THE TRAUMA OF CHILD SEXUAL ABUSE

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THE TRAUMA OF CHILD SEXUAL ABUSE

A Research Paper

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In Partial Fulfillment

of the Requirements for the Degree

Master of Science

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by

Peggy Floyd Tapscott

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To the Graduate and Research Council:

I am submitting herewith a Research Paper, written by Peggy Tapscott entitled: "The Trauma of Child Sexual Abuse." I have examined the final copy of this paper for form and content, and I recommend that it be accepted in partial fulfillment of the requirements for the degree Master of Science, with a major in Guidance and Counseling.

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Major Professor

Accepted for the Graduate and Research Council:

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Dean of the Graduate School

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CHAPTER 1
Introduction

Sexual abuse of children is a shockingly widespread problem affecting large numbers of children and their families each year. Many researchers predict that it has developed into epidemic proportions, whether Americans are willing to believe it or not. A private telephone poll conducted in 1983 in Nashville, Tennessee, of 1100 random households revealed that 11% of the women and 7% of the men contacted had been sexually abused as children (Hyman, 1983). A San Francisco study of 900 randomly selected women revealed that 28% had been sexually abused before the age of eighteen. The results of the San Francisco study have been translated into predictions of child sexual abuse across America. These researchers predict that more than one-third are molested by age eighteen (Hyman, 1983). This grave problem cuts across all social, economic, and educational levels.

Child sexual abuse includes a range of sexual acts, including touching the genitals, forced masturbation, digital penetration, oral-genital contact, intracrural intercourse, and vaginal and anal penetration. Other sexual activities which are imposed on children are voyeurism, exposure and involvement in photography or filming for pornographic purposes (Berlinger and Stevens, 1982).

Even though infants are known to be molested, child sexual abuse usually involves young children. In one large sample of 730 child sexual assault victims (16 years and younger) who sought services over a one year period, almost two-thirds were under twelve years of age at the time of disclosure and 41% were under eight years of age (Berliner & Stevens, 1982). Though both boys and girls are potential

victims, it is well known that girls are more susceptible than boys to molestation.

Previously, child sexual abuse went unreported, especially in incest-related cases, with incest being defined as "the crime of marrying and/or having coitus with a person or persons who are biologically closely related (consanguineous) (Public Education and Research Committee of California, 1973). However, with the rapid changing culture across America, more sexual abuse of children is being reported and brought to the forefront of our society. Today, the existence of sexual abuse of children is a known fact, but it is generally believed that the unreported incidents still far exceed the reported ones. As Americans, as Tennesseans, we can no longer ignore this horrendous problem. We can no longer consider the number of adults who were sexually abused as children as insignificant. As educators and counselors we must be prepared to reach out to these children and adults with compassion, concern, willingness to listen, comfort, knowledge, and empathy.

CHAPTER 2

Symptoms and Effects

Sexual abuse can leave a mark on a child that can last a lifetime. Most abuse victims do survive as adults and "behave" normally; however, the shame and guilt from childhood is carried into adulthood. These feelings ultimately affect every relationship involving the person (victim). Even though these injured parties may appear unaffected, manifesting no visible scar tissue or disability, many carry with them a sense that things just are not right with them. This affects them and all of their decisions, especially if the abuse began in the preschool years. When the child, and later the adult, is engulfed with guilt and shame, there is no way that she/he can feel good about him/herself (E. Hart, personal communication, March 5, 1986).

Consequently, the desire and ability to create and maintain relationships with friends, family and spouses are definitely affected. Child sexual abuse affects all of our lives, not just the victim. The pain felt by the abused does not stop with their bodies, but it is passed on in every relationship they have. The scars of this early damage with remain with the victim throughout his/her lifetime.

These scars may manifest themselves in many different forms. Alone or in combination, they reflect the stress and distress that the victim has been suffering as a result of the early trauma. The following eleven maneuvers are exhibited by abuse victims as a means of self-protection and pain avoidance (Hyde & Kaufman, 1984).

