INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

Bell & Howell Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA

UMI®
800-521-0600

LIFE CRISIS AS AN IMPETUS FOR CHANGE: A GROUP INTERVENTION FOR SEXUALLY INAPPROPRIATE CHILDREN

BY

ELVERA J. WATSON

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements for the Degree of

MASTER OF SOCIAL WORK

Department of Social Work
University of Manitoba
Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

Life Crisis as an Impetus for Change: A Group Intervention for Sexually Inappropriate Children

BY

Elvera J. Watson

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of Master of Social Work

TABLE OF CONTENTS

ABSTRACT

Research on adult perpetrator of sexual abuse indicates that the majority of adult sexual offenders began their sexually intrusive behaviour when they were adolescents (Lane & Ryan, 1997). It is now clear that this behavior may begin at an earlier age (Pearce & Pezzot-Pearce, 1997). The realization that children are sexually molesting other children is cause for a growing concern for professionals and parents alike. There are increased numbers of children under the age of twelve who are being sexual with other children (Gil & Johnson, 1993; Lane & Ryan, 1997). The concept that adults involve children in sexual acts is abhorrent by most social standards, but even more startling is the idea that children are molesting other children. Furthermore, the observation that this increased number of sexually acting out children are often missed or ignored, presents the additional concern of how to protect other children from potential abuse. A sexually acting out child under the age of twelve bypasses the legal ramifications of his/her behaviors and social service agencies do not have policies in place that help these children and simultaneously protect other children.

A growing awareness of sexually acting out behaviour in young children in the social service stream prompted an exploration of resources for this population. Unfortunately, only limited resources and interventions are available to address the behaviours of young sexually acting out children. The purpose of this practicum was to explore effective interventions for sexually acting out children and then to develop, implement and evaluate an intervention that would assist these children and their caregivers. Additionally, the purpose was to practice advanced clinical social work skills.

The primary intervention was a group format, utilizing a psychoeducation, cognitive approach, informed by small group theory. There were two simultaneous groups conducted, one for the children and one for their caregivers. The children's group provided participants an avenue for understanding their sexually acting out behaviours, examining feelings, addressing sexuality and developing healthy manifestations of sexuality, reducing isolation and stigmatization and practicing healthy problem-solving and coping skills. The parent group facilitated an understanding of the sexually acting out behaviours and developed positive coping strategies through the provision of mutual support, education, reduced isolation and improved parent/child relationships.

The preliminary research findings indicate that the children's group was beneficial to the group members. Some of the most significant findings were that the participants' and caregivers' sense of isolation and stigmatization were minimized and that members experienced an enriched understanding of sexually acting out behaviours. For the children's group, they identified that the recognition of their own triggers to sexualized behaviours and strengthened positive coping strategies were important to them in the prevention of further sexual inappropriate behaviours

DEDICATION AND ACKNOWLEDGMENTS

To my father, Edmund Fleming Watson, who always believed living was learning.

Heartfelt appreciation and thank-you to my family for their constant encouragement, support, and love. I thank my partner, Marcial, for his continued support and his help, my son, Siobhan, who bore with this process, and my son, Diego, born during this process. I am grateful to my family and friends, who always knew I would finish, even when I thought I could do no more, who provided babysitting, editing and comfort. Thank-you to my friend and colleague, Arliss Kurtz, who lit the path for me.

Acknowledgments go to the members of my committee for their many hours of editing, supervision, consultation and support. Gratitude is extended to New Directions for the use of their facility and their enthusiasm in my project. I offer my appreciation in particular to Alison Lund, M.S.W., who co-facilitated the children's group, and Barbara Quesnel M.S.W., who provided supervision and facilitated the parent group.

CHAPTER ONE

Introduction

For the past ten years I have worked with young children at Winnipeg Child and Family Services. I repeatedly receive referrals for preadolescent children that are described as sexually inappropriate in their behaviors. Many of these children are identified at a point when they have already elicited sexual actions from other children. In reflection, the caregivers have observed the child as engaging in other overt sexualized behaviors prior to the point of elicitation. However, due to lack of knowledge and understanding, they waited too long to intervene. This suggests that with education and intervention, many children could be identified and helped *before* they reach the stage of acting out sexually on other children.

Sometimes these children are living in the homes of their biological family and the victims of their sexually intrusive behaviours are younger siblings or extended family members. In other situations, the children are living in foster care and they are sexually inappropriate with foster siblings. Sexually acting out children do not always limit their inappropriate behaviors to their homes, but are also observed to act inappropriately in schools, at daycare centers or in their communities. Due to the lack of current knowledge in this area, sexually acting out behaviours are more often than not ignored or minimized because individuals do not know how to respond to the behaviors nor do they recognize the seriousness of the behaviour.

Not only is there confusion about what constitutes healthy and expected sexual behavior in young children, but when sexual behaviour is identified as a problem there is a

noted gap in resources for the sexualized preadolescent. Many professionals do not know how to assess these situations, nor do they have the social policies in place to guide them through the process of working with these children and their families. Nation-wide, there are no social policies in place that address this issue. Since the issue is not dealt with by the judicial system it falls into the realm of child welfare or children's mental health. These systems do not have the necessary social policies that direct intervention. As a result, over time, without intervention these children will likely continue to act out sexually.

Without possible intervention, the behaviours may become progressive in nature and other children continue to be harmed and affected (Gil & Johnson, 1993). In some cases their caregivers renounce any commitment to care for the children because they do not feel able to manage, help, control or change the child's behaviours. The circumstances for these children continue to compound often becoming very complex. It is observed that schools, communities and peers quickly follow suit in rejecting these children based on their sexualized behaviours.

Frequently, sexually intrusive children come to the attention of child welfare agencies because they are posing the potential risk of harming other children. When the family or caregiver voluntarily seek private therapy, the tendency is to use models of intervention that have been developed for the adult or adolescent sexual offender. Unfortunately, these interventions can not always be effectively transposed for children. One differentiating consideration is that sexually acting out children often have not yet reached a level of perpetual offending. The sexually intrusive child still feels shame and

remorse and wants to stop his/her behavior (Gil & Johnson, 1993).

As well, young sexually intrusive children and their families have few resources at their disposal. If these children come into care (typically for other reasons), the sexually acting out behaviours make these children difficult to place. Because they may pose a risk to other children and caregivers may not know how to manage sexually acting out behaviours, finding such behaviour offensive, no one is quite sure what to do with these children. Other issues, such as a lack of education and support for caregivers increases the likelihood that when these children are placed in foster homes they will be unsuccessful in maintaining their placements. Obviously, without a specific intervention that addresses these issues, children who are sexually intrusive are at risk to continue in their behaviours. This practicum was designed to understand the context of sexualization in young children and explore intervention options that would support families and decrease this behavior in children.

Practicum Objectives

In light of the above information and concerns, the primary practicum objective was to provide a resource for preadolescent sexually acting out children and their families or caregivers. To accomplish this goal, a group intervention was designed and implemented. A psycho-educational group format was adopted and a cognitive behavioral model of intervention was utilized.

Objectives for the group intervention were as follows:

1. To provide education and support for those individuals parenting sexual acting out children. The intervention was to emphasize the need to understand the

child's behavior and to help the child monitor and control the behavior.

2. To help sexualized children understand the context of their behaviour, encourage them to take responsibility for their actions and emphasize impulse control and self-monitoring techniques to control their behavior.

3. To help sexualized children develop healthy coping strategies for stressors, problem-solving skills, enhance self-esteem and practice healthy social skills.

Learning objectives for the practicum included the following:

1. To help sexually acting out children develop feelings and empathy recognition.

2. To broaden and practice my clinical social work skills with small groups, to become more familiar with cognitive theory, and group work theory, particularly with this presenting problem.

6. To gain a greater understanding of and use standardized assessment measures, and evaluate their usefulness as pre and post intervention tools.

CHAPTER TWO

Literature Review

Sexualized Behaviour Defined

Sensuality or sexualization are not usually concepts attributed to young children. Yet, sensuality is the enjoyment of human touch. Human beings are inherently sexual in nature. Human touch is one of the first and most important stimuli experienced by a child. It is used to comfort, to elicit smiles and to create laughter. These touches are the beginning connections in human relationships. As newborns, parents introduce children to kissing, touching and cuddling. Rarely do parents think of these behaviors as sensual, let alone sexual in nature. Young children are perceived as asexual, not sexual beings. Gil and Johnson (1993) suggest that not only are children sensual, but they are sexual beings and it is natural, expected and healthy for children to develop these traits. Gil and Johnson (1993) differentiate between "healthy and expected sexuality" in children and unhealthy sexualized behaviors.

Gil and Johnson (1993) developed a continuum of sexualized behaviors in children. One end of the continuum identifies healthy and expected sexual behaviours such as same aged preschoolers involved in a mutual body exploration. The other, more extreme, side of the continuum describes unhealthy childhood sexual activity which includes adult-like sexual behaviours. Unhealthy sexualized activity includes such conduct as active molestation of other children (Johnson, 1993). In the literature there are many phrases used to describe sexualized behaviors in children. Terms used to categorize childhood sexual behaviors are sexually inappropriate, sexualized, sexually

reactive and sexually aggressive. A clarification of these terms provides an understanding of the diversity of sexualized behavior in children. This also helps avoid the dilemma that language presents in offering only two words to describe child victims of sexual abuse and children acting out sexually. The children are described as "victims" or more recently, "survivors", or "offenders ", with nothing in between. It is recognized that in discussing children who are sexually intrusive, there are several progressions between victim and offender. Therefore, most children who act out sexually are not "offenders", therefore, defining the terms helps to put sexually acting out behaviours into perspective.

Gil and Johnson use the expression sexualized or sexually inappropriate children in reference ". . . to children who exhibit a range of problematic sexual behaviors such as sexual language, excessive masturbation, or sexual preoccupation (Johnson, 1993, p. xiv). Sexually aggressive children are characterized as sexually molesting other children. Generally, these children are identified as selecting younger, more vulnerable children and using force to obtain compliance and their sexualized behaviours are more progressive in nature (Gil & Johnson, 1993). Gil and Johnson (1993) define sexually acting out children as children involved in excessive masturbation, exposing themselves to others, inserting objects in themselves and sometimes engaging peers or siblings in sexual activity. Gil and Johnson (1993) use the term sexually reactive behaviour when describing sexualized behaviours occurring as a possible coping response to the effects of sexual abuse. Child victims of sexual abuse may use sexual activity to process their trauma experience or to relieve anxiety related to their victimization (Gil & Johnson, 1993). As well, Gil and Johnson (1993) state sexually reactive children have not always experienced direct sexual

abuse at the hands of a perpetrator but, for example, may be responding to a highly sexualized home environment.

Gil and Johnson (1993) group sexual behaviors in children according to the intensity of the sexual acts. Of the children referred as a result of the child's sexual behaviour, Gil and Johnson (1993) identify four different groups. The behaviours in the groups range from healthy and expected behaviours, to behaviours that are corrosive and compulsive placing other children at risk. Group one consists of healthy and expected sexual behaviors in children. Children in this group are experimenting with same age, same size children. These children are curious about sexuality and are acting in a mutual and amicable way with other children. The largest percentage of children who are referred with sexualized behaviour concerns fall into the healthy and expected sexual behavior category. For example, this group would include behaviors described as natural sexual exploration. Children in this group may behave inappropriately and need to be told to stop the behaviours. Often these children feel excited, silly, confused or guilty about their actions, but do not feel shame.

Other behaviors, such as excessive masturbation, exposing one's self and involving other children in sexual acts, but not using force are characteristics of group two. This group of children seem to have a heightened sexuality and higher degree of interest in sexual activity. Children in this group often become obsessed with sexual behaviours, for example masturbating, to the extend that the activity takes over a large part of their daily lives. Sometimes, group two children attempt to involve other, usually same age children, in their activity. These children do not use force or coercion when

engaging other children. Approximately 10% of children will fall into group two. Children in group two tend to feel ashamed and remorseful about their conduct. These children are viewed as wanting to stop their sexually inappropriate actions and are responsive when interventions occur.

Group three includes children who engage in extensive mutual sexual activity that is adult-like in manner. Such behaviours include simulating intercourse, sexual touching and mutual masturbation. Group three children, unlike the children in the other groups, seem ambivalent about their behavior, feeling neither shame, confusion nor anger. Children in group three represent approximately 5% of children who are referred due to intrusive sexual behaviours. This group of children tend to have experienced physical, emotional or sexual abuse and /or live in highly sexualized environments. Sexual activity seems to be a form of human connection for group three children. These children often include other children in their activities and sometimes vacillate to group four, using force to do so (Gil & Johnson, 1993). Sexualized children are distinguished from sexually aggressive children who are aggressive and coercive in their acts (Gil and Johnson, 1993).

Group four consists of children sexually acting out on other children. Generally, these children act out sexually on other children in an angry and aggressive way without empathy or remorse (Gil & Johnson, 1993). Group four children are described as "molesting" other children. This group of children often exhibit disturbed toileting behaviours such as defecating on the floor, urinating outside the toilet, or wearing soiled underwear. All of these children have a past history of emotional abuse, family violence and environments characterized by their lack of boundaries. The parents of the children in

group four often have a history of sexual abuse. The children in this group pair emotions like rage, fear and loneliness, with sex. This population presents a serious risk of offending against other children. When these children act out sexually they feel worse and the intensity of their feelings remains high. Approximately 3 % of sexually acting out children fall into the fourth group (Gil & Johnson, 1993).

Gil and Johnson (1993) say that there are several considerations that assist in determining if sexual activity is age-appropriate. One such factor examines the roles of power and status in the relationships between the children. Other concerns are extreme differences in age and size between the children involved. Additional dynamics that differentiate age-appropriate sexual behavior from unhealthy sexual activity is the type, frequency and intensity of sexual activity observed. For example, if one child was the babysitter they would be perceived as having greater power, size and status in the relationship (Gil & Johnson, 1993). In this case, the sexual activity would likely be described as inappropriate.

Friedrich (1990) describes unhealthy sexual acts in children somewhat differently. He describes three levels of sexual behaviour including inappropriate sexual behavior, sexually aggressive children, and sexually reactive children (Friedrich, 1990). Sexually inappropriate or sexualized activity consists of persistent or open masturbation, touching the genitals of others, asking others to touch their genitals, excessive interest in sexual matters, sexualizing non sexual situations, imitation of adult sexual behavior and sexualized play (Friedrich, 1990). Sexually aggressive children display behaviours that involve other children by the use force or coercion (Friedrich, 1990). For Friedrich

(1990) sexually reactive children present themselves in a heightened sexual manner. These children are characterized as interacting with other children or adults in a sexualized manner. Friedrich (1990) identifies sexually reactive activity as one of the responses a child may have to a sexual abuse experience.

Beverly James (1989) identifies sexualized behavior in children as developing from a traumatic event such as sexual abuse. James (1989) associates eroticized or sexualized behaviors as a victim's reaction to his/her sexual abuse experience. Sexualized behaviors are distinguished from sexually aggressive actions which generally include an element of coercion (Friedrich, 1990; Gil & Johnson, 1993; James, 1989).

Further literature reviewed by Burton, Christopherson and Rasmussen (1992) suggests that there are five factors that contribute to children engaging other children sexually. These predictors are listed as prior trauma, inadequate socials skills, lack of social intimacy, impulsiveness and perceived lack of accountability Possible combinations of these factors result in outcomes such as lowered self-esteem, self-destructive behaviors and sexual or physical assaults on others (Rasmussen et al., 1992). Sexually acting out behaviors in children are viewed as a manifestation of a trauma in conjunction with one or several precursors (Rasmussen et al., 1992). For example, a victim of sexual abuse with low self-esteem and poorly defined social boundaries is apt to be at risk to act out sexually on other children.

For the purposes of this practicum, Gil and Johnson's (1993) definition of sexually acting out children will be used (i.e., children engaged in sexualized behavior with other children). The term sexually acting out is understood to mean the child is

acting out sexually and may, or may not have been sexually abused. The terms sexualized, sexually intrusive, sexually acting out and sexually inappropriate will be viewed as interchangeable throughout this report. Sexually reactive children will be considered sexualized in their behaviours as the result of an overt or covert past sexual abuse experience (Friedrich, 1990). In accordance with Johnson and Gil (1993) not all sexualized children have been sexually victimized. Therefore, as described by the literature (Gil & Johnson, 1993; James, 1989; Rasmussen et al, 1992) this practicum defines sexually acting out behaviours as resulting from a possible past trauma in the child's life. For example, the sexualized behaviours in children can result from posttraumatic stress disorder.

Sexualized behaviors are only one of the many symptoms seen in posttraumatic stress disorders (Abueg, Follette, & Ruzek, 1998; Friedrich, 1990; Gil & Johnson, 1993; James, 1989). Trauma events may involve experiences such as sexual abuse or extreme physical abuse. The sexualized behavior is viewed as the child's attempt to gain mastery over feelings of helplessness, anxiety or powerlessness (Friedrich, 1990; Gil & Johnson, 1993; James, 1989; Ryan, 1989).

A Review of Healthy Sexuality in Children

A review of natural and healthy sexuality in children clarifies what behaviors are considered atypical sexual development in children. Friedrich (1990) identifies sexual development as occurring naturally in infancy through to twelve years of age. Some healthy sexual behaviors observed in infants are erections in male babies (recorded as occurring at five months of age), masturbation (rubbing against toys or objects) and

orgasmic-like responses by infants (as young as five months). Preschoolers are discovered exploring each other's body, enjoying exhibitionism, modeling adult mannerisms and joining in homo/heterosexual sex play (Friedrich, 1990). Friedrich (1990) typifies these overt sexual behaviors as diminishing as children reach 5 to 6 years of age.

Kuehnle (1996) confirms that there is a range of sexual activity performed by sexually abused and non sexually abused children. Kuehnle (1996) points out that babies under a year undertake genital stimulation and these behaviors are observed to continue as children age. Sgroi (1988) compartmentalizes healthy childhood sexual development into three categories: touching oneself, looking at others and touching others. Healthy sexual activity in children includes self stimulation and observing others in such acts as dressing, bathing or using the toilet. As children age, healthy sexual behaviors extend to touching others. Children become involved with other children in games like playing doctor (Kuehnle, 1996). Evidently, sexual interest and exploration is a natural and healthy part of childhood development. Friedrich (1990) perceives that as children grow older their curiosity and exploration regarding sexuality becomes more covert. Children hide their sexual interests as they accept their cultural and social norms.

What is not considered healthy sexual conduct in children is the initiation of sexual activities by adolescents with younger children or when younger children employ older ones. Unhealthy sexual development is also marked by excessive masturbation and preoccupation with sexual acts which interfere in daily social life. Another indicator of unhealthy sexual behavior is the use of coercion to gain compliance in sexual acts

(Kuehnle, 1996; Sgroi, 1988).

Factors Associated with Sexually Acting Out Behaviours

The literature contains numerous assumptions about the cause of sexually acting out behaviours (Friedrich, 1990; Gil & Johnson, 1993; James, 1989). Most commonly, sexually inappropriate behaviors are described as one of the potential manifestations of sexual abuse in young children (Friedrich, 1990; James, 1989; Pearce & Pezzot-Pearce, 1997; Ryan, 1989). Pearce and Pezzot-Pearce (1997) report that Friedrich found that 28% of children who are sexually assaulted act out in sexualized ways. These victim effects can persist into adolescence or adulthood.

Evident is the increased occurrence of adolescent offenders who began offending prior to the age of twelve (English, Henderson, & Mackenzie, 1989). English et al. (1989) reported that 34% of the 73 cases included in their study admitted using force to commit sexual acts on others at a preadolescent age. Data by English et al. (1989) indicate that 75% of the adolescents disclosed a history of sexual victimization. This research suggests a correlation between sexual victimization of males and adolescent sexual offending behaviours.

Gil and Johnson (1993) and Ryan (1989) draw parallels between victims of childhood sexual abuse and the sexually acting out behaviours. They suggest that sexual offending may be part of the post-traumatic stress disorder caused by the child's own victimization. The child's sexualized behaviour is an attempt to master and control his/her own sense of helplessness and powerlessness over his/her abuse. A past childhood sexual abuse event often becomes connected to the feelings elicited by that event.

Frequently, victims describe these feelings as shame, anger, fear, and helplessness. Subsequently, when any life situation triggers those feelings, the victim response is to enter a cycle of sexual arousal and sexual aggression (Ryan, 1989). Ryan (1989) characterizes the victim and the offender as both having power and control issues. The child victim is viewed as identifying with the perpetrator and integrating the offender's distorted thinking patterns (Ryan, 1989). It is an attempt to work through confusion about one's own sexuality. In later research, adolescent sexual offending is described as "healthy sexual development gone wrong" (Lane & Ryan, 1997, p. 37). This type of behaviour is more common to the group two children described by Gil and Johnson (1993).

Bagley, Wood, and Young (1994) explored the connection between sexually acting out behavior in childhood sexual abuse victims and further sexual offending behaviors as an adolescent or adult. Consistent with Ryan (1989), Bagley et al. (1994) found that a relationship exists between adult offending behaviors and emotional abuse combined with multiple events of sexual abuse in childhood. Gil and Johnson (1993) suggest that children who are molested often respond to their own victim experience by reacting to others in a sexual manner.

Another perspective, offered by Canavan, Meyer, and Higgs (1992), suggests that sexualization of children often begins within the sibling relationship. Canavan et al. (1992) review sibling incest, delineating two types of experiences. Sibling incest is separated into that occurring in a nurturing relationship and secondly, incest happening in a power dominated relationship. The sexualized behaviours which occur at similar ages,

in a nurturing experience, do not betray trust and are found to be non traumatic. This experience is viewed as a mutual and natural sexual exploration. On the other hand, incest occurring in a power charged relationship has negative after effects (Canavan et al., 1992).

De Jong (1989) agrees that cousin/sibling incest is a common forum for sexual interactions among children. Cousin/sibling incest can be experimental or exploitative in nature (De Jong, 1989). This information is important in assessing the impact sexually acting out behaviors have on the victim. This information concurs that sexualized behaviors between children that is mutual and does not betray trust or power, has no long lasting effect. The literature indicates that sexually acting out behaviors usually occur in the context of a power differentiation and are not always mutual in nature. Therefore, these behaviors would indicate sexually acting out children pose a serious risk to other children.

Many sexualized children first experiment within the family setting (Gil & Johnson, 1993). Johnson (1989) also reports that many female child victims of incest in turn victimize children in their own families. This emphasizes that girls, as well as, boys adopt sexualized and sexually acting out behaviors . Further, Johnson (1989) emphasizes that a victim's issues need to be addressed to prevent further victimization in a family. Kuehnle (1999) also agrees that child sexual abuse victims need to reclaim healthy sexual boundaries.

Social learning theory adds further information as to why children may act out sexually. Bandura (1977), a social learning theorist, says that behavior is a learned

experience. Accordingly, social learning theory assumes that a sexualized child has either witnessed sexual behavior or has been victimized (i.e., that the behavior is learned in a social context by observation or experience). In heeding Bandura's principles, sexually acting out behaviors in children are an integrated learned behaviour. That behavior is then reciprocated. Behavior comes from observing and later, modeling, or acting out those observations (Bandura, 1977).

Kuehnle (1999) claims that some young children have been inappropriately sexualized. A sexualized child must unlearn his/her sexualized behaviors the same way all children are discouraged from repeating socially unacceptable behaviors such as nose picking (Kuehnle, 1999). Kuehnle (1999) suggests that these children cognitively integrate sexualized behaviors and therefore, can unlearn such behavior.

Kuehnle (1999) also agrees that sexually reactive behaviors are consistent with sexually abused children. Kuehnle (1999) claims that very young children do not display adult sexual behaviors without having some affiliation with such behavior. She states that very young children who have not disclosed sexual abuse, may demonstrate sexually acting out behaviors. These children may have been sexually abused prior to a time when they had the cognitive ability to process the experience to memory (Kuehnle, 1999). For example, children who are preverbal usually do not have the language skills and cognitive skill to understand a sexual abuse event. Although there may have been physical evidence that a child was sexually assaulted at a young age, a child may not have any memory of such an incident, but may act out sexually (Kuehnle, 1999). Kuehnle's interpretation supports the concept that sexualized behaviors are learned.

An examination of 'pop' culture further expands and supports social learning theory. Popular culture offers insights to the changing trends in today's social values. Twenty years ago, open displays of sexual activity were not permitted on such venues as television or films ("Tracing Sex," 1992). Far more liberal standards apply today. Music videos, films and prime time television programming such as cartoons, soap operas and movies graphically show sexual behaviors. Sexual and violent overtones are seen in many formats by children (Gil & Johnson, 1993). How could this not be viewed as stimulating or encouraging sexual acting out? Professionals, parents and caregivers need to address the role the media has in promoting the sexualization of young children.

Influence of Trauma on Sexually Acting Out Behaviors

Although there is agreement among researchers (Bagley, 1994, English et al., 1989; Friedrich, 1993; Gil & Johnson, 1993; Ryan, 1989) that there is a correlation between childhood sexual abuse and later offending behaviors, that in itself is not sufficient. There is no clear linear causality between the victim becoming the victimizer. The question as to what is the underlying cause of sexually acting out behaviours remains unanswered. Absent in the research is a complete understanding of why non sexually abused children may exhibit sexually intrusive, or sexualized behaviors. Why is it that some children who have never had a sexually abusive experience are sexual with other children? Or for that matter, why is it that all children who have been sexually abused are not molesting other children? Clearly, there are many variables that contribute to a child's sexual acting out. Therefore, any effective intervention must consider and respond to all possible factors.

Rasmussen et al. (1992) emphasize how a variety factors combine to influence sexually acting out behavior. One factor is non sexual traumatic events in an individual's life. Rasmussen et al. (1992) do not adhere to defining the trauma experience within the narrow parameters of sexual abuse. Trauma effects relate to a multitude of situations. For example, trauma effects are observed when a child experiences a separation or loss, is a witness to violence such as a domestic assault or murder or experiences a natural disaster or accident. The literature (Gil & Johnson, 1993; James, 1989; Rasmussen et al., 1992) suggests that traumatic events combined with poor coping skills, a lowered sense of self-esteem and a sense of helplessness may pose a risk for sexualized behavior.

Beverly James (1989) describes trauma as "...overwhelming, uncontrollable experiences that psychologically impact victims by creating in them feelings of helplessness, vulnerability, loss of safety and loss of control" (James, 1989, p.1). James (1989) visualizes trauma as a relative experience; what may be traumatic for one individual may not be traumatic to another. Trauma effects can be life-long depending on an individual's ability to cope, the meaning of the event to the individual and his/her developmental stage (James, 1989). The resulting post-trauma behaviors, categorized as paraphilia behaviors, can become secretive, ritualistic re-enactments of the trauma itself (James, 1989). This replaying of the event serves an emotional need and is an attempt to master the frightening incident. Paraphilia behaviors, left unaltered by a therapeutic process, have the potential to escalate (James, 1989). Manifestations of paraphilia behaviors may occur when the victim becomes the victimizer (James, 1989).

In summary, this literature review highlights the need for greater understanding of

sexualized behaviors in children and maximizes the need for an intervention for this population. In conclusion, sexual abuse does not exclusively explain all sexually inappropriate behaviours in young children, but may be one factor that does contribute. Many factors may be involved in sexually inappropriate behaviours of young children such as a traumatic events, low self-esteem, poor coping skills, pop culture, and sexualized behaviours. Intervention with sexually inappropriate young children is warranted to minimize the continuation of sexualized behaviours. Early intervention offers the sexually acting out preadolescent an opportunity to develop the skills necessary to manage their own behavior, prevents future sexually inappropriate behaviors and offers support and education for the family.

Approaches to Treatment for Sexually Acting Out Children

Several approaches to treatment have been utilized when working with sexually intrusive young children. Gil and Johnson (1993) suggest that many children benefit from individual therapy, group therapy, family therapy or a combination of all three therapeutic approaches dependent on the needs of the child and his/her family. Sexually acting out children that pose a risk to other children, are developmentally delayed, and have a psychiatric diagnosis are better served in an individual therapy program (Gil & Johnson, 1993). Individual therapy is advocated when the child's sexually acting out behaviors do not involve other children. Children can also be prepared for group therapy on an individual basis. Family therapy is encouraged when there are several siblings involved as victims of the acting out child.

Group therapy which involves a parent/caregiver component is recommended by

Johnson and Gil (1993) for the following reasons:

1. Involving parents ensures that the environment that the child was sexually acting out in changes via the parent.

2. Engaging the significant adults in the child's life encourages reinforcement and consequences needed.

3. Children have greater learning success in an interactive environment which provides immediate practice and feedback.

4. Group therapy reduces the sense of isolation that sexually acting out children feel and reduces the level of discomfort for or related to discussing sexual issues.

