# STRUCTURED PSYCHOTHERAPY GROUPS FOR SEXUALLY ABUSED CHILDREN AND ADOLESCENTS

Billie Farmer Corder, EdD

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# Introduction

This book represents a distillation of research and clinical work with adolescent and children's therapy groups which spans more than 30 years. The work has been conducted in state mental hospitals, juvenile court settings, mental health centers, group homes, outpatient clinics, county social services settings, outpatient clinics, and private practice. The techniques for structuring psychotherapy groups with sexually abused children and adolescents were developed in response to needs for effective, time-limited therapeutic interventions for this victimized population, and are based on my work with colleagues on trauma, sexual abuse, and the process of mastery by which children handle trauma.

# PART I

# PSYCHOTHERAPY FOR THE SEXUALLY ABUSED

PSYCHOTHERAPY
FOR THE
SEXUALLY ABUSED

CHAPTER 1

# Theoretical Issues and Approaches

## THE EXTENT OF ABUSE

There is no question that the sexual abuse of children, adolescents, and teenagers in our culture represents a cogent challenge to mental health professionals. Sexual abuse of children and adolescents is almost sure to be an issue in professional mental health practice, regardless of the clinician's theoretical orientation or type of workplace. In a climate of diminishing resources for medical and psychological care, it is clear that mental health practitioners must face this issue with responsible, solid techniques. There is a need for cost-effective mental health interventions in the field of treating our sexually abused youth.

Statistics regarding the numbers of victimized children often vary, due in part to differing definitions of sexual abuse and also to our culture's continually changing resources, methods, and facilities for reporting and investigating abuse. What we do know is that sexual abuse exists and that it can drastically alter the way children develop and behave.

A 1981 survey by the National Center for Child Abuse and Neglect reports that 5% of children are sexually abused by an adult who is familiar to them. Finkelhor, Hotaling, and Lewis (1990) estimate that 27% of women and 16% of men may have experienced some form of sexual abuse. Burgess, Groth, and Holmstrom (1978) suggest that, estimating conservatively, one of every five females in our society has suffered sexual abuse. Nasjleti (1980) and Finkelhor (1987) moreover, propose that the abuse of males is quite likely underreported due to reluctance to admit weakness and fear of accusations of homosexuality. The number of victimized children in the United States is staggering when incest, extrafamilial sexual abuse, and unreported incidents of sexual abuse are combined, according to Mayer (1984). In addition to prevention and awareness that will help to reduce these numbers, there is clearly a need for services and interventions that assist those children whose abuse has already been substantiated.

## EFFECTS OF SEXUAL ABUSE ON CHILDREN AND ADOLESCENTS

Many researchers and child development experts have documented the negative effect of sexual abuse on the development and long-term adjustment of children and adolescents. The extent and depth

of the effects of abuse appear to be related to several factors, including (a) the length of time over which the abuse was committed (one incident, short-term abuse, or longstanding abuse); (b) the relationship of the abuser to the victim (victimization by a family member or a trusted, family-like figure as opposed to a casual acquaintance or a stranger); (c) whether or not threats, coercion, or additional physical abuse were used; (d) the presence or absence of adult and family support; and (e) the availability of counseling or therapeutic intervention (Mayer, 1984).

Finkelhor and Browne (1986) have proposed that the degree of trauma from abuse is related to the extent of premature sexual stimulation, feelings of powerlessness, stigmatization related to the child's feeling damaged, shamed, and guilty, and feelings of betrayal by a trusted person. Schetky and Green (1988), proposing a more general framework for evaluating the symptoms and extent of abuse, use the following parameters: developmental level and age, duration and frequency of abuse, presence or absence of physical trauma or coercion, strengths and weaknesses within the child's personality prior to abuse, degree of closeness between the child and the abuser, and the family's and society's handling of the issues involved in disclosed abuse.

Terr (1991), who has divided all childhood trauma into two types — Type I (acute, sudden onset) and Type II (longstanding or repeated trauma) — has observed that both types are likely to produce symptoms such as thought suppression, problems in sleeping, hypervigilance and startle responses, regressive behavior, unusual fears and panic, avoidance behaviors, and irritability. Both Types I and II may result in repeated traumatic memories, repetitive behaviors (possibly in attempts to work through the trauma), fears related to the trauma, depression and lack of enjoyment, and changed attitudes about the future and the trustworthiness of others.

