WHAT KIDS THINK:
AFTER TREATMENT FOR SEXUAL BEHAVIOUR PROBLEMS

by

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ABSTRACT

Children 12 years and under with sexual behaviour problems experience shame and isolation and present a profound community concern. Empirical, clinical, and theoretical literature is inconclusive, lacking consensus on what to label children, how to characterize either 'normal' or problematic sexual behaviours, theory of etiology and risk factors, and treatment approaches for these children. The sensitive nature of this research with very young children is a factor in the paucity of systematic studies on the scope of this problem. A formative program evaluation was carried out on SHIFT (Sexual Health and Family Therapy), a brief multi-modal approach offered to treat an outpatient population. SHIFT centers on contextual family therapy integrated with individual directive therapy where children create 'problem-gone' solutions. Narrative and cognitive behavioural strategies combine for a highly compatible union. Children and parents were interviewed up to three years after treatment. Rennie's (2000) application of hermeneutics to the grounded theory method was employed to conceptualize categories from interview text in response to the constant comparative analysis of meaning units. Most children and their parents reported significant reduction in behavioural symptoms of problematic sexual behaviour. Conversation excited spontaneous and reflective description of essential components of this model. Children valued creating a new preferred story that mapped their success. Discussion includes features of the program that can both promote and diminish the experience of change. Attachment theory provides insight into the therapeutic alliance. Key findings included the importance of parental involvement and the power of externalization in personifying the problem.

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CHAPTER I: INTRODUCTION

Children under 12 years of age with sexual behaviour problems present significant concern to adults in schools and communities. The problem leaves the young people at risk for expulsion from school, social ostracism, and community shaming and can severely limit children meeting their potential as adults. The empirical, clinical and theoretical literature on the scope and parameters of this problem remain limited. There is a pressing need for treatment studies and sharing of common descriptive information that explicates key data on these children. SHIFT (Sexual Health and Family Therapy) offers concurrent contextual family therapy and individual directive child therapy. This treatment embraces a combination of interventions in reaching a 'problem-gone' solution that embody narrative therapy as well as cognitive-behaviour experiential therapy and include structural and strategic interventions. SHIFT has been consistently employed with an outpatient population for children under 12 in the Upper Fraser Valley of British Columbia, Canada.

An influential theorist, Patton (1990), advocates that method choices should largely match the concrete information needs of the identified evaluation audiences, not transfer primarily from an abstract philosophical paradigm. Patton further determines that when needs entail themes such as multiple perspectives, contextualized meanings, or the experience of program participation, qualitative methods should be employed. It is suggested that the qualitative study presented here both reflects the information needs of the evaluation audiences and also embraces my chosen philosophical paradigm. With the philosophical framework of inquiry as formulated in the influential work of Guba and Lincoln (1989, 1981),

an interpretivist logic of justification is held dominant. An interpretive framework promotes pluralism in evaluation contexts as well as forging channels to program improvement. Furthermore, this framework seeks to enhance contextualized program understanding for stakeholders closest to the program (program directors, staff, and beneficiaries) in addressing how the program is experienced by the beneficiaries. Stake's (1975) and Guba and Lincoln's (1981) responsive approaches to evaluation are major exemplars of this qualitative evaluation approach.

This program evaluation of the SHIFT implementation design was based on the qualitative grounded theory analysis originally developed by Glaser and Strauss (1967). The aim of grounded theory methodology is to generate analytic schema called 'a substantive grounded theory' that emphasizes the context by which findings are understood at a higher level of abstraction (Glaser & Strauss, 1967). This study was strongly influenced by David Rennie, who first introduced grounded theory thematic analysis into the field of psychology in l987 (Rennie & Brewer). In purposefully modelling my study after Rennie's 'methodical hermeneutics' (2000), I have been considerably challenged in the hope of gaining a thorough and accurate understanding of the justification of this method but equally excited and energized by the process.

To evaluate the SHIFT implementation design, participants were interviewed to examine the process of therapy as experienced by the children as well as their parents. The children had completed this treatment for children with sexual behaviour problems up to three years prior to this investigation. Grounded theory analysis not only recognizes the uniqueness of lived experience but also

details human commonalties in the meaningfulness of lived experience as theory grounded in the data is understood and developed. Qualitative research looks in detail into how people make meaning as well as how and why they think and behave as they do (Ambert, Adler, Adler, & Detzner, l995; Nelson & Poulin, 1997). This paradigm lent itself well to the present study that emphasized processes and meanings, as did the research question also center on how experience was created and given meaning. In this manner, the outcome of this evaluation of SHIFT program design now seeks to draw you into this unique corner of the world experienced by these children as participants answer the foci research question: “What is your experience of the treatment program?”

CHAPTER II: LITERATURE REVIEW

A review of the literature appropriately includes dissemination of two discrete areas of research. The foci here are on the growing body of literature on children with sexual behaviour problems specifically relevant to the proposed study, as well as the writings on program evaluation involving relevant terminology and important execution considerations.

Family-based therapy is widely praised as a treatment for children as it deals with the contextual and multidimensional aspects regarding etiology and treatment, placing the family on center stage. Moreover, considerable work with children today incorporates aspects of both family therapy and individual therapy. As well, cognitive-behavioural therapy is often a mainstay to clinicians' work with children and families within the chosen framework. Furthermore, the influence of the resurgence of narrative therapy, while less well known, is also reflected in much of the literature, most noticeably in the use of externalization in the personification of the problem and accompanying techniques. Many therapists in employing a variety of interventions will also use structural, strategic, and trans-generational strategies in effecting change in family relational patterns.

The literature as a whole, in responding to this significant problem with prepubescent children, contributes substantial heterogeneous information and remains scattered and inconclusive. Correspondingly, there is a lack of empirical research and very little systematic clinical evidence to be found as to what actually works with different children who demonstrate sexually intrusive behaviours. Thus, with numerous programs being implemented in North America for the

treatment of children with sexual behaviour problems, we have very little program evaluation to guide us

In evaluating the implementation design of the SHIFT program, an interpretivist logic of justification was used in order to answer the research question "What is your experience of the treatment program?" Data for judging this formative evaluation were acquired through the participant-observation approach and conducted from an internal evaluator's perspective. Three major areas of influence have played some part in my creative interpretations as a result of my developed understanding of the text. Through the process of inquiring about the unique experiences of the children and their parents, essential systematic research is provided that advances our understanding of the scope and parameters of children with sexual behaviour problems.

Children with Sexual Behaviour Problems

Consensus in the Field. It is only by applying a collaborative focus that clinical researchers will begin to synthesize this complex and prismatic knowledge accumulated from the major voices in the field and from the systematic research. Two seminal reports based on clinical consensus serve to extend and integrate understandings of these children. They are Best Practice Issues and Suggested Practice Standards in Working with Children with Sexual Behaviour Problems (Wachtel, l996) and The Revised Report from the National Task Force on Juvenile Sexual Offending (1993, Appendix H). As well, the Task Force review of theoretical explanations and treatment issues with these children is found in Appendix M. Throughout this thesis, references will be made to these two documents as the 'Provincial Consultation Group' and the 'Task Force'.

These reports document the consensus building authority of many professionals and researchers working in this field. The SHIFT program model reflects these reports in recognizing the multiple dynamics that influence the presence of sexual behaviour problems in children and subscribing to a multi-focus approach to meet the individual family's relational needs.

In examining how these children are described in the scientific and clinical literature at large, what seems most readily apparent is the very substantial lack of consensus in the field. Accepting that this area of study is a sensitive social issue and requires a social response that is appropriate and informed I have included in appendices a number of specific domains designed to help inform the interested reader: characteristics of children with sexual behavioural problems (Appendix I); labelling children with sexual behaviour problems (Appendix J); sexual development and sex play in children (Appendix K); sexually intrusive versus 'normal' sexual behaviour in children at different developmental stages (Appendix L); and, theoretical explanations of etiology and associated treatment issues for children with sexual behavioural problems (Appendix M).

Having reviewed the various descriptors in the literature, I have chosen a label for these children with the intention of making research more consistently informative as well as reaching a middle ground between a very broad category that may conceal the problem behaviour and one that argues for recognition of these children as abusers, molesters, or child perpetrators. Therefore, I will refer to these children as 'children with sexual behaviour problems' or 'children who exhibit problematic sexual behaviour'. Moreover, in describing the children's problematic behaviour at the high end of the continuum I will use the terminology

used by the Provincial Consultation Group and by SHIFT (Act II, 1995). Thus, highly problematic sexual behaviour will be referred to as 'sexually intrusive' (please refer to section on program evaluation [Wachtel, l995] for explication of categories and classification used by SHIFT).

Treatment Programs: Prevalence and Rationale. Although the clinical literature, like the theoretical literature, continues to remain limited, numerous programs attempting to provide services for this group of children are emerging. I draw particular reference here to the Safer Society Survey (1986-1996) and the substantial program review by Araji (l997). The Safer Society Nationwide Survey (Burton, Smith-Darden, Levins, Fiske & Freeman-Longo, 1996) summarizes 10 years of program operations, specialized treatment, and treatment methods for sexual behaviour problems from l986 through 1996. Beginning in 1994 the Safer Society, in addition to surveying treatment services to adolescent sex offenders and adult sex offenders across the United States, started including survey questions directed at those who provide treatment to children with sexual behaviour problems. In 1996, Burton et al. reported 317 separate programs for children, including 17 residential programs and 300 community-based programs. This 1996 survey requested that providers name only one overriding model that best described their treatment approach with these children. Clearly, at the time of this survey the overwhelming majority of respondents chose the combined cognitive behaviour/relapse prevention model (74%). In terms of treatment technique, the focus on 'thinking errors' was the primary method reported in residential programs for both adult and juvenile populations, while community-based programs for these groups reported family treatment as the primary

technique utilized followed by thinking errors. This survey did not address analysis for the children in treatment in deference to addressing adult and juvenile male sexual offender treatment. An interesting exception, however, was the observation that delivery of services for children, youth, and adults across the various treatment models differed little from one another. This observation suggests that services for treating these children are failing to consider the importance of the role of developmental issues.

There are at least ten individual treatment programs or practices in the United States representative of current treatment and practice trends and identified to be serving children under the age of 13 who are sexually abusive (Araji, 1997). Contrary to the findings of Safer Society Survey, according to Araji, all the programs she reviewed have developed interventions based on the child development literature and reflect differences in age, cognitive, or maturity levels. However, Araji does report that details regarding the specific developmental theories used and the application of theories are mostly absent from the program descriptions. While program designers of most of these programs incorporate information about sexual abuse in their treatment formulations, various others consolidate knowledge from perpetration prevention, while still other designers borrow from adolescent and adult models to plan interventions that focus on personal accountability, the sexual abuse cycle, and relapse prevention. Of these programs Araji recounts that the majority of professionals reflect a cognitive and behavioural orientation, wherein sexually problematic behaviour is viewed as learned behaviour. In theory, this learning suggests a progression of behaviour ending in sexually intrusive behaviour directed against other children or

individuals viewed as vulnerable. Additionally, the majority of programs Araji reviewed are reported to incorporate a biopsychosocial orientation, which draws from theories addressing the psychological development of the child, the relationships influencing the child's development, and societal forces impinging on personal growth and development.

In looking at these individual programs reviewed by Araji (1997), it seems apparent that no single theory has been found adequate in addressing the complex and interactive nature of the various individual, family, and ecological processes associated with children with sexual behaviour problems. Furthermore, when examining the services that are offered to work with the individual, peer, pair, and group with these children, the primary treatment modality reported is group therapy. However, the decision to use group therapy needs to be dependent on each child's level of maturity and ability to benefit from working with other children. Moreover, while interventions stress the elimination of the sexually problematic behaviour, they are also aimed at replacing maladaptive behaviour with sexual feelings, thoughts, and behaviours that are age appropriate and, as a general treatment strategy, include teaching prosocial and adaptive skills.

For every program, agency, or private practice reviewed (Araji, 1997), parental involvement was unvaryingly considered important to the treatment process. However, there does not appear to be agreement as to the range of family problems that should be included in treatment. Some clinicians treat family units as a whole, covering multiple problem areas and providing a variety of services. Others choose to remain focused on the childhood sexual abuse and directly related family issues as does the SHIFT program model. The degree to which the

child receives treatment for a personal history of sexual abuse varies as a function of clinical preference, available resources, or how treatment services are designed.

When considering the field as a whole, it seems apparent that considerable creativity is being brought to the clinical arena in treating children with sexual behavioural problems. Professionals are expressing this originality is many service areas that encompass the expertise, experience, and theoretical orientation of the provider; several treatment modalities; the utilization of available resources; and collaboration with colleagues, both locally and nationally.

Description of the SHIFT Program Model

Theoretical Approach: Trauma Outcome Process. SHIFT joins many practitioners and writers in using developmental theory to identify guidelines for what is considered normal sexual development at various ages (see Appendix L). These guidelines are then used as a yardstick for measuring behaviours that deviate from these expectations. Besides focusing on stages of normal development patterns, developmental theory also encompasses the notion of disruptions that occur during children's development and how these disruptions help explain sexually problematic behaviours. SHIFT therapists also assess the children's problematic sexual behaviour by viewing it on a continuum from normal to problematic. In this manner behaviour is considered in reference to the context of its occurrence, the child's life, and the social norms appropriate to that context (see section on program evaluation [Wachtel, l995] for categories and classification used by SHIFT).