Other literature reviewed by Acton (1998) and Hird and Morrison (1996) supports group intervention as the most effective resource, ideally, inclusive of caregivers. An intervention that is inclusive of family members or caregivers assures that the child will have ongoing as well as future support and reinforcement to correct his/her behaviors. In addition, family members can assist in protecting other children in the family from victimization (Kuehnle, 1999). As noted by Canaan et al. (1992) and De Jong (1989), siblings or extended family members are often the first victims of sexual acting out. A younger child will be more dependent on adults to monitor, supervise and set limits on his/her behavior (Kuehnle, 1999). This type of intervention offers the most effective and successful approach to working with this population. Early intervention offers the sexually inappropriate preadolescent an opportunity to develop the skills necessary to manage his/her own behavior.

Rasmussen et al. (1992) adopt a treatment approach that is based on social

cognitive theory; the client has a choice to change from unhealthy to healthy coping. The individual can choose to develop the necessary skills to monitor his/her own behaviour. Gil and Johnson (1993) and Rasmussen et al. (1992) favor minimizing abuse effects. Abuse effects, such as lowered self-esteem and helplessness play a critical role in the continued involvement in sexualized behaviors. Therapeutic techniques that increase self-esteem and offer a sense of mastery and control over one's behavior can prevent self-destructive, sexual offending behavior. Gil and Johnson (1993) and Rasmussen et al. (1992) also advocate for early intervention and treatment for sexually inappropriate behaviors in children.

Lane and Ryan (1997) advocate for an intervention that operates on a continuum of care. Lane and Ryan (1997) emphasize that the continuum of care includes ongoing assessment and treatment components. The ongoing assessment should examine the frequency, the degree of exploitation and the amount of justification surrounding sexualized behaviors. Intervention and prevention should focus on heightening victim empathy through cognitive restructuring belief systems and narrative therapy (Lane & Ryan, 1997). Group therapy and family treatment are recommended as effective interventions for juvenile sex offenders (Lane & Ryan, 1997). In their work, Lane and Ryan (1997) suggest that group interventions can be adapted for ten to twelve year old children. The need for skill training is emphasized in such areas as self-talk, self-stopping tactics and impulse control (Lane & Ryan, 1997).

As well, Ryan (1997) proposes that treatment considerations for child sexual abuse victims/ victimizers should attempt to dispel secrecy, address the child's own victimization

and include a component that develops empathy for the child's victim. Therapists should maintain an awareness that children are sometimes preoccupied with fantasies of reenacting one's own victimization (Ryan, 1997). Ryan (1997) supports an early intervention that uses a cognitive approach in a group format for sexually acting out children.

Further literature by Lane and Lobanov-Rostovsky (1997) proposes a combined treatment module for sexually acting out children which involves individual, family and group therapy. Lane and Lobanov-Rostovsky (1997) recommend that groups run simultaneously with family and individual counseling. Group treatment is structured and educational, cultivating accountability and stressing boundaries, privacy, healthy sexuality, problem solving techniques and includes an adapted version of the sexual abuse cycle.

Lane and Ryan (1997) suggest a pyschoeducational group format guided by cognitive restructuring. Group sessions focus on empathy building/victim awareness, sexuality, the role of family dynamics, victimization of self and relapse prevention (Ryan, 1997). Lane and Ryan (1997) propose that cognitive distortions are typical of young sexual offenders. Cognitive distortions allow the individual to support and excuse their inappropriate sexual behavior. Confronting and restructuring the child's misconceptions are critical to address the thinking that permits sexually acting out behaviors (Lane & Ryan, 1997). Cognitive restructuring believes the key to changing one's behavior lies in challenging one's belief system and thinking (Ryan, 1997).

In addition, a training manual developed by Act II Child and Family Services in Coquitlam, British Columbia highlights that professionals need to consider several

approaches when working with children who have sexual behavior problems. This manual favors an approach that involves individual counseling and family therapy. Group treatment can complement and reinforce other therapies. Group work offers sexually inappropriate children a safe therapeutic environment to connect with peers, develop social skills and confront their behaviors (ACT II, 1995).

In considering the usefulness of a cognitive therapy intervention for helping victims of trauma, Abueg, Follette, and Ruzek (1998) reviewed several empirical studies. The research examines trauma experienced by adverse exposure to a stimuli that produces fear and an escape/avoidant response. Such traumatic events are identified as war, natural disasters, physical abuse or sexual abuse (Abueg et al., 1998). Foa, Hearst-Ikeda, and Perry (1995) compared the effect of a brief cognitive-behaviourial prevention program to a no treatment control group of sexual and nonsexual assault survivors. The results demonstrate that most participants improved and those receiving therapy improved at a greater rate, especially in the areas of depression and re-experiencing symptoms.

Resick and Schnicke (1992) conducted a 12 week group based on cognitive processing therapy. The group of 19 sexual assault survivors was compared to 20 survivors on a wait list. Seventeen of the participants showed significant posttreatment reduction in symptoms which were maintained at 3 and 6 month follow ups. This supports the use of a cognitive therapy model in treatment with this population.

Abueg et al. (1998) reviewed several studies involving cognitive behavioral interventions and trauma in children. One such study conducted by Burke (1988) involved a brief, group intervention with 25 sexually abused girls. The group was based on

cognitive therapy strategies which reinforced coping and preventing behaviors. Collected data on depression and anxiety was compared to a no-treatment control group. The outcomes suggest that this model is useful in reducing symptoms, but that the specific population limits the external validity of the study.

Another study, reviewed by Abueg et al. (1998) was conducted with a group consisting of 3 boys and 15 girls. The children in this group experienced externalizing and internalizing post-trauma behaviours like flashbacks, heightened anxiety, depression and fear. This intervention examined the irrational cognitions of the children, reframed these cognitions and rehearsed alternate social and coping skills. The researchers (Hoier, Inderbitzen-Pizaruk, & Shawchuck, 1988) suggest that cognitive therapy is effective in minimizing internalizing behaviors, but not externalizing ones. Abueg et al. (1998) point out that this study did not involve enough male participants to prove externally valid.

Overall, the outcome research reviewed by Abueg et al. (1998) advises that cognitive behavior therapy is an effective intervention for reducing behaviors with children experiencing trauma symptoms. Abueg et al. (1998) imply that this research holds several areas of concern. Often, the analysis did not comment on the comprehensiveness of the assessment process of the child (i.e., Abueg et al. (1998) question the thoroughness of researchers' data base and if assessments were completed on the child's environment). This is indicative of the possibility that the diagnosis of serious problems were missed. As well, the long-term impact of sexual abuse is very diverse and certain behaviors may be ignored such as sexually acting out behaviours. The articles usually maintained a focus on females, reducing the generalizability of the study. In addition, Abueg et al. (1998) note

that the data points out the benefit of involving caregivers in treatment interventions for supporting the intervention process and maintaining long-term effects.

Rose (1987) and Malekoff (1997) concluded that cognitive behavioral group therapy offers youth a context for social reinforcement of prosocial behaviours. As the child moves beyond the family circle, peer groups become critical to the developing adolescent. Malekoff (1997) insists that a strong theoretical base in cognitive theory and group development theory are essential when developing groups. Theoretical knowledge supports the group process and discourages costly mistakes (Malekoff, 1997).

Gil (1995) advocates that clinicians work conjointly with children who are acting out sexually and their parents. She says that it is important for parents to understand what sexually inappropriate behaviour is and why it may occur. Gil (1995) encourages the parents/caregivers to be involved in the treatment phase for the child. The child needs parental support and to increase the long-term benefits of therapy (Gil, 1995).

The results of this research offer several therapeutic options for sexually acting out children. First, this review advocates for individual, family and group intervention. Therapy options which include the child's caregivers promises a more long lasting treatment effect. The involvement of caregivers, not only educates, but offers support and concrete tools to help manage the child's behavior. In turn, the caregivers then can support and reinforce the treatment process. Secondly, the literature develops an understanding of factors that influence sexually intrusive behaviors and directs a psychoeducational cognitive approach to help sexually acting out children eliminate, reduce or change their behaviour.

CHAPTER THREE

Theoretical Frameworks

Cognitive theory and therapeutic strategies can inform group interventions designed for young sexually inappropriate children. As per the literature review (Abueg, et al., 1998; Bandura, 1977; Friedrich, 1990; Gil & Johnson, 1993; Kuehnle, 1999; Lane & Ryan, 1997; Rasmussen, et al., 1992) an intervention that is founded on cognitive theory, narrative therapy, and small group theory is emphasized. Small group theory supports the idea that children learn from each other and offers a safe place to understand sexualized behaviours, practise new cognitions and alternate behaviours. In the current practicum, group tasks were used to develop client awareness of cognitive distortions, its relationship to emotions and its role in individual behavior.

Cognitive Theory

Learning theorists such as Pavlov (1927), Skinner (1953) and Bandura (1977) pioneered studies on how individuals acquire and interpret knowledge. Pavlov (1927) is renowned for his contributions of classical conditioning and Skinner (1953) for his instrumental learning theory which shows a learning correlation between a stimulus and consequence. Bandura (1977) added social learning theory that incorporates the belief that individuals learn behaviour through a variety of ways such as observation, imitation and modeling. Learning theory suggests that sexualized children have learned their behaviours through conditioning, observation, imitation or modeling. Sexually acting out behaviours would be described as the negative consequence of a sexual stimulus, occurring in the context of victimization or trauma.

Cognitive theory rests under the umbrella of learning theory. Piaget (1928) introduced cognitive theory, adding an understanding of how cognitive abilities develop via an interaction with one's environment. Later, cognitive theorists such as Ellis (1971) and Beck (1979) expounded on Piaget's (1928) constructs, connecting individual thinking to patterned responses and actions. One aspect of cognitive theory is how individuals develop the set of concepts held about themselves. Ingrained concepts and ideas of ourselves are predictors of how we may respond in any given context. Ellis (1971) introduced the idea that individuals personalize and construct specific meanings to the events in their lives. Ellis (1971) suggests that people create a set of cognitions that influence their interpretation of how they should evaluate and respond to life situations. These constructs are influenced by emotions.

These preconcepts of self are the triggers for thoughts and feelings that arise in certain situations (Bernard & Ellis, 1983). In turn, these cognitions form the path that directs individual actions and response patterns to specific contexts (Bernard & Ellis, 1983). Behaviours, thoughts and feelings become interconnected in a never ending cycle. At the same time, people often attach irrational or negative meanings to situations that become ingrained in their belief system. Irrational beliefs are also known as dysfunctional thinking processes which lead to cognitive distortions (Bernard & Ellis, 1983). Irrational cognitions result in stressful emotional reactions like depression or anxiety and intense behaviourial repercussions such as anger and aggression (Bernard & Ellis, 1983). These misconceptions must be challenged and new cognitions formulated to change fixed response patterns (Bernard & Ellis, 1983).

Beck (1978) and Barth (1986) concur with Ellis (1971) that negative affect and maladaptive behaviour are the result of defective cognitions. Similarly, Beck (1978) and Ellis (1971) agree that positive affect and adaptive behavior are the result of rational belief systems. Beck (1978) offered that incorrect responses can be viewed as a set of rules. Beck (1978) suggests people internalize a set of response rules similar to Ellis' (1962) 'ABC' sequence of conversion. For example, Beck (1978) says that when an individual encounters a situation it is understood by a pre established cognitive process that the person has. People develop cognitive misconceptions and beliefs that are self-signals, triggering thoughts, directing emotional reactions and behavioral responses (Beck, 1978). Accordingly, Beck (1978) says that the detrimental emotions intensify and confirm the beliefs an individual holds to be true of his/her schema or view of self. Individuals become involved in a self-perpetuating process (Beck, 1978). Beck (1978) claims that misconception needs to be corrected to alter emotional reactions and change behaviours.

Beck (1978) and Barth (1986) contend that these changes come about when individuals become aware of their thinking and recognize that their thoughts are erroneous. In order to change maladaptive thoughts individuals must recognize their internalized statements, (representing the view of self), and by experience, challenge their hypothesis (Barth, 1986; Beck, 1978). New experiences can alter the thought processes and the subsequent response patterns.

In application, cognitive theory suggests that sexually acting out behaviours in children are the result of defective thinking and adverse emotional consequence. Accordingly, Beck (1978) and Ellis (1971) agree that changing the negative affect means

changing the meaning attached to a person's interpretation and construct of a given context. In cognitive therapy, changes in behaviour occur via two paths (Alford & Beck, 1997). One path to behaviourial changes is by effecting changes in individual thinking patterns. The restructuring of thinking causes individuals to change their behavior.

Another path is that changing ways of behaving leads to changes in thinking about one's view of self, and ultimately, one's actions (Alford & Beck, 1997). Cognitive theory suggests that interventions intending to reduce or eliminate sexually acting out behaviours are more effective when based on principles that create changes in thinking (Ryan, 1997). Cognitive theory implies that sexually acting out behaviours are a situational response pattern to preestablished thinking triggered by emotions or events. Individuals react in sexually inappropriate ways that become internalized patterns of response (Ryan, 1997). Clearly, cognitive thought processes are evident in controlling and directing behaviors (Alford & Beck, 1997). Long-term positive outcomes are effected by contextual and relational learning (Alford & Beck, 1997).

Premises of Cognitive Therapy

Cognitive interventions are geared toward eliminating, reducing or restructuring entrenched thought patterns that are hurtful and self-deprecatory (Beck, 1976). Beck (1976) identifies three therapeutic processes that must occur in cognitive therapy. First, the therapist must convey that the individual's perception of reality is not the correct reality. Second, the therapist helps the individual understand that his/her interpretation of reality is dependent on falsely integrated cognitions. Third, individuals must be able to test their hypotheses (ideas). Beck (1976) suggests that hypothesis testing depends on having

reliable and sufficient knowledge about a situation to make choices. Often, people make inferences in situations based on internal cognitive processes rather than on actual information, also known as 'jumping to conclusions' (Beck, 1976).

Effective cognitive therapy occurs when the client recognizes that his/her cognitive processes are maladaptive (Beck, 1976). Ellis (1962) proposes that frequently, an individual's faulty cognitions become internalized statements that arise without reflection, automatically. This implies that maladaptive self-talk is voluntary and can be changed or switched on and off. In cognitive therapy individuals are trained to identify these automatic thoughts and observe the sequence of different external events and their reaction to them.

Ellis (1962) describes this sequence as the 'A, B, C'. 'A' is the activating stimulus or event, 'C', is the inappropriate, conditioned response and 'B' is the blank or bridge between 'A' and 'C' (Ellis, 1962). Therapeutically, helping individuals fill in the blank with alternative or adaptive responses to a situation becomes the cognitive intervention (Ellis, 1962). When the 'blank' is filled with adaptive responses, individual's internalized belief system becomes challenged (Ellis, 1962). Individuals then begin to question the validity of their thoughts; new behaviors are enacted and new cognitions are created (Ellis, 1962).

How does the cognitive therapist change the internalized thinking and system of rules an individual engages in? The major technique is to help the client be aware of his/her attitudes and decide if these attitudes are self-defeating (Beck, 1976). Once the client becomes aware of his/her distortions and the internalizing self-talk that perpetuates

the distortions, the client needs help to revise his/her problem-solving skills (Beck, 1976). This is accomplished by self-observation, affirming the relationship between thoughts and actions, recognizing that thoughts are hypotheses not facts, and developing an awareness that the underlying beliefs generating such hypotheses are incorrect (Beck, 1976).

In addition, Freeman (1987) says that there are a variety of methods that effect self-examination of thought processes and behavior. Some of these include helping clients explore the following: clarify the meaning they attribute to a problem, question the evidence of their ideas, distribute the responsibility for a situation accordingly, examine alternatives, fantasize about the consequences of their situation, list pros and cons of their thinking, label distortions, examine paradoxical situations and use replacement imagery, externalized voices and cognitive rehearsal to reinforce the new thinking (Freeman, 1987).

Basic assumptions of cognitive therapy are that faulty thinking contributes to maladaptive behavior and changing these thoughts produces future healthy behaviours and thoughts (Cormier & Cormier, 1985). Once the client becomes aware of his/her distorted thinking, there are several techniques used by cognitive therapists to help individuals change that thinking. Techniques such as cognitive modeling and thought stopping, self-instructional training, cognitive restructuring and reframing, and stress inoculation produce change (Cormier & Cormier, 1985).

The cognitive modeling and self-instructional training is a strategy that shows clients how and what to say to themselves when they are performing a task. One example is teaching a client to give himself/herself positive instructions like telling himself/herself to slow down and to complete each step carefully before continuing to the next task. This

helps the client develop self-control over his/her impulses (Cormier & Cormier, 1985). Thought stopping is another technique that is taught to the client. Thought stopping teaches the client to examine his/her negative self-talk and the circumstances in which it occurs. The client is taught to recognize and interrupt such comments as "I can't do this"! or "I'm too stupid"! by teaching him/herself to say "Stop!" (Cormier & Cormier, 1985).

Cognitive restructuring and reframing is a strategy developed by Ellis (1975) in his rational-emotive therapy. Restructuring or reframing is the process of identifying the client's irrational thoughts or perceptions which then, helps the individual change his/her irrational beliefs. The client is taught to discriminate between rational and irrational thoughts by reframing (Barth, 1986; Cormier, & Cormier, 1985). Therapists encourage clients to compare and examine the influence that their self-defeating thoughts have on the problem versus what impact results from self-enhancing thinking. The therapist models the link between emotion and events, introducing positive coping and self-statements. The client then practices his/her alternative coping and self-statements in stressful situations (Barth, 1986; Cormier & Cormier, 1985).

Cognitive reframing is a technique that encourages clients to reflect on their thinking or events from a different perspective (Barth, 1986; Cormier & Cormier, 1985). This is done by reframing or challenging the meaning a client may have attached to a particular problem behavior. In the past, that attached meaning has maintained and perpetuated the problem. Often people become fixated on this pattern of thinking and will only see things from this perspective. The assumption is that once the meaning is changed, then the behavior changes, provided the new meaning is valid for the client (Cormier &

Cormier, 1985).

Stress inoculation teaches the client future physical and emotional coping skills (Barth, 1986; Cormier & Cormier, 1985). This involves educating the client about potentially stressful events, reviewing appropriate physical and cognitive coping methods and helping the client apply his/her skills. Approaches to stress management include mentally practicing and preparing for a confrontation by using several strategies such as mental relaxation, meditation, reinforcing self-statements or mental imagery. Other practices that reduces physical responses include training in muscle relaxation, deep breathing and stretching (Cormier & Cormier, 1985).

Cohen and Schleser (1984) remind therapists that one way to measure the success of cognitive therapy with children is to observe whether the child has generalized the desired behavior to other situations. Cohen and Schleser (1984) say generalized behaviors are achieved by several methods. Children are invited to use reinforcement or self-instructions which are child produced. As well, training or practising the concepts in multiple contexts gives the child a chance to generalize behavior. This is accomplished by providing the child with multiple tasks to rehearse in settings that are similar to reality (Cohen & Schleser, 1984). Another technique that reinforces generalization is developing an adaptation to other situations (i.e., how to analyze similarities and differences between situations and apply the correct techniques accordingly) (Cohen & Schleser, 1984).

Narrative Therapy

Narrative therapy builds on the premise that unhealthy thoughts and behavior can be changed by reframing negative cognition. Narrative therapy is a solution focused model

and attempts to shift thinking by using tools such as story telling that offer new hope and choices. This in turn provides opportunity to change (Epston, Freeman, & Lobovits, 1997). Narrative therapy acknowledges that the client is the expert in his/her situation and encourages the client to find new meaning to old 'stories' that make sense for the individual and helps the individual move in the desired direction of his/her therapeutic goals (Nylund & Smith, 1997). The client is viewed as the most knowledgeable about his/her circumstances and as having the ability to 're-author' his/her stories (Nylund & Smith, 1997).

In narrative practice, people discover new stories about themselves based on their strengths, hopes, dreams and preferences. Narrative therapy externalizes problems, creating a forum that makes them more controllable and less intimidating (Nylund & Smith, 1997). Language, and how things are said is key to this model, always maintaining a respectful position vis a vis the client. Therapists use reframing and restructuring questions to change a client's negative thoughts to positive ideas, tools which are adopted from cognitive theory (Nylund & Smith, 1997).

Creative approaches to narrative work involve strategies like dramatization, art, sand play, role-playing or story writing. The clinician assumes a collaborative, co-authoring role with the client in therapy. Together, the therapist and client, co-author the therapeutic process. Critical in this approach, is respect for individuals, their own untapped resources and their ability to problem-solve. Clients are given the opportunity to examine alternate ways of thinking and behaving, choosing the ones that are most valid and meaningful for them. Children can accept responsibility, uncover a new found self-

confidence and gain insight to their own issues through narrative techniques, a process that offers hope and effects change (Epston et al., 1997).

Narrative therapy offers sexually acting out children a means to externalize what may often seem like shameful behaviours. A variety of forums such as story-telling, puppetry or crafts can be introduced to help educate children, increasing their awareness of cognitive distortions. At the same time, different mediums can encourage them to examine alternate thoughts and practice adaptive behaviors.

Narrative therapy was chosen to inform this group intervention because it advocates for a child centered approach that helps children find meaningful ways to solve their own problems. In addition, narrative therapy allows children to place distance between themselves and a sensitive topic, encouraging them to find meaning and understanding. Narrative was selected for its parallels to cognitive theory. Narrative therapy offers children the chance to reframe faulty cognitions and change their maladaptive behaviours for positive ones through reauthoring.

Group Theory

Historically, group work practice began in the early 1900's and was traditionally affiliated with education and community work. As it developed, group work was seen as a therapeutic intervention in the mental health setting (Rivas & Toseland, 1998). Over the years group work has developed into an independent field of study. Eventually, group work was adopted by social work as a useful intervention tool (Rivas & Toseland, 1998). Early group work contributed several models of intervention. Toseland and Rivas (1998) identify the initial group models of the 1960's as social, remedial and reciprocal. The

group purpose often defines the chosen model. Social groups focus on socializing members to social values and operate on the power of group action (Rivas & Toseland, 1998). The group format involves discussion and carrying out tasks that effected social change. The group goals are accomplished through activities (Rivas &Toseland, 1998).

Remedial groups focus on rehabilitating members through a leader centered approach that uses structured tasks such as problem-solving. The group focus is to change the individual's behavior through the group context (Rivas & Toseland, 1998). These groups are frequently used in mental health settings with people exhibiting serious behavioral problems.

Reciprocal groups stress the interdependent interactions between group participants and society. This type of group assumes that individuals are influenced by their environment. The reciprocal nature of the group involves the leader and participants working together to address the group issues. In a reciprocal group the emphasis is not on individual participants, but on the progress of the group as a whole (Rivas & Toseland, 1998).

In later years, these three models were integrated to form a fourth category of group work. This became known as a mainstream model of group work and includes remedial, reciprocal and social group elements, as well as therapeutic components (Rivas &Toseland, 1998). This mainstream approach is based on mutual aid. The purpose of the group is defined by the common goals of leaders and participants (Glassman & Kates, 1990). The goals are achieved through group interactions, activities and tasks that problem solve, make decisions and deal with conflict (Glassman & Kates, 1990). The

group participants develop and practice alternate ways of thinking and behaving through a supportive group process. The framework of this mainstream model is accessed to build the group intervention used in this practicum.

Small Group Work Theory

In the 1960's small group work entered the realm of generic group work practice (Garvin, 1997). The values of small group work included the right to mutual aid and support within a group, the right to empower its members and the right for the group to facilitate understanding for its members (Rivas & Toseland, 1998). These generic values parallel social work and feminist principles. In social work groups, workers respect and value the goodness of people. Respect and dignity for the worth of others and empowerment are strategies that help group members overcome interpersonal difficulties (Glassman & Kates, 1990). Small group work theory builds on the mutual aid principle wherein participants come together, helping each other process common agendas. This system is founded on several humanistic values that guide the process in which participant and facilitator will work together, interact and deal with conflict (Glassman & Kates, 1990).

Small group theory supports the values and premises of humanistic group work (Glassman & Kates, 1990). It includes humanistic values which prevent stigmatization, acts of violence, stereotyping and blaming of others. Groups are seen as one method of intervention that maximize empowerment for socially boycotted and oppressed people. A group operates in a democratic medium, facilitating the establishment of group norms under such a system. Groups act under the premise that people are responsible for one

another and strengthen such values as respect for the inherent worth of others. Everyone has the right to freedom of speech, the right to choose and the right to question and constructively challenge others (Glassman & Kates, 1990). Further to these principles, it is understood that groups members have the right to belong, share and be heard. Children are inherently valued and they, too, are invited to criticize and question the information provided (Glassman & Kates, 1990).

Small Group Development and Dynamics

Small groups facilitate change in members based on the interaction between participants and leader. Small group theory proposes that the group dynamics contribute to the effectiveness of the group intervention. Group maturation is observed to occur in sequential periods throughout the life of the group (Garvin, 1997; Rivas & Toseland, 1998)

Most theorists agree that all groups pass through similar phases of development, but some theorists outline other levels of group progression such as the pregroup, the planning and the pre-termination stage (Rivas & Toseland, 1998). Another group development theory like the life-cycle model (Garland, Jones, & Kolodny, 1965, 1972), compares the development of a group to the life-cycle: birth, growth and death. This model emphasizes the importance of how group members struggle to form closeness. Different conflicts are observed concurrently at each new stage of group development. These conflicts are pre-affiliation, power and control, intimacy, differentiation and separation (Garland et al., 1965, 1972).

Generally, every group is observed to follow three chronological stages as group

formation takes place (Garvin, 1997; Johnson & Johnson, 1997; Rivas & Toseland, 1998). These steps are characterized according to the organization of participant interaction as it impacts on group maturation and cohesion (Rivas & Toseland, 1998). Each group is viewed as encompassing a beginning, middle and end stage of group. Additional levels have discernable structural differences than that of the previous period or the next stage (Rivas & Toseland, 1998). A description of the principle differences follows.

The beginning stage of group work is characterized by the conception or idea for the group. This phase focuses on the preplanning and organization of the group, establishing the location, the purpose, the goals, the tasks, the membership and the recruitment. As well, the beginning point of group centers on the orientation of participants to group. In this stage members are in the pre-affiliation stage; their connection to the group is dependent on common life experiences (Garland et al., 1965, 1972). During this time, group members characteristically display ambivalence and approach-avoidance tactics as they resist becoming a part of the group. The development of trust among members is crucial to further group growth (Garland et al., 1965, 1972). Garvin (1997) emphasizes that conflicts may occur among group participants as roles, norms and processes are established. Leaders normalize the process and facilitate problem solving among group membership (Rivas & Toseland, 1998). At this phase, the group dynamics center on establishing the purpose, values, roles and norms of the group interaction (Garvin, 1997; Rivas & Toseland, 1998). At each new level of group development different dynamics occur, reflecting the growth of the group.

As the group norms and roles become established, the group enters the middle

stage of development. This phase is classified as the 'working level' of group development where group structures of power are formed and intimacy develops (Garland et al., 1965, 1972; Garvin, 1997; Rivas &Toseland, 1998). After group members have established group norms, roles and patterns of interactions, the group becomes cohesive. Together the membership begins the process of accomplishing the tasks and goals that were decided upon. Several terms such as problem-solving, intimacy, maintenance, power and control stage, and performance are used to describe this level of group maturation (Garland et al., 1965, 1972; Garvin, 1997; Rivas & Toseland, 1998).

The final stage, the ending or termination of group, is characterized by the completion of group tasks and goals. This phase of group development is accompanied by evaluation and feedback of the group process. This step of group is marked by review and celebrates the achievements of the group (Rivas & Toseland, 1998). The dynamics reflected at this stage may return to the approach-avoidance behaviours observed in the beginning interactions. Members may feel angry that the group is over, be ambivalent, or show signs of flight or withdrawal (Garland et al., 1965, 1972; Garvin, 1997). The group feeling of cohesion begins to deteriorate and the facilitators support the process of the group separation, returning to a focus on the individual (Garland et al., 1965, 1972; Rivas & Toseland, 1998).

Group facilitators should have a knowledge of the many stages of group development and dynamics so that they can intervene when it appears necessary to facilitate the group process (Rivas & Toseland, 1998). An understanding of group stages provides leaders with the knowledge that can be used to promote group dynamics

(Berman-Rossi, 1992). Group dynamics are characteristically different at each level of group development. Dynamics are the communication and interaction patterns observed between group members (Rivas & Toseland, 1998). Dynamics demonstrate group cohesion, subgroups, power and status, and the social controls that maintain interactions within a group (Dimock, 1976; Garvin, 1997; Rivas & Toseland, 1998). Group dynamics can contribute or detract from the achievement of group goals and tasks (Rivas & Toseland, 1998). As the group evolves, it develops its own culture. This culture is a mixture of the values and beliefs of the group members and the influence of the environment. Together the group membership forms their own culture from the varied backgrounds. The group culture affects the functioning of the group dynamics, it decides how and what tasks are addressed (Rivas & Toseland, 1998).