In addition to the preceding symptoms, however, children who have experienced longstanding Type II trauma are also more likely to experience psychic numbing (not feeling alive, "forgetting"), self-hypnosis and dissociation ("separating" themselves from their body and their perception of the trauma), and feelings of rage and anger, sometimes turned against themselves (Terr, 1991).

Children who have experienced sexual abuse often resemble those who have been traumatized in other ways. Physical symptoms of sexual abuse often include injuries and irritation to genital and anal areas, urinary tract infections, enlargement of anal and vaginal areas, and pregnancy (Mayer, 1984). Behavioral and emotional symptoms may include those of posttraumatic stress disorder: avoidant behavior, intrusive memories, unusual fears, and so on, but they are also likely to include cognitive distortion (guilt, low self-esteem, hopelessness, self-blame, negative attributions to causes of external events, etc.), altered emotionality (depression, anxiety demonstrated by hypervigilance or unusual fears), or disturbances in relationships (distrust, feelings of isolation, and difficulties with sexual intimacy). Coping/Avoidant behaviors such as dissociative states, substance abuse, and self-injurious behaviors are not unusual, nor are tension-reducing behaviors such as impulsive acting out, developmentally inappropriate sexual behaviors, eating and sleep disorders, and the presence of impaired self-references (failing to establish boundaries and an adequate, internalized sense of self) (Briere & Runtz, 1987).

Even less chronically and severely abused children, according to Sgroi (1982) may suffer from "damaged goods" syndrome, guilt, fear, depression, low self-esteem, poor social skills, and repressed anger and hostility. Sgroi notes that the absence or presence of these symptoms may be crucial in the development of self-mastery and control, independent behavior, and effective decision-making skills.

Long-term effects of sexual abuse often include problems with parenting, sexual dysfunction, and the development of severe personality disorders such as multiple personality disorder. In some instances sexual abuse is also a factor in child molestation behaviors in adulthood (Mayer, 1984).

## VULNERABILITY AND MASTERY: MITIGATING FACTORS

Not all traumatized children respond alike, and not all traumatized children respond with the severe symptoms mentioned earlier. Among the many factors involved in the ability of children to adapt and cope with stress and trauma are their developmental skill level, their relationship to the perpetrator, the severity and chronicity of abuse, and the response of others to disclosure of the abuse. Anthony and Cohler (1987), Pines (1984), and Rutter (1978) have reported early studies of personality traits and environmental factors that appeared to help children cope and succeed despite trauma and/or victimization. These children are often referred to as "invulnerable." They do not exhibit crippling symptoms or severe developmental delays; rather, they display characteristics such as (a) an ability to attract and utilize support from adults around them; (b) social interaction skills for developing friendships and sharing activities with others; (c) the experience of an intense and satisfying creative outlet such as writing, painting, making models, and so forth; (d) the presence of at least one area in which they are recognized as achieving well; (e) a sense of autonomy and an ability to seek out a "private place" within a chaotic environment; and (f) evidence of cognitive mastery, coping skills, cognitive problem-solving skills, or the ability to "relabel" anxiety-provoking elements in their environment (Pines, 1984).

Anthony and Koupernick (1974) described the ability of "invulnerable" children to develop cognitive receptive and representational skills for creating an adequate frame of reference for thinking, conceptualizing, and making directed decisions. Rutter's 1978 studies of children in deprived socioeconomic groups noted that the ability of children to cope is also affected by the number of stressors facing them at any given time: for instance, a mother's marital stress or psychiatric disorder, a father's criminal record, or whether a child has been placed in foster or institutional care.

In addition to the degree of severity of environmental factors, it can be assumed that "invulnerable" children are less likely to suffer physical or mental handicaps or to possess characteristics and temperament with some "goodness of fit" with that of their mother or primary caregiver. They are also less likely to have been scapegoated or otherwise selected to serve a deviant family defense mechanism against stress (although in our experience this latter characteristic is typical of many sexually abused children).

All of these concepts — the extent of abuse, the effects of abuse, and the ability of some abused children to cope more effectively than others — must be considered when planning for intervention and treatment for sexually abused children. They are crucial for setting goals and evaluating progress within the treatment process.