Taken as a whole, the SHIFT program design is guided by the trauma outcome process model, which incorporates the sexual abuse cycle. This treatment

is a process of helping children to become aware of their feelings and vulnerabilities prior to offending. Among the program designers implementing the trauma outcome process model are SHIFT (Act II, 1995) and Burton & Rasmussen (1998; see Rasmussen, Burton, & Christopherson, 1992). This model, an adaptation and extension of the sexual abuse cycle,[1] is both an explanation of the etiology of children with sexual behaviour problems and a treatment approach. This framework is based on psychodynamic, social learning, and humanistic theories. With this approach the abusive process of the sexual abuse cycle is viewed as only one of three possible responses to traumatic experience(s). Additional potential responses are recovery and self-victimization. The recovery response represents healthy coping, while the self-victimization and abuse responses represent maladaptive coping styles. Similar to other psychodynamic trauma models that emphasize developmental and coping theory (e.g., the post traumatic stress disorder model [PTSD]), the trauma outcome process model views internal conflicts and unresolved feelings related to traumatic events as important motivators of behaviour. Additionally, like the sexual abuse cycle and social learning models (e.g., traumagenic dynamics of abuse model, Finkehor & Browne, l985, l988), the trauma outcome process highlights the role of adaptive and maladaptive thinking processes. In addition, this framework is humanistic because it stresses awareness and choice as factors that determine an individual's response to traumatic events. The trauma outcome process model is useful as a practice model for treating both victims and offenders. Clinicians use this

[1] With young children SHIFT employs a linear creation of the abuse cycle (e.g., "steps" or ladder notion with problematic behaviour at the top step/rung; see Cunningham & MacFarlane, l991, p. 173); SHIFT also uses 'counter-talk' (e.g., this will cause me trouble or hurt others).

conceptual framework to help children with sexual behaviour problems identify their individual responses to traumatic events, determine if their responses are healthy or dysfunctional, and replace dysfunctional responses with adaptive responses. Correspondingly, parents can be encouraged to confront their own prior traumas, identify their individual reactions to stress, and strengthen their positive coping styles. In the trauma outcome process, individual and family characteristics as well as ecological factors all interact to influence a child's responses to traumatic events (Act II, l995; Burton & Rasmussen, 1998; Rasmussen, Burton, & Christopherson, l992).

Contextual Family Therapy: A Multi-Faceted Approach. The SHIFT design manual emphasizes that children with sexual behaviour problems are dissimilar in many areas including the type and level of sexual behaviour they exhibit and will respond to treatment in different ways. In keeping with this rationale the SHIFT program design can be described under the umbrella of contextual family therapy. This is a relational approach that strives to integrate significant premises from various approaches to psychotherapy in a manner that is ethically concerned and contractually responsive to the interests of all the persons whom the therapy potentially affects. Additionally, the approach endeavours to arrive at the most effective preventive design. Contextual therapy integrates the systemic view of classical family therapy with a multiple individual level of dynamics. The contextual orientation assumes that the leverages of all therapeutic interventions are anchored in relational determinants. However, while we speak of relational determinants for therapy, the contextual approach never loses sight of

the goal of benefiting persons, not systems. The entry point of intervention can be one individual's 'complaints' or symptoms, as well as relational problems.

With this understanding the SHIFT program designers recognize that when thinking about and working to change a child's sexually problematic behaviour, it is necessary to view inappropriate behaviours as part of the child's system of behaviours and interactions with others. The role of the family is considered central to the therapeutic change process. As a program goal SHIFT becomes dispensable to the family after serving as a catalyst for its formation and interpretation. Since from the outset the family members' role has been one of an exercise in responsibility, the therapist makes no major shift in role when the termination of treatment approaches. Interventions are based on the belief that a family-based approach is the best way to draw out the family's strengths and to focus them on the creation of a solution to the family's situation. With the contextual family approach the therapist actively directs the client from the beginning of therapy. This family therapy orientation includes components from solution-focus narrative, structural, and cognitive behavioral realms. Moreover, this multi-faceted approach is structured so as to encompass: (a) family therapy, including work with non-family members of significance (e.g., social workers or foster parents); (b) individual and dyadic therapy with members around issues adding to presenting problem applying (e.g., use externalization where the problem is personified in problem-centered directive play therapy); and, (c) consultation with and support to parents to address the problem's influences in the community and school.

Generally, SHIFT therapists work from a narrative position by, for example, attending to aspects of the family's stories which are not problem laden; empowering the family to begin to uncover a new perspective and a new enduring story. This new story is based on strengths and resources that the family can use to solve current and future problems. In this model, structural considerations address the hierarchies, roles, system and subsystem boundaries, and overall functioning within the family. It is accepted that structural work is often needed to prepare the family for other interventions by securing clarity, flexibility, and consistency with the family. Further, working from a cognitive-behavioural approach the connecting links between one's thoughts and one's behaviours are recognized and a solution can be created through the interruption of the child's behavioural schema that often accompanies that recognition. From experience, the designers believe that precursors to these thought patterns exist, not just in the children, but in their family as well. With the help of his therapist, the child can see the patterns in his or her own thinking and that these patterns can lead to intrusive behaviour. New choices and new responses, with practice, can become intrinsic to the child's behavioral repertoire.

Contextual Family Therapy: Treatment Structure. With the implementation of the SHIFT program designers' flexible approach reflecting the needs of the family, treatment can be structured in various ways. It may involve a therapist and a participant observer, a co-therapy mode with the family unit, or separate but simultaneous individual sessions with family members. In this last case, the family are initially seen together, then the child and family members are seen separately for simultaneous sessions, concluding with the reconvening of the

family session to share information and debrief. Treatment is designed to help the family establish open but appropriate communication about the problem and to establish appropriate family boundaries between generations and around content topics. All modes of the therapy process are integrated with family members continuing to work together as a team.

Contextual Family Therapy: Treatment Logic. Even in the case of children in care, SHIFT designers consider the influence of the family is paramount. Because the family does not live in isolation, the family in its turn is deeply affected by its social and community environment such that it becomes part of a set of unfamiliar relationships with community and professions responding to the situation from various perspectives ranging from supportive to adversarial. Thus, with a contextual perspective, it is considered helpful to look at the impact of the macro community and at times work directly with it.

As the family describes the behaviour, the SHIFT therapist might speculate about the roots in the belief that he or she as well as the client could benefit from knowing. Experiences suggests that sometimes in knowing 'why', what makes sense can seem to make more sense and are accompanied by a reduction in fear and helplessness. Nevertheless, the SHIFT therapist is advised not to allow treatment to be driven by these speculations in order that treatment options remain open. In preference to trying to determine cause(s) of the problem, the SHIFT therapist prioritizes the creation of a collaborative atmosphere by finding, for example, a common language to discuss the behaviour and the affect going with it. Even without such a disclosure, as is more often the case, the collaborative emphasis of the contextual approach allows the therapy to move

forward in terms of solving present problems and anticipating future dilemmas. Experience has shown that the hope of a disclosure about the 'acting out' child's experience of abuse can prevent the family from focusing on present problems to reach a problem-gone solution.

With the contextual family approach it is the therapist's task to assist the family to separate from a problem-saturated story about themselves in the process of facing present difficulties by focusing on exceptions to problematic responses and on the family's strengths. The principles of the contextual family approach include: viewing the family as the unit of treatment, empowering the family by recognizing its strengths and highlighting exceptions to problematic behaviours, guiding for change within the context of the day-to-day life of the family, adopting a non-hierarchical and collaborative stance, focusing on the solution of problems in the present, and addressing related and parallel problems to the problematic sexual behaviour. The SHIFT therapist does not insist on the attendance of all family members although they are all invited to participate.

The therapist locates the problematic behaviour in the family by utilization of 'relative influence questioning' (see White & Epston, 1990). This technique sees to find out how the family perceives, thinks about, and responds to the problem. The meaning or 'story' given to problematic behaviour by family members establishes an atmosphere that influences the relative strength or weakness with which it persists. Family stories about sexuality and sexual behaviour governs what the family identifies as inappropriate or shameful, and how it subsequently responds.

Fundamentally, the contextual approach explores the interactive environment of the problematic behaviour. In this manner, problematic sexual behaviour takes its place as a problem-among-problems in the course of the changing day-to-day life of the family. With family strengths continuously elicited and the focus on solutions and exception to the problem behaviour, the family members join together to defeat the problem and its influences and to strengthen connections among family members.

Contextual Family Therapy: Interventions. Just as there is a continuum of childhood sexual behaviours, there exists a continuum of interventions. SHIFT program designers emphasize that the degree and nature of the intervention needs to fit the problem. In this manner interventions are not more invasive or extensive than is necessary to obtain the desired outcome.

In adopting an intervention the SHIFT therapist is able to choose from a broad variety of strategies within the realm of family therapy. In meeting the individual family's needs, the SHIFT treatment can include structural and strategic interventions, inter-generational work and narrative strategies including externalization.

With structural interventions the focus is on the clarification of boundaries, particularly inter-generational boundaries and on the decision making practices of the family. Interventions here are based on suggestions by the therapist about ways in which the practices might be restructured and are often enhanced by the use of contracts.

Strategic intervention are based on the idea that problematic patterns can be resolved by (a) changing key sequences of behaviour with them or (b) creating new meaning for the behaviours. Interventions of this type are facilitated by the therapist's acceptance of the client's 'world view' and introduction of suggestions for change that do not disturb it in any fundamental way.

The inter-generaltional approach is founded on the idea that unresolved emotional issues between generations affect subsequent generations. Resolutions between parents and grandparents can free children and parent from re-enacting such issues.

The narrative approach focuses on the 'story-making' or 'meaning-creating' practices of families and communities. With this perspective 'stories' we tell ourselves and others 'shape' our experience and form the basis of our actions. Rather than viewing the child as deficient or dysfunctional, the narrative approach views children as 'subject to' or 'captured by' the enactment of problematic stories. With this outlook problems are 'externalized' counteracting the more prevalent practice of locating problems within children and within family relationships. With externalization children, families and counsellors receive a compelling invitation to join together to overcome the problem story and its enactments. Externalization establishes a conversational context in which 'the problem becomes the problem'.

Although, on the face of it, externalization appears to free children of responsibility for problems, the effect is quite the opposite. It creates a conversation in which children can consider their relationship to problems in contrast to a more internalizing version in which the conversation constructs a

sense of being identified or ‘at one’ with the problem. The idea of relationship immediately introduces the possibility of mutual influence suggesting ways that the problem influences the child and ways that the child influences or acts effectively against the problem. In the course of exploring mutual influences or relative influence questioning’ (see White & Epston, 1990) personal agency is evoked. In this manner, the territory in which the child, the family, or significant others are influencing, combating, or overcoming the problem become the starting point for an ‘alternative story’ featuring the child’s separation and, ultimately, freedom from the problem. In addition, with the narrative approach, language is considered to be the material from which social and emotional realities are constructed. Hence, the counsellor works within the language system of the child or offers terminology that is ‘user friendly’ to children. Additionally, while the sexual behaviour is the primary focus, because clinical experience suggests that multiple stressors, both historical and ongoing, can add to the maintenance of the behaviour, the contextual precursors of the behaviour as well as inter-personal and intra-personal precursors are examined.

Duration of Treatment: Rationale. The SHIFT treatment approach is of shorter duration than many programs, but it is not considered strictly a brief therapy model. As a general rule the program is offered for one hour a week for 12 weeks. SHIFT considers change a discontinuous process, with period of change and periods of stabilizing. They contend that for many families, it is not necessary to attend therapy during their stabilizing periods and that the break from therapy is experienced as a vote of confidence in the family’s ability to carry on and allow the family opportunities to explore and integrate their strengths and solutions.

Individual Therapy: Rationale. Although SHIFT is described as including an individual counselling component, it considers that 'individual therapy' may be a misnomer in that individual therapy occurs within a context that is especially tuned to family dynamics. In this manner, individual therapy can often serve as an essential complement to conjoint therapy with the family. The purpose of the individual therapeutic work with the child is premised on the belief that generally children, at specific stages of therapy, are more free to explore certain topics and dynamics separately from their parents than they are with parents present. The therapist focuses his or her attention on the child creating an accepting, non-punitive atmosphere. With the child being the carrier of the problem, the child is the one uniquely impacted by identification with the behaviours, often being blamed, isolated and stigmatized. Often both the child and others no longer relate to him or her, except as the person who exhibits inappropriate behaviours. Here the child is the problem and the problem is the child. The therapist's individual work with the child promotes a safe environment for the child to begin to discuss the sexual behaviour problem. Later work with the child is focused on the child's level of sexual knowledge, the 'mapping' of the sexual behaviour and its internal and external precursors, and the child's ability to control impulsive behaviour. The family begins to develop this shared understanding of the problem, which forms the foundation of subsequent work. As all family members are seen as collaborators in the change process, with the locus for change placed within the family, the responsibility for change remains with the parents as well as the children. This contextual family approach requires that the work of each family member, while respecting personal and generational boundaries, must be shared

with other members as it supports the process of change for which the family has contracted.

Individual therapy: Cognitive-Behavioural Approach. Many of the activities used in treating these children are based on the principles of the cognitive-behavioural approach. The SHIFT program designers chose a directive and structured psycho-educational approach to treating these children, maintaining that the counselling of adult and adolescent sex offenders could be replicated in their individual work with the children. This undertaking required that cognitive-behavioural concepts be translated from those understandable by adults and adolescents into a language and form that could be handled by this group of children. This task was made particularly difficult because this group of children serves ages five to 12, representing two distinct sub-groups of cognitive ability. The younger children (generally ages five to seven) tend to be able to focus on only one aspect of a situation or problem at a time. However, the older group, given no complicating neurological conditions such as FAS, can hold two perspectives[2] that can significantly improve their ability to see relationships between events. Younger children are impulsive, their perceptions of others can not be easily understood, and their reports of events are less reliable than the reports of the older children. Consequently, with this younger group, rather than teaching self-control techniques to the children, repetition of the exercises and

[2] SHIFT has come to realize that even though older children may be able to successfully solve piagetian conservation tasks (the physical world), they are delayed (because of social experiences) in their ability to use such cognitive skills in the personal and social domain. Thus, time is spent helping chlordane to *catch up* in the ability to realize that one can have two feelings at the same time; i.e., can be raging mad but thinking self control thoughts at the same time.

lessons is required as well as more emphasis on teaching the caregivers to ensure safety, rather than teaching self-control techniques to the children.