Knowledge and understanding regarding the stages of group development and group dynamics help group workers determine several points of intervention (Dimock, 1976; Garvin, 1997; Rivas & Toseland, 1998). Preknowledge helps the facilitator predict events, see where in the group process their intervention is necessary and to help the members move through the stages. This understanding provides the group leaders with the ability to assess how the group is processing, checking that members are supportive of each other and addressing the tasks at hand. Group leaders need to assess several areas in group growth such as roles, norms, rules, communication, belonging, the development of trust, interactions patterns and task achievement (Rivas & Toseland, 1998). Group development models help the group worker maximize the potential of the group, assess if it is developing as expected and when and how to intervene if it is not (Rivas & Toseland,

1998).

Types of Group

Although a variety of purposes may define a group, groups can be typically divided into many classifications (Garvin, 1997; Rivas & Toseland, 1998). In later years, social work groups became associated with a variety of different group interventions. These include structured groups, psycho-educational groups, psycho-therapy groups, self-help groups, support groups and action groups. For the purposes of this practicum structured psycho-educational/therapeutic groups are explored further.

Psycho-educational groups are interventions that focus on providing members with knowledge. Knowledge is assumed to reduce anxiety and maximize coping (Anderson, Griffin, Holder, Pagonis, Rossi, & Treiber, 1986). Education is conducted in lecture format, discussion groups, experiential exercises and homework assignments. Psycho-educational groups are supportive and serve to decrease isolation and enhance problem solving (Anderson et al., 1986). These groups provide members with useful information regarding the relevant problem.

Psycho-therapeutic groups are characterized by group members coming together around a common issue. This type of group attempts to provide rehabilitation and behavioral change through the use of mutual support, peer feedback and group interaction (Garvin, 1997; Rivas & Toseland, 1998). Therapy groups help members address personal issues, alter their behavior and develop coping strategies (Johnson & Johnson, 1997). Facilitators provide constructive confrontations and helpful feedback (Johnson & Johnson, 1997).

Structured, time-limited groups are interventions that have predetermined curriculum and goals set by the facilitators. These types of groups are limited in nature by the number of sessions that will evolve. The length of the group is also predetermined by the leaders (Papal & Rothman, 1980). Since the nature and objectives of the group are preselected, groups members join the group as a source of help and service.

Summary

In summary, the theoretical underpinnings of the group intervention in this report were cognitive theory, narrative theory and small group theory. The group intervention described in this report was based on the assumption that children's sexually acting out behaviours are contributed to by their cognitive distortions.

Narrative therapy, also informed by cognitive theory, offers the most congruent complement for the therapeutic group process. Narrative therapy is considered an effective means of actualizing the goals of cognitive therapy. A narrative approach reframes cognitive structures that help sustain sexually acting out behaviors. In seeking to effect changes in sexually inappropriate behaviours in young children, cognitive theory presents an understanding of how sexualized behaviours become internalized responses for children and how to change those patterned responses (Beck, 1979; Ellis, 1971). Narrative therapy offers a compatible and child-sensitive approach to helping children create and implement alternate ways of thinking and subsequently, acting. Group was the environment that offered the most support for the participants and provided a chance to try out new ideas and practise their learning.

CHAPTER FOUR

Description of Practicum Intervention

The group intervention implemented for this practicum was based on a psychoeducational, structured, time-limited treatment group model. The practicum objectives intended to provide a group intervention for sexualized preadolescents and their caregivers. The group purpose was to assist these children to understand and manage their sexually inappropriate behaviors. In this context the desired objectives were helping the sexually intrusive children (a) take responsibility for their behaviors, (b) learn impulse control, © develop self-monitoring techniques, (d) foster and practise healthy coping strategies such as problem solving skills, (e) enhance self-esteem and practise social skills, (f) develop feeling and empathy recognition, and (g) broaden this writer's clinical social work skills in the area of therapy, data collection, analysis and evaluation.

The psycho-educational element consisted of educating the children regarding sexual abuse, healthy sexuality for preadolescents and identifying their triggers for sexual touching (Acton, 1997; Gil & Johnson, 1993; Lane & Ryan, 1997). Cognitive theory provided the base for the therapeutic reframing, restructuring and examining alternate behaviors. Cognitive theory contributed the basis for skills training offered in social controls, problem-solving techniques and healthy coping strategies (Alford & Beck, 1997; Beck, 1976; Cormier & Cormier, 1985; Ellis, 1962). Cognitive reframes were endorsed and supported via a narrative approach (Epston et al., 1997; Nylund & Smith, 1997). The utilization of the narrative model provided children with an opportunity to externalize their experience, examine their own stories and 're-author' them in ways that were meaningful

to them.

In order to reinforce learning, a variety of resources were accessed such as a video on sexuality, story-telling, brainstorming, list making, letter writing, and other interactive experiential activities. Assessment of the appropriateness of material and group member's needs were achieved through evaluations, a suggestion box and a weekly journal entry. The group members also completed an informal feedback form at the end of the group sessions.

Group Setting

Often agencies do not have the resources to choose between several settings. A setting that is relaxed, conducive to communication arrangements and is safe for the children attending is optimal (Gil & Johnson, 1993; Rivas & Toseland, 1998). An informal atmosphere, comfortable chairs, a table for a work area, and child friendly pictures on the wall would be a good choice. Smaller rooms provide a sense of intimacy. Consistency is served best if the same space is used for the life of the group (Mandell et al., 1989). When working with children, sometimes this writer finds that sitting in circles on the floor develops an intimate, comfortable atmosphere.

This writer has had opportunity to facilitate groups in a mandated child welfare setting. This may compromise the feeling of safety for the children that attend the group and increasing fears and anxieties. Children have encountered estranged family members or perpetrators of abuse in the child welfare building. Child protection services have often become involved in children's lives because of the abuse or the sexualized behaviors. Children may be reluctant to attend such a setting which may revive difficult memories and

feelings. For these reasons, this practicum was held in a non-mandated child welfare setting.

This group was held in the office building of New Directions in a centrally located downtown area. A large classroom was used for the group meetings. The room held several tables and chairs, a television, a video recorder, bookshelves and a flip chart. One part of the room contained a sitting area that included a coffee table, a couch and several chairs. The room had easy access to the bathroom and to a kitchenette with a microwave. Initially, the facilitators selected the couch area for the intimacy it offered. After the first two sessions this idea was rejected and the tables and chairs were moved together to provide a work area. This arrangement was selected because in the couch area the children tended to ignore the themes presented, focusing on socializing. Instead, the children were permitted to move to this area when group was over, signaling snack and socialization time. The size and layout of this room did not reflect a warm, comfortable working environment. Instead, it was more classroom like.

Often the room was left in an untidy state by the previous users. The room would be littered with food, papers and pens. The classroom materials that were left out and were visually accessible to those using the room were often inappropriate for children in a group for sexually acting out children. The regular members of this classroom were young women who had engaged in street prostitution. The materials left about the area reflected the nature of their experiences. There were books and activities that contained explicit sexual content. Further, the situation was compromised by the display of condoms which proved to be attractive to the young children in the group. They frequently attempted to

take these when entering or exiting the group room.

It is recommended that a more appropriate setting be considered should this group continued to be offered at New Directions. Other concerns were that the size of the room was not conducive to an intimate and comfortable atmosphere. A smaller, more intimate room would be a better choice. A room that did not display materials that consisted of explicit sexual content would be more appropriate.

Group Design

In designing a group for latency aged children several factors bear consideration. Respect for the identified problem of the client population encourages a structured, closed group format. Children who are sexually acting out are coping with a behaviour that is shunned by society. Sometimes these children have been sexually abused or have experienced a heightened sexuality. The nature of the topic is extemely sensitive, and often embarrassing for children to discuss. Sexually abused and sexualized children frequently experience loose boundaries in their personal environments.

A structured group model was selected because it is necessary to establish and mirror clear boundaries for these children. Structure provides predictability, creating an environment of safety and trust (Castaldo, Damon, Larsen, Mandell, Monise, & Tauber, 1989; Gil & Johnson, 1993). Anderson (1980) points out that the use of structured group experiences can be useful in several ways. Structured activities such as compiling a list of group norms can increase the participants' awareness of the group process. The group members' autonomy and interdependence are maximized by structured activities by the group assuming the responsibility for the what the group needs to do and each member

choosing for themselves what they want to know. As well, structure provides the group and its members a way to evaluate the usefulness of the experiences introduced. This gives each group participant a chance to choose what is meaningful for his/her individual growth (Anderson, 1980).

The chosen group format was a psycho-educational treatment group that incorporated humanistic values and a mutual aid component (Glassman & Kates, 1990). The group intervention followed an outline of sequential, overlapping themes. The group layout moves from nonthreatening themes to more challenging content. The group progressed through the topics based on readiness and degree of comfort of the participants. Sometimes the participants met the concepts with reluctance and delays. Reintroduction of challenging material can occur after more emphasis has been placed on preparation, feelings of safety and building trust within the group context (Mandell et al., 1989). In this writer's experience, when the material is uncomfortable for the children, proceeding or rushing through material when the children are unprepared, results in fractious and disruptive behaviour in the group.

Group Structure

Several guidelines need to be addressed when developing a pre adolescent children's group. The concerns are:

1) Gender. It is preferable to compile a same-sex group when working with children that are pre adolescent. Gil and Johnson (1993) recommend that membership for such a group is either all female or all male. Discussions with pre adolescents on sexual issues can produce anxiety and embarrassment. The mixing of genders would increase that

embarrassment. Another rationale for same-sex groups is that boys' and girls' experiences regarding sexual matters are different at this age, for example their interest in the opposite sex begins at this age. A consistent peer reference point for the children is one aspect of group which reinforces the intimacy of same-sex friendship (Mandell et al., 1989).

Although the literature suggests that optimally, the selection of a group cohort is either all male or all female participants (Garvin & Reed, 1983; Gil & Johnson, 1993), the facilitators were open to combining both genders in one group if there was insufficient referrals for a same-sex group. This decision was based on the concept that mixing genders in a group setting will minimize gender inequalities and model that future gender separation may prove to be unnecessary (Brown & Mistry, 1994; Garvin & Reed, 1983; Martin & Shanahan, 1983). In contrast, gender division in preadolescent groups may perpetuate myths that discussing sexual issues in mixed company is cause for anxiety and embarrassment. The cohort selection was based on not having a minority status of any particular group, be it sex, age or other (Brown & Mistry, 1994).

2) Age. Participants will find commonalities when they are close in age. All group members should be within a one or two-year age range (Gil & Johnson, 1993). Particularly when children have been sexualized or are sexual with other children, the less the gap in ages, the less vulnerable younger children will be to being victimized by older children. Although younger children may be older than their years in terms of sexual development, their emotional and maturity levels may be much similar to a younger child (Gil & Johnson, 1989). It is helpful to assess both developmental age, social age and chronological age of potential members (Mandell et al., 1989). For the purposes of this

intervention, all membership selected were approximately within a one year age range to reduce the potential of placing children at risk of victimization.

3) Number of Participants. Behaviour problems may dictate the maximum number of children a group can tolerate (Mandell et al, 1989). When children have experienced sexual abuse or are sexualized, it may be difficult to manage the number of symptomatic and disruptive behaviors (Gil & Johnson, 1993). Sexualized children tend to regress in their behavioral presentation when confronted with uncomfortable feelings (Gil & Johnson, 1993). This type of group will challenge the children to examine many difficult issues and behaviors. Unless there is thorough preparation, leaders may observe an increase in discomfort, resulting in further disruptive behavior (Gil & Johnson, 1993).

Recommended maximum group membership is staff/member ratio of one facilitator to every four participants (Gil & Johnson, 1993; Mandell et al., 1989). Gil and Johnson (1993) suggest that sexually acting out children be grouped according to the intensity and degree of sexual molestation enacted. Children who have been offending other children for longer periods of time, without remorse are better grouped with children of similar behaviors. It was decided that this group should include a maximum of eight members.

4) Time. Establishment of the group's time frame depends on the age of the children, their ability to concentrate, transportation arrangements and even the weather (Rivas & Toseland, 1998). Groups held during the daytime can disrupt school/work schedules for parents/caregivers and children. An end of the day time, preferably 3:30 p.m. or 4:00 p.m. loses less to school programs. The selection of a midweek day ensures the sequential, weekly nature of the group because sessions would not be canceled due to

holidays or long weekends. Inclement weather such as a famous Winnipeg blizzard, can bring an abrupt end to a planned session. Groups organized in the spring or fall have less absenteeism due to weather problems. For these reasons, this group intervention was conducted on a Wednesday, between 4:00 p.m. and 5:30 p.m. The group began February 24, 1999 and ended April 28, 1999.

Missed sessions were followed up with participants. A telephone call or visit ensured that participants would return. If a member completely withdrew, efforts were made to have closure with that individual. Closure was viewed as an important group dynamic for both the group participants and the leaders. If there was no chance to say good-bye, group letter writing or a card had the desired effect (Mandell et al., 1989).

Most latency-aged (6-12 years old) children have the ability to sit still and concentrate on a topic for an extended period of time. The minimum length of time to complete a session would be 45 minutes. For older children, the maximum length a sessions should be 1 ½ hours (Mandell et al., 1989). Faithfulness to start times, end times and snack times contributes to the mirroring of critical concepts such as boundaries, limits and structures (Gil & Johnson, 1993; Mandell et al., 1989).

Snack breaks were scheduled aside from the session time. Snacks are a symbolic demonstration of nurturance, frequently an absent aspect in the lives of sexually acting out children (Mandell et al., 1989). Children are often hungry coming from school and they need a snack to manage the wait for their evening meal. Children use food as a coping tool for feelings or to meet their nurturing needs. This writer has found that the provision of snacks can also present an opportunity to model healthy coping and nurturing. Snacks

that are healthy and nutritious reinforce future positive food choices. The act of sharing food creates a relaxed atmosphere and provides emotional distance that encourages debriefing and sharing (Mandell et. al, 1989). Routine snack times at the end of group sessions can be productive debriefing sessions. Mandell et al. (1989) recommends serving snacks prior to beginning group sessions clarifying that group participation is not contingent upon food.

5) Open/Closed Group. A closed, structured time-limited group format is advocated when working within a pre adolescent treatment group focused on a sensitive topic (Corder, DeBoer, & Haizlip, 1990; Edleson & Rose, 1987; Gil & Johnson, 1993; Mandell et al., 1989; Rivas & Toseland, 1998; Rose, 1985). Time-limited and closed groups provide consistency and an opportunity to form trusting intimate relationships. Structure helps the children maintain focus and enter into a treatment process in group work. In contrast, members in open groups may experience a constant readjustment if new members are added. This can interrupt the process or stage where other members may already be actively engaged. Groups participants in a closed group start at the same time and end at the same time. This facilitates the probability that membership will enter group development stages at the same time. When organizing a group that deals with progressively intense sexual matters, participants that are at the same stage of readiness are optimal (Rose, 1985).

In this writer's group work experience it has been observed that children and their caregivers are far more prepared to commit to a shorter term of group sessions. Often the clients do not have consistency in their personal lives and committing to long periods of

time can be overwhelming. Generally, brief times are viewed as easier to accommodate.

In light of such suggestions, this group intervention was scheduled for Wednesdays, starting February 24, 1999. The sessions ran from 4:00 p.m. to 5:30 p.m. The completion date was April 28, 1999. Snacks were provided at the end of group sessions, during the last ten minutes. The proposed intervention was a closed, time-limited group because of the sensitive nature of the material. This type of group was thought to be more successful if group members were at the same stage to proceed with such difficult material. A time frame of 8-10 weeks was selected. This allowed ample opportunity for participants to engage in a trusting relationship with each other and the facilitators. Cohesive relationships between members encourages the group's ability to address and resolve conflicts and difficult material.

Description of Group Goals

Group goals can be defined in several ways. The group leaders can define the group goals, or the purpose of the group transfers into goals, or the participants delineate the goals. Goals are assessed and reevaluated throughout the group process. In treatment groups the goals are frequently decided on by the designated purpose of the group intervention (Glassman & Kates, 1990; Rivas & Toseland, 1998). Goals are the overarching, hopeful outcomes of the group intervention. Goals guide and direct the learning process.

Group goals characterize the common needs of the collective (Rivas & Toseland, 1998). In turn, common problems, interests, and needs point out the ability of the group to support and help each other, emphasizing the mutual aid system (Glassman & Kates,

1990). Glassman and Kates (1990) state that the process of refining and stating group goals should be done in conjunction with the participants. Identifying the goals will direct the actualization of the group intervention. For this group, the goals were defined by the professional in terms of problem commonalities and needs which was decreasing the sexually inappropriate behaviours. These goals were evaluated and refined during the group process. The goals for the children's group were defined as follows:

1) Reduction of sexualized behaviors in the participants.

2) Increased understanding of natural and healthy sexuality.

3) Increased understanding of family patterns that may influence the sexualized behaviours.

4) Increase the participants' ability to observe their own behaviors and understand the consequences.

5) Increased ability to recognize one's own and other's needs and how to meet them in a socially appropriate way.

6) To strengthen the participants' ability to form and maintain relationships with others.

Considerations for Facilitator Selection

Number and Gender of Facilitators. Two group leaders are better than one (Garvin, 1997; Rivas & Toseland, 1998). As a facilitator there are a number of leadership responsibilities, such as observing, interpretation and processing group interactions. As well, leaders manage participant behaviour and facilitate family connections (Mandell et al., 1989). Gil and Johnson (1993) recommend that a group with sexually intrusive

children have a low number of participants (six or eight) with two therapists. Two therapists permit the individual members the attention they may need for the group process and stops any member competition for limited resources. In addition, the facilitators can share responsibility for planning, preparing and tidying after group sessions. Other advantages of co-facilitating are opportunities for conjoint evaluation, skill learning, support and debriefing (Mandell et al., 1989).

Organizations may consider the cost and time factors when assigning employees to group work, opting for the least expensive route. In this writer's work experience, volunteers have been used to offset costs. Many professionals are prepared to volunteer time in exchange for an educational opportunity.

Gil and Johnson (1989) recommend selecting mixed gender facilitators in a group for sexually acting out children. Mixed gender leadership provides the children positive role models. A male therapist in an all female group models talking about sexual matters in a positive way. As well, male co-therapists have the opportunity to embody respectful, equitable and non sexist relationships with a female co-facilitators (Brown & Mistry, 1994; Gil & Johnson, 1993; Martin & Shanahan, 1983).

In contrast, Gavin and Reed (1983) and Mandell et al. (1989) suggest that same gender facilitators and participants reduce tension and anxiety regarding a sensitive topic. This author has co-facilitated a male adolescent sexual offender group that had mixed facilitators. In that particular situation it did increase anxiety and embarrassment for participants when discussing sexual issues. A forthright manner of the opposite gender facilitator demonstrated sensitivity and comfort regarding sexuality issues which quickly

dispelled any apprehensions.

Ideally, co-leaders that are of mixed gender increase the benefit for modeling appropriate male/female relationships in a preadolescent sexually acting out group of children (Garvin & Reed, 1983). The next logical choice would be same sex participants/ leaders to reduce any anxiety produced by the nature of the material presented. Sometimes circumstances do not present optimal choices and groups leaders are chosen based on available bodies versus gender sensitivity.

Other considerations that promote a positive selection of a co-facilitator in a group intervention for sexually intrusive children are listed as: (1) how to choose and work with a co-therapist, (2) understanding the role of the therapist in group treatment, and (3) facilitators' comfort level with the topic of sexualized behavior (Gil & Johnson, 1993). There are a variety of resources that aid in the process of leader selection. One is a therapist rating tool, helping facilitators explore expectations about group leadership roles (Corder, 1994). This is a self-report tool that explores therapist style. Each group leader completes a form and shares the information with his/her co-leader. This tool opens communication between facilitators and offers opportunity to resolve differences. There are many other resources that help facilitators define their working relationship (Corder, 1994; Dies, 1994; Roller, 1993; Rutan & Stone, 1993; Yalom, 1995).

Co-leaders benefit from exploring each other's style of interaction, strengths and areas for development, preferred model of intervention, roles and methods of conflict resolution (Herzog, 1980; Poey, 1985). Communication is enhanced if co-facilitators meet at regular intervals to plan for the next group, review and debrief previous sessions,

discuss transference issues and the successes observed (Herzog, 1980; Rivas & Toseland, 1998). Regular meeting times can be useful in assigning tasks, roles and activities to each facilitator and helps to build a mutually supportive and trusting relationship between co-facilitators (Poey, 1985; Rivas & Toseland, 1998). In addition, consistent supervision by an outside member assist co-leaders in examining missed issues (Herzog, 1980; Poey, 1985)

It is this writer's practice, when working with sexualized children, facilitators benefit from completing and sharing an analysis of attitudes and feelings regarding sexuality and sex. This tool helps facilitators understand their own biases, comfort levels and difficulties with this theme. Johnson (1995) has designed a similar questionnaire for caregivers of sexually acting out children, but it can be adapted for this purpose.

Failing the opportunity to select male/female co-leader team, this group was co-facilitated by a female team. This writer teamed with Alison Lund, M.S.W., an experienced group leader and therapist on staff at New Directions: Families Against Sexual Assault. The co-facilitators completed the therapist rating tool to further understand each other's leadership styles. The two co-facilitators of the children's group were both female, Caucasian and of a similar age. Although co-leaders of mixed gender are considered optimal (Brown & Mistry, 1994; Gil & Johnson; 1993), for this group there were no male volunteers to select from.

As recommended by Herzog (1980) and Rivas and Toseland (1998) this writer and Alison Lund met several times to discuss the project, explore each other's style of facilitation and areas of experience and expertise. Alison Lund is an experienced therapist

and group worker who practises a feminist and narrative approach to therapy. Immediately, there was an apparent compatibility between the two facilitators. Although the group design was this writer's, Alison Lund was invited, and did contribute significant and valuable ideas. Weekly meetings helped the co-leaders form a strong cohesive working relationship.

The co-leaders met weekly to discuss, plan, prepare and record progress notes. After each session, the leaders met to confer and debrief the sessions. Alison Lund was involved as an equal partner throughout the group process. She was active in the prescreening of referrals and the selection process. She took an active role as a co-leader in the group sessions, processing group dynamics, guiding group interaction, managing group conflict, presenting material and facilitating activities. As well, Alison Lund contributed to the closing summaries and was present at all closing interviews.

Supervision

Supervision for the group process was provided by Barbara Quesnel, M.S.W. advisor, adjunct professor, at the University of Manitoba and a therapist with the New Directions FASA program. At New Directions, this writer joined the four M.S.W. therapists working in the Families Affected by Sexual Assault Program (FASA). FASA has been serving the community since 1985 and provides counseling, support, education, and advocacy to families with children who have experienced third party sexual assault. This writer's practicum committee consisted of Barbara Quesnel, M.S.W., University of Manitoba faculty advisor, Ron Kane, M.S.W., external examiner, and Diane Hiebert-Murphy, Ph D., University of Manitoba Faculty of Social Work. Barbara Quesnel,

M.S.W., provided direct supervision which focused on the planning of group sessions, the selection of a co-leader and the subsequent relationship, and debriefing the progress notes of each session. Supervision also ensured that the group facilitator met the protocols of the sponsoring agency in such areas as documentation, file recording and reports.

Selection of Membership

Group candidates must be carefully screened and prepared prior to their involvement in a group. Screening maximizes the success of the group process, eliminates inappropriate participants and ensures a successful group (Mandell et al., 1989). In assessing the appropriateness of a referred group members, facilitators should examine the developmental level of the child, his/her presenting behaviors, his/her ability to communicate regarding the sexual behaviors, current coping skills, outside resources, and previous group experience. A thorough psycho-social assessment may not be an affordable luxury, but preliminary screening and a referral form are utilized to refine the selection process (Gil & Johnson, 1993). Group referrals were open to social service agencies, city-wide and province wide. All accepted referrals became clients of the FASA program.

Personal interviews conducted with potential candidates serves two purposes: assessment and preparation. Interviews permit facilitators to assess the child's potential to respond to limit setting and his/her behavioral controls. The interviews should establish the child's capability to discuss his/her history and then, assess the child's tolerance for hearing other, similar stories. In addition, the leaders evaluate the children's capacity to take turns and follow rules which impacts on group process.

The interview should additionally include an assessment of the child's cognitive skills and capacity for abstract thinking. This directs the type of activities and materials used in the group format. Children that are developmentally or academically delayed may have difficulty completing writing exercises, but art can be utilized as a replacement (Edleson & Rose, 1987; Gil & Johnson, 1993; Mandell et al., 1989). Inclusion of caregivers in the interview process provides collateral information. Interviews that include the parents/caregivers helps engage their support for the group process. Interview questions should begin with neutral topics, later, moving to more intimate/ uncomfortable questions. An outline of interview questions were developed prior to the interview. Children diagnosed with a psychotic illness were considered an inappropriate referral for this group. Children denying their sexually inappropriate behaviours are unlikely to benefit from group (Gil & Johnson, 1993).

Each child and his/her caregiver/identified significant person were invited to participate in a pre-selection interview. These interviews were approximately 45 minutes in duration and focused on assessing the child's appropriateness for group, the degree of caregiver support for the process and future involvement. In addition, the interviews permitted the children and caregivers to determine whether such a therapeutic resource was applicable for their needs and whether they wanted to participate in the intervention. As well, the interview provided the potential participant an opportunity to gauge his/her comfort level with this topic and the facilitators. The first part of the interview involved the caregiver and the child, the latter portion of the interview assessed the child alone.

Recruitment

As this was a specific treatment group, criteria were established for membership selection. Rivas and Toseland (1998) advise that the selection of membership for treatment groups is based on common problem areas. Group participants were required to meet the following classifications: (a) aged 9, 10, 11 or 12 years, (b) had acknowledged sexually acting out behaviours, © were without serious developmental delays, (d) were in a stable environment, and (e) may or may not have disclosed sexual abuse. A request for referrals listing the group criteria and describing the objectives (see Appendix A) was attached to a referral form (see Appendix B). The request for referrals was advertised throughout Winnipeg Child and Family Services, Provincial Regional agencies, Native Child and Family Service agencies and several privately funded organizations that provide treatment for children. The intervention was available to all children who met the criteria. Referrals were made by social workers, medical practioners, therapists or by individuals. As recommended by Rivas and Toseland (1998) this worker met and discussed the project with supervisors, co-workers and outside collaterals, outlining the need for the group and the model of intervention.

Referral requests were sent two months prior to the commencement date of the group, allowing time for response and preselection interviews (Mandell et al., 1989; Rivas & Toseland, 1998). Approximately twelve candidates were referred for this service. Several of the candidates were rejected based on age or unstable environment. Eight clients were considered appropriate candidates and were asked to attend a preselection interview. Of those eight, seven were selected for the group. The client that was rejected

refused to attend this group as she felt it did not meet her needs. Transportation was the responsibility of the referral source, but parking costs, activity needs and snacks were covered by the FASA program.

Client Profiles

Referrals for the group intervention came from a variety of sources. The majority of referrals were from Winnipeg Child and Family social workers. Other referrals sources included Interlake Child and Family Services, Knowles, Child Protection Centre and self-referrals. There were twelve children referred in total. The children were of mixed gender ranging in age between 7 years and 13 years. The age cohort was grouped at the 11, 12 and 13 year mark. As recommended by Gil and Johnson (1993) the group was selected on the closest age cohort. Rejected referrals were those children falling below the 11 year mark. Mixed genders were selected because there were not enough candidates to complete a group of single sex membership. Eight of the children, aged 11, 12 and 13, were chosen for preselection interviews, four boys and four girls. Facilitators expected that gender subgroups would form, but believed that group process and cohesion would counteract this problem.

Each child was invited to attend a preselection interview with his/her caregivers/parents. Interviews were held at New Directions, FASA program, conducted by the facilitators, and each interview lasted approximately 45 minutes. Preplanned interview questions were explored. These questions were chosen to assess the following factors: (1) the child's interest and suitability to group; (2) the degree of parent support, interest and commitment; (3) the child's degree of comfort in discussing past sexual

behaviour problems; and (4) the child's developmental level. In addition, this interview provided an opportunity to collect demographic, contextual and baseline information. Individual goals and expectations were explored and an outline of the group format and goals was provided (Mandell et al., 1989). Issues such as confidentiality, privacy and sharing of information were clarified in the preliminary interview. As suggested by Mandell et al. (1989), during this time parents and children were familiarized with the setting and the group room.

Seven of the eight children interviewed were considered appropriate for the group intervention. All candidates for group were advised that attendance was totally voluntary. One of the children interviewed, a girl, indicated that she was not prepared to attend at group a this time. She was invited to consider attending, but maintained a continual refusal. Each of the seven children selected indicated a desire to be part of a group for sexually acting out children. All the children said, with varying degrees of comfort, that they believed they had a problem with touching other children. Of the seven children selected, only five completed the group. One child, an 11 year old male terminated after the third session. Another child, an 11 year old female, withdrew after the fifth group meeting.

