SEXUALLY ABUSED CHILDREN AND GROUP THERAPY:
A GUIDE FOR COUNSELORS

by
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STATEMENT BY AUTHOR

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APPROVAL BY THESIS DIRECTOR

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ABSTRACT

Sexual exploitation of children is not new. Although there has been recent growth in awareness of child sexual abuse, a corresponding growth in the quantity of systematic research of its impact and treatment has not ensued, and there is still relatively little empirical literature to guide treatment planning. Consequently, many counselors feel unprepared to work with this population.

The group approach to treatment of child sexual has the largest amount of data to support it and appears to be the type of therapy most frequently used. The focus in this study is on group therapy in the clinical setting because that is where the majority of literature representing this intervention is based.

A survey of the literature ascertained the availability of information, theoretical framework, and validity for its use. A handbook for counselors working with sexually abused children in group treatment settings was formulated. It was piloted by experts in the field who offered suggestions for improving clarity, content and usefulness.
Chapter I

INTRODUCTION

Sexual exploitation of children by adults is not new. What is new is that parents, mental health providers, and other caring adults who work with children are becoming more aware of the problem and are reporting it in ever increasing numbers (Oates, 1991).

Although there has been growth in awareness of child sexual abuse, a corresponding quantity of systematic research of its impact upon children has not ensued. There is still relatively little empirical literature to guide treatment planning (Gomes-Schwartz, 1990) and, consequently, it is not surprising that many counselors feel unprepared to work effectively with this population (England & Thompson, 1988).

In recent years, however, a number of mental health researchers have presented evidence which shows group treatment to be a particularly effective therapeutic means of assisting individuals achieve goals and resolve problems (Yalom, 1985; Mandell & Damon, 1989; Capuzzi & Gross, 1992). An underlying assumption is that it takes clients out of the isolation in which they often exist and puts them into guided contact with others. The resulting interaction becomes the context within which many of the
problems confronting the client can be resolved (Yalom, 1985).

It has been shown that group therapy with sexually abused children can effectively provide them with support, assist in the assimilation of effects, and aid in mastery of the trauma involved (Oates, 1990). As a result, group intervention for children is frequently viewed as a preferred treatment modality. The unique constellation of symptoms found among these children is particularly amendable to the group setting (Porter, et al., 1982; as cited in Celano, 1990, p. 419) and it lends itself to efficient use of increasingly restricted resources (Kitchur & Bell, 1989).

PURPOSE OF THE THESIS

The purpose of the thesis is to review current literature and research in sexual abuse treatment with children to support the use of groups as a primary approach. Based on the findings, a handbook will be constructed which will serve to orient new counselors to the effective use of groups in the treatment process.

THE ROLE OF THEORY IN GROUP TREATMENT

Although it has been said that group therapy does not represent a specific theoretical orientation or consistently demonstrate a direct relationship between
psychological theory and treatment and should be considered atheoretical (Winters, 1991), current research demonstrates that the counselor's orientation clearly influences the way she or he functions within groups (Corey & Corey, 1992). Identified variables, including relationship, leader role, member role, process, and outcome are swayed by the group leader's theoretic/therapeutic position. Thus, a sound ideological basis is vital for effective group practice (Capuzzi & Gross, 1992).

Theory can help to clarify many therapeutic questions. Ultimately, however, the most meaningful theoretical perspective is one that reflects the counselor's own values and personality (Corey & Corey, 1992).

Theoretical Dilemma for Counselors. The following statement encapsulates one of the major dilemmas coming from discussions of theoretical/therapeutic concepts as applied to group practice:

There is an apparent paradox in the notion of group psychotherapy. The locus of therapy is the group, and yet the group is not in need of treatment. Unless the group in question is a natural group (family, management, etc.), group therapists are using a group format to treat individuals. The goal of the leader is not to alter the group per se but to provide treatment and growth for the members of the group.
This problem is reflected in the development of therapeutic approaches to groups. Most of the extant group therapies are in fact individual therapies which subsequently were applied in group settings for reasons of economy. (Shapiro, 1978, p. 44-45)

Current practice demonstrates that all approaches have been applied across both individual and group counseling. Thus, selection of a treatment system is often based upon philosophical position and what is believed regarding personality development and change. It also may stem from an experiential position based on the individual counselor's education and working background (Capuzzi & Gross, 1992).

It may be said that although the necessity of sound theoretical constructs is essential, it is not advisable to wholly adhere to a single theory (Capuzzi & Gross, 1992). Rather, as is stated by Corey and Corey (1992) the effective group practitioner will most likely function within an integrative framework.

Principal Theorist. Perhaps the most widely recognized contemporary group theoretician is Dr. Irvin Yalom. From his work has come much of the foundation and subsequent framework for group psychotherapy as it is practiced today. He states that:
Group therapy methods have proven to be so useful in so many different clinical settings that no longer is it correct to speak of 'group therapy.' Instead, we must refer to 'the group therapies.' And, as one can learn from even a cursory survey of professional journals, the number and scope of the group therapies is mind boggling. (1985, p. 456)

Yalom (1985) asserts that in order to comprehend how groups work and to be able to effectively use them the [counselor] must have an understanding of the primary, or trunk of group therapy which is the long-term outpatient group therapy model. Once familiar with this the [counselor] is ready for the next step, which is the adaptation of basic group therapy principles to any specialized clinical situation.

Theoretical Basis of Handbook. The primary conceptual structure used in the accompanying handbook is integrative. It takes into account the thinking, feeling, and behaving dimensions of human experience (Corey & Corey, 1992).

ASSUMPTION

The recognition of the prevalence of child sexual abuse in the United States of America and other developed Western nations has stimulated interest in the broader cross-cultural record. This acknowledgement has challenged conventional and scientific wisdom that incest taboos are
strong enough to preclude all but rare occurrences of sexual behavior both among family members and outside the family context. The cross-cultural record is a rich, but largely untapped resource for assessing the antecedents and consequences of sexual conduct with children. Since research in group therapy has focused primarily on Anglos or culturally-mixed groups of children, the extent to which the findings are generalizable is unknown (Oates, 1991).

Because of the limited scope of this thesis, there will not be an attempt to explore the cross-cultural aspects of group therapeutic intervention with children. It can be said, however, that the sexual abuse of children spans all races, economic classes, and ethnic groups (Bass & Thornton, 1991).

SUMMARY

Childhood sexual abuse is a complex problem. In spite of a tremendous increase in research, there are too few empirical studies with large sample sizes, adequate comparison groups, objective measures, and statistical data which provide clear guidelines for treatment. Notwithstanding the limitations, one way to increase knowledge and effective group leadership is through advocating acquisition of a sound theoretical core and the use of a standardized method of orienting counselors (Capuzzi & Gross, 1992). A concise handbook will be
developed. Cross-cultural aspects will not be explored in this study.
CHAPTER 2

METHODS AND PROCEDURES

It can be said that research is integral to all levels of clinical practice and that the development of a scientific foundation is the essential priority for research (LoBiondo-Wood & Harber, 1990). Studies may be based on original data or founded entirely upon documentary sources (Goode & Hatt, as quoted in Laing, 1990). In either type of research, "... the investigator uncovers facts and then formulates a generalization based on the interpretation of facts" (Tuckman, 1988, p. 3).

This study is based on a review of research literature making it, in effect, an historical study (Best and Kahn, 1989). Historical research is the systematic assembling of data and the critical presentation, evaluation, and interpretation of facts regarding people, events, and occurrences of the past. Its process is not merely the writing or chronicling of historical events, but like other research designs, it is based on the gathering of data related to either research questions or hypotheses (LoBiondo-Wood & Haber, 1990). While some historical studies involve themselves with "the conflicts among nations," others focus on "domestic battles within a family" (Shulman, 1988, p. 21).
Historical investigation has many of the characteristics of scientific research. It involves delimiting a problem; formulating hypotheses or raising questions; gathering and analyzing data; testing the hypothesis to ascertain its correlation with the evidence; and development of conclusions. While the investigator does not directly gather data or observe events, (s)he does use the testimony of many witnesses who have examined the event from various vantage points. The observations may be either qualitative or quantitative. As a result of the investigation, a synthesis and presentation of facts is produced in a logical, ordered format (Best & Kahn, 1989).

Survey of Need

Local practitioners who work in a community agency that utilizes group therapy to treat children and adolescents who have been sexually abused were contacted to determine the need for a handbook to orient new counselors. The need was indicated and the formulation of such a handbook was encouraged.

A number of steps were taken to determine the availability of current literature. This included a careful inspection of relevant articles and books to ascertain the empirical basis of the content, and a search of selected bibliographies and end notes to determine other recent publications of a similar nature. Some germane
articles were copied and several recently published books were purchased or procured through the university library.

A descriptive outline for the potential handbook was then drafted. It was sent to selected local experts in the field to obtain suggestions regarding general format and specific content areas.

**Handbook Development**

Employing the historical research method, a handbook was developed which answers the following questions: Is group therapy effective as a primary treatment method with children and adolescents who have been sexually abused? Which type(s) of group structure is most effective in treating this population? What is the role of the therapist? What content areas need to be addressed and how should they be ordered with regard to sequence and time frame? What is the significance of peer dynamics within the group and how do these dynamics shape desired outcome?

The primary conceptual structure used in the accompanying handbook is integrative. This takes into account the thinking, feeling, and behaving dimensions of human experience. Although it is recognized that many clients benefit from catharsis, the belief subscribed to here is that some kind of cognitive work is also essential in order to gain the maximum benefit. For this the
cognitive-behavioral approaches are drawn upon heavily (Corey & Corey, 1992).

Also emphasized is the significance of helping group members to identify and express their feelings. The experiential therapies, such as Gestalt and person-centered, are considered of value. This allows clients to release buried feelings and enables them to work through emotional barriers (Corey & Corey, 1992).

Underlying the integrated focus on thinking, feeling, and behaving is a philosophical inclination toward the existential approach, in which primary emphasis is placed on the role of responsibility in the therapeutic process. The assumption is that much of what is done in groups occurs because people exercise their freedom to change situations. Within the group context individuals have opportunities to learn how to use the freedom they have (Corey and Corey, 1992).

Evaluation Procedures

Following the development of the first draft of the handbook, it was submitted to a panel of eight experts to judge the content for accuracy and utility. The experts are all professionals involved in some aspect of mental health treatment of sexually abused adolescents and/or children. They include:
1. Two university professors;
2. An adjunct university professor who specializes in group work;
3. The treatment coordinator at a large community-based mental health agency which uses groups as a primary treatment mode for children and adolescents who have been sexually abused;
4. Two private therapists with expertise in the area of child sexual abuse, and who have experience working with children's groups;
5. A social worker/therapist who utilizes group therapy in a church-related social services agency;
6. The director of adolescent programs at a large psychiatric hospital.

A copy of the handbook (Appendix A) a cover letter, and an evaluation form (Appendix F) was given to each evaluator in order to carry out the evaluation process. They were asked to judge the material for ease in reading, length, clarity, content, and format. All participants were asked to return the manuscripts and completed evaluation forms within approximately 2 1/2 weeks from the time the materials were received. The evaluations were tabulated and summarized and suggested changes to the handbook were effected.
SUMMARY

A survey of need was conducted and, using historical and descriptive research methods, a handbook was developed. It was submitted to an panel of experts in the field for evaluation.
CHAPTER 3

RESULTS, EVALUATIONS AND CONCLUSIONS

Introduction

The purpose of this thesis is to develop a handbook for mental health counselors in group practice with children who have been sexually abused. The expected benefit of the handbook is an increase in awareness of some basic components of effective group counseling with this population.

The handbook was submitted to eight mental health professionals for evaluation. Included in this group were: two university professors, an adjunct university professor who specializes in group work, the treatment coordinator for a community-based agency which focuses on the treatment of sexual abuse, two therapists who work with sexually abused children and adolescents in a group setting, a social worker who utilizes group therapy in a church-related social services agency, and the director of adolescent programs at a local psychiatric hospital. The evaluation was returned by seven of the eight professionals.
Evaluation Results

The results of the evaluation were encouraging, but revealed the need for some editing of the manuscript. In addition to responding to specific items on the evaluation sheet, the reviewers offered a number of suggestions which will be helpful in improving the overall usefulness of the handbook.

Questionnaire

The questionnaire was divided into eight areas. The first and second questions asked for a "strength of response" along a continuum. Responses ranged from 1 (most positive) to 7 (most negative), with the exception of "Too Long" in which 4 was the optimum reply. Questions three through eight required a hand-written answer. The replies to each question are indicated and will be discussed separately. Percentages are rounded to the nearest whole number for convenience.

Handbook Evaluation

1. Generally I found the information (please circle response);

Easy to Read 1 2 3 4 5 6 7 Difficult to Read
RESPONSE: 57% 43%
All respondents indicated that they found the handbook easy to read, with four (57%) placing it in the optimally readable category.

The length of the handbook is the area in which most of the respondents felt improvement is needed, with five of the seven reviewers indicating that this is a problem area. One (14%) reported length to be a major concern.

Clarity appears to be an area of strength for the handbook. All seven respondents rated it as being clear or mostly clear.

All respondents indicated that the handbook is informative: One person stated that she "wanted more" information in the area of specific interventions within a
group. Another reviewer indicated that the treatment models were not balanced (i.e., considerably more information was provided for latency age groups than for adolescent groups).

2. The Format is:

Easy to Follow 1 2 3 4 5 6 7 Difficult to Follow
RESPONSE: 14% 72% 14%

According to the reviewers the format of the handbook is generally easy to follow. One respondent suggested placing the sections in a different order to facilitate the general flow of information.

3. I would like more information on: Treatment models, particularly those addressing the needs of adolescents; differences between in-home and out-of-home sexual abuse; reasons why some populations appear to be more at risk, and whether ethnic and demographic differences relate to reporting patterns (i.e., frequency of reporting); long-term effects and data regarding suicide, self-mutilation, drug use in children who have been sexually abused;
4. I would like less information on: Theory.

5. I would like clarification on: Privileged communication and who is exempt; Duty to report; what a protective order entails;

6. I would omit: no recommendations for omissions were suggested.

7. I would add: more information regarding court appearances; more clarification of therapist goals and how these may impact court appearances (i.e., types of questions that may be asked, typical ways of responding and how the court has responded in certain types of situations); more information on adolescent group models.

8. Additional comments or suggestions: "Well done!"; "The introductory sections were solidly presented and academically sound. As a 'handbook' perhaps long. This is a dilemma—so I wouldn't recommend rewriting. Nice summary of the issues."; "I think of a 'handbook' as something that gives me info on how to better work—it's 'hands on' vs. a research tool. In places it is a little too 'research like.' I feel the need for more immediate hands on
information."; "It's great!"; "I think this is really an improvement over your original draft. It may be a bit long given the population who will read it. Otherwise, I really like it."