Integration of Cognitive-Behavioural and Narrative Therapy. Prior to attempting to teach the connectedness of thoughts, feelings, and actions, and that it is possible to be 'the boss' of the touching problem, the therapist first ensures that the children understood what was meant by a touching problem. SHIFT expertise suggests that the notion of externalization (Tomm, l989; White, l989) where the problem is personified is particularly effective in this regard. SHIFT program designers were aware that the younger children, as well as many older children who were developmentally delayed due to their social deprivation, saw themselves at different points in time in black and white terms such as 'all perfect' or 'all bad', rather than comprised of several aspects. With the personification of the problem or externalization, the child is invited to name the problem and, in therapeutic discourse, it is given human characteristics. Therapists might inquire about how the family responds when its members are 'pushed around' by the problem. The child might be asked how the problem 'sneaks up' on them. With externalization, the child seems better able to talk about his or her behaviour, whom he or she had touched, how it was made stronger or weaker, and where the problem came from. The language of externalization provides opportunities for further therapeutic work such as metaphorically enacting the defeat of the problem and offers the family a 'shorthand' with which to discuss the problem comfortably. Once the problem behaviour is personified, the child is helped to recognize events, feelings, and situations that precede incidents of inappropriate touching behaviour, label these

feeling and situations as problematic or ‘Red Flag’ and recognize the effects the behaviour has on others and themselves. Here the model is, in effect, integrating cognitive-behavioral theory and techniques of narrative therapy (externalization), which they have found to be a compatible combination.

Individual Therapy: The Steps Notion. The steps notion (see Cunningham & MacFarlane, l991, p. 173) has been found to be very useful both for teaching awareness of the problematic behaviour and also as a basis for a safety plan. Here, the way the questions are posed is believed to be critical. For example, as the child is challenged to reconstruct the sequence of the behaviour, such as, “if the touching problem is up here at the top… and when you are at the bottom, here, and your Mom and Dad are all together with you and not drinking, and everybody is safe… what would have to happen to make things a little bit less safe, or get you up one step to be closer to the top where the problems is?” This child responded that “Mom and Dad leaving” would get him up one step. Their departure, probably to go drinking, would prompt him to feel angry, lonely, and bored. SHIFT therapist have found board games, such as Talking, Feeling, Doing Game, or Breakaway, or Frustration, (see Act II, pg.) very useful as they deal with the problematic behaviour head on, asking direct questions.

Individual Therapy: The ‘Reactive’ Child. Although SHIFT designers have found it very helpful to teach children the connections between events, they also realize that for some children whom Gil and Johnson (1993) call the ‘reactive’ type and who exhibit considerable anxiety, they tend to ‘act out’ their confusion or heightened impulsivity through their sexual behaviour. With these children there are no patterns or ‘red flags’ such that they are unable to learn about

factors or situations that might trigger sexual acting out. SHIFT has found that with this group, sexual behaviour is infrequent but often serious in terms of its impact. For these children impulse control training is not appropriate. The most important factors in therapy are disclosure of past abuse, further removing of secrecy around this and other issues, good information, and frank discussion.

Individual Therapy: Antecedent Feelings and Consequences. Considering themselves good behaviourists, SHIFT designers have attempted to teach the idea that behaviours are related, that they don't just happen, and that actions have antecedents and consequences. However, being good cognitive-behaviourists, they also teach the notion that some of what precedes problem touching has to do with feelings and thoughts as well. While some children were found to clearly not identify any antecedent feeling or situation claiming that the behaviour just seemed 'to happen' (i.e., the reactive child), others became able to identify feeling 'mad', others claimed to be 'bored, while still others reported feeling 'scared' or 'lonely'. The SHIFT program model takes the view that sexual behaviour sometimes serves to compensate for, displace, or distract the child from such feelings. Further, children who have been sexualized through repeated exposure to the sexual behavior of adults and pornography have reported that they felt 'horny' or 'sexy.' SHIFT has experienced some success in teaching children over age seven about awareness of thinking an attritional errors called 'stinky thinking', which is the equivalent to 'cognitive distortions' used with adolescent and adult sex offenders. Clinicians have found that many older children can identify

thoughts that preceded touching behaviour such as ‘she won’t say anything', or ‘I wanna be bad’ or ‘Mom does this’.[3]

Managing Problem Sexual Behaviour: The Safety Plan. The most powerful aspect of this entire process is considered to be the dispelling of secrecy that has traditionally surrounded the behaviour as it has been found that secrecy interferes with the change process. To help counteract this secrecy, the family and child share the metaphor that the problem is external as soon as it is developed. Together, the family can explore their ‘stinky thinking’ or ‘red flag situations’ in preparation for a safety plan. In this way the child is not expected to lead the parents. The therapist works with the parents to develop their readiness to receive their child’s feedback from his or her individual sessions.

Essentially, a safety plan restricts or moves the child from areas or people, or ensures that such access is suspended (and in many cases closely supervised because ‘the touching problem can sometimes be very sneaky’). SHIFT uses a solution-based approach. First, the contexts in which the behaviour occurs are elaborated. The child and family are then invited to discover ‘unique outcomes’ when he child has resisted the impulse to touch although conditions were ‘ripe’. This provides an entry for exploring the child’s existing internal controls that, when enhanced, will reinforce the safety plan. At times, the child might already engage in an effective alternative activity, for example, or use a method of ‘thought-stopping’ on occasion.

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[3] More recently SHIFT has used the concept of ‘red flag people’ as children would engage in behaviour with a specific person only or a specific kind of person, the behaviour pattern was heretofore restricted to specific interpersonal situations. For example, it would occur at home with sisters but not at school.

Assessment: Ongoing Process. In keeping with the contextual family approach, a constant thread running through the program design is the need for openness to facilitate change. As information gathering proceeds, a collaborative/narrative approach is utilized such that there is no sharp distinction between assessment and therapy. Both the collaborative nature of this approach and the structure of the therapeutic hour promote the exchange of pertinent information. For example, a safety plan when developed needs to be coordinated with the school and community to meet the child's needs. As the family experiences the therapist's understanding and acceptance of the disclosed information, the process can deepen the therapeutic relationship. The task of the initial assessment can increase the effectiveness of the treatment process in a number of significant ways: by beginning to reduce the person's initial distrust about the helping system, by developing sufficient comfort with discussing sex and sexuality in the family, by initiating the gathering of the information needed for therapy to proceed, and by planning appropriate therapeutic goals.

The First Session. In the first session the therapist works to engage all children, explaining that the program is specialized for children with a 'touching problem', assuring children that many other children have been seen with touching problems, and asking the children why they are there. In SHIFT, skills used and questions asked are considered the same as the narrative approach used with any other problematic behaviours and their supporting dynamics. There is emphasis on the context of the behaviour including the family and community and the specifics of the behaviours, as well as a focus on family strengths. With the narrative approach is used to gather this information, each family member

contributes to the narrative. Therapists avoid dominant stories that narrate a history of defeats or emphasize an exclusive focus on the child as the problem by seeking out exceptions to the dominant problem-laden story, and by chronicling family victories or supporting the family in dealing with the macro community, such as schools or protection services. Such interventions represent a tool for treatment planning that may be developed with appropriate interventions from solution-focused methods, narrative therapy or family of origin approaches as well as implementing cognitive-behavioural, structural, and strategic components.

Accordingly, the SHIFT model integrates a mix of theoretical orientations within a holistic framework. Notwithstanding the treatment approach called upon from the broad range of choices, the program designers stipulate that two factors are crucial to implementation of the SHIFT implementation design: (a) an attitude of clinical curiosity, because an unnecessary move to an investigative stance will impair the therapeutic relationship, and (b) perseverance over program sessions, rather than relying on the first session alone, in order to assure that family members are forthcoming with all needed information. For the interested reader Appendix F offers further elaboration on SHIFT program strategies or interventions that can be implemented in the treatment of children with problematic sexual behaviour.

State of Research on Children with Sexual Behaviour Problems

In searching the available literature, what does seem clear is that there is general agreement that these children and their families need services. However, the field of treatment for sexually intrusive children is new and so there is limited research available on individual characteristics, family dynamics, etiology,

therapeutic approaches, and treatment outcomes or program evaluations. It is apparent that many professionals treating these children have had to rely on their clinical experiences or have had to make developmental adjustments to treatment approaches used with adult and adolescent sex offenders. Additionally, despite the pervasiveness of treatment programs today, the literature reflects an absence of program evaluations. We are now standing at the threshold of knowledge development. Continued advancement in this field will require systematic inquiry including validation highlighting the importance of evaluating programs that provide services to children with sexual behaviour problems and their families

Nevertheless, systematic evaluation of the efficacy of various treatment approaches with children who exhibit sexual behaviour problems has been undertaken in the United States (Bonner, Walker, & Berliner, l997; Gray & Pithers, 1998, 1999) and Canada (Wachtel, l995). The first of these studies was the 5-year research project of Bonner, Walker, & Berliner (1997), while the second investigation was a formative evaluation of the SHIFT program (Wachtel, l995). The former investigation served to widen and synthesize understanding in such areas as children's characteristics, parent's characteristics, family dynamics, etiology and theory, and treatment approaches. The latter research was particularly relevant in illuminating components of the SHIFT program to shed further light on the implementation design of the program. .

The Bonner, Walker, and Berliner (1997) Treatment Study. These researchers carried out a 5-year controlled treatment outcome study on 12 weeks of one-hour group treatment for children ages 6-12 with sexual behaviour problems and their parents. These children were assessed and treated in order to

develop a typology and compare efficacy of two brief group treatment approaches: cognitive-behavioural (CBT) and dynamic play therapy (DPT). Caregivers received similar group treatments. Assessment was carried out with 201 children as well as their caretakers and 118 children entered treatment, with 69 of the participants completing a required 9 of 12 treatments. A comparison group of 50 children with no sexual behaviour problems was matched on their reported history of physical abuse, neglect, and emotional abuse. These researchers endeavoured: (a) to systematically assess the existence of a continuum of problematic sexual behaviour in children from normal to inappropriate to intrusive sexual behaviour, and (b) to establish a typology of sexual behaviour problems in children.

Referral behaviour was used to develop a classification system for children's problematic sexual behaviours, which delineates three levels of progressively problematic disturbance as sexually inappropriate, sexually intrusive and sexually aggressive.[4] Both treatments were found equally effective in terms of reports on additional incidents of sexual behaviour problems (CBT – 15% vs. DPT – 17%), given 2 years after treatment. Significant differences were reported between the three groups on factors such as age, gender, history of physical abuse, and levels of inappropriate and aggressive sexual behaviour.

Demographic information of the 201 children was collected at assessment. Of the 126 boys and 75 girls, the average age was 7 years, 8 months. The sample of children included a representative cross-section of the cultural population of Oklahoma and King Counties. Almost 60% of the children had a history of receiving mental health counselling in the past. Reports of maltreatment (51% of

[4] Bonner et al (1998) include a classification system proposed by Berliner, Manois, & Monastersky (1986): precocious, inappropriate, and coercive sexual behaviours.

the boys and 73% of the girls) included physical abuse, sexual abuse, emotional abuse, and/or neglect. Of the 201 children 32% had a reported history of physical abuse, 48 % sexual abuse, 35% emotional abuse, and 16% neglect. Some children were reported to have experienced multiple forms of abuse. In this sample of 201 children with sexual behaviour problems (CSBP), 59% including 64 boys and 55 girls had experienced at least one form of abuse or neglect, while 48% containing 49 boys and 48 girls had a reported history of sexual abuse. No history of abuse was reported by 25% while 16% did not answer the question. The comparison group (CB) of 52 children, aged 6 to 12, had no reported sexual behaviour problems. The average age of the CG group was eight years, five months, making it six months older than the CSBP group. The CG, with no sexual behaviour problems, had been matched on physical abuse, neglect, and emotional abuse. However, findings demonstrated that the families of the CSBP group experienced significantly more stress and that a significantly higher number in the CSBP group (48% vs. 31% in CG group) reported a history of sexual abuse. Overall, 59% of experimental group had a substantiated abuse or neglect history versus 48 percent the comparison group.

All data were collected on biological parents only. Parents of experimental group (n = 36) and comparison group (n = 47) provided data on instruments completed in assessment phase of study. The marital status of the CSBP and the CP were both diverse, although the CG was significantly more likely to be married to their first spouse (p = < .05). Another significant difference found between the two groups of parents was family income, with CG significantly more likely to be in the $40,000 plus range than the CSBP group.

Information reported on both groups of children (n = 253) included assessment of current functioning on intelligence, behaviour, affect, self-perception, and view of the family environment. The children with sexual behaviour problems reported significantly higher levels of anxiety, post-traumatic stress, ADHD, oppositional and conduct disorder, depression and dysthymia. In general the CSBP children reported significantly more problems with school, friends, activities, physical complaints, and in their families. Additionally, on the Rorschach,[5] the CSBP group showed higher levels of intensity and lack of modulation in their outbursts, were less interested in people, more avoidant of affect, less likely to anticipate that people would be co-operative, and more likely to view the world as aggressive.