(1) Amnesia: There may be an inability to remember large portions of her childhood, specifically around the time that the abuse was taking place. The

continuim may range from no memory of the sexual abuse at all to only a vague dream-like repulsive recollection, which she may deny as untrue or distorted.

(2) Dissociative episodes (or fugue states): The child may develop this type of defense to escape the trauma. As an adult, the female victim finds these experiences occurring during sexual intimacy or demands for intimacy. These reactions are out of her control and are highly disruptive to her relationship. If the abuse as a child was prolonged and included other types of abuse, some victims have developed multiple personalities as a defense (Bowman, Blix, & Coons, 1984).

(3) Phobias or anxiety states: The phobias particularly involved are those that interfere with normal, everyday functioning, such as claustrophia. Panic attacks and physical complaints also may be exhibited, such as headaches, neck pain, tingling and/or paralysis of the extremities, nausea, and gastro-intestinal disease.

(4) Flashbacks, nightmares, or intrusive recollections: Occurring while either awake or asleep, this experience involves the remembering of the original trauma. This is extremely painful due to the vivid pictures, including sounds and smells, that occur as if the original trauma were recurring.

(5) Negative differentness: As the child grows into adulthood, negative concepts of herself often are reflected in her relationships. Many young women have described themselves as feeling diseased, bad, and dirty.

(6) Isolation from peers: As the victim's feelings of uncleanness manifest themselves, she anticipates rejection from friends. She may also sexualize relationships unnecessarily that could develop into supportive friendships.

(7) Distorted perception of parenting figures: There are two distorted perceptions that cause the child to maintain the secrecy of sexual abuse, especially in cases of incest. From the child's point of view, the abusing parent may be viewed as extremely omnipotent with unrealistic powers or as fragile and weak requiring special caretaking services from the child. In the case of either distorted perception, the child's own future parenting styles are definitely negatively affected, as well as the impact of relationships with any authority figures.

(8) Low self-esteem and massive guilt: Early victimization results in attitudes of self-blame, excessive guilt and low assertiveness.

(9) Body image concerns: As the victimized child matures, obesity, anorexia, and/or uncontrolled eating disorders are signs that may be manifested from her struggle with sexuality.

As an adult she may appear provocative and seductive, presenting herself as a desirable sexual object, or as a slovenly unkempt, self-neglecting woman, defending herself against sexual advances and intimacy.

(10) Depression: This is usually a chronic symptom which may range from low energy and agitation, diminished interest in activities, to estrangement from others and in sleep, appetite, and concentration. Suicide attempts are very common.

(11) Stimulus avoidance: The sexual abuse victim avoids activities that arouse recollections of the early trauma or those that symbolize any forms of sexual molestation, such as television documentaries on the topic or books and stories relating to molestation.

In addition to these eleven maneuvers used by sexually abused children, there are some important signs that indicate that incest has occurred. Signs in children and adolescents include conversion disturbances. excessive bathing, obsessions or phobias regarding sexual matters and public masturbation. Common signs in older children are sexual abuse of younger children, seductive behaviors toward adults, chronic urinary tract infections venereal disease or pregnancy, delay or disruption of menstruation, vaginal, anal or urethral bleeding. Adults may exhibit compulsive behavior, severe difficulties with intimacy and trust, sexual problems (especially difficulty integrating mind, body and feelings), feelings of being

a freak, poor body image, amnesia about childhood, guilt and shame, severe contempt for, and hostility and distrust toward men (especially of one's own ethnic group), and phobias of being touched (gynecological exams), fear of losing control (O'Hare & Taylor, 1983).