The age range between group members was approximately 1.5 years. The mean age of the group participants was 11.3 years. The children were from a variety of ethnic backgrounds and socio-economic groups. Of the seven members, two of the children lived with their biological families and had never been in care. The remaining five children were under the care of Child and Family Services. Three of these children lived in group care

and two resided in family based foster homes. Only two children were identified as being in care because their sexually reactive behaviors posed a risk to other children. The other children were in care for a variety of reasons: parents unable to provide care, substance abuse or family violence. Each child had at least one significant family member or caregiver willing to join the concurrent parent group. Some children had two caregivers or parents/foster parents committed to attending the parent group.

Some of the participants were involved in other therapeutic resources. Three of the children were in concurrent individual counseling. One child had previously received individual and family therapy. Two of the children were on waiting lists to receive individual therapy. Only one child identified having past involvement in an anger management group intervention.

Profiles

All names have been altered to protect the privacy and respect the confidentiality of the individuals involved in this practicum. Any strongly identifying information has been excluded to ensure the confidentiality of those involved. The resultant profiles are based on self-reported and referral information. The group membership included the following individuals, three girls, Kate, Ann and Tracy, and four boys, Rick, Keith, Charly and Ken. The life situations of the clients will be described to give the reader a sense of the social history and past issues experienced by the group members.

Kate

Kate was an 11 year old Caucasian female. She was referred to the group by her Child Care Worker, Nora. Kate resided in a residential care facility that generally housed

seven or eight other girls. She had resided in this placement for more that one year. Kate has been in individual counseling for more than one year. She and her mother have recently started family therapy sessions.

Kate disclosed a history of multiple sexual victimization. These events involved sexual molestation and sexual intercourse by adult male babysitters. Although no charges were laid for reasons that are unclear, it is understood Kate was supported and believed by her mother. Approximately 18 months ago, Kate's mother witnessed Kate sexually touching her younger siblings. Since this time, Kate has lived in residential care. Nora stated that Kate was involved in sexual touching with several different girls in her group home on more that one occasion. Frequently, Kate behaved in a sexual manner by changing her clothing in front of open doorways, making sexual comments and talking about sex. Kate also attempted to touch the girls in sexually intrusive ways.

In her initial interview Kate acknowledged that she was involved in sexual touching with other girls her age and that she had a touching problem. Kate said she felt she needed help with this problem. Kate indicated that she was willing to attend group. Also, she said she felt very comfortable speaking about sexuality and her inappropriate touching. Kate described feeling angry about her abuse history.

The referral source indicated concern that Kate continued to act out sexually and wanted Kate to receive assistance with this issue. Kate's behaviours were identified as having sexually touched her younger brother (aged 3 years), simulated sexual intercourse with female peers, invited peers to touch her breasts and vagina, kissed others and exposed herself. Kate, on four separate occasions, engaged four different children in sexual

behaviors. Nora admitted that the staff in the group home had little knowledge regarding this behavior and how to protect other children in their care. Nora was prepared to attend the parent group on Kate's behalf. As there was a possibility that Kate may return home, Kate's mother was also invited to attend the parent group, but she refused to attend, citing childcare, employment and distance as inhibiting factors. Kate stated that she had a strong network of people in her life to support her while she attended the group such as her therapist and her key child care worker.

Ann

Ann, 11 years of age, was referred to this group by Sherry, the Child Care Worker in her home. Ann resided in a four-bed shelter, operated by Child and Family Services. She had been in care for several months because of her mother's self-reported inability to parent. Ann had been in foster placement on other occasions. She indicated that the plan was for her to return home in the near future.

In the preselection interview, Ann confirmed that she had been a victim of sexual abuse. In the interview she disclosed that she had witnessed family violence. During group she disclosed she had once been part of a hostage taking incident. She was sexually assaulted by a third party, adult male. She admitted that she needed to be part of a group for children who were acting out sexually on other children because she thought she needed help with such an issue. Ann presented as forthright, sharing that in the past she had used drugs and currently, she smokes cigarettes. Ann said that she sometimes feels very frustrated and angry about her past experiences and admitted that she used her 'attitude' to deal with her feelings.

Sherry, the referral source, described Ann as using sexually explicit language, making sexual comments to adults or peers and undressing in front of others. As well, Ann was frequently observed to wear "sexy clothing" and behave in a sexual way. Other concerns were that Ann was involved with peers that engaged in sexual activity with each other and older men. Ann stated that she had witnessed her friends 'eating each other out' and that one time her friend had taken her to an old man's house to have sex with him. Ann claimed she had refused to become involved in these activities.

Sherry indicated that she was willing to support Ann throughout the group process. As Ann said she was likely to return home in the near future, Ann was asked to consider inviting her mother to attend. Ann's mother was also invited to attend the group, but did not. Ann's mother offered no explanation to the facilitators as to why she could not attend the parent group.

Tracy

Tracy was the youngest member of the group at aged 10. She turned 11 after the group started. She was referred to this group by her social worker. The referral source indicated that six months prior, Tracy had been observed to simulate sexual intercourse with her younger sister. There were no other documented incidences of sexually acting out behaviours by Tracy, only that her younger sister continued to act in a sexualized manner. Tracy's sibling was also referred to this group, but as she was several years younger, Tracy was chosen instead. Tracy was identified as having been a victim of sexual abuse by a teenage, male cousin. She appeared shy and retiring in the preselection interview. Tracy did not disclose touching other children, but she did indicate that she

thought she should be part of a group for children touching other children.

Tracy was currently residing in a four-bed shelter operated by Child and Family Services. She was in care due to issues surrounding extended family substance abuse and family violence. The social worker said that she planned to return Tracy to her family in the upcoming months. Tracy's child care worker, Jackie, said that she was prepared to accompany Tracy to group. Tracy's parents were invited to attend as well, but chose not to come, citing child care and transportation as a problem.

Tracy did not complete the group. Jackie questioned whether this group was an appropriate resource for Tracy, claiming that although Tracy had once been observed to sexually act out with her sister, there had not been any other sexually inappropriate behaviours since. Jackie suggested that Tracy was a sexually abused child and not sexually inappropriate in her behaviours. The leaders spoke with Jackie and the referral source, reminding them that Tracy indicated that she wanted to continue attending group. In the end, Tracy attended approximately five sessions before Jackie made the decision to remove Tracy from the group process without consultation. This in reflection highlights the difficulties that some professionals have with the terminology used in the group.

Rick

Rick was the oldest group member, aged 13 years. He was referred to group by his individual therapist. Rick is a permanent ward of Child and Family Services. He has lived in the same professionally parented foster home for the past eight years. Rick's social worker indicated that several times in the past two years, Rick has behaved in a sexually inappropriate manner with children, a 4 and a 5 year old girl. His foster mother

observed that Rick was sexually aroused during two incidents that involved inviting girls to sit on his lap. Another incident involved Rick taking a 5 year old girl into his bedroom where he sexually touched her. There was another, more recent event wherein he exposed his genitals and invited a little girl to touch his penis. His foster parent indicated that Rick was involved in sexual behaviors with six different children on as many different occasions. Rick's foster mother said that Rick still continues to try touching her breasts. His foster mother says "Rick lies about everything," and that he denies behaviours that he is observed to do.

It was reported that, prior to age five, Rick was a victim of sexual touching by his biological mother. At the age of seven, he was invited to simulate sexual intercourse, and was fondled by a foster sister, aged 13. Rick recalls his biological mother as sexually promiscuous, involved with several unknown men on an irregular basis. Rick describes his birth mother as being physically abusive and verbally threatening to 'kill me' and remembers that she once "hung me over a bridge, threatening to release me".

Keith

Keith was referred to this group at the request of his biological parents. Keith had just disclosed that he was involved in mutual sexually acting out behaviours with another 13 year old boy in the neighborhood. Keith was 11 years old, an only child, living with his biological parents, at the time of referral. He had disclosed his sexual activity to his father upon being told about the dangers of Auto Immune Deficiency Syndrome (AIDS). Keith had then disclosed that he had involved a younger boy in similar sexual activity. His parents had no previous therapeutic involvement for this issue. They had become involved

with the police, Child and Family Services and Child Protection Centre. The parents admitted their shock at Keith's disclosures, and stated they wanted to help their son with this matter. Other than the sexualized behaviour with the older child, Keith did not disclose having a history of sexual or physical abuse. Keith presented as very ashamed and embarrassed by his behaviour, saying he "did not know this was wrong".

Keith and his parents only attended the first three sessions of group. After the third session, Keith's mother contacted the facilitator to say that she did not find group was helpful, and that she was feeling emotionally very distraught by the group experience. Keith's mother told the group leader that she was experiencing a revival of her own unresolved sexual abuse issues. She stated that she was feeling that the other group members in the adult group were not experiencing the sexually acting out behaviours of their children in the same way she was (i.e., that the majority of the other parents were foster parents and did not feel that they were somehow responsible for the child's sexualized behaviour). The mother said that she was prepared to let her child continue at group should he want to do so, but that she preferred that "he just left this stuff behind". Keith did not return to the group. Later contact with Keith's father revealed that the mother had been hospitalized due to the emotional state created by this situation.

Charly

Charly, an 11 year old foster child, was referred to group by his foster home co-ordinator. Charly's biological mother, professional parent foster mother and foster home co-ordinator attended his interview. The referral source said that Charly's younger cousins had alleged that he had invited them to engage in sexual touching and that he had

talked about sex with his cousins. Since that incident, in September, 1998, Charly was placed in foster care. Charly's birth mother said that Charly had witnessed extreme family violence. His mother said that Charly's father had been very physically abusive towards her. As well, he had sexually assaulted Charly and his older brother. Charly had not lived with this man since he was approximately three years of age. Charly's mother indicated that she had and her children had the benefit of many counseling interventions. His mother said that she currently attends individual therapy, as does Charly. Charly's foster parent indicated that Charly is currently involved with a girlfriend that is 16 years of age. She has discouraged this relationship, but Charly persists. Charly was also found to have taken and hidden the underwear belonging to the foster mother's adult daughter. All the adults present at the interview said that Charly has a problem with lying (i.e., that "he lies about anything and everything").

Initially, Charly stated that he had no intention of attending a group for sexually acting out children. He later changed his mind and attended every group session. Charly seemed to be motivated to attend this group by his desire to please his mother and a hope that he could return home in the near future.

Ken

Ken, another 11 year old male, was referred to this group by his social worker. Ken lived at home with his mother and two brothers. His referral information suggested that Ken had recently touched a younger girl's vagina over her clothing. Other unsubstantiated allegations were that he had behaved in a sexually inappropriate manner with two younger boys in his community. Ken attended this interview with his birth

mother. In his interview, Ken said that he had sexually touched another child and that he had made a mistake. He indicated to the leaders that he would never do such behaviours again, but could not say how he would stop its reoccurrence. He disclosed that he was a witness to severe family violence and a victim of physical abuse. He said he had never been sexually abused. Ken said that he had gone to a group the year prior, for children who had problems with anger. Ken confessed that he was "stupid" at school work and could not read or write very well.

His mother and his social worker described Ken as having challenging and difficult behaviours. He was identified as frequently being suspended from school for his aggressive and angry acting out towards other students and teachers in school. Ken was being assessed for Attention Deficient Hyperactive Disorder (ADHD). During group, Ken began taking ritalin for the first time. Ken said the medication make him feel much better and that he could now concentrate at school and do his work. This was substantiated by teachers and Ken's mother who observed a significant improvement in his behaviour and ability to complete school tasks. Ken's mother was prepared to accompany Ken to group and attend the parent component.

In review, every group participant was a voluntary member for this group. Only one interviewed client identified no desire to attend. Each child was identified as having acted out sexually with other children. In the preliminary interview, six of the seven children interviewed said they should be part of a group for sexually acting out children. As well, five of the seven children self-reported a history of sexual victimization; one child disclosed a highly sexualized family environment, one child reported physical abuse and

two children described witnessing severe family violence. Another traumatic event disclosed by one child was a hostage taking. Five of the seven children had previous counseling experiences. It is noted that of the children residing in foster placements, all biological parents were invited to attend as well as caregivers. Only three biological parents attended group out of a possible seven. The degree of support from the foster parents was much greater than that of the birth parents.

Preparation for Group Process

Mandell et. al. (1989) recommended using the initial interview with children as an opportunity to prepare the group members for the group process. Children benefit in several ways from this orientation experience. In orientation, the children were told what the group would be about, they met the leaders, viewed the setting, received an explanation of group themes and an outline of the group format. In addition, the children and their caregivers were advised that this group was a practicum project and that they could choose not to participate. The writer informed the individuals involved that the information collected from this group would be compiled in a final report and that the participants were welcome to read the report should they so wish. The workers told the participants and their caregivers that this project aimed to protect the confidentiality and privacy of those involved.

Preparation reduced anxiety for the children and offered the caregiver and the child the assurance that the practioner would protect and support the children in the group. Interviews prepared children for the eventuality that they would be invited to talk about their sexually inappropriate behaviors in the group environment. At the same time,

children were assured that this would only occur when/if the child felt comfortable enough to do so. Facilitators included a designated time for debriefing, planning activities, writing progress notes and reports in their group preparation (Mandell et al., 1989).

Another phase of preparation was to address the issue of respecting privacy and confidentiality. Children were advised that confidences would be respected and that everyone would follow the rule "whatever is said in group stays in group". Children needed to know that they could trust the facilitators and other group members to respect confidences shared in group (Attinson & Skolnik, 1978; Mandell et al., 1989). At the same time, children needed to know that disclosures of abuse would be reported as required by the child welfare mandate. Caregivers were also notified that children were encouraged to respect the confidences shared in the group forum, but the children were permitted to discuss their own situation if they so chose.

The facilitator intended to guide the participants through pre-set group modules, in a format intended to increase the children's understanding of the context of their behaviors. The group structure mirrored and modeled the skills and techniques necessary to control their behaviors. The pre-established format and modules were as follows:

Group Format

The outline of weekly sessions was designed to operate for a consecutive eight to ten week period. Each session would last for one hour and fifteen minutes, excluding the break. Snack and debriefing time was allocated fifteen minutes at the end of every session, to complete a total of 1 and a ½ hours of group time. Each module followed a consistent structured format that permitted the integration of the specific goals and objectives. Every

step of the session was geared to provide an opportunity to reinforce or practice one or several objectives. Each session had a beginning, middle and ending component, modeled after group developmental stages (Rivas & Toseland, 1998). The outline for each session may be adapted to suit a variety of purposes, ages and time frames.

Every group meeting involved 'hands-on,' participation activities for the members. This type of activity was chosen for the benefits it has for assimilating material (Celano, 1990; Mandell et al., 1989). Activities provided an opportunity to practice the skills demonstrated. Activities helped the children to remain focused and be involved in the learning. Active learning created interaction amongst members and facilitators, encouraging a pattern of reciprocity to develop, where the children and leaders engaged in reciprocal communication that developed from the activities (Celano, 1990; Cormier & Cormier, 1985; Dimock, 1976; Mandell et al, 1989). Undoubtedly, activities are far more "fun" to do than sitting for lectures or discussions.

Housekeeping was a scheduled time for informing participants of upcoming events, program changes or necessary reminders. Check-ins and check-outs accorded members an occasion to discharge emotional energy, center their thinking prior to entering the group process, and for debriefing prior to leaving the group (Mandell et al., 1989; Rivas & Toseland, 1998). These few minutes offered a time to model interaction and show group support for each other. Check-ins and check-outs helped establish and model the necessary boundaries for the beginning and end of the group process (Mandell et al., 1989). Relaxation exercises mirrored positive coping strategies, practiced stress inoculation techniques and helped children discharge energy prior to departure (Cormier &

Cormier, 1985)

Journal writing was included for those children who had difficulty expressing themselves in the group discussion forum, allowing them to ask questions or communicate ideas and concerns. Children had the choice of writing, dictating, printing or drawing in their journals. The members chose to have the facilitators respond to their journal entries. The leaders wrote weekly responses in the journals that focused the children's thinking on upcoming material or behaviors. Journals were helpful in exploring the participants' understanding of the presented theme (Mandell et al., 1989). Journals actualized the use of narrative therapy (Nylund & Smith, 1997). Journals attempted to provide a place for the children to record their own stories, thoughts and hopes for the future.

Socialization time was held during the last 15 minutes of the group session. It included an opportunity for the children to play a variety of therapeutic board games, music or talk. This time period gave the children a chance to make friends, continuing to integrate the group objectives and encouraged interaction (Mandell et al., 1989).

Between group sessions the children received a general group letter composed by the facilitators. This was a short letter that intended to bridge the gap in time between groups and provide continuity of the group experience beyond the weekly session. It also provided a way for the children to receive feedback on the group process and dynamics. The letters were used to point out group development, roles, conflict and struggles with the material presented. At the end of group, at the request of the members, each child received an individual, specialized letter, reflecting his/her own progress, issues and concerns.

Generally, the format was as follows:

1) Check-in. Approximately 5 minutes.

2) Housekeeping. Approximately 5 minutes.

3) Introduction of main theme. Approximately 10 minutes.

4) Activities that promoted an active, integrative learning environment for each session theme. These activities are also chosen for their contribution to group dynamics, group development and group interactions. Approximately 20-30 minutes.

5) Journal activity. Approximately 10 minutes.

6) Check-out and relaxation exercises. Approximately 10 minutes.

7) Snack and socialization time. Approximately 15 minutes.

It was apparent that the amount of time allotted for the group was too short. There was never time for the children to experiment with relaxation exercises. It was also clear that the children would not be able to remain focused should the length of group be extended. This part of the agenda was sacrificed in favour of time to use the journals, to debrief and to socialize.

Evaluation Tools

An important consideration when choosing an evaluation method, especially when working with children, is to keep the tool brief, simple, age-appropriate and, where possible, culturally-free. It is essential to choose a questionnaire that is adaptable for children who are academically challenged. Many children and adults do not want to fill out lengthy questionnaires (Mandell et al., 1989; Rivas & Toseland, 1998).

Toseland and Rivas (1998) suggest several useful approaches to evaluating group

objectives. Clinicians must decide what aspects of group they want to evaluate and examine the options available for evaluating the chosen area. The target of evaluation and the method chosen will have to coordinate with the objectives of a facilitator's employer. Factors such as cost and time will be considerations (Rivas & Toseland, 1998).

For the purpose of this group intervention the goals of the group and those of the individual members were considered in choosing evaluation tools (Rivas & Toseland, 1998). The primary goal of this group intervention was to minimize or eliminate sexualized behaviours in children. A secondary goal was to assess the influence of trauma in relation to sexualized behaviours. Standardized questionnaires, measuring and monitoring child sexual behaviour and assessing trauma impact, contributed to the formal evaluation of the group intervention.

The Trauma Symptom Checklist for Children (TSCC) developed by Briere (1997) and the Child Sexual Abuse Inventory (Friedrich, 1997) were two of the chosen instruments. These questionnaires were administered at pre and post group to assess changes in the children's behaviours. The TSCC is a brief self-report measure that examines posttraumatic symptoms and related manifestations (Briere, 1997). This tool is intended for use with children, aged seven to seventeen who have experienced traumatic events, such as childhood sexual abuse, physical abuse, loss, family violence or natural disasters (Briere, 1997). Briere (1997) offers a fifty-four item scale that measures several symptoms of trauma such as anxiety, depression, anger posttraumatic stress, disassociation and sexual concerns. The TSCC is designed to assess children's responses to unspecified traumatic events in a broad range of categories (Briere, 1997). This scale

includes items that control for hyper response, a desire to appear symptomatic or overwhelmed by traumatic stress, and under response which reflects the tendency toward denial, or a need to appear symptom free (Briere, 1977).

Anxiety items assess generalized anxiety and worry, specific fears of men/women, the dark, death or a sense of danger. Depression scales are used to examine feelings of sadness, loneliness, guilt, desire to be self-injurious and sucidality. The anger items include an examination of thoughts, feelings and actions such as feeling mad, hating others, being mean, wanting to yell, argue and fight others. Posttraumatic stress items involve distracting thoughts and images of past traumatic events, nightmares, fears and avoidance of feelings. The dissociation scales measure such items as emotional numbing, a sensation of one's mind going blank, day dreaming, difficulty remembering and pretending to be someone else. This category has two subscales, overt dissociation and fantasy dissociation. The final scale, sexual concerns, measures sexual thoughts or feelings that are considered deviant when occurring earlier than expected in children and with greater than normal frequency. It also assesses sexual conflicts, negative responses to sexual stimuli and fear of being sexually exploited. This category has two subscales evaluating sexual preoccupation and sexual distress (Briere, 1997).

This questionnaire is given to the child to complete. The child checks his/her response to a list of thoughts, feelings and behaviours and circles a range of responses from 0 (never happens) to 3 (happens almost all the time). The TSCC can be completed in 15 minutes and scored in 10 minutes. The TSCC is scored separately for males and females and 8-12 year olds and 13-16 year olds. Scoring is simple to complete, calculating

a raw score and plotting the corresponding T-score. The profile form reflects the cutoff point for a normal distribution which is 1.5 standard deviations and a normal T-score (T=50). The standard deviation is higher for sexual concerns and hyper/under response (Briere, 1997).

Briere (1997) reported that the reliability of the TSCC shows high internal consistency for five of the six clinical scales (i.e., 0.82 to 0.89). The other scale, sexual concerns was moderately reliable (0.77). Studies (Briere, 1997) indicate that the scale significantly correlates most with the Child Behaviour Checklist (Friedrich, 1997).

The Child Sexual Behaviour Inventory (CSBI) by Friedrich (1997) which is a shorter version of the Child Sexual Behaviour Checklist (Friedrich, 1990) was completed by the caregivers. This scale measures a parent-report of the sexual behaviours observed in children 2- 12 years of age. This questionnaire is used to assist in the assessment of children who have been sexually victimized or are suspected to have been victimized. The CSBI was developed in response to the understanding that sexual abuse is related to sexually inappropriate behaviours. This is a brief questionnaire, covering 38 items. The items assess a range of behaviour in several areas such as boundaries, exhibitionism, gender roles, self-simulation, sexual distress, sexual interest, sexual intrusiveness, sexual knowledge and voyeuristic behaviours (Friedrich, 1997).

Scores are achieved by summing the responses and plotting the subsequent T-score. The scores are interpreted according to the normative score. Scores range from 0 to 114, total raw scores above 45 are very unusual or may be ruled as an invalid response by the clinician. The child's score on each item can also be compared to frequency tables

for normative comparison. Friedrich (1997) reports the reliability as alpha=0.92. The test-retest reliability was calculated as alpha=0.85 on the first test and a correlation of .91 on the retest. The intercorrelation of the items is reported to be significant on most items. The scale also correlates significantly with a history of sexual abuse but not other types of abuse. In addition, the scale discriminates between samples of sexually abused and non sexually abused children (Friedrich, 1997).

Briere (1997) and Friedrich (1997) both recommend against using their scales in isolation because they do not provide enough information to make reliable statements about the cause of the sexualized behaviours or to determine if the child has/is being sexually abused. Friedrich (1997) encourages the use of the CSBI scale as a supplemental assessment tool that is completed by as many significant others as possible to gain more extensive information. It is suggested that the scales be used in combination with other clinical scales, teacher reports and parent child interviews (Brieres, 1997; Friedrich, 1997).

Pearce and Pezzot-Pearce (1997) concur that no one assessment tool is faultless and that sexually acting out children will and can respond in socially desirable ways that underestimate their behaviours. They stated that the CSBI and the TSCC offer two ways to collect data on sexualized children. Pearce and Pezzot-Pearce (1997) emphasize that all assessments of sexualized children involve an interview with the child. In that interview the clinician tries to gain an understanding of the meaning the sexualized behaviours have for the child and what purpose the child sees those behaviours as having (Pearce & Pezzot-Pearce, 1997).

The TSCC was completed by each child at the preselection interview and again

post group. The caregiver/parents completed the CSBI at pre and post group intervals. This was completed in 15 to 20 minutes. In addition, parents completed another, more detailed, measure that reports and monitors the children's sexually acting out behaviors, The Child Sexual Behaviour Checklist (CSBC) also developed by Friedrich (1990). This was completed by parents at the second group session. As well, data was obtained from the referral source and via the parent/child selection interviews.

Each participant completed an informal client satisfaction questionnaire at the end of the group intervention. This questionnaire intended to provide feedback and evaluate the group process for the client. It explored areas such as format, the duration, the facilitators, the material covered and assessed the value and effectiveness. Closing interviews were held at a two week interval after the termination of group. This also presented an opportunity to share helpful information, make recommendations and receive feedback. Individual and general closing summaries were also completed on each group participant and provided to the referral source.

Dimock (1976) suggests a thorough group evaluation occurs when group dynamics and development are observed. Included in the evaluation are the weekly facilitators' group and individual progress notes. These notes contribute anecdotal information that offer a qualitative perspective and help describe the influence of the group process. Anecdotal information supports the construct of empowerment i.e., the client is the expert on his/her own story. Other anecdotal information came from the children's weekly journal recordings. The journal recordings bring forth the narrative element where children tell their own story and explain the meaning that story has for them. This is

another important piece that respects the client as the expert concerning his/her own situation. Evaluation provides an opportunity to ensure goals and objectives are met by the group intervention. As well, facilitators can assess the strengths and weaknesses of their own skills and the actual program. Evaluation highlights areas for improvement (Garvin, 1997; Rivas & Toseland, 1998).

CHAPTER FIVE

Outline of Group Modules and Session Description

This writer has included a detailed outline of the group sessions, the objectives and the activities that were used to integrate the group material. In addition, group stages, dynamics and expected challenges for each session are discussed. The outline explores the specific issues that may arise for the practioner and the members in that stage. It is understood that sessions can and were adapted for various reasons. For example, developmentally delayed children would have shorter meetings which accommodate their shorter attention spans. Activities can be and were changed to reflect the ability, age, gender or culture of the participants. A list of additional resources completes the session outline. Throughout the group process, facilitators maintained an awareness that the process dynamics of any group can overturn the best laid plans. Workers were prepared and did sideline structure in favor of productive process such as attending to a group member in crisis.

Session I: Getting to Know Each Other

The first stage of group concentrated on establishing trust, beginning relationships and preparing the framework from which the group norms emerged. The facilitators attempted to create a safe context in which children could share painful experiences and feelings connected to their sexually acting out behaviors. The first theme centered on developing relationships between the members and the facilitators in an atmosphere that was conducive to trust, mutual cooperation, acceptance and approval (Dimock, 1970; Garvin, 1997; Rivas & Toseland, 1998). At this first level, the group members and leaders

got to know each other, identifying commonalities that lead to building a trusting relationship. The group established the norms that facilitated the group achieving its objectives. Practioners had an opportunity in the first group meeting to assess individual participants' level of social skills. These assessments helped guide the intervention, highlighting those areas that were too sophisticated, or conversely, too basic for the children's developmental levels (Mandell et al., 1989).

Session I Objectives:

1.Together the group defined acceptable group behavior and the guidelines for monitoring such behaviour.

2. Leaders promoted and reinforced the participants' interactions and cooperation.

3. Leaders acknowledged, validated and clarified common experiences among participants

4. The purpose of the group was discussed with the members.

Practitioner Issues: The worker's role at this first stage was to educate, establish appropriate guidelines for interactions and conflicts, modeling and reinforcing positive social behaviours (Dimock, 1970). The group worker's tasks were to stimulate interaction between members and find a balance between differences and commonalities (Gil & Johnson, 1993). The facilitators anticipated testing of the limits and of their ability to maintain a safe and protected environment (Mandell et al., 1989). Facilitators helped members feel connected to the group by pointing out commonalities. Group workers had an understanding of the possible dynamics that may arise at this first stage. Areas monitored were communication and interaction patterns, cohesion, group culture and social control mechanisms, such as norms, roles and status (Rivas & Toseland, 1998).

Client Issues: In this first session, participants had feelings of either ambivalence, excitement or anxiety, or all three. Often members appeared hesitant and uncertain about the group experience. Approach-avoidant conflicts appeared as the session progressed. Children advanced, trying to get to know others, only to recede when it seemed too intimate (Rivas & Toseland, 1998). In addition, children seemed cautious about what type and how much information they were prepared to reveal. Sexually acting out children frequently have poor boundaries and some self-disclosed too much information. This seemed to be expected behaviour and it could be threatening for other group members (Gil & Johnson, 1993). As the development of group norms occurred children had a clearer understanding of what the group expected from them. Members were assumed to respond in a variety of ways to the first group session. Some children were anticipated to be withdrawn, whereas, others were more boisterous.

Session I Agenda: Getting to Know Each Other

1. Introductions: Facilitators introduced themselves, explained check-in and modeled the expected check-in behaviour to the remainder of the group, stating how they were feeling about attending group. Afterwards, the leaders asked the group members to introduce themselves, by first name only, and to complete the check-in exercise via a 'around the table' (Duffy, 1994). The group leaders then identified and modeled some of the expected group behaviour such as limits and boundaries (i.e., the leaders emphasized that in the future all group sessions are to start on time and end on time).
2. Housekeeping: Group guidelines for behaviour/expectations were created by the

participants. The leaders addressed and explained the expected behaviour regarding respecting privacy and confidentiality in the group.

