proponents of this view contend that the evidence for trauma is meager and based on inadequate samples and unwarranted inferences (Constantine, 1977; Henderson, 1983; Ramey, 1979). Evidence, however, is accumulating and it is bearing out that sexual abuse is a serious mental health problem. In a recent review of the research regarding the impact of child sexual abuse, Browne and Finklehor (1986) concluded that even though the existing body of literature is insufficient to draw clear-cut conclusions, the implication of these studies is that a history of childhood sexual abuse is associated with greater risk for mental health and adjustment problems in adulthood. Female survivors confirm that the abusive experience has left them neither happy nor well-adjusted as Ramey would have us believe. According to Herman (1981) who cites a study by Judson Landis conducted in 1956, most victims remember the childhood sexual encounters as unpleasant.

Of the women studied, 76% reported that they were frightened, shocked, or emotionally upset by the incidents. Only 2.1% said that they found the experience "interesting." In John Gagnon's view of the Kinsey data (Herman,1981), 84% of the women reported negative reactions to sexual contacts with adult men, 13% had "mixed reactions", and only 3% felt positive about the episodes. The most common reaction was simple fright but responses ranged from that to vomiting and hysteria. Herman (1981) summarizes the conclusions of several studies of long-term outcome for these adult victims. She found that it is common for these adults to have a history of divorce, institutionalization, or prostitution, to show impairment in "sexual self-esteem", to encounter sexual difficulties in adult life, and to have a tendency toward repeated victimization.

There is an extraordinary amount of variability in the literature regarding the effects of the sexual experience on young children; in fact, Mrazek and Mrazek (1981) list over 60 effects reported by various authors. Although some studies have concluded that the effects can be positive (e.g. Perhaps it is the only form of affection

a child receives in an otherwise deprived environment) or mixed, the great majority have argued that they are harmful.

Lusk and Waterman (1986) have compiled a fairly comprehensive summary of the effects of sexual abuse on preschool children, but it would seem that these sequelae could be applied to latency-aged and adolescent subjects as well. The authors have proposed that the effects can be divided into several different sub-categories, the first of which is affective reactions. One affective reaction is guilt. Children may feel especially guilty if they enjoyed some aspect of the sexual activity or if they feel that their disclosure resulted in the breakup of their family. As children get older and begin to gain a clearer understanding of cultural norms and taboos, their guilt often intensifies (Rosenfeld et al., 1979).

Anxiety is another affective reaction and it is often the major presenting problem in children (Adams-Tucker, 1981; Brant & Tisza, 1977; DeFrancis, 1970; Tufts New England Medical Center, 1984; Westermeyer, 1978). It can be manifested in relations with the opposite sex, via somatic and behavioral symptoms, through phobias and

nightmares, and in anxiety over separation. Appendix A contains a comprehensive list of physical and behavioral symptoms gleaned from the literature.

The last three affective reactions listed by Lusk and Waterman are: extreme levels of fear, which may arise during the abuse and/or later in life, depression, and anger, commonly directed toward both parents.

The second sub-category is physical effects which, Stern and Meyer (1980) assert, are reported much less often than affective correlates of sexual abuse. The most common of these are probably somatic complaints, including psychosomatic problems (Adams-Tucker, 1982; Burgess & Holmstrom, 1975; Sgroi, 1982; Westermeyer, 1978). Others are pregnancy; actual physical injury such as bruises or bleeding in the genital area, problems walking or sitting, or sexually transmitted disease; and finally, changes in eating or sleeping patterns.

Cognitive and school-related problems are also often observed in children who have been sexually abused. Shaw and Meier (1983) and Johnston (1979) have noted that these children have difficulty concentrating on tasks, they often have short attention spans, and Jiles (1981) writes that

they feel powerless and perceive a lack of control in many situations.

A fourth category of effects proposed by Lusk and Waterman (1986) is behavioral symptoms and "acting out." They submit that symptoms can be grouped according to whether they involve a form of a) acting out, b) withdrawal, or c) repetition of the abusive experience. Behaviors involving acting out include: hostile-aggressive behavior, antisocial behavior, delinquency, stealing, tantrums, and substance abuse. Some sexually abused children, however, have been observed to exhibit behaviors which indicate withdrawal into fantasy, staying inside and refusing to leave, or regressive behavior. Finally, a number of authors have found that many victims repeat the abusive experience in some way later in life (Blumberg, 1981; Brooks, 1982; Green, 1982; Rosenfeld et al., 1977). They may engage in further sexual relationships with adults while they are still young or they may go on to have abusive relationships with their partners or children in adulthood. Clinicians are now finding that adolescent and even latency-aged victims often try to master their own trauma by victimizing younger children (Lusk & Waterman, 1986).

Self-destructive behaviors are another common sequelae of sexual abuse. "The self-hate many of these victims feel is translated into self-punishment..." (Summit, 1983, p. 179). Self-mutilation has been observed in many victims, and in extreme forms, this inward anger has led to suicidal thoughts and attempts, both successful and unsuccessful, in children and in adults.

Child sexual abuse has also been associated with a range of psychopathology (e.g. neurosis, character disorders, and other psychotic features) and several studies have suggested that many victims are psychologically disturbed both in the long and short term (Adams-Tucker, 1982; Briere & Runtz, 1987; DeFrancis, 1970; Tufts, 1984). There is simply not enough evidence to date to permit firm conclusions to be drawn about the relationship between psychopathology and child sexual abuse; however, Lusk and Waterman estimate that between 20% and 50% of victims experience some degree of psychological disturbance (1986).

Another category of effects are those related to sexuality. Many authors believe that sexual abuse leads to sexualized behaviors in children (Kempe & Kempe, 1984; Sgroi, 1982; Tufts, 1984). This is one of the most

consistent findings reported in the literature for children of all ages. As well, molested children often become preoccupied with sexual matters and exhibit atypical knowledge of sexual acts, and they may display concerns about their sexual orientation (Jiles, 1981). As adolescents and adults, victims may become "promiscuous"; many writers feel that child sexual abuse can lead to prostitution (Blumberg, 1978; Herman, 1981; Kempe & Kempe, 1984). Sexual dysfunction, sexual inhibition, and orgasmic dysfunction are common in adult victims of childhood abuse (Blumberg, 1978; Rosenfeld, et al., 1977; Sgroi, 1982; Westermeyer, 1978).

Lusk and Waterman (1986) list three other types of effects which the abusive experience bestows upon its victims. The first type results from the intervention of the court and social service systems. When a child is placed in a foster home, a father goes to jail, or a young victim is subjected to a host of interviews and court appearances, more stress, resentment, and tension are added to the situation. Gibbens and Prince (1983) studied the effects of the court process on sexually molested child witnesses in England and found that these children were

"significantly negatively affected" compared with a control group. Some feel that the effects of agency and legal intervention are more damaging than the abuse itself (James, 1975; Ramey, 1979).

The other two types of sequelae are low self-esteem and problems with interpersonal relationships. Several authors believe that sexual abuse results in a negative self-concept and low self-esteem (Herman, 1981; Sgroi, 1982). An empirical study conducted at Tufts New England Medical Center, however, found no difference in self-esteem betweem sexually abused 4- to 6-year-olds and their non-abused peers (1984). Thus, the relationship between abuse and self-esteem, at least for young children, has yet to be empirically established. Problems in interpersonal relationships have been noted both for short-term relationships with peers and longer-term heterosexual liaisons. It has been suggested that these difficulties stem from a lack of social skills, a lack of trust which arises from the betrayal inherent in abusive situations and/or because of poor attachment to the mother. Other contributing factors may be the feelings of differentness and distance from others, a tendency towards "oppositionality" and a low amount of self-disclosure.

Some suggest that childhood sexual abuse has different degrees of impact on different individuals due, in part, to certain mediating conditions. In brief, they may include: the emotional climate of the family prior to the abuse (DeFrancis, 1970; Elmslie & Rosenfeld, 1983; Steele & Alexander, 1981), the child's mental and emotional health prior to the abuse (Adams-Tucker, 1981), the degree of closeness between the offender and the child (Adams-Tucker, 1982; Landis, 1956; Mrazek, 1980; Steele & Alexander, 1981), the age or relative maturity of the child (Adams-Tucker, 1982; Dixen & Jenkins, 1981), the type of sexual contact (Adams-Tucker, 1982; Mrazek, 1980), the use of force or coercion (Schecter & Roberge, 1976), the amount of guilt the child experiences around the abuse (MacFarlane & Korbin, 1983; Schecter & Roberge, 1976; Summit & Kryso, 1978), the sex of the victim (Adams-Tucker, 1982), and parental response to the child's victimization (Constantine, 1979; Summit & Kryso, 1978).

It should be noted that Finklehor and Browne (1985) feel that since there is little empirical substantiation regarding the impact of the above mediators, assumptions should not be made about their contributions to the child's

trauma. Instead, they propose a four-part model consisting of four trauma-causing factors: 1) traumatic sexualization, 2) betrayal, 3) powerlessness, and 4) stigmatization. Assessing each victim in terms of the four kinds of trauma, they feel, is a better alternative at this point for assessing impact of the abuse on the child than, for example, speculating that the closeness of the relationship to the offender or the fact that penetration occurred will significantly increase the damage. In their study, Finklehor and Browne explain how their model can be adapted for such use.

Child Sexual Abuse: Treatment

Introduction. In beginning this practicum, it quickly became apparent that the body of literature concerning the treatment of victims of child sexual abuse, particularly preschool or latency-aged victims, is sparse. Of the existing knowledge, most is based on clinical anecdotes and case studies rather than carefully conducted empirical investigations. Actual treatment protocols or

detailed therapy plans for young sexually abused children are still in the developing stages.

Phases of treatment. Treatment of child sexual abuse can be divided into three main phases: 1) crisis intervention, 2) short-term therapy (six to twelve months), and 3) long-term therapy (up to two years or more).

The crisis intervention phase includes investigation and validation of the allegations, child protection, alleviation of immediate sexual and emotional trauma, and instituting precautions for the prevention of further sexual abuse (Kempe & Kempe, 1984; Sgroi, 1982). Social worker, Melanie Grace, proposed and initiated in her Master's Practicum (1984) a crisis intervention plan for victims of sexual abuse and their families which is being continued to date by staff at the Child Protection Center in Winnipeg. Her program was the first of its kind to be effected in Manitoba and so far, it has proved very successful.

Depending on the individuals involved and the specific circumstances of each situation, Grace's crisis intervention technique can include from two to ten or

more meetings with the victim and family. In these meetings, the therapist deals with immediate concerns precipitated by the disclosure. Victims and families often require "total life support," a mixture of concrete environmental services and intensive day-to-day support and guidance. In brief, this service can include assisting victim and family to cope with investigative interviews, medical examinations, involvement with child protection services and law enforcement personnel, attorneys and the judicial system, as well as publicity following disclosure. If separation of family members has occurred, the therapist must also deal with matters such as food, clothing, money, shelter and transportation.

Grace lists a number of other treatment goals which crisis intervention may also encompass:

1) To assist the victims' parents to believe and support the victim, to reassure her that she is not to blame, and to protect the victim from further abuse.
2) To help the victim express feelings about the abuse.
3) To provide the victim and her family with factual information regarding sexual abuse.

4) To help the parents understand the victims' reactions to the abuse (e.g. precocious sexual or acting out behavior) and develop ways of handling these.

5) To provide the child and family with factual information on prevention.

6) To assure the victim and her family that they are not alone.

Although these goals were not specified, Grace also:

7) Aided parents in expressing their feelings around the abuse.

8) Assured the victim and family (after a medical examination validated this) that the victim was not physically damaged.

9) Assisted parents in responding appropriately to their child when she talked or asked questions about the abuse.

10) Referred victims and their families for further treatment.

Short-term therapy follows crisis intervention and for some victims it will suffice, providing they have not been subjected to severe physical and emotional trauma and

that they receive much support from significant others (Lusk & Waterman, 1986). "In general, the greater degree of support for the child in his or her family circle or community, the more likelihood that short-term therapy will be able to resolve the treatment issues" (Porter, Blick, & Sgroi, 1982, p. 141). These authors also feel that the other key factor is the perpetrator's relationship to the victim. If he does not reside with the victim and if parents are supportive, short-term therapy may be all that is indicated. Children who have been severely physically and emotionally traumatized and who receive little support from significant others will probably require long-term therapeutic intervention. Other children likely to need long-term treatment include: children in foster home placment; children of punitive, resistant or uncooperative parents; children of parents who deny the abuse occurred; children still residing with the perpetrator; children involved in custody/visitation disputes; children of parents who themselves feel deeply injured, insecure, and in need of parenting; and those children who need to experience bonding or re-bonding with their mothers (Long, 1986).

Treatment modalities. The primary concern in treating any victim of sexual assault is "to reduce or prevent any negative effects of the abnormal and coercive experience" (Berliner & Ernst, 1982, p. 109). There exists a range of approaches to addressing the many possible types of reactions that are seen in child victims. Most authorities favor a combination of interventive techniques for each family involved, depending on the circumstances surrounding the sexual assault (Berliner & Ernst, 1982; Giaretto, 1976; Mrazek, 1981; Sgroi, 1982; Sturkie, 1983; Waterman, 1986).

Individual therapy with the victim should begin in the crisis intervention phase and continue until the child is strong enough to be sustained by another treatment modality (Porter, Blick, & Sgroi, 1982). Some children may need to learn to trust a single therapist and to begin to express feelings on an individual basis before they can progress to a group setting. Individual therapy allows these victims a safe time and place to "put the pieces together" and to begin rebuilding their self-esteem. For some children, the emotional trauma is too great to participate in a group and they may become confused and

disoriented by the intimacy of sharing such emotionally packed issues with peers. These children will require long-term individual therapy or, in rare cases, even more intensive treatment such as brief psychiatric hospitalization, day treatment, residential treatment or medication.

Group therapy is the preferred eventual treatment for most victims (Berliner & Ernst, 1982; Mrazek, 1981; Porter, Blick, & Sgroi, 1982). From a developmental point of view, the process of carving out a personal identity occurs through interaction with others. At about school age, peer relationships begin to become important, increasingly so as a child approaches adolescence. Making friends and a sense of belonging and acceptance are a necessary part of developing a positive sense of oneself. When children are rejecting towards another child, it can, according to Berliner and Ernst, contribute to lifelong problems with self-esteem which in turn can lead to ostracization of that child (1982). To not be a part of a peer group is a major loss in the developmental process. A sexually abusive experience automatically makes these children feel different and one of their greatest fears is

that others will discover the "secret" and stop liking them (Berliner & Ernst, 1982). It acts as a barrier to forming relationships, often well into adulthood. Even if child victims are accepted by their peer group, they often suspect it would not be the case if their experiences were revealed.

Group treatment of these children provides a peer forum of others who have undergone similar experiences; therefore, acceptance within the group is virtually guaranteed. The therapist has a better opportunity in this setting to correct distorted thinking by providing accurate information, clarifying misunderstandings and promoting expression of feelings and fears. Other group members cannot only provide support, but provide feedback and model appropriate social skills. Simply meeting other victims of sexual abuse makes the experience much less alienating for a child.