The true, full impact of child sexual abuse (incest inclusive) is therefore not known because each individual child varies. Some children may exhibit symptoms at disclosure, and some have a much longer, delayed response. Some children do not appear affected at all, while some are clearly seriously and permanently damaged. Physical consequences, such as venereal disease, may occur in some children. There is evidence of an association between runaways, prostitution, drug abuse, sexual dysfunction, acting out, hysterical reactions, and a history of sexual abuse (Hyman, 1983; James & Meyerding, 1977; Benward & Denson-Gerber, 1975).

A significant number of child sex offenders were themselves abused as children and many were victims of sexual exploitation during childhood. Furthermore, some research has shown that as high as 80% of physically abusive mothers were abused as children and most physically abusive fathers were abused or sexually exploited as children (Hyman, 1983). In these cases, the legacy of abuse is passed on from generation to generation which is an alarming concept.

Almost all victims express a sense of guilt and/or feelings of responsibility for the abuse or its aftermath. The unforgettable events of the trauma cause the child to feel bad, ugly, or damaged. The immediate impact on the child disrupts the normal developmental process.

When violence is used or threatened along with sexual abuse, it almost always produces a fear response. As a result, the child behaves fearfully, has nightmares, clings to the parent and exhibits regressive behaviors. Children who are sexually abused over long periods of time may become withdrawn, sullen, or defiant.

The significance that the relationship between child and offender has on the impact of sexual abuse is related to the extent to which the child depends on the offender to meet physical or psychological needs. When there are other positive or neutral aspects of the relationship the child may want the abuse, but not the relationship, to end. When the offender is a parent, there is also a major impact because the parent-child relationship is clearly defined with the expectation of meeting needs for protection, nurturance, and love. If a parent sexually abuses his/her own child, this basic form of trust is permanently impaired, and can never be completely restored. The child may learn that acceptance or love is related to the exchange of sexual favors, and this can significantly influence all future relationships (E. Hart, personal communication, April 4, 1986).

Who the offender is also influences others' responses to the child's report at disclosure. Adults find it hard to accept that a person they like, respect, or depend on would sexually abuse a child and, therefore, might prefer to believe that the child is lying. When believing the child's report requires some change or action on the part of the parent or relative, it may be easier to discount. The child who is believed and supported will, of course, have the best chance of recovery. For the child who does not tell at all, or waits many years to tell, the impact of not telling also delays the recovery and has a negative influence on the recovery process.

The child's developmental stage at the time of abuse may significantly affect the impact of the abuse. The child may be too young to even remember or understand the meaning of the behavior. An older child could understand, but not be able to integrate an experience which is premature and foreign to his/her own age level and experiences. If the abuse occurs over a period of time, the child is prevented from having the normal childhood experiences which form the basis for healthy adult adjustment (E. Hart, personal communication, April 4, 1986).

Since children's personalities differ, it follows that their coping styles will differ. Children who are shy or are late developing might be viewed as easier targets because they are already "different." Individual children handle similar sexual abuse situations in different ways; one child might deny and dissociate the experience, another might be defiant and retaliate, while another might accommodate and participate.

The disclosure process and the subsequent events following disclosure also greatly affect the child. Above all else, the child must be protected from further victimization, both physically and psychologically. Until the offender is separated from the child and she/he receives treatment there is a strong possibility that the offenses will recur. Even though the offender requires treatment and therapy, the main concern is the abused child with all efforts devoted to providing support for the child and minimizing any further trauma (E. Hart, personal communication, April 4, 1986).

Patterns of abuse are as varied as the offenders and victims themselves. However, the offender will generally continue to attempt

molestation as long as he has access to the child, the child does not disclose, or he does not get caught.

Example: T. and C., seven and eight-year-old girls, went to the school yard after hours to play; they met a "friendly" man who said he would show them something. He then pulled out his penis and asked them to touch it. The girls refused and ran home immediately to report the incident to their parents (Berliner & Stevens, 1982).

The abuse might be an ongoing situation involving one child, who for some reason accepts the sexual contact in exchange for meeting emotional or social needs.