Data collected from parents' reports detailing children's level of sexual behaviour, behavioural affect, as well as social, school, and life skill competencies were notably similar to children's self reports. Information assessing parents' own environment, life stress, parenting, and attitude toward the child found that parents of the children with sexual behaviour problems reported significantly more stress and significantly less positive attitudes than parents of the comparison group.

Expert analysis of children's manifest behaviour measured the degree of (a) appropriateness versus inappropriateness and (b) aggression or intrusiveness of the behaviours reported. Group II (n= 74) viewed as intermediate in the ratings of their inappropriateness included 39 boys and 35 girls. This group was seen to have higher self-concept scores than Group III. Reports from 47 parents reflected

[5] This was the most frequently refused instrument in the batter.

similar scores for CSBP Group II and III. Both groups showed high levels of sexual behaviour, although not specifically highly 'aggressive'. Parents in Group II reported higher levels of physical abuse and neglect, but similar rates of sexual abuse and emotional abuse. Group III (n = 87) were significantly older and significantly more likely to be male (64 boys vs. 23 girls). The data from the children's self reports and parents' reports on the children showed few significant differences among the three groups. However, experts' ratings found significant differences between the three groups, judging the groups as increasingly less appropriate and more 'aggressive' from Group I to Group III.

Treatment outcome data showed both treatment approaches to be equally effective in increasing the children's social competencies while reducing their behavioural, affective, and sexual behaviour problems. The authors introduce some interesting considerations. Although these researchers initially designed the groups of children to be mixed by gender but divided by age, in the end they randomly assigned the children with no regard to age and reported no problems regarding the age differential. Further, Bonner et al. included among their treatment recommendations: the intentional involvement of a key caretaker; a sensitivity to the nature and effect of the children's behaviour on caregivers and on children; and a recognition of the effective use of individual cognitive-behavioural therapy with these children, as presently also practised within their treatment model.[6]

SHIFT Program Evaluation (Wachtel, l995). This largely formative,

[6] While the group model may be very beneficial for such adolescents and adults, the research demonstrates no clear evidence that a group approach is the model of choice for these children.

program evaluation was begun roughly six months after the program was started. To build profiles of these children investigators developed an enhanced client information system intended to (a) capture treatment issues, (b) explore relationships between family and child and intrusive behaviours, and (c) make recommendations for further developments.

SHIFT treatment program rationale is such that the ideas from a number of U.S. therapists (e.g., Berliner, Cunningham, Friedrich, Gil, Johnson, and MacFarlane) are included. As reported by Wachtel (1995) these therapists have produced considerable documentation describing counselling approaches with these children through small group work, or individually through art, play and other expressive therapy, especially various kinds of role play and metaphorical re-enactment. SHIFT is a little different from other treatment programs in that the emphasis of treatment is as much or more on work with the parents and other family members (Wachtel). In this regard the literature just cited is not clear about how to engage families or about what sorts of case work with the family is possible. It appears to be better at discussing tasks that need to be accomplished such as support, monitoring for safety and clarifying boundaries (see Gil & Johnson, l993).

SHIFT assessment of children includes assignment to one of three categories:

1. children exhibiting sexually appropriate behaviour, who engage in developmentally appropriate sexual activity that is exploratory, mutual, non-compulsive, and so on (and, rather than therapy, requiring minimal interventions such as redirection, clarification, sex education, or the like);

2. children exhibiting sexually inappropriate behaviour, who engage in developmentally inappropriate sexual activity such as touching or fondling other children or adults, public masturbation, oral sex, and so on; and
3. children who exhibit sexually intrusive behaviour, who don't differ necessarily in the kinds of sexual activity they engage in from those exhibiting sexually inappropriate behaviour, but whose actions are characterized by aggression, coercion, or non-mutuality of other kinds.

The SHIFT program deviates from the continuum of Cavanagh Johnson (1994, as outlined in Appendix C) such that SHIFT combines Johnson's second and third classification (sexually reactive behaviours and extensive mutual sexual behaviours, respectively) as 'sexually inappropriate' behaviour and Johnson's most serious category (children who molest) as 'sexually intrusive' behaviour.

The evaluation database focused on 34 children assessed as exhibiting some degree of sexually problematic behaviour. In general there was a 'focal' child whose actions provoked the referral, but often one or more siblings were either involved in the activity (as victims, co-participants) or themselves showed problematic sexual behaviour (along with some who had earlier offended against/initiated the focal child). Thus, while information collected was on the focal child, assessment and counselling often included siblings.

The client information system approach, increasingly used by agencies to demonstrate accountability, includes three main parts that parallel a typical case file: (a) intake and assessment information, (b) case planning and monitoring information, and (c) case closure and follow-up. It allows programs to document that they are taking on appropriate clients, have a good foundation for case

planning, are providing particular kinds and levels of service, and are attempting to assess the changes clients are going through. Wachtel reported various constraints on the implementation of this information system: (a) ongoing development of SHIFT treatment model, (b) lack of a treatment manual to determine if treatment essentials were implemented, (c) evaluator's acknowledged lack of familiarity with family therapy, (d) therapists' uncertainty regarding the evaluation process, and (e) absence of standardized measures of child and family functioning. Although SHIFT adopted the continuum of behaviours that are outlined in the work of Johnson (1994, see Appendix E), data compiled included only fragmentary information on the victim/offender relationship, contextual aspects of the offences, and the time period. One further issue complicating data inputs pertained to the fact that that the SHIFT implementation design is an approach rather than a standard treatment, such that family interventions are tailored to meet the particularities of the case.

The SHIFT program evaluation allowed for two main observations. First, descriptions of sexual and other behaviours were not particularly prominent in the therapists' reports. Second, much of the behaviour was reported as having ceased at least some months before. Further interpretation was viewed as risky for two reasons: (a) the suspicion that parent perceptions could be subject to certain biases involving possibly both under-reporting and over-reporting and (b) the lack of any good baseline information on typical sexual behaviour among children at the time.

Analysis suggested some possibly noteworthy considerations on children's abuse histories and individual characteristics, although most of the recommendations pertain to improvements on the information system. With a

small sample size and confidence lacking in accuracy of data collected, no definitive information on client profiles was built. Findings and program rationale are noteworthy, however, when compared with a prevalent view in the literature that sees children's sexual behaviour problems as a reaction to their sexual abuse. SHIFT does not make this assumption. Study findings suggest that 20% of assessed children had no reported or suspected history of sexual abuse victimization, though most of the children had some history of abuse that may be related to problematic sexual behaviour. Notable research findings suggested a significant relationship between intrusiveness and physical abuse; the possibility of a relationship between intrusiveness and emotional abuse; and a history of being witness to violence in the family. More generally, significant findings draw attention to the overall breadth of abuse experienced. Children assessed as sexually intrusive as compared to those assessed as sexually inappropriate demonstrated a greater tendency towards being behaviourally disturbed, socially inept, and hostile. Also, there was a suggestion that considerable percentages showed ADHD and other learning disabilities.

Regarding parent and family issues and treatment, much of the literature on children with sexual behaviour problems (see Friedrich, 1993) points to the centrality of parental involvement and to the likelihood of ongoing extensive family dysfunction. Although the family constellation database was a late addition to the SHIFT evaluation, some simple information on family structure was captured on 56 families. The logic of the SHIFT program was that parental response and parental action was necessary to solving their children's sexual behavioural problems. Generally, it was found that greater child problems were

matched by more problematic parental responses. For example, measures on children's problematic dependency, hostility, and withdrawal tended to correlate with poor parent-child relationships and these parents tended to have trouble with denial, discipline and support.

The database input on treatment issues was confined to 26 cases involving around 300 contacts. Most session issues involved several of the following foci: forming or maintaining a therapeutic alliance, monitoring or safety, working on relationship issues, and working on an action plan. More prominent topics in child sessions included: check in on how the week had gone, abuse history, denial, feeling recognition, self knowledge, abuse dynamics, metaphorical mastery, problem solving skills and prosocial skills. Overall, the assessment issues (or the self-understanding ones) were reported as most prominent with planning and skill rehearsal slightly less evident. Family sessions and child group [7] work reinforced many of the foregoing topics; findings offer clear evidence that parents were helped to respond effectively in controlling or stopping children's problematic sexual behaviour. Topic interrelatedness in children's sessions was found to indicate a consistent flow that began with an understanding the child's history and abuse dynamics, continued to a discussion of understandings connected with the child's present sexually problematic situation, and moved on to planning how to avoid or overcome these problems. Though it was more typical for several aspects of understanding to be covered in a session, the topics dealing with planning and skill mastery were usually accessed individually as the focus of a particular

[7] SHIFT presently has dropped group treatment with these children in preference to implementing individual directive child therapy and concurrent family sessions.

exercise or session activities. Feeling recognition was prominent in sessions, but empathy work was reported as being absent.[8]

Session descriptions did not include reports of improvements in family accounts or therapists' observations. From 18 cases limited to closure information of problematic sexual behaviour and parenting and couple issues to what was apparent at assessment, it was suggested that families of children with sexually intrusive behaviour are more troubled at assessment, show more movement in treatment, and are more troubled at closure

At the time of this evaluation there was a pilot initiative to conduct follow-up telephone interviews at least 6 months after closure but this information had not been compiled as part of the larger database. Nevertheless, 10 interviews were completed and the evaluation report includes the responses from these interviews that can be useful in considering the information that is coming forward.

Research on Program Evaluation

In the matter of program evaluation, what importantly distinguishes one evaluation methodology from another is not methods, but rather what stakeholders' questions are addressed and which values are being promoted (Denzin & Lincoln, l994). The dominance of an interpretivist logic of justification employed in the present formative evaluation can be traced primarily to the influential work of Lincoln and Guba (1985; Guba & Lincoln, l981, 1989). Greene (1994) draws considerably from the work of Guba and Lincoln and John Smith (1989) in offering an overview of the interpretivist paradigm in evaluation. At root, interpretivism concerns contextualized meaning such that social reality is

[8] Cognitive development with many of these young children precludes work on empathy. Treatment is better focused on building awareness of consequences such as 'counter-thinking'.

viewed as significantly socially constructed "based on a constant process of interpretation and reinterpretation of the intentional, meaningful behaviour of people—including researchers" (Smith, as cited in Greene, 1994, p. 536).[9] Social inquiry therefore is mind dependent; inquiry descriptions and interpretations are themselves developed constructions and (re) interpretations; and there can be no separation of the investigator from the investigated (Smith, as cited in Greene, l994). Interpretivist inquiry is unabashedly and unapologetically subjective. It is also dialectic as the process of the meaning constructed transforms the constructor. Of particular weight is awareness of people's interpretations and sense makings of their experiences in a given context. As Smith (as cited in Greene) notes, this process is inevitably hermeneutic because "investigators, like everyone else, are part of the circle of interpretations" (p. 536). The goal of interpretivist inquiry is to understand meaning. Rather than this inquiry being a matter of manipulation and control, particularly via method, it is instead the subject of openness and dialogue. Most qualitative evaluators will carry out certain tasks: (a) emphasize context, but not generalizability, as an essential element of meaning; (b) rely heavily on qualitative methods for meaning construction; (c) acknowledge, if not celebrate, the influential presence of their own selves in the inquiry process; and (d) seek in their work primarily to augment practical program understanding.

[9] Grounded theory 'methodical hermeneutic' analysis used in this study argues that qualitative research does generate a creative yet systematic 'theory' of interpretation.

Participant-Oriented Approach

It is important to question the extent to which a program is effective after it is fully implemented. In order to answer that question it is important to learn the extent to which the program implementation strategies actually reflect the program implementation design. This evaluation presents evaluation findings gained through the process of examining and interpreting data acquired through the participant-oriented approach which draws on the classification schema of Worthen, Sanders and Fitzpatrick (2001). Researchers embracing this approach are likely to be sensitive to the different values of program participants, to build feedback materials that reflect the natural language of the participants, and to shift the locus of formal judgement from the evaluator to the participants. Moreover, with the participant-oriented approach ideas about evaluation are drawn from the interpretative approach that uses hermeneutic philosophy and interpretive theories of knowledge in generating descriptive interpretations and judgements about the object of evaluation.

According to Stake (1975), using the participant evaluation approach includes dependence on inductive reasoning such that understanding emerges through the process of discovery. Rennie (2000) contends that this implies an ongoing creative and circular reflexivity of both facts and interpretation such that understandings are developed rather than discovered. In using the participant-observation approach multiple realities can be recorded. All perspectives are accepted as correct as only an individual can truly know what he has experienced. A central task of an evaluator is to capture these realities and portray them without sacrificing the program's complexity. The potential for gaining new insights and

usable new theories about the object of the study stands among the greatest strengths of this approach. Other advantages of this method are its flexibility and attention to contextual variables.

Internal and External Evaluation

The type of evaluation is relevant to the distinction of internal and external evaluation. The internal evaluator is almost certain to know more about the program than any outsider will, but she may also be so close to the program that she finds it difficult to adopt alternative perspectives. There is seldom much reason to question the objectivity of the external evaluator and this dispassionate perspective is perhaps her greatest asset. Conversely, it is difficult for an external evaluator to ever learn the program as completely as the insider will. In this project I was involved as co-therapist and joined by the program provider in implementing the SHIFT program with one family referred to the Ministry of Children and Family Development for treatment. Additionally, I conducted interviews with children as well as their parents who had completed the program up to three years before. Although an external program evaluator is much less likely to be influenced by a priori perceptions of its basic worth, I believe that my first-hand experience of program implementation served to heighten my sensitivity to the multi-faceted aspects that influence sexual behaviour problems in prepubescent children.