Statement of General Response by Evaluators
The evaluators responded favorably to the handbook. The feedback indicates the content successfully addresses some areas of professional concern, and that this type of publication may be helpful to group counselors who work with sexually abused children.

Projected Changes Prior to Publication
Many of the suggestions made by the evaluators will be incorporated into the handbook in order to make it optimally useful. For example, author/publisher reprint permission will be obtained where indicated and proper citation will be provided. Appropriate summaries will also be provided at the end of each section.

In addition, research will be done to find additional data which can be applied to adolescent groups, and the adolescent model will be expanded. This will be done to more closely correlate the volume of material found in the adolescent and latency-age models.
The Criminal Code of the State of Arizona will be reviewed to determine what the law says about mandatory reporting requirements for counselors. More information will also be gathered regarding counselor accountability, and guidelines regarding documentation of client contact will be expanded.

Possible Uses of the Handbook

The handbook is intended as a resource for mental health counselors with limited experience in group work with sexually abused children. It is also helpful to professionals who have experience in the field. For the counselor with interest in further study, the handbook includes a sizable list of references. Although its contents specifically address the needs of children, much of the information contained in it also has application to groups made up of adults molested as children.

Summary

Professional responses to the survey regarding the Handbook were tabulated and discussed. Recommendations for additions and deletions were provided and suggestions, positive comments, and opinions were reviewed. Projected changes prior to publication were introduced.

The evaluation indicates the usefulness of the information presented in the handbook. Some of the
material contained in it is not easily accessed in any other single source and it appears to be useful in filling an information gap for counselors who work with sexually abused children.
CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS AND SUMMARY

Sexual exploitation of children is not new. Although there has been recent growth in awareness of child sexual abuse, a corresponding growth in the quantity of systematic research of its impact and treatment has not ensued, and there is still relatively little empirical literature to guide treatment planning. As a result many counselors feel unprepared to work with this population.

The group approach to treatment of child sexual abuse has the largest amount of data to support it and appears to be the type of therapy most frequently used. The focus in this study is on group therapy in the clinical setting because that is where the majority of the information is based.

A survey ascertained the general availability of information about group work with sexually abused children. Following a careful review of information from a variety of different sources, including professional literature and state laws and regulations, a handbook was formulated. It was then piloted by a panel of experts in the field, who offered suggestions for improving its clarity and usefulness.
The result is a handbook for mental health counselors who do group work with sexually abused children and adolescents. It is well formatted, concise, and useful.

Conclusions

This thesis resulted in a practical handbook for use by group counselors who work with sexually abused children and adolescents. The principal purpose of this project is to assist in effective orientation of group leaders. It also has value as a reference resource. A leading assumption of the handbook, however, is that the various techniques and "cook book" interventions used in group treatment are never the focus in group work. The focus must be on the leader, group members and the quality of the interactions between them (Corey, et al., 1992). This puts emphasis on the need for counselors to develop their own interest, background, and skills in working with children and adolescents in groups.

Recommendations for Handbook Use

Research confirms that groups are an effective method in satisfying many of the therapeutic needs of adolescents and latency-age children who have been sexually abused. The handbook is intended as a resource, and will be useful in assisting group counselors to more clearly understand group treatment process and how to use it more effectively.
It is expected that the information provided in the handbook will motivate professionals in the field to enhance academic backgrounds, acquire additional skills in group work, increase fundamental respect for clients, and pursue further study of group processes. The sections dealing with documentation, the court, and malpractice are expected to increase counselor awareness of salient legal concerns and thereby assist in avoiding unnecessary and possible legal difficulty in these areas.

The handbook will be useful in workshops and courses which offer training to counselors. One possible application is to use it as extra course material in a graduate or undergraduate class in which the use of group treatment is discussed.

Recommendations for Future Research

Child sexual abuse is a relatively new topic for research. Many of the most up-to-date studies have not yet been published or are difficult to obtain, and the individuals investigating this problem do not come from the same discipline or methodological tradition. Thus, there has been little opportunity for scholars and practitioners in the field to come together and develop consensus regarding treatment methodology (Finkelhor, 1986).
The majority of published studies address the treatment needs of latency-age girls in the context of structured groups. This leaves a serious gap of information regarding effective group strategies for other populations of children including: (1) boys, and (2) members of cultural minorities.

**Cultural Minorities:** The cross-cultural record is a rich, but largely untapped resource for assessing the antecedents and consequences of sexual conduct with children. Since research in group therapy has focused primarily on Anglos or culturally-mixed groups of children, the extent to which the findings are generalizable is unknown (Oates, 1991).

Many identifiable (and often not so identifiable) minority groups make up our population, and each has its own unique background and heritage. Until recently, the training of mental health providers and researchers has not addressed the special needs of these people. The therapeutic and research communities simply have not been prepared to be culturally responsive (Newlon & Arciniega, 1992).

Sexual exploitation of children, however, knows no cultural or ethnic boundaries. Child sexual abuse researchers must develop an awareness of ways in which cultural factors affect treatment strategies. Study and
refinement of those approaches which appear to be productive must be vigorously pursued, and the unique needs of sexually abused children within these populations appropriately addressed.

**Boys:** A Psych-Lit computer search in the university library yielded few articles regarding group treatment for sexually abused boys. Likewise, a review of tables of content and indexes in a number of current (1985 to the present) text and reference books on child sexual abuse produced few references to the specific treatment issues and concerns of boys. This is in spite of the fact that in a recent study (Finkelhor, et al., 1990) 16% of men acknowledged being molested in childhood.

**If Dreams Came True**

The ideal world would allow each child who has been sexually abused to receive a comprehensive assessment, a carefully prepared treatment plan, and a professional support "team" made up of fully qualified and caring mental health providers. Each therapeutic step would be systematically evaluated and no time or cost factor would hinder therapeutic efforts (Hindman, 1991).

Unfortunately, this ideal world does not exist for the vast majority of sexual abuse victims. Children who receive treatment are often placed in therapy that is conducted in settings with limited resources and
opportunities, and guided by counselors with limited exposure to critical training and information. This handbook is one step in the direction of expanding vital counselor knowledge to bring the dream more in line with reality.

**SUMMARY**

This study utilized a historical research design. Following a careful review of the literature a handbook was constructed. A panel of experts in the field reviewed the manuscript and provided feedback regarding its content, clarity, and potential use by group counselors who work with sexually abused children.

Recommendations for additions, deletions, and changes in format and content were provided. Suggestions, comments, and opinions were reviewed and a number of changes were incorporated.
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INTRODUCTION

Entering the world of treatment with sexually abused children invokes a variety of responses, and a counselor's feelings of anxiety and inadequacy may undermine effectiveness. This may be particularly true in group treatment settings with leaders who have limited training or experience with groups (Donigian & Malnati, 1987).

PURPOSE

The purpose of this handbook is to orient group counselors working with sexually abused children and adolescents. Emphasis is on practical applications, supported by relevant theory, practice, and research. Legal and ethical information is also addressed.

A primary assumption is that the focus is on the leader, group members, and the quality of the interactions between them rather than techniques used in group treatment. The importance of developing interest, background, and skills in working with children and adolescents in groups is underscored (Corey, et al., 1992).

This handbook is to be used as a guide. While it is not a definitive presentation of group constructs, the information contained in it is offered to stimulate an interest in more productive group leadership by encouraging counselors to develop sound theoretical foundations, engage in an exchange of ideas with other group therapists, and participate in relevant workshops.

HISTORY OF GROUP TREATMENT

Group counseling can be traced to the early 1900's when Joseph H. Pratt, a Boston physician, first used the "class" method to provide support to patients with tuberculosis. At approximately the same time, another physician, J. L. Moreno, began developing psychodramatic
methods in Vienna, Austria. By the 1920's Alfred Adler, also in Vienna, had initiated group
guidance procedures for the family (Capuzzi & Gross, 1992).

In 1947, a multidisciplinary group of practitioners and researchers from community and
university settings throughout North America attended a history-making conference in Bethel,
Maine. Here the National Training Laboratory (NTL) in Group Development of the National
Education Association (NEA) held its first "laboratory session." It was here that training groups
and the laboratory method were born. This precipitated a variety of marathon and encounter
groups and helped foster an era of openness, self-awareness, and getting in touch with feelings
(Bradford, Bigg & Benne, 1964). In spite of highs and lows of societal enthusiasm and
apprehension regarding the use of groups, the 60s and 70s was a time of intense interest in group
work for professionals involved in providing mental health care (Capuzzi & Gross, 1992).

During the 1980's use of the group format with specialized populations such as alcoholics,
incest victims, adults molested as children, underassertive individuals, overweight people, and
victims of violent crimes began to proliferate. The increasing specialization brought with it a need
for higher standards of preparation for group leaders evidenced by development of ethical
standards for group work professionals (Association of Specialists in Group Work, 1983). In 1988
the Council for the Accreditation of Counseling and Related Educational Programs included in its
standards specific group work specialist preparation guidelines for the graduate-level university
educator.

In the current decade, and doubtless beyond, the use of group counseling will continue to
grow (Capuzzi & Gross, 1992). Because little is known about how groups work and what makes
them effective, it is likely that consumers and funders will increase their demands that practitioners
demonstrate the value of their therapeutic strategies. For specific clinical populations, participation
in and application of research results will be of primary importance (Capuzzi & Gross, 1992).
SECTION I

INCIDENCE AND EFFECTS OF CHILD SEXUAL ABUSE

Increasing numbers of child sexual abuse cases are being reported each year and, although it occurs at all socioeconomic levels, certain groups of children appear to be more at risk.

Common physical and behavioral indicators of sexual abuse have been identified (Gil & Edwards, 1988; Brown, 1991; Finkelhor, 1986).

Incidence

Child sexual abuse is not uncommon but the actual number of children affected by it is not known (Gil & Edwards, 1988). Clear, precise statistics are limited due to variation in definitions and lack of consistency in reporting (Everstine & Everstine, 1989).

Sexually abused children live with secrecy and isolation and only a small number reveal the abuse experienced during childhood (Finkelhor, 1984). Current information shows a range between 15% to 45% of women, and 3% to 16% of men report being molested as children (Everstine & Everstine, 1989; Finkelhor, et al., 1990).

Distribution

While sexual abuse occurs at all socioeconomic levels, it is not randomly distributed. Certain segments of society are more at risk (Everstine & Everstine, 1989).

Risk Factors

- Preadolescent
- Unhappy family life
- Absence of biological mother or father
- Spousal violence
- Step families or foster families
- Large families

Effects

Physical and behavioral characteristics common to many sexually abused children are:

Initial effects:
- Fear
- Anxiety
- Nightmares
- Phobias
- Regressive behavior
- Somatic complaints
  (Kitchur & Bell, 1989; Browne & Finkelhor, 1986; Gill & Edwards, 1988)
Progressive deterioration in functioning

Without intervention the initial effects of child abuse can produce progressive deterioration that is a precursor for more serious complications in adolescence and adulthood (Browne & Finkelhor, 1986; Kitchur & Bell, 1989).

Long-term effects
- Aggressive behavior
- Anger and hostility
- Interpersonal problems
- Guilt and shame
- Sleep and eating disturbances
- Dissociation
- Interpersonal problems
- Physical symptoms
- Powerlessness
- Psychopathology
- Running away
- Truancy
- Inappropriate sexual behaviors (Finkelhor, 1986; Brown, 1991)

Other Consequences
In addition to behavioral effects, children's beliefs, values and attitudes are influenced and shaped by sexual abuse. Victimization erodes positive self-concept and shatters three basic assumptions about the world:

- Belief in personal invulnerability
- Sense of personal invulnerability
- Perception of the world as meaningful and predictable (Brown, 1991).
Table 1

**Behavioral Indicators of Sexual Abuse**

- Sexually precocious, seductive, or sexual acting out
- Abnormal knowledge about sex or sex acts
- Radical mood swings
- Sense of impending danger
- Changes in eating habits
- Boredom with same-age peers or activities
- Nightmares or sleep disturbances
- Change in school performance, including radical improvement in grades (overachieving)
- Depression
- Substance Abuse
- "Damaged goods" syndrome
- Hostile behavior
- Fear of being photographed
- Anxiety toward authority figures
- Refusal to disrobe in gym class
- Pseudomature
- Overcompliant
- Aggressive
- Babyish or clinging behavior
- Bedwetting
- Attention-getting behavior, beyond normal
- Recruiting other peers into involvement with adults
- Suicidal tendencies
- Inability to trust
- Hints regarding sexual abuse
- Unexplained fears
- Self-mutilation or other self-injury
- Hyperactivity, inability to concentrate

### Table 2

**Physical Indicators of Sexual Abuse**

- Sexually transmitted disease
- Bruising or bleeding on any area of body or sexual areas
- Frequent stomach or digestive pain
- Somatic illnesses
- Urinary tract and yeast infections
- Colon problems
- Weight loss/gain
- Purging
- Foul odor from sexual organs
- Discharge from sexual organs
- Lubricant residues around vagina and rectum
- Persistent sore throats
- Strong gagging reflex
- Unexplained gifts
- Exhaustion


### Table 3

**Behavioral Indicators of Caretaker**

- Is extremely jealous, overprotective, or overinvolved with the child, prohibiting normal socialization with peers
- Has a distorted perception of the child's role in the family; sees child as adult, or mate, and seeks to interact on that level
- Has extremely low self-esteem; seems to need unconditional love and approval; feels threatened by peers
- Has inadequate coping skills
- Marital or sexual difficulties
- One adult is physically or emotionally unavailable, while the other adult seeks comfort or attention from child disproportionately
- Lacks social and emotional contacts outside the family
- Abuses alcohol or drugs

Table 4

**Adolescent Rape: Some Symptomatology**

- Sudden personality change
- Rapid drop in school performance
- Withdrawal from school or social activities
- Flagrant promiscuous behavior
- Sudden phobic behavior
- Withdrawal from social activities
- Obvious self-destructive, risk-taking behavior
- Drug abuse
- Eating disorders such as bulimia or anorexia
- Sudden unexplained alienation from peers or family

(Hilberman, 1976; Everstine & Everstine, 1983; as cited in Everstine & Everstine, 1989, p. 74).
SECTION II

WHY GROUPS?

According to Hindman (1991) an ideal world would allow each child who has been sexually abused to receive a comprehensive Sexual Victim Trauma Assessment. Emerging from the assessment would be a carefully prepared treatment plan with a professional treatment team to implement it. Every child, rich or poor, would receive optimal therapy, carefully designed for complete rehabilitation. Each therapeutic step would be systematically evaluated. There would be no time or cost factor to restrict efforts.

Unfortunately, for most sexually abused children this ideal world does not exist. In reality, sexual victims receive less attention than their offenders. Children who receive treatment are often placed in therapy that is conducted in settings with a narrow range of resources. (Hindman, 1991).

While groups have been effective in treating sexually abused children (Knittle & Tuana, 1989; Mandell & Damon, 1989; Capuzzi and Gross, 1992), the broad challenge for therapists and supporting treatment teams is to demonstrate creativity and commitment to the process (Furniss, 1991).