An ongoing unstructured easy-entry group model seems to work best for adolescents (Berliner& Ernst, 1982; Porter, Blick, & Sgroi, 1982). Newer participants can learn from role modeling of older members and the group can become a primary support system and forum for

discussing problems and concerns common to most adolescents. Berliner and Ernst report that group therapy tends to last from 12 to 18 months (1982).

A time-limited group model with more structure seems to make more sense with pre-teenagers for developmental reasons. Relationships outside the family are not as significant for this age group and also, lack of structure may be a bit more difficult to tolerate. Younger children tend to become unruly and disorganized very quickly in group situations so a number of possible activities should be planned for each session, ensuring that group attentiveness and cohesion is maintained and that the group does not focus around something that is negative or destructive. These children need more play and physical activity in a group, whereas with older children, discussion can be the primary means of communication.

Group approaches have been used by many programs offering services to sexually abused children. Ongoing support and education groups for adolescent female victims has been the most widely reported group approach with children (Berliner & Ernst, 1982; Blick & Porter, 1982; Giaretto, 1976; Sturkie, 1983). These groups are often

for victims of incest which occurred over an extended period of time, frequently as a part of a family reunification program's approach. More recently, clinicians have begun to write about their group experiences with younger children. Mrazek conducted a group in 1981 with seven sexually abused girls who ranged in age from 4 to 7 years using a modified version of Frank's activity group therapy (1976). In 1982, Berliner and Ernst developed a format for group work with preadolescent victims of sexual abuse, and in 1986, Damon and Waterman published their "Parallel group treatment of children and their mothers," devoted specifically to the treatment of pre-school victims.

It should be noted that there is some disagreement about the chronological order of individual versus group treatment for child victims. Porter, Blick, and Sgroi (1982), for example, feel that individual therapy should precede group treatment, whereas, McDonnough and Love (1987) see group treatment as preparatory for individual treatment. Still others recommend that the two can happen concurrently (Berliner & Stevens, 1982). Mrazek (1981) suggests that group therapy can serve as a

diagnostic tool. When a child's behavior is significantly different from that of other victimized children or when a child has difficulty joining in group activities or is out of control in peer settings, more intensive, individual therapy may be warranted. Practically speaking, however, treatment resources tend to be so limited that individual therapy or groups are not always available for children when they are needed. Therefore, children often receive the type of treatment available at the time rather than that which would seem ideal for the child's particular circumstances.

For the younger child, arts therapy is always a useful approach. Often young children have not reached a level of cognitive competence where they can attempt to resolve their problems verbally. Arts therapy or play therapy can provide these children with alternative forms of expression. For example, a child can use puppets to play out his or her anger at parents and in the process, learn appropriate ways of expressing that anger. Drawing is another medium which may be used in arts therapy (e.g. to promote body awareness or "talk" about specifics of the abuse). This treatment modality can be used in

individual therapy or in a group setting, primarily with younger nonverbal children but also with an older child who is depressed and withdrawn or hostile.

In cases of father-daughter incest, it is important to have some sessions with the mother and daughter together to discuss their relationship (mother-daughter dyad therapy). Porter, Blick, and Sgroi (1982) suggest that this type of therapy follow individual treatment but occur simultaneously with group therapy. Issues for discussion and resolution include: understanding the breakdown in communication between mother and daughter and working to restore it; understanding why the mother did not or could not protect her daughter from the abuse; correction of a role-reversal relationship; expression of hurt, anger, and jealousy; establishing where blame for the abuse lies; and planning for future protection of the daughter. These sessions tend to be very difficult and painful for both parent and child so mothers should also be attending a concurrent support group during this phase of treatment.

Family therapy should be preceded by individual therapy and, in some cases, group therapy for everyone

involved. In fact, Henry Giaretto in his treatment program in Santa Clara, California recommends the following order of treatment for incest cases: 1) individual counselling for mother, father, and child, 2) mother-daughter counselling, 3) marital therapy, 4) father-daughter counselling, 5) family counselling, and finally 6) group therapy for some or all family members.

Family therapy can only succeed if parents truly take responsibility for the sexual abuse of the child. In cases of intrafamilial abuse, the perpetrator must assure the child that it will not reoccur and that he alone was to blame, while the non-offending parent must assume responsibility for not adequately protecting the child. Siblings and any other involved family members should be included to discuss: the emotional pain associated with the abuse, the role reversal, age-appropriate behavior for children, blurred boundaries, poor communication patterns, good parenting skills and the expansion of social and support systems for all family members. Although family therapy is generally talked about in relation to intrafamilial sexual abuse, many of these issues are relevant to families where a child has been sexually abused by a third party.

Impact issues and implications for treatment.

Whether victims are treated on an individual or group basis, or both, therapists must have an understanding of the significant impact issues for the victim. Treatment goals should be a reflection of these impact issues. Porter, Blick and Sgroi in the Handbook of Clinical Intervention in Child Sexual Abuse (1982) have compiled one of the most comprehensive summaries of ten impact issues and corresponding implications for treatment that can be found in the literature to date.

The first issue they mention is the "Damaged goods" syndrome. The child's sense of damage may stem from actual injury or fear that such injury has occurred. Older children may also have concerns about being able to have children, whether those children will be normal, or whether their future partners will be able to determine that they have had sexual relations. The community's response to the abuse can also contribute to the victim's perception of damage. The sexually experienced child is sometimes viewed with intense curiosity, pity, disgust, and/or hostility and may be looked on as an easy target for other abusers.

Treatment of the "damaged goods" syndrome should begin with a physical examination and treatment of any injury. If no physical injury has actually occurred, this fact should be emphatically conveyed to the child and her family. The therapist can then go on to convince the involved parties that the victim is not otherwise damaged by the abuse; distorted perceptions of the sexually experienced child should be refuted directly. Parents, siblings, teachers and others should be made aware of the importance of treating the victim as a child of appropriate age and experience.

The second impact issue is guilt. According to Porter, Blick, and Sgroi, sexually victimized children tend to experience guilt on three levels:

1) Responsibility for the sexual behavior. Society tends to blame victims of sexual abuse of any age (Burgess & Holmstrom, 1974) and, unfortunately, many child victims feel the abuse was somehow their fault. As the child begins to perceive society's response to his/her sexual experience, the sense of responsibility for the abuse is reinforced and feelings of guilt intensify.

2) Responsibility for disclosure. Children may either purposely or accidently disclose the abuse to a friend, neighbor, or teacher. Not only do they tend to assume responsibility for disclosing the "secret" but for betraying a trust relationship with the perpetrator. They may even assume responsibility if someone else discovers what is happening, perhaps thinking that they should have been more careful about the time or the place of the encounter. The guilt response is intensified if the perpetrator ascribes responsibility for the disclosure to the child and conveys hostility or reproach at the same time.
3) Responsibility for disruption. Disclosure can result in profound disruption for the victim, the victim's family, significant others, and the perpetrator, particularly if the abuse is intrafamilial. A child rarely anticipates the degree of disruption and will often assume responsibility for it. Likewise, a victim's family and others affected by the disruption may perceive him or her as responsible for any pain or

inconvenience they may suffer. Again, the result is that guilt is intensified.

In treatment, therapists must basically reiterate time and again that blame for the sexual activity, the disclosure, and the disruption lies solely with the perpetrator. The child must be helped to identify his or her guilt feelings and to deal with them. Occasionally, victims come to occupy a position of favor with the abuser and they learn to use this position to their advantage, sometimes to the detriment of others. In these cases, guilt may be appropriate and rather than attempt to absolve the child of it, the therapist must assist him or her to expiate legitimate guilt and redirect future behavior.

Fear is the third impact issue. Child victims of sexual abuse may experience fear on a variety of levels and to varying degrees. They may fear physical damage and future disability in interpersonal or sexual relationships. Anticipation of subsequent episodes of sexual abuse both before and after disclosure as well as reprisals from the offender are other sources of fear for the victim of child sexual abuse. Still another is fear

of separation from home, family, and sometimes even the abuser. These fears may be expressed on a conscious level or they may manifest themselves in sleep disturbance, particularly nightmares. Regressive behaviors such as thumb-sucking, bedwetting, and eating problems can also be fear responses (Long, 1986).

The therapist's responsibility in treating this issue lies in assisting the child in identifying her fears, expressing them, and ventilating her feelings surrounding these fears. The child's environment should be made as safe as possible, building in new trust relationships and reinforcing existing ones.

The next impact issue is depression, a symptom exhibited to some degree by almost all child victims of sexual abuse following disclosure and sometimes prior to disclosure as well. Signs of depression may be overt (e.g. sadness, withdrawal, sullenness) or masked (e.g. fatigue or physical illness). Self-mutilation or suicide attempts sometimes signal their despair.

Therapists must anticipate depression in sexually abused clients and encourage them to vent their feelings. It is also important that victims are reassured that they

are believed and that they are given much support. More severely disturbed victims may require medical referrals. Depression may also be treated by working on low self-esteem and poor social skills, the next impact issue for sexually abused victims.

Society tends to reward winners and to hold losers and victims in contempt. This, coupled with the "damaged goods" syndrome, fear, and guilt contributes to the low levels of self-esteem so commonly observed in sexually abused children (Berliner & Stevens, 1982; Blick & Porter, 1982; Burgess & Holmstrom, 1978; Kempe & Kempe, 1984; Long, 1986; Mrazek, 1981; Porter, Blick, & Sgroi, 1982). Since victims frequently come from families where outside relationships are discouraged, these children often have limited social skills and are unsuccessful in cultivating friendships among agemates and initiating other social relationships (Butler, 1980; Herman, 1981). This commonly results in further decline of self-confidence. "Victims often feel helpless and are rarely assertive on their own behalf. They also feel unworthy and undeserving of anything" (Porter, Blick, & Sgroi, 1982, p. 119). It is not unusual for the negative perception to extend to

visual images of themselves; for example, a slim, attractive girl may describe herself as "fat and ugly".

Therapists must anticipate the acting out behavior characteristic of children with low self-esteem. In this way, these children attempt to test out others' perceptions of them to substantiate their own negative self-perception. Porter, Blick, and Sgroi recommend individual counselling initially to help children identify and express negative feelings about themselves, and then group therapy (1982). Victims can derive intense support from a group experience and learn from the honest feedback of other group members as well as therapists.

These first five impact issues are likely to affect all children who have been sexually victimized, whether it be by a family member or a third party. The next five issues may also affect children in each category but are probably most commonly found in children who are victims of intrafamilial abuse (Porter, Blick, & Sgroi, 1982). As has been previously discussed, the line between intrafamilial and extrafamilial abuse is not always clearly distinguishable.

Repressed anger and hostility is the next impact issue. Although sexually abused children may appear outwardly passive and compliant, they are usually harboring anger about a great many things: at the perpetrator, at family for not protecting them, and possibly even at friends, neighbors, teachers, peers, or others depending on their reactions to the child's disclosure.

In treatment, victims must be helped to recognize repressed anger and express it in a healthy and non-destructive manner. Some assertiveness training may have to accompany or precede this. Group therapy is recommended to provide opportunities for victims to learn to express anger in a safe setting and to assist them in finding more appropriate ways to do so.

Victims of sexual abuse, especially those who have been abused by a known and trusted individual, may logically react by developing an inability to form trusting relationships, the seventh of the ten impact issues. The degree of impairment is dependent upon a variety of factors: the relationship of the perpetrator to the child, the degree of pain or discomfort (or

pleasure and satisfaction) experienced by the child, the amount of disruption following disclosure, and so on. Inability to trust can also be a consequence of broken promises by the abuser and/or significant others. For example, the abuser may promise to stop if the child asks him to do so, but when she does ask, he ignores the request. Family members who have pledged support and protection may respond with disbelief and withdrawal of support.

To once again develop the ability to trust, the victim must experience improved self-esteem and more satisfying interpersonal relationships. Porter, Blick, and Sgroi (1982) again feel that a combination of individual and group therapy can best accomplish these objectives.

Most authors in the field of child sexual abuse give mention to the next impact issue, the phenomenon of blurred role boundaries and role confusion, observed particularly in cases of intrafamilial sexual abuse. Mother-daughter roles may become blurred when a daughter assumes responsibility for cooking, cleaning, and childcare in her mother's absence. The child's role

confusion may then become shared by other family members. These factors in combination with the increased opportunity for sexual contact increases the likelihood that sexual abuse will occur. "For an adult who occupies a power position to turn to a relatively powerless child for a sexual relationship implies a profound disregard for the usual societal role boundaries" (Porter, Blick, & Sgroi, 1982, p. 123).

The therapist's task is to assist the child in resolving this role confusion, and it is extremely important that an adult family member validate the therapist's assertions regarding appropriate role boundaries. Treatment should include role-playing and role-modelling appropriate behavior to reduce role confusion.

The next impact issue is pseudomaturity and failure to complete developmental tasks. The extensive stimulation and preoccupation with the sexual relationship tend to interfere with normal developmental tasks of childhood and adolescence. Also, the role confusion discussed above may lead to premature assumption of an adult-like role. This can isolate the child from peers

and as the gap widens, the sexually abused child can become permanently isolated from agemates. She is then left with no appropriate social outlets and is therefore more alone and vulnerable than ever.

Pseudomature victims must be allowed to relinquish adult responsibilities and assume a more child-like role in the family, leaving them more open to accomplish developmental tasks previously left undone. Porter, Blick, and Sgroi (1982) emphasize that if the child's home situation does not permit her to relinquish the inappropriate role, this issue cannot be treated. A group modality is the treatment format of choice so that the child can be exposed to appropriate child-like behavior and so that the child can learn to engage in such behaviors.

The final impact issue identified by Porter, Blick and Sgroi (1982) is self-mastery and control. Basically, sexual abuse involves the violation of a child's body, privacy, and rights of self-mastery and control. All other issues have self-mastery and control components so that this violation has profound and long-lasting effects.

A therapist must assure a child that she is indeed entitled to certain rights, such as that of privacy, and

should be allowed to make choices and to have some control over what happens to her. "Self-mastery and control imply accountability, behaving responsibly toward oneself and others, development of independence from one's family and background, and freedom to make one's own choices" (Porter, Blick, & Sgroi, 1982, p. 125). If there is not family cooperation, it is virtually impossible for a victim to accomplish these goals while still living at home. Treatment should include role-modelling, role-playing, peer group support, and positive peer pressure. Victims must be allowed to make choices and decisions and to learn from the consequences of these and from the feedback of a support group.

Long (1986) has delineated five additional treatment issues especially important in working with younger children. One of these is teaming with the child's mother. The therapist enlists the mother's help in treatment of the child and attempts to teach the mother how to deal with and support the child. As well, the mother herself is probably in crisis after the disclosure and in need of nurturance and support. After working separately with mother and child, the goal of the

therapist becomes to build or rebuild the bond between the mother and her daughter.