Role of Program Evaluation

A final point with regard to program evaluation has to do with its role. Scriven (1967) first distinguished between the formative and summative roles of evaluation and the terms have become almost universally accepted in the field. A formative evaluation was conducted that provides information to interested stakeholders on what is going on in the program and how the program has developed. Such information is helpful in illuminating how the SHIFT program implementation design was implemented in the treatment strategies and how these strategies were experienced by the participants. Observations and understandings developed from this evaluation suggest important areas for deliberation regarding program design and strategies and can be useful in considering the information that is emerging. My focus of concern in this program evaluation is centered on the SHIFT program designers' theory of action as actually practised and implemented.

Researcher's Perspective

Many of the theories and models used in existing programs of treatment for children with sexual behaviour problems connect the internal world of the child (affective, cognitive, and behavioural) with the child's external world (Friedrich, W., 1995; Gil & Johnson, 1993). Contextual Family Therapy offers a major contribution for this purpose in that it situates explanations for children's sexually abusive behaviours within a relational context and focuses on circular rather than linear causality. Overall, my perspective will reflect a prevailing preference for the major components of the contextual family approach in believing that children develop sexually problematic behaviour as a result of the

interaction of individual characteristics with family dynamics and ecological factors. More particularly, however, in assessing the children's experience of the SHIFT implementation design, I acknowledge my consideration of three major understandings: social learning theory, attachment theory, and narrative therapy.

Social Learning Theory. The socialization process begins in a child's first significant relationship with the parents and most typically the mother. Friedrich (1990) notes that lack of socialization and failure to accept rules of normal behaviour are common in children with sexual behaviour problems. For example, when the child fails to learn how to negotiate or compromise, the child develops inconsistent and sometimes explosive patterns of relating. A child, who is frequently criticized and degraded, learns how to criticize and degrade.

The cognitive therapeutic approach maintains that emotions and behaviour are mediated by thought. In focusing on the maladaptive thinking or 'stinky thinking' that supports or justifies problematic behaviour, individuals can be helped with their emotional problems. Cognitive restructuring is used to counter stinky thinking and maladaptive patterns with co-constructed, reality-based interventions. Such problem-solving solutions can satisfy the client's needs without hurting others. By way of illustration, children can be taught self-instruction procedures through which they learn to (a) define problems; (b) think about various solutions; (c) evaluate the probable consequences of each choice; and (d) reward themselves with a congratulatory self statement such as "I did it right!" or, when they have chosen incorrectly, to use a coping statement such as "On the next problem I'll stop and think."

Within this theory, the goal of social skills training is expressed as increasing feelings of self-efficacy. Social skills training, implemented with cognitive-behavioural approaches, is an umbrella term for a group of methods aimed at improving children's interpersonal skills, including: modelling and positive reinforcement; coaching, role-playing, and behaviour rehearsal; and cognitive strategies for better problem solving. Once behaviours are demonstrated to the child, the child then practices role-taking what has been modelled with therapist as coach. Progressive approximations to the desired behaviour are reinforced with the child encouraged to reflect on what he or she might do a little differently. Once experiential components are incorporated into treatment, the child's cognitive awareness is further enhanced by experiential evocation that may make bodily cues available for reworking and reprocessing. Practice to develop new habits plays a noted role in creating experiential change.

A cognitive perspective is highly prevalent today regardless of theoretical orientation. Modern psychoanalysts are now arguing that what is learned in early childhood are cognitive representations of early childhood relationships. As well, many modern systems theorists today are constructivists, believing that we construct reality through our beliefs and concepts,

Attachment Theory. Bowlby (1973) originally developed the attachment theory to explain the extreme emotional distress that follows unwilling separation from or loss of particular others. An evolutionary biosocial theory of development, the attachment theory presumes that the predilection to make strong emotional bonds to a differential and preferred person, conceived as either stronger or wiser or both, is a basic component of the human nature distinct from

feeding and sexuality. Bowlby (1980) proposed that the attachment behavioural system has evolved to promote the survival of young children by ensuring that they maintain proximity to a caregiver (the attachment figure) especially under conditions of threat (as cited in Bartholomew, Kwong & Hart, 2001, pp. 197). As the system is organized homeostatically, it is especially prone to activation when children are afraid, hurt, ill, or tired. The attachment relationship functions as a 'safe haven' such that children's anxiety is relieved and the attachment behaviour terminated when caregivers are successful in providing a sense of security. While the attachment system goal is maintenance of proximity with the attachment figure, the goal from attached individual's position is the regulation of a sense of felt security (Sroufe & Waters, l977, as cited in Bartholomew et al., 2001, pp. 197). To quote Bowlby (l988b, p. 2) the key hypothesis of the theory is that "variations in the way these [attachment] bonds develop and become organized during the infancy and childhood of different individuals are major determinants of whether a person grows up to be mentally healthy." Hence, over time, based on experience of the caregivers' responsiveness and accessibility, children build internal working models or schemas about the self, close others, and the self in relation to others. Internal working models are a system of expectations and beliefs about the self and others that allow children to predict and interpret an attachment figure's behaviour. When children's experience is consistently responsive and supportive, children are hypothesized to develop positive expectations of close others and confidence in their own worthiness as someone deserving of support. Alternatively, a family history characterized by an inconsistent and rejecting caregiving would be expected to give rise to schemas

that see others as unavailable and rejecting in times of need. Within Bowlby's model, early attachment experiences do not directly cause later personality organization and outcomes but they initiate the child along one of many potential developmental pathways. Some of these pathways reflect healthy development, and others deviate in various directions toward less healthy psychosocial outcomes.

Hence my frame of reference includes attachment theory to conceptualize the nature of the therapeutic relationship developed by these participants and how implementation design and strategies of the SHIFT program model may both facilitate and challenge the therapeutic relationship. The literature today reflects the consideration of the therapeutic relationship as a common factor at work enhancing desired change in all psychotherapeutic orientations (Hubble et. al, 1999). Similarly, Bolby (1988a) recommends the provision of an intentional atmosphere of respect for the client's legitimate needs for comfort and protection in preference to utilizing specific therapeutic interventions or techniques for specific symptoms. A restorative therapeutic relationship can provide the security and space within which a healing narrative can begin to emerge (Holmes, l995).

Narrative Therapy. White and Epston (1990), viewed as pioneers of narrative therapy, utilize a highly focused set of intervention techniques to help people reexamine the stories they have developed that constitute the way they live their lives. Narrative therapy centers on the narrative metaphor—that our sense of reality is organized and maintained through stories by which we circulate knowledge about ourselves and the world we inhabit (White & Epston). In this manner, the approach engages individuals in externalizing conversations to help

them attach new meanings to their experience. Externalization, practiced by White as the personification of the problem, is designed to help people simultaneously separate from the symptoms and develop personal agency. As the problem 'personified' becomes a separate entity rather than an internal characteristic, the family is encouraged to unite to fight the external problem's tyrannical influence over their life. When a clear separation from the problem is experienced by the client through externalizing conversations, the therapist uses 'relative influencing questions' (White, 1995) to help the client look at his or her relationship with the problem.

Consequently, the narrative approach is considered a collaborative venture as, in principle, no interpretation by the therapist is privileged over the view of the client. In this respect, it is worth considering the commentary of Karl Tomm (1993) concerning Michael White's narrative method. Tomm recognizes the noteworthy contributions of White and Epston's (1990) book and considers the special care White takes to most explicitly base his work on the lived experience of his clients recognizing the preferred outcomes that the client identifies in treatment. However, Tomm believes that White's diligence in this matter can not assure the provision of ethical practice as the therapist decides what meanings will be selected for investigation and used in the client's reconstruction of a preferred narrative.

Externalizing is apt to hold great appeal for families who see their inability to rid the symptomatic person of the problem as a reflection of themselves as failures. With this approach they are presented with a nonpathological, externalized view of the problem in which no one is to blame. This two-fold

process includes deconstructing the history of the problem that has shaped their lives and reconstructing an alternative story. When the family has separated themselves from their self-defeating and unworkable stories they can then begin working as a team to defeat the now-externalized problem (White, l995). As is the case for most social constructionalist therapists, White (1989) is less interested in the cause of a problem than in how the problem impacts negatively on family life over time. Following externalization of the problem, the narrative therapist uses White's 'relative influence questioning' (1988) in asking the family to search for 'unique outcomes' (1989) that represent exceptions which contradict their dominant problem-saturated story; exceptions where the problem did not defeat them. These interventions are all in the service of starving the problem rather than feeding it. The family restories their narrative to add a new sense of empowerment, in which problem-saturated stories are replaced with stories emphasizing solutions. Families are later helped to redescribe themselves in terms of these unique outcomes and are encouraged to engage in behaviour that parallels these alternative stories.

Accordingly, I embraced this program evaluation with a narrative lens in place emphasizing an attitude of curiosity and a 'working towards' understanding of the participants' experience. My focus maintained interest in a number of areas that required me to ask ongoing questions: How does the treatment see persons? How does the treatment have clients 'treat' themselves? How does it press the therapist to act with people who seek help? How does the treatment press the client to behave with the therapist who offers help? Does the therapy divide and isolate the client or give the client a sense of community and collaboration? Does

the process generate alternatives? Does the model require the client to enter the therapist's 'expert' knowledge or does it require the therapist to enter the 'world of the client'? Does the practice of externalization offer a sense of awareness, choice, empowerment, responsibility and hope? Such questions focus largely on the actual effects of therapeutic actions on people's lives.

One final comment is offered concerning my perspective in this thesis. All views expressed here are ultimately my own and may not accurately reflect the perspectives of the various clinicians, researchers, agencies and programs. In addition, the topics included and issues discussed do not make up all the areas that are important in undertaking work with children with sexual behaviour problems.

Summary

Without an acceptable way to express how they feel, children may hurt themselves or strike out and treat others abusively. If they display harmful sexually inappropriate behaviour they have sexual behaviour problems. It is clear from the literature that this problem presents significant concern for the person responsible for the behaviour and for the community. The available research highlights the need for systematic clinical investigation with this client base to extend knowledge and develop consensus as well as the responsibility to extend theoretical knowledge in this field through the use of complimentary terms that best facilitate understanding.

My research task here was to enter the frame of reference of the youth whose world and experience was being investigated to apply the 'double hermeneutic' that is entailed in the study of social life. I have followed the lead of Rennie (1995) in choosing to use the first-person singular when referring to my

role as researcher, while expressing my awareness that assertions are my interpretations.

This formative evaluation implemented the grounded theory approach to qualitative research, in interviewing participants who had completed the SHIFT program for children under 12 with sexual behaviour problems up to 3 years earlier. I chose the grounded theory method with the expectation that valuable theoretical insights could extend knowledge on the parameters of this problem. Process data allowed examination of the SHIFT implementation design and description of the internal dynamics of program operation, such that I was able to isolate critical elements that contributed to program success and failure. Descriptions also permit understanding for people not familiar with the program. SHIFT is shown as a model worthy of dissemination and replication. This study extends Wachtel's (1995) evaluation of the SHIFT program model in comparing the participants' experience of the program to the manualized SHIFT program. Acknowledged influences brought to the conceptualization of analysis include social learning theory, attachment theory and narrative therapy. This research answered the overriding research question "What was your experience of being in this program?" [10]

Definition of Terms

Qualitative data: Abstractly it refers to essences of people, objects, and situations; essentially as a raw experience that is converted into words, typically

[10] Throughout the paper, considerations concerning the SHIFT designers' manual are referenced as the SHIFT *implementation design*, while those concerning the program as actually practised by the provider, are referenced as the SHIFT *implementation strategies.*

compiled into extended text. However, qualitative data, most accurately, needs to refer to verbal text with reference to the entire approach to inquiry

Conceptual framework: This lays out the key understandings and the presumed relationships among them.

The researcher's understanding of theory resulting from the analysis of text: This is a model with a series of connected interpretations that specify relations, often hierarchical, among categories.

Descriptive analysis: This refers to one level of two understandings involved in qualitative analysis that calls for a reasonable accounting of the phenomena observed in answering the basic questions of what is going on and how things are proceeding.

Explanatory analysis: This refers to one level of two understanding involved in qualitative analysis that offers clarification that is progressively connected, making the description intelligible. Explanations are always condition and context dependent, partial, inconclusive, and indeterminately applicable; features that are not limited to qualitative studies.

Analytic induction: This is a procedure used to gather facts and uncover concepts based on the core belief that there are regularities to be found in the physical and social worlds and that the theories that we derive express these regularities as precisely as possible.

Interative procedures: This refers to a succession of question-and-answer cycles involving a set of tactics at play; entails examining a given set of cases and then refining or modifying those cases on the basis of subsequent ones. The resulting inferences are deemed "valid" in the relaxed sense that they are

probable, reasonable, or likely to be true. These procedures correspond to the grounded theory approach in qualitative research.

Hermeneutics: Hermeneutics traditionally has been defined as "the theory of the interpretation of understanding in it's relation to the interpretation of text" (Ricoeur, l978, as cited in Rennie, 2000, p. 483). Further, Rennie distinguishes between hermeneutics per se and hermeneutics "influenced by Heidegger's preoccupation with pre-reflective engagement in the world more than with reflection about the world" (p. 496). Thus, when transferring this broad framework onto the grounded theory method, Rennie warrants the information addressed in the procedure is hermeneutic even when it involves reports on experience.

Reliability: Reliability refers to repeatability and stability of the meanings as described in the classification of categories.

Validity: Validity concerns 'justifiable' interpretation based on an accurate description of the lived experiences of participants' as reflected in the shared meanings of the lower order categories subsumed within the main categories. I am best able to maximize construct and descriptive-contextual validity and assure that my interpretations connect with people's lived experience through minimal 'a priori' instrumentation (i.e., bracketing).