How Do Groups Help?

Therapeutic change is an enormously complex process and occurs through a complex interplay of various guided human experiences (Yalom, 1985).

Therapeutic factors of the group

Yalom (1985) refers to the essential ingredients of change in human behavior as the "therapeutic factors." They include:

1. Instillation of hope
2. Universality
3. Imparting of information
4. Altruism
5. The corrective recapitulation of the primary family group
6. Development of socializing techniques
7. Imitative behavior
8. Interpersonal learning
9. Group cohesiveness
10. Catharsis
11. Existential factors (p. 3).

"...these factors may represent different parts of the change process; some . . . refer to
actual mechanisms of change. . . others may be more accurately described as conditions for
change" (Yalom, 1985, p. 4).

The corrective emotional experience

Intellectual insight alone is insufficient (Franz, 1946; as cited in Yalom, 1985). In order to
be helped the child must undergo a corrective emotional experience which is suitable to repair the
influence of previous traumatic events. It is critical that children feel the group to be a safe and
supportive place which allows differences, honesty of expression, and feedback, creating an
environment in which effective-reality testing may be experienced (Yalom, 1985). They are then
able to integrate new behaviors and feelings which enable the development of a stronger and

Focus Within the Group

Group treatment for sexually abused children has traditionally focused on:

- Healthy socialization (Fowler et al., 1983),
- Restoring self-respect (Delson & Clark, 1981),
- Externalizing and working through conflict
  (Carozza & Heirsteiner, 1982),
- Clarifying the dynamics of sexual abuse (Sturkie, 1983),
- Education and prevention (Pescosolido & Petrella, 1983).

Ego strength and Group therapy

Multimodal treatment, with special emphasis on groups, is recommended for victims
(Berman, 1990). The group process is a dynamic, therapeutic tool producing change, and individual
members must have the ego strength to participate and experience positive benefits. Insufficient
ego stamina can compound rather than correct the negative experience of abuse (Powell &

Children's Need for Social, Communication
and Problem Solving Skills

The indirect effects of sexual abuse often hinder children's ability to profit from an insight-
oriented group. They may enter treatment behaving immaturely for their age. These indirect
effects -- developmental delays in social growth -- are considered to result from the social isolation
of their families. Direct teaching of social, communication, and problem-solving skills is
considered effective for decreasing developmental delays. Group participation is enhanced by
listening to others, identifying feelings, expressing empathy, and recognizing, cause and effect
relationships in human interactions (Berman, 1990).
Treatment Issues

Long (as cited in Rencken, 1989) has adapted Sgroi’s treatment issues for victims of sexual abuse to the younger population. These are summarized as follows:

1. "Damaged goods" syndrome. This refers to self-, familial and societal perception of the child as different, used, vulnerable, and perhaps partly to blame.
2. Guilt. Children may feel they are the cause of the chaos and confusion in the home, absence of the father, and "strange" reactions of the mother.
3. Fear. Fear of abandonment is primary for children.
4. Depression. It is usually related to anxiety and somatic complaints (particularly stomach pain), listlessness, and "spacey" behavior.
5. Low self-esteem and poor social skills. This relates to feelings of powerlessness and helplessness. It may manifest itself by withdrawal, bossiness, or highly controlling behaviors in dealing with peers or adults.
7. Inability to trust. This may be the most important issue, particularly in intrafamilial abuse. It may be aggravated by the duration of the contact and amount of physical pain or discomfort experienced.
8. Blurred role boundaries and role confusion. The child perceives significant problems with regarding who is in charge of the family and questions who is responsible for protection. Importance of the mother as a strong protective person in the recovery process is emphasized.
9. Pseudomaturity and failure to complete developmental tasks. This is related to power issues. The child is put into an inappropriately powerful role and does not move through developmental stages in sequence. This includes issues of sexualization, but also affects physical, cognitive, and affective development.
10. Self-mastery and control. The child feels no sense of control or options. Regaining these options is an important goal of treatment (pp. 70-71).

Length of Treatment

Estimates regarding the need for length of treatment varies from short-term (less than 6 months) to longer term (over a year) depending on the level of trust achieved and the overall stability in the child’s life (Rencken, 1989; Yalom, 1985).

Termination

As the course of therapy nears its conclusion, it is important to evaluate the progress which has been made toward long-term treatment goals. According to MacFarlane, et al. (1988) there are a number of indicators which signal that the child may be ready to terminate treatment. These include:

- Feelings of guilt, fear, anger, confusion, and depression have been sufficiently addressed.
- The specific nature of the molester, the methods of coercion, and negative and positive feelings about what occurred have been dealt with.
- There are decreased feelings of responsibility for the sexual behavior, the turbulence following disclosure, and the disruption to the family.
- Anger and hostility at the perpetrator for the molester and the mother for lack of protection have been confronted.
- There is evidence of trust in the mother (or a trusting relationship with another significant adult) and she is seen as a protector.
- There is awareness of the earlier confusion between sex and affection.
- There is an ability to set limits on sexual advances.
- There is a capability to seek help in the event of another inappropriate sexual approach.
- There is an overall increase in social skills.
- Outside social contacts and activities have been developed.
- Age-appropriate activity is evidenced.
- Ego boundaries have been strengthened.
- There is a better feeling about self.
- The child is generally more trustful (p. 240).

**Different Needs of Adolescents, Latency Age**

The varying developmental needs of children have implications for group boundaries. While flexible, open-ended groups may work well with adolescents, time-limited, structured groups may best suit the relationship needs and concrete thinking style of preadolescents (Berliner & Ernst, as cited in Kitchur & Bell, 1989). The exercises employed in structured group environments may serve as a guide for individual work (Mandel & Damon, 1989).
SECTION III

EFFECTIVE GROUP LEADERSHIP

In this section the usefulness of theory in group work, personal characteristics desirable in group leaders, and basic skills needed for effective leadership are addressed.

Theory and the Group Counselor

The counselor's orientation influences the way he or she functions within groups (Corey & Corey, 1992). Identified variables, including relationship, leader role, member role, process, and outcome are influenced by the group leader's theoretic/therapeutic position. A sound ideological basis is vital for effective group practice (Capuzzi & Gross, 1992). It may be said that:

Attempting to lead groups without having an explicit theoretical rationale is like flying a plane without a flight plan. Though you may eventually get there (and even find detours exciting), you're equally likely to run out of patience and gas and do nothing but fly aimlessly in circles. Group leaders without any theory behind their interventions will probably find that their groups never reach a productive state (Shapiro, 1978, p. 7).

Theory

- Is not a rigid, step-by-step prescription of how a counselor should function
- Serves as a general framework that helps the therapist make sense of the many facets of group process
- Gives direction to what is done and said in a group
- Helps in thinking through the possible results of particular interventions
- Is most useful if it relates closely to one's own values, beliefs, and characteristics (Corey & Corey, 1992, p. 7)

Cognitive map

Theoretical orientation is a cognitive map, although not fixed. Continual rethinking of theoretical orientation in group practice is emphasized because this enables the therapist to recognize how human nature is viewed and influences the selection of techniques.

'Front' and 'core' of group therapy

It is important to separate "front" from "core" in group therapy. The front consists of trappings, form, techniques, specialized language. The core (theory) consists of those facets of therapeutic experience intrinsic to the process; the bare-boned mechanisms of change (Yalom, 1985).

Group therapists must develop their "core." Effective group leadership demands an intellectual support base from which to function. From this base come the general guidelines of group therapy (Donigian & Malnati, 1987).
Counselor values and personality

A meaningful theoretical perspective reflects the counselor's own values and personality. Developing a well-defined and integrated theoretical model takes time and requires reading and practice in leading groups (Corey & Corey, 1992).

Formulation of a personalized theory

Theory guides practice and is ongoing. Observations develop into a systematic order and explain predictability. Leadership styles are developed consistent with desired therapeutic outcomes (Corey & Corey, 1992).

Some questions which need to be answered are:

- Can (children and adolescents) be trusted to determine their own direction in a group, or do they need strong intervention to keep them moving productively?
- Should the goals of the group be determined by the members, the group leader, or both?
- Should the group leader function as a facilitator? director? expert? consultant? resource person?
- How much responsibility for the group's work lies with the leader? with the members? To what degree should the group be structured by the leader?
- What techniques are best for a particular group and why?
- How can techniques be introduced that will maximize individual progress and link the work of several members simultaneously?
- How can the success of a group be measured?

(Corey & Corey, 1992, pp. 7-8).
SECTION IV

PLANNING AND MAINTAINING AN EFFECTIVE GROUP

Goals for Groups

It has been suggested that group leaders working with children who have been sexually abused develop two sets of goals; general and process:

General goals

These initiate a psychological environment which supports children as they work toward personal goals. They may include:

- Constructive release of feelings
- Strengthen self-esteem
- Face and resolve problems
- Improve skills in recognizing and resolving interpersonal and intrapersonal conflicts
- Enhance ability to consolidate and maintain therapeutic gains (Capuzzi & Gross, 1992, p. 7).

Process goals

Process goals teach (children) appropriate ways to share their concerns and provide feedback to others (Corey, et al., 1992).

Therapeutic Relationships

Positive client change and a good therapist/client relationship is the most consistent empirical finding in psychotherapy literature (Dies, 1983).

Developmental Concerns

Important developmental tasks occur during latency and adolescence and sexual abuse hinders progress through these phases. Therapy must:

- Address the traumatic effects of the sexual abuse
- Enhance age-appropriate skills
- Focus on improved socialization
- Teach respect for self and others
- Strengthen impulse control and reality testing (Mandell & Damon, 1989).

To the extent that abuse at an earlier age is unresolved, the child organizes internal thinking and interpersonal relationships around the traumatic experience. The world is perceived as a dangerous place in which victimization and victimizing are normal (Friedrich, 1991).
The Structured Format

From the developmental perspective the structured format is beneficial and positive results have been documented (Colman, et al., 1985; Haugard & Reppucci, 1988; Damon & Waterman, 1986). This type of treatment curriculum has certain key elements. Included are:

1. A structure that reinforces awareness and respect for boundaries, decreases anxiety, and gives clear direction to children, their caretakers, and therapists.
2. Therapist expectations of the group.
3. Assurance that all salient issues of the molest and disclosure within the age context will be given significant importance and attention.
4. Introduction and arrangement of material congruent with the children’s level of readiness.
5. Formalized activities which help children to organize their thoughts and thereby increase their sense of mastery.

Organization

For therapy to be useful, information is introduced in ways that decreases anxiety and allows children to guard newly acquired defenses. When themes are presented in a sequence of progressive difficulty, and coincide with comfort and confidence in the group, treatment is greatly enhanced (Mandell & Damon, 1989).

Discomfort and conflict are often manifested in behavioral symptoms rather than verbal communication. A structured and directive group treatment program assists sexually abused children to experience relief, achieve confidence and mastery, develop age-appropriate defenses, and enjoy the beginnings of mutually respectful and gratifying friendships (Mandell & Damon, 1989).

Critical Incidents in Groups

There are moments when critical incidents evolve as natural consequence of group development. These present either barriers or opportunities for growth. The way the therapist manages such incidents determines how group development proceeds (Donigian & Malnati, 1992).

Incident #1: The initial session

How can the initial session and the way in which it is handled have an important effect on the future of the group? (Donigian & Malnati, 1987, p. 81).

Incident #2: A deep disclosure near session termination

When a relatively nonverbal group member suddenly discloses deep feelings near the end of a session how does the way it is handled by the therapist affect the individual? the group? (Donigian & Malnati, 1987, p. 153).

Incident #3: A group member maintains distance

How does the therapist deal with a group member who sets him/herself apart from the rest of the group. What are some ways to interpret the individual’s behavior? the behavior of other group members? (Donigian & Malnati, 1987, p. 181).
Incident #4: A member chooses to leave

When a group member suddenly discloses that this his or her last session what effect may the therapist response have on the person and on other group members? (Donigian & Malnati, 1987, p. 133).

Client Characteristics, Change, and Group Relationships

There are client characteristics which facilitate the group processes. They include:

- the ability to trust and be trusted;
- a moderate need for social approval.

Group composition is the immediate interplay of these client attributes and whether they blend so the group "jells" quickly and interacts therapeutically (Fuhriman & Burlingame, 1990). "Underneath all the activities lies the assumption that . . . change is based on the exploration and reworking of relationships in the group" (Lieberman, 1977, as cited in Fuhriman & Burlingame, 1990, p. 9).

Within a group, the counselor continually moves the focus from outside to inside, from abstract to specific, and from general to personal. Group members are taught to request and offer feedback, and good timing and an understanding of what individuals within the group are experiencing become important elements of the corrective experience (Yalom, 1985).

Responsible leadership compels the counselor to understand basic group constructs, carefully follow ethical guidelines, receive sufficient training to be able to employ skilled interventions and seek continual supervision and peer review. These are needed if individual participants are to receive the maximum benefit from the group experience (Corey, 1990).

Considerations Before the Group Begins

1. Take responsibility for getting needed training and supervision. Avoid undertaking a group that is clearly beyond your scope.
2. Maintain and upgrade knowledge and skills. Take courses and professional workshops.
3. Know what state law says regarding the practice of group work. Be aware of ways to decrease possibilities of becoming involved in a malpractice suit.
4. Develop screening skills that help you determine if an applicant is suitable to the group. Be able to explain to prospective participants or their parents your expectations of them, the techniques you will use, and the ground rules governing the group. This helps to ensure partnership in the group.
5. When working with minors, strive to bring the parents into the process.
6. Discuss the importance of confidentiality. Stress that confidentiality in the group cannot be guaranteed.
7. Before the group begins help prospective group members assess potential psychological risks of participation.
8. Articulate a theoretical orientation that guides your practice and provides a rationale for your interventions.
Early Stages of a Group's Development

1. Clarify the purposes of your group. Ensure that your techniques and methods are appropriate.
2. Be aware of the impact of your personal values on group members. Expose rather than impose your values.
3. Be aware of cultural differences and diversity. Modify techniques to fit the needs of various cultural and ethnic groups.
4. Monitor your behavior, and be conscious of what you are modeling in the group.
5. Remain alert to ways in which your personal reactions to members may inhibit the group process. Monitor your countertransference. Avoid using the group for your own therapy.
6. Pay attention to how resistance affects you. Be aware of the role resistance plays in the group process.
7. Be alert for symptoms of psychological debilitation in group members which may indicate their participation should be discontinued. Be able to refer appropriately.
8. Protect the rights of individual group members (refer to Client Rights, Table 9, p. 95).
9. Show genuine respect for group members.
10. Be aware of current research findings.
11. Communicate regularly with supervisor, co-leader.
12. Assist members in evaluating their own progress (pp. 48-49).