A second issue that Long identifies is inappropriate attachment behavior. Most of these children tend to be so emotionally impoverished that intense attachments rapidly form to the therapist. Feelings of countertransferance may develop on the part of the therapist but it is important to set limits for the child while being appropriately nurturing. Clear boundaries for the child must be set. The intense attachment gradually tapers off as the child begins to feel more secure and to need the therapist less.

Infant regressive behavior is frequently observed in sexually abused young children in treatment settings. The child needs to regress and complete her unfinished developmental tasks. An approach that addresses this need is theraplay, components of which include intruding (when appropriate), nurturing, structuring and challenging the child (Jernberg, 1979). Gradually, the mother is assisted to engage in these types of activity with the child; these are the kinds of bonding activities which did not take place for the child in her early months or years.

Another issue that Long mentions is the need for body contact and body awareness. In incestuous families, young children often have little sense of body space, where to touch and where not to touch, or how to hug and show affection. They need to be taught about appropriate body contact and how to perceive their bodies in a wholesome and positive light. It is also necessary to give the child accurate information on sex and reproduction, involving the parents if possible, and to educate the abused child regarding ways in which they can avoid being revictimized.

The need for education about feelings is the last issue Long raises. Mothers of victims often do not have the personal resources to help their children express their feelings about the abuse, thereby beginning to sort out the confusion. The therapist's aim here would be to help mother and child to identify feelings, to talk about them, to experience acceptance for having them, to learn self-acceptance, and to see that there are choices in the ways they are expressed. Several games and activities can help in accomplishing these goals.

Intervention. Porter, Blick, and Sgroi (1982) feel that the key issue in treatment is not simply working

through feelings regarding the sexual violation but the strengthening of the child's ego to help improve her self-image, learn to trust others and begin to feel secure. To begin this process, the victim needs permission to accept the feelings of anger and hurt typically associated with sexual abuse so that these feelings may be expressed without experiencing further guilt. They go on to say that each child must vent: a) feelings of guilt and shame around the sexual trauma, b) positive and negative feelings toward the perpetrator, c) positive and negative feelings toward the non-offending parent(s), d) feelings about the reaction of siblings, and e) feelings about the reaction of peers and people in the community. Once these feelings can be shared, the children can begin to focus on the effects of the criminal justice system on their lives, parent-child relationships and intrafamilial roles, communication patterns within their families, and, depending on age and level of maturity, boy/girl relationships, sex education and birth control.

Berliner and Ernst stress that the focus should be on the issues that are most relevant to the individual (1982).

They suggest that these basic themes should be covered in age-appropriate ways: a) acknowledgement of the assault experience (e.g. "I am here because I was molested."), b) understanding of the responsibility of the abuse (e.g. "It's not my fault."), c) recognition and labelling of feelings about being sexually abused (e.g. "I was afraid," or "I still love him."), d) sense of affinity with other victims (e.g. "I am not the only one."), and e) what they have learned which might protect them in the future (e.g. "I would run away."). They agree that ego-enhancing activities and positive interaction with other victims are major parts of any victim's treatment. Important areas to emphasize here are healthy body image, positive psychological sense of self, skill-building, sharing and giving.

According to Mrazek (1981), overall group goals should include providing a safe setting in which victims can talk and play through their feelings, providing male and female adult role models different than they have experienced in their home environment (e.g. caring without exploitation), providing an opportunity for the children to relate to peers who have had similar sexual experiences, and helping them to improve their social skills.

Summary. In 1981 when Patricia Beezley Mrazek wrote about the group she had conducted with seven latency-aged sexually abused girls, documentation of the usefulness of such groups was limited, and in 1988, it is still limited. In fact, empirical documentation of any part of the whole issue of the sexual exploitation of children is rare. Clinical studies, however, do provide some direction for treatment of these young victims: Porter, Blick, and Sgroi (1982) have detailed impact issues and their ensuing implications for treatment; Mrazek (1981) has determined overall group goals and has expounded on the experience of a group for individual group members; Berliner and Ernst (1982) have taken this one step further and outlined a short-term treatment strategy session by session; and Damon and Waterman (1986) have recently compiled a 13-module treatment package designed specifically for preschool children (and older) and their mothers. These authors' contributions are the primary sources on which the following practicum is based.

CHAPTER III

The Practicum

Purpose

The general purpose of this practicum was to provide short-term treatment to latency-aged female victims of child sexual abuse, to begin to develop a framework within which to conduct such treatment, and to attempt to examine, in an objective manner, the effect of this treatment on the children. On a personal level, I wanted to cultivate some skills in working with this population, to become more familiar with theoretical issues relating to treatment, and to expand my knowledge base in the area of sexual abuse in general. It was also my intention to make a contribution to the existing body of knowledge regarding the treatment of child victims of sexual abuse in hopes that other social service personnel may find it useful in their work with these children.

Objectives

Group treatment as opposed to individual short-term therapy seemed to be the mode in which our process objectives would be most effectively met. (The rationale for group treatment has been discussed in the section on "Treatment modalities.") Those objectives were:

1) To expose the children to other victims and make them aware that they were not the only ones who had been sexually abused.
2) To provide a safe setting in which the child could talk about the abuse, listen to others' experiences, and give and receive feedback.
3) To provide caring and supportive female adult role models.
4) To help the child develop appropriate social skills by interacting with peers and observing appropriate behavior.

The fact that group treatment was chosen as the mode, however, made formulation of outcome objectives more difficult. Considerations in setting outcome objectives

for the group were different than they would have been with individual outcomes, and the fact that these clients were children further complicated this process. The abuse experience, reaction to it, and resulting problems differ from individual to individual and each person responds in his or her own way to the generalized trauma. Therapy with children is made even more difficult because not only do they have individualized experiences and reactions, but they are also frequently unable or unwilling to verbalize their feelings, needs, and/or difficulties. It is not a matter of a client presenting the therapist with a problem for which he or she formulates an appropriate intervention. Clinical experience shows that even when there are not specific signs of emotional or behavioral disorder, sexual abuse still has its impact on the victim.

Throughout their discussion of ten impact issues common to most victims of sexual abuse, Porter, Blick, and Sgroi (1982) emphasize that the implications for therapy which these issues raise center to a great extent around bolstering the self-esteem of the client. Browne and Finklehor (1986) in a recent review of the research on the impact of child sexual abuse find some empirical support

for this theory. Therefore, the first outcome objective of the proposed intervention was: to attempt to raise the level of self-esteem of group members, defined as increasing the number of positive self-statements the child makes about herself in combination with a decrease in the number of negative self-statements as indicated by the selected standardized measure of self-esteem.

Since many children who are sexually abused are often re-victimized, it is important that children are made aware of their rights under such circumstances and taught how to react. Consequently, the second outcome objective was that each child be able to correctly describe how she should respond in a subsequent abusive situation or one that has potential to become so.

Method of Intervention

It should be noted that prior to the proposal of this practicum, another social worker and I conducted two short-term treatment groups for latency-aged victims as a kind of pilot project for the practicum. Some of the rationale for conducting the two successive treatment

groups reviewed on the following pages was gleaned from the experience of those initial pilot groups.

Participants

Blick and Porter (1982) recommend that in selecting group participants, certain common features between prospective members should be considered. Some of these are age, gender, developmental level, the type of sexually abusive experience, the family's reaction, and the victim's reaction. As well, group leaders need to assess, from meeting the child and from information accompanying each child's referral, the appropriateness of group treatment for the child at that point in time. Prospective group members need to be able to communicate with children of the same age. A child who is very resistant or in a phase of denial may need to wait for group treatment. A severely disturbed child would probably only disrupt the group and experience further rejection and alienation, rather than benefit from the treatment.

Clinicians are collectively undecided about whether or not victims of intrafamilial child sexual abuse should be treated together with victims of third party sexual abuse. The range of definitions which determines the parameters of each of the above categories (discussed earlier) adds further confusion to this dilemma. In a treatment group for adolescents conducted by Connecticut's Sexual Trauma Treatment Program, both victims of intrafamilial and third party sexual abuse were initially admitted. They found, however, that the third party victims participated to a much lesser degree than victims of intrafamilial abuse, so membership gradually come to include only incest victims (Blick & Porter, 1982).

In many cases, children who have been victimized by a third party know the perpetrator and have had a pre-existing relationship with this person who is often a family friend, relative, teacher, babysitter, or residence caretaker. Therefore, there are frequently common issues of betrayal of trust and ambivalence for all victims, regardless of the relationship of the offender. Berliner and Ernst feel that the major issue is not the type of relationship between the victim and the offender, but

whether or not the child will have a continuing relationship with the offender (1982). No authors seem to be adamant about groups being strictly homogeneous in terms of the relationship of the perpetrator to the child. What Berliner and Ernst (1982) do suggest, however, is a "mini-group session" for those children whose issues differ from those of the rest of the group.

As there was not a problem treating both victims of intra- and extrafamilial sexual abuse in the pilot groups, children who fit into either of the two categories were considered for admission to the two treatment groups discussed here. Subjects were twelve latency-aged females who had been abused by a male. This population was chosen for several reasons: a) Since most abusers are male and most victims female, a larger pool of subjects were available to draw upon, b) fewer services were available to latency-aged children than to older girls in Winnipeg at that time, and c) in both pilot groups, members expressed a desire to limit the groups to females.

Since the author was working with Northwest Child and Family Services of Winnipeg at the time of this study, a notice was sent to each of the five regional teams in this

agency, informing them of the plan to carry out a victim's group and asking for appropriate referrals. Eleven children were referred and accepted for group membership. A twelfth child was referred from the Child Protection Center at Children's Hospital in Winnipeg and accepted. An attempt was made to keep each of the two resulting groups as homogeneous as possible in terms of age, relationship of the perpetrator to the child, and type of abusive experience but that was not always possible. In one instance, two sisters, ages 8 and 10, had to attend together as their foster mother had no automobile and transportation could not be provided for each girl separately. Ideally, the 8-year-old would have fit in better with the younger children and the 10-year-old with the older children. In another case, a mother was unable to bring her 7-year-old on the evening that the younger group met due to her own ongoing therapy, so the child was allowed to attend the older group sessions. No problems were observed to arise from these placements. In fact, the older children were anxious to help the younger ones.

Tables 1 and 2 show the breakdown of each group in terms of demographic data. Complete information,

especially in regards to the type of abusive experience was not always available, primarily because many girls simply refused to supply these details to anyone, including parents, social workers, and police.

All of the subjects in this study were from low socioeconomic families; five girls were of Native Canadian extraction, four were Caucasion, two were Metis, and one was from a Philippine family. Five of the victims were living in foster homes at the beginning of treatment but one of those five was returned to her natural mother before termination of the groups. Another two (sisters) were moved from one foster home to a second foster home. Five other subjects were living with their natural mothers while the remaining two girls resided with their natural mothers and their non-offending partners.

Therapists

Although Mrazek (1981) feels that victims need to interact with a therapist of the sex of the abuser in a safe setting, there is another school of thought which asserts that the presence of a male therapist may inhibit

TABLE 1

Descriptive Data of the Children Attending the Monday Evening Group

CHILD	AGE	OFFENDER	DURATION	TYPE OF ABUSE
Charlotte	6	Two cousins (teenagers), Possibly more?	Years	Digital penetration, Fondling, Fellatio, Cunnilingus, Intercourse
Rosanne	7	Natural Father	Several instances	Fondling, Digital penetration
Diane	8	Maternal Grandfather, Possibly more?	?	Fondling, Genital contact
Melanie	9	Maternal Grandfather, Possibly more?	5 Months	Fondling, Digital penetration, Possible partial intercourse
Tracey	9	Uncle, Possibly Mother's Common-law	Years ?	Fondling, Forced fondling of offender, Fellatio, Probably more
Nina	9	12-year-old Brother	6-12 Months	Fondling, Digital penetration, Penile penetration

TABLE 2

Descriptive Data of the Children Attending the Wednesday Evening Group

CHILD	AGE	OFFENDER	DURATION	TYPE OF ABUSE
Crista	7	22-year-old Uncle	1-2 Years	Exposure to video pornography, Mutual masturbation, Fellatio, Cunnilingus, Interlabial and possibly vaginal and anal intercourse
Sara	8	Natural Father, Possibly Mother's Common-law	Several Years ?	Breast and genital fondling, Possible penile penetration
Lila	10	60-year-old Uncle, Probably more?	Several Years ?	Fondling, Chronic penetration (from physical evidence only-child denies)
Colleen	10	Mother's Common-law	Few Instances	Fondling of genital area
Lauren	12	30-year-old Neighbor	3 Instances	Fondling breasts under blouse

female subjects and impede their progress in a group. Blick and Porter (1982) felt that their female group members needed to work through their feelings about men in a non-threatening environment and that a male therapist may indeed be seen as a threat. They found that in their treatment group of adolescents, a new girl generally related in a withdrawn or seductive manner towards the agency's male clinician. Even though the pilot groups were conducted very successfully with a male and a female therapist, to ensure the comfort of the subjects, therapists for the groups in this practicum were exclusively female and, as the literature suggests, each group was conducted by two therapists.

All therapists were social workers with Northwest Child and Family Services in Winnipeg during the practicum and had generic group skills as well as a working knowledge of and comfort with the issue of sexual assault. Therapists were supervised by a child psychologist who specialized in treatment of child victims of sexual abuse.

Setting

Sessions were held in the observation nursery school unit of the Child Development Clinic at Children's Hospital in Winnipeg. The facility consisted of a kitchenette, a large open play area, and a smaller area where a round table and child-sized chairs were arranged. The play area was well stocked with dolls, a play kitchen, balls, blocks, a mini-trampoline, and a climb-and-slide set. Crayons, markers, pencils, paper, tape, paste, scrap books, and other materials for group table activities were provided by the therapists. A video player and monitor were also available as needed.

Procedure

Group sessions were held once per week for 90 minutes from 6:30 P.M. to 8:00 P.M. Mrazek (1981) suggests that latency-aged children can tolerate sessions of from 60 to 90 minutes at a time. The first pilot group to be conducted began with 60 minute sessions, but after three weeks it became apparent that this was not sufficient to

complete all weekly tasks. From that point on, all sessions were 90 minutes in duration.

Short-term treatment groups in the literature range from the six-week format of Berliner and Ernst (1982) to the six-month group conducted by Mrazek in 1981 and longer. Since Berliner and Ernst recommend time-limited treatment groups for pre-teenage children for developmental reasons, and because groups were based on the twelve lessons of the C.A.R.E. Kit, duration of group intervention was set at twelve weeks. This time frame was supported by the behavior of the children in the pilot groups. At about the ten-week mark, the girls seemed to get restless and more difficult to manage, suggesting that possibly they had had enough for the time being.

Suggestions for size of a group range from the maximum of thirteen adolescents accommodated by Sgroi (1982) to the three to seven children recommended by Berliner and Ernst (1982). Because each pilot group consisted of six children and seemed manageable, the successive two treatment groups each consisted of six girls.