Bracketing: Husserl (1913, as cited in Rennie, 1994) introduced the phenomenological reduction, or use of 'bracketing', which is the concerted effort to set biases aside so that the 'essence' of a phenomenon may be understood objectively. In other words researchers are asked to put aside their intuitions,

expectations, hypothesis, and so on, about the phenomenon of interest and record them in a research log (Rennie, 2000). Such expressions of reflexivity are advocated in the interest of objectifying the understanding of the phenomenon of interest. Rennie cites Freud (1900; 1913) and Heidegger (1927; 1962) who stressed the role of interpretation in understanding human affairs. He appraises this bracketing quest in consideration of hermeneutics, citing the philosophical hermeneutic critique (Gadamer, l960; 1992; Heidegger's, l927; 1962) of Husserl's transcendental phenomenology (e.g. Husserl, l913; 1962). Rennie acknowledges that this critique makes a solid argument against the conviction that it is possible to achieve transcendental objectivity through the procedure of bracketing, pointing out that "certain aspects of an individual's horizon of understanding unavoidably are inaccessible to self-reflection" (p 496). He also points out that "there are aspects of the horizon that *are* accessible (cf. Ericsson & Simon, l980; Nisbett & Wilson, l977), if not in the transcendental sense." These aspects, once understood, are made objective in terms of the local culture of which they are a part. The outcome of this, says Rennie, "is that grounded theorists' efforts to contain biases by being reflexive in various ways eventuate in a middle ground between realism and relativism" (p. 486). Here Rennie is referring to the objectivity having to do with local cultures, rather than the kind of universal, ahistorical objectivity quested for by Husserl.

Realism and Relativism: Realism proffers the existence of a foundational theory of truth or structure of the world independent of those it represents. Realism acknowledged that the character in the properties of the world is recognized by the researcher, thus purporting that the structure of the actual world

is cognitively transparent to or is representable by us. In favour of extending this tenet, while relativism recognizes the revelation of this elemental structure, relativism necessitates the researcher tease out such essential properties so as to advance a fuller understanding of them within a particular research context. In this manner, any understanding embodying the researcher's reconciliation of realism and relativism must be examined as the outcome of the interaction between the researcher and the phenomena under study.

Methodical Hermeneutics and the Grounded Theory Method: Rennie's version of methodical hermeneutics published in 2000 includes his dispute of the philosophical hermeneutic argument that is pointless to attempt to escape from ones "horizon of understanding" (p. 495). Rennie maintains that a relativist version of Husserl's technique of bracketing offers a middle ground between realism and relativism as long as the investigator makes a conscious effort to be self-reflective and express the fruits and spoils attributable to reflexivity (for detailed explication see Rennie, 1998; 2000). Moreover, Rennie (1998) contends that his grounded theory method improves on traditional hermeneutics as it emphasizes concepts from particularities rather than emphasizing the particularities themselves.

With the cyclical understanding of particularities (the hermeneutic circle) the researcher initially projects onto them a 'whole', or 'frame of reference', which in turn is influenced by the [interpreter's] meaning of the particularities" (Rennie, p. 111). Accordingly, Rennie warrants that with the application of his methodical hermeneutics, the danger of 'vicious circularity' and limitation to particularism in traditional hermeneutics is reduced when hermeneutics is

integrated with both Pierce's theory of inference and the phenomenological procedure of bracketing. Pierce, as cited in Rennie (1998, p. 111), presents three theories of inference: "abduction is hypothesizing, induction is testing of abductions, and deduction is the demonstration of apodictic truth by deriving a consequence that is entailed tautologically in its premises" [i.e., no new knowledge gained]). For Pierce, new knowledge does not come about through deduction, which, for him, is circular; instead it is developed through the interplay of abduction and induction. Further, "within this framework … qualitative research … involves the symbiosis of abduction and induction … achieved by bracketing preconceptions of phenomena of interest and delaying the development of conceptualizations until they are derived from immersion in the data pertaining to the phenomenon." In this manner, the holistic understanding applied to particularities are derived from the particularities themselves by means of the combination of bracketing and the symbiosis of adduction and induction and adherence to conceptualizations is dependent upon the overall support of the data. Thus abductions are conceived through the activity of induction and are symbiotically validated by merit of that same induction (testing of abductions).

Rennie references Pierce's description of abduction as the imaginative creation of a hypothesis representing the sheet anchor of science. Moreover, Rennie extends Pierce's logic applied to natural science to that of human science. In this manner Pierce, in contending that knowledge is always tentative, has provided a link with hermeneutics. Further, this position is also applicable to the grounded theory method as "Regardless of the set of procedures used to conceptualize categories, any category in effect is an abduction (hypothesis)

awaiting validation as the grounded theory analysis proceeds" (see Rennie, 2000, for further explication). With the original grounded theory method of categorizing abduction *awaited* the inductive sorting of codes into clusters from whence a category was formed, with this abduction tested by ensuing inductive analysis. With 'methodical hermeneutics" induction mostly involves additional texts acquired *as the analysis proceeds* in that the gathering of data and their analysis continue at the same time. Rennie (2000) accedes the human sciences are rhetorical, but with the reconciliation of realism and relativism, meritorious considerations can warrant some interpretations being arguably better than others. In this manner the grounded theory method instantiated the hermeneutics more completely than the quantitative approaches to method in the social sciences.

Hermeneutic circle: This "is the cyclical understanding of particularities by initially influenced by the [interpreted] meaning of the particularities. (Rennie, l998, p. 111). Thus, "the understanding of the whole of the text influences the understanding of part of it and the understanding of each part in turn influences the understanding of the whole (Rennie, 2000, p. 496). In this manner the hermeneutic circle is expressed, as earlier text is examined and interpreted in light of later categories developed to see if later categories apply to earlier text. The entire process involves a looping back of assorted effects onto understanding that produce new effects as the analysis unfolds over time. In keeping with Rennie's approach, words I use to express my understanding of the categorical structure such as 'conceptualize' and 'interpret' suggest that the categories developed from the grounded theory method as an outcome of my involvement in the data. projecting onto them a 'whole', or frame of reference, which in turn is

Saturation of the Data: Rennie (2000) speaks of the activation of the hermeneutic circle in this process. In this manner the researcher continued to select new data sources until the new data was judged to add little to the development of new descriptive categories, at which point the data was considered to have reached saturation. The circling of part to whole and back again, inherent in the judgement or analysis of meaning units, results in progressive understanding that, in principal, is non-ending. However, " hopefully it reaches a stability at least within the horizon of a particular hermeneutic" (Rennie, p. 484).

Double Hermeneutic: To quote Rennie (2000, p. 484), "any understanding of a person's utterances and displays is an interpretation of an already interpreted text." Rennie (p. 483) refers to what Gidden called the 'double hermeneutic'; an understanding of a pre-interpreted world where people, as agents, choose the way in which they represent their experience. With this understanding, as much as people strive to present their experience honestly, people are made to interpret their experience of themselves affected by their welfare, passions, convictions and so on. Rennie (p. 484) cites Taylor (1989) in expressing that although it may be the case that the person having the experience can better know its meaning than anyone else, it may also be possible that the opposite is the case. Further, given that shared language and customs can help the Other understand what the person relates, this understanding is in turn influenced by the Other's passions, convictions and interests. Rennie informs "that the human sciences, especially, are hermeneutical in virtue of their involving an interpreting subject [researcher] addressing a self-interpreting referent [participant**]**" (1998, p. 111).

Rennie's analytic procedure: Grounded theory informed by 'methodical hermeneutics' has the researcher break the text into blocks (units of analysis or 'meaning units' [MU]) and progressively categorize the meaning interpreted to be 'in' each unit as the researcher works through the text proceeding from MU to the next. A list develops as analysis goes ahead with referral to the list as each MU is addressed, such that the unfolding new categories and categorie s to represent them are added to the list along with an understanding of the relationships among them. In working progressively from MU to the next, supported by a good index system, the researcher is afforded a sense of control. Moreover, the researcher is encouraged to work imaginatively. In this manner abstraction and creativity are activated in the initial descriptive phase of categorization. The method's interplay of abduction and induction in the constant comparative analysis is the 'central procedure' affording a self-correcting process to analysis such that hypothesised categories not sufficiently representative of the data are cast off by the end of the analysis. The analyst's developed understanding allows the researcher to credibly, with "warranted assertibility" (Dewey, l938, as cited in Rennie, 1996, pp. 327), move beyond the participants' interpretations of their experiences to a more abstract and all-encompassing awareness.

Abductive analysis: Describing this self-validating procedure, Rennie (2000, p. 489) explicates "Thus, for Pierce, the proximal course of science involves the gathering of facts [induction] which gives way to an abduction which is then tested by further induction. The significant consequence is that induction is self-correcting (Tursman, l987)." With Rennie's methodical hermeneutics, the fruits of the symbiosis of abduction and induction are the researcher's creative

hypotheses (abductions) in the form of his or her conceptualized categories. The hypothesis is that the given category will be pertinent not only to ensuing and preceding meaning units in a particular transcript, but to other transcripts as well. In the course of analysis, once conceptualized in the form of a category, the abduction is tested by subsequent induction that may lead to the retention of the original category (i.e., the abduction), or to its modification, or to its being folded into another category, or to its abandonment. Again, it is through the interplay between induction and abduction that induction becomes self-validating. And so, when developed in this way, a grounded theory can stand on its own feet.

Metaphorical Vehicles in Therapy: Connected to the emergence of the social constructivist perspective, these are features of human knowing and meaning creation that both reflect and influence the client's personal and social realities. Metaphorical vehicles—including externalization (labelling the problem), deconstructing and re-authoring stories, and ceremony (celebration of attainment of a new preferred reality)—promote understanding, change and growth in the therapeutic setting.

Relative Influence Questioning (see White, l988): This process of questioning invites family members to derive two different descriptions of their association with the problems that they bring to therapy. The first is a description of the influence of the problem in the lives and relationships of family members; the second is a description of the influence of family members and their relationships in the life of the problem. Relative influence questioning also invites

family members to participate in the construction of a new description of the problem itself—an externalized description.[11]

*Nud*Ist* (Non-numerical Unstructured Data Indexing Searching & Theorizing) qualitative data analysis program; Melbourne, Australia; QSR International Pty Ltd., Version 6.0, 2002): This is a leading software package for qualitative researchers for many years; originally conceived at a university in Melbourne Australia in 1989. N6, the latest version, helps the user develop theory through hierarchically related codes/nodes. For example, 'A' is an instance of a higher-level concept 'B' which in turn is subsumed in a more general 'C'.

[11] Relative influence questioning utilizes the cultural practice of objectification against itself by objectifying and externalizing problems (see White 1987), thus challenging the objectification of persons.

CHAPTER III: METHOD

Grounded Theory Method

Grounded theory is a general method, a way of thinking about and conceptualizing data. This method explicitly involves generating theory and doing social research as two parts of the same process (Glaser, l978). If existing [grounded] theories seem appropriate to the area of investigation, then these may be elaborated and modified as incoming data are meticulously played against them (Glaser & Strauss, 1967). Researchers can usefully carry into current studies any theory based on their previous research, provided it seems relevant to these, but again the matching of theory against data must be rigorously carried out. The major difference between this method and other approaches to qualitative research is its emphasis upon theory development. Theory development is grounded in the data, generated and developed through interplay with data collected during the course of the research project.

Built into this style involving extensive interrelated data collection and theoretical analysis is an explicit mandate to strive toward validation of conceptual relationships formulated as creative hypotheses. Theoretical conceptualization means that grounded theory researchers are interested in patterns of action and interaction between and among various types of social units. They are also much concerned about understanding process, reciprocal changes in patterns of interaction, and in the relationships between changes of conditions and the process itself. With this method, theories will always be traceable to the data that give rise to them, living within the interactive context of data collecting and data analyzing in which the analyst is also a crucially significant interactant.

Furthermore, grounded theories have a striking fluidity because they embrace the interaction of multiple actors and they emphasize temporality and process. They call for exploration of each new situation to see *if* they fit, *how* they might fit, and how they *might not* fit. Thus they demand an openness of the researcher based on the forever-provisional character of every theory. The interpretive nature of grounded theories means that such conceptualizing is an intellectual process that necessarily extends throughout the project. However, this process does not rule out the representing of systematic statements of plausible relationships with the grounded theories (Glaser, l978; Glaser & Strauss, l967; Guba & Lincoln, l989; Rennie, Phillips & Quartaro, l988; Strauss, l987; Turner, l981).

Procedure

Participant Selection. Participants were obtained from a list of clients initially provided by the Act II SHIFT program provider located in files belonging to the Ministry of Children and Family Development (MCFD) of clients who had completed therapy for the treatment of sexual behaviour problems up to 3 years earlier. This provider had been under contract to the MCFD for over 10 years to provide the SHIFT program model, along with the co-therapist involvement of a MCFD therapist or intern, at various ministry sites in the Upper Fraser Valley. This initial list was given to the regional mental health consultant who, on behalf of the Ministry, sent a letter of to the clients on the list (see Appendix A). The letter informed prospective participants about the study and the opportunity to participate, outlining the nature and purpose of the study and the manner in which participants' confidentiality would be protected. The client base was told that the letter would be followed up by a telephone call from the ministry consultant the

following week to ascertain their willingness to take part in the study. The study information was repeated orally during the ministry phone contact and also in the consent signed by participants before the interview began form (see Appendices B and C). I was not the recipient of any information regarding the initial list, including reasons for refusal to take part in the study, other than that the participants were to have gone through the program within the previous two years, as I had requested. Hence, I had no access to client files and remained unaware of any information regarding the participating clients, such as a description of their problem behaviour, history, and so on. A $10.00 inducement was offered to the children for their involvement as well as to each parent who participated in an interview. Participants were advised, both by MCFD staff at the time of their acceptance and by me prior to interview, that if the process was distressing during or after interview they would have quick access to MCFD staff, should they choose, for counselling support. When the ministry consultant had confirmation that a client family was amenable to participating in the study, only then was the contact information for the willing participants passed on to me.