Consideration During Later Stages of Group Development

1. What kind of modeling are you providing? Are you willing to do in your life what you encourage group members to do?
2. Be concerned about promoting members' independence from the group. Use only interventions which empower members and encourage taking responsibility for their own healing.
3. Use only those techniques for which you are trained.
4. Encourage feedback about sessions. Help group members develop personal feedback skills.
5. Help participants deal with negative reactions from others as they apply group learning to daily life. Encourage development of a support system outside the group.
6. Help members translate what they have learned in group to daily life. Consider the use of written or verbal contracts they will put into action after leaving the group.
7. Seek consultation. Continued supervision is a hallmark of a good group counselor (p. 50).

SECTION V

TREATMENT MODELS

Preteen or Latency Age Treatment Model #1

The following is an adaptation of a model offered by Berman (1990) and is an open-ended, structured format designed as a primary mode of treatment. It provides a long(er)-term, highly intensive experience which uses an insight-oriented strategy from a developmental, skill-building perspective. Unique features include an emphasis on the direct and indirect effects of sexual abuse on each child. Individual treatment goals are focused on the special needs of each participant.

The children work on individual and group goals while participating in physical activities, games, dramatic scripts, and discussion groups. These activities help them to understand the direct effects of sexual abuse in terms of low self-esteem, poor body image, role confusion, precocious sexual adjustment, loss of personal control, and guilt.

Children entering a group come with different levels of social skills. In this model, each one is assigned goals according to low, medium, and high levels of difficulty. Focus is placed on social skills because these are considered important in developing constructive relationships with peers and adults. It is assumed that to master high-level goals a child would first master the low and then medium levels (Table 5, p. 67-68). This structure ensures that the group does not lose track of someone's individual recovery needs while issues common to everyone are pursued.

Format

At the beginning of each (eight to) ten-week period old goals are reviewed and the group leader determines, using clinical judgement, whether a child is ready to move on to another goal at the same or higher level of difficulty. At the end of each (eight) to ten-week period goals are reviewed and the children are encouraged to give each other constructive feedback on their individual levels of progress.

Each child works on his or her own personal goals while participating in (90 minutes) of activities that stress the general group goals of increasing social, communication, and problem-solving skills. The session is divided into activity time and serious discussion time.
Activity time

During activity time, the children engage in structured activities such as jazzercise, games, etc. Activity time has three main purposes: to help children unwind and therefore promote better concentration later in the session; to develop constructive peer relationships through cooperative play; and to foster a healthy body image. It can be noted that as the group’s level of cooperative play increases, the children’s ability to participate in more direct discussion with less aid of a physical activity is enhanced.

Serious discussion time

During serious discussion time, important family and peer problems are discussed. Sexual abuse is a recurrent topic and discussions may include the dynamics of the victim, abuser, and family; dealing with others who may have known about the abuse; and body image and understanding one’s own sexuality.

Themes

Specific themes can be addressed during each session. These might include:

- Disclosure
- The offender(s)
- Families
- Trust
- The nonprotective parent
- Body Education
- Why offenders offend
- Sex Roles
- Court
- Prevention
- Saying "goodbye" to the group
  (Kitchur & Bell, 1989)

Possible additional topics are:

- The right to say "no"
- Self-portraits
- Anger
- Relationships
- Meeting strangers safely
- Touching with people you know quite well
- Yes and no feelings; secrets
- Touching with people you know very well
- Telling someone
  (Powell & Faherty, 1990; Nelki and Watters, 1989)

Some participants engage more easily, take part more effectively, and demonstrate more growth during treatment. Regular attendance is a major factor when determining high vs. low group achievers. When parents voluntarily consent to parallel treatment, probability of success is heightened (Berman, 1990).
Table 5
Example of Low-, Medium-, and High-Level Goals

<table>
<thead>
<tr>
<th>Low-Level Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physical self-Control</td>
</tr>
<tr>
<td>Share, take turns, follow instructions, stay with the group.</td>
</tr>
<tr>
<td>2. Verbal Self-Control</td>
</tr>
<tr>
<td>Don't interrupt, speak assertively, apologize when appropriate.</td>
</tr>
<tr>
<td>3. Talk appropriately in the Group</td>
</tr>
<tr>
<td>Be honest, use an appropriate voice level, stay on the topic.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medium-Level Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recognize personal feelings</td>
</tr>
<tr>
<td>Notice mood changes in oneself, express one's feelings and possible reasons for one's feelings.</td>
</tr>
<tr>
<td>2. Recognize the feelings of others</td>
</tr>
<tr>
<td>Be a good listener, notice when another (person's) mood changes.</td>
</tr>
<tr>
<td>3. Express the feelings of others</td>
</tr>
<tr>
<td>Explain possible reasons for other persons' feelings, express empathy for the feelings of others.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High-Level Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Talk about everyday problems</td>
</tr>
<tr>
<td>Discuss school performance, sibling and peer relationships.</td>
</tr>
<tr>
<td>2. Talk about serious problems</td>
</tr>
<tr>
<td>Discuss parental divorce, physical or sexual abuse, neglect.</td>
</tr>
<tr>
<td>3. Help others talk about serious problems. Encourage others to talk about problems, offer moral support.</td>
</tr>
</tbody>
</table>

Preteen or Latency Age Model #2

Powell & Faherty (1990) present a treatment plan designed to address specific needs of latency age victims of sexual abuse. The treatment incorporates theories of creative arts therapies and group process, and provides a time-limited psychoeducational intervention that is used as a first intervention with young victims.

This model addresses the developmental stage of latency and is designed for sexually abused girls. Many of the concepts, however, are applicable to boys and adolescents and can be used with these populations effectively (Rencken, 1989).

Primary focus of treatment
The treatment plan is designed to assist group counselors in developing their own treatment plans and is not to be viewed as a rigid recipe for working with child survivors (Powell & Faherty, 1990).

Behaviors and implications for treatment
Behaviors commonly exhibited by sexually abused children, include:

- guilt
- fear
- depression
- low self-esteem
- poor social skills
- anger
- inability to trust
- denial
- blurred boundaries
- role confusion
- immaturity
(Powell & Faherty, 1990, p. 35)

The primary focus of treatment is to strengthening the child's ego. To produce positive therapeutic results it is important for group counselors to understand thoroughly the dynamics of sexual abuse on latency age children (Powell & Faherty, 1990).

Introductory Phase
The goal is to establish a safe and trusting environment. Because sexually abused children often come from family environments with few boundaries, learning to trust and feel safe is frequently difficult.

Group activities are designed to introduce members to the leader(s), and to the other children (Mandell & Damon, 1989). Verbal communication is often hard for these children and the creative arts therapies provide less stressful ways to assess and treat. Children are engaged through
picture drawing related, either directly or indirectly, to the traumatic events (Powell & Faherty, 1990).

Beginning stages of treatment include nonthreatening interactive activities (puppets and self-portraits). Sharing of introductory information about themselves is encouraged. There is discussion and role play about self-protection and safety issues. (Powell & Faherty, 1990).

**Commonality of Experience Phase**

Group members begin to share their individual experiences and feelings related to the abuse. Children in this age-group often feel they alone have had this experience. Participating in a group with other victims lessens the sense of isolation and results in an increased sense of self-worth and connectedness (Capuzzi & Gross, 1992; Yalom, 1985; Erikson, 1980).

Children are offered activities which allow sharing of feelings through creative play and dialogue. Anger, often suppressed but always present in these children, is dealt with as normal, healthy, and necessary (Powell & Faherty, 1990).

**Integration Phase**

Children are prepared to deal directly with their own experiences. They feel safe in the therapeutic environment and internalize that others share their feelings and experiences. They begin the process of a corrective experience by reworking the trauma.

It is important that each child understand what has occurred will not be forgotten, but a new and less agonizing view with the abuse will be developed. It is important to clarify that sexual abuse is an abuse of power committed by an out of control adult (Sgroi, 1982). Activities include a psychoeducational session about perpetrators, and each child shares what happened to him or her.

By now the children have created a cohesive, supportive, and trusting group that provides the strength needed to face the trauma of sexual abuse directly. The result is a clearer understanding of each person's role in the abuse; whether it is victim, significant other adult, or perpetrator (Powell & Faherty, 1990).

**Termination Phase**

This final stage is critical and significant issues surrounding separation and loss must be addressed within the group. There is no standard or typical termination (Rencken, 1989) and concerns about loss and separation relating to both the family and group arise. (Corey & Corey, 1992).

**Treatment Plan**

**Session I: Introduction and Puppet Play**

Goal: To initiate group process through review of treatment goals explained at the screening interview. The use of puppets helps children explore feelings about the family. It helps the children get to know each other in a fun, yet interactive way.
Session 2: The right to say "No" and Self-Protection

Goal: To educate and explore different possibilities for self-protection. Development of a strong sense of self-protection is vital to minimize further possible victimization (Furniss, 1991; Rencken, 1989).

Session 3: Self-Portrait

Goal: To draw a self-portrait. This is a diagnostically important activity to measure individual self-image (Kelley, 1984). See Figures 1 and 2.

Session 4: Private Parts

Goal: To clarify boundary issues as related to the child's body and to discuss issues of control and touching.

Session 5: Anger

Goal: To identify, act out, and release angry feelings in a safe way; receive support for anger.

Session 6: Relationships and "Sex Questions Grab Bag"

Goal: To address issues of "healthy" relationships and give an occasion to ask questions about sexuality and physical changes in their bodies. This session allows group members to differentiate between past adult abuse of power and future relationships that foster an equal balance of power with trust and intimacy. Children learn about hormonal changes taking place in their bodies and how these changes may affect body image.

Session 7: Mothers

Goal: To allow children to address both positive and negative feelings toward their mother or mother figure.

Sessions 8 & 9: Initial Disclosures

Goal: To share initial disclosures; how, who, and why you told about the sexual abuse by using art, psychodrama. By using group process, drawing, and role play, children experience release of emotions related to their disclosure. Prior to these sessions, it is essential that group cohesiveness, trust, and safety be established.

Session 10: Fantasy

Goal: To allow children to try out new roles through fantasy. The "remasking" process of dressing-up in a guilt-free atmosphere can be empowering and enjoyable. It is important to include this session, at some point, in every treatment plan as it allows the group to be creative and take a break from sexual abuse issues. Therapy provides old or fantasy clothing, accessories (Cinderella, etc.).
Sessions 11 & 12: What Happened to You?

Goal: To share sexual abuse experience victims need to be able to work through the feelings experienced at the time of the abuse by retelling the story in a safe and caring environment. As with "initial disclosure," children often display some anxiety and resistance prior to sharing this information.

Sessions 14 & 15: Sexual Abuse Drama

Goal: To encourage children to further integrate and assume control over their sexual abuse through role play. This activity can take up to four sessions to complete. Through dramatic reenactment children gain an understanding of the different roles portrayed (i.e., perpetrator, sibling, mother, investigator, and victim). The role play allows for a corrective experience.

Session 16: Self-Portraits and Good-Byes

Goal: To draw final self-portrait. By comparing second portraits with the first, progress in self-image can be visually observed. Original self-portraits are brought to the session and children comment on any changes they notice.

Self Portrait by Child
Fig 2

Portrait of an Offender by Child
Adolescent Treatment Model

The professional literature offers a number of treatment models for adolescents. What follows is a composite developed from formats offered by Rencken (1989), Hazzard, et al., (1986) and Knittle and Tuana (1980).

Although many of the therapeutic concerns addressed with younger ages apply to adolescents, sexually abused teenagers have additional therapeutic needs that are unique. These include:

- Minimize self-destructive behavior
- Resolve emotional conflicts
- Change negative self-images
- Promote the normal developmental tasks of adolescence (Knittle and Tuana, 1980)

General format

A useful group seems to be one in which group members can, with guidance from the group leader, determine the group direction as they express conflicting feelings, explore self-doubts, and come to the realization that they share common concerns with their peers (Corey, 1990).

Dealing with emotional constriction

As they enter therapy, many sexually abused adolescents are initially very emotionally constricted. Structured exercises can be useful in decreasing anxiety and initiating discussion about personal issues. "Ice breakers" are helpful when a new member joins the group. These may include:

- One-to-one interviews between group members,
- Drawings focused on questions such as:
  "What animal would you like to be and why?"
  "What is your favorite activity?"
- "Go around" exercise where each member shares one "happy" and one "unhappy" event from the preceding week (Hazzard, et al., 1986, p. 220).

Therapeutic concerns

The increased independence of adolescents has four major implications for counselors:

1. There is a significant resistance to treatment because often there is not a strong incentive to reunite with the family and, specifically, the offender.
2. There is a clear danger of runaway behavior.
3. The risk of suicide remains throughout the treatment process.
4. Dissociative behaviors are not uncommon. Counselors must be alert to statements or behaviors that indicate "tuning out" (Rencken, 1989, p. 76).
Role of the therapist

The therapist helps the adolescent victim resolve important issues (see p. 49) relating to the still-evolving sense of self and deal with issues relating to developing sexuality. (Hazzard, et al., 1986; Everstine & Everstine, 1989). The key to a successful adolescent group is in the therapist’s ability to implement group process to provide corrective emotional experiences.

Developmental considerations

Adolescence is a period of transition. It is a time for testing limits, rejecting dependency ties, and establishing a new identity. Most of all, it is a time of conflict. This is seen in the contrast between wanting to break away from parental control and fearing the consequences of independent decisions (Corey, 1990).

Seven Therapeutic Themes

Seven themes have been categorized as either short-term or long-term issues. It should be noted that any of these themes may occur at any point throughout the course of therapy (Hazzard, et al., 1986).

Short-term issues

- Emotional reactions of others. One of the first concerns of the abused adolescents’ is the reactions of others to the disclosure of sexual abuse. Many feel guilty and may blame themselves. Often the disclosure results in much turmoil and chaos within a family and the adolescent may feel responsible for creating a family crisis. As they develop the ability to cope with the impact of others’ reactions, they can move toward deeper exploration of their own feelings.

- Court Testimony. The prospect of testifying in court is an area of immediate concern. Adolescents are fearful that the judge and others will not believe them. They are anxious about seeing their assailants, whom they fear might harm them when released in the future. When issues surrounding court appearances are addressed in group, it tends to demystify the experience. This includes the acquisition of coping strategies, such as deep breathing to relax and looking at a supportive person’s face while testifying.

- Personal Emotional Reactions. These reactions usually include anxiety, anger, depression, and guilt. Some adolescents develop phobias and may feel anxious in situations or with people who remind them of the abuse incident(s).

Long-term issues

- Family Relationships. Expressing and working through feelings about both parents is a critical issue, particularly for children who have experienced intrafamilial sexual abuse. Most have mixed feelings of anger, pity, loyalty, and love towards the significant adult who was the perpetrator. In cases where the family is attempting to remain intact, a central goal is to rebuild a positive parent-child relationship while maintaining the child’s rights to express anger about sexual abuse or other issues. In cases where the father-daughter relationship appears to be permanently severed, it is important not to ignore feelings of positive attachment and mourning which may underlie expressions of anger or indifference.