The leaders introduced and clarified the purpose for the group, asking group members for input and comments. A simple statement was made about the type of group this was, the commonalities of the children in respect to sexually acting out behaviours and the need to help each other with such behaviours.

3. Introduced Theme: Getting to know each other.

4. Activities.

All the activities selected began the process of getting to know each other. A simple nonthreatening activity that was intended to be fun, and have the children interact cooperatively with each other, was selected. Children operated from an individual base for the first activity, but were encouraged to rely on and help each other. In order to move the group from an individual focus to a group focus, these activities provided limited resources and materials that had to be shared.

Activity One: Children were asked to pair off, playing the "Reporter Game". In this game, the children were paired off, either self-selected, or leader directed. They were given 5 minutes to gain three pieces of neutral information about their partner. At the end of an allotted time, each member 'reported' back to the remainder of the group, sharing what they knew about their partner.

Activity Two: The second activity was to play a game that helped identify innocuous commonalities among the children. The children sat in a circle of chairs.

One child/ adult stood in the centre and had no chair. The person in the centre

asked all the children to rise if they had, for example, cornflakes for breakfast. Those individuals standing located a new chair. The person left without a chair, remained in the centre and started the process again by asking all children to rise for a common experience. The game continued until everyone had a turn.

5. Introduced journals: Children were invited to write, draw or print any thoughts they had about today's group session. The children were also invited to decorate their journals and asked if they wished to use the journal as a communication tool or was it to be private. All chose to leave the journal as an open communication between themselves and the leaders. Leaders suggested that the first entry should include one of their hopes, dreams and goals about coming to this group.
6. The leaders introduced the suggestion box. The children were invited to make suggestions for group and place them in the box.
7. Check-out: Check-out was modeled by the leaders as a turn-taking opportunity for all participants and leaders to comment on group.
8. Snack, social time and good-byes.
9. Facilitators debriefed, recorded progress notes, tidied the group room and composed a group letter that was mailed to the children the next day.

Additional Resources:

Other suggested 'getting to know each other' cooperative games are:

Balloon Toss. Children blow up several balloons and place the balloons on a sheet. The goal of the game is for the children to grasp the sheet, throwing the balloons into the air and catching as many as they can on the sheet.

Name Game. A child or the leader begins by saying "My name is_____. What is your name_____?", turning and asking the individual sitting next to them. This continues until all the children in the circle have been named.

In hindsight, breaking this first meeting into an extra session would have given ample time for the group to further strengthen and form relationships. The group would have benefitted from a chance to confirm trust and strengthen cohesion. The ability of the group to comfortably progress to the next more intimate session would have been enhanced if more time was focused on getting to know each other. The activities in this first session could easily form two sessions and encompass an additional group meeting. The orientation stage could always use more emphasis, if time permits (Rivas & Toseland, 1998).

Session II: Sexual Abuse, Boundaries and Everyone has Feelings.

Session two continued to provide the children with an opportunity to build trust and form relationships with each other. The children and the leaders got to know each other better. Emphasis was placed on children feeling safe within the group environment. At this point in the group, some participants may have decided to withdraw without saying good-bye. The group may add new members in the second session (Garvin, 1997; Rivas & Toseland, 1998). When the group is still in the early stages, the other members are not often affected by changed membership. Missed sessions and adding new members is not recommended after the second session (Rivas & Toseland, 1998).

Session II: Objectives:

1. Establishment of a safe environment in which children can feel comfortable sharing

experiences and feelings.

2. Further ensure group cohesion by continued support and encouragement of group interaction.

3. Establish an acceptance of differences and diversity among group members.

4. Increase the participants' ability to recognize, accept and express affect.

Practitioner Issues: In this session, the practitioner's focus was to assist the participants in joining together and increasing their reliance on each other. Children were encouraged to interact in positive ways that respected the norms and values of mutual aid group work (Glassman & Kates, 1990). Facilitators observed the emerging interaction patterns and began to identify group roles. Leaders were inclusive of all members, ensuring that no participant was left out of the group bonding process (Mandell et al., 1989). Practitioners observed continued avoidance/intimacy conflict for some members. Participants were invited to express and identify their feelings. Leaders helped the group examine the process in which they were involved (Glassman & Kates, 1990).

Client Issues: Some points observed in the group development were that some participants continued to feel anxious and uncertain about attending group. As the group continues to interact, alliances or dyads may form (Rivas & Toseland, 1998). Some children may feel left out. Children can react by vying for attention or withdrawing from the group. Some children may still experience ambivalence about the group.

Session II Agenda: Sexual Abuse, Boundaries and Everyone Has Feelings

1. Check-in: Participants and leaders were encouraged to restate their names. Children were invited to state their names during check-in and to comment on their reaction

to the group letter.

2. Housekeeping: A quick review of group guidelines was made for the new members. The guidelines were written on a poster board by a group member and displayed in a visible area. Leaders invited discussion on the different ways the children were talking about the group with friends or school mates.

3. Introduce Themes: Boundaries, Definition of Sexual Abuse and Everyone Has Feelings.

Children were invited to share their understanding of what boundaries are and why they were established. Participants were asked to brainstorm about everyday boundaries during ordinary events such as when they were visiting a friend's house, opening the friend's refrigerator, using the bathroom or using someone else's toothbrush. Then children were asked to describe privacy boundaries. The discussion moved to defining sexual abuse and how that crosses personal boundaries. The group participants were asked to identify feelings that they have when boundaries are not respected. Feeling lists were placed on the flip chart. Children were asked to think of feelings that are both positive and negative. Participants were asked to relate their own experiences, only if they felt comfortable doing so. The presented topics remained fairly neutral in nature, but with a slight increase in intimacy.

4. Activities.

Activity One: Personal Boundary Marking. Members were invited to form two lines, facing each other. First, one line of children was asked to advance on the other

line, shortening the physical distance between themselves and the opposite children. As the one line of children advanced closer, the other children were asked to stop them when they felt the opposite children were too close and upset their sense of comfort. This was repeated by the other line.

Activity Two: Inside/Outside Art ("Artist helps kids bring the inside out with installation art," 1996). Participants were invited to make a pictorial representation of their internal/external feelings related to when they felt their boundaries were violated. The children could draw or select pictures from magazines that reflected their feelings. The leaders clarified that inside feelings were the feelings that the children kept hidden from others, outside feelings were reflective of the feelings the children showed the world. This activity was completed as a group, sharing materials and helping each other, inviting group cohesion.

Often sexually acting out children are able to recognize the feelings which are the most overwhelming for them, such as anger, but they tend to have difficulty describing and expressing underlying feelings, such as sadness (Johnson, 1995).

5. Journal writing: Children were asked to comment or draw in their journals why they thought boundaries may be violated.
6. Check-out: Children were asked to comment on this group and how they experienced it.
7. Snack time, social time and good-byes.
8. Facilitators tidied the room, debriefed, wrote progress notes and composed the group letter.

Additional Resources:

Handbooks with feeling activities:

Neuman, S. B., & Panoff, R. P. (1983). Exploring feelings. Atlanta, Georgia: Humanics.

Dlugokinski, E., & Suh, H. (1989). My workbook: Dealing with feelings. New York: Point Wood Laboratory.

Session III: Feelings About Sexual Abuse and Empathy Building.

At this time, the group membership had formed preliminary relationships. Personal connections were made between group participants. By now, the members were familiar with group structure and the concept of group was becoming clearer. Some children were looking forward to the next group session. Some members, if asked if they like group, responded that "group is fun and I like coming". Leaders found that children began to use check in as a time to share personal feelings about events during their week. This indicated that members were feeling more comfortable and willing to share with each other.

It was anticipated that by the third or fourth group session the group entered the middle stage of development (Glassman & Kates, 1990; Rivas & Toseland, 1998). Facilitators and members began to work together on more difficult themes. It was understood that the group entered into the 'storming' stage. Facilitators watched for conflict and power issues within the group. Resolution of conflicts occurred before the group could continue to progress (Glassman & Kates, 1990).

Session III: Objectives

1. Develop participants' empathy for sexual abuse victims. Participants are invited to increase their empathy skills in a variety of areas such as perspective taking, expression of empathic concern for others and an understanding of the emotions of the victim.
2. Provide members an opportunity to address their own victim issues.
3. Increase participants' feeling recognition and understanding of the effects of sexual abuse.
4. Increase participants' empathy for others and develop empathy into a generalized social skill.

Practitioner Issues: At this stage of group, the leaders anticipated the group members would challenge the facilitators' authority role. The leaders expected they may react to the conflict with feelings of inadequacy (Glassman & Kates, 1990). The facilitators' role was to help participants explore their feelings and respect their right to do so. Self-disclosure and sharing of feelings was believed to help members with this process (Glassman & Kates, 1990). Leaders expected to clarify the group process for the members. Facilitators pointed out the present interactions and facilitated group communication (Rivas & Toseland, 1998). Leaders attempted to avoid interpreting or answering for the children, but let them express themselves.

Client Issues: An expected client behaviour was that one or more group members would hesitate and attempt to avoid the group 'work' of exploring themes. At this stage, some children may make disclosures about personal abuse histories. It is critical to validate the child's experience and ensure his/her safety (Mandell et al., 1989). Children

may be overwhelmed by their feelings, resulting in disruptive behavior in the group meeting.

Session III Agenda: Feelings About Sexual Abuse and Empathy Building

1. Check-in: Children were invited to share experiences or thoughts about their group letters.
2. Housekeeping: At this stage, it was helpful to remind children to respect the privacy and confidences of others.
3. Introduction of Themes: Further Empathy Building and Feelings about Sexual Abuse. Children were asked to relay and list their understanding of what it feels like to be abused. What does it feel like to talk about the abuse? Who can children tell about abuse? The concept that other types of traumatic experiences bring forth familiar feelings of powerlessness, fear, guilt, sadness and anger was introduced. Facilitators presented children with the idea that feelings come in 'clumps' and that one feeling can hide or layer over another (e.g., clowns and their painted on smiles). This introduced a discussion on masks and how people use masks to hide their feelings. The children were encouraged to examine which feelings they felt safe to expose to people. Leaders invited comments on what would happen if hidden feelings were expressed. Lists were made of healthy and unhealthy ways people cope with feelings.
4. Activities.

Activity One: The group made individual feeling masks on paper plates. On one side the group members put a representation of the feelings they regularly show to the

outside world and the other side of the plate showed the feelings they keep hidden inside. Each member was asked to describe a time she/he wanted to or felt a need to hide his/her feelings.

5. Check-out: The participants were asked to share their feelings about group.
6. Journal entry: What were the participants' feelings about sexual touching and how did they mask these feelings?
7. Snack, social time and good-byes.
8. Leaders tidied, debriefed, made notations on the group and composed the group letter.

Additional Resources:

Activity: Body Mapping. Children draw their bodies and 'map' their feelings onto the shapes.

Child Sexual Abuse: The Untold Secret. (1981). National Film Board: Toronto, Ontario.

Dolan, Y. M. (1991). Resolving sexual abuse: Solution-focused therapy and Ericksonian hypnosis for adult survivors. W. W. Norton & Co.: New York.

Foon, D., & Knight, B. (1985). Am I the Only One? Vancouver: Douglas and McIntyre.

Hemy-Napier, J. (1991). Sexual abuse. What happens when you tell: A guide for children. Sexual Abuse Information Series. Vancouver: National Clearinghouse on Family Violence.

James, B. (1989). Treating traumatized children: New insights and creative interventions. Toronto: Lexington Books.

Kid's Rights (1998). United States. (1-800-892-KIDS).

Session IV: Resolving Victimization Issues and Modeling Taking Responsibility

At this point, it was expected that the group had reached the level where conflicts are resolved (Rivas & Toseland, 1998) and were now ready to move to the 'work' stage of group. As the stages progressed, the intensity of themes increased. This increased potential for the children to feel discomfort and to be challenged. The children were given the opportunity to consider often ignored issues. The group roles and dynamics were monitored to ensure all participants were involved in the group process (Glassman & Kates, 1990).

Session IV Objectives

1. Increase understanding about past traumatic events and how to cope with these feelings.
2. Increase awareness about the impact of unhealthy touching on others.
3. Increase recognition of feelings surrounding unhealthy touching.
4. Empower, support and validate the participants' past experiences.
5. Decrease the sense of isolation felt by sexually acting out children.

Practitioner Issues: At this stage of group, the practitioner assumed the role of director, observer and facilitator. The leaders supported the group members in exploring the various roles and facilitated a sharing of these roles. Workers began the process of further involving the members in productive work (Glassman & Kates, 1990). As the topics heightened anxiety for the children, workers, too, might have found it aroused their own discomfort. Leaders anticipated a need to recognize their levels of comfort and bias

regarding sexual matters.

Client Issues: At this time, it was assumed group conflicts were resolved and power differences equalized. Clients began to relay positive feelings about the group experience and started working on issues. This was seen as the productive time, when the group joined together and worked hard to accomplish the purpose of the group (Glassman & Kates, 1990). Concerns to monitor were (a) clients may feel embarrassed to discuss sensitive material, (b) they may also become aroused at the discussion of sexual issues, (c) children need to be encouraged to express themselves openly.

Session IV: Agenda: Resolving Victimization Issues and Modeling Taking Responsibility.

1. Check-in: Leaders invited children to share thoughts on the weekly letter.
2. Housekeeping: It was shared with children that one member has decided to withdraw. The group discussed any concerns the members brought forth. The facilitators advised the children that the group session was canceled during the school holidays.
3. Introduced Themes: Victimization Issues and Modeling Taking Responsibility. Group members were asked if anyone had ever apologized to them for the traumatic events that had occurred in their lives (i.e., sexual abuse, physical abuse, family violence and loss). Discussion centered on whether anyone had ever taken responsibility for the events.
4. Activities. The children were asked to write or make voice recordings of healing letters. This is a process which attempts to ensure the child experiences a sense of

support and validation regardless of the perpetrator's actual response (Dolan, 1991).

Activity One: Each child wrote a letter to the person who had hurt them in their past. Some children chose to write letters to the individual who had sexually offended against them, and some children wrote a letter to the person who was physically abusive in their life. These letters began "Dear Offender..... ." The intent in the exercise was to describe the details of a past abuse event in the child's life. In this process the child expressed his/her feelings about that event, how it had impacted on his/her life and how the perpetrator could make amends to him/her (Dolan, 1991).

Activity Two: Each child then wrote a return letter from the individual who they had written to in the first letter. This letter began, "Dear Person..... ." In this letter the children wrote as if they were the "Dear Offender...." person responding to themselves. The children were asked to write what they believed the perpetrator's response would be to their first letter (Dolan, 1991).

Activity Three: Each group member wrote another letter titled, "Dear Offender.....". In this letter the children were free to write what ever they wanted to the person who had hurt them. In this letter the children wrote the response they wanted and needed from the perpetrator. This letter was written as if the perpetrator was taking responsibility for his/her actions and was prepared to make amends to the child for what she/he had done (Dolan, 1991).

Activity Four: In order to discharge strong emotions, children were invited to draw

representations of the person who had hurt them, tack this picture to the wall and toss play dough balls at the picture. With each tossed ball, the children expressed an emotion they had felt.

5. Journal writing: Children were encouraged to record feelings they had about expressing themselves to the person who had hurt them. Children were asked to think about how it would feel if the person who had hurt them apologized.
6. Check-out: Children were asked to comment on the group experience.
7. Snack, social time and good-byes.
8. Leaders tidied the classroom, make group process notes, debriefed and composed a group letter.

Additional Resources:

Dolan, Y. M. (1991). Resolving sexual abuse: Solution focused therapy and Ericksonian hypnosis for adult survivors. W. W. Norton & Co.: New York.

Johnson, T. C. (1995). Treatment exercises for child abuse victims and children with sexual behavior problems. California: Toni Cavanagh Johnson.

Mayle, P. (1975). What's happening to me? New Jersey: Lyle Stuart.

Session V: Secret Keeping and Feeling Powerless

Group five continued on at the working stage. Children were encouraged to explore difficult themes as the original purpose of group began to be actualized. Group members were expected to work harder and become more involved in discussion, offering information and sharing their stories (Rivas & Toseland, 1998)

Session V Objectives:

1. Open communication between group members and dispel the myths surrounding secrets.
2. Increase the participants' understanding of the feelings such as powerlessness.
3. Involve the group members in an exploration of negative and positive uses of power.
4. Expand the participants' knowledge of positive/ negative coping options.

Practitioner Issues: At this step of group development, leaders continued to educate the group. Leaders pointed out conflicts, interactions and group process to the group members. The facilitators encouraged the members to maintain involvement and make decisions about the group dynamics. Leaders suggested group members try different roles and ways of interacting within the group setting (Garvin, 1997; Rivas & Toseland, 1998). Johnson and Johnson (1997) remind facilitators that the group as a whole becomes more interdependent from the facilitators, at this time. The participants could be observed taking charge of their own learning experience.

Client Issues: During the middle stage of group, participants can challenge the information or learning offered by the leaders. At this phase, the clients sometimes refused to listen to the instructions of the leaders, even ignored the facilitators altogether. The group became more cooperative as leaders observed more 'we' and less 'me.' The children start to direct and motivate each others' learning. These interactions may have a negative outcome, leading the group off topic (Johnson & Johnson, 1997).

Session V: Agenda: Secret Keeping and Feeling Powerless

1. Check-in: Children were again encouraged to share comments on their weekly group

letters.

2. Housekeeping: A reminder was provided that group was half finished. Issues regarding the observed gender related comments made last week were addressed.

3. Introduced Themes: Secret Keeping and Powerlessness. In a discussion format, group members were invited to explore the different types of secrets and when not to keep secrets. The participants were asked to consider the effects secret keeping had on their lives and how secrets contributed to feelings of powerlessness and helplessness.

4. Activities.

Activity One: Members were asked to sit in a circle. Each was given a piece of paper. Each group member was asked to write on his/her paper a secret that they had never told anyone. Then the children were asked to fold their paper into small pieces. The 'secret' was then passed to someone of the writer's choice. At this point, there was discussion about how it feels to let that secret go to someone else and how much do they trust the other with their secret. Then the children again passed the secret on to someone else. There was more discussion about how difficult it was to trust others with your secrets and that once the secret was passed the children no longer had a sense of control.

Activity Two: Story telling. A therapeutic story, The Lion in the Hole (Davis, 1989), acting as a metaphor for the positive/negative uses of power, was read to the children. The group was asked to reflect on the different ways power can be used. Groups members were asked to list positive and negative coping methods that they

used.

5. Check-out: The leaders asked the children to express their feelings about the group meeting.
6. Journal entries: The leaders asked the group members to record what types of situations make them feel helpless/powerless.
7. Snack, social time and good-byes.
8. Facilitators tidied, debriefed, completed file recording and the composed the children's group letter.

Additional Resources:

Davis, N. (1989). The use of therapeutic stories in the treatment of abused children. Journal of Strategic and Systemic Therapies, 8, 18-21.

Session VI: Identifying the Sexual Abuse Cycle, Triggers to Touching, Tricks and Bribes

Group six continued at the working stage of development. The group had become strongly connected and cohesive. Together the participants were working towards the completion of tasks that would actualize the purpose of the group. Together, the group membership was challenged to work on achieving their initial group goals. Members challenged each other to stay on task with the learning objectives.

Session VI Objectives:

1. Increase group members' understanding and awareness of the cycle of sexually acting out behaviors.
2. Facilitate the participants' understanding of the context of sexually inappropriate behaviors.

3. Increase the participants' ability to identify possible triggers to this behaviour.

4. Assist the participants in their ability to recognize when the cycle of sexual touching could be interrupted.

5. Increase the participants' capabilities in identifying and understanding the role that feelings such as guilt, shame and responsibility play in the sexually acting out cycle.

Practitioner Issues: Facilitators anticipated the participants might feel discomfort discussing the sensitive nature of this topic. The leaders prepared to address their own and others' discomfort. Facilitators modeled a forthright and relaxed manner in exploring this topic. Facilitators monitored and observed behaviors, processed dynamics and directed interaction so that the children were helped, not hurt by this examination (Gil & Johnson, 1993; Mandell et al., 1989).

Client Issues: Several client issues present a possibility when discussing the sexual acting out behaviours such as (a) children may feel shame and guilt about their behaviour, (b) the group members may be reluctant to assume responsibility and may withdraw, (c) children could become anxious and uncomfortable with the intense nature of the theme, and (d) children may act out their emotions by engaging in disruptive behaviours. Those children experiencing difficulty talking about this theme could interrupt the group process, distracting the facilitators and the participants from group goals. The group members required encouragement to stay focused.

Session VI Agenda: Identifying the Sexual Abuse Cycle, Triggers to Touching, Tricks and Bribes

1. Check-in: The leaders encouraged the children to share comments on the weekly letter.

2. Housekeeping: A reminder was given that group is now at the half way point.

3. Introduced Themes: Sexual Acting Out Cycle (see Appendix C). Leaders described the cycle of sexual acting out for the children. Children were asked to think about and to create a list of feelings they had before touching. Members were asked to explore what they thought they wanted from the touching and how they felt after the touching.

4. Activities.

Activity One: The leaders demonstrated the steps to inappropriate sexual touching, delineating how thoughts and feeling can push a child around and invite trouble into the child's life via a story telling exercise. The leaders created a story about an 11 year old boy. In the story the character's thoughts and worries were described. The story related the series of events that caused the boy to have sad, mad and bad feelings. As the story progressed, the character is portrayed entering into the sexual touching cycle. At first, the boy has fantasies about positive ways to make himself feel better. The narration identified the boy as becoming angry and having difficulty controlling his feelings. The boy thought of how he could get revenge. The story progressed to a point where the boy planned and enacted a touching incident. The therapists asked the group members to consider questions like "How did the boy stop himself from having feelings about the person when he did the touching? What ways did the boy cope with his feelings? When could he have changed what happened? How could the boy have managed his feelings differently? The character in the story was used to describe the sexual thoughts and

body feelings of a child doing sexual touching. The boy in the story talked about the how the tension progressed and how he planned the touching. The leaders outlined how the boy 'groomed' or prepared his victim. The last part of the story described how the boy avoided being caught. The children were asked if they wanted to share any of their thoughts and feelings about the story.

5. Journal writing: The children were invited to make journal entries centered on the feelings about this group session.
6. Check-out: The children were asked to comment on the group activity.
7. Snack, social time and good-bye. In social time the children chose to play small video games, cards or talk.
8. Facilitators tidied the room, made notes on the session, debriefed the meeting and composed the group letter.

Additional Resources:

Cunningham, C., & MacFarlane, K. (1988). Steps to healthy touching: A treatment workbook for kids 5-12 who have problems with sexually inappropriate behaviour. Florida: Kidsrights.

Johnson, T. C. (1995). Treatment exercises for child abuse victims and children with sexual behavior problems. California: Toni Cavanagh Johnson.

Session VI: Problem Solving and Skills Training

The time allotted for group was coming to an end. This period concentrated on the completion of group goals and purpose. Children were given a chance to practise their learning and translate it to other situations (Cormier & Cormier, 1985; Garvin, 1997;

Rivas & Toseland, 1998). At this point in the group process children were prepared for the upcoming termination of group sessions (Dimock, 1970).

Session VI Objectives:

1. Provide the participants with problem-solving skills and assertiveness training.
2. Provide the participants with a safe environment to practice these skills.
3. Provide the participants with an opportunity to offer retribution for their behaviors.

Practitioner Issues: Absenteeism amongst the participants occurred occasionally in this group. The leaders felt frustrated at the lack of member commitment. The leaders responded to this situation by following up with all missing participants and encouraging attendance. The facilitators recognized the various responses participants had to the termination of group. The leaders facilitated and invited discussion on these feelings. Facilitators continued to direct, observe and cultivate interactions and dynamics. The noted absenteeism and the feelings others had surrounding such behaviour was opened for discussion. Facilitators dealt with ambivalence towards the production phase (Glassman & Kates, 1990).

Client Issues: At this stage of group, it was predicted that members would start missing (Rivas & Toseland, 1998). Absenteeism can be attributed to a member's desire to avoid the working phase of group. Other children had feelings about the missing members. At this stage, absent members are missed by the regulars (Rivas & Toseland, 1998). Sometimes children internalized the missed members as rejection of others in the group (Rivas & Toseland, 1998).

Session VI Agenda: Problem Solving and Skills Training

1. Check-in: An exercise in silent greetings were practiced. Here, the children practiced saying hello without verbal expression. This provided an opportunity to practice recognizing affect.

2. Housekeeping: A reminder was given that the group was over in two weeks. Leaders asked the group members for their input on closing celebration/ceremonies. Everyone was invited to include their choice of an activity, snack or music.

3. Introduced Theme: Problem Solving and Skills Training

4. Activities.

Activity 1: The activity used role-play scenarios which modeled problem-solving strategies such as practicing saying no, telling one's self to stop and think, and other assertiveness skills. Scenarios included: You tell the teacher that another boy wants you to touch his penis, but she thinks it is a lie. What do you do? A peer tries to have sex with you, you try to walk away, but you are stopped What could you do? An adult wants to do some sexual things with you and you are afraid What could you do? You think about telling your parents, but the adult says if you tell, no one will believe you. What can you do?

Activity 2: Children were offered the opportunity to write apology letters to one person that they may have touched. As a group, a generic letter was written first. This gave facilitators the forum to dispel any distortions. Afterwards, each child wrote his/her own letter. The letters were shared if the children chose do so and it was appropriate. The letters were mailed to the victim if appropriate.

5. Journal writing: The leaders suggested the children record different ways of saying no.
6. Check-out: The children commented on the group experience.
7. Snack, socialization time and good-byes
8. Group workers tidied the classroom, recorded progress notes, debriefed and prepared the group letters.

Additional Resources:

Acton, W. (1996). Principles of treating sexually intrusive children. Unpublished manuscript.

Cunningham, C., & MacFarlane, K. (1988). Steps to healthy touching: A treatment workbook for kids 5-12 who have problems with sexually inappropriate behaviour. Florida: Kidsrights.

Johnson, T. C. (1995). Treatment exercises for child abuse victims and children with sexual behavior problems. California: Toni Cavanagh Johnson.

Session VII: Kids Touching Rules and Self-Care

This was the third last session. The leaders began the process of review and summarization of learning that the children had experienced thus far. The group focus began moving back to an individual focus. The children returned to more individualized activities and reviews (Douglas, 1976; Rivas & Toseland, 1998).

Session VII Objectives:

1. Provide group members an opportunity to review the group experience.
2. Safety plan with group members for stopping future behaviour problems. Each child outlines what they need to do to keep trouble out of their lives.

3. Address self-care needs of group members and provide referrals to other services as necessary.

4. Include group members in planning a celebration and a closing ceremony.

Practitioner Issues: One of the practitioners had ambivalent feelings about the closure of group. Facilitators with unresolved loss issues tend to hurry the good-bye process. Leaders focused on preplanning and preparing the good-bye ceremonies. The children were asked to consider their future events. The facilitators addressed the feelings the children had about the group ending. There was even a sense that there was a need to keep the group process going. The facilitators evaluated the progress of the members and decided on whether they need more service. The facilitators ensured closure on all situations for all members prior to ending. Leaders encouraged the participants' in the exploration of feelings about termination in relation to past rejection and loss. The readiness to end was reinforced.

Client Issues: Participants had a variety of feelings about termination. Termination can create different reactions in the group participants. Some children regressed in behaviour and denied the end of group was upon them. Some children responded with flight tactics, a return to avoidance, or looked forward to the end in a positive manner (Corey & Corey, 1997; Rivas & Toseland, 1998). At this time, the children needed to review their successes and plan for the future. Some group members planned to meet outside the group, wanting to continue the relationships they have made with others. The wide variety of feelings the children needed closure before the group ends.

Session VII Agenda: Kids Touching Rules and Self-Care

1. Check-in: Leaders opened a discussion on the participants' feelings regarding the upcoming end of group sessions.
2. Housekeeping: Together, the leaders and participants planned the good-bye event. The group designated the contributors of food, the place, the time, the guest list, and the type of ceremony involved.
3. Introduced Theme: Kids' Touching Rules and Self-Care.
4. Activities.

Activity One: Together the group brain stormed, creating a list of rules (see Appendix D) that children need to stop inappropriate touching. The children were then asked to make wallet-sized, individual plans for themselves. Each plan listed the kids' touching rules that were the most important to their situation. The children were recommended to use this card to review the rules as they need.

Activity Two: The children were asked to review their own resources and personal social networks that acted as a helpers when trouble comes into their life. The children 'mapped' their network of support people and places onto a sheet of paper. This sheet of paper was in an accessible place should the child need to review it.

5. Journal writing: The children were invited to record concerns or thoughts about the kids' touching rules.
6. Check-out: The children were asked to comment on their group experience.
7. Snack, socialization time and good-byes.
8. The leaders tidied the group room, recorded notes, debriefed the session and composed

the group letter.