Example: An eight-year-old girl, S., used to go to the next door neighbor's house often in the afternoons after school. It seemed to her family that S. was very attached to the neighbor and received much attention, as well as gifts, from him. Two years later, it was revealed that the neighbor had made S. suck his penis and masturbate him during those visits (Berliner & Stevens, 1982).

A group situation involving many children might occur. In such cases, offenders may establish a "ring" of children who participate in the sexual activities as a part of initiation or group membership (Burgess, Groth & McCausland, 1981).

Example: K.'s father had molested her since the age of five. When she turned ten, he began to also force her friends to perform oral sex on him. He would involve them in a sexual game of "truth or consequences" and would pay the girls with cigarettes, jewelry, or money.

Eight others girls were eventually involved as victims (Berliner & Stevens, 1982).

When the abuse occurs within a family, it usually involves the oldest female child. In one-third of intrafamily sexual abuse cases, more than one child is victimized (Sexual Assault Center, 1980). As expected, a range of types of sexual abuse occurs, even within families.

Example: E. is an eighteen-year-old whose mother was schizophrenic. From age eight, E. took over many of the usual responsibilities of wife and mother. She cared for the younger children and did much of the housekeeping. Her father told her many times he would like to marry her. He began introducing her to sex with him at age eight and demanded intercourse regularly in her teen years (Berliner & Stevens, 1982).

Example: T. was molested by her alcoholic father from age eight to fifteen. He would come to her bed and fondle her genitals and sometimes masturbate against her body. She pretended she was asleep during these sexual abuse incidents (Berliner & Stevens, 1982).

Child sexual abuse and incest, as in the two cases stated above, have been shrouded for years in myths and biases. Some of the most well-known are listed below (O'Hare & Taylor, 1983).

(1) Incest is the child's fantasy rather than an adult's behavior.

(2) Incest only happens among social outcasts or the psychologically disturbed.

(3) A "bad mommy" is responsible for the abuse.

(4) The offender tells the daughter that she is special in the family (i.e. special daughter theory).

(5) Some types of incest are worse than others.

(6) Affection theory (Proponents argue that the child is getting sexual information/education at home and receiving affection).

The reality behind each of these myths finds children who have learned to split themselves in two as a way of living with an horrendous secret for which they feel guilty and responsible. They have been unable to organize massive defense efforts that block the awareness that the incest/sexual abuse has occurred or is presently occurring. In some cases, tremendous amounts of energy are devoted to keep anxiety and fear from showing and to maintain the appearance of normalcy. The trauma, for the most part, will remain "in place" until another crisis occurs that shakes it loose, or until a time of greater stability and courage enables the victim to seek out a person to whom to tell her story.

Most children tell a parent, teacher, or significant other, even though there may have been a delay in time since the last incident(s). Should the child choose a teacher to be the disclosure figure, the teacher should always remember that there may be some basis for the student's statements and that it must (legally) be investigated. The trust, confidence, and respect given to the teacher by the student should not be mistreated. It is far better to believe a child (student)

initially and disprove the statements later than to disbelieve the child and consequently keep that child (student) in a sexually abusive situation.

There are some actions that have proved beneficial to teachers who may find themselves in such a situation (Roscoe, 1984):

(1) Show feelings of genuine concern for the student.

(2) Make oneself available and provide opportunities to allow the student to talk freely about feelings, fears, etc.

(3) Maintain the student's normal status within the classroom, (i.e., do not overtly single out the abuse victim from normal, ordinary contacts with peers as the child may already feel different from classmates).

(4) Reassure the student that he or she is not responsible for the assault which occurred.

(5) Present learning activities which enhance the student's self-concept and self-esteem.

(6) Provide experiences which allow the student's self-expression and facilitate the constructive venting of emotion.

(7) Respect and maintain the student's privacy.

(8) Present oneself as a model for appropriate adult-child relationships.

(9) Help the student keep fears and anxieties from growing out of proportion.