CHAPTER 2

# Implications for Treatment

Sgroi (1982) has noted that short-term therapy, even for less severely abused children, is often focused on the symptoms that interfere with control and self-mastery. Without adequate mastery skills, he writes, it appears unlikely that effective independent behavior, judgment, and decision-making skills can develop. Sgroi's treatment techniques have included role-modeling, role-playing, peer group support, and structured practice in independent decision making within an accepting and supportive framework.

In describing approaches for intervention with many types of traumatized children, Beverly James (1989) lists the following considerations for therapy: (a) exploration of emotional pain; (b) continued treatment at various developmental ages and levels; (c) active participation of caregivers; (d) direct approaches to material that may not be produced spontaneously in therapy; (e) enjoyable, positive clinical messages which attend to all of the child's damaged parts (physical, cognitive, emotional, etc.); and (f) a focus on discovering and dealing with secret dysfunctional, sexualized deviant behaviors.

In further support of dealing directly with the abuse experience, Berliner and Wheeler (1987) has written that direct confrontation, not only of the abuse itself but also of victims' negative coping responses, fear, anxiety, and sexual behavior problems, should be combined with therapeutic interventions to address specific family or child behaviors, perceptions, and functioning.

In other work with this population, Scheinberg, True, and Fraenkel (1994) have used a multimodal approach to address many of these criteria. By combining individual, group, and family therapies, they propose that specific problems revealed during treatment can be addressed in any one of the three modalities. Although in reality many facilities are unable to provide such a spectrum of separate but interrelated interventions, Scheinberg et al.'s emphasis on interpersonal work with peers and family members is shared by most other writers and practitioners.

The American Academy of Child and Adolescent Psychiatry's *Textbook of Child and Adolescent Psychiatry* (Yates, 1991), for example, suggests that family therapy may be the most effective intervention when reunification of the family is the goal of treatment. Although individual therapy is considered to be more necessary for severely disturbed or dysfunctional children, group therapy is viewed as most useful for support and restructuring soon after abuse is discovered.

For adolescents in particular, given their predominant focus on peer interactions, group therapy is often the treatment of choice. Berkowitz and Sugar (1975) list the goals of adolescent group therapy: (a) to support assistance and confrontation from peers; (b) to provide a miniature real-life situation; (c)

to develop new ways of dealing with situations in human relations; (d) to stimulate new concepts of self and new models of identification; (e) to alleviate feelings of isolation; (f) to provide protection from the adult world; (g) to help maintain continued self-examination as a "bind" to therapy; (h) to allow the swings of rebellion and submission that encourage independence and identification with a group leader; and (i) to uncover relationship problems not evident in individual therapy.

Our own work (Corder, Whiteside, & Vogel, 1977) indicates that adolescents most value goals a, c, and e above. Following Yalom's research with adults, we studied the situations and conditions of group process selected as most and least curative by adolescents in various groups. Our group members most valued group experiences that offered opportunities for, in their words, "being able to say what was bothering me instead of holding it in," "learning how to express my feelings," "learning that I must take ultimate responsibility for the way I live my life," and "having other members honestly tell me what they think of me." For one member, "being in the group was, in a sense, like being in a big family, only this time, a more accepting and understanding family."

Treatment that fosters these "curative factors" of learning and belonging is clearly helpful for sexually abused children and adolescents, because it encourages the mastery exhibited by invulnerable children. For children and adolescents alike, group therapy can provide rich opportunities to further treatment goals involving coping skills, problem-solving, and interpersonal skills in addition to positive intellectualization and self-esteem.

CHAPTER 3

# A Group Psychotherapy Program

## HISTORY AND RATIONALE

Synthesizing the research, theories, and approaches cited in Chapters 1 and 2 with our own clinical experience with sexually abused children and adolescents, my co-workers and I (Corder & Haizlip, 1989; Corder, Haizlip, & DeBoer, 1990) have developed psychotherapy groups for preadolescent and adolescent girls over the course of the past 30 years.

Our structured approach in these groups focuses on (a) exploring cathartic, shared emotional responses to abuse, (b) teaching techniques for mastery of the abuse experience, (c) encouraging development of some of the coping skills demonstrated by "invulnerable" children, (d) discouraging vulnerability to further abuse, (e) improving intellectual understanding of the abuse experience by both child and primary caregiver, and (f) improving communication between the child and the caregiver about the experience.