- Mother-daughter relationships are frequently conflicted. In incestuous families this dyad is particularly stormy. Girls are typically angry at their mothers for perceived lack of nurturance and protection. For some girls, however, it is difficult to acknowledge these angry feelings because of the fear of total abandonment.
- Interpersonal Relationships. The experience of sexual abuse leads to a deep distrust of others, particularly males. Difficulties with interpersonal relationships are often compounded by the victim's experience of isolation, limited nurturance, and blurred interpersonal boundaries within the family. The adolescent may have difficulty with intimate relationships and/or may adopt a "victim" role in relationships.

- Sexuality. Recent studies suggest that a large percentage of rape and incest victims experience sexual adjustment difficulties as adults. These include: fear of sex, desire problems, orgasmic dysfunctions, sexual-orientation confusion, or promiscuity. In the study by Hazzard, et al., (1986) sexual behavior patterns involved either avoidance or promiscuity and most of the girls had limited or inaccurate knowledge about sexual functioning, even if they were sexually active.

- Self-Esteem and Self-Assertion. These are tied to other key issues. As adolescents become better able to assertively and appropriately express themselves, their relationships typically improve. They then are able to acknowledge their individual strengths. (Hazzard, et al., 1986, pp. 214-218).

Length of therapy
The therapy group should be available from 6 to 12 months and may be followed by a support group. The support group continues the validation and empowerment process, including assertiveness and sex education. The support group can deal with typical adolescent concerns such as relationships, school, and career with an emphasis on how these concerns may be affected by the abuse (Rencken, 1989).
SECTION VI

CHILDREN'S GROUPS AND COUNSELOR ACCOUNTABILITY

There is little in the counseling literature concerning documentation and record keeping (Snider, 1987). Mental health professionals, however, are beginning to learn the importance of adequate records and how they benefit both the client AND the counselor (Piazza & Baruth, 1990).

Documentation

In the best interests of clients, keeping data in the form of written notes is recommended. A primary reason is to ensure a smooth transition in treatment if a change in therapists should occur (Everstine & Everstine, 1989). The records demonstrate justification for a counselor's actions and are a part of counselor accountability (Snider, 1987).

The primary purpose of the record...is not only to document that treatment occurred but also to facilitate the coordination and continuity of services, to assist in evaluation of the client's condition and progress, and to evaluate the success or failure of treatment. Ultimately, the record should exist to serve the client. (Soisson, et al., 1987, p. 501, as cited in Christensen, 1991).

Guidelines for documentation

Case notes document client progress toward treatment plan goals. Piazza & Baruth (1990) suggest specific guidelines which include the following elements:

1. A statement of the counselor's goals for the session showing a logical connection to previous sessions with the client. Goals should be flexible to allow for pressing, immediate client concerns.
2. An evaluation of goal attainment for the session delineating what techniques or interventions worked and/or failed, and what might have been done differently.
3. Clinical impressions that are based on client behavior or statements.
4. Plan of action for the next session, indicating the ongoing goals of treatment. (p. 315)

What to include in client records

Essentially, the counselor writes what can be ascertained from some other public sources of information. In addition, the counselor documents certain actions that were taken as a part of his or her legal duties of care toward the client and the community: specifically, such actions as making a Tarasoff (1976) warning, making a report of child abuse or neglect, and/or establishing a no-suicide contract with the client. If accurately recorded, this action is not likely to harm the client and may serve to protect the therapist (Everstine & Everstine, 1989).

DePauw (1986) summarizes record-keeping recommendations of the American Psychological Association "Specialty Guidelines for the Delivery of Services by Counseling Psychologists." The following are the minimum which should be included in counselor notes:
- Identifying data
- Date of services
- Significant actions taken
- Outcome at termination (p. 305)

The APA guidelines also stipulate that:

1. Records be completed within a reasonable time
2. Records be retained for the length of time specified
3. A system be established to protect confidentiality
4. Special safeguards be used when electronic data systems are involved

There is general agreement that clinical notes should be written as soon after the session as possible. The counselor who waits to update clinical notes will find those notes less helpful in court than those written very shortly after a session (Greenlaw, 1982, as cited in Christensen, 1991).

What NOT to include in client record

According to Soisson, et al., (1980, p. 500, as cited in Christensen, 1991) there are six areas of information that are not contained in the record. These include:

- No guarantee of results
- No over optimism for treatment outcome
- No hunches or value judgements
- No emotional statements
- No personal opinions
- No information about illegal behavior, sex practices or other sensitive information that may embarrass or harm the client or others.

The general rule is to omit whatever one would not want to hear if it were to be read aloud in a court of law. Generally, the concept is to NOT write that which could only be learned about the client from a therapy chart (Everstine & Everstine, 1989).

Counselor Records and the Court's 'Right to Know'

Problems associated with record keeping usually come from the clinician's lack of knowledge concerning the workings of the legal system and courts. Counselors are aware that, from the viewpoint of those administering justice, any information which assists in making a just decision is within the scope of their "right to know." In other words, any knowledge possessed by someone who is in some way connected with a court case "belongs" to the court (Everstine & Everstine, 1989).

Documentation and the Malpractice Suit

Although it can be said that clinical notes contribute to good practice, counselors sometimes cite the likelihood of subpoena as a reason for keeping no notes. However, Watkins & Watkins (1983) state:

...it is ...prudent to record all treatment decisions, and, where appropriate, the reasons therefore (p.68).
In a malpractice suit inadequate records usually count against the counselor and in favor of the client (Beahrs, 1990). Malpractice suits commonly take five years between the time of the alleged incident until the time of the trial, (Wills, 1987, as cited in Christensen, 1991) and the record is often the most reliable evidence of proper diagnosis and treatment: (Soisson, et al., 1987, p. 499, as cited in Christensen, 1991).

The Counselor and the Court

Most professional counselors can expect to testify in a court of law at some point during their career. The testimony may be given in the role of defendant, plaintiff, expert witness, or friend of the court (Krieshok, 1987). The appearance may take place in a number of judicial settings including: family, juvenile, civil, or criminal court. The subpoena is a common manner for summoning the counselor to appear (Bennett, et al., 1990).

Subpoena

A subpoena is simply a court-sanctioned demand that a person become a witness in a court proceeding. The subpoena by itself does not automatically void counselor-client privileged communication. This stands until the client explicitly waives it or until the court determines it no longer exists. Failure to comply with a subpoena can be construed by the judge as "contempt of court" and the counselor who refuses can be punished (Everstine & Everstine, 1989).

Subpoena duces tecum

This requires that the witness (counselor) bring to court specific physical evidence, such as client records (Everstine & Everstine, 1989). When files are subpoenaed everything in the file must be turned over with no alterations or abridgements (Whittington, 1988, as cited by Christensen 1991). The counselor may lodge a protest of such orders with the judge, but may not refuse to comply (Hopkins & Anderson, 1990).

Protective order

When testimony is requested about a client, the client’s attorney should ask the judge for a protective order. This limits the areas about which the counselor must testify (Krieshok, 1987).

When Appearing in Court

Christensen (1991) offers the following advice to counselors who must appear in court:

- Dress and behave conservatively.
- Arrive on time, sit quietly outside the courtroom, avoid conversation with the litigants, and leave after making your appearance.
- Be yourself.
- Testify only within the area where your expertise is clear.
- Maintain the neutral position of an unbiased third party.
- Avoid the use of pompous mental health jargon.
- Maintain a professional style and even temperament (even when the challenge is discourteous).
- Avoid over-elaboration.
- When necessary concede on requisite issues in order to maintain an honest and creditable posture.
- Avoid personal, social or moral statements (pp. 229-230).
SOAP Method of Documentation

One standard pattern for recording client sessions is the Subjective, Objective, Assessment, and Plan (S.O.A.P.) (see Table 6, p. 88). The results of a recent survey of Arizona counselors indicate that 67% of those who use a specific method of record keeping use the S.O.A.P. or a modified S.O.A.P. method (Christensen, 1991).
Table 6
S.O.A.P. Progress Notes Form

Client:

Date: _____________________________  Session # _________________________

SUBJECTING (what client said)

OBJECTIVE (counselor observations)

ASSESSMENT (counselor impressions)

PLAN (intervention)

TREATMENT
Some Ways to Reduce the Chance of Personal Litigation

To avoid malpractice suits, the group leader must follow reasonable, ordinary, and prudent practices. Mental health providers protect themselves from lawsuits by practicing within the boundaries of competence. Knowing and following ethical standards as developed by the ASGW is important. Guidelines for translating the terms reasonable, ordinary, and prudent into specific actions are:

1. Provide potential members of your groups with enough information so they are able to make informed choices about if and how they choose to participate in the group.
2. Know the legal limitations and state laws that govern group counseling and maintain these boundaries. Inform members about legal limitations such as exemptions to confidentiality and mandatory reporting.
3. Don’t promise group members anything that you can’t deliver. Help them understand that their degree of effort and commitment will be keys to the outcomes of their group experience.
4. When working with minors, always secure written permission from their parents or guardians.
5. When in doubt, consult with colleagues. This indicates a high level of professionalism.
6. Learn to effectively assess and intervene in cases in which clients pose a threat to themselves or others.
7. Spend the necessary time to screen, select, and prepare the members of your group.
8. Avoid mixing professional and social relationships.
9. Be able to explain the techniques you use in groups. Have a theoretical perspective to support your rationals (Corey, 1990, pp. 39-40).

SECTION VII

SOME LEGAL AND ETHICAL CONCERNS

There are a number of important legal and ethical issues with which the group counselor should become acquainted. Included are (1) counselor limitations, (2) client rights, (3) informed consent, (4) duty to warn, (5) reporting, (6) counselor accountability, (7) documentation and record keeping, and (8) the court.

Limitations for New Group Counselors

The reputation of group counseling has suffered from irresponsible practitioners. It is imperative that group leaders provide only those services and use only those techniques for which they are qualified by training and experience. Group leaders must recognize their personal limitations. Questions to be asked include:

- What kinds of clients am I capable of dealing with?
- What are my areas of expertise?
- What techniques do I handle well?
- Am I able to work well with children and adolescents who have been sexually traumatized?
- When should I seek consultation about a client?
- When should I refer a client to someone else?
(Corey & Corey, 1992, p. 41).

Promote the Welfare of the Client

As stated in Section B1 of the AACD Ethics Standards, (1988) the primary obligation of the (group) counselor is to "respect the integrity and promote the welfare of the client (child), whether . . . assisted individually or in a group relationship. In other words, the therapist's primary obligation is to intervene in such a way as to promote the overall welfare of the child (Peterson, 1990).

Professional Consultation

There are times when clear and simple decisions must be made. Working within the guidelines of established ethical codes will be a beginning, but it is important to ground group practice on sound, responsible, and informed judgement. Consult with colleagues and get continued supervision and training (Corey & Corey, 1992).
Client Rights and Responsibilities

The Association for Group Work (ASGW, 1989) has established ethical guidelines for providing information about services to prospective clients. Participants have certain rights and responsibilities (See Table 9, p. 95).

The leader also stresses that participation in the group brings certain responsibilities. Some of these include:

- Attend regularly
- Be prompt
- Take reasonable risks within the group
- Be willing to talk about yourself
- Give feedback to others
- Maintain confidentiality
- Ask for what you need from the group

(Corey, 1990, pp. 25-26)

Client Information

The responsible group practitioner is clear about how information received from clients is handled. Counselors must be familiar with certain definitional terms. This protects the counselor as well as the client (Corey, 1990).

Privileged communication

This relates to the courts and is a notion of law which is:

The legal right that protects clients from having their confidences revealed publicly from the witness stand during legal proceedings without their permission (Mappes, et al., 1985, p. 248).

Privileged communication is established by law and applies only when a professional, who has been legally granted that privilege, is called into court as a witness (Hopkins & Anderson, 1990). It protects confidential information given to the counselor by a client from being disclosed during legal proceedings (Rinas & Clyne-Jackson, 1988; De Kraai & Sales, 1982).

Confidentiality

This is an ethical idea and is often confused with privileged communication, which is a legal concept. It respects a client's right to control personal information and to access it.

The notion of confidentiality posits that the therapist has a moral, ethical, and professional obligation not to divulge information without the client’s knowledge and authorization unless it is in the client’s interest to do so (Corey, et al., 1988). Generally, the privilege to waive confidentiality belongs to the client and not to the professional (Schwartz, 1989). Confidentiality is:

...an ethical standard of conduct that requires professionals to prevent disclosure to third parties of any information communicated by patients or clients in the course of the professional relationship. ... (Butz, 1985, p. 84).
Privacy

This is a term derived from moral philosophy. It identifies the right of a person to choose what others may know about him/her and under what circumstances it will be disclosed (Stadler, 1986).

Privacy is defined by Siegel (1979, p. 250; as cited in Peterson, 1990) as "the freedom of individuals to choose for themselves the time and the circumstances under which and the extent to which their beliefs, behavior, and opinions are to be shared or withheld from others." Information obtained in clinical or consulting relationships is to be discussed only in professional contexts and only with persons clearly concerned with the case.

Sensitive material revealed by a client to the therapist can be an area of concern for new counselors. It has been shown that by following in a systematic way the guidelines of the Association for Specialists in Group Work (ASGW), and American Association for Counseling and Development (AACD) the best interest of the client can usually be protected. In situations of reported abuse the therapist must continually ask "who"requires "what"information, then provide only that. It is imperative that each practitioner develop a system for handling client information prior to the need for its use (McWhirter and Okey, 1989).

Informed consent

Informed consent is based "on the philosophy of individual freedom and choice and pertains to the rights of an individual" (Bray, et al., 1985, p. 51). The informed consent principle holds that clients be given adequate information in order to become "active participants in the therapeutic relationship" (Corey, et al., 1988, p. 168).

A client cannot, under any circumstances, be encouraged to consent to professionally unacceptable or illegal treatment. In such situations, the counselor may be held liable for wrongdoing even though the client gave consent (Leesfield, 1987, as cited by Christensen, 1991).

The Duty to Warn

There are exceptions to the client rights as stated above. "The protective privilege ends where the public peril begins" (Tarasoff Court). In 1974 a legal precedence was set. It states that therapists are to exercise reasonable care to protect potential victims. The court also ruled that whereas confidentiality is to be highly valued, it is not to be regarded as an absolute (Christensen, 1991).

This means that, although rulings vary from state to state, the therapist has an obligation to act if a client makes general threats against individuals or property (Herlihy & Sheeley, 1988).
Table 8

**Information Clients Deserve before Joining a Group**

* a clear statement regarding the purpose of the group
* group format, procedures, and ground rules
* a pregroup interview to determine whether this particular group with this particular leader is at this time appropriate to one’s needs
* an opportunity to seek information about the group, to pose questions, and to explore concerns
* a statement describing the education, training, and qualifications of the group leader
* information concerning fees and expenses and whether the fee includes a follow-up session; also information about the length of the group, frequency and duration of meetings, group goals, and types of techniques being employed
* psychological risks involved in group participation
* limitations of the confidential character of the group; i.e., circumstances in which confidentiality must be broken because of legal, ethical, or professional reasons
* clarification of what services can and cannot be provided within the group
* help from the group leader in developing personal goals
* a clear understanding of the division of responsibility between the leader and participants
* a discussion of the rights and responsibilities of group members (Corey, 1990, p. 25).