Initial Interviews

Before the groups began, the therapists interviewed each prospective participant and her family in the family home. The purpose of the interview was to assess each child's suitability for the group to ensure that each group would be fairly homogeneous in terms of maturity and level of functioning. The interviews also served as a means of gathering basic information about the victim, her family, and the abuse incident. As well, therapists were able to discuss the group, its content, and the facilitative role that parents could play. Parents were provided with a general description of the C.A.R.E. Kit and some basic information regarding the sexual abuse of children. Interviews lasted from 30 minutes to almost three hours, depending on how much parents chose to say or the questions they asked. Some desperately wanted to talk so the therapists generally listened for as long as their time permitted.

Transportation

In the pilot groups, parents were required to bring their children to sessions and pick them up. Taxicabs were provided by Northwest Child and Family Services on the rare occasions when parents were unable to transport their children. In the following two groups, however, only six of the twelve families were able to provide regular transportation to and from sessions for a variety of reasons. One child's mother was blind and others had no automobiles. Still others lived quite a distance from the hospital so that escorting their daughters would have meant over an hour in a car or on a bus, resulting in a very late evening for the girls. This problem was resolved by using taxicabs on a regular basis to convey children back and forth to sessions.

Group Format

Each of the group sessions followed a basic format similar to those described by several authors (Berliner & Ernst, 1982; Damon & Waterman, 1986; Frank, 1976; Mrazek,

1981; Porter, Blick, & Sgroi, 1982). A session began with the girls sitting around a table, sharing, in turn, incidents of the preceding week. One of the activities of the first session was making "feeling cards," small pieces of colored construction paper on which each girl illustrated her perception of particular feelings and then labelled them. The children could make as many "feeling cards" as they wished and the set could be expanded upon each week as needed. At the beginning of each session, the group did a "feeling check" where each member, including therapists, produced one or more "feeling cards" and explained why the card was an appropriate label for the emotions she was experiencing that evening.

Next came the structured activity: a lesson from the C.A.R.E. Kit. Developed in British Columbia by the Child Abuse Research and Education (C.A.R.E.) Productions Association of B.C., the Kit was presented to the Surrey school system in 1982 and was favorably evaluated by parents, teachers, government, administrators, and, most importantly, children.

The C.A.R.E. program is organized around twelve key statements of messages, each illustrated by a Message

Card. (Facilitative Discussion Cards accompany each Message Card.) It consists of a three-part program, each of which is comprised of four Message Cards conveying a series of related messages:

Part I: Here, children learn that each person owns and is responsible for his or her own body and feelings. Message Cards for this section are:

1) Everyone has feelings.

2) Everyone has a body.

3) Some parts of your body are private.

4) Your body and your feelings belong to you.

Part II: In this section, the subject of sexual abuse is introduced through a discussion of touching. Children learn how sexual abuse happens, who the offender might be, how to recognize potentially dangerous situations and what to do to prevent sexual abuse. Message Cards for Part II are:

5) Different kinds of touching give you different feelings.

6) Some touching may confuse you and can be wrong.

7) Someone might try to talk you into touching that is wrong.

8) Someone might tell you to keep a secret about touching.

Part III: This part focuses on self-protection and reporting. Children are given the opportunity to practice assertive behavior and to identify adults to whom they can go for help. Part III Message Cards are:

9) Trust your feelings.

10) You can say "NO."

11) You can talk to someone about touching that is wrong.

12) There are people who can help you.

Although the C.A.R.E. Kit was originally developed as a preventive tool, it has been instrumental in eliciting countless disclosures. It also seems to be the best method for teaching already abused children how to protect themselves should they be revictimized.

After the C.A.R.E. theme was presented, the therapists introduced one or more crafts or play activities related to this theme. Often, the activity was one suggested by the C.A.R.E. card; but sometimes therapists introduced one of their own choosing. Puppet shows, drawing, games, skits, and reading stories are just

a few examples. (See Appendix B for a more complete account of weekly sessions.)

All sessions ended with a snack provided by the therapists.

Preparation

Therapists met 60 to 90 minutes prior to each group meeting to go over plans for the upcoming sessions. Initially, therapists had also planned to meet following each session as well but this proved to be impossible much of the time due primarily to problems with transportation. Taxis were often late and sometimes did not arrive at all to return the children to their homes. This task, then, frequently fell on the therapists.

Supervision

The therapists met weekly with Dr. Laura Mills, a child psychologist from the Child Development Clinic at Children's Hospital in Winnipeg who specialized in treatment of sexually abused children. Meetings were held at her office and lasted approximately 60 minutes. The

content of the meetings generally centered around problems with the children's behavior or discussing how therapists could better respond to issues and specific occurrences in the group. For example, Dr. Mills pointed out that a child who continually left the group and ran into the hall may have been threatened by the subject matter and trying to escape the discussion, rather than simply trying to get attention. Therefore, instead of taking an authoritarian approach, the therapist could more effectively have told the child that she realized that the content of the sessions could be frightening and that she understood and could try to help.

For several reasons, sessions were not audio- or videotaped. Initially, therapists attempted to audiotape discussions but the group frequently changed locations within the playroom and the recorder could not pick up sound from the entire facility. More importantly, the children seemed very uneasy about being taped and tended to "accidentally" shut off the machine, erase the tape, or move the recorder. After three weeks, attempts to audiotape the sessions were abandoned.

Parents' Session

Between the fourth and sixth sessions, therapists arranged a meeting with parents and other care providers of the children to discuss how the group was progressing and to offer help in managing the children at home. This session was held on an evening other than those scheduled for the children's groups, and parents of children from both groups were invited. Northwest Child and Family Service's conference room at their main office served as the setting for this gathering which was slated for 7:00-9:00 P.M. but which, in fact, lasted until 10:30 P.M. All in attendance received an information package which the therapists compiled specifically for the parents. The package contained articles on children's issues, parents' issues, and more general information on sexual abuse. One therapist gave a presentation based on Hart-Rossi's A Parent's Resource Booklet (1983) which is written to be used with the children's book It's My Body by Lory Freeman (1982). It is designed to assist parents in protecting their children from sexual abuse and emphasizes

three areas of importance: 1) sexual abuse prevention, 2) enhancement of the child's self-esteem, and 3) teaching a child about sexuality. The therapists felt that the parent activities in this handbook would also aid parents in supporting their already-abused child during this intervention. After this presentation, one of the other therapists detailed the structure of the children's groups as well as the themes for the twelve sessions and accompanying activities. The meeting was then opened for general discussion.

Methods of Evaluation

Outcome variables. The outcome variables include the previously stated objectives of treatment regarding a change in the number of positive self-statements each child emitted as well as the increased accumulation of knowledge of self-protection techniques in abusive situations.

There is a wide range of problematic behavior that can develop in child victims of sexual abuse not only as a

result of disclosure and the ensuing consequences, but also as a result of raising and discussing painful issues in therapy. For some children therapy may precipitate a reduction in inappropriate or problematic behavior; but for others, an increase in such behavior may accompany therapy. Therefore, an additional variable, inappropriate or undesirable behavior, was also measured. Since the therapists saw the children for only 90 minutes per week, it seemed more plausible that parents or care providers would more readily note changes in behavior at home. This third variable, then, was a measure of the change in parents' perceptions of their child's behavior at the beginning of the twelve week period and at its end.

Measures. The Self-Appraisal Inventory (Frith & Narikawa, 1972) was used to assess the self-concept of the group participants in this practicum. This scale is a paper-and-pencil, self-report measure consisting of a primary (K-3) level, an intermediate (4-6) level, and a secondary (7-12) level form made up of 36, 77, and 62 questions respectively. As well, it can yield subscale scores for four different dimensions of self-concept: 1) esteem that comes from family interaction, 2) esteem

associated with peer relationships, 3) esteem derived from performance in scholastic endeavors, and 4) a comprehensive estimate of self-esteem. Subscale scores are obtained by counting one point for each positive response to items representing respective subscales. A high score on all of the Self-Appraisal Inventory (SAI) subscales indicates a high level of emotional-affective adjustment. Children respond to questions in yes/no fashion, requiring the child to evaluate whether or not each statement describes him or her most of the time. The measure can be administered in 20 to 30 minutes if completed by the client independently and in less time if it is orally administered.

Overall test-retest reliability has been estimated at .73 for the primary level, .88 for the intermediate level, and .87 for the secondary level, whereas indices of internal consistency are estimated at .37, .87, and .75 respectively. The scale has face validity in that the items deal explicitly with how the child feels about himself/herself (e.g. "I am easy to like." or "I often feel ashamed of myself."). Obviously, more rigorous empirical investigation of this scale needs to be undertaken.

One of the major shortcomings of the SAI is that the items on the scale are not disguised, which may serve to prompt socially desirable responses. Despite this, however, this measure is one of the only instruments available to assess very young children's evaluations of themselves and which provides comparable forms for children at the primary, intermediate, and secondary grade levels. Since the subjects in this study were of such varied levels of functioning, it was necessary that the method of evaluation be able to accommodate all of them. The SAI seemed best able to do so.

In the first session and again in the last session, the SAI was administered to all group participants. Each child was given standardized instructions. Those children who were able to complete the questionnaire independently were asked to do so, while other children, either those in lower grades or those having poor reading and/or comprehension skills, required verbal administration. The examiner also defined any words that the children did not understand. (See Appendix C for copies of the two levels of the SAI used in this practicum.)

To measure the second variable, accumulation of self-protection skills, the Child Questionnaire included in the C.A.R.E. Kit was used. (See Appendix D.) This is a test of retention which covers the basic concepts put forth in the Kit's lessons. Scores are arrived at by simply tallying the number of correct responses. Because the questions on this measure sometimes required in-depth responses, a therapist took each child aside individually, read the questions, and recorded the child's responses. The Child Questionnaire was administered to each child during the first session of each group and once again during the last session.

In order to determine whether parents or other care providers perceived a change in their child's behavior after attending the group, the Revised Child Behavior Profile was administered during the initial interviews and again following termination of the groups. Unfortunately, this latter interview was conducted anywhere from one to six weeks after groups ended because parents missed appointments, could not be contacted for extended periods, moved, or, in one case, refused to answer any more questions. Parents who felt comfortable completing the

measure on their own did so; others responded orally to the items read aloud by the therapist who also recorded the responses. This was done in the family home and in the child's absence.

The Revised Child Behavior Profile (RCBP) was developed by Jon R. Conte (1984) from T.M. Achenbach's Child Behavior Checklist (1978) and was designed to measure the impact of child sexual abuse on the child. This scale was developed by administering the items from two previously established measures of child behavior to a group of children not known to have been sexually abused. The items which best discriminated between sexually abused children and those who had no such history were combined with items reflecting symptoms reported in the clinical literature, and together form the 110-item scale. The psychometric properties of the scale are currently being tested and further refinements are expected to be forthcoming.

The profile is divided into four parts: the first provides demographic information; the second part asks parents to identify the availability and quality of their support systems and how effectively they and their child

cope with stress; the third part asks parents to note significant events in the victim's recent past and to evaluate the stressfulness of each for the child; and finally, the last part consists of 110 items which refer to the victim's behavior. Parents are asked to evaluate that behavior on a continuum of frequency of occurrence in terms of whether the child engages in that behavior never, rarely, sometimes, often, or almost always.

The RCBP is too recently developed to have been properly evaluated; however, it is the only instrument of its kind available specifically for child victims of sexual abuse. (See Appendix E for a copy of the measure.)

Since some parents voiced objections to supplying the demographic information and others found parts two and three confusing and difficult to understand, only part four which deals specifically with parents' evaluations of their child's behavior was reliably completed. Since the focus of this practicum was not on social support systems or past stressful incidents, this was not seen as problematic.

The final method of evaluation was simply to ask the children and their parents for their opinions and

suggestions regarding the group. Children were asked to respond during the last group session, whereas parents were questioned in the follow-up interview.

Results and Discussion

Introduction

The results of the three measures administered show no common trends across treatment groups or across children; therefore it is difficult to attribute any of the measured changes directly to the intervention. It is more likely, in fact, that any changes which did occur in the children resulted from the interaction of many variables, including group attendance and personal circumstance. The following discussion is an attempt to associate those variables of which we were aware to the changes which were measured and observed in each child.

It should be noted that data were collected on all children in the Monday evening group; however, one child in the Wednesday evening group failed to attend five of the twelve sessions including the last three, so data are

only available for the remaining five children in that group. Accordingly, results from the administration of the Revised Child Behavior Profile are available for eleven parents or primary care providers.

The results of this practicum will be discussed on two levels: First, they will be analyzed across all participants and then they will be discussed in relation to individual subjects.

The Self-Appraisal Inventory (SAI)

The results of the SAI can be found in Table 3. In this table, scores have been recorded according to the level of the SAI used as well as by group. Four girls from the Monday group and two girls from the Wednesday group completed the K-3 level, while two girls from the Monday group and three girls from the Wednesday group completed the 4-6 level. Subscale scores were computed for the four dimensions of self-concept along with the composite score. The table lists scores for pre- and post-test administrations of the SAI expressed as percentages of the total number of items in each category,

TABLE 3

SAI Measures of Self-Concept Before and After Group Treatment

CHILD	PEER		FAMILY		SCHOOL		GENERAL		TOTAL		CHG.
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	
Monday Group											
K-3 Level:											
Charlotte	77	77	55	66	55	33	88	77	69	64	-5
Rosanne	77	77	77	88	66	44	77	44	75	64	-11
Diane	88	88	77	99	88	66	88	66	86	81	-5
Tracey	22	11	0	44	55	11	66	22	36	22	-14
4-6 Level:											
Nina	47	47	68	79	45	80	68	89	44	57	+13
Melanie	53	47	84	68	68	60	63	63	66	60	-6
Wednesday Group											
K-3 Level:											
Crista	88	88	88	99	66	88	77	99	81	94	+13
Lila	33	55	33	66	66	66	55	33	16	19	-6
4-6 Level:											
Sara	89	53	100	65	100	65	95	63	96	70	-26
Lauren	21	47	53	68	15	15	37	58	32	48	+16
Colleen	95	100	95	95	85	70	89	100	91	91	0

the higher the score, the more positive the measure of self-concept. Changes in scores are the differences between the pre- and post-test computations. A plus denotes an increase in self-esteem as measured by the scale, whereas a minus indicates a decrease.

Peer subscale. On the peer dimension measure, three children's scores decreased, three increased, and five remained the same. Changes ranged from -36% to +26%.

Therapists anticipated that for most of the children, these scores would increase since the group experience is said to decrease the feeling of differentness and to be the best forum in which to work on self-esteem (Berliner & Ernst, 1982). Since three of the children's scores actually did increase, this may have been true for those children. For the others, perhaps the treatment could not significantly impact on the girls' sense of self-worth because of the short-term nature of the intervention and the fact that they spent only 90 minutes of each week in sessions. Relationships formed within the group could hardly compete with those formed at school, at home, or in the neighborhood where each child spent much more of her time. In general, scores on the peer subscale of the girls

who completed the K-3 measure (the younger or less mature girls) tended to remain the same from pre-test to post-test. This is consistent with the widely held theoretical orientation which states that peer relationships are less important to the younger child; as children get older, the influence of the peer group intensifies.