(10) Interact closely and cooperatively with professionals who have been trained to work with sexually abused children (e.g., social workers, police, and school psychologists).

The reasons for disclosure are many. Children may tell because the abuse is escalating or progressing to other children. The might tell because of a situation change that makes the child feel it is now safe to disclose (mother has decided to divorce the offender), or because she/he is now old enough to assert him/herself. Finally, sometimes it is disclosed for reasons unrelated to the sexual abuse, such as parent-child conflicts over rules, discipline, and restrictions. No matter what the child's reason for disclosure or the person to whom she/he first talks, disclosure is a progression toward counseling, help, and therapy (see Figure 1).

Figure 1

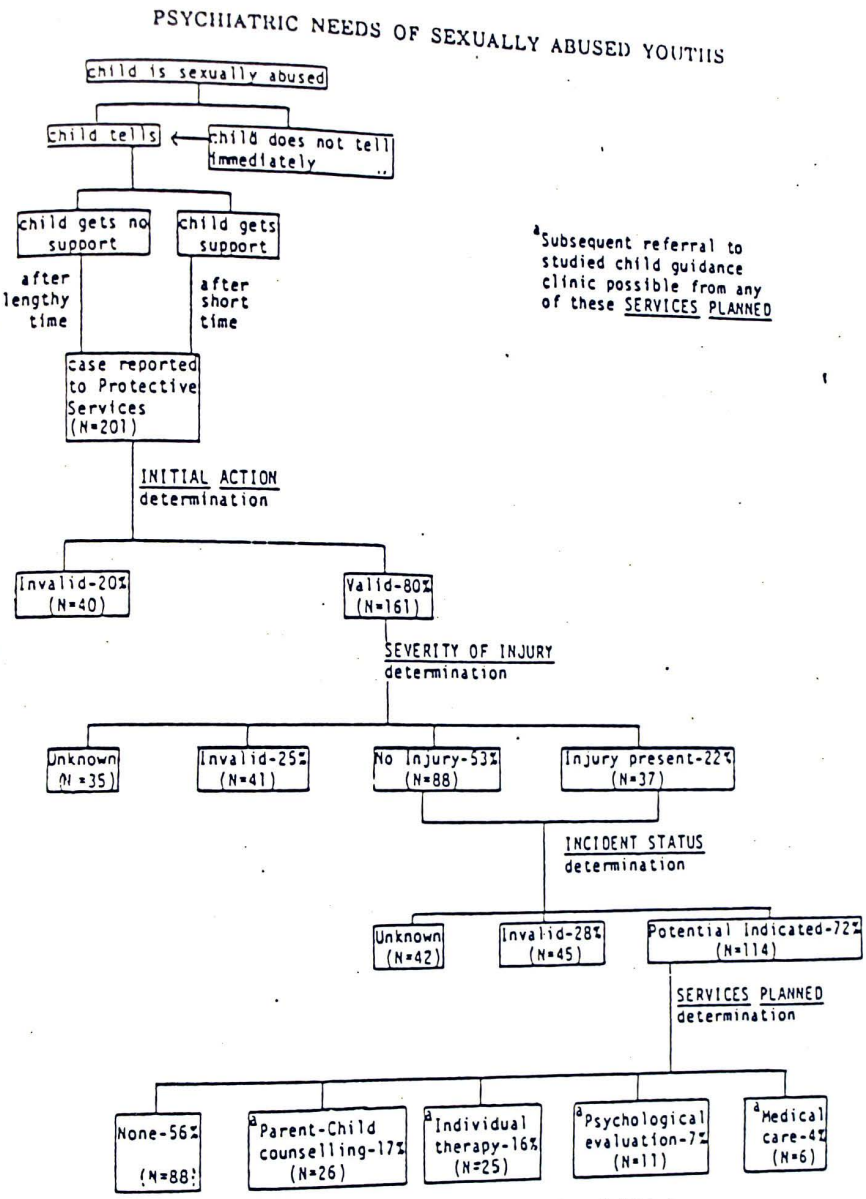

FIG. 1. Features of reporting and investigation of child abuse.