Table 9

**Client Rights During the Course of a Group**

* instructions concerning what is expected
* freedom to leave the group if it is not what was expected or needed
* notice or any research involving the group and of any tape recording or videotaping of group sessions
* if recording does take place, the right to stop it if it restricts member participation
* opportunities to discuss what has been learned in the group and to have closure to the group experience
* consultation with the group leader should a crisis arise as a result of participation
* reasonable safeguards on the leader’s part to minimize potential risks of the group
* respect for member privacy as to what will be revealed and the degree of disclosure
* freedom from undue group pressure
* observance of confidentiality by group leader and other group members
* freedom to choose own values
* opportunity to use group resources for growth
* the right to be treated as an individual (Corey, 1990, p. 26).

SECTION VIII

EVALUATION

The evaluation of group therapy effectiveness is viewed in two forms: (1) as an evaluation of the counselor's own group leadership skills; (2) as an assessment of the direction the group is taking and its level of productivity for both the group and individuals within the group.

Evaluations are addressed in both private and group discussions. The use of a written evaluation or checklist is recommended (Corey, 1990).

Assessing Group Leadership Skills

It is not unusual for beginning group counselors to feel overwhelmed when contemplating all the skills needed for effective group leadership. Like other kinds of skills, group-leadership mastery exists in degrees, and is not an all-or-nothing proposition. Through training and supervised experience, constant improvement can be achieved (Corey, 1990). An overview of leadership skills is presented in Table 12, p. 101-102.

Assessing group direction and productivity

It is difficult to objectively assess group and individual outcomes by using objective measures. Subtle changes in attitudes, beliefs, feelings, and behavior are not easily measured by tests and inventories (Corey, 1990).

A review that centers on the personal and subjective views of the individual participants seems to provide the clearest information regarding effectiveness in a group experience (Rogers, 1970). Some of the subjective procedures typically used are client and therapist "reaction" statements (verbal and written), and individual postgroup interviews.

90 Day Review

Another possible assessment tool for evaluating the effectiveness of sexual abuse treatment groups has been designed by Wortman (1992). It is used on an ongoing basis and is administered to each group participant at three-month intervals. It is reviewed with each child individually and is signed by both the counselor and group participant (see Table 10, p. 80).
Table 10

TREATMENT REVIEW OF SERVICES

90 Day Review

Date: ____________________

Client Name: ________________________________________________________________

Date of Services __________

Therapist Name _____________________________________________________________

MODE OF COUNSELING: INDIVIDUAL_____ GROUP_____ NO. OF SESSIONS_____

1. Progress Toward Treatment Goals:
   A. 
   B. 
   C. 
   D. 

2. Progress Toward Treatment Plan Objectives:
   A. 
   B. 
   C. 
   D. 

3. Problems Hindering Treatment Progress (Specify Client/Agency Based):
   A. 
   B. 
   C. 
   D. 

4. New Treatment Plan Objectives:
   A. 
   B. 
   C. 
   D. 

5. Changes in Treatment Plan:
   A. 
   B. 
   C. 
   D. 
Table 10. Treatment Review of Services (Cont.)

6. Anticipated Length of Treatment:________________________________

7. Change in DSM III-R Diagnosis:

AXIS I__ AXIS II__ AXIS III__ AXIS IV__ AXIS V__

SIGNATURE OF CLIENT:

__________________________________________

SIGNATURE OF THERAPIST/PROVIDER:

__________________________________________
Suggestions for Helping Clients Track And Assess Therapeutic Progress

1. Ask clients before entering the group to write their concerns and expectations from the group.

2. Encourage group members to keep an ongoing journal of experiences within the group and in their everyday lives between sessions. This helps to focus on relevant trends and key issues they are discovering about themselves and others through the group interaction.

3. After the group ends, ask members to write a reaction statement or paper before the follow-up meeting. This gives participants an opportunity to recall significant happenings in the group and provides an opportunity to discuss specific things within the group which were liked or disliked.

4. Offer a brief questionnaire in which the members evaluate the techniques used, the group leader, the impact of the group on them, and the degree of change experienced because of their participation in the group. Possible questions might include:

- Did the group have any positive effects on you?
- How has the group influenced you in relation to others?
- Have changes been lasting?

(Corey, 1990, p. 138-139).

Table 11

### Table 12
OVERVIEW OF GROUP LEADERSHIP SKILLS

<table>
<thead>
<tr>
<th>Skills</th>
<th>Description</th>
<th>Aims and Desired Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>Attending to verbal and non-verbal communication w/o judging or evaluating</td>
<td>To encourage trust, self-disclosure, and exploration</td>
</tr>
<tr>
<td>listening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restating</td>
<td>Saying in slightly different words what a participant has said (clarify meaning)</td>
<td>To determine if the leader has understood client's statement</td>
</tr>
<tr>
<td>Clarifying</td>
<td>Simplifying client statements by focusing on the core of the message</td>
<td>To help client sort out conflicting &amp; confused feelings</td>
</tr>
<tr>
<td>Summarizing</td>
<td>Pulling together the important elements of interaction or session</td>
<td>To avoid fragmentatation, give direction provide continuity</td>
</tr>
<tr>
<td>Questioning</td>
<td>Asking open-ended questions that lead to self-exploration of &quot;what&quot; and &quot;how&quot; of behavior</td>
<td>To elicit further discussion; get information; stimulate thinking; to increase clarity &amp; focus</td>
</tr>
<tr>
<td>Interpreting</td>
<td>Offering possible explanations for certain behaviors, feelings, &amp; thoughts</td>
<td>To encourage deeper self-exploration; to provide a new perspective for understanding behavior</td>
</tr>
<tr>
<td>Confronting</td>
<td>Challenging discrepancies between words &amp; actions or body and verbal messages</td>
<td>To encourage honest self-vestigation</td>
</tr>
<tr>
<td>Reflecting</td>
<td>Communicating understanding of the content &amp; feelings</td>
<td>To let members know they are heard and understood beyond words</td>
</tr>
<tr>
<td>feelings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting</td>
<td>Providing encouragement and reinforcement</td>
<td>To create an atmosphere that encourages continuance of desired behaviors</td>
</tr>
<tr>
<td>Empathizing</td>
<td>Identifying with clients by assuming their frame of reference</td>
<td>To foster trust; understanding, encourage self-exploration</td>
</tr>
<tr>
<td>Facilitating</td>
<td>Opening clear &amp; direct communication w/in the group, helping members assume increasing responsibility for group's direction</td>
<td>To promote effective communication among members; to help members reach own goals in the group</td>
</tr>
<tr>
<td>Table 12. Evaluation of Group Leadership Skills (Cont.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiating</td>
<td>To prevent needless group floundering; to increase pace of group process</td>
<td></td>
</tr>
<tr>
<td>Initiating</td>
<td>Promoting group participation &amp; introducing new directions in the group</td>
<td></td>
</tr>
<tr>
<td>Goal Setting</td>
<td>Planning specific goals for the group process and helping participants define concrete &amp; meaningful goals</td>
<td></td>
</tr>
<tr>
<td>Goal Planning</td>
<td>To give direction to the group's activities; to help members select and clarify goals</td>
<td></td>
</tr>
<tr>
<td>Evaluating</td>
<td>Appraising the ongoing group process and individual and group dynamics</td>
<td></td>
</tr>
<tr>
<td>Evaluating</td>
<td>To promote better self-awareness and understanding of group movement, direction</td>
<td></td>
</tr>
<tr>
<td>Giving feedback</td>
<td>Expressing concrete &amp; honest reactions based on observations of members' behaviors</td>
<td></td>
</tr>
<tr>
<td>Giving feedback</td>
<td>To offer an external view of how the person appears to others; to increase client self-awareness</td>
<td></td>
</tr>
<tr>
<td>Suggesting</td>
<td>Offering advice &amp; information direction, &amp; ideas for new behavior</td>
<td></td>
</tr>
<tr>
<td>Suggesting</td>
<td>To help members develop alternative courses of thinking &amp; action</td>
<td></td>
</tr>
<tr>
<td>Protecting</td>
<td>Safeguarding members from unnecessary psychological risks in the group</td>
<td></td>
</tr>
<tr>
<td>Protecting</td>
<td>To warn members of possible risks in group participation; to reduce those risks</td>
<td></td>
</tr>
<tr>
<td>Disclosing oneself</td>
<td>Revealing one's reactions to here-and-now events in the group</td>
<td></td>
</tr>
<tr>
<td>Disclosing oneself</td>
<td>To facilitate deeper levels of group interaction; to create trust; to model ways of revealing oneself to others</td>
<td></td>
</tr>
<tr>
<td>Modeling</td>
<td>Demonstrating desired behavior through actions</td>
<td></td>
</tr>
<tr>
<td>Modeling</td>
<td>To provide examples of desirable behavior; to inspire members to fully develop potential</td>
<td></td>
</tr>
<tr>
<td>Linking</td>
<td>Connecting the work that members do to common themes in the group</td>
<td></td>
</tr>
<tr>
<td>Linking</td>
<td>To promote member-to-interactions; to encourage the development of cohesion</td>
<td></td>
</tr>
<tr>
<td>Blocking</td>
<td>Intervening to stop counter-productive group behavior</td>
<td></td>
</tr>
<tr>
<td>Blocking</td>
<td>To protect members; to enhance to flow of group process</td>
<td></td>
</tr>
<tr>
<td>Terminating</td>
<td>Preparing the group to close a session or end its late, existence</td>
<td></td>
</tr>
<tr>
<td>Terminating</td>
<td>To help members assimilate, integrate, and apply in-group learning to everyday life (pp. 71-72)</td>
<td></td>
</tr>
</tbody>
</table>

SELECTED READINGS

For Children


For Group Counselors


GLOSSARY OF TERMS

Universally accepted definitions in the area of child sexual abuse have not been established (Association For Advanced Training, 1988; Oates, 1990). In spite of the lack of absolute consensus concerning legal descriptions of sexually abusive situations and behaviors, there are a number of generally accepted definitions helpful to the understanding and treatment of child sexual abuse.

The following is a selected list:

Child, Youth or Juvenile: This refers to an individual who is under the age of eighteen years (Arizona Revised Statutes, 13-3623, A-1)

Confidentiality: ...an ethical standard of conduct that requires professionals to prevent disclosure to third parties of any information communicated by patients or clients in the course of the professional relationship ... (Butz, 1985, p. 84).

Exhibitionist: One who exposes his or her genitals. (Everstine & Everstine, 1989).

Group Therapy: Any form of collective therapeutic treatment. Frequently the process involves group meetings of patients with the therapist, who acts as a discussion leader. It is assumed that hearing other people's problems and how they are being resolved may have both cathartic and therapeutic effects on the individual (Chaplin, 1985).

Incest: Sexual activity between two persons who are not permitted by law to marry. It refers to sexual contact between a child and (a) consanguineal parent; (b) a relative, including a stepparent; or (c) someone who fulfills the role of stepparent, such as a common-law husband or wife who is viewed by the child as a parent surrogate (Everstine & Everstine, 1989).

Intervention: Professional action in child sex abuse, which includes removing a child from the home, counseling the victim, offender, and the family, and legal action.

Molestation: Included within the category of sexual assault. It refers to an adult's caressing, fondling, kissing, or masturbating a child without making bodily penetration (Everstine & Everstine, 1989).

Pedophile: A person who molests prepubertal children. It also refers to any nonfamilial molester of a minor (Everstine & Everstine, 1989).

Privileged Communication: The legal right that protects clients from having their confidences revealed publicly from the witness stand during legal proceedings without their permission. (Mappes, et al.,1985, p. 248),
Rape: Refers to forced penetration of a child’s vagina or anus, either by an adult’s penis or finger, or by an object. Forced oral copulation is another form of rape and is referred to as ‘oral rape’ (Everstine & Everstine, 1989).

Sexual Assault: Any form of adult-child sexual contact in which an adult actually touches, fondles, or penetrates the child’s body (Everstine & Everstine, 1989).

Sexual trauma: Encompasses the entire range of the physical categories, as well as traumatic events of childhood that are of a sexual nature, such as witnessing the "primal scene" or inappropriate or seductive behavior by an adult (Everstine & Everstine, 1989).

Sodomy: Forced anal penetration by penis or finger, or by an object (Everstine & Everstine, 1989).

Trauma: An emotional shock that creates substantial, lasting damage to an individual’s psychological development. It also refers to overwhelming, uncontrollable experiences that psychologically impact victims by creating in them feelings of helplessness, vulnerability, loss of safety, and loss of control. The (child) victim may exhibit severe psychiatric symptoms or may superficially appear symptom-free (James, 1989).

Sexual Abuse: Is complex and thus difficult to define. One widely used definition is that of Schecter and Roberge (as quoted in Oates, 1991, p. 6).

The involvement of dependent, developmentally immature children and adolescents in sexual activities which they do not fully comprehend, are unable to give informed consent to and that violate social taboos of family roles.

Sgroi also give a useful definition that emphasizes the power relationship between the perpetrator and the victim, pointing to the fact that the child has no choice.

Child sexual abuse is a sexual act imposed on a child who lacks emotional, maturational, and cognitive development. The ability to lure a child into a sexual relationship is based upon the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child’s age, dependency and subordinate position. Authority and power enable the perpetrator, implicitly or directly, to coerce the child into sexual compliance (Sgroi, 1982; as quoted in Oates, 1991, p. 6).

A definition offered by Salter (1988, pp. 10-11) defines sexual abuse as sexual activity between a child or adolescent with an adult or another child five years or more older than the child.

Sexual activity . . . include(s) exhibitionism, voyeurism, fondling, oral genital sex, attempted intercourse, "dry" intercourse (rubbing the penis between the thighs or buttocks of a child), intercourse (penetration), photographing or otherwise exhibiting children sexually, exposing children to pornographic literature, and forcing or manipulating children to engage in sexual acts with each other or with animals. Sexual experiences with relatives and violent
or coerced experiences (are) automatically considered sexual abuse regardless of the age differential.