Additional Resources:

Toseland, R. W., & Rivas, R. F. (1998). Group work practice. London: Allyn & Bacon.

Cunningham, C., & MacFarlane, K. (1988). Steps to healthy touching: A treatment workbook for kids 5-12 who have problems with sexually inappropriate behaviour. Florida: Kidsrights.

Johnson, T. C. (1995). Treatment exercises for child abuse victims and children with sexual behavior problems. California: Toni Cavanagh Johnson.

Session VIII: Healthy Sexuality

In this session, the clients were offered an opportunity to explore what was typical and healthy sexual behaviour for children their age. The main discussion centered on exploring healthy sexuality for children aged 11 and 12 years.

Session VIII Objectives:

1. Promote a greater understanding of healthy and expected sexual behaviour for children 11 to 13 years of age.
2. Dispel any sexual myths and distortions held by the participants.
3. Improve the ability of the participants to recognize sexual feelings and increase their understanding of what to do with these feelings.

Practitioner Issues: This material was viewed as awkward and embarrassing by the children. The leaders' role was to involve the children in exploring the presented material, bringing forth questions and dispelling discomfort. The leaders recognized their own

biases and levels of comfort regarding sexuality. The leaders anticipated that the parents/caregivers could disagree with the information on sexuality that was offered to the group members. Some parents felt the material was to detailed or explicit for their child (Mandell et al., 1989).

Client Issues: Some children felt shy and awkward. The discussion of sexual matters can cause feelings of embarrassment. The children needed encouragement to ask questions and challenge their learning regarding expected sexual behaviours for preadolescents (Mandell et al., 1989). Group members may also become sexually stimulated by the material presented (Gil & Johnson, 1993).

Session VIII Agenda: Healthy Sexuality

1. Check-in: Leaders invited participants to remark on their letters.
2. Housekeeping: Workers advised children about the loss of another group member. Workers discussed ways the children could ask questions or receive more information if they feel too shy to ask in the group setting. Reminders were given as to how many group sessions were left.
3. Introduced theme: Healthy Sexuality. General discussion on what is healthy sexual activity for preadolescent children.
4. Activity.

Activity One. Video. A viewing of the video from the "Growing Up Series".

Activity Two. Leaders invited the participants to debrief and discuss the video. The leaders generated conversations about what information from the video was new information to the group about sexuality. The leaders discussed common

misconceptions about sexuality. Some children brought forth questions on homosexuality, how to use condoms and at what age to have sex. These children were interested in discussing the in/appropriate age group (i.e., 12 and 17 year olds dating) to form relationships.

5. Journal entry: Group members were invited to use their journals to address unanswered questions about sexuality.
6. Check-out: Children were asked to comment on their reaction to the group material.
7. Snack, social time and good-byes.
8. Leaders cleaned up the classroom, debriefed the session, recorded notes and composed the group letter.

Additional Resources.

Mayle, P. (1975). What's happening to me? New Jersey: Lyle Stuart.

Mayle, P. (1975). Where did I come from? New Jersey: Lye Stuart.

Session IX: Good-bye Ceremony

This last session was left to celebrate the accomplishments of the children in a formalized manner. The group gathered together for the last time. At this good-bye event the check-in and check-out process continued. The first portion of this session focused on leaders reviewing and recapitulating the group objectives and goals. The group events and learning were reviewed. Emphasis was on reviewing group purpose, group accomplishments, future plans and healthy closure (Rivas & Toseland, 1998). Each child was given a chance to write a good-bye letter which outlined what she/he had learned in the group process. This presented an opportunity to reflect on the group process.

Children completed an informal self-report and the standardized questionnaire. The remainder of the group's time involved the presentation of certificates, self-care packages, a return of the participants' journals and completed work. The group members could choose to take a picture if all members were comfortable with this. The last event was for all members to share in the celebration. Whenever possible parents and caregivers were invited into the last session to show their support to the child and to witness his/her accomplishments.

Session IX Objectives:

1. Focus on group members returning once more to an individual status.
2. Recognize accomplishments and progress of the participants.
3. Identify future risks and established safety and self-care plans for the participants.
4. Process termination feelings of the leaders and the participants.
5. Assess the need to make future referrals for the participants.

Practitioner Issues: Some facilitators may have unresolved issues of loss. As a result the leaders may have difficulty addressing closure issues(Rivas & Toseland, 1998). It was important to recognize unresolved issues and not to rush through the good-bye process or only focus on the celebration aspect. Sometimes facilitators felt they needed to keep the group going past the allotted time. Facilitators fell prey to the participants reluctance to end group.

Client Issues: It was important leaders were aware of the reactions to group closure that group participants typically engage in. Flight/avoidance, anger, denial, regressive behavior or a healthy anticipation may all be responses of the participants

(Rivas & Toseland, 1998). An awareness of these varied reactions to a termination process assisted group leaders to facilitate discussions or role-plays that address client concerns about the group ending.

Session IX Agenda: Good-bye Ceremony

1. Check-in: Children were asked to focus their check-in time on their feelings about group termination.
2. Housekeeping: The leaders reviewed the group's accomplishments and considered individual future plans.
3. Activities.

Activity One: Members were asked to complete client satisfaction forms. The children were then asked to fill out the Trauma Symptom Checklist for Children.

Activity Two: Each member composed their own safety shield. On this shield they drew or wrote their supports, their triggers, their controls and their safety rules.

4. Celebration events: Parents and caregivers were invited to join in with the children's group, at this point. All group members, caregivers and facilitators took part in the socialization and pizza time.

   Everyone was given a certificate of achievement, a list of important helper numbers (i.e., Klinic and Teen Touch), and a return of his/her journal.
5. Check-out and good-bye. In this final check-out, leaders encouraged each member to state what personal goals he/she had achieved during the group process.
6. Workers tidied the classroom, debriefed the final session, made notes and composed the individual group letters. The leaders planned a later meeting to write closing

summaries and to organize the closing interviews for the children.

Additional Resources:

Castaldo, P., Damon, L., Larsen, N., Monise, L., Mandell, J., & Tauber, E. (1989). Group treatment for sexually abused children. New York: Guilford Press.

Wickham, E. (1993). Group treatment in Social Work: An integration of theory and practice. New York: Allyn & Bacon.

CHAPTER SIX

Analysis of Group Intervention

Referral Information and Preliminary Interviews

Every referral resource completed a brief, ten point referral form on the client he/she wished to send to group. The referral forms were intended to assist in the group membership selection phase (Rivas &Toseland, 1998). Experience has taught this writer that long forms, requesting extensive social histories on clients from the referral source were often ignored. Social service workers bypassed a request for referral that increased the workload for them. Therefore, the intent of the referral form was to obtain basic demographic information and a brief summary of why the referral source considered the child applicable for this particular group. The referral forms helped the leaders advance to the next step of selection. Several referrals were rejected at this step based on age.

In hindsight, these forms could have been enhanced by requesting more contextual information about the specifics events or recent incidences of sexually acting out behaviours that preceded the referral. This information was requested, but provided in sketchy and with sometimes, confusing details. A review of these forms suggested that a personal interview with the referral source would be appropriate and allow the group leaders to request further details. This approach seems inhibitive though when the group leaders and social workers are restrained by time lines, but at the very least a telephone call for this purpose should be arranged.

The preliminary interviews were established to eliminate candidates who did not meet the remainder of the original criteria. These interviews assessed the capacity of the

children to talk about their sexually acting out behaviours, their social skills and their comfort with entering a group setting. At this time, parent support and involvement were determined. In retrospect, the initial questions asked in the interviews offered the leaders information about the children's interest in attending this group, the parent commitment and support and a cursory impression of the child's social skills and developmental level. Information that seemed to be lacking from the interview was the history of the problems in the child's life and the history of sexual abuse experiences/behaviours by extended family. In addition, a clear portrayal of the parent's comfort level, understanding of and reaction to sexual abuse and sexually acting out behaviours was absent. A private interview with the parents/caregiver would have given the group leaders an opportunity to explore several of these issues. Instead, the leaders concentrated the interview on gaining an extensive assessment of the children's needs and skills. Again, time constraints did not allow a chance to complete another or more thorough interview with the caregivers/parents.

The leaders could have devoted more time to completing a more thorough assessment. This would have provided a better orientation to the child and the parent. More detailed information about the client's history and the parents' level of comfort in coping with sexually acting out behaviours would provide a clearer understanding of the gaps in knowledge, the direction the group needs might take and the capacity of the intervention to be effective. Focusing greater time on collecting detailed client social histories would help the entire planning and preparation procedures for group. For example, the discovery of parental unresolved personal sexual abuse issues that are

unknown well into the group process could influence the parents' capacity to help and support their children in this process. An awareness of this information would help the clinicians do more preparation with the parent/caregiver.

Group Development and Group Dynamics

As anticipated, this group appeared to move through the sequential stages of development. At the first group meeting, two of the seven children did not attend. These absences were later explained: one parent did not have adequate child care and a second parent had a flat tire on her car. At the second session all the children attended. But, by the sixth session, two members had withdrawn completely from the group.

The first session showed how the group members moved through the steps of getting to know each other, acknowledging the purpose of the group and learning to trust each other and the facilitators. The participants began the first session with a variety of feelings and behaviours, indicating their increased levels of anxiety. Everyone sat removed or separated from others. Some kept their jackets on and some children hugged pillows. Most conversation came from the facilitators. Those children that spoke, did so very quietly.

After the initial introductions children were observed to be more relaxed. Members were seen talking together and sharing general information about themselves. Once the 'getting to know each other' activities were finished, children were observed to call each other by name and express shared commonalities. By the end of group, some members were tossing pillows at each other, ignoring the leaders and demonstrating a 'flexing of muscles' (i.e., some children cracked their knuckles). One child, Charly, was

notably more aggressive and challenging in his behaviour. He ignored instructor directives, attempting to control the environment and do what he wanted. Leaders had to establish normative and expected group behaviours such as no throwing items at each other and no hitting others. The goal of getting to know each other appeared to have been achieved. The children seemed to have relaxed a considerable degree in the one and half hour session. The group participants accomplished all the items on the agenda for the first session, including activities that integrated the session themes. The exception was that there was not enough time to introduce relaxation exercises or to focus the social time on playing games.

In this first session, group leaders noticed that the participants had a wide range of levels and abilities, socially, academically and developmentally. For example, the leaders observed that one child said he could not read or write. Another child showed a limited ability to read and write. Other children were able to express themselves more eloquently. The instructors noticed that some children had short attention spans.

By the second group, the participants missing from the first group were present. The children had to reintroduce themselves to the new members. Some children volunteered to share what they recalled from the material covered in the first group meeting. As in the first meeting, workers established the purpose of the group for the participants. This helped to center the group and keep the members focused (Mandell et al., 1989). The group development remained in the orientation stage, likely due to the introduction of new members (Rivas & Toseland, 1998). The group participants continued to form relationships and build trust with each other.

In this session, group members who had been there for the first session tried to make connections with each other. One child, Charly, arrived early, brought his stereo and played tapes for the other children. Some participants brought pictures of their girl/boyfriends and others brought photos of family members. Leaders continued to do most of the talking, assuming the role of educator, ensuring that no one was left out of the group process. Group leaders facilitated interaction and discussion. The topic of sexual abuse appeared to heighten the anxiety levels for the participants. Children were observed to become disruptive in their behaviour, interrupting and distracting from the topic. The facilitators made many reminders asking the children to stay on topic. It was noted that the group participants were gaining in trust and some children took personal risks, sharing information about their feelings. One child, Kate, commented that she felt very "sexy" when she thought about "bras and kotex pads". Another child, Ann, was heard to comment that this was "weird" behaviour. Immediately it was clear by the questions asked (i.e., "How do gays have sex?") that children were lacking information about sex and sexuality. Ken shared with one of the leaders that he had sexually touched another child, but it was an "accident". He said he never intended to do it and would never do such a thing again. From these comments it was obvious that the children were feeling comfortable and seemed prepared to talk about very private thoughts and feelings. At the same time, their anxiety was heightened at taking such risks.

The majority of the agenda was accomplished, but there was not enough time to complete relaxation exercises or engage in a structured social time. The leaders requested that the parents and children extend the group time for an extra fifteen minutes. The

leaders acknowledged the need to lessen the number of activities in each session. The relaxation exercises were sacrificed, as workers concentrated on completing activities that helped integrate the weekly themes. The leaders recognized the need for the children to be actively involved in learning. The children were observed to respond better to a hands-on learning experience than a discussion or lecture format.

Not all members attended in the third session (Keith was absent). Keith's mother had contacted the group facilitator, Alison Lund, to say she felt the parent group was not helpful for her. She said that she wished to discontinue as it was creating emotional stress for her. She added that this group revived unresolved sexual abuse issues for her and she was struggling to deal with the emotional fallout. The mother said that she just wanted her child to "deal with his issues and move on". She was prepared to have her child continue in group if he wanted to attend and said he would return next week. Her child never did return to the group setting.

It was noticed that all the children participated in the group and had important thoughts to share with the others. At this phase of group development, relationships were formed and trust was established. As the topic turned to a discussion of sexual abuse, it placed more demand on the children and created anxiety and discomfort. It was obvious that the group bond was strong and supportive as some children ventured to talk about their own sexual abuse experiences. Almost all the children shared that they had experienced physical or sexual abuse or other forms of violence in the past. The group members said that they had experienced physical abuse, sexual abuse, verbal abuse, witnessed family violence, and one child, Ann, said that she had been part of a hostage

taking situation. The overt commonalities and the similarities of experiences between the children increased. As one child, Charly, talked about wanting to hurt himself, another, Kate, shared having similar feelings and experience.

The group had developed a trusting cohesive bond among themselves. They identified strong commonalities amongst themselves and were sharing more intimate details of their lives with each other. These disclosures were met with warm support and encouragement from the others. Heard around the room was the refrain, "That's like what happened to me". The leaders observed gender subgroups as the girls and boys sat apart from each other during socialization time. They talked between the own groups, but remained in small gender divided subgroups.

By the fourth group, one participant, Keith, withdrew. As the group was still in the early stages of development this loss appeared to have little effect on the remaining group members and no regressed behaviours were noted (Rivas & Toseland, 1998). Mostly out of curiosity, the others asked why that participant withdrew. The group began to transition to the middle stage of development. As suggested by Toseland and Rivas (1998) this period was characterized by power and control issues. By this time, the group had established some norms and was ready to work on activities that achieved the purpose of the group (Garvin, 1997). Observed temporary norms in the group appeared (e.g., "bad" behaviour equated into "cool" behaviour). Ann talked about her involvement in street life. She told the other children that she "smoked drugs and cigarettes" and that she saw her girlfriend "eat out" another girl. Kate announced that she "used to be a lesbian" and that she had sex regularly and may even be pregnant. Participants began to learn how

to problem solve and deal with differences in opinions (Garvin, 1997). Differences or conflicts arose over leadership, goals and activities. Conflict was necessary to strengthen group cohesion and to establish group leadership. Conflict resolution reflected the ability of the group to resolve differences (Garvin, 1997).

As anticipated, group process began to evolve and leaders were challenged. Kate called the group leader, Alison, a 'bitch' when confronted about taking condoms. This comment was dealt with by Alison in a direct manner as she reminded Kate that disrespectful behaviour was not an acceptable way of showing feelings in this group. Ann aligned herself with first one leader then the other, commenting, "You are nicer than her". This seemed an attempt to create conflict between the group leaders. Rick was heard to remark "the kids are becoming more bold".

The group members resisted the seating arrangements, arguing that they preferred to sit in the more comfortable couch area. Some members became more defiant and challenged directions given by to the leaders. Some children simply talked over the facilitators. The leaders found themselves restating guidelines for group behaviour. There were many comments of "boring" and some children refused to participate in activities. Kate and Ann physically removed themselves from the group table and needed to be encouraged to rejoin the group. Some children initiated behaviour and others followed their lead. Rick stated he did not receive his group letter and all other children said that they too had not received their letter. These examples encapsulate the presenting norms, the conflicts and the challenging of authority. The leaders used this opportunity to model conflict resolution, point out dynamics, reflect on positive norms and illustrate problem

solving approaches. It was apparent by this session the group had moved to the conflict stage. This was an excellent example of struggles for power and control and helped to lay the groundwork for resolving future conflict issues and opening the door for communication.

Session five continued with similar behaviours as those observed in the previous group. Rick was absent in this session; later the leaders were advised that the absenteeism was because Rick was required to attend a school meeting for the use of sexually inappropriate language with another female student. The view of the "group" as a whole became more pronounced as some children became more blatant in their attempts to control the agenda, ignoring the facilitators, despite the activities and repeated invitations to rejoin group. More comments of this is "boring stuff" were heard. As well, Kate and Ann refused to participate, challenging the leaders on the contents of the group letter, saying that it inaccurately reflected the group experience. The leaders noticed that the children were more expressive of their feelings. The facilitators worked hard to keep the group focused.

Once the activities began, the children did return to the group and focused on completing the tasks. When they completed the task of letter writing they became involved in the play dough bomb activity. In this activity the children drew pictures of the persons who had hurt them in their past. They then posted the picture on a board and threw play dough balls at the picture. In this activity the children showed enthusiasm, but, as well, an underlying sense of rage against the perpetrator. This seemed to be a turning point for many of the children. They had never openly expressed such feelings before and

many of the children talked about wanting to hurt the person who had hurt them. Somehow the activity seemed to free the children to talk about other experiences they had. Kate announced how she was recently accused of touching another girl's privates at the group home where she lives. This accusation had resulted in a household meeting that talked about the inappropriate touching. Charly says that he would never tell anyone about the "stuff" he had done because he was afraid people would turn away from him. Ken remarked that his sexual touching had created a situation where he no longer had any friends at school and that everyone at school knew what he had done. He described being ostracized because of sexually acting out behaviours. Ken announced that he solved this by making friends with the younger children in the playground at school and that these children "look up to me and think I am cool". Facilitators used this as an opportunity to discuss the misuse of power and with what ages the children of the group should be forming friendships.

Although stormy, most group members continued to openly share their experiences. It was observed that some of the group participants tried to use the group forum to understand their experiences. In addition, it was noted that the children were cohesive and supportive of each other. They begin to take charge of their own learning, asking questions to gain understanding.

As the sessions progressed, so did the intensity for the children. Each added group session demanded the children address and examine difficult feelings and experiences. By the sixth meeting, conflict had been resolved and Rick emerged as a group leader. This role was sometimes tried out by Ann. Kate continued to follow the person receiving the

most attention by other group members. Of the other two members, Charly, became withdrawn and resistant to the demands of the group.

In the seventh session, the other group members challenged Charly's lack of participation and his constant denial of having sexually acted out with other children. Rick admitted to the other children that he has a problem with sexual touching. The other group members offered their support, encouragement and recognition that he had the courage to make this statement. The group cohesion strengthened as others made similar personal disclosures. Everyone participated, offered their comments and shared information. Ann remarked that the story created and read by the facilitators about a child who sexually touches other children revived "old memories and bad feelings" for her. Ann disclosed that she too, "used to do sexual touching, when I was babysitting". Kate disclosed that she continues to do sexual touching and that she had recently "put my mouth on another girl's breast at my group home". Several group members commented that they recognized their own triggers to sexual touching. Rick offered to draw the cycle of sexual touching, showing his leadership skills and his knowledge to the others. His peers reacted positively to his involvement.

The children offered insightful comments to their behaviours. Kate said she thought she "wants to touch other children because I was touched". Rick offered the explanation that he was like a "walking time bomb" waiting to explode. The children said they were angry about what has happened to them. Throughout this group session Charly remained withdrawn and refused to participate in the activities. The group members again challenged his resistant behaviour, commenting that he was just trying to appear "cool"

and that everyone knows he was there for the same reason, sexual touching. Ken remarked that pretending that you never did the sexual touching just means that it will not go away. Other children agreed that sexual touching was something they needed help to stop doing. Although Charly continued to verbally withdraw from the group, he eventually partook in the activity when invited by a leader.

Not all tasks were accomplished during this group, but it was observed that all members helped create the list of "Kids' Touching Rules". The participants debated which rules should be included. Some children recognized the need to keep themselves and other children safe. The group was working together, accomplishing tasks and fulfilling the purpose of the group.

As group eight began, leaders recognized that the final stages of group development and dynamics had started. By this time there are only five group members left. Children were commenting that this was the second last session and discussion centered on planning and preparing for termination of group and the final celebration session. There was some disagreement as to whether the parents should be invited to the last session. The children worked out a compromise with each other and voted to have the parents attend half the session. The children showed their cohesion and practiced their problem solving skills. Some children made comments about not wanting the group to end. Ann said she wished that group was "from 10:30 a.m. until 6:00 p.m., all day every day". Other children, like Charly, commented that he really did not care about group and was glad it was almost over.

This session went quickly with children cooperating and asking questions. The

members said that watching a video about sexuality in a mixed gender group did not make them feel uncomfortable. In fact, most of the children asked questions about sex and sexuality. Ken confirmed that he was curious about condoms and asked to see one. Everyone showed an interest in the topic. Several children indicated that this is an area that is talked about at school and were now asking the questions that they had not been comfortable asking in the past.

In the last session, as group entered the final stage, group dynamics surrounding termination were apparent in some children. As suggested by Corey and Corey (1997), a variety of behaviors and feelings can be observed in the clients as they end the group. Some group members regressed in behaviours, some seemed angry, some suddenly seemed helpless, others were ambivalent, or denied that group was ending, and still others acted happy and announced they were looking forward to the end (Corey & Corey, 1997). As recommended by group theorists (Corey & Corey, 1997; Johnson & Johnson, 1997; Rivas & Toseland, 1998) the last group meeting concentrated on dissolving the group format and returning to the individual focus. The last session included a recapitulation and review of the group purpose, an assessment of the group process, an evaluation of the group, and a celebration of achievement. The children created their own shields (like the ones carried by knights in olden days for protection and safety) that integrated the group learning. This task outlined triggers, healthy coping, support networks and their individual Kids' Touching Rules.

During this process, Charly continued to engage in avoidant behaviours. He announced that he could not stay for the entire event as he had to play baseball. Rick

announced that he was "finished with therapy" and that he "did not even want to attend the closing interview". Kate appeared ambivalent, happily exchanging telephone numbers with the others and saying good-bye. Ken commented that he would "never ever do this again". The session ended with a pizza party with the parents. Children were given certificates of achievement. Some children did not have a parent/caregiver in attendance to recognize this achievement and offer them support, and this was mentioned by those children without a support person as an issue. Those children said they felt bad, left out and unloved. At this last session, children were offered their journals, cards with emergency support numbers and an invitation to attend a closing meeting. As requested by the children, each child received, at a later date, a closing letter, that was individual and reflective of their specific needs, progress and concerns.

Johnson and Johnson (1997) point out six factors that are useful in assessing the effectiveness of a group. A group is deemed effective if these variables are observed (1) clear group goals were identified; (2) group members communicated feelings and ideas accurately and clearly; (3) members participated and provided leadership among themselves; (4) members influenced each other; (5) members showed flexibility in decision-making procedures; and (6) members disagreed, challenged each other and showed controversy (Johnson & Johnson, 1997). In review, this group had a clear common goal which was to understand and stop sexually acting out behaviours. Members communicated their feelings clearly and effectively, influenced each other and were involved in conflict. For the most part, all members participated and showed leadership (Rick and Ann). The members used problem-solving techniques and were flexible on

decision making processes such as voting. Having met the above six factors, it would appear that this was an effective group.

As well, the group moved through apparent stages of development, reflecting a beginning, middle and end process. The different phases of group development portrayed a variety of group dynamics such as power and control, leadership, problem-solving, and the establishment of group culture. Observed in this group were themes of mutual support, mutual aid and empowerment among the leaders and participants. The children formed a unit together, and offered each other support, hope, and ways of healing. Together, this group joined as individuals and formed a group that worked together to accomplish the group purpose (Rivas & Toseland, 1998). Members appeared to successfully address the original purpose of the group at a beginning level.

In the first group sessions it was clear that all members needed an opportunity to process and find resolution for their own victimization issues before they could move on to addressing the original group purpose. More of the group time than was planned was consumed by the need to address victim issues. The victimization issues included all types of traumatic experiences such as family violence, hostage taking, physical abuse, and sexual abuse. Once the children had a chance to express their feelings about their own victim issues and responsibility taking was modeled for them, they were able to move on to the original purpose of the group. Although ambivalence, mistrust and avoidance were characteristic of the first stage, the group provided a safe avenue to explore past and current histories. This was apparent from the many disclosures heard. All members admitted that they had done sexually inappropriate touching and some were able to

describe specifics. Although initially many participants were reluctant to state that this area was problematic for them, they eventually were able to do so in the group process. The group helped the children discuss the stigmatization of sexually touching, recognize that they were not 'permanently damaged' by what they had done and provide each other with hope for a future in which they could control such behaviours.

Pre and Post Test Analysis

As previously stated the group membership completed a data collection process. The children completed a self-report questionnaire, the Trauma Symptom Checklist for Children (TSCC) by Briere (1997) at the preselection interview and again, at the last group session. Parents added a parent-report questionnaire, the Child Sexual Behavior Inventory (CSBI) by Friedrich (1997). This was also filled out at the first interview and the last group session. In addition, at the last session, all participants completed a client satisfaction questionnaire.

As previously mentioned, these scales were relatively inexpensive. The cost of the TSCC and the CSBI, manuals and score sheets, were approximately $100.00 Canadian. The brevity of the scales made them easily completed in less than 20 minutes. Those children that struggled with reading had some difficulty understanding the instructions and the wording used in some questions. This potentially contaminated the data as the children may have responded to questions without understanding the full meaning of the question. The instructions for scoring the tests seemed somewhat sketchy, but scoring the questionnaires was easily accomplished once the instructions were understood.

There appears to be no other standardized tests that measure sexually

inappropriate behaviours in children and these two tests appear to be the best option. Pearce and Pezzot-Pearce (1997) note that these scales are the most widely recommended for use in the assessment of this issue. These scales were developed specifically for assessing sexual behaviours in children. As well, the tabulated test results seem to correlate with the clinical observations and the described client profiles. Overall, the TSCC and the CSBI are recommended as useful tools in the assessment and evaluation of child sexual acting out behaviours.

Trauma Symptom Checklist for Children

To interpret the TSCC scores an overview of the scores' significance is presented. Any item, except sexual concerns and its subscales, that has a T-score of 65 or greater is considered clinically significant. Scores in the 60-65 range suggest that the client has difficulty in that area. In the sexual concern items, T-scores 70 and over are considered clinically significant. All scores below 60 are considered within a typical, normative range (Briere, 1997).

The TSCC controls for the possibility that children may hyper respond to the questionnaire. Hyper response is when the child checks the highest frequency occurrence on many or all symptoms. A T-score of 90 or greater on the hyper response item makes the scale invalid. Scores between T= 75-89 are to be considered potential hyper responders. At the same time, the scale controls for under response which is when the children mark a high number of 0's. All T-scores of 70 or higher on this subscale are to be considered under responding, invalidating the scales. Scores ranging between 65-70 are to be viewed as a client that is possibly under responding to the questionnaire.

Elevated scores on the anxiety (ANX) scale may suggest that the child has an anxiety disorder or is experiencing a hyper arousal which is connected to symptoms of posttraumatic stress (Briere, 1997). Raised scores may refer to fears about danger, past victimization and witnessing violence or the elevated score may reflect fear of events that have not occurred. High scores on the depression (DEP) scale may indicate that the child is in a depressed episode. It is important to assess suicidal ideation and self-injurious behaviours when this score is elevated. Anger (ANG) scores that are above average are indicative of children who are seen by others as verbally aggressive, physically aggressive or hostile towards others. Such a child may be acting out in an aggressive manner at home or school. The Post Traumatic Stress (PTS) scores show posttrauma symptoms such as nightmares, fears, reliving past events, and avoidance of negative thoughts and memories. Children with elevated posttraumatic stress scores often have had more than one traumatic event in their past. For example, a child with a high posttraumatic stress score may have been physically, and/or sexually abused on more than one occasion.

Dissociation (DIS) measures how much the child uses dissociation coping strategies to deal with his/her experiences. Such techniques as daydreaming, pretending to be someone else or somewhere else and the mind going blank are often engaged in. High scores on this item suggest that the child is emotionally detached and unresponsive to his/her environment. A child with a high score on this item would likely use several dissociating coping strategies. The child may be seen as over involved in fantasy. Sexual concerns (SC) and its subscales measures sexual distress and preoccupation. High sexual concern scores suggest that the child may have had sexual experiences that were

traumatizing. The child may have also been exposed to adult sexual behaviours that prematurely sexualized the child. For example, the child may have watched pornography or adults engaged in sexual activity. This high score could reflect a past sexual abuse incident or exposure to sexual activity at a young age. Elevated sexual concern scores reflect a sexual preoccupation that is unusual for children of a given age. Such a child may be interested in watching adult sexual behaviour on television or show an interest in the opposite sex. High scores on the item known as sexual concerns-dissociation suggests the child may be experiencing some feelings of sexual distress or sexual conflict. For example, a child with elevated sexual concerns-dissociation scores may have sexual fears or unwanted sexual feelings and behaviours that they do not know what to do with. Fear of sexual exploitation or negative responses to sexual stimuli may be overwhelming for the child with high sexual concern scores (Briere, 1997).