We have chosen group therapy as the basic intervention because it provides interaction with peers and helps to ameliorate two typical symptoms of abuse: the child's sense of "differentness" and that of being "damaged." Using a direct, structured approach with goals similar to those of authors cited in the preceding chapters, we have been able to use available treatment time to address the abuse experience, emotional responses, and current dysfunctional behaviors in an open and direct manner. Our concern that this structured approach might not allow for enough individualized response from group members is balanced against the restraints of time. We believe that the very directness of the structured group approach mitigates feelings of shame and perceptions of the experience as too deviant to be discussed matter-of-factly.

Our groups have focused on techniques that may help children to acquire some of the coping skills possessed by the "invulnerable" children described by Rutter (1978) and others. We believe that some of these skills, although they may have developed in an intuitive fashion among "invulnerable" children, can, at least to some extent, be taught to abused children as learned coping mechanisms.

## GOALS OF STRUCTURED GROUP PSYCHOTHERAPY FOR SEXUALLY ABUSED CHILDREN AND ADOLESCENTS

General goals for these groups have been as follows:

1. *Improving cognitive and emotional mastery of the trauma* through group activities and processes such as drawing, games, and story-telling. This involves techniques for emotional catharsis, intellectual understanding of the abuse process, relaxation techniques, anger release, and improved communication skills. In addition, the motivations and treatment of abusers are investigated.
2. *Building self-esteem* through cognitive relabeling practice that uses role-playing, group chants and cheers, and game activities to teach intellectual understanding of the abuse, the abuser, and family reactions. These games and activities help remove children's feelings of rejection and "differentness." Intended to negate child victims' feelings of shame and blame, specific material includes information about the frequency of abuse in our society, the abuser's responsibility for the abuse, involuntary pleasurable responses, and using abuse to satisfy needs for closeness.
3. *Improving problem-solving skills* using original board games, structured stories, role-playing, and so forth. These techniques focus on encouraging group members' abilities to identify and deal with potentially abusive situations, acquiring basic techniques for self-protection, and learning how to seek out and approach helping adults. Children are taught how to seek support from authority figures and facilities in their environment in order to meet their needs in ways that will not endanger them for further abuse. Appropriate and nonthreatening techniques for meeting needs for closeness and intimacy are encouraged and explored.
4. *Developing or improving communications, understanding, and coping between mother or caregiver and child victim.* Through homework assignments, actual parent/caregiver participation during specific sessions, and didactic material concerning common parent concerns, group members are given skills and confidence that improve their family relationships.

In addition to providing many opportunities, through games and activities, for cathartic release, our groups teach facts and skills, including negotiation and communication skills. Our group members are given training in cognitive techniques (visualization, thought-stopping, etc.) and in relaxation and the use of biofeedback techniques. These skills, useful in many types of interventions, fit well into our model of increasing individuals' sense of control over their bodies and environments (Corder, Whiteside, & Haizlip, 1986). Strobel and Glueck (1973, p. 380) have written that this type of training is a structured form of "self-learning to incorporate the concept of individual responsibility" that places people in a "position of importance in their own prevention and treatment programs." It encourages a sense of mastery over memories and feelings engendered by the abuse experience.

Specific techniques for providing structure and some of the therapeutic games and materials we have used differ with the developmental and chronological ages of children and adolescents; however, the basic goals for all groups are the same. These techniques and materials, developed for two different age groups, are discussed more fully in Part III of this book.

CHAPTER 10

# Groups for Sexually Abused Children Ages 6 to 9 and 10 to 12

## SESSION ONE

### Purpose

To familiarize members with group format, alleviate anxiety, build expectations for participation and behavior, and initiate cognitive relabeling and desensitization.

### Materials Needed

Pretest (Form GM), if not previously administered, and pretest answer sheets, one per member; The "Worry List" if teen version of pretest is used, one per member (see Chapter 8); pencils or crayons; clipboards; soft foam ball; and refreshments.