Previous to beginning this study I completed a one-year internship at the MCFD under the supervision of the regional consultant who suggested that I do this program evaluation for my master's thesis. In other words, I terminated my involvement with the ministry upon completion of my internship contract prior to my interviewing of participants for this study.

Although my intention was to acquire participants who had completed the SHIFT program *within* 2 years of their interview, the understanding was related through MCFD channels such that files were taken from a database of clients who

had taken the program *over* 2 years earlier. Consequently, by the time the appropriate avenues for MCFD and caretaker approval were forged and the participants were contacted, children were close to 3 years from having completed the program. Over the period of 6 weeks, ten interviews were scheduled with children ages 8 to 12, made up of twelve youth (ten boys and two girls). Additionally, eight parents were interviewed over seven interviews. As detailed under interview procedures, my final analysis was based on seven child interviews involving nine children (eight boys and one girl) and seven parental interviews involving eight primary caretakers (two biological mothers, one heterosexual foster couple, three foster mothers, and one foster father).

Data Collection. In preparation for the interviews with the participants my groundwork for the study was two-fold. Initially the program provider was interviewed to acquire his perspective on the key features of the program. Additionally, at my request and upon receiving a specific invitation, I joined this same SHIFT provider as co-therapist in providing the program to a male client and his mother over 10 weekly sessions. To his credit, this child was already well on his way to solving his problem when he first entered the program as he had accepted that his behaviour was highly inappropriate and he strongly desired to take the necessary steps to resolve the problem. As this youth could be considered the 'model client', I believe that the co-therapy sessions were somewhat limited in allowing me to appreciate fully the strength of the program. In any case this involvement added to my general knowledge and appreciation of the SHIFT program model's framework and theory of change. Furthermore, I gained a good idea of what language would be understandable to my participants and what

language they might use to describe program activities. I then undertook to use the language provided by each participant for the rest of the interview; it seemed to me that questions that use the participant's own language are most likely to be clear to the respondent.

Interview Procedure. Once participants were recruited, interviews were set up over a period of about 6 weeks in order to capture their experience of the SHIFT program. Both children and their parents participated in a separate audio-taped interview of approximately one hour. A consent form (see Appendices B and C) was provided at the beginning of the interview for each participant. In order to maintain confidentiality, all clients chose a pseudonym, which was then applied to audiotapes and interview transcripts. As the children's understanding of their experience was the main focus of the research question, I interviewed most children first followed by the parents.[12] Three siblings and their caretaker were interviewed together for approximately one hour and a half. This decision was made because the three children were differentially affected by Fetal Alcohol Syndrome (FAS), had been treated together, and their social worker recommended it. Three separate interviews with two brothers and a sister, where no caretaker was involved, had to be discarded when I realized, toward the end of the third interview, that all three participants were recalling the experience of another program. The audiotape of the interview with one parent was defective such that most of the interview was not usable. However, shortly after this interview I made

[12] As the grounded theory method along with the narrative and contextual approaches fundamentally embrace the interaction of multiple actors, it may seem incompatible that I have titled this paper "What Kids Think … ." Although all voices resonate in my understanding of this experience, it is the children's voice that rings the loudest and the clearest and for whom all others' voices hold importance in virtue of informing me what these children thought.

notes of this participant's conversation detailing my observations and understandings.

When conducting research interviews I chose to be as open-ended as possible, while maintaining a clear focus on what it was I was attempting to understand. Within this framework, while prepared questions provided a general guide for the interview, questions also came up in the light of the analysis of the data from pervious interviews. As interviews proceeded I was more likely to save prepared questions to use toward the end of the current interviews. Much as Glaser and Strauss (1967) suggest, I was concerned that to do otherwise could unduly shape the information gained.

When interviewing the children, I asked them to tell me about both helpful and unhelpful experiences during their treatment sessions with the therapist. With the parents I focused on their experience of the treatment program, rather than their experience of their children's behavioural problem. For example, when I was asked a question that did not pertain to my research question, I would gently remind my participants of the purpose of the interview by restating my research question and ask if their concern could relate to what I was asking.

Previous to the actual taping, all young participants were given a $10.00 bill to place safely away out of sight. I also offered them a drink and a snack as I enquired what name they would like me to print on a certificate I presented to them affirming their valuable contribution to research**.** Further, I spent some time initially in building rapport with the children, talking briefly about their interests, their understanding of the process, and how they were feeling being there. I wanted my participants to see that their knowledge, experiences, attitudes and

feelings were valuable in that they could add to research, improve the program and help other children. Generally, I invited the children to discuss how the program had been for them, what they had felt about the activities, what they had found helpful and not so helpful, what they would like to see changed in the program, what advice they would give to a friend who was starting the program, and other issues they chose to mention. Following the lead of Rennie (1996) and Toukmanian (1992), I drew on process interventions as described by experientially oriented therapists. These interventions in emphasizing what is happening in session rather than what is being said, leave the content of the information more free to vary within the focus of the participants' attention. For example, the client is asked "Can you say a little more abut that" or "I notice that you changed topics. Did you notice that?" This interview process is meant to control interview bias. In this part of the interview, which makes up the body of the data, I was comparatively less active when interviewing expressive participants who showed little discomfort with the research experience. Such participants were able to discuss this sensitive subject and were able to connect with distant memories of their experiences of the program. Additionally, as categories developed during the course of analysis and became increasingly saturated, there was both less need and less inclination to maintain activity (see Rennie's interview strategy, l992). The process indicated that, although the children were initially somewhat uncomfortable, they were not distressed by the interview and seemed generally interested in trying to help me. As they became comfortable, they chose what and how they wanted to discuss their experience. The use of 'metaphor vehicles', as had been applied in the SHIFT program,

allowed them to portray their problem behaviour as external to themselves. Further, as the children had chosen metaphors in the program to describe their particular sexually problematic behaviour they could enjoy a measure of privacy by using their preferred metaphors when discussing their experience with me. In recognizing that the participant's account is invariably constructed in response to the demands that are situationally determined, I made a concerted effort to resist the impulse to co-construct the participant's experience. In general, my degree of participation in the interview was dependent on how active I had to be in order to establish a comfortable relationship and to probe judiciously their memory of the program, such that I was somewhat more active with participants who had difficulty articulating their experience. Follow-up interviews were not carried out with participants as originally suggested for two reasons. First, Rennie's methodical hermeneutics does not require this 'member checking' type of validity check (see Rennie 2000). Second, I felt that participants may have been uncomfortable or challenged in acknowledging details of their experiences in print because some of their negative reflections were expressed with some discomfort that I associated with a sense of vulnerability (see Validity and Reliability).

Data Analysis. This grounded theory study employed Rennie's 'methodical hermeneutics' which depends heavily, although not exclusively, on inductive methods of analysis in generating theory from the data (for a detailed description see Rennie, 2000). This method of analysis entails the constant interplay between abduction and induction. Hermeneutics traditionally has been defined as "the theory of the interpretation of understanding in its relation to the interpretation of text" (Ricoeur, l978, as cited in Rennie, 2000, p. 483)**.** Here, in

engaging with the semantic aspects of the text, it is held that interpretation is involved in developing u nderstanding of the meaning of the transcript. From this view, when the text is considered difficult to understand, the activity of understanding is hermeneutic. The researcher has a choice here to stay close to the manifest meaning of the words or to engage in 'depth hermeneutics' (Ricoeur, l981, as cited in Rennie, 2000, pp. 483) such that the hidden or more abstract meaning of the text is interpreted. With the intention of avoiding developing a huge number of categories to help assure a manageable analysis, I determined during this procedure to strive for abstraction even in the initial phase of categorizing (i.e., the descriptive phase of categorizing). With this task I constantly asked myself when addressing the data, 'So, this is the topic being discussed, but what does this unit of analysis mean?' Additionally, the use of metaphor was activated when it seemed to fit. Such engagement as will be referenced elsewhere in the thesis is considered acceptable as the method is self-correcting such that I had discarded any categories not sufficiently representative of the data by the time analysis was completed. This claim is warranted in virtue of the essential symbiosis of abduction and induction in the constant comparative analysis (Rennie, 1996, 2000; also see *Definitions* for a more complete explanation)

In this manner, this interpretation used systematic and disciplined procedures (see Rennie, Phillips, & Quartaro, 1988; Turner**,** l981) in attempting to conceptualize the participants' interpretation in an organized and orderly way. Such procedures included the constant comparison method necessitating the interplay between abduction and induction, theoretical question and theoretical

memoing, concept development, and my relationship with the participant. Certain considerations affecting the application of the grounded theory method are particularly supportive to the researcher's claims to knowledge. In support of their application of this procedure, researchers implement specific guidelines: (a) use of figures to conceptualize categories (i.e. metaphor), (b) expression of reflexivity throughout the inquiry, (c) detailing of the systematic and deliberative procedures, (d) staying grounded when interpreting the text, and (e) the use of clear vivid language (Rennie, 2000).

With the act of interviewing the research participants I entered the hermeneutic circle, such that I gained a sense of the text before it was transcribed. The act of transcribing itself can deepen the understanding of the text. Having first obtaining a transcriber's pledge of confidentiality in writing (see Appendix D), she was then engaged to assist me in the transcribing of certain interviews. In addition, I listened to each interview, comparing what I heard with the transcription to double check it, making changes as necessary. .

With each new interview completed, I began my active analysis on the text available to me. This developed understanding of these young participants included a number of considerations: (a) an intuitive grasp of the relationship between the client and the researcher; (b) considerable spontaneity in the children's responses; (c) a sense that children enjoyed having an audience for their success and their heroism, as well as their frustrations; (d) the observation that the children seemed proud of their participation in a research study; (e) the children's expressed concern that I be the only one to hear the interview[13], and (f) the

[13] Children were reminded that an outside person could be used to type up the interview but that she was (a) sworn to secrecy and (b) had no connection to SHIFT or to the Ministry.

forthright admission by children that they continued to be challenged by the problem behaviour. Additionally, as most of the children were foster children, I think it was most likely that these parents would portray the children's success, or lack thereof, in an accurate light. In this regard, foster parents do not carry the shame associated with the child's behaviour that may be carried by a biological parent. As well, foster parents are indisposed to downplay the considerable challenges that they face with children in care.

In keeping with the ongoing reflective stance of the method, as descriptive categories developed, I recorded ideas and hunches as theoretical memos. Initially, such recordings were made in a logbook. As I gained more familiarity with NUD*IST (QSR International Pty. Ltd., Revision 6, 2002), I was able to store such theoretical memos in a program file, separate from my indexing system where categories were held. I experienced considerable tension as the analysis proceeded, between deciding to conceptualize concrete or abstract categories. These and other considerations became the subject of ongoing, thought-provoking discussions with my advisor and occasional dialogue with colleagues.

Grounded theorists represent their understandings in the form of categories and relations among them. "[It is] because the grounded theory method has to do with the meaning of the semantic aspects of text [that] any theory coming out of the application of the method is about understanding, not explanation" (Rennie, 2000, p. 483). Each inquiry transcript was broken into units of analysis or 'meaning units' (MU), the meaning of which was represented in terms of conceptualized categories, whereupon the given unit of datum was assigned to as many categories as were conceptualized to be pertinent to it. Concepts were then

drawn out of the data, 'grounded' in the raw material of the interview (see Rennie, l995; Rennie, Phillips, & Quartaro 1988; Turner, 1981, for the details of the analysis). The MU lengths vary from a line or two to more than a half page of text, depending on the judgement of the analyst. Accordingly, in my analysis, MU were passages of the transcript that stood out as conveying a significant element, important interpretation, or central understanding uttered by participants. On further consideration of the meaning unit, I often understood it to contain other meanings as well. As my interpretations of the MU continued, they were re-worked and re-ordered innumerable times over a period of months using the software indexing system, such that they attained increasingly higher levels of abstraction. Although the MU were initially understood and interpreted while maintaining an intimate alliance with the data, I also had the need to abstract in this initial phase of categorizing by constantly questioning what each MU meant. Rennie (1996) recommends, as an aid to abstraction, the use of imagination, intuition, and metaphors. Further, Rennie maintains that the researcher's flights of fancy do not minimize the credibility of the manuscript due to the fact that the method's constant comparative analysis is self-correcting such that categories that do not well represent the data will be rejected by the end of the analysis.

As categorizing of categories was carried through higher orders of abstraction, at the final stage of my analysis I conceptualized a supreme or 'core' category, with all the categories it subsumed considered it's properties. All the while I assured that developing classifications were able to account for the meanings in the new data. At this point my analysis represented a hierarchical conceptual structure, with descriptive categories serving as properties of the

primary lower order categories, these primary categories serving as properties of the main higher order categories, and the main higher order categories serving as properties of the supreme core concept category.