In addition the scale highlights which areas are of critical concern. If a child indicates high frequency on specified items such as suicide ideation or fear, the clinician can incorporate that information into his/her assessment. High subscale frequency scores would suggest further investigation is required on those items to determine the meaning of the scores (Briere, 1997).

As shown in Table 1, the pre-test T-scores of the five members that completed group are varied. To begin with Kate would be considered a hyper responder and her responses would be considered invalid. Ann's T-scores are quite high and she would be deemed a potential hyper responder. Rick's T-score reflects that he may be a possible under responder. The other children, Charly and Ken, have T-scores which suggest they

Table 1.

Results of the pre-test scores on the Trauma Symptom Checklist self-report questionnaire.

	Und	Hyp	Anx	Ang	Dep	Pts	Dis	Dis-O	Dis-F	SC	SC-P	SC-D
Ann	52	83	71*	69*	74*	60	67*	68*	62	62	43	69*
Kate	42	139	71*	84*	68*	74*	83*	87*	67*	190*	204*	139*
Cha	41	47	44	43	40	45	39	43	45	48	50	49
Rick	54	67	41	66*	51	60	62	58	65*	69*	63	88*
Ken	56	47	42	43	46	45	43	42	48	48	47	49

Notes:

Abbreviations for Items

Und-Under response
Hyp-Hyper response
Anx-Anxiety
Ang-Anger
Dep-Depression
Pts-Posttraumatic Stress
Dis-Dissociation
Dis-O-Dissociation Overt
Dis-F-Dissociation Fantasy
SC-Sexual Concerns
SC-P-Sexual Concerns Preoccupation
SC-D-Sexual Concerns Distress

Interpretation of T-Scores

Clinically Significant- T-Score 65 or greater (significant scores are marked thus *)
Difficulties-T-Score 60-65
Nonsignificant-T-Scores 70 or greater
Under response-T-Scores 90 or greater

are not over responding or under responding to this questionnaire. Ann's T-scores are clinically significance in every area except for posttraumatic stress, dissociation fantasy, sexual concerns, and sexual concerns-preoccupation, although scores on these subscales suggest areas of difficulty.

Kate's T-scores are elevated on every item, indicating clinical significance. In the areas of sexual concerns and the subscales, sexual concerns-preoccupation and sexual concerns-distress, Kate's T-scores are extremely high. Charly, on the other hand, has no T-scores which are of clinical significance or that suggest he is having difficulty. Rick's results reports T-scores that are clinically significant in the areas of anger, dissociation-fantasy, sexual concerns and sexual distress. He records T-scores that indicate difficulty on sexual concern-preoccupation, dissociation and posttraumatic stress. Ken's T-scores indicate no difficulty on any item scored.

In interpretation of these scores, at pre-test, three group members (Kate, Ann and Rick) reported elevated scores of significance on the items recording sexual concern and sexual distress. Kate's scores are extemely elevated and suggest that she over responds, prefers to be viewed in a "problematic light" or was self-reporting a heightened arousal. Kate, Ann and Rick also reported areas of difficulties on the majority of the other items, whereas, Ken and Charly reported no areas of difficulty or concern.

The post-test T-scores (see Table 2) for the majority of group members show a decrease for most subscales. Some scores remain consistent while others reflect a slight increase in levels. Kate continues to show an invalid test, with hyper responding still elevated. Ann no longer appears to be over responding to the scale. Rick's and Ken's sc

Table 2.

Results of the post-test scores on the Trauma Symptom Checklist self-report questionnaire.

	Und	Hyp	Anx	Ang	Dep	Pts	Dis	Dis-O	Dis-F	SC	SC-P	SC-D
Ann	42	65	57	63	54	57	62	72	62	72*	66*	69*
Kate	52	120	81*	79*	65*	69*	75*	76*	67*	144*	196*	69*
Cha	61	47	39	40	70*	47	54	87*	43	53	54	44
Rick	67	46	39	43	48	36	38	37	41	45	48	45
Ken	66	47	44	37	43	34	37	37	43	48	43	54

Notes:
Abbreviations for Items
Und-Under response
Hyp-Hyper response
Anx-Anxiety
Ang-Anger
Dep-Depression
Pts-Posttraumatic Stress
Dis-Dissociation
Dis-O-Dissociation Overt
Dis-F-Dissociation Fantasy
SC-Sexual Concerns
SC-P-Sexual Concerns Preoccupation
SC-D-Sexual Concerns Distress

Interpretation of T-Scores
Clinically Significant- T-Score 65 or greater (significant scores are marked thus *)
Difficulties-T-Score 60-65
Nonsignificant-T-Scores 70 or greater
Under response-T-Scores 90 or greater

scores suggest they are potentially under responding. Rick reported a marked decrease in T-scores on all items; none of his scores reflect clinical significance or difficulties in any area. Charly's scores, on the other hand, show an increase, reaching a level of clinical significance on several subscales. In particular, his scores are elevated on the dissociation-overt and depression subscales. In his first tests results, Charly had not reported difficulties in these areas.

What is notable in the post-test scores reported by the group are the elevated scores for Charly on several subscales, the possibility that Ken is under responding and the noted decline in his scores on all subscales. The differences between pre and post T-scores suggest that a pre-test (1) the children felt a heightened anxiety, embarrassment or avoidance about attending such a meeting; (2) they viewed their sexually acting out behaviour as a stigma; and (3) the children had never before talked or reported about their sexual thoughts, behaviour or concerns. The children may naturally have been reluctant or have had difficulty reporting accurately or honestly about thoughts and behaviours that were embarrassing. After nine weeks of discussion, communication, information and destigmatization, the children were more comfortable recording problematic thoughts and behaviours. At the same time, they may also have been trying to deny any possible remaining problems in the area of sexual touching.

Alone, the TSCC, would not be a predictor of past sexual abuse histories or sexualized behaviour. What is observed is that the TSCC highlights and confirms the self-reported information made by the group participants. As well, the group leaders observed similar behaviours in the participants during the group process. As a predictor of change,

the TSCC reflects only encapsulated moments in time. The T-scores show improved areas that have now moved into the nonsignificant range. To consider the decreased scores as significant, as in an absolute indicator that the problem is gone, other information such as behaviour reports from teachers, parents, group home staff or discussion with the group participants about these items would need to be included in the assessment This is a useful tool as an addition to other sources of data collection. It confirms several of the impressions and observations made by the group leaders about the group participants, but as the sole predictor of behaviour or assessment tool, critical pieces of information may be missed or ignored. In addition, it is relatively inexpensive, brief to complete and easy to score. The questionnaire may be difficult to administer with children who have difficulty in academic areas such as reading. Sometimes the children did not understand the language used or were confused by the instructions. This makes it harder to keep the data uncontaminated by not offering to interpret the questions for the children or the children just answering questions "blindly".

Child Sexual Behaviour Inventory

The Child Sexual Behaviour Inventory requests that parents/caregivers indicate the behaviours that they have observed in their child in the last six months. This short questionnaire was developed by Friedrich (1997) to assist in the assessment of the significance of sexualized behaviours in children. This tool can be used with many of the significant adults in a child's life.

The parents/caregivers completed pre and post group the Child Sexual Behaviour Inventory (Friedrich, 1997). As noted in Table 3, the pre and post test T-scores reflect the

total score and the scores for the two subscales. The total score examines such areas as boundaries, sexual interest, sexual intrusiveness, masturbation, sexual anxiety, gender role behaviour, and exhibitionism/voyeurism. A score of 65 or greater is considered clinically significant and a T-score of 60-64 suggests that the child has some difficulty in that area. The subscale, developmentally related sexual behaviour (DRSB), compares typical and expected gender sexual behaviour with the behaviours of the child assessed. The other subscale, sexual abuse specific items (SASI) specifically explores whether the client's behaviours are related to a sexual abuse history.

As observed in Table 3, the parents' pre-test scores show that all group participants, except Ken, had total CSBI scores that were in the clinically significant range. As well, except for Ken, the parents reported that the children were scoring in the clinically significant range or had difficulties on the developmentally related sexual behaviours subscale. The CSBI scores indicate that 3 out of 4 children had clinically significant behaviours in the sexual abuse specific item subscale.

The post test scores for all members reported showed that the total CSBI score remained consistent or elevated after the intervention occurred for most participants. Although Ann, for example, scored slightly lower, going from 110 to 94. In the developmentally related sexual behaviours subscale, the scores were also consistent with the scores from the pre-test. This scale indicates that the participants (Ann and Charly) responded to items that are consistent with behaviours observed in sexually abused children.

The CSBI provided the assessor the additional information that was reported by an

Table 3.

Results of the pre and post test scores for the Child Sexual Behaviour Inventory parent/caregiver report questionnaire.

	PRE-TEST *T-SCORES*			POST-TEST *T-SCORES*		
	TOTAL	**DRSB**	**SASI**	**TOTAL**	**DRSB**	**SASI**
ANN	110*	71*	21	94*	71*	+110*
KATE	94*	58	105*	m/d	m/d	m/d
CHARL	107*	72*	110*	102*	84*	110*
RICK	110*	73*	110*	m/d	m/d	m/d
KEN	43	45	44	45	43	48

Note.

Abbreviation for Subscales

DRSB refers to developmentally related sexual behaviour.
SASI refers to sexual abuse specific items.

Interpretation of Scores

Clinically Significant- T-Score 65 or greater (clinically significant scores are marked *)
Difficulties-T-Score 60-64
Nonsignificant-T-Scores 59 or less
M/D-missing data

observer of the child's behaviour. An interpretation of these scores exemplify the usefulness of this scale. The participants' pre-test scores suggest total CSBI score is elevated for all children. Most participants have very high and clinically significant scores for children of this age and gender. For example, Ann's caregiver reported that Ann frequently exhibits several behaviours consistent with a child that has been sexualized : (1) dresses like the opposite sex; (2) hugs adults she does not know well; and (3) stands too close to people. Caregivers/parents for other participants itemized similar behaviours in their children as occurring often: (1) shows sex parts to others; (2) tries to look at pictures of nude people; (3) talks about sexual acts; (4) kisses children/adults he/she does not know well; (5) tries to undress adults against their will; and (6) is very interested in the opposite sex. The first set of responses show that most of the participants' have high total CSBI score that can be identified as relating to specific problem areas. For example, Ann's problem areas were identified as her ability to correctly interpret appropriate physical/sexual boundaries. She appears to hug and kiss child/adults she does not know, attempts to undress adults she does not know and is very interested in the opposite sex.

For example, Ann's developmentally related sexual behaviours score (T=71) compares Ann's caregiver reported behaviours to those behaviours that are typical and in the developmental range for children her age. Ann's score on this subscale is clinically significant. Friedrich (1997) remarks that higher developmentally related sexual behaviours scores are related to the child's experience of family sexuality. Usually a high score reflects a child that has had a greater exposure than the average child to adult nudity and sexuality. This is consistent with 11 year old Ann's disclosure of sexual abuse by an

adult male, her remarks about having observed peers engaged in oral sex, an invitation by peers to have sex with an adult male and the observed sexualized manner in which she presented herself. By contrast, Ann's caregiver, reported a low score (T=21) on the sexual abuse specific items subscale. This scale reflects the measurement of sexually intrusive behaviour and age/gender appropriate sexual interest. This low score appears inconsistent with the self-disclosed sexual abuse, the sexualized activities with peers and the sexualized manner Ann has. In interpretation, the writer would suggest that Ann's caregiver was not aware of the different types of sexually acting out behaviours and failed to report them accurately. Ann's second total CSBI score (T=94) and her developmentally related abuse behaviours score, (t=71), suggest that her behaviours have remained relatively consistent and clinically significant over time. It is significant that her sexual abuse specific items score has dramatically increased, as almost 5.5 times higher in the second set of responses. This elevated score suggests Ann's behaviour is consistent with children who have been sexually abused.

Ann's caregiver indicated Ann has highly sexualized behaviours and sexual interest. There are several possible interpretations of the differences in scores such as: (1) that after the group intervention the caregiver is more cognizant at reporting sexualized behaviour; (2) that Ann may currently be experiencing physical/sexual abuse, or; (3) the group intervention has revived memories of past sexual abuse and heightened her behaviours. Friedrich (1997) recommends that a child with Ann's behaviours needs to be monitored to prevent the likelihood of her victimizing other children. As well, Friedrich (1997) advocates for a continued intervention to reduce the intensity of the

sexualized behaviours in the child.

It is critical to note that Ann had disclosed to the group that she had touched younger children. This was new information to the facilitators and to her caregiver. Ann, herself, asked for continued therapy to help her with her sexualized behaviours, suggesting that she felt she had a problem. In addition, Ann's foster placement was tenuous. The plan was that Ann would return to her family, but that the actuality of that occurring seemed to remain uncertain. Friedrich (1997) comments that children in life transitions like puberty or unstable environments are situations that activate feelings of low self-esteem which causes a return of sexualized behaviours.

When the information from the participants TSCC, self-reported scores, and CSBI, parent reported scores are compiled, it suggests that the children's behaviours are in the clinically significant range. The elevated scores indicate that most of the children have sexualized behaviours that are (1) consistent with those of sexually abused children; and (2) that their scores reflect that they feel conflicted and distressed over unwanted sexual interest and behaviours. The participants' self-reported post intervention scores show that almost every participant reports higher scores (than the pre-test) that are clinically significant in the areas of sexual concerns.

When the referral source information, preselection interview data and observations of behaviour throughout the group process are included in the assessment, the participants' high scores would suggest that their behaviours are consistent with a child who has experienced sexual abuse. It was noted that several of the children requested further therapy. As well, it was recommended that several of these children continue to

receive intervention to reduce and monitor the child's sexualized behaviour (Friedrich, 1997). It is possible that some of these children may act out sexually on other children again, if their behaviour is not monitored. For professionals working with these children, it would be helpful to be aware of each child's self-reported areas of difficulties and concerns.

Friedrich (1997) recommended that the CSBI not be used alone in the assessment process. Friedrich (1997) proposes that assessments use other forms of data gathering such as the self-report TSCC, referral source and interviews with as many significant others as possible. Friedrich (1997) suggests that the child's teacher, both parents or foster parents completed the CSBI and the Child Behaviour Checklist for Children (Friedrich, 1990).

Parents/caregivers also completed the Child Sexual Behaviour Checklist (Friedrich, 1986). This questionnaire is a lengthier, 44 item scale (Friedrich, 1997). This longer scale provided the parents/caregivers an opportunity to outline in more detail some of the observed sexual behaviours of their children in the last three months. This scale was only completed once by the parents/caregivers in the first group session. In this questionnaire, parents/caregivers circle the number of times a behaviour may have occurred. The behaviours reported on were (1) an interest in sex and sexuality; (2) hugs/kisses others; (3) masturbation; (4) acts as the parent; (5) swears; (6) behaves in a sexual manner; (7) bathroom behaviours; (8) bowel/bladder problems; (9) shows private parts to others; (10) nudity; (11) underwear; (12) talks about sexual things; (13) touches other children/asks others to touch them; (14) looks at others/asks others to look at them; and (15) has sex

with animals. This questionnaire also reports on any known sexual abuse, physical abuse, history of family violence, and family boundaries. The information in these forms was not tabulated, but used to gain more descriptive detail on the child's sexual behaviours. These questionnaires were quite long and sometimes the parent/caregivers announced they found the questions intrusive and personal. Some parents were reluctant to answer what they thought were very personal and private questionnaires about their child's behaviour. It would suggest that parents that have difficulty discussing sexual matters comfortably may refuse to complete the form or report inaccurately on this scale.

Some caregivers/parents reported on the longer version of the Child Sexual Behaviour Checklist (Friedrich, 1986) that their children have inappropriate boundaries regarding intimate physical contact with adults (for example, that Ann hugs and kisses adults and children she does not know very well and she is observed to play house or doctor with little children frequently). Another caregiver reported that she observed her child acting in a sexual manner, dancing or dressing in a "sexy" way. Also, some parents/ caregivers recorded that their children had bowel and bladder problems such as constipation, avoided urinating, refused to have bowel movements, and sometimes had accidents during the day. One caregiver reported that her child often showed her privates to others and walked around in her underwear at home. Other significant information reported by caregivers was that some of their children have been sexually abused and witnessed family violence. This questionnaire added a greater depth and detail to the amount and type of sexual behaviours the group members were engaged in either alone or with others. It was useful in confirming other information provided by the participants'

self-report questionnaire and that of the referring source.

Friedrich (1997) also advises that the clinician clarify the results of the CSBC with the child's statements, recent stressors in the child's life, the accuracy/validity of the caregivers' reports, and the cultural background of the client. Friedrich (1997) suggests empirical reports on sexual behaviour indicate that sexual behaviours increase in correlation to family violence, maternal education, life stress, family sexuality, hours in daycare, and exposure to pornography. For example, in Ann's situation it is known that she has a history of sexual abuse, violence (hostage taking) and much exposure to sexual activity. In addition, Ann's life is in several transitions (i.e., adolescence and her physical environment). Ann's sexually acting out behaviours can be understood in this context.

As a for the usefulness of these measures, it confirms that some of the participants' behaviours are consistent with those indicative of a history of past sexual abuse. Although, the scale cannot tell how much the intervention impacted on the children, it is unlikely there is another scale that can provide that information because the clinician cannot control for all the variables in the interventions. The results of the questionnaires could suggest several factors may be apparent in this process. For example, in Ann's first TSCC was close to being invalid because she was potentially hyper responding to the questionnaire. The presenting problem seems to be that most of these children view sexually acting out behaviours as a stigma. It would be understandable that their anxiety levels are heightened just at the thought of speaking to anyone, particularly strangers, about such sensitive issues. The clinician could assume that some children will attempt to hide their anxieties or their problematic behaviours by over responding or under

responding. It would suggest that the group intervention has given the child the language and means to talk about their problems. As the child gains confidence to discuss this sensitive topic, maybe he/she feels comfortable reporting more accurately his/her thoughts and feelings. Thereby, the second set of data may be more representative of the child's actual feelings and behaviours. What remains unknown is what risk these children present to themselves and to other children.

In order to address some of the outstanding concerns for these children, it would seem that a more in-depth assessment period which involved other caregivers like the child's parent/foster parent, social worker, therapist, or his/her teacher at school, may have provided more breadth to the information. Increasing the information collected enhances the clinician's ability to help a child.

Client Satisfaction and Feedback

Each group member and his/her parent/caregiver were given a client satisfaction form to complete. The children/caregivers were told they could remain anonymous on their responses if they so choose. All the participants indicated their name on their forms. The children were asked to rate their overall impressions (i.e., choosing between a lot, some, a little or not at all) on various aspects of the group intervention. Clients were asked to score whether they now felt more comfortable talking about what happened to them and what they have done. The survey explored the children's level of supports (i.e., did they feel comfortable talking to their parents, did they feel liked by peers and did they feel understood). The questionnaire also checked how the children felt about the group in the following areas: was group too long, were they now better informed about sexual

abuse, did they like journals, snack, and the number of people in the group. Children were then given open ended questions to offer comments about the facilitators, the group goals, what was helpful to them, what was not helpful.

Overall, all the children indicated that they now felt more comfortable talking about sexual abuse and sexual acting out behaviours. They shared that they were now better informed about sexual abuse. All members responded that they felt they were able to talk about their experiences with someone significant.

The children varied in their responses concerning the length of group meetings and the group itself. Three out of five children suggested that group was too short, one indicated it was too long, the other said that the length was fine. One child asked that group run for a longer period of time and that her ideal was a group that went every day.

Four out of five children said that they did not like journal writing. Five out of five children said they enjoyed snack time. All participants indicated that the group had taught them something new. As for the facilitators, the children all stated that they liked the facilitators (they were nice and okay). When asked what was most helpful about group one child stated "learning about triggers", and another said "knowing other kids did touching". Other comments included "talking about this sexual assault," "knowing not to do it anymore," and "activities." The least useful aspects of group were remarks such as "sitting on hard chairs"or "no chips for snack". In general, the children indicated a high level of satisfaction with the group process and five out of five participants recommended running a similar group again for other children.

In retrospect, the evaluation neglected to inquire if the children felt that it was

helpful to have their parent/caregiver part of the group process. For future group planning, another question that would have been useful would be to ask if the children thought it would have helped to have group sessions in conjunction with the parents. A post client satisfaction questionnaire administered at a six month interval might have offered a picture of the long term effects of the group intervention (Rivas & Toseland, 1998).

Four out of six caregivers from the parent group also completed a client satisfaction questionnaire. The parents reported high satisfaction in all areas of group. As a group they indicated that the material was well-presented, helpful, informative and that they felt they had learned about inappropriate sexual behaviors and how to help their children. Three parents indicated that they felt this group intervention was helpful for their children. It is significant to note that every parent stated that his/her relationship with his/her child had improved completely. Two of the four parents commented that they would have preferred more information from the children's group and expressed a desired to know what their children were doing in the group sessions.

Closing Interviews

Each child and his/her caregiver were given an opportunity to attend a closing interview two to three weeks after the final group session. In this interview the children were asked to invite the most significant people in his/her life that they wanted to attend this meeting. Guardians were asked to sign consent forms for the purpose of sharing information with other professionals. Some children invited their caregivers and social workers, others asked their therapist to attend. The closing interview provided a helpful

overview of the group process for each child, an opportunity for the child to comment on their group experience and for the facilitators to make recommendations on the child's future needs.

These interviews were approximately 45 minutes to 1 hour in length. In these interviews, all group participants indicated that they felt the group process had been helpful for them. Each child commented that the group had given him/her a chance to learn about sexual acting out and to know that he/she was feeling less isolated and more able to talk about his/her behaviours. The caregivers that attended the closing interview stated that they felt group had been a helpful process for themselves and their child. Some caregivers were concerned that the children's behaviours would reoccur and that the children would be without support or resources. The facilitators gave the parents a list of available resources.

Summary

In conclusion, the TSCC and the CSBI suggest that the clients' behaviours decreased marginally after the group intervention. Of all the children in the group, only one child, Kate, was known to have acted out sexually during the group process. As for the client satisfaction questionnaire, all of the children/caregivers reported that they were satisfied with the group process, but many indicated that it was not long enough and some suggested that they were concerned that the children would not continue to have a resource available in the future. The most significant outcomes of the group process appeared to be the reduced isolation for the children with sexually acting out behaviours, an awareness that this is a manageable problem and that the individual could acquire skills

to cope with this problem. For the parents, there was an appreciation of the education, regarding such issues as healthy and expected sexual behaviours, how to eliminate inappropriate sexual behaviours and how to talk to and support their children surrounding sexuality.

CHAPTER SEVEN

Discussion and Conclusions

Value of the Chosen Model of Intervention

As previously documented, this group intervention was based on cognitive theory, small group work theory, and narrative therapy. The following discussion delineates the usefulness of these chosen models.

The Value of Group Therapy

Treatment groups provide participants with many advantages such as support, education, growth, socialization and therapy. Children coming together in a treatment group have the advantage of making connections with others (Rivas & Toseland, 1998). Sexually acting out children are often isolated, ashamed and friendless because of their behaviors (Gil & Johnson, 1993). The intervention offered in this practicum provided a group of children an opportunity to resolve past experiences, make new friendships and practice age appropriate socialization skills.

In addition, in group settings sexually intrusive children receive validation, self-understanding and learn new coping strategies for their behavior (Gil & Johnson, 1993). Group mirrors healthy interactions, models respect for others and encourages positive self-esteem. The children can explore confusing and scary experiences in an atmosphere that is validating, safe and supportive (Mandell et al., 1989). At the same time, group gives children a safe and supportive environment for practicing new skills. A desired outcome was that these skills were externalized to the outside world.

Group treatment appeared to be the optimal intervention for this population as it

decreases isolation, improves social interactions and provides a setting for children to address touching behaviors in a nonjudgmental environment. The value of group therapy for children is well documented in the literature by such authors as Johnson and Gil (1993), Rivas and Toseland (1998), and Rose and Edleson (1987).

As per the literature review, this group intervention had many positive effects for the participants. Group process enabled both peer group confrontation and support. The group offered a way to assess and evaluate changes in behavior. Hird and Morrsion's (1996) conclusions about the positive benefits of group work are confirmed. The children in this group relayed that attending group offered them hope and validated their histories. Group acted as a catharsis for the participants to have an interpersonal learning experience. Utilizing a cognitive based group intervention gave these children an opportunity to enhance assumption of responsibility, develop positive cognitive strategies, restructure distorted thinking, and build empathy.

Malekoff (1997) also emphasizes that adolescents have historically utilized social groups for exploring and developing several areas. These groups have helped youth accomplish the many challenging tasks of adolescence like separating from family, forming a healthy sexual identity, preparing for the future and developing moral value systems (Malekoff, 1997). Groups offer these children a sense of belonging, worth and competence. In this group, the children had a supportive and safe place for corrective experiences, to learn new skills, to practice decision making and to provide the availability of support long after the group terminates (Malekoff, 1997).

It was observed that this group intervention proceeded through the expected

developmental stages. Group members formed a cohesive and supportive bond between each other. The group advanced to a level where they trusted each other enough to disclose personal and intimate stories about themselves. Members challenged each other's thinking and confronted behaviours in a safe environment. Even with young children, it is noted that a group of peers can provide a mutual learning and support to each other. The group also gave the children a chance to practise new problem solving and coping skills and further integrate their learning. Group helped these children form friendships and feel less isolated about their sexually inappropriate behaviours.

The facilitators noted that sexually inappropriate behaviours are an extremely sensitive and challenging topic to discuss. The majority of these children had been sexually abused and they seemed to have attached a stigma to their sexually intrusive behaviours. Most of these children made comments that the person who had sexually offended against them was "pathetic", "a pervert", "disgusting", or a "sick" individual. Many of the children felt that the person who had offended against them should be "sent to jail" or "shot". How is it then, that these children understand their own sexually acting out behaviours any differently? Most of the children had internalized views of their own sexually acting out behaviours as "perverted". Even the children who were not sexually abused, had integrated ideas that people who sexually abuse others are "disgusting perverts". As leaders, it was difficult to find a way to move beyond the internalized concepts that these children maintained about their behaviours and balance this with the understanding that sexually inappropriate behaviours are wrong, and need to be stopped.

It was noted that the children had a very difficult time talking about their own

sexually inappropriate behaviours. The group reacted to such discussion by disruptive, distracting behaviours that forced the facilitator to concentrate more on behaviour management in the group setting than on discussing the themes. It would be recommended that a group that must address such sensitive material have a small membership. As recommended by Gil and Johnson (1993) the size of such a group should only have between 6 or 8 members. As this is a sensitive topic, it is recommended that other groups with sexually acting out children remain closed. The children needed to form trusting relationships with each other to feel safe enough to share thoughts and feelings on such shame-laden behaviours. An open group forum would have continually disrupted the formation of trust and prevented children from feeling safe to disclose their own behaviour.

It seems that a structured, time-limited group is necessary to model boundaries, create predictability and enhance the establishment of a safe environment (Mandell et al, 1989; Rose, 1985). Once the children had established trust and formed relationships with each other the group could move from nonthreatening to more difficult themes. The structured progression of themes helped the group move at a slow pace and according to the level of comfort of the group. Facilitators adapted the structure to suit the needs of the group, revisiting some topics, such as sexual victimization issues, before proceeding to the themes related to sexually acting out behaviour.

The length of the group sessions proved to be too short to accommodate the structured themes. The disruptive and distracting behaviours of the children when sensitive topics were addressed delayed the progress through the group material. It was

decided to increase the length of the session from 75 minutes to 90 minutes and to forgo some of the structure such as the relaxation exercises. As such, it would be recommended that the length of any future group sessions be 90 minutes in length so that ample time is allotted for difficult topics.

This group intervention was only 9 sessions in duration. Most of the children said they felt this was not a long enough time. Many of the group modules could have benefitted by allowing more time to integrate the material. The original outline of groups sessions could have been further broken down into 12 modules and spread out over a 12 week period. Therefore the amount of energy and time spent dealing with distracting behaviours of the children would not detract from the time needed to integrate difficult themes. It was unfortunate that the length of group did not permit the children to practice the stress inoculation exercises initially proposed. A longer group would have given more opportunity to the children to practise the learning presented.