### Format

1. Therapists' introduction/discussion.
2. Critter "Name Game" to introduce members to one other.
3. Pretesting, if necessary.
4. "Cheers and Chants" for positive self-concept and cognitive behavior modification.
5. Refreshments for social skills and nurturing.
6. Clean-up for closure.
7. Positive reinforcement good-byes by therapists.

### Contents of Session One

1. *Therapist Introduction/Discussion.* Defining the group as one for sexually abused children, the therapists introduce themselves as people who work with children who have been sexually abused. Most groups will be composed of children who have been referred following investigation and confirmation of abuse, placement decisions, and initial counseling for trauma; nevertheless, it is still essential to define sexual abuse to the group. For example:

"We are (names), and we work with children of all ages who have been sexually abused. You know that sexual abuse means that another person has used your body or made you use theirs in a sexual way that ended up making you feel confused and bad. And that is not the right way to show any kind of love feelings to someone your age. In this group we are going to talk about your feelings about the abuse, learn how to keep yourself safe, learn all the true facts about abuse, learn all the good and strong things about yourselves, and have a good time learning, getting to know each other, and playing together."

2. *Name Learning Exercise* (develops group cohesion, lowers anxiety). "First thing, let's get to know each other's names by playing a game. We'll go around the room and say our names and pick a "critter" (such as an animal, insect, reptile, or bird) that has a name starting with the same letter as ours. I will be [Dr. Corder Camel]." Children each choose a critter that has a name starting with the same letter as their own first name (Betsy Bat, Helen Horse, etc.). You may want to have some names of animals, insects, birds, and reptiles ready and even some pictures of those with which the group may not be familiar. When we began these groups we were sometimes stuck for a critter name when a child refused to use easy or obvious ones; therefore we include suggestions for letters of the alphabet on page 52.

   After the names have been picked, the foam ball is tossed randomly around the room from child to child. For the first round, the child simply says her (his) name and critter, and throws the ball to any other person in the group, who then jumps up and says her (his) own name and critter (Alice Antelope, etc.).

   For the next rounds, the child says her (his) name and animal and then repeats the name and animal of the person to whom she (he) plans to throw the ball, who repeats the process.
3. *Pretesting.* Following introductions, therapists may wish to introduce the pretest (see Chapter 8) which, along with refreshments and learning a group "cheer," will finish the first session. This task can be included as part of the therapists' description of the group's purposes and described as "going over some of your ideas about some of the things we will be talking about in the group." The drawback of administering the pretest during this first session is that it takes time away from interactions and activities more enjoyable to children. On the other hand, it can also serve to stimulate discussion and focus attention on the issue, and it saves a tremendous amount of time when compared to individual pregroup administrations.

   Introduction of the pretest might sound like this:

   "We are going to read to you some things that people sometimes think about sexual abuse. What we want to know is what YOU think about every one of these sentences. We will read out loud each sentence, and you will draw a circle around the word (on your answer sheet) that tells if you think that the sentence is true, not true, or you're not sure or you don't really know.

   "Let's practice on something really easy. Suppose the first sentence says: 'I came here today with my mother.' You would circle: true, not true, or not sure. What would each of you circle? Now this second one is harder. But you can put down what you really feel. Suppose the second sentence says: 'I wanted to come to this group today.' Circle true, not true, or not sure. Excellent. Now I will read out loud the sentences and you circle your answer, whether you think the sentence is true, not true, or you're not sure or you don't really know."

Chapter 8 contains copies of the pre- and posttest which can be reproduced. Please note that we have usually used the longer teen (PT) version for children aged 10 and over; however, either version is appropriate.

4. *Cheer* (initiates desensitization and cognitive relabeling). "Now that you're all finished with this worksheet, we're going to do a 'cheer' or 'chant.' That means we say a poem that has something important to remember in it while we clap hands with each other."

   For cheers, pair members (using therapist as a partner if numbers are uneven) and repeat the cheer emphasizing the words in rhythm with clapping. Each person (a) claps hands on knees, palms down, (b) then claps own hands together, (c) then claps hands, palms out with their partner, (d) then claps own hands together, (e) then claps own knees, palms down, and begins again.

   Even the "rhythmically challenged" can eventually handle this exercise, which is a more complicated version of "patty-cake." However, it is probably a good idea to practice this with your co-therapist or a willing co-worker so it will be easy to demonstrate it for the group.