Family subscale. On the family subscale of the SAI, differences in scores from pre-test to post-test ranged from -16% to +44%. Eight girls showed increased levels of self-esteem from their scores on this measure, while two girls showed a decrease, and one showed no change.

The fact that most of these children came from multi-problem, sometimes very chaotic family situations makes it difficult to even speculate on the reasons for the extremely positive nature of the results of this subscale. As well, six of the eleven children changed care providers and/or places of residence during the period of this intervention. These data can better be understood when related to individual circumstances (discussed later).

School subscale. On the school subscale, seven girls' scores decreased, two increased, and two remained the same. Changes in scores ranged from -44% to +35%. Since it has been observed that children who have been sexually abused often show a decline in academic performance, the decreased scores on this subscale could reflect a continuing trend for the girls in this area. Subsequent comments cannot be made, however, as the author did not have sufficient information regarding the children's performance in scholastic endeavors to draw further conclusions in relation to changes in scores on this subscale.

General subscale. Scores on this subscale are said to generate a comprehensive estimate of self-concept. Here, the scores of six girls decreased over the twelve weeks, four increased, and one remained the same. Changes in scores ranged from -44% to +22%. In general, scores tended to change in an extreme fashion in either direction with only a few exceptions, and increases in self-esteem on this subscale tended to occur with the older participants. Perhaps this can, at least in part, be explained by developmental variables. Since younger children tend to

be more egocentric and blame themselves for virtually everything that goes on around them, their lower scores may reflect self-blame for the sexual exploitation they have experienced. The cognitively more advanced older children may have been better able to understand that the abuse was not their fault. This concept was reiterated time and again within group sessions.

Total scores. Total scores equal the total number of positive self-statements emitted by each child on the SAI divided by the total number of items on that particular level of the scale. Changes in total scores ranged from -26% to +16%. Six children showed a decrease in self-esteem as measured by the SAI over the twelve-week period, four showed an increase, and one child's score remained the same from pre-test to post-test. Overall, the scores of children from more supportive home environments tended to be more positively skewed than the scores of children from less stable home situations. Indeed, Sgroi (1982) and Damon and Waterman (1986) feel that parental support is essential for successful treatment of the sexually abused child. The author also

examined the possibility of a relationship between the SAI scores and chronicity as well as type of abuse. None, however, could be found for either variable.

Problems with the SAI. Several problems arose in administering the SAI to the children. First pf all, the measure was administered to the children during the first (pre-test) and last (post-test) group sessions. In order to complete the scale for all children, most of those sessions were devoted primarily to this task. This left therapists unable to maintain order and adequate supervision. As well, it resulted in the loss of valuable therapeutic time. In subsequent groups, tests will be administered during initial interviews and follow-up interviews instead.

Secondly, while Melanie was filling in her questionnaire, the therapist noticed that she was marking "Yes" responses exclusively. When asked if she really meant to answer "Yes" to all of the questions or if she was simply checking off answers, Melanie replied that she was indeed just checking off answers. Melanie was asked to respond again to those questions, which she did, but it is possible that other children responded in similar

fashion or that some responded as they felt the therapists wanted them to respond, particularly since many of these children wanted so desperately to be accepted and liked.

Finally, the girls in these groups tended to be very active, to be difficult to manage at times, and to have fairly short attention spans. For those reasons, it was not possible to regularly fit assertiveness and esteem-building exercises into the sessions as was initially planned. Had this been done, the SAI may have yielded somewhat more positive results.

There are many possible explanations which could be offered here for the somewhat unexpected results which the scale produced. It could be, however, that this instrument is simply not sensitive enough to detect the subtle changes which may occur in short-term treatment. Few measures are. As mentioned previously, more rigorous examination of the SAI needs to be undertaken.

Aside from the above difficulties, the SAI proved to be a suitable measure for these children. None found the questionnaire difficult to understand or lost interest before they had completed the entire measure. Since this group of children seemed to vary more in terms of

developmental levels (which was reflected in their grade placements at school) than in age, the graded levels of the SAI were preferable to using one questionnaire for all children.

The Child Questionnaire

Table 4 shows the pre- and post-test results of the Child Questionnaire. This table is arranged according to group. Scores are expressed in raw form and as a percentage of the total points possible (20). Scores range from 12 (60%) to 19 (95%) on the pre-test and from 10.5 (52.5%) to 20 (100%) on the post-test. The change in scores was calculated by simply subtracting pre-test scores from post-test scores. Changes in scores range from a decrease of 2 (10%) to an increase of 6 (30%). Five girls experienced a drop in retention scores from pre-test to post-test, four girls showed increased retention scores, and two girls' scores remained the same.

The Child Questionnaire was constructed as part of the C.A.R.E. Kit to measure retention after exposure to the twelve lessons of the Kit. The children in these

TABLE 4

Scores on the Child Questionnaire Before and After Group Treatment

CHILD	PRE-TEST	POST-TEST	CHANGE
Monday Group			
Charlotte	15 (75%)	13 (65%)	-2 (-10%)
Tracey	18 (90%)	17 (85%)	-1 (-5%)
Diane	15 (75%)	17 (85%)	+2 (+10%)
Melanie	17 (85%)	17 (85%)	0
Rosanne	12 (60%)	10.5 (52.5%)	-1.5 (-7.5%)
Nina	18 (90%)	18 (90%)	0
Wednesday Group			
Crista	15.5 (77.5%)	18 (90%)	+2.5 (+12.5%)
Sara	19 (95%)	18.5 (92.5%)	-.5 (-2.5%)
Colleen	18 (90%)	19 (95%)	+1 (+5%)
Lauren	14 (70%)	20 (100%)	+6 (+30%)
Lila	19 (95%)	17 (85%)	-2 (-10%)

groups, however, found it confusing and difficult. Therapists felt that it did not reveal a true picture of what the children learned in the sessions and the author found it difficult to score as questions were too open-ended and often unclear as to what they were asking. This was not apparent until the children attempted to complete the questionnaire. In the future, group leaders would do well to construct their own measure of retention.

The Revised Child Behavior Profile (RCBP)

Of the four parts of the RCBP, this study was concerned only with part four where parents or other primary care providers evaluated their children in terms of the frequency with which each child demonstrated each of the 110 listed behaviors. Some behaviors on the scale are desirable behaviors, whereas others are maladaptive. Since no scoring key is as yet available for this scale, the responses of parents were scored in the following manner:

For desirable behaviors:

Almost always.....4 points

Often.....3 points

Sometimes.....2 points

Rarely.....1 point

Never.....0 points

Scoring for maladaptive behaviors was just reversed:

Almost always.....0 points

Often.....1 point

Sometimes.....2 points

Rarely.....3 points

Never.....4 points

The highest possible score is therefore 440 and the lowest is 0 on the measure. Table 5 summarizes the results of the parents' responses on the RCBP.

Once again, this table is arranged according to group. Scores from both the pre- and post-tests are shown for each child. The change in scores is simply the difference between pre- and post-test scores; it is a

TABLE 5

Scores on the RCBP Before and After Group Treatment

CHILD	PRE-TEST	POST-TEST	CHANGE
Monday Group			
Charlotte*	284 (65%)	333 (76%)	+49 (+49%)
Tracey*	210 (48%)	339 (77%)	+129 (+29%)
Diane*	387 (88%)	361 (82%)	-26 (-6%)
Melanie*	352 (80%)	330 (75%)	-22 (-5%)
Rosanne	370 (84%)	367 (83%)	-3 (-1%)
Nina	306 (70%)	315 (72%)	+9 (+2%)
Wednesday Group			
Crista	319 (73%)	332 (75%)	+13 (+3%)
Sara	289 (66%)	339 (77%)	+50 (+11%)
Colleen	295 (67%)	294 (67%)	-1 (0%)
Lauren	310 (80%)	334 (76%)	+24 (+5%)
Lila	351 (80%)	378 (86%)	+27 (+6%)

* Indicates that pre- and post-test measures were not completed by the same care provider.

negative change if the pre-test score is greater than the post-test score and positive if the post-test score is greater. All scores are expressed in raw form and as a percentage of total possible points. Scores range from 210 (48%) to 387 (88%) on the pre-test and from 294 (67%) to 378 (86%) on the post-test. Changes range from -26 (-6%) to +129 (+29%). The parents of seven of the girls gave a more positive evaluation of their child's behavior at the conclusion of the intervention, while the foster parent of two of the girls (sisters) indicated that their behavior had deteriorated over the period of treatment. The two remaining parents rated their children's behavior as virtually unchanged (a difference of less than 1% from pre- to post-test). These results, however, are a bit misleading for several reasons.

First of all, the four children whose names are followed by an asterisk (*) were rated by a different care provider on the pre-test than on the post-test. Three of the four children changed foster homes during the course of the twelve-week intervention, while the fourth child was removed from her foster home and returned to her natural mother. Therapists were not notified or consulted about

these moves; in fact, they learned of them from the children themselves after the moves had already been made. Therefore, the RCBP scores for these four children yield little useful information regarding any change in how their behavior was perceived over the course of treatment. One can comment, however, on the fact that none of these parents rated their children extremely negatively on either the pre- or the post-test evaluations. The therapists who administered the RCBP's in the initial and follow-up interviews felt that, on a subjective basis, all care providers for these four children (with the exception of Tracey's natural mother who completed the initial measure) looked on their wards in a very positive light.

The scores for the remaining seven girls showed that their parents perceived their behavior as either remaining virtually the same (decreases of less than 1%) over the twelve-week period or improving. That change can probably, at least in part, be attributed to group treatment.

Problems. There were some difficulties in using the Revised Child Behavior Profile to measure parents' perceptions of their children's behavior. Some felt that

the questionnaire was too long. Others said that they resented being asked the demographic information and some refused to give certain responses (e.g. range of income, level of education). The most serious problem, however, was that most of the parents and care providers found some of the terms difficult to understand and the five-level system of evaluation difficult to use. This instrument was chosen because it is the only one of its kind specifically designed for use with child victims of sexual abuse, but for evaluations of children's behavior in the future, therapists will consider alternative measures.

Individual Results

In this study, the author was not only interested in the effects treatment had on the group as a whole, but also in the effects it had on individual participants. In the following section, the results of treatment for each child is discussed, beginning with the youngest child and progressing to the oldest child. All names used here are fictional.

Charlotte. This child was six years old and Native Canadian. She was the victim of multiple abusers, mostly family members and her abuse included a variety of sexual acts from fondling to intercourse. At the beginning of the study, Charlotte was living with foster parents; halfway through treatment, however, she was returned to her natural mother, a move Charlotte was eagerly anticipating. The foster family was a very middle class one in every way, whereas her natural mother was single and on welfare. Hers was a chaotic, multi-problem family fraught with violence and drug and alcohol abuse. The fact that both Charlotte and her mother were extremely happy about their reunion was reflected in Charlotte's SAI scores. On the family subscale, there is an 11% increase in esteem derived from family relationships at the study's termination. As well, Charlotte's mother judged Charlotte's behavior to more positive (by 11%) than did her foster parents. This is, however, probably more indicative of the differences in expectations and in points of refernce for evaluating Charlotte's behavior, rather than an actual change in her behavior.

On the general subscale and on the SAI overall, Charlotte's level of self-esteem was noted to decrease with treatment. Two different factors may be involved in this outcome: a) Group attendance may have made Charlotte more accutely aware of the implications and significance of her abuse and/or b) returning home to the family in the context of which the abuse occurred may have made Charlotte unsure of her continued safety. If either or both of these hypotheses were true, they would explain the measured drop in self-esteem for Charlotte on the SAI.

During the intervention, Charlotte reported two further instances of abuse, one which occurred in her foster home with another foster child (who was 12 years old but developmentally functioning closer to Charlotte's level) and another which occurred with one of her playmates at around the time that the group ended. Upon investigation, the social worker assigned to Charlotte's case determined that both were instances of experimentation between peers rather than sexual abuse per se. It did demonstrate, however, that Charlotte was now better able to protect herself in that she was aware of the course of action she should take if she is again in danger of victimization.

In sessions, Charlotte did not mix easily with the other girls; rather, she remained a "loner" and it is possible that the association with other victims did not serve to decrease her feelings of "differentness." Partially responsible for this was Charlotte's lack of adequate social skills. She often made inappropriate and sometimes, unintentionally unkind comments to others in the group. She did not seem uncomfortable in the company of group members, however, and frequently mentioned how much she enjoyed sessions.

Rosanne. Rosanne was seven years old at the beginning of this project. She was fairly immature and was the victim of fondling and digital penetration by her natural father over a period of a few months. Rosanne's mother initially responded with disbelief but quickly came to believe her daughter and offer much support. At the termination of treatment, Rosanne's father was still denying her allegations and regularly harassing the family, putting much pressure on Rosanne's mother and limiting the amount of support she could provide. In interviewing this woman, the therapists felt that she was beginning to subtly coerce Rosanne into possibly denying

the abuse had occurred or at least minimizing the experience. She did this by continually reiterating the hardships Rosanne's disclosure had placed on the family. In spite of this, Rosanne's mother's perceptions of her daughter's behavior on both the pre-test (84%) and the post-test (83%) of the RCBP were extremely favorable. As well, the therapists observed that mother and daughter seemed to have a very loving relationship. This may also partially explain why Rosanne showed on the family subscale of the SAI that she derived much of her self-esteem from family relationships (77% pre-treatment and 88% post-treatment). It does not, however, explain the 11% increase over the course of treatment.

Although Rosanne's mother told therapists that Rosanne was willing and cooperative about attending group sessions, Rosanne seldom uttered a single sentence during the 90-minute meetings. She was often withdrawn and uncommunicative, particularly during C.A.R.E Kit lessons and discussions pertaining to sexual activity and abuse. At one point, when a therapist was administering the Child Questionnaire to Rosanne and asked her the names of male and female genitalia, Rosanne became almost trance-like,

completely tuning out the therapist and, it seemed, her whole environment. Rosanne rarely talked or associated with the other group members; she could usually be found in a corner by herself.

Rosanne's social worker felt that she was dealing with the abuse well and that she was ready to confront her father and go on with her life. The therapists, on the other hand, felt that she was not dealing with the abuse at all and recommended that she receive individual input at the conclusion of group treatment and that the plans for confrontation be shelved indefinitely. Rosanne and one other child, Sara, were judged by the therapists to be the most traumatized by their abusive experiences. They speculated that the overall decrease in Rosanne's scores on the SAI could be seen as a continuing trend for this child which was probably occurring independently of group treatment. Alternatively, it was possible that the group may have heightened the impact of the abuse on Rosanne and coupled with her alienation from other members, had the effect of decreasing her self-esteem as measured on the SAI.

It must be noted that it is very difficult to even speculate about what was happening with this child, not only because of the degree of emotional disturbance she exhibited, but also because there were cultural variables operating here. Rosanne's family was originally from the Philippines and felt that these matters should be left to the family to resolve. They were also very suspicious of social service personnel and reluctant to accept any outside input.