Another issue to consider is whether combining genders in a group for sexually intrusive preadolescents is problematic. The literature (Gil & Johnson, 1993; Mandell et al., 1989; Rose, 1987) discouraged mixing genders at the preadolescent age. Prior to the start of group, the facilitators carefully thought through the issues that may arise and how they would be handled. For example, the facilitators anticipated that there would be a gender split into subgroups during the group process. An awareness that the children may form subgroups helped the leaders to monitor potential divisions and counteract it by openly addressing the formation of subgroups. From the onset the children indicated that they did not feel uncomfortable discussing sexuality and sexually acting out behaviours in

a mixed gender group. The children did start to form subgroups, but this was openly addressed and quickly discouraged by the facilitators. Some of the girls showed an interest in splitting the group into "boy-girl pairs". This behaviour was openly confronted and challenged by some of the boys and eventually it dissipated.

Mixed gender membership helped the children understand that sexually acting out behaviours occur across genders. It appears that when considering the impact of gender splitting for a group for sexually acting out children, the issue is not that the children feel uncomfortable talking about sexual matters in mixed company, but that no group has a minority membership of any category. It is argued that not separating the genders reduces future distorted thinking that supports that genders are different and should be treated as such. Contrary to the literature (Brown & Mistry, 1994; Garvin & Reed, 1983; Martin & Shanahan, 1983), this facilitator found that mixed gender groups had more positive benefits that not.

It was also found that literature encouraged mixed gender leaders. Same sex facilitators did not appear to detract from the degree of comfort the male children had in discussing sexual matters in the group setting. In fact, it seemed that the children who had negative experiences with adult males, were less threatened by same female leaders that a mixed gender leadership.

In consideration of the chosen theoretical framework it appears that the parents/caregivers and children presented with many cognitive distortions related to sexually acting out behaviours. Parents/caregivers, children and the professionals all struggled with internalized cognitions surrounding healthy/unhealthy sexuality,

inappropriate sexualized behaviours and the stigmatizations related to those individuals engaged in inappropriate sexual touching. The facilitators encountered numerous maladaptive patterns of thinking that perpetuated the children's behaviours. The thinking patterns seemed to be tied to intense emotional experiences. All the children viewed their own sexually inappropriate behaviours as "disgusting" and attached to this concept was deep shame and guilt. Cognitive theory introduced a way that reframed the thinking surrounding these behaviours, allowing the children to progress to a stage where they could stop the behaviours. Cognitive theory presented the leaders with an understanding of maladaptive thinking patterns and how to change these patterns. In this group the children benefitted from an experiential learning format. The heightened sensitive nature of this topic was often met with avoidance, but the children always participated in "hands-on" activities that helped them learn the tasks at hand. The children were able to use the group in which to practise their newly learned skills.

Narrative therapy was an approach that offered the children a chance to talk about a very threatening topic. The narrative therapy introduced an externalized way to address sexually inappropriate behaviours. As suggested by narrative therapists (Eptson et al, 1997; Epston & White, 1990) the leaders introduced story telling and letter writing as a way to discuss sexually acting out behaviours. The children responded to these strategies with enthusiasm. They were able to attach their own meaning and express themselves in ways that made sense for them. The leaders composed group letters to the children that provided an overview of the group session, commented on behaviours, roles and themes. The letters seemed to connect the children to the group process and the themes discussed

the previous week. The letters to the children served as a review and a reminder for the children and the leaders of what had transpired in the last group session. At the end of group, the children requested a personalized, individual letter that addressed their own specific needs and concerns. This seemed to be helpful to the group process, providing a safe way to disclose embarrassing information, building cohesion, strengthening positive roles and emphasizing positive behaviours. This approach encouraged the children to seek their own meaningful ways to empowerment to stop their behaviours.

Learning Objectives

This clinical practicum attempted to meet several learning objectives for the writer. One of the initial learning goals of this practicum was to provide an education and support group for the parents/caregivers of sexualized children. Although, this writer did not facilitate the parent/caregiver group, there was a group that ran simultaneously. This gave the parents a chance to learn about sexualized behaviours and how to help their children control and monitor their own behaviour. In addition, the parents were informed of the weekly goals of the children's group and encouraged to offer consistent supportive messages support in the home in between sessions. Those caregivers/parents that completed the parent group stated that they appreciated the education and support offered by the group. The parents who did not complete the group were the foster parents for Rick and the biological parents of Keith. As experienced foster parents, Rick's caregivers stated that they felt they were knowledgeable about sexualized behaviours and that the group was in many ways redundant for them. Keith's parents identified that they withdrew from the group process because (a) they felt they were one of two biological

parents in the group setting and that the others in the group were there in a different capacity, and (b) because the group revived painful unresolved memories of past childhood sexual assault for one of the parents. Keith's parents identified that they were experiencing intense emotional upset to the recent behaviours of their son. They had not received any therapeutic intervention prior to their attendance at the group and felt misunderstood and overwhelmed by the group process.

Keith's parents believed that as biological parents versus those in caregiver roles, they were much more emotionally devastated by both their child's victimization and sexually acting out behaviour, and that the total effect on their family could not be understood by other group members. At the first group meeting, after introductions, one of the questions posed by the facilitators was how often the parent/caregiver group should meet. The options were each week or alternate weeks. Keith's parents clearly stated that they were there for their son and would do whatever they had to so things would get better. One of the key support workers for another child in the children's group stated that they were being paid whether they attended the group or not. Thus it did not matter to them. The differences in these responses clearly exemplified the different mind sets of the respondents. The biological parents felt that the caregivers lacked caring and were not invested in the child "getting better". To some degree they were correct. Some caregiver had stated that she was there because she was "paid to be there". Unlike Keith's parents, the other adult group participants could say these children were not their own children and they did not attach any personal responsibility to the problems the child was experiencing. What was clear to the facilitators was that these caregivers were able to distance and

depersonalize the nature of the sexually acting behaviours of their children. There was a tremendous difference in the perspectives, needs and expectations of the group between the biological parents responsible for their child's care, and professional foster parents or child care staff, and the two should not attend the same group. Undeniably, this writer continues to support the concept of a parallel parent/caregiver when working with children in a group setting. Parallel parent/caregiver groups provide education, support to the parents who in turn can provide the same to hi/her child. Parents/caregivers of sexually inappropriate children have identified that this is sexually inappropriate behaviours cause them to feel overwhelmed and helpless. As caregivers are far more able to distance themselves emotionally from the child's sexually acting out behaviours, it is clearly better to separate biological parents and caregivers when asking them to support children in group treatment.

It is argued that the group intervention created a safe environment that proved to offer the children in attendance a learning format. Every child that attended group stated that he/she had learned something new about sexually acting out behaviours in the group process. All children could identify what were sexually inappropriate behaviours and their own triggers to sexual acting out. It was apparent the children had difficulty taking responsibility for their own sexually acting out behaviours because of the shame and stigma they attached to such behaviours. If the offender, or a significant person in the child's life modeled the assumption of responsibility for the events that had happened to the child, the child was more likely to take responsibility for his/her own behaviours. The group provided the participants with an opportunity to explore self-monitoring techniques

that they could use to control their behaviours. The group provided the children with strategies for healthy coping and a place to practise alternative problem solving and social skills.

Throughout the group process, this writer was challenged to practice social work and group skills. An experienced and creative co-leader gave this writer the opportunity to observe practiced skills in narrative therapy and group work. These in turn were encouraged and supported in this writer throughout the group process, and there certainly was professional growth in this area.

Implications for Future Social Worker Practice with Sexually Acting Out Children

Friedrich (1990) has provided research that tell us that 28% of sexually abused children will act out sexually. This number does not account for the children who have never been sexually abused and act out sexually. What is known is that there are greater numbers of these children needing service. We know that interventions must be developed and implemented to prevent the further victimization of children by children from continuing to occur. This practicum has highlighted several important considerations when working with sexually acting out children. Primarily, it is emphasized that young sexually acting out children do not fall into an age group where the legal system intervenes. As well, social service and mental health policies do not address the potential fact that sexually acting out children are victimizing other young children. Systems are not in place that decide when a child's sexually acting out behaviours are at the point where other children are at risk and the situation becomes a "protection issue", warranting Child and Family Service involvement. There are too few resources, not only for the sexualized

child, but the person/s parenting the child find that his/her needs are often not met. Guiding policies have yet to be written, and few professionals have the skills necessary to clinically assess and the sexually acting out child and his or her family.

Parents/caregivers of sexually inappropriate children tend to succumb to distortions about sexualized behaviours such as, "talking about it means doing it" and "ignoring it means it will go away". Further, addressing sexuality is a difficult and sensitive area and adding the stigma of sexualized behaviours compounds the comfort level of professionals, caregivers and the client. Sexualized behaviours have a great deal of shame attached to them and any intervention that aims to help sexualized children has to confront this issue. Parents and children tend to deny, minimize and avoid dealing with sexual matters that seem personal and shameful.

Another important consideration is the possibility that the clinicians involved in this process will fall victim to the stigma attached to sexually acting out or to the minimization of sexualized behaviours in children that they know. In this group, the leaders found it initially was sometimes difficult to find terminology or language that was non labeling or stigmatizing for the caregivers/children. At the same time, it was important to be cognizant of minimizing the sexually acting out behaviours.

In addition, the results suggested that children and caregivers often attributed adult sexual offending characteristics and concepts to the child's behavior. This view becomes internalized, increasing the child's sense of shame and limiting his/her inclination to take responsibility for their own actions. These findings suggest further study is needed to examine the impact that the sexual offender's actions, and what the child victim's

perception and understanding of their offenders's actions has had on the child's self-esteem and ability to benefit from interventions.

Other results noted were that sexually acting out children had frequently experienced other traumatic events such sexual or physical abuse. For some children, the ability to successfully overcome their touching problem, hinged on his/her historical model for the assumption of responsibility. Those children that who had a significant adult in their life who had assumed responsibility for the victimization the child experienced, had a model for taking responsibility for their own behaviour and seemed to progress further in his/her treatment.

It is also clear from this intervention that less attrition of group members will occur if a thorough, detailed family assessment is undertaken prior to the start of group. Such an assessment would explore the extended family members' past sexual abuse history and resolution, their comfort level in discussing sexuality and sexually acting out behaviours, and their understanding and meaning of sexually acting out behaviours. In this assessment it is important to discuss with the child, and as many significant others as possible, the details of the known, past sexually acting out behaviours. A critical element would be to determine the meaning the child places on his/her behaviours, so as to provide the clinician with a more complete baseline for assessing such behaviours. The TSCC and the CSBI are two useful tools for gathering data and could be used to assess the sexually inappropriate behaviours. The CSBI could be utilized with several significant adults in the child's life such as both parents/caregivers, social workers, therapists, teachers, grandparents and day care providers. It is helpful to have an understanding at what

therapeutic stage the parents/caregivers and the child are at prior to a group intervention.

This group intervention can be seen as a beginning phase for the majority of the children and their caregivers. Some children were still unable to talk about their sexualized behaviours at the end of group. Many children presented long-term, ongoing unresolved issues in the group process. These issues included family violence, separation and loss, and physical and sexual assaults. Many children stated they wanted and needed continued therapy. Ongoing individual or family counseling would have given the children an opportunity to process some of these issues as they surfaced in the group. Although some children did have individual therapy available to them, their therapists were not connected or informed of the issues that arose during the group process. If the group intervention does not have individual sessions attached it would be helpful to have consent to share information with other therapists involved. As well it may have been helpful to share the results of the Child Sexual Behaviour Inventory and the Trauma Symptom Checklist for Children with the caregiver and therapists.

There is still a great deal to learn about helping sexually acting out children. This is an important area that needs further study. There is a continued need for similar interventions to help these children and stop the possible further victimization of other children. Undeniably, professionals, caregivers and children will benefit from ongoing education and support regarding this issue. Not only is education and training needed for professionals, parents and caregivers, but social policies are needed to help professionals plan for these children and protect other children from being hurt. Professionals need guidelines that can direct the planning for sexually acting out children. One suggestion

may be to develop programs that include a liaison worker within the child welfare system who coordinates the interventions and training for this issue.

Further, the need for funding for future group interventions and research in this area is essential to inform services for sexually acting out children. There is little recognition of the seriousness this problem nor its manifestations in children. It is strongly advocated that research continue and we as professionals continue to build on this knowledge base.

References

Abueg, F. R., Follette, V. M., & Ruzek, J. I. (1998). Cognitive-behavioral therapies for trauma. New York: Guilford Press.

ACT II Child and Family Services (1995). Working with children and sexual behaviour problem: A family-based approach. Coquitlam, B. C.: Family Violence Prevention Division Health Canada.

Acton, W. (1998). Principles of treating sexually intrusive children. London, Ontario: Madame Vanier Children's Services.

Adams, J., Ensign, J., McCann, J., Voris, J., & Wells, R. D. (1995). Emotional, behavioral and physical symptoms reported by parents of sexually abused, nonabused and allegedly abused prepubescent females. Child Abuse and Neglect, 19, 155-163.

Alford, B., & Beck, A. (1997). The integrative power of cognitive therapy. New York: Guilford Press.

Anderson, C. M., Griffin, S., Holder, D. P., Pagonis, I., Rossi, A., & Treiber, R. (1986). A comparative study of the impact of education vs. process groups for families of patients with affective disorders. Family Process, 25, 185-205.

Anderson, J. (1980). Structured experiences in growth groups in social work. Social Casework: The Journal of Contemporary Social Work, 12, 277-287.

Attinson, L., & Skolnik, L. (1978). Confidentiality in group work practice. Social Work with Groups, 1, 65-73.

Bandura, A. (1977). Social learning theory. Englewood Cliffs, New Jersey: Prentice-Hall.

Bagley, C., Wood, M., & Young, L. (1994). Victim to abuser: Mental health and behavioral sequels of child sexual abuse in a community survey of young adult males. Child Abuse and Neglect, 18, 683-697.

Barth, R. P. (1986). Social and cognitive treatment of children and adolescents. San Francisco: Jossey-Bass.

Beck, A. (1976). Cognitive therapy and the emotional disorders. New York: International Universities Press.

Beck, A. (1989). Love is never enough: How couples can overcome misunderstandings, resolve conflicts, and solve relationship problems through cognitive therapy. New York: Harper & Row.

Bernard, M. E., & Ellis, A. (Eds.). (1983). Rational-emotive approaches to the problems of childhood. New York: Plenum Press.

Bernard, M. E., & DiGiuseppe, R. (Eds.). (1989). Inside rational-emotive therapy: A critical appraisal of the theory and therapy of Albert Ellis. New York: Academic Press.

Berman-Rossi, T. (1992). Group work reaching out: People, places and power. New York: Haworth Press.

Briere, J. (1997). Trauma symptom checklist for children: Professional manual. Florida: Psychological Assessment Resources.

Brown, A., & Mistry, T. (1994). Group work with 'mixed membership' groups: Issues of race and gender. Social Work with Groups, 17, 5-20.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of

the research. Psychological Bulletin, 99, 66-77.

Burton, J. E., Christopherson, B. J., & Rasmussen, L. A. (1992). Precursors to offending and the trauma outcome process in sexually reactive children. Journal of Child Sexual Abuse, 1, 33-48.

Canavan, M. M., Higgs, D. C., & Meyer, W. J. (1992). The female experience of sibling incest. Journal of Marital and Family Therapy, 18, 129-142.

Celano, M. P. (1990). Activities and games for group psychotherapy with sexually abused children. International Journal of Group Psychotherapy, 40, 419-429.

Cormier, L. S., & Cormier, W. H. (1985). Interviewing strategies for helpers: Fundamental skills and cognitive behavioral interventions. California: Brooks/Cole Publishing.

Cohen, R., & Schlser, R. (1984) Cognitive behavior therapy with children. In W. Meyers & W. Craighead (Eds.). Cognitive behaviour therapy with children (pp.72-93). New York: Plenum Press.

Corey, M., and Corey, G. (1997). Groups: Process and practice. Boston: Brooks/Cole.

Craighead, W. E., & Meyers, A. W. (Eds.). Cognitive behavior therapy with children. New York: Plenum Press.

Cunningham, C., & MacFarlane, K. (1988). Steps to healthy touching: A treatment workbook for kids 5-12 who have problems with sexually inappropriate behaviour. Florida: Kidsrights.

Dimock, H. G. (1978). Factors in working with groups. Quelph, Ontario:

University of Quelph.

Dimock, H. G. (1970). Planning group development. Quelph, Ontario: University of Quelph.

Dimock, H. G. (1973). How to observe your group. Quelph, Ontario: University of Quelph.

DeJong, A. R. (1989). Sexual interactions among siblings and cousins: Experimentation or exploitation? Child Abuse and Neglect, 13, 271-279.

Dlugokinski, E., & Suh, H. (1989). Exercises for enhancing emotional competence. Raleigh, N. C.: Feelings Factory Inc.

Dolan, Y. M. (1991). Resolving sexual abuse: Solution-focused therapy and Ericksoninan hypnosis for adult survivors. New York: W.W. Norton.

Duffy, T. K. (1992). The check-in and other go-rounds in group work: Guideline for use. Social Work with Groups, 17, 163-173.

English, R., Henderson, A., & MacKenzie, B. (1989). Perpetrator gender and type of child maltreatment: Overcoming limited conceptualizations and obtaining representative samples. Child Welfare League of America, 6, 543-553.

Epston, D., Freeman, J., & Lobovits, D. (1997). Playful approaches to serious problems: Narrative therapy with children and their families. New York: W. W. Norton.

Epston, D., & White, M. (1992). Experience, contradiction, narrative, and imagination: Selected papers of David Epston & Michael White, 1989-1991. Dulwich Centre Publications: Adelaide, Australia.

Eron, J. B., & Lund, T. W. (1996). Narrative solutions in brief therapy. New

York: Guilford Press.

Foreyt, J. P., & Rathjen, D. P. (Eds.). (1978). Cognitive behavior therapy: Research and application. New York: Plenum Press.

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

Friedrich, W. N. (1997). Child sexual behavior inventory: Professional manual. Florida: Psychological Assessment Resources.

Freeman, A., & Greenwood, V. (Eds.). (1987). In Cognitive therapy: Applications in psychiatric and medical settings. New York: Human Science Press.

Garland, J. A. (1992). Developing and sustaining group work services: A systemic and systematic view. Social Work with Groups, 15, 89-98.

Garvin, C. (1997). Contemporary group work (3rd ed.). Boston: Allyn & Bacon.

Garvin, C., & Reed, B. (1983). Gender issues in social group work: An overview. Social Work with Groups, 6, 5-18.

Gil, E. (1995). A guide for parents of children who molest. Rockville, MD: Launch Press.

Gil, E., & Johnson, T. C. (1993). Sexualized children: Assessment and treatment of sexualized children and children who molest. United States: Launch Press.

Glassman, U., & Kates, L. (1990). Group work: A humanistic approach. London: Sage.

Hollon, S. D., & Kendall, P. C. (Eds.). (1979). Cognitive-behavioural interventions: Theory, research, and procedures. New York: Academic Press.

Hollon, S. D., & Kendall, P. C. (Eds.). (1981). Assessment strategies for cognitive-behavioural interventions. New York: Academic Press.

James, B. (1989). Treating traumatized children: New insights and creative interventions. Toronto: Lexington Books.

Johnson, D. W., & Johnson, F. P. (1997). Joining together: Group theory and group skills. Boston: Allyn and Bacon.

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

Johnson, T. C. (1992). Let's talk about touching in the family: A therapeutic game. Charlotte, N. C.: Kidsrights.

Johnson, T. C. (1995). Treatment exercises for child abuse victims and children with sexual behavior problems. California: Toni Cavanagh Johnson.

Kolodny, R. (1980). The dilemma of co-leadership. School of Social Work, 3, 31-34.

Kuehnle, K. (1996). Assessing allegations of child sexual abuse. Sarasota, Florida: Professional Resource Press.

Kuehnle, K. (1999). Assessing allegations of child sexual abuse. Unpublished manuscript. Tampa: University of South Florida.

Lane, S., & Ryan, G. (1997). Juvenile sexual offending. San Francisco: Jossey-Bass Publishers.

Madanes, C. (1990). Sex, love, and violence: Strategies for transformation. New York: W.W. Norton.

Malekoff, A. (1997). Group work with adolescents: Principles and practice. New York: Guilford Press.

Martin, P. Y., & Shanahan, K. A. (1983). Transcending the effects of sex composition in small groups. Social Work with Groups, 6, 19-32.

Martinez, D., & Sermabeikian, R. (1994). Treatment of adolescent sexual offenders: Theory-based practice. Child Abuse and Neglect, 18, 969-976.

Nylund, D., & Smith, C. (Eds.). (1997). Narrative therapies with children and adolescents. New York: Guilford Press.

Piaget, J. (1973). Memory and intelligence. New York: Basic Books.

Pearce, J. W., & Pezzot-Pearce, T. D. (1997). Psychotherapy of abused and neglected children. New York: Guilford Press.

Poey, K. (1985). Guidelines for the practice of brief, dynamic group therapy. International Journal of Group Psychotherapy, 35, 331-354.

Rivas, R. F., & Toseland, R. W. (1998). An introduction to group work practice. Massachusetts: Allyn & Bacon.

Rose, S. R. (1985). Time-limited treatment groups for children. Social Work with Groups, 8, 17-27.

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

Rutan, S., & Stone, W. (1994). Special technical considerations: The use of cotherapists in group psychotherapy. In S. Rutan & W. Stone (Eds.). Psychodynamic groups psychotherapy. New York: Guilford Press.

Skinner, B. F. (1953). Science and human behaviour. New York: Macmillan.

Sgroi, S. (1988). Vulnerable populations. Lexington, MA: Lexington Books.

Tracing sex through the media. (1992, December 8 & 9). Free Press.

Yalom, I. D. (1995). The theory and practice of group psychotherapy. New York: Basic Books.

Zimmerman, J. (Ed.). (1998). Psychological assessment resources, Inc.: Catalog of professional testing resources, 21. United States: Cadmus Graphic Solutions.

Appendix A

Group for Children with Sexually Inappropriate Behaviours

Setting: New Directions for Children, Youth and Families

400-491 Portage Avenue

Winnipeg, M. B.

R3B 2E4

Group Starting and Finishing Dates:

February 24th, 1999. Running for 10 weeks until April 28, 1999

Time: Wednesdays 4:00pm -5:15pm

To Refer:

Contact Elvera Watson at 944-4163.

**Referrals accepted until February 10, 1999 in order to provide opportunity for screening interviews. **

Appropriate referrals:

(1) children aged 9, 10, 11 and 12 years

(2) presently in a stable placement

(3) developmentally on target

(4) exhibiting sexually inappropriate behaviours (touching other children)

(5) does not need to have disclosed sexual victimization, but must be able to acknowledge their sexually inappropriate behaviour.

Philosophy:

Children need help: to understand sexually inappropriate behaviours and the cycle of such sexual acting out behaviours; to learn about healthy sexuality; to understand feelings; to practise and learn new coping strategies; to understand the relationship between the interpersonal and the intrafamilial level.

(1) examining and understanding sexually reactive behaviours

(2) knowing and recognizing feelings

(3) addressing sexuality and healthy manifestations of sexuality

(4) developing and practicing healthy problem-solving and coping skills

New Directions 400 - 491 Portage Avenue, Winnipeg, Manitoba, Canada R3B 2E4 Telephone: (204) 786-7051 Fax: (204) 774-6468 TTY: (204) 774-8541 Families Affected by Sexual Assaults Family Therapy' Manitoba Learning Centre .

Appendix B

Sexually Inappropriate Children's Group Referral Form

PLEASE RETURN TO: ELVERA WATSON

2ND FLOOR 831 PORTAGE AVE.

WINNIPEG, MANITOBA

R3G 0N6

TELEPHONE: 944-4613

FAX: 944-4250

1. CHILD'S NAME & DATE OF BIRTH:

2. PARENT/CAREGIVER'S NAME & ADDRESS:

3. TELEPHONE NUMBERS HOME:

WORK :

4. NAME AND TELEPHONE NUMBER OF A PROFESSIONAL WHO IS AVAILABLE FOR CRISIS MANAGEMENT DURING GROUP:

5. REFERRING WORKER & ORGANIZATION:

6. HOW LONG HAS THE CHILD/FAMILY BEEN INVOLVED WITH YOUR

PROGRAM? HOW LONG WILL YOU BE INVOLVED?

7. IS THERE CHILD & FAMILY SERVICES INVOLVEMENT? FOR HOW LONG?

8. OTHER AGENCY INVOLVEMENT?

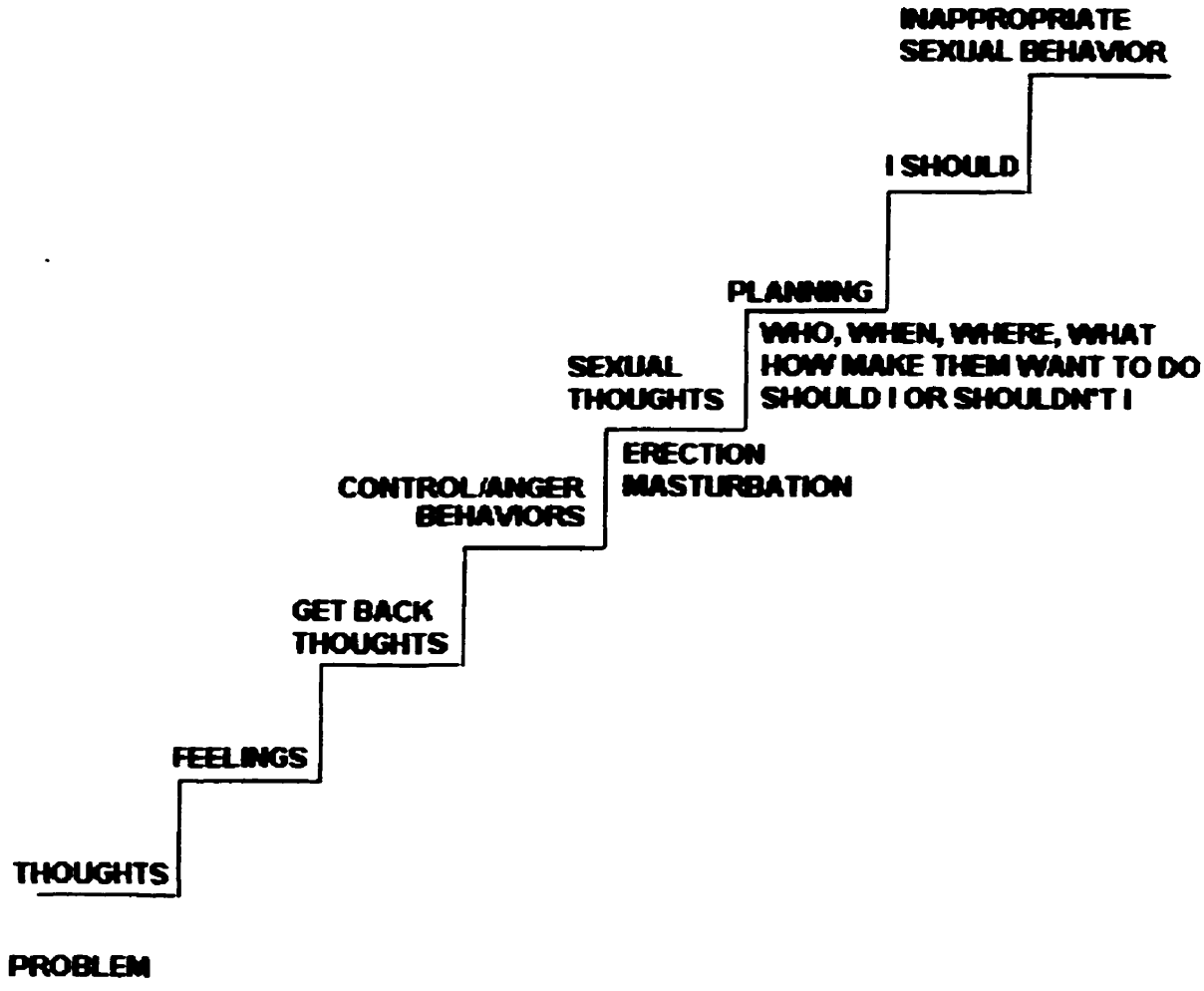
   PAST & PRESENT GROUP/THERAPY?

9. PROVIDE A BRIEF DESCRIPTION OF THE CHILD'S BEHAVIOURS AS THEY MIGHT AFFECT GROUP DYNAMICS. PLEASE ASSESS AS TO HOW MUCH CHILD AND GROUP MIGHT BENEFIT.

10. ANY OTHER PERTINENT INFORMATION?

Appendix C

RSA SEXUAL ABUSE CYCLE/STEPS FOR PRE-ADOLESCENTS



Acton, V. (1996) Principles of treating sexually intrusive children. London, Ontario Madame Vanier Children's Services.

Appendix D

Kids' Touching Rules

1. No babysitting.
2. Always ensure there is an adult around when with younger children.
3. Do not put things aside. Always talk with a grown about your feelings.
4. No touching privates of other people except when consenting same aged kids.
5. Watch out for triggers.
6. Get help when you feel your triggers are happening.
7. Remember how you can choose to cope with your feelings.
8. Keep a list of support people and people who care close at hand.