Note: From "The Unmet Psychiatric Needs of Sexually Abused Youths: Referrals from a Child Protection Agency and Clinical Evaluation" By Christine Adams-Tucker, 1984, Journal of American Academy of Child Psychiatry, 23, p. 663.

CHAPTER 3

Treatment Methods

For young children, ages 3-10, art therapy is an emerging modality for dealing with sexual abuse (Kelley, 1984). Victims of this young age need age-appropriate ways for the ventilation of their fears, anger, aggression, hostility, and feelings concerning the sexual assault. By using the method of art therapy, the child is able to use a less threatening means of expression these feelings, in contrast to verbalization.

During the actual counseling session, the child is given blank sheets of paper and asked to draw a self-portrait, a picture of the offender, a picture of "what happened," and a pictures of a "whole person." After the completion of the pictures, she/he is asked to describe the details of the pictures. In this way the therapist gains insight into the child's reaction to the actual assault, as well as the factual information. Four to six weeks later, pictures are again drawn by the child to aid the therapist in finding out how much change or progression from the initial counseling session the child has made.

From this writer's research, group therapy, in combination with other types of treatment, seems the best method of treating the victims of sexual abuse. This method is suitable and appears productive for young children through adulthood. A group for abused children provides a group of peers who know about the sexual abuse, who share common experiences, and whose acceptance is therefore guaranteed (E. Hart, personal communication, April 4, 1986). The therapist has a tremendous opportunity in the group

sessions to correct the distorted thinking of those involved, to clarify misunderstandings, as well as to allow the free expression of feelings and fears. By listening to the others in the group, it is hoped that each child will come to fully understand and totally integrate the information that she/he is not at fault in any way for having been victimized. Just knowing that there are others who have experienced something similar makes the abuse experience less alienating and threatening for victims. Appendix A (Berliner & Ernst, 1984) includes a suggested format for a six-session therapy group. This suggested format does not need to be followed rigidly because flexibility should be an on-going group priority. At any time, if the children are absorbed in the discussion, it should be allowed to continue. This type of group process encourages discussion, activities, improvement of the self-image, acceptance of self and others, and the making of lasting friendships. As a group continues, the girls find themselves interested in helping their fellow group members cope with their anxieties and fears, rather than being as "I-centered" as they once were (J. Sledge, personal communication, May 18, 1986).

Conclusion

Parents and educators must be concerned with this tragedy and attempt to find ways and means of educating and preparing children to avoid potential abuse situations, and to prevent an initial approach from becoming a sexual assault. Prevention strategies should be presented in a realistic, non-threatening manner so as not to frighten the child (Koblinsky & Behana, 1984). Children who know what to look for and who to tell will be less fearful than those with sketchy or exaggerated information, such as sex maniacs take off your clothes, murder you, and cut you up into about a hundred pieces (Kyblinsky & Behana, 1984). Listed below are ten strategies of prevention that parents and teachers should find useful (Koblinsky & Behana, 1984).

(1) Teach children that some parts of their bodies are private.

(2) Help children identify different types of touching.

(3) Teach children to say no to unwanted touching.

(4) Explain that bad touches could come from someone that the child knows.

(5) Encourage open communication and discourage secrets.

(6) Teach children how to tell.

(7) Use games and stories to reinforce prevention concepts.

(8) Continue to discuss safety rules concerning strangers.

(9) Encourage children to trust their own instincts.

(10) Teach children about the positive aspects of sexuality.

The trauma of child sexual abuse can be prevented and eliminated from the lives of many children through the willingness of adults to get involved with this tragic situation that surrounds us all. No child

should have to suffer from this kind of tragedy. No child should have to hide such an awful secret. No child should have to live with such a tremendous level of fear and anxiety. No child should have to awake from the horrible nightmares that these children have. Care and concern is not enough, however. As teachers and educators, we must incorporate prevention programs into our classrooms, curriculums, in-service programs, PTA meetings, and even instigate parent training programs. As history shows, this problem has been with us for hundreds of years. Now is the time for adults to begin to think of all children and how we can help to spare them from a future legacy of child sexual abuse.