   Cheer #1, Session One (clap in emphasis with capitalized words):

   Lots of PEOPLE have been ABUSED.
   We know THAT 'cause we heard it in the NEWS.
   It's NOT my fault abuse happened to ME.
   I'm a good PERSON everybody will AGREE.

5. *Refreshments.* These should be simple. Their purpose is to lower anxiety, teach social skills, and demonstrate caring and giving, particularly to those children who have not experienced them sufficiently or appropriately. Refreshments are usually a plate of cookies and paper cups of juice or soda. In subsequent sessions refreshments will be served by the child or children who draw the *Hostess (Host)* role at the beginning of the group session. Therapists may invite children to help during this first session. Dietary or religious restrictions for any group member should have already been explored by therapists in initial referral planning.
6. *Clean-Up.* Cleaning up may be shared by the group or defined as part of the role of the person drawing the *Hostess (Host)* card. This activity provides closure and may help to develop a sense of ownership of the group and its process.
7. *Ending the Session: Positive Feedback Good-Byes* (build self-esteem, encourage mastery, enhance group cohesion). The therapist stands at the door (in later sessions with the child or children who have picked the designated role of *Complimenter* or *Hostess [Host]*), shakes each child's hand, and says, "Good-bye Sally Seal, I am looking forward a lot to seeing you next week." The therapist then adds a compliment (positive feedback): a simple positive statement about the child's behavior in the group. In later sessions, these statements will be a repetition of positive feedback statements given by members in the *Complimenter* role.

   This form of saying good-bye helps to define some of the "good touches" and appropriate forms of caring that will be discussed in later sessions. It is an opportunity to give "positive strokes" or feedback to members concerning their participation in the group and to set expectations for appropriate group behaviors.

# SUGGESTED CRITTERS FOR THE "NAME GAME"

A: armadillo, antelope, anteater, alligator, ant
B: bat, buzzard, bull, bird, butterfly
C: cat, cougar, crocodile, camel
D: dog, deer, duck, dolphin, dinosaur
E: elk, eagle, elephant, ermine
F: frog, fish, falcon, fawn, finch
G: gnat, gazelle, giraffe, gorilla, grasshopper
H: horse, hippo, hedgehog, hornet, hummingbird
I: insect, ibis, iguana
J: jaguar, jackrabbit, jay, jackal
K: kangaroo, kingfisher, kiwi
L: lamb, leopard, lion, llama, lobster
M: moose, mink, marlin, mastodon, mockingbird
N: nightingale, newt, newfoundland (dog)
O: otter, owl, orangutan, oriole, ostrich
P: panda, panther, parrot, penguin, pigeon
Q: quail
R: rabbit, raccoon, ram, raven, reindeer
S: sable, sandpiper, seal, seahorse, sparrow
T: tiger, tern, turtle
U: unicorn
V: vole, vulture, vicuña
W: whale, walrus, wren, weasel, woodchuck
X: xeme (an arctic gull)
Y: yak, yellow jacket
Z: zebra

## SESSION TWO

### Purpose

To promote group cohesion, alleviate anxiety, set expectations for group behavior, begin self-identification as sexually abused and reduction of feelings of "differentness," and practice mastery, assertiveness, social skills, and problem solving.

### Materials Needed

Foam ball, role basket (see description below), easel/markers or chalkboard/chalk, *"Wouldn't It Be Nice"* coloring book: cover page A1 through page A6 (one each per member), clipboards or drawing surfaces, pencils, crayons, Homework Assignment #1 (one per member), and refreshments.

### Format

1. "Name Game." Introduction of parents/caretakers if they are attending.
2. Therapists restate group goals and introduce session.
3. Role selection and therapists' description of roles.
4. Setting up group rules.
5. Announcing and beginning a group task (coloring book exercise to illustrate the idea that when bad things happen to good children it is not their fault).
6. Cheer.
7. Summary by member who has drawn *Reminder* role.
8. Compliments by member who has drawn *Complimenter* role.
9. Refreshments.
10. Clean-up.
11. Passing out homework.
12. Positive feedback good-byes.