Crista. Crista was seven years old at the group's inception. She lived with her natural mother, her mother's common-law partner, and her younger brother. She was the victim of a 30-year-old uncle who also abused several of Crista's cousins while babysitting them over a period of years. The abuse consisted of a variety of sexual activity ranging from exposure to video pornography to intercourse. This whole family network was incredibly close and supportive which was reflected in Crista's scores on the three measures. Crista's mother's perceptions of her behavior were very positive on both the pre- and post-tests of the RCBP (73% and 75%). It was apparent to group leaders that Crista was both enjoying

and benefitting from the group experience. She fit in well with the other girls and actively participated in group discussion and other activities. Over the course of the intervention, Crista's scores on the SAI remained unchanged on the peer subscale, and increased by 11%, 22%, and 22% respectively on the family, school, and general subscales. Her overall score increased by 13%. Therapists felt that the group treatment was responsible for much of the change in Crista's scores on this self-concept measure, as was the continuing support of her family.

Diane and Melanie. These two Native Canadian sisters, ages eight and nine, will be discussed together. Little is known about their abuse experiences except that one offender (for both) was the girls' maternal grandfather. When the group began, they were living with a foster mother who was a single parent; halfway through the group, however, they moved to a second foster home. Both girls asserted that they were happy in this second home and indeed Diane's SAI score on the family subscale bore this out. It showed an increase of 22% in self-esteem derived from family relationships. Melanie's scores did not. She

showed a decrease of 16% on the family subscale. Before the therapists had been made aware of this move, they had noticed a very profound change in Melanie's behavior. Usually pleasant and cooperative, Melanie became attention-seeking, hard-to-handle, rebellious, and angry. Obviously the move was much more difficult for Melanie than initially supposed. Although both foster mothers judged the girls' behavior very positively on the RCBP, the first foster mother's perceptions were more positive (88% for Diane and 80% for Melanie) than were the second foster mother's (82% for Diane and 75% for Melanie). These scores were probably less indicative of behavior change in the girls than they were of the foster mothers' differences in reference points for frequency of behavior.

Both girls were well-accepted by other group members and seemed to enjoy attending the sessions. As well, they were generally active participants in discussions and other activities. The subjective impression of the therapists was that Melanie and Diane benefitted greatly from attending group sessions. They became more communicative and more confident over the 12-week period.

SAI scores, however, do not indicate that either girl experienced an increase in self-esteem: Melanie's total scores dropped by 6% and Diane's by 5%. Perhaps their unsettled home environment interfered with the benefits which might have been derived from group treatment.

Sara. Sara seemed to be a very mature and very bright 8-year-old when she joined the group. She lived with her natural mother (who was legally blind) and two younger siblings who had also been abused. This child, because of her mother's handicap, took on a very responsible position in this household. Little is known about the extent of the abuse Sara endured at the hands of her natural father and possibly her mother's subsequent common-law partner; she refused to speak of it and often tried to change the topic of discussion in group sessions. When the abuse was disclosed, Sara's mother initially responded with disbelief and at one point suggested Sara be placed in a foster home. Before this could happen, however, her attitude changed and she eventually became very supportive of Sara. In the initial interview, this mother spoke very highly of her daughter, and her responses on the RCBP bore this out. Her pre-test score was 66% on this measure and the post-test score was 77%.

On the peer subscale of the SAI, Sara's score dropped by 36% over the course of treatment. This was not surprising to the therapists since Sara was often critical of other children in the group and frequently withdrew altogether from group activities to do something else in another area of the facility. Unlike most of the other children, Sara formed no alliances within the group and other group members indicated by their comments that she was not well-accepted. In spite of this, Sara maintained that she loved attending group sessions and was never absent.

Sara's scores on the SAI actually dropped in every category and, for the most part, very substantially. On the family subscale her score decreased by 5%, on the school subscale it decreased by 35%, and on the general subscale it dropped by 32%. Overall, her score dropped by 26%. One explanation for this extreme decline may be that Sara's initial scores on all subscales of the SAI and overall were unrealistically high. The therapists felt that Sara was trying to impress them with her answers at first. After she came to trust them, she probably responded more honestly, meaning that post-test scores actually yielded a truer picture of Sara's self-image than did pre-test scores.

As in the case of Rosanne, Sara presented as a very disturbed child and her deteriorating sense of self-esteem was seen as a continuing trend resulting from her sexual abuse. Therapists recommended intensive individual treatment for Sara as it was felt that it would take much more than one short-term therapy group to effect any change in the damage done to this child.

Tracey. Tracey joined the group shortly after she was placed in her second foster home. Her natural parents abused her physically, emotionally, and sexually, and her first foster home asked that she be placed elsewhere because they found her behavior too difficult to handle. The second foster family became quickly attached to Tracey and she blossomed there in every way. This relationship was probably the reason for the 44% increase on the SAI family subscale score over the period of intervention. As well, these foster parents judged Tracey much more positively in the RCBP than did her previous care providers. The score was 29% more positive. This figure probably reflects both a behavior change on the part of Tracey in reaction to her new home environment in addition to the relaxed expectations and less critical attitude of the second set of foster parents.

The remainder of Tracey's SAI scores were not so positive. Each subscale measure showed a marked decrease during this intervention and the total score dropped by 29%. One explanation might be that these scores do not necessarily reflect an actual drop in self-esteem. Before Tracey knew the therapists (pre-test), she attempted to present herself as more confident than she actually felt. Her social worker saw this facade as a survival or coping mechanism. Tracey may simply have been more honest in her responses on the post-test administration of the SAI because she had then developed a degree of trust in the therapists. Rather than demonstrating an actual decrease in self-esteem, Tracey's post-test score may have merely indicated a truer measure of that concept. After years of various kinds of abuse, this child's level of self-esteem was probably very low and will, as with others in the group, take more than short-term therapy to recover.

On a subjective level, Tracey was very much a leader in this group and was well-liked and accepted. She indicated that she enjoyed attending sessions and she was one of the most active participants in discussion and other activities. Although her scores do not indicate it,

the therapists felt that Tracey left the group feeling more confident and secure and with improved social skills. As well, she was much better informed about the course of action she should take should revictimization ever become a possibility.

Nina. Nine-year-old Nina was sexually abused by her 12-year-old brother for six to twelve months before it was discovered. Although Nina's parents were unhappy that her brother had to be removed from the family home, they were wholeheartedly supportive of their daughter. They rated her very positively on both the pre-test and post-test of the RCBP (70% and 72% respectively). Nina, in turn, scored 68% on the pre-test and 79% on the post-test of the SAI family subscale. This supportive family atmosphere was probably in large part responsible for the overall increase of SAI scores during the intervention. Any positive effect of treatment was likely facilitated by the family's attitude. Nina's total score over the course of treatment rose by 13%.

Although the therapists felt that the group was of great benefit to Nina, she did not mix easily with the other girls, but neither was she excluded. Instead she

formed a very close relationship with one of the therapists conducting the group.

Nina's parents and group leaders felt that Nina's communication skills improved significantly during the treatment period. Nina's knowledge of prevention and her ability to use those acquired skills were also felt to be greatly enhanced.

Lila. Lila was ten years old when she entered the group. She was a Native Canadian child who lived with her older sister in a very chaotic household. Her sister was a single parent of several very young children. She often relied on Lila to care for the children and the living quarters. While Lila admitted only to one incident of abuse by a 60-year-old uncle, the physical evidence pointed to chronic penetration.

Lila's relationship with her sister seemed to be a very positive one and indeed test scores reflect this. Lila's score on the SAI family subscale increased by 33% and her sister's perceptions of Lila's behavior were consistently favorable (80% on the pre-test and 86% on the post-test of the RCBP). On the SAI peer subscale, Lila registered an increase of 22% over the course of the

treatment. Since she fit in extremely well with the other girls in the group and was well-liked, these results are not unusual. On the general subscale, however, Lila's score decreased by 22% over the twelve weeks. The therapists thought that this decline may have been due to a greater awareness of the significance of her abuse.

There is no doubt that the group experience was of benefit to Lila. This is supported by her SAI scores as well as by the therapists subjective observations. Not only did they feel that she benefitted from meeting other victims but she was also able to take a break from her responsibilities at home and, for a change, engage in age-appropriate activities. Lila never discussed her own abuse in group sessions but she was very vocal about what kids can do if they are in danger of further abuse. She seemed better able to protect herself as a result of attending these sessions.

Colleen. Colleen was an extremely bright ten-year-old child who lived with her mother and older brother. This family was not a stable one in that Colleen's mother had a history of drug use and prostitution. When Colleen disclosed the abuse by her

mother's common-law partner, she was initially met with disbelief and denial, resulting in foster home placement for Colleen for some weeks. Eventually, however, her mother accepted the reality of the situation and became very supportive of Colleen.

Colleen was a very attractive and confident girl who excelled socially, scholastically, and musically. She presented as very mature and saw herself as her mother's care provider. In turn, Colleen was given responsibilities beyond those usually given a child of this age. Even though she lived many blocks from the Children's Hospital where sessions were held, Colleen was often sent off on her own and expected to return home alone in the dark. Therapists often resorted to transporting Colleen themselves.

Colleen was probably one of those few children who seem to survive on their own strengths and indeed, even do well in spite of the abusive experience. Her pre-test scores on all subscales and in total were very high and remained so on the post-tests. It may be that for this child, treatment served to increase her already high level of self-esteem in spite of the family situation.

Lauren. This child was one of the group's success stories. Although Lauren was 12, the oldest of the girls, she was very immature for her age. Slowly, she carved a place for herself in the group and eventually fit in well. Lauren's parents were divorced and though she lived with her mother, her father continued to be very involved with the children. Lauren was abused by a neighbor in their apartment building and when she disclosed, the family immediately moved to protect Lauren from further abuse. Well into the twelve weeks, therapists were informed that the family was again moving. A group of children at Lauren's school often teased and demeaned her; in fact, she and a friend had been physically attacked on one occasion. Lauren's mother decided that she would move her family once more so that Lauren could attend another school. This proved to be a wise decision as Lauren was happy and better accepted at her new school. It was evident that this child's family was very caring and supportive of her. Her mother rated Lauren's behavior in a favorable light on both pre- and post-tests of the RCBP (70% and 76% respectively). As well, Lauren's score on the SAI family subscale increased by 15%. In fact, all

of her SAI scores (with the exception of the school subscale) increased significantly over the course of treatment. The score on the general subscale rose by 21% and the total score by 16%. Her positive group experience coupled with the supportive home atmosphere may help to explain these figures.

Therapists watched Lauren undergo changes in her self-confidence and in social skill acquisition while she attended the sessions. She also became more communicative and knowledgeable about abuse prevention. This child probably derived the most benefit of all of the girls from the treatment program. The therapists felt that she left the group a happier, healthier child.

Evaluations by Parents and Children

All comments by parents and children regarding the group were favorable. The children liked the group and were sorry to see it end, as were parents, who were anxious to see more and longer treatment groups offered for their daughters. The girls had few suggestions about changing the group, with the exception of wanting "to play

more." Parents stated that they felt their children were less tense, happier, and more willing to talk to parents, not only about the abuse. They commented that the girls did not have to be reminded or coaxed to attend sessions; rather, children made sure that their parents remembered dates and times.

Parents' Session

Unfortunately, the parent sessions were poorly attended in both the pilot study and the practicum study. Parents were told about the parents' session during the initial interview and most, at that time, responded quite enthusiastically. However, only two sets of foster parents (representing two of the girls in total) from the two groups attended. In the follow-up interviews, therapists had the opportunity to discuss this with parents who did not attend. Some did not have transportation or had other commitments, but others said that they had gone through so much at home, in court, and in other therapy sessions that they could not face more discussion about the abuse at that time. The parents that

were at the meeting felt that it was extremely worthwhile and indeed, the discussion ran over the allotted time by about 90 minutes. Because these people benefitted from the sessions, the therapists felt that it was time well spent.

Problems and Changes

There were many problems in running the pilot groups and the two treatment groups which followed. Some of these difficulties can be corrected in subsequent groups and others, therapists may have to learn to work around.

One of the greatest difficulties encountered was that of transportation. As previously mentioned, some children were transported to and from the group via taxicab. Arrangements had been made with the taxi company well in advance of the beginning of the groups by Northwest Child and Family Services. Inevitably, however, one or two children were not present when a session was set to begin. Therapists then had to phone the company and wait in the lobby downstairs from the session area for the late children. As well, cabs would arrive late to return the

children home, sometimes by as much as an hour, so therapists would have to wait in the lobby once again until the car arrived, or transport the children themselves. This cut into or completely eliminated the discussion time set aside after group meetings for the therapists to review what had occurred in that session. Children were also unescorted on these rides and on one occasion a child was harassed by a driver. If these children arrived early, they were left unattended in the lobby.

As time went on, the dispatchers at the company's office got to know the therapists' voices and were extremely rude and unaccommodating. Drivers were told at one point to wait only five minutes for a child and then to leave. This experience created much frustration for the therapists who then, too often, came into sessions stressed and anxious.

In the pilot groups, parents regularly transported their daughters to and from the group; taxis were only used in exceptional circumstances.' In future groups, these therapists will require parents, care providers, or social workers to guarantee regular transportation for

each child before that child will be guaranteed a place in the group. It was felt that the effects of the transportation difficulties were serious enough so as to have affected the quality of the treatment offered here.

Another problem which confronted group leaders was one of behavior management. The children in the pilot groups had been fairly easy to manage so the practicum children took therapists by surprise. The strategy to control this behavior took the form of attempting to "read" the children (e.g. Were they just seeking to draw attention to themselves or away from a threatening topic of discussion?) and then rearranging the activities accordingly. In the future, better planning and anticipating the possibility of behavioral difficulties will go a long way to aborting this problem.

Another part of this problem was that the girls wanted to play a good deal of the time. If sessions would have included a weekly scheduled free play period of only ten or fifteen minutes, the children may have been more patient and more willing to participate calmly in other activities. Also, as Damon and Waterman (1986) suggested, a third therapist would have enabled better management of

behavior. Two therapists for six girls seemed sufficient for the pilot groups; but for the lower developmental levels of the girls in the practicum groups, a therapist for every two children would have been more practical. Assessing each child developmentally before group admission may be a partial solution in that therapists may then have a more accurate idea of the type of children with whom they will deal. For example, many of the children in the practicum groups had very short attention spans. This is a relevant variable in organizing the structure of group sessions and planning frequent changes in activities.

The above-mentioned problems are very minor compared to the larger issues facing agencies coordinating or attempting to coordinate treatment. During the intervention, the children's social workers were almost impossible to contact. In one session during the pilot study, a child disclosed further abuse and it was almost a week before her social worker could be contacted about this new information. Treatment for parents was, in many cases, in place before any treatment was available for their children. When children did get treatment, the

children's therapists had no contact with parents' therapists; the two treatments were mutually exclusive. Damon and Waterman (1986) stress the importance of coordinating mothers' groups and daughters' groups. They talk about the common issues facing mother and child and about the necessity for ongoing communication between the groups. As previously stated, there are very few existing treatment options for victims and their families, but hopefully, as options increase, these difficulties will begin to be resolved.