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APPENDICES

APPENDIX A

GROUP FORMAT

Each session follows a format. At the start of each group, the children are reminded why they are there in age-appropriate language. Each child then reports on a positive event that has taken place in the previous week (e.g., good test score, no arguments with brother, birthday party). The food is introduced at the beginning, and the children share in passing it out or pouring. After the first session the members can select the next week's treat. After a brief period of eating and sharing (10 to 15 minutes), a group activity, either art or drawing, is introduced. Then there may be a discussion, demonstration, or mini-lecture. A final group exercise or activity closes the session. This format does not need to be rigidly adhered to because there should always be the flexibility to continue with a particular activity if the children are absorbed and are enjoying it. A lively discussion with a lot of participation or a particularly elaborate role play might take up most of one session.

Note. From Victims of Sexual Aggression: Men, Women, and Children (pp. 118-123) by Irving Stuart and Joanne G. Greer, 1984, New York: Van Nostrand Reinhold Company, Inc.

APPENDIX B

SUGGESTED FORMAT FOR A SIX-WEEK SESSION THERAPY GROUP

Session One:

Introduction of leaders and children.
Statement of common experience ("Everyone is here because someone molested/assaulted/touched them in a wrong way/place").

Ground rules:
No one has to talk about what happend if he or she doesn't want to.
No physical or verbal violence in group.
What is said is private unless it affects their safety/respect for each other's privacy.

Food:
Pass out/discuss/plan for next week.

Art:
Children draw a picture name tag - things, activities, places, that have special meaning to them.

Discussion:
Labeling/defining sexual abuse:
"Can anyone say what molestation is?"
"What's the person it happened to called?"
"Who is responsible?"
"How many people were molested by someone they know?"
"How many by a parent?"
"How old were you when it started?"
"How many people had it happen one time or how many had it happen a lot of times?"
"Who did everyone tell?"
"Did they believe you?"
"Is it better before you tell or after?"
"What does it feel like when you're keeping the secret?"
"What does it feel like when someone thinks you're lying?"

Group exercise:
Little kids:
Whisper down the line, squeezes around in circle, London Bridge.
Older kids:
Physical exercises (stretching, touching toes, etc.)

Closing:
"Does everyone know everyone's name?"
"What did you learn about each other?"

SESSION TWO:

The offender/what happens.
Introduction/sharing something positive, food.

Art:
Draw a picture/representation of opinion about the offender.
Put up on wall for rest of group (rogues' gallery).

Discussion:
What did you think about him before he molested you?
Did your feelings change?
Why do you think he did it?
How did he make you?
What did you think would happen if you told?
What should happen to the sex offenders?

Role Play:
Act out courtroom handling of case. Children are given tags (judge, victim, defendant, defense attorney, lawyer, baliff, juror, prosecutor). They make up the scenes and case. Have them change roles/do several.

Relaxation exercise:
All members lie on floor with heads in center and imagine happy places, practice relaxation techniques.

Closure:
Ask children to bring picture of self as baby for next session.

SESSION THREE

Body Image.
Introduction, sharing, food.

Art:
Draw self-portrait. Use mirror/have children talk about what part of body they like. Share baby pictures.

Discussion:
Label body parts/functions.
What are all the names you can think of for where a boy (girl) goes pee?
What is the real name?
Which parts of your body are private?

Note: With pubescent children there will be much greater interest and a whole session might be directed to changing bodies:
Who has her period?
What did you think when it started?
Who knows what masturbation is?
What are the changes a boy (girl) goes through?
Who can you ask questions about these things?
Who went to a doctor? What was the exam like?