Consenting sexual experiences with nonrelated peers within five years of the child’s age are not considered sexual abuse. Also, there are exceptions to the age-differential criterion when common sense indicates that a particular situation is abusive. For example: manipulated consent of a retarded child by a non-retarded child of a similar age. In this case the chronological age is the same, but the mental age is sufficiently different (Salter, 1988).
APPENDIX B

ETHICAL GUIDELINES FOR GROUP COUNSELORS

(ASGW 1989 Revision)
Ethical Guidelines for Group Counselors (ASGW 1989 Revision)

PREAMBLE

One characteristic of any professional group is the possession of a body of knowledge, skills, and voluntarily, self-professed standards for ethical practice. A Code of Ethics consists of those standards that have been formally and publicly acknowledged by the members of a profession to serve as the guidelines for professional conduct, discharge of duties, and the resolution of moral dilemmas. By this document, the Association for Specialists in Group Work (ASGW) has identified the standards of conduct appropriate for ethical behavior among its members.

The Association for Specialists in Group Work recognizes the basic commitment of its members to the Ethical Standards of its parent organization. The American Counseling Association (prior to July of 1992 known as the American Association for Counseling and Development or AACD) and nothing in this document shall be construed to supplant that code. These standards are intended to complement the AACD standards in the area of group work by clarifying the counselor in the group setting and by stimulating a greater concern for competent group leadership.

The group counselor is expected to be a professional agent and to take the processes of ethical responsibility seriously. ASGW views "ethical process" as being integral to group work and views group counselors as "ethical agents." Group counselors, by their very nature in being responsible and responsive to their group members, necessarily embrace a certain potential for ethical vulnerability. It is incumbent upon group counselors to give considerable attention to the intent and context of their actions because the attempts of counselors to influence human behavior through group work always have ethical implication.

The following ethical guidelines have been developed to encourage ethical behavior of group counselors. These guidelines are written for students and practitioners, and are meant to stimulate reflection, self-examination, and discussion of issues and practices. They address the group counselor's responsibility for providing group counseling services to clients. A final section discusses the group counselor's responsibility for safeguarding ethical practice and procedures for reporting unethical behavior. Group counselors are expected to make know these standards to group members.
1. **Orientation and Providing Information:** Group counselors adequately prepare prospective or new group members by providing as much information about the existing or proposed group as necessary.

   * Minimally, information related to each of the following areas should be provided.
     
   a. Entrance procedures, time parameters of the group experience, group participation expectations, methods of payment (where appropriate), and termination procedures are explained by the group counselor as appropriate to the level of maturity of group members and the nature and purpose(s) of the group.
   
   b. Group counselors have available for distribution, a professional disclosure statement that includes information on the group counselor's qualifications and group services that can be provided, particularly as related to the nature and purpose(s) of the specific group.
   
   c. Group counselors communicate the role expectations, rights, and responsibilities of group members and group counselor(s).
   
   d. The group goals are stated as concisely as possible by the group counselor including "whose" goal it is (the group counselor's, the institution's, the parent's, the law's, society's, etc.) and the role of group members in influencing or determining the group's goal(s).
   
   e. Group counselors explore with group members the risks of potential life changes that may occur because of the group experience and help members explore their readiness to face these possibilities.
   
   f. Group members are informed by the group counselor of unusual or experimental procedures that might be expected in their group experience.
   
   g. Group counselors explain, as realistically as possible, what services can and cannot be provided within the particular group structure offered.
   
   h. Group counselors emphasize the need to promote full psychological functioning and presence among group members. They inquire from prospective group members whether they are using any kind of drug or medication that may affect functioning in the group. They do not permit any use of alcohol and/or illegal drugs during group sessions and they discourage the use of alcohol and/or drugs (legal or illegal) prior to group meetings which may affect the physical or emotional presence of the member or other group members.
i. Group counselors inquire from prospective group members whether they have ever been a client in counseling or psychol-therapy. If a prospective group member is already in a counseling relationship with another professional person, the group counselor advises the prospective group member to notify the other professional of their participation in the group.

j. Group counselors clearly inform group members about the policies pertaining to the group counselor's willingness to consult with them between group sessions.

k. In establishing fees for group counseling services, group counselors consider the financial status and the locality of prospective group members. Group members are not charged fees for group sessions where the group counselor is not present and the policy of charging for sessions missed by a group member is clearly communicated. Fees for participating as a group member are contracted between group counselor and group member for a specified period of time. Group counselors do not increase fees for group counseling services until the existing contracted fee structure has expired. In the event that the established fee structure is inappropriate for a prospective member, group counselors assist in finding comparable services of acceptable cost.

2. Screening of Members: The group counselor screens prospective group members (when appropriate to the theoretical orientation). Insofar as possible, the counselor selects group members whose needs and goals are compatible with the goals of the group, who will not impede the group process, and whose well-being will not be jeopardized by the group experience. An orientation to the group (i.e., ASGW Ethical Guideline #1), is included during the screening process.

* Screening may be accomplished in one or more ways, such as the following:
  a. Individual interview,
  b. Group interview of prospective group members,
  c. Interview as part of a team staffing, and,
  d. Completion of a written questionnaire by prospective group members.

3. Confidentiality: Group counselors protect members by defining clearly what confidentiality means, why it is important, and the difficulties involved in enforcement.

a. Group counselors take steps to protect members by defining confidentiality and the limits of confidentiality (i.e., when a group member's condition indicates that there is clear and imminent danger to the member, others, or physical property, the group counselor takes reasonable personal action and/or informs responsible authorities).
b. Group counselors stress the importance of confidentiality and set a norm of confidentiality regarding all group participant's disclosures. The importance of maintaining confidentiality is emphasized before the group begins and at various times in the group. The fact that confidentiality cannot be guaranteed is clearly stated.

c. Members are made aware of the difficulties involved in enforcing and ensuring confidentiality in a group setting. The counselor provides examples of how confidentiality can non-maliciously be broken to increase members' awareness, and help to lessen the likelihood that this breach of confidence will occur. Group members about the potential consequences of intentionally breaching confidentiality.

d. Group counselors can only ensure confidentiality on their part and not on the part of the members.

e. Group counselors video or audio tape a group session only with the prior consent, and the members' knowledge of how the tape will be used.

f. When working with minors, the group counselor specifies the limits of confidentiality.

g. Participants in a mandatory group are made aware of any reporting procedures required of the group counselor.

h. Group counselors store or dispose of group member records (written, audio, video, etc.) in ways that maintain confidentiality.

i. Instructors of group counseling courses maintain the anonymity of group members whenever discussing group counseling cases.

4. Voluntary/Involuntary Participation: Group counselors inform members whether participation is voluntary or involuntary.

a. Group counselors take steps to ensure informed consent procedures in both voluntary and involuntary groups.

b. When working with minors in a group, counselors are expected to follow the procedures specified by the institution in which they are practicing.

c. Within voluntary groups, every attempt is made to enlist the cooperation of the members and their continuance in the group on a voluntary basis.

d. Group counselors do not certify that group treatment has been received by members who merely attend sessions, but did not meet the defined groups expectations. Group members are informed about the consequences for failing to participate in a group.

5. Leaving a Group: Provisions are made to assist a group member to terminate in an effective way.
a. Procedures to be followed for a group member who chooses to exit a group prematurely are discussed by the counselor with all group members either before the group begins, during a pre-screening interview, or during the initial group session.

b. In the case of legal mandated group counseling, group counselors inform members of the possible consequences for premature self-termination.

c. Ideally, both the group counselor and the member can work cooperatively to determine the degree to which a group experience is productive or counterproductive for that individual.

d. Members ultimately have a right to discontinue membership in the group at a designated time, if the predetermined trial period proves to be unsatisfactory.

e. Members have the right to exit a group, but it is important that they be made aware of the importance of informing the counselor and the group members prior to deciding to leave. The counselor discusses the possible risks of leaving the group prematurely with a member who is considering this option.

f. Before leaving a group, the group counselor encourages members (if appropriate) to discuss their reasons for wanting to discontinue membership in the group. Counselors intervene if other members use undue pressure to force a member to remain in the group.

6. Coercion and Pressure: Group counselors protect member rights against physical threats, intimidation, coercion, and undue peer pressure insofar as is reasonably possible.

a. It is essential to differentiate between "therapeutic pressure" that is part of any group and "undue pressure" which is not therapeutic.

b. The purpose of a group is to help participants find their own answer, not to pressure them into doing what the group thinks is appropriate.

c. Counselors exert care not to coerce participants to change in directions which they clearly state they do not choose.

d. Counselors have a responsibility to intervene when others use undue pressure or attempt to persuade members against their will.

e. Counselors intervene when any member attempts to act out aggression in a physical way that might harm another member or themselves.

f. Counselors intervene when a member is verbally abusive or inappropriately confrontive to another member.

7. Imposing Counselor Values: Group counselors develop an awareness of their own values and needs and the
potential impact they have on the interventions likely to be made.

a. Although group counselors take care to avoid imposing their values on members, it is appropriate that they expose their own beliefs, decisions, needs, and values, when concealing them would create problems for the members.

b. There are values implicit in any group, and these are made clear to potential members before they join the group. (Examples of certain values included: expressing feelings, being direct and honest, sharing personal material with others, learning how to trust, improving interpersonal communication, and deciding for oneself.)

c. Personal and professional needs of group counselors are not met at the members' expense.

d. Group counselors avoid using the group for their own therapy.

e. Group counselors are aware of their own values and assumptions and how these apply in a multicultural context.

f. Group counselors take steps to increase their awareness of ways that their personal reactions to members might inhibit the group process and they monitor their countertransference. Through an awareness of the impact of stereotyping and discrimination (i.e., biases based on age, disability, ethnicity, gender, race, religion, or sexual preference), group counselors guard the individual rights and personal dignity of all group members.

8. Equitable Treatment: Group counselors make every reasonable effort to treat each member individually and equally.

a. Group counselors recognize and respect differences (e.g., cultural, racial, religious, lifestyle, age, disability, gender) among group members.

b. Group counselors maintain an awareness of their behavior toward individual group members and are alert to the potential detrimental effects of favoritism or partiality toward any particular group member to the exclusion or detriment of any other member(s). It is likely that group counselors will favor some members over others, yet all group members deserve to be treated equally.

c. Group counselors ensure equitable use of group time for each member by inviting silent members to become involved, acknowledging nonverbal attempts to communicate, and discouraging rambling and monopolizing of time by members.
d. If a large group is planned, counselors consider enlisting another qualified professional to serve as a co-leader for the group sessions.

9. Dual Relationships: Group counselors avoid dual relationships with group members that might impair their objectivity and professional judgement, as well as those which are likely to compromise a group member's ability to participate fully in the group.

a. Group counselors do not misuse their professional role and power as group leader to advance personal or social contacts with members throughout the duration of the group.

b. Group counselors do not use their professional relationship with group members to further their own interest either during the group or after the termination of the group.

c. Sexual intimacies between group counselors and members are unethical.

d. Group counselors do not barter (exchange) professional services with group members services. Group counselors do not admit their own family members, relatives, employees, or personal friends as members to their groups.

f. Group counselors discuss with group members the potential detrimental effects of group members engaging in intimate inter-member relationships outside of the group.

g. Students who participate in a group as a partial course requirement for a group course are not evaluated for an academic grade based upon their degree of participation as a member in a group. Instructors of group counseling courses take steps to minimize the possible negative impact on students when they participate in a group course by separating course grades from participation in the group and by allowing students to decide what issues to explore and when to stop.

h. It is inappropriate to solicit members from a class (or institutional affiliation) for one's private counseling or therapeutic groups.

10. Use of Techniques: Group counselors do not attempt any technique unless trained in its use or under supervision by a counselor familiar with the intervention.

a. Group counselors are able to articulate a theoretical orientation that guides their practice, and they are able to provide a rationale for their interventions.

b. Depending upon the type of an intervention, group counselors have training commensurate with the potential impact of a technique.
c. Group counselors are aware of the necessity to modify their techniques to fit the unique needs of various cultural and ethnic groups.

d. Group counselors assist members in translating in-group learnings to daily life.

11. Goal Development: Group counselors make every effort to assist members in developing their personal goals.

a. Group counselors use their skills to assist members in making their goals specific so that others present in the group will understand the nature of the goals.

b. Throughout the course of a group, group counselors assist members in assessing the degree to which personal goals are being met, and assist in revising any goals when it is appropriate.

c. Group counselors help members clarify the degree to which the goals can be met within the context of a particular group.

12. Consultation: Group counselors develop and explain policies about between-session consultation to group members.

a. Group counselors take care to make certain that members do not use between-session consultations to avoid dealing with issues pertaining to the group that would be dealt with best in the group.

b. Group counselors urge members to bring the issues discussed during between-session consultations into the group if they pertain to the group.

c. Group counselors seek out consultation and/or supervision regarding ethical concerns or when encountering difficulties which interfere with their effective functioning as group leader.

d. Group counselors seek appropriate professional assistance for their own personal problems or conflict that are likely to impair their professional judgement and work performance.

e. Group counselors discuss their group cases only for professional consultation and educational purposes.

f. Group counselors inform members about policies regarding whether consultation will be held confidential.

13. Termination from the Group: Depending upon the purpose of participation in the group, counselors promote termination of members from the group in the most efficient period of time.

a. Group counselors maintain a constant awareness of the progress made by each group member and periodically invite the group members to explore and reevaluate their experiences in the group. It is the responsibility of
group counselors to help promote the independence of members from the group in a timely manner.

14. Evaluation and Follow-up: Group counselors make every attempt to engage in ongoing assessment and to design follow-up procedures for their groups.

a. Group counselors recognize the importance of ongoing assessment of a group, and they assist members in evaluating their own progress.

b. Group counselors conduct evaluation of the total group experience at the final meeting (or before termination), as well as ongoing evaluation.

c. Group counselors monitor their own behavior and become aware of what they are modeling in the group.

d. Follow-up procedures might take the form of personal contract, telephone contact, or written contact.

e. Follow-up meetings might be with individuals, or groups, or both to determine the degree to which: (i) members have reached their goals, (ii) the group had a positive or negative effect on the participants, (iii) members could profit from some type of referral, and (iv) as information for possible modification of future groups. If there is no follow-up meeting, provisions are made available for individual follow-up meetings to any member who needs or requests such a contact.

15. Referrals: If the needs of a particular member cannot be met within the type of group being offered, the group counselor suggests other appropriate professional referrals.

a. Group counselors are knowledgeable of local community resources for assisting group members regarding professional referrals.

b. Group counselors help members seek further professional assistance, if needed.

16. Professional Development: Group counselors recognize that professional growth is a continuous, ongoing, developmental process throughout their career.

a. Group counselors maintain and upgrade their knowledge and skill competencies through educational activities, clinical experiences, and participation in professional development activities.

b. Group counselors keep abreast of research findings and new developments as applied to groups.

SAFEGUARDING ETHICAL PRACTICE AND PROCEDURES FOR REPORTING UNETHICAL BEHAVIOR

The preceding remarks have been advanced as guidelines which are generally representative of ethical and professional group practice. They have not been proposed as rigidly defined prescriptions. However, practitioners
who are thought to be grossly unresponsive to the ethical concerns addressed in this document may be subject to a review of their practices by the ACA Ethics Committee and ASGW peers.