Summary

All in all, therapists rated the groups as successful in spite of all of the problems encountered. Group leaders and children felt sessions were very worthwhile and looked forward to each one. Some of the children needed much more therapy than could be offered in a short-term group and they were referred elsewhere for further treatment. Others explored their issues in the group as much as they were ready to explore them at that time. Therapists felt that they would, however, rehash

those issues again and in different ways at different stages of their development. Hopefully, more treatment groups will be available to aid them in that endeavor. For still others, the intervention ended prematurely. A longer group may have been sufficient for those girls.

Mention needs to be made, in closing, of the results that the data do not reflect. Therapists and parents observed many positive changes that were nowhere measured. Some of the girls were simply happier more of the time. This was confirmed by parents. Other girls' communication skills were greatly enhanced. Not only were they able to talk about the abuse but they also learned to recognize and label feelings so as to use that information to respond appropriately in abusive as well as other situations. They learned that it is acceptable to be angry, afraid, and hurt and they learned constructive ways to express those emotions. The girls also improved socially. A child who was rude and uncooperative when the group began, was observed explaining to another child that her behavior had hurt a third child's feelings and that she should behave differently in the future. The children, with few exceptions, came to be very candid in

the groups because, we assume, they found that they were liked and accepted unconditionally. A trusting relationship developed between the therapists and most children. The relationships between the children came to be very special as well. They generally got on well together and were very sad to leave their friends at the group's end.

Therapists hypothesized before the groups ever began that simply exposing the children to other victims would make the experience a valuable one and that hypothesis has been validated for the therapists. Many things can and will be changed in future groups. For example, since this practicum was completed, MacFarlane et al. (1986) have published a format for treatment groups for young children which these therapists will use in treating future group participants. For the first time, group leaders are not only told what to do but how to do it. Progress in developing treatment has been slow. For now, victims must be content with any kind of treatment offered, as many are offered nothing. Perhaps, however, the time is not too far off when resources will be more plentiful and child victims will, without exception, receive the type and amount of treatment they require.

Personal Benefits

The author derived immeasureable personal benefits from conducting the pilot and practicum treatment groups.

On a professional level, I became much more familiar with the literature on sexual abuse in general and in particular, that part of it which deals with the impact and treatment issues for victims. I had the opportunity to apply that knowledge and to build on it in group sessions. I learned what is involved in putting together such a group, determining the content and structure of sessions, and most importantly, dealing with child victims on an appropriate level. There is a considerable amount of skill involved in communicating with children of this age, in interpretting their behavior, and in responding therapeutically. The regular supervision I received from Dr. Laura Mills was largely responsible for the enhancement of my skills in this area.

On a more personal level, I learned much about myself. Conducting treatment groups for sexually abused children can be both rewarding and exhausting. I found the groups to be a humbling experience; the girls were very special children

and continually amazed me with their abilities to cope and adapt. Never before have I so fully appreciated my own life circumstances. At the end of a session I was usually completely drained but also very satisfied.

Recommendations

In working with these children, one cannot help but become aware of the shortcomings of the present system. The following is a brief summary of recommendations for improvement and change on a variety of levels:

1) Professionals need to write about their treatment strategies and techniques and to make this information available to other professionals so that we do not duplicate the efforts of others, but rather, build on them. While I was conducting this practicum study, I came across several practitioners who had valuable contributions to make to this body of knowledge but had neither the time nor the resources to share it.

2) The need for treatment of male as well as female victims must be recognized. In dealing with the families of the children in this study, I came across a number of male child victims for whom treatment was nonexistent.

3) Treatment needs to be empirically evaluated. Very few practitioners examine the effectiveness of treatment, other than anecdotally. One difficulty inherent in such investigations is the lack of measures sensitive enough to detect subtle changes in individuals. More need to be developed, particularly children's measures.

4) That part of the social service system set up to deal with abuse lacks coordination. Crisis intervention workers, therapists (for the victim, the victim's family, and the offender), medical personnel, agents of the legal system, and schools often operate independently of each other. Rather than progressing through an orderly continuum of stages with the system, a victim is often shuffled haphazardly from one agent to another. Much refinement of this process is needed.

5) Children need to be evaluated and assessed in a standardized manner when they enter the system. Each victim has been affected differently and has different needs and capabilities. These areas should be assessed and treated accordingly.

6) Professionals working in the area of abuse need more training. Often social service personnel are

overworked and lack the knowledge and the time to deal with abuse of children in an efficient and appropriate manner. Government must make this problem a priority and allocate sufficient funds and personnel to intervene.

7) In Manitoba, child protection personnel are mandated to provide therapy as well as crisis intervention to child victims. Their heavy caseloads, however, make it impossible to do both. Therefore, crisis intervention takes precedence and few victims receive any kind of therapy. In B.C., M.S.S.H. is mandated only to provide crisis intervention; therapy is left to the private sector. This means that here, as well, therapy is neither a priority nor equally accessible to all who need it. Sexual abuse is the problem of society as a whole; therefore, the governing body of our society should be obliged to provide treatment for victims unconditionally.

8) Finally, even though prevention of child sexual abuse is being promoted by social services and taught in many schools, such programs are often optional and reach a only a select group of people. If our communities make a firmer commitment to educating children about abuse and about sexuality, we stand a greater chance of bringing the rapidly increasing statistics to a standstill.

Appendix A

Indicators of Child Sexual Abuse

Behavioral:

-Change in performance at school
-Unwilling to change for or participate in P.E. classes
-Arriving early at school, and reluctant to leave OR
Sudden dislike of school, refusal to attend, fear of teacher, upset on returning home
-Inability to concentrate
-Pretending to be "dumb" or incapable
-Difficulty expressing opinions
-Many new fears and anxieties
-Irritability, crankiness, unexplained anger
-Defiant behavior
-Aggressive behavior, tantrums
-Overly compliant behavior
-Withdrawal, fantasizing, infantile behavior
-Depression
-Clinging to parent

-Rebellious in the home

-Pseudomaturity; takes on adult roles, adult interests

-Poor self-esteem

-Unprovoked crying

-Anxiety regarding strangers

-Fear of being alone or separation

-Delinquency, stealing, running away

-Change in appetite; refusal to eat or binge eating

-Change in sleep pattern, bedwetting, nightmares, sleeping in clothing

-Reluctant to go to a particular place or a particular person

-Self-mutilation, substance abuse, suicide threats and/or attempts

-Change in hygiene practices

-Secretive behavior, frequent reference to secrets

-Hyperactive behavior

-Refusal to say please or thank you

-Very controlling behavior

-Exaggerated need for predictability; wanting to know everything that is happening

-Setting self up for punishment, getting in trouble for no apparent reason

-Takes unnecessary risks

-Frequent lying

-Avoidance of rooms that have only one exit

-Keeps doors shut and locked OR
Extreme fear of closed doors

-Psychosomatic complaints; medical complaints with no basis

-Extremely protective of siblings

-Conservative and modest dress; covering up; wearing an extraordinary amount of clothing

-Refusal to undress under normal circumstances

-Change in how victim refers to offender (e.g. from "father" to first name basis)

-Poor or few peer relationships

-Lack of trust, especially with significant others

-Extraordinary fear of males

-Seductive behavior, promiscuity

-Preoccupation with sexual matters

-Bizarre, sophisticated, or unusual sexual behavior or knowledge

-Involves peers in sexual play

-Becomes physically or sexually abusive of others

-Acts out abuse in play

-Excessive masturbation

-Frequent use of sexually explicit terminology

-Discomfort with nurturing touch

-Extreme difficulty accepting blame for even minor problems; often blaming and overly critical of others

-Indiscriminate, overly affectionate behavior

Physical or Medical:

-Difficulty walking or sitting

-Torn, stained or bloody underclothing

-Pain, swelling, or itching in genital area

-Pain on urination

-Bruises, bleeding, or lacerations on external genitalia, vaginal, or anal areas

-Grasp marks

-Injury to lips

-Weight change

-Recurrent headaches

-Recurrent abdominal pain

-Trauma to buttocks, breasts, lower abdomen, thighs

-Frequent sore throat, difficulty swallowing, frequent choking sensations

-Difficulty with bladder and bowel control

-Anxiety-related illness (e.g. stomach pain, asthma)

-Poor sphincter tone

-Repeated urinary tract infections

-Pregnancy

-Sperm in vagina, anus

-Unusual genital odors

-Vaginal or penile discharge

-Venereal disease

-Foreign bodies in genital, rectal, urethral openings

-Abnormal dilation of urethral, rectal, vaginal openings

-Difficulty with menstruation or delayed onset of menstruation

-Sudden weight gain or extreme weight loss

Appendix B

Agendas for Each of the 12 Sessions

1) -Introduction Games
   -Why are we here?
   -Definition and description of sexual abuse
   -C.A.R.E. Kit Lesson #1
    "Everyone has feelings."
   -Activity: Make name cards
   -Fill out Child Questionnaire and SAI
   -Snack and conversation

2) -Share previous week's happenings and review previous session
   -C.A.R.E. Kit Lesson #2
    "Everyone has a body."
   -Body awareness (relaxation and physical exercises)
   -Activity: Make "feeling cards"
   -Read: My Body Belongs to Me
          Feelings
   -Snack and conversation

3) -Share previous week's happenings and review previous session

-Feeling check with feeling cards

-C.A.R.E. Kit Lesson #3

"Some parts of your body are private."

-Make lists of public and private things

-Activity: Body tracing

-Snack and conversation

4) -Share previous week's happenings and review previous session

-Feeling check with feeling cards

-C.A.R.E. Kit Lesson #4

"Your body and your feelings belong to you."

-Guest Speaker: Leslie Galloway, R.N.
Child Protection Center
Topic: "The medical exam."

-Read: Your Body is Your Own

-Snack and conversation

5) -Share previous week's happenings and review previous session

-Feeling check with feeling cards

-C.A.R.E. Kit Lesson #5

"Different kinds of touching give you different feelings."

-Activity: Puppet show by children: "Good touch, bad touch."

-Read: I Can Touch

-Snack and conversation

6) -Share previous week's happenings and review previous session

-Feeling check with feeling cards

-C.A.R.E. Kit Lesson #6

"Some touching may confuse you and can be wrong."

-Christmas party

Break over Christmas

7) -Catch-up: What happened over Christmas?

Review previous sessions

-Feeling check with feeling cards

-C.A.R.E. Kit Lesson #7

"Someone might try to talk you into touching that is wrong."

-Popcorn and movie: Don't Touch

-Discussion about movie

8) -Share previous week's happenings and review previous session

-Feeling check with feeling cards

-C.A.R.E. Kit Lesson #8

"Someone may tell you to keep a secret about touching."

-Activity: Puppet show by children: "Keeping secrets."

-Read: The Trouble With Secrets

-Snack and conversation

9) -Share previous week's happenings and review previous session

-Feeling check with feeling cards

-C.A.R.E. Kit Lesson #9

"Trust your feelings."

-Discussion about anger and the abuse

-Activity: Make a feeling collage

-Read: I Was So Mad and/or Today Was a TErrible Day and/or Alexander and the Terrible, Horrible, no Good, Very Bad Day and/or Grover's Bad, Awful Day

-Snack and conversation

10)-Share previous week's happenings and review previous session

-Feeling check with feeling cards

-C.A.R.E. Kit Lesson #10

"You can say NO."

-Activity: Make a full-sized drawing of an offender and talk to the picture

-Read: Excerpts from It's O.K. to Say NO

-Snack and conversation

11) -Share previous week's happenings and review previous session

-Feeling check with feeling cards

-C.A.R.E. Kit Lesson #11

"You can talk to someone about touching that is wrong."

-Activities: Make believe: Each child may phone her offender and say what she has always wanted to say

Puppet show by therapists: "Sara, an abused child."

-Snack and conversation

12) -Discussion and review of group

-Feeling check with feeling cards

-How do we say good-bye?

-C.A.R.E. Kit Lesson #12

"There are people who can help you."

-Read: <u>It's Not Your Fault</u>

-Fill out Child Questionnaire and SAI

-Fare well party

Appendix C

Self-Appraisal Inventory

Grades K-3

Name: _____

Sex: _____ Yes No

Grade: _____

1. Are you easy to like?
2. Do you often get in trouble at home?
3. Can you give a good talk in front of your class?
4. Do you wish you were younger?
5. Are you an important person in your family?
6. Do you often feel that you are doing badly in school?
7. Do you like being just what you are?
8. Do you have enough friends?
9. Does your family want too much of you?
10. Do you wish you were someone else?
11. Can you wait your turn easily?

Yes No

12. Do your friends usually do what you say?
13. Is it easy for you to do good in school?
14. Do you often break your promises?
15. Do most children have fewer friends than you?
16. Are you smart?
17. Are most children better liked than you?
18. Are you one of the last to be chosen for games?
19. Are the things you do at school easy for you?
20. Do you know a lot?
21. Can you get good grades if you want to?
22. Do you forget most of what you learn?
23. Do you feel lonely very often?
24. If you have something to say do you usually say it?
25. Do you get upset easily at home?
26. Do you often feel ashamed of yourself?
27. Do you like the teacher to ask you questions in front of the other children?

	Yes	No
28. Do the other children in class think you are a good worker?		
29. Are you hard to be friends with?		
30. Do you find it hard to talk in your class?		
31. Are most children able to finish their schoolwork more quickly than you?		
32. Do members of your family pick on you?		
33. Are you any trouble to your family?		
34. Is your family proud of you?		
35. Can you talk to your family when you have a problem?		
36. Do your parents like you even if you've done something bad?		

Self-Appraisal Inventory

Grades 4-6

Name: _____

Sex: _____ Yes No

Grade: _____

1. Other children are interested in me.
2. Schoolwork is fairly easy for me.
3. I am satisfied to be just what I am.
4. I should get along better with other children than I do.
5. I often get into trouble at home.
6. My teachers usually like me.
7. I am a cheerful person.
8. Other children are often mean to me.
9. I do my share of work at home.
10. I often feel upset in school.
11. I'm not very smart.
12. No one pays much attention to me at home.
13. I can get good grades if I want to.
14. I can be trusted.
15. I am popular with kids my own age.

	Yes	No
16. My family isn't very proud of me.		
17. I forget most of what I learn.		
18. I am easy to like.		
19. Girls seem to like me.		
20. My family is glad when I do things with them.		
21. I often volunteer to do things in class.		
22. I'm not a very happy person.		
23. I am lonely very often.		
24. The members of my family don't usually like my ideas.		
25. I am a good student.		
26. I can't seem to do things right.		
27. Older kids like me.		
28. I behave badly at home.		
29. I often get discouraged in school.		
30. I wish I were younger.		
31. I am friendly toward other people.		
32. I usually get along with my family as well as I should.		