### Contents of Session Two

1. *"Name Game."* Described in Session One, the "Name Game" is played at the beginning of Session Two to promote group cohesion and reduce tension. Members use the same critter names as in Session One. If parents and caretakers are present, each group member should introduce the adult accompanying her (him). At the therapists' discretion, parents may also participate in the "Name Game."
2. *Introduction of Session and Restatement of Goals.* To promote intellectualization and set expectations, therapists use statements from Session One to restate group goals.
3. *Drawing a Role from the "Role Basket."* This activity provides practice in mastery, assertiveness, problem solving, and social skills. After names are learned in the "Name Game," each member selects the role she (he) will take in this session from role cards (see next page) placed face down in a small basket or box. Some therapists like to tape the roles on members' shirts during the first few group sessions, and most like to be sure there are equal numbers of role cards and members. Some suggested roles and their functions are:

| | |
|---|---|
| ***Hostess (Host)*** (there may be two cards with this role): | *Hostesses (Hosts)* give out refreshments and shake each member's hand at departure, saying the member's name and critter name. With the therapists' help, they also repeat one of the "compliments" given to that member in the group, for example, "Good-bye Sally Seal. We liked the way you talked a lot in the group today." |
| ***Rules Enforcer***: | Reminds people in the group of the group rules and points out when someone is breaking a rule. |
| ***Homework Person***: | Passes out homework, collects it, and helps with "grading." |
| ***Group Helper***: | Helps anyone who needs help with drawings or tasks in the group. Therapists call on this person when they see that another member needs assistance. |
| ***Group Actor(s)***: | In future sessions, one or two role-playing cards may be included. These members are to do any initial role-playing exercises that are part of group tasks, although more members may be involved in role-play in the session. |
| ***Group Neatness Officer***: | This member is responsible for leading the group in clearing the room and returning materials after the session. |
| ***Reminder or Summarizer***: | At the end of the session, with help from the therapists, the *Reminder* verbalizes "what we did in the group today, and what we learned." |
| ***Complimenter***: | This task may be combined with that of the *Reminder* in older children's groups, or with that of *Hostess (Host)*. This member's role is to go around the group and tell each member, "What I liked about what you said or did in the group today" (with assistance from therapists if necessary). |

4. *Setting Up Group Rules.* This task encourages problem solving, encourages assertiveness, and improves group cohesion. Using easel or chalkboard, the group leader initiates the task. "In this group we will have rules that will help us use our time well, make sure everyone gets to participate, and make sure nobody gets hurt feelings. We already have one rule that the leaders have suggested. Now what are some other rules you would like us to follow to make this a good, fun, but hard-working group?"

   The leaders have written out their rule: "Everyone will try all the games and workbooks we use in the group." If there are no suggestions from the group, the leader might say, "What do you think the rules should be about talking to other people, except your mother or caretaker, about what goes on in this group?" "What rules would make it easy for everyone to get a chance to talk?" "Should we make a rule about cleaning up?"

   Rules should be few and simple, but should include confidentiality ("No one will talk about what we say here in the group except to your mother or caretaker so that we can feel free to say whatever we want to"). Be sure to add that group leaders might sometimes have to talk to a parent/caretaker or adult if they believe a member is doing something hurtful or is being hurt in some way, so that it can be stopped.

Rules should always include being respectful while others are talking. A rule about cleaning up and using the facility reinforces responsibility. It is helpful with younger children to insist that everyone should go to the bathroom before the session, since children sometimes use trips to the bathroom as tension relievers when group tasks are difficult for them. With many of our youngest groups it has been part of the routine to stand outside the door while all members are ushered to the bathroom before the group. They are told, "Everybody has to try to go to the bathroom, even if they don't think they need to, because we can't leave the group room after we get started."

5. *Session's Group Task: Introducing Coloring Book.* Group leaders may say, "Remember what we said about the reasons we are here: to learn that the abuse was not your fault, to understand all the facts we know about abuse, to remember that many, many people have been abused and you are not alone, and to learn what a good and strong person you are and how you can take care of yourself and get help from others so you won't be sexually abused again. One way we're going to do this is to learn from a special coloring book, like this one, that each one of you will have. You'll get a few pages of it at a time, and get to keep it after the group is over. Let's color the first page and put your name on it." The group will color a few pages of the book at a time during the following sessions. Selected pages will reflect the subjects of the session's specific task.