Have books available:
Teen Body Book.
Changing Bodies.
What's Happening To Me?

Activity:
Active game/play for younger children.
Relaxation exercise.

Closing:
Ask children to bring family photos or mementos from friends/family.

SESSION FOUR

Family/friends.
Introduction, sharing, food.

Art:
Kinetic family drawings.

Discussion:
What is a family?
Who is in your family?
What is the most important thing about mom (dad)?
Are you mad at/feel let down by anyone in your family?
What would you like to be different?

Friends:
Tell something about your best friend.
What would your best friend say about you?
What is a good friend?

Role play:
How to be a friend if someone tells you they are abused.

Closing:
Children to bring a joke to share next week.

SESSION FIVE

Ego enhancement
Introduction, sharing, food.
Joke telling.

Group game:
"The Ungame".

Problem solving:
List all the problems from being abused (put paper on wall).
Choose one problem for group to help solve (e.g., being afraid at night: group discussion on techniques to fall asleep, night-lights, hall light, warm drink before bed, checking doors, parents reading story).

Physical contact/activity:
Group hug relaxation exercises.

SESSION SIX

Prevention.
Introduction, sharing, food.

Activities:
Prevention.
What would you do if: (molest scenario, rape scenario).

Discussion, role play, movie:
Little kids - who to tell.
Bigger kids - how to fight back/get away.

Preoffense warning signs:
How to know if someone may molest you (e.g., treating you different, wanting to be alone, accidentally-on-purpose touching you).
Mini-self-defense ideas (how to get out of wrist, neck hold, how to walk confidently, shouting for help).
List places/people who can help if it ever happens.
Party.
Closure, goodbyes, sharing names and numbers (older kids).

APPENDIX C

SOME SUCCESSFULLY USED EXERCISES

Art Work
Picture tag.
Self-portrait.
Kinetic family drawing.
Offender representation.
Group mural.

Self-Esteem Exercises
Self-affirming statements/sentence completions:
"I am wonderful because. . . "
If repeated each week the therapist keeps a record and at the end of group children can take list home.
"What I do well is . . . (better with older children).
Guided fantasy (Wait until third or fourth session when children are comfortable and secure. Have children draw the place they imagine.)
Ask children to name a wish. (One 5-year-old said: "I wish my dad would stop playing with my weiner.")
Ask who was the loudest, the quietest, the funniest?
At the last session ask how each child contributed.

Read a story:
"There's a Monster in My Closet"
"Sylvester and the Magic Pebble".

Therapeutic games:
"Ungame"
Talking-feeling-doing game.

Bring camera and take picture of individuals/group. (Caution, in one group a 9-year-old girl said, "You aren't going to take dirty pictures?" Many cases of sexual abuse involve pornography.)

Mirror - have available in room.

Have children bring in baby picture/family photograph album.

APPENDIX D

SKILL BUILDING ROLE PLAYING

Learn to problem solve:
Identify problem, list alternatives, select choice, etc., learn to negotiate.
Relaxation.
How to make a friend.
How to say no/assertiveness.

Movies:
"Who Do You Tell".
"Child Molestation: When To Say No".
"No More Secrets".

APPENDIX E

Clarksville, Tennessee 37040
615/647-8811

To Whom It May Concern:

RE: Copyright Permission

Permission was granted from the Van Nostrand Reinhold Company (1-212-254-3232) by Mr. Yosef Dorman (1-212-580-3675) to use the information in Appendix A.

Permission was granted by Christine Adams-Tucker, M.D., (1-502-458-1700 - Office) of the Medical Arts Building, Louisville, Ky. (1-502-458-4449) to use the flow chart on page 15.

Both parties readily granted permission. They both stated that since the reprinted information was of such a limited nature and was not for publication purposes that they preferred to verbally grant use approval. Should there be any question, I have included their phone numbers and they will gladly confirm their approval.

Respectfully submitted,

Peggy Tapscott