	Yes	No
33. My teacher makes me feel I'm not good enough.		
34. I like being the way I am.		
35. Most people are much better liked than I am.		
36. I cause trouble to my family.		
37. I am slow finishing my school work.		
38. I am often unhappy.		
39. Boys seem to like me.		
40. I live up to what is expected of me.		
41. I can give a good report in front of the class.		
42. I am not as nice looking as most people.		
43. I have many friends.		
44. My parents don't seem interested in the things I do.		
45. I am proud of my school work.		
46. If I have something to say, I usually say it.		
47. I am among the last to be chosen for teams.		

	Yes	No
48. I feel that my family usually doesn't trust me.		
49. I am a good reader.		
50. I can usually figure out difficult things.		
51. It is hard for me to make friends.		
52. My family would help me in any kind of trouble.		
53. I am not doing as well in school as I would like.		
54. I have a lot of self-control.		
55. Friends usually follow my ideas.		
56. My family understands me.		
57. I find it hard to talk in front of the class.		
58. I often feel ashamed of myself.		
59. I wish I had more close friends.		
60. My family often expects too much of me.		
61. I am good in my school work.		
62. I am a good person.		
63. Others find me hard to be friendly with.		
64. I get upset easily at home.		

	Yes	No
65. I don't like to be called on in class.		
66. I wish I were someone else.		
67. Other children think I am fun to be with.		
68. I am an important person in my family.		
69. My classmates think I am a poor student.		
70. I often feel uneasy.		
71. Other children often don't like to be with me.		
72. My family and I have a lot of fun together.		
73. I would like to drop out of school.		
74. Not too many people really trust me.		
75. My family usually considers my feelings.		
76. I can do hard homework assignments.		
77. I can't be depended upon.		

Appendix D

Child Questionnaire

1. I am going to show you a card. It shows a boy and a girl.

   (a) When I say the private parts of the girl point to them:

   Vagina (or Genitals)_____ Breasts_____ Bottom_____

   (b) When I say the private parts of the boy point to them:

   Penis (or Genitals)_____ Bottom_____

2. We all have a body. Tell me who your body belongs to. Record child's response.

   _____

   _____

3. We all have feelings. What are some feelings that people have? Parent may encourage by saying, "And what other feelings do you know about?"

   _____

   _____

4. What do you think Trust your feelings means? Record child's response.

_____

_____

5. (a) Is it O.K. for someone you know to touch your private parts? Check child's response.

YES_____ NO_____ SOMETIMES_____

Other responses: _____

(b) Tell me more about it._____

_____

(c) If the response to 5(a) is YES or SOMETIMES, ask the following question: When is it not O.K. for someone you know to touch your private parts?

_____

(d) If the reponse to 5(a) is NO or SOMETIMES, ask the following question: When is it O.K. for someone you know to touch your private parts?

_____

6. What can you do if someone touches you in a way you don't like? Record child's response. Parent may also say, "And what else can you do?"

_____

_____

7. If someone wants you to touch their private parts, what can you do? Record child's response.

_____

_____

_____

8. Who can you tell if someone touches you in a way you don't like? Record child's response. Parent may encourage by saying "Who else can you tell?"

_____

_____

9. Is it ever O.K. to keep a secret about touching?

Check child's response. YES_____ NO_____

Other responses:_____

_____

Appendix E

Revised Child Behavior Profile

In order to better help us understand your child, please answer each of the following questions about your child and family. When describing your child, please think about his/her behavior during the past month. Please try to answer each question. All information will be kept confidential. Select only one answer for each question.

The following questions apply to you. Please circle the best answer as it applies to yourself.

1. You are the child's:
   1. Mother
   2. Father
   3. Stepmother
   4. Stepfather
   5. Other, specify

2. Education: (circle one)
   1. None
   2. Grades 1-4
   3. Grades 5-8
   4. Grades 9-12
   5. Tech. or Voc. Training
   6. University Education
3. What is the appropriate yearly family income from all sources:
   1. less than $5,000
   2. $5,000-$9,999
   3. $10,000-$19,999
   4. $20,000-$29,999
   5. $30,000-$39,999
   6. over $40,000
4. How many people are dependent on this income?_____
5. Are you currently:
   1. Married
   2. Living as married
   3. Separated
   4. Divorced
   5. Widowed
   6. Never married

6. Please list the people living in your home:

Name	Age	Relationship to you

7. The following questions ask you to describe your life as you now see it. Circle the best answer to each question.

   a. Are there adults you know whom you could call upon for help if you really needed it?

YES	NO	NOT SURE
1	2	3

   b. If you needed to leave town quickly, is there someone whom you would trust to look after your house and belongings?

YES	NO	NOT SURE
1	2	3

c. If you had to leave town quickly, is there someone whom you would trust to look after your child(ren)?

YES	NO	NOT SURE
1	2	3

d. Have you engaged in a social activity with other adults outside your home in the last:

24 HOURS	WEEK	MONTH
1	2	3

e. Have you engaged in a social activity inside your home in the last:

24 HOURS	WEEK	MONTH
1	2	3

f. Have you talked with an adult who cares about you, and you care about, in the last:

24 HOURS	WEEK	MONTH
1	2	3

g. Are most of your contacts with other adults initiated:

1. By you
2. By others
3. Sometimes by you and sometimes by others

h. Are most of your contacts with other adults:

1. Positive, supportive or pleasant
2. Neutral, neither positive nor negative
3. Negative, conflictual or aversive

8. The following questions have to do with the child you believe may have been sexually abused. Sometimes significant events in a child's life are important in understanding a child's behavior and emotional reactions. Following is a list of events. Please read through the list two times. As you read through the list for the first time, please place a check mark in Column 1 beside any event which has occurred in your child's life anytime in the past year.

Whether any of the events listed are in fact stressful to a particular child is very much individually determined. Please read the list a second time and for each event which has happened in your child's life in the past year, if you believe that event has been stressful to the child, place an X in Column 2.

Column 1 Did it occur? (✓)		Column 2 Stressful? (X)
_____	Death of a parent	_____
_____	Serious injury/illness to child	_____
_____	Serious injury/illness to parent	_____
_____	Serious injury/illness to sister or brother of child	_____
_____	Change of schools	_____
_____	Family moved to new house or apartment	_____
_____	New infant or adult joined the family	_____
_____	Family income significantly decreased	_____
_____	Child's parents divorced or separated	_____

9. For each of the following statements, indicate whether the statement is true or not true by placing an (X) in the appropriate column.

	TRUE	NOT TRUE
a. My family is usually under some kind of stress.	____	____
b. My child is behaving more or less like she/he always does.	____	____
c. I do not handle stress well.	____	____
d. I have close friends whom I trust.	____	____
e. I am able to tolerate stress and problems well.	____	____
f. My child is able to tolerate stress and problems well.	____	____
g. My child is usually not happy.	____	____
h. I am basically alone with no one to help or support me.	____	____
i. Our family life is often hectic and chaotic.	____	____
j. I am usually happy.	____	____

10. Thinking about the child you believe has been sexually abused, please put an (X) in the blank which most nearly describes how often each behavior or characteristic occurs for the child.

	Never	Rarely	Some-times	Often	Almost Always
1. Academic problems	_____	_____	_____	_____	_____
2. Aggressive behavior (e.g. yells, hits or breaks things)	_____	_____	_____	_____	_____
3. Hangs around with a bad crowd	_____	_____	_____	_____	_____
4. Can't fall asleep	_____	_____	_____	_____	_____
5. Has concern for others	_____	_____	_____	_____	_____
6. Excessive activity, restlessness, fidgity	_____	_____	_____	_____	_____
7. Stubborn, negative, obstinate	_____	_____	_____	_____	_____
8. Doesn't do what told	_____	_____	_____	_____	_____
9. Bullies other kids	_____	_____	_____	_____	_____

	Never	Rarely	Some-times	Often	Almost Always
10. Moods change quickly	_____	_____	_____	_____	_____
11. Easily frustrated or distracted	_____	_____	_____	_____	_____
12. Nice or pleasant disposition	_____	_____	_____	_____	_____
13. Temper tantrums	_____	_____	_____	_____	_____
14. Doesn't listen	_____	_____	_____	_____	_____
15. Has difficulty talking or communicating	_____	_____	_____	_____	_____
16. Thinks a lot about or talks a lot about accidents or tragedy	_____	_____	_____	_____	_____
17. Has difficulty waiting for his/her turn	_____	_____	_____	_____	_____
18. Blames others for what he/she has done wrong	_____	_____	_____	_____	_____

	Never	Rarely	Some-times	Often	Almost Always
19. Dizziness/fainting	_____	_____	_____	_____	_____
20. Spends time with friends or other children	_____	_____	_____	_____	_____
21. Breaks household rules	_____	_____	_____	_____	_____
22. Sets fires	_____	_____	_____	_____	_____
23. Breaks into other people's homes	_____	_____	_____	_____	_____
24. Feels guilty or badly after doing something wrong	_____	_____	_____	_____	_____
25. Lies/doesn't tell the truth	_____	_____	_____	_____	_____
26. Goes to the bathroom (soils clothing) during the day	_____	_____	_____	_____	_____
27. Clings to parents	_____	_____	_____	_____	_____
28. Afraid of the dark	_____	_____	_____	_____	_____
29. Demanding, needs constant attention	_____	_____	_____	_____	_____

	Never	Rarely	Some-times	Often	Almost Always
30. Reluctant to go to school	_____	_____	_____	_____	_____
31. Avoids contact with peers	_____	_____	_____	_____	_____
32. Overly concerned with what people say about him/her	_____	_____	_____	_____	_____
33. Sexaully active	_____	_____	_____	_____	_____
34. Acts like a baby (e.g. uses a bottle, whines a lot)	_____	_____	_____	_____	_____
35. Has panic or anxiety attacks	_____	_____	_____	_____	_____
36. Avoids contact with non-related adults	_____	_____	_____	_____	_____
37. Afraid of being alone	_____	_____	_____	_____	_____
38. Easily startled, overly sensitive to noises	_____	_____	_____	_____	_____

	Never	Rarely	Some-times	Often	Almost Always
39. Runs away, takes off	_____	_____	_____	_____	_____
40. Depressed or very unhappy	_____	_____	_____	_____	_____
41. Withdraws from usual activities of friendships	_____	_____	_____	_____	_____
42. Generalized fears (e.g. afraid of leaving home, or riding in a car)	_____	_____	_____	_____	_____
43. Tries to kill self	_____	_____	_____	_____	_____
44. Involves younger children in sexual play	_____	_____	_____	_____	_____
45. Kind, considerate, helpful	_____	_____	_____	_____	_____
46. Overly concerned about cleanliness	_____	_____	_____	_____	_____
47. Does not like his/her body	_____	_____	_____	_____	_____

	Never	Rarely	Some-times	Often	Almost Always
48. Keeps anger or hostility bottled up inside	____	____	____	____	____
49. Day dreams excessively, has memory loss, unable to concentrate	____	____	____	____	____
50. Major problems with police	____	____	____	____	____
51. Hurts self physically	____	____	____	____	____
52. Bizarre behavior, incoherent or loose speech and thoughts, sees or hears things which are not really there	____	____	____	____	____
53. Overly compliant, too anxious to please	____	____	____	____	____

	Never	Rarely	Some-times	Often	Almost Always
54. Uses drugs or alcohol	_____	_____	_____	_____	_____
55. Motivated	_____	_____	_____	_____	_____
56. Walks in his/her sleep	_____	_____	_____	_____	_____
57. Afraid of adult men or boys	_____	_____	_____	_____	_____
58. Talks about hurting or killing self	_____	_____	_____	_____	_____
59. Stomach aches, headaches	_____	_____	_____	_____	_____
60. Places self in dangerous situations (risk-taking)	_____	_____	_____	_____	_____
61. Overly affectionate	_____	_____	_____	_____	_____
62. Talks about doing violence (hurting others)	_____	_____	_____	_____	_____
63. Overly emotional (cries easily, supersensitive)	_____	_____	_____	_____	_____

	Never	Rarely	Some-times	Often	Almost Always
64. Afraid of certain places	_____	_____	_____	_____	_____
65. Nightmares	_____	_____	_____	_____	_____
66. Thinks about or talks about the same thing over and over	_____	_____	_____	_____	_____
67. Non-academic school behavior problems	_____	_____	_____	_____	_____
68. Difficulty making and maintaining friendships	_____	_____	_____	_____	_____
69. Is able to relax	_____	_____	_____	_____	_____
70. Minor problems with police (e.g. shop-lifting	_____	_____	_____	_____	_____
71. Shy or socially isolated	_____	_____	_____	_____	_____
72. Very concerned with following family rules	_____	_____	_____	_____	_____

	Never	Rarely	Some-times	Often	Almost Always
73. Steals	_____	_____	_____	_____	_____
74. Has good moral or ethical values	_____	_____	_____	_____	_____
75. Loyalty to others	_____	_____	_____	_____	_____
76. Periodically binge eats (eats to excess)	_____	_____	_____	_____	_____
77. Self critical	_____	_____	_____	_____	_____
78. Does not finish things he/she starts	_____	_____	_____	_____	_____
79. Wets bed at night	_____	_____	_____	_____	_____
80. Responds quickly to directions	_____	_____	_____	_____	_____
81. Is pleasant, nice to be around	_____	_____	_____	_____	_____
82. Gets upset easily	_____	_____	_____	_____	_____
83. Attends school regularly	_____	_____	_____	_____	_____
84. Is irritable	_____	_____	_____	_____	_____
85. Lots of pep, energy	_____	_____	_____	_____	_____

	Never	Rarely	Some-times	Often	Almost Always
86. Goes to the bathroom (wets clothing) during the day	____	____	____	____	____
87. Easily quieted	____	____	____	____	____
88. Fusses and frets	____	____	____	____	____
89. Slow to understand	____	____	____	____	____
90. Easy to care for	____	____	____	____	____
91. Uncontrolled, unruly, defiant	____	____	____	____	____
92. Cooperative	____	____	____	____	____
93. Tense	____	____	____	____	____
94. Nervous	____	____	____	____	____
95. Patient, calm	____	____	____	____	____
96. Rational, logical, uses common sense	____	____	____	____	____
97. Lethargic or lazy	____	____	____	____	____
98. Loving, caring	____	____	____	____	____
99. Antagonistic, hostile	____	____	____	____	____

	Never	Rarely	Some-times	Often	Almost Always
100. Conscientious	_____	_____	_____	_____	_____
101. Feels inferior	_____	_____	_____	_____	_____
102. Works hard	_____	_____	_____	_____	_____
103. Able to concentrate	_____	_____	_____	_____	_____
104. Dislikes parents	_____	_____	_____	_____	_____
105. Thinks others don't like him/her	_____	_____	_____	_____	_____
106. Seductive	_____	_____	_____	_____	_____
107. Gets pushed around	_____	_____	_____	_____	_____
108. Lacks self-confidence	_____	_____	_____	_____	_____
109. Secure, confident	_____	_____	_____	_____	_____
110. Loss of appetite	_____	_____	_____	_____	_____

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