As noted earlier, each child should have a clipboard or stiff drawing surface slightly larger than the book's page size, and a pencil and package of crayons to use while sitting on the floor in an informal manner. If this is not possible, a large table may be necessary, although tables make the atmosphere more formal and less enjoyable.

The purpose of this activity is to help members begin to identify themselves as sexually abused in ways that promote desensitization, reduce feelings of "differentness," and build group cohesiveness. The therapist states: "While you are coloring the first page, we will go around the group, and each person will say their name and critter and say who abused her (him)." ("I'm Denise Deer, and my daddy abused me.") Using the coloring activity during this disclosure appears to lower anxiety considerably while it helps children to identify themselves and their abusers. Therapists introduce themselves as, "I'm Dr. _____. I have worked with lots and lots of children who have been abused, and I know some things that help them which I am going to teach you." Or, if it is true and therapists wish to share the information with the group, they might say, "I'm Dr. _____, and I was abused when I was a child by my _____. I have learned to handle my feelings about being abused, I feel good about myself, and I know how to take care of myself. I am going to help teach you some of these same things I have learned."

After handing out coloring book pages and initiating the round of abuse disclosure, the leader might say, "Today we are going to talk about how sometimes bad things happen to good people. It isn't their fault; it's just the way things are. There ARE some things we can do to help take care of ourselves and try to help us keep bad things from happening. That's what we are going to learn from these pages. While you color the pages, I'll read what they say." (Therapist reads pages A3 to A6 of the coloring book.) During this activity, therapists compliment and support coloring activities. They may also ask the *Group Helper* to assist in this activity.

"These pages are about getting sick, even though you didn't do anything to deserve it. Sexual abuse is a lot like that. Older people should know better than to abuse children, so it is not your fault that this happened to you. Sexual abuse happens to many people. Some people who study about abuse say that one in every five girls has been sexually abused. This means that probably somebody in your class at school, or in your church, or in your neighborhood has

also been abused, even though you might not know about it. Let's go around the group and have everybody tell about something *besides* abuse that happened to her (him) that was not her (his) fault. It could be like when you had an accident and were hurt, or when you got sick, or even when somebody you know got sick and died. After we do that, let's all go around the group and say, 'I have been abused, but it's never the child's fault, it's the older person's fault. It was not my fault.'" This reinforces cognitive relabeling and intellectualization.

6. *Cheer* (desensitization, cognitive relabeling). "Now that you're all finished coloring, we're going to do a Cheer. That means we say a poem that has something important to remember in it while we clap hands with each other. Repeat cheer from Session One:

Lots of PEOPLE have been ABUSED.
We know THAT 'cause we heard it in the NEWS.
It's NOT my fault abuse happened to ME.
I'm a good PERSON everybody will AGREE.

7. *Summary by the Reminder* (intellectualization, group cohesion, drill in cognitive behavioral modification). The leader assists the member who drew the role of *Summarizer* or *Reminder* by saying, "First tell something we learned in the group today." If she (he) is hesitant, therapists can help by starting: "We learned that abuse is not the child's fault. It is the fault of the _____, because he (she) is older and knows better and knows it is against the law for an adult to abuse a child."
8. *Positive Strokes or Compliments* (building self-esteem, feelings of mastery, reinforcing positive behaviors). The member with the *Complimenter* role, with therapists' help, goes around the group and tells something she (he) liked about what each person did or said.
9. *Refreshments* (group cohesion, nurturance, building social skills). The *Hostess (Host)* takes charge of this activity and models polite eating, "please" and "thank-you."
10. *Clean-Up* (see Session One).
11. *Passing Out Homework* (mastery, intellectualization, drill in cognitive behavioral modification, positive interaction with mother/caretaker). "Here is some homework for you and your parent or the person who takes care of you. It is different from other homework, because your parent or helping person has to read it out loud, and you have to help her or him fill it out if she or he doesn't know the answers. If your parent or helping person doesn't have time to do this with you or you can't get them to finish it, that's okay, too. But we have told your parents and caretakers to help you with the homework, and they probably will do it, especially if you remind them."

    The therapist and group often review homework together, with therapists reminding members of the "right" answers. (Homework Assignment #1 appears on page D3.)
12. *Positive Feedback Good-Byes* (see Session One).