COMPLAINTS:

* For consultation and/or questions regarding these ASGW Ethical Guidelines or group ethical dilemmas, you may contact the Chairperson of the ASGW Ethics Committee. The name, address, and telephone number of the current ASGW Ethics Committee Chairperson may be acquired by telephoning the ACA office in Alexandria Virginia at (703) 823-9800.

* If a group counselor's behavior is suspected as being unethical, the following procedures are to be followed:
  a. Collect more information and investigate further to confirm the unethical practice as determined by the ASGW Ethical Guidelines.
  b. Confront the individual with the apparent violation of ethical guidelines for the purposes of protecting the safety of any clients and to help the group counselor correct any inappropriate behaviors. If satisfactory resolution is not reached through this contact then:
  c. A complaint should be made in writing, including the specific facts and dates of the alleged violation and all relevant supporting data. The complaint should be included in an envelope marked "CONFIDENTIAL" to ensure confidentiality for both the accuser(s) and forwarded to all of the following sources:

1. The name and address of the Chair-person of the state Counselor Licensure Board for the respective state, if in existence.

2. The Ethics Committee
c/o The President
American Association for Counseling and Development
5999 Stevenson Avenue
Alexandria, Virginia 22304

3. The name and address of all private credentialing agencies that the alleged violator maintains credentials or holds professional membership. Some of these include the following:
National Board for Certified Counselors, Inc.
5999 Stevenson Avenue
Alexandria, Virginia 22304

National Academy for Certified Clinical Mental Health Counselors
5999 Stevenson Avenue
Alexandria, Virginia 22304

American Psychological Association
1200 Seventeenth Street, N.W.
Washington, D.C. 20036

American Group Psychotherapy Association, Inc.
25 East 21st Street, 6th Floor
New York, New York 10010

APPENDIX C: Part II

Arizona Revised Statutes, Title 13, CRIMINAL CODE
The following is a segment of Chapter 33 of the Arizona Revised Statutes, Sections 13-3620, 13-3620.01, and 13-3623.

Arizona Revised Statutes, Title 13, CRIMINAL CODE

CHAPTER 36: FAMILY OFFENSES

13-3620. Duty and authority to report nonaccidental injuries, physical neglect and denial or deprivation of necessary medical or surgical care or nourishment of minors; duty to make medical records available; exception; violation; classification

A. Any physician, hospital intern or resident, surgeon, dentist, osteopath, chiropractor, podiatrist, county medical examiner, nurse, psychologist, school personnel, social worker, peace officer, parent or counselor or any other person having responsibility for the care or treatment of children whose observation or examination of any minor discloses reasonable grounds to believe that a minor is or has been the victim of injury, sexual abuse pursuant to section 13-1404, sexual conduct with a minor pursuant to section 13-1405, sexual assault pursuant to section 13-14-6, molestation of a child pursuant to section 13-1410, commercial sexual exploitation of a minor pursuant to section 13-3552, sexual exploitation of a minor pursuant to section 13-3553, incest pursuant to section 13-3608 or child prostitution pursuant to section 13-3213, death, abuse or physical neglect which appears to have been afflicted upon such minor by other than accidental means or which is not explained by the available medical history as being accidental in nature or who has reasonable grounds to believe there has been a denial or deprivation of necessary medical treatment or surgical care or nourishment with the intent to cause or allow the death of an infant protected under section 36-2281 shall immediately report or cause reports to be made of such information to a peace officer or to the child protective services of the department of economic security. Such report shall be made forthwith by telephone or in person forthwith and shall be followed by a written report within seventy-two hours. Such reports shall contain:

1. The names and addresses of the minor and his parents or persons having custody of such minor, if known.
2. The minor's age and the nature and extent of his injuries or physical neglect, including any evidence of previous injuries or physical neglect.
3. Any other information that such person believes
might be helpful in establishing the cause of the injury or physical neglect.

B. Any person other than one required to report or cause reports to be made in subsection A of this section who has reasonable grounds to believe that a minor is or has been a victim of abuse or neglect may report the information to a peace officer or to the child protective services of the department of economic security.

C. A person having custody or control of medical records of a minor for whom a report is required or authority under this section shall make such records, or a copy of such records, available to a peace officer or child protective services worker investigating the minor's neglect or abuse on written request for the records signed by the peace officer or child protective services worker. Records disclosed only in a judicial or administrative proceeding or investigation resulting from a report required or authorized under this section.

D. When such telephone or in-person reports are received by the peace officer, they shall immediately notify the child protective services of the department of economic security when the child protective services and make such information available to them. Notwithstanding any other statute, when the child protective services receives these reports by telephone or in person, it shall immediately notify a peace officer in the appropriate jurisdiction.

E. Any person required to receive reports pursuant to subsection A of this section may take or cause to be taken photographs of the child and the vicinity involved. Medical examinations including, but not limited to, radiological examinations of the involved child may be performed.

F. A person furnishing a report, information or records required or authorized under this section, or a person participating in a judicial or administrative proceeding or investigation resulting from a report, information or records required or authorized under this section, shall be immune from any civil or criminal liability by reason of such action unless such person acted with malice or unless such person has been charged with or is suspected of abusing or neglecting the child or children in question. Except as provided in subsection G of this section, the physician-patient privilege, the husband-wife privilege or any privilege except the attorney-client
privilege, provided for by professions such as the practice of social work or nursing covered by law or a code of ethics regarding practitioner-client confidences, both as they relate to the competency of the witness and to the exclusion of confidential communications, shall not pertain in any civil or criminal litigation or administrative proceeding in which a child's neglect, dependency, abuse or abandonment is an issue nor in any judicial or administrative proceeding resulting from a report, information or records submitted pursuant to this section nor in any investigation of a child's neglect or abuse conducted by a peace officer or the child protective services of the department of economic security.

G. In any civil or criminal litigation in which a child's neglect, dependency, abuse or abandonment is an issue, a clergyman or priest shall not, without his consent, be examined as a witness concerning any confession made to him in his role as a clergyman or a priest in the course of the discipline enjoined by the church to which he belongs. Nothing in this subsection discharges a clergyman or priest from the duty to report pursuant to subsection A of the section.

H. If psychiatric records are requested pursuant to subsection C of this section, the custodian of the records shall notify the attending psychiatrist, who may excise from the records, before they are made available:
   1. Personal information about individuals other than the patient.
   2. Information regarding specific diagnosis or treatment of a psychiatric condition, if the attending psychiatrist certifies in writing that release of the information would be detrimental to the patient's health or treatment.

I. If any portion of a psychiatric record is excised pursuant to subsection H of this section, a court, upon application of a peace officer child protective services worker, may order that the entire record or any portion of such record containing information relevant to the reported abuse or neglect be made available to the peace officer or child protective services worker investigating the abuse or neglect.

J. A person who violates any provision of this section is guilty of a class 1 misdemeanor.
13-3620.01. False reports; violation; classification

A. A person acting with malice who knowingly and intentionally makes a false report of child abuse or neglect or a person acting with malice who coerces another person to make a false report of child abuse or neglect, is guilty of a class 3 misdemeanor.

B. A person who knowingly and intentionally makes a false report that a person has violated the provisions of subsection A of this section, is guilty of a class 3 misdemeanor.

13-3623. Child abuse; definitions; classification

A. In this section, unless the context otherwise requires:
   1. "Child, youth or juvenile" means an individual who is under the age of eighteen years of age.
   2. "Physical injury" means the impairment of physical condition and includes but shall not be limited to any skin bruising, bleeding, failure to thrive, malnutrition, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ or any physical condition which imperils a child's health or welfare.
   3. "Serious physical injury" means physical injury which creates a reasonable risk of death, or which causes serious or permanent disfigurement, or serious impairment of health or loss or protracted impairment of the function of any bodily organ or limb.

B. Under circumstances likely to produce death or serious physical injury, any person who causes a child to suffer physical injury or, having the care or custody of such child, causes or permits the person or health of such child to be injured or causes or permits such child to be placed in a situation where its person or health is endangered is guilty of an offense as follows:
   1. If done intentionally or knowingly, the offense is a class 2 felony and if the victim is under fifteen years of age it is punishable pursuant to section 13-604.01.
   2. If done recklessly, the offense is a class 3 felony.
   3. If done with criminal negligence, the offense is a class 4 felony.

C. Under circumstances other than those likely to produce death or serious physical injury to a child, any person who causes a child to suffer physical injury or
abuse as defined in section 8-546, subsection A, paragraph 2 except for those acts in the definition which are declared unlawful by another statute of this title or, having the care or custody of such child, causes or permits the person or health of such child to be injured or causes or permits such child to be placed in a situation where its person or health is endangered is guilty of an offense as follows:

1. If done intentionally or knowingly, the offense is a class 4 felony.
2. If done recklessly, the offense is a class 5 felony.
3. If done with criminal negligence, the offense is a class 6 felony.
The following is a segment of Chapter 33 of the Arizona Revised Statutes, Sec. 32-3251 to Sec. 32-3322.

**CHAPTER 33. BEHAVIORAL HEALTH PROFESSIONALS**

Sec. 32-3251. Definitions

In this chapter, unless the context otherwise requires:

9. "Unprofessional practice: includes:

(a) Conviction of a felony

(b) Use of fraud or deceit in connection with rendering services as a certified behavioral health professional or in establishing qualifications pursuant to this chapter.

(e) Betraying a professional confidence.

(k) Engaging or offering to engage as a behavioral health professional in activities which are not congruent with the certified behavioral health professional's professional education, training or experience.

(l) Violating any provisions of this chapter or refusing or neglecting to comply with rules adopted pursuant to this chapter or any lawful order of the board or a credentialing committee.

Sec 32-3283. Privileged communications

In any legal action a certified behavioral health professional shall not, without the consent of his client be examined as to any communication made by the client to him or as to any such knowledge obtained with respect to personnel dealing with the client. Unless the client has waived the behavioral health professional-client privilege in writing or in court testimony, a behavioral health professional shall not be required to divulge, nor shall he voluntarily divulge information which he received by reason of the confidential nature of his practice as a behavioral health professional except that he shall divulge to the board of any information it subpoenas in connection with an investigation, public hearing or other proceeding. The behavioral health professional-client privilege shall not extend to cases in which the behavioral health professional has a duty to report nonaccidental injuries and physical neglect of minors as required by Sec. 13-3620.
APPENDIX D

QUESTIONS VICTIMS ASK OFFENDERS
Questions Victims Ask Offenders

1. Why did you do those things to me?
2. Will you ever do those things to me again?
3. Why me? What did I do?
4. Why did I have to keep secrets?
5. Was mom in on this with you?
6. How do you feel about my telling and being angry with you?
7. What if you weren't turned in? What would have happened?
8. Why do I feel badly about the offense, Mom's unhappiness and the breakup of our home?
9. Why did you seem the better parent rather than Mom?
10. What did you do to set me up and continue controlling me?
11. How will I know if you are about to hurt me again? Should I trust you?
12. What can I do to protect myself? What if I feel you're about to do those things to me again?
13. How will things be different at home? How will our relationship be different?
14. Will my friends be safe? Do they need to know? Who knows now?
15. Tell me about your counseling.
16. ____________________________________________________________

APPENDIX E

LETTERS OF PERMISSION
June 3, 1992

Susanne L. Peterson
4348 N. Windrige Loop
Tucson, AZ 85749

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Sincerely,

Leanne Seddon
Publications Administrator

enc
Dear Ms. Baron:

In conjunction with my Master's thesis project in the Dept. of Counseling and Guidance at the University of Arizona, I am preparing a handbook for mental health counselors new to group work with sexually abused children. As per our telephone conversation on 5-15-92 I am requesting permission to use two tables found in a book which your company publishes. It is: Gil, E., & Edwards, D. (1988). Breaking the Cycle: Assessment and Treatment of Child Abuse and Neglect, (3rd ed.). The tables are, "Indicators of Sexual Abuse," p. 59, and "Behavioral Indicators of Sexual Abuse," p. 61.

This project is not for profit and there are no current plans for general publication. If publication occurs at a later date, additional written permission will be obtained from both you and the authors.

Your cooperation is appreciated. If you have any questions I can be reached at the telephone number shown above.

Sincerely,

Susanne Peterson

I agree to use the copyrighted material as requested.

Raylene Baron
Association For Advanced Training in the Behavioral Sciences
3390 Duesenberg Drive
Westlake Village, CA 91362

I agree to use the copyrighted material as requested.

Permission is given for use of the copyrighted material as requested.

May 15, 1992
DATE: May 15, 1992
FROM: Carline Haga, Permissions Manager
TO: Susanne L. Peterson
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To be included:

- Overview of Group Leadership Skills, pp. 71-72.

The above will be used as part of my Master's thesis project in the Dept. of Counseling and Guidance, University of Arizona.

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Susanne L. Peterson

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Susanne L. Peterson 6-17-92

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Permissions Manager
June 2, 1992

Ms. Susanne Peterson
4348 N. Windridge Loop
Tucson, AZ 85749

Dear Ms. Peterson:

You have my permission to include my table "Example of Low-, Medium-, and High-Level Goals" as it appears in Child Welfare, Vol. LXIX(3), May-June 1990 in your Master's Thesis.

I wish you good fortune in the speedy and successful accomplishment of your Master's degree.

Sincerely,

Pearl Berman, PhD
Ms Susanne L. Peterson  
4348 N. Windridge Loop  
Tucson  
AZ 85749  
USA

Our Ref: AJ/JJ/45/P  
Date: 3 June, 1992

Dear Ms Peterson,

Re. The Arts in Psychotherapy, Vol. 17, pp. 35-37, 1990

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Susanne L. Peterson

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Mary Gallagher 6/15/92

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Ms. Susanne Peterson  
4348 N. Windridge Loop  
Tucson, Arizona  (85749)

Dear Ms. Peterson,

Enclosed please find the copy of the mandatory reporting law as requested during our conversation this afternoon. Please let me know if I may be of any further assistance.

Sincerely,

Linda Cunningham,  
CPS Specialist III

Encl. (1)
HANDBOOK EVALUATION

Sexually Abused Children and Group Therapy:
A Guide to Counselor

1. Generally, I found the information: (Please circle response)

   Easy to Read 1 2 3 4 5 6 7

   Too long 1 2 3 4 5 6 7

   Clear 1 2 3 4 5 6 7

   Informative 1 2 3 4 5 6 7

   Difficult to Read

   Too Short

   Confusing

   Not Informative

2. The Format is:

   Easy to Follow 1 2 3 4 5 6 7

   Difficult to Follow

3. I would like more information about:

4. I would like less information about:

5. I would like clarification on:

6. I would omit:

7. I would add:

8. Additional comments or suggestions (please use back):
Please return this evaluation and handbook draft to Susanne Peterson by Friday, May 8, 1992. If this is a problem or if you have any questions, please don't hesitate to call me at 749-2756.

Send to:

Susanne Peterson
4348 N. Windridge
Tucson, AZ 85749
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