*NUD*IST (QSR International Pty Ltd., Version 6.0, 2002).* In using this software I was provided with tools that eased my laborious task and which enabled me to organize my analysis in a timely and convenient manner. With this in mind it is important to state that it is the researcher him- or herself who designs and directs how research tasks and activities are to be implemented in this database program. Nevertheless, the program can be very helpful. As I conceptualized categories, the software facilitated exploration and creativity by providing a convenient way of recoding and resorting a given datum, once I realized that it no longer 'fit' with how it had been initially categorized. Additionally, the software allowed me to store all the information about a category or theme in one place so that all the information about it could be viewed together. With the NUD*IST index system, there is a place for each category at a node that holds an address number, a label including any number of words, in addition to a definition of unlimited length. The researcher is able to organize categories or nodes either as a hierarchy, a flat structure, or as unstructured data called 'free nodes'. Ideas about nodes are stored in memos kept separate from the categories. What begins as a formless bag of information develops into a system of nodes that the researcher uses in ongoing inquiry, searching and theory building throughout the project. With the N6 Student Software, the project can be perceived as two metaphorical 'bags', sitting alongside each other. On the one hand, there is the big bag of documents; data that depict life and experience of life

in all its detail, complexity, richness, messiness and apparent chaos. The development of the index system assists the abstraction of structure and patterns so that the researcher is able to talk about the data and tell the story of this bag of documents. The document bag can be picked up to find out what's in it; the text of a document can be retrieved, browsed, and searched for a word or phrase and how many times it was used and such. Similarly, the index bag can be opened and browsed in order to find out what nodes have been created, the names given those nodes and how the have been defined. Nodes can be organized into a system whose shape shows the researcher's ideas that are being explored and the questions that are being asked.

In using this software it is important to reiterate that it is the researcher who draws a connection or series of connections between the index system and the document system. This process of 'drawing connections' is a coding or categorization process. Moreover, coding can be done much more swiftly than doing it manually because work is being done with the text on the screen, in which a reference to that bit of document is easily accessible by virtue of its attachment to the node or category; it is not necessary to refer to the transcript in and of itself. Although the reference delineating the links between the document and index system shows one document and one node or code, within a project there are many documents and many nodes where a particular piece of text may be coded at many nodes. Indeed, there is no limit to the number of categories at which a segment of text can be coded.

Interative Process to Saturation. This ongoing analysis, encompassing the symbiosis of abduction and induction involved in the constant comparative

procedure, is directed toward the conceptualization of a core category that colligates all other categories. Thus, the meaning within the higher order categories should in the main be evident in the lower order categories and in the relationships among them and so on. The core category is chosen to capture the best overall understanding of the experience being studied. During this examination, theoretical memoranda were increasingly drawn on as I conceptualized more abstract categories that subsumed the descriptive categories, yet were grounded in them. Analysis continued as, in the expectation of further describing the nature of the conceptual structure**,** I continued to select new data sources. Eventually I judged the emerging categories to be stable as the new data added little to the development of new descriptive categories; That is in my judgement the categories had reached saturation. Rennie (2000, pg. 485) speaks of "this circling of part to whole and back again [resulting] in progressive understanding that, in principle, is non-ending, although, hopefully, it reaches a kind of stability, at least within the horizon of the particular hermeneut [see Dilthey, l976, for more on the hermeneutic circle]."

Figures, such as metaphor, have been used in the conceptualization of categories in order to convey understanding. A reflective stance was activated and some of this reflexivity is given in the Discussion chapter.

Examination of Validity and Reliability

Doing the analysis required considerable flexibility as well as tolerance of ambiguity. I periodically took time away from the interview data for reflection, planning and consultation with my supervisor, as well as with colleagues. In carrying out this analysis, I have accepted the understanding that the qualitative approach can never be objective and that its logic of justification includes consensus about constructed representations of reality (Giorgi, l988; Smith & Heshusius, l986; Rennie, 1992). This agreement, the validity encompassed therein, and reliability are now discussed.

My reflections on the analysis that entailed, as indicated, the interplay of abduction and induction during the conduct of the constant comparative method added to the coherence of my understanding. I hypothesized the meaning to be 'in' each unit as I went along, such that I continually checked my understandings with the data that had come before and would come after. Thus, internal validity, within this framework, developed along with my ability to show that the categories were grounded in the data. Internal validity was further enhanced as cross-interview meaning was established as categories common to all children were compared with the categories derived from parents' experience of therapy. In implementing Rennie's method (1995), I developed categories working on my own such that no judges or 'team' were systematically used to get indices of inter-subjective agreement on my evolving categories. External validity was improved to the extent that my conceptualization makes sense to the reader in light of their experience with the phenomenon in question.

Rennie (2000) observes that those employing the grounded theory method who identify with positivism are inclined to import 'natural scientistic' notions of

reliability and validity. Such notions include, for example, the actions of member checking which involves checking with participants about the adequacy of formulations (Guba & Lincoln, l982). However, Rennie maintains this usage can be slippery. Such engagement, although holding utility in its intended exercise of limiting researcher bias and while supporting the humanistic values in qualitative research, presents the quandary of whom to believe when the respondents disagree with the researcher's interpretation. Furthermore, although it is true that the respondents may know the meaning of their text better than anyone else, it also may be the case that these participants are defensive about their expression of their experience represented in the text. Previous to my having an in depth understanding of the validity checks that are encapsulated in my chosen method itself, I had planned to include the actions of member checking in this study. An additional peripheral support for my position in rejecting the use of member checking rests with my developed understanding that my participants would be uncomfortable in being asked to review certain of their experience as expressed in written form. In this regard, I perceived my participants' expression of negative associations with the program to be expressed with varying degrees of uneasiness. For example, participants expressed apprehension that the interview data could be accessible to anyone other than myself. In short I had concern that participants would be defensive in seeing expressions of their experience portrayed in words.

In using the grounded theory method there was the expectancy that important theoretical insights into the parameters of treating this problem could be provided. With this approach, I am able to claim predictability for theory developed to the extent that such understanding can specify outcomes and their

related conditions in the restricted sense that if elsewhere approximately similar conditions uphold then the approximately similar consequences should occur. Confidence in the reliability of the research results is further enhanced, as justification of outcome categories was forthcoming, as previously mentioned, through the collateral ongoing partnership with my advisor.

CHAPTER IV: RESULTS

Results of the categorical structure of the clients' experience of the SHIFT program model are given in Table 1. This conceptual framework is offered only after having subjected the interview transcripts to the rigorous method as reported in the previous section. I have conceptualized a core category that subsumes all other conceptual and descriptive categories. The higher order categories have been conceptualized under four main categories with the corresponding main category's primary categories, eight in all, listed beneath it. In turn the 35 descriptive categories beneath these represent concepts that emerged directly from the transcripts and the accompanying descriptive ingredients may include personal phrases or words directly spoken by the participants. With this understanding I offer one example of interview text for each MU, taken from different participants. The number of participants that fall into each category are listed directly underneath the category description. In analyzing the interview transcripts, I drew from a number of sources: the design paradigm as set out in the SHIFT manual, information from the program provider's expressed rationale and treatment, communications with colleagues familiar with the SHIFT implementation design and strategies, my own first-hand experience as co-therapist, the considerable research in this area as advanced in the appendices, and my personal therapeutic interests as previously delineated.

Following Table I, an elaboration of the core category is provided which in the grounded theory approach is conceptualized to capture the meaning common to the all other categories and to their interrelationships. It follows that for the most part the individual meaning units and the relationships between them will be reflected in the meaning of the core category. Presentation of additional findings with include descriptive categories as understood to be particularly relevant to this program evaluation. The reader is encouraged to turn to Appendix G for a more detailed and selective, though not exhaustive, presentation of quotations from the participants representing the categorical conception of *What Kids Think After Treatment for Sexual Behaviour Problems.*

Table 1

CLIENT'S RESTORYING IN RELATIONSHIP (Core Category)

Main Category 1: The Client's (C) Relationship with the Problem

(a) Client's active pursuit of a 'problem-gone' narrative

Invitation to Restory: (Talking opens a door; reflects both the children's and the parent's experience of safety/trust/understanding.[14])
- This property codes 13 documents out of 14—7 children and 6 parents.

*When I kept it inside I just didn't like myself. I felt dumb and weird. Just getting it out, I felt all opened. By telling someone how I felt I didn't feel guilty—like when nobody knew about it. I was happy about my self. I could tell the truth. I knew that that what is said in that room stays in that room. (Child—*Client's Understanding of Story-Line, Portrayal of Problem, Client's Contact with Feelings, Interruption of Behavioural Schema and Alliance with Therapist.

Understanding of Story Line: (C's awareness/acceptance bearing on etiology and/or magnitude of problem; willingness to create a new story with the help of others.)
- This property codes 12 documents out of 14—7 children and 5 parents.

To another kid who was going to take this program I'd say it's okay to talk to Steve about it because they help you. Your mom can help you too because it is a family organization—your family needs to know. Most people will understand. If a family member doesn't understand that you have that problem, the program helps you understand and helps them understand too. (Child)

*Opening Spaces Through Story/Story-Writing: (*Collaborative discovery of preferred scenarios and new/alternative behaviours and shifting of fixed meanings; blue-print of the child's construction of a problem-gone solution.)
- This property codes 12 documents out of 14—7 children and 5 parents.

To me the story meant that we had to get it all written down and this would probably help more with getting the problem away. We wrote about a lot of stuff in there on how to stay away from the problem. I could always look back if I needed to find out something It was about things I have done wrong, things I am starting to get right, and things that can help me along the way. It's about how I got better. It's a keepsake so that I never forget. I read the story and I feel good

[14] With the intent to enrich the reader's understanding of the grounded theory analysis, additional meaning that I judged this meaning unit to convey are included with this one excerpt.

Table 1 (cont.)

CLIENT'S RESTORYING IN RELATIONSHIP (Core Category)

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about myself for being able to get through the program. (Child)

Portrayal of Problem: (Externalization/personification of problem as invitational reframing/ person not the problem; opens up C's horizon of hope and agency.)
- This property codes 13 documents out of 14—7 children and 6 parents.

By giving the problem a name King K. is separated from the problem. King K. can say 'I'm not a bad guy, it's the problem that's bad and I'm going to remove it myself and throw it away. It's getting me into trouble and I don't want that.' (Parent)

Client's Contact with Feelings: (C connects with emotions that include experiences of remorse/diminished guilt] a sense of hope, power and accountability; reflected in restorying.)
- This property codes 12 documents out of 14—7 children and 5 parents.

I felt that I had the power to get it all away. I felt very, very bad when the touching problem was near me, but as soon as I came here I felt relieved. It was like I knew that Steve and the other person are going to help me get the touching problem away. (Child)

Team Support: (On-going team approach starts with child picking a team name and members including program provider, co-facilitator, parent(s), and appropriate others to0 help in restorying a problem-gone narrative; paves way for the child's role as 'hero' or quarterback both in the therapy setting and in the world.)
- This property codes 11 documents out of 14—6 children and 5 parents.

*The fact that there was a team that was built around solving the problem was great — like a captain and who would be the players and who would be part of that team. It made it a team effort so Dan C. didn't feel it was just his problem to deal with by himself. He felt he had a support system around him. (*Parent)

Team Activity: (Treatment plan involves construction and writing up of structured safety plan to ensure 'safe zones'/environmental controls; development of boundaries/habits of respect/ psychoeducation/ information sharing.)
- This property codes 13 documents out of 14—7 children and 7 parents.

I mostly talked about things to avoid to stay out of trouble—like no forts with younger children and no sleepovers. Well, the important thing is that the

Table 1 (cont.)

CLIENT'S RESTORYING IN RELATIONSHIP (Core Category)

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behaviour will never happen again and I can carry on so that people don't get hurt. The program taught me a lot because I never knew that being disrespectful really hurt people. I pretty much used to only think of what was happening to me but in the program I learned how my behaviour hurt my Mom and my step dad. (Child)

Interruption of Behavioural Schema: (Implementation of cognitive-behavioural techniques allow C to connect links between thoughts, behaviour and consequences; sharing of information is encouraged to map internal and external precursors of problem.)

- This property codes 13 documents out of 14—7 children and 8 parents.

We talked about what we should do and shouldn't do and what would happen—using this sheet of paper. If we have a stinky thought, what should we do? Like somebody asks you to touch somebody, you should not do it. You could either hurt the other person or they might not want to be around you—you could lose most of your friends; you can go to jail. You'd get into lots of trouble. (Children)

Metaphoric Defeat of Problem: (C's experiences the C/T's use of metaphors in process of personifying the problem (externalization) to enact the defeat of the problem behaviour.)

- This property codes 9 documents out of 14—6 children and 5 parents.

If the problem came towards us we had to yell for it to fly away. We had to yell loud: "Get away Mr. Stinker!" . . . We felt very brave . . . We drew Mr. Stinky to see how it looked. It was very, very ugly. Mr. Stinky had dots all over his face and ears that went wooooh. We actually drew the problem. That's how it looked. Of the pictures, I think we only cut up one. And we put it in the shredding machine and it never came back. (Children)

Clients' Metaphors: (C's uses metaphorical language to speak of his or her experience—stinky thinking / tomb squad team / space invaders / bubble spaces / safe zones and so on.)

- This property codes 12 documents out of 14—8 children and 7 parents.

My team is called the "Tomb Squad". It's from an ancient world. Tomb Squad in Egypt means that we are the best and I know we can all do it as long as we work together. (Child)

Table 1 (cont.)

CLIENT'S RESTORYING IN RELATIONSHIP (Core Category)

Observational Factors: (C's spontaneous joy and excitement / anger at power relationships / uncertainty as to one's strength to beat the problem / discomfort with talking specifically about problem; needing assurances about confidentiality in expressing criticism.)

(b) Disconnection with story-building solutions

Strategic Barriers: (C's experienced a dilemma over implementation of program strategies/interventions/techniques such as the story-writing process/the use of metaphors/the program activities. For some participants the experience represented a major disjunction in treatment while others perceived the experience as merely unhelpful or unpleasant.)

- This property codes 6 documents out of 14—5 children and 3 parents.

The noodle exercise was supposed to beat up on the problem and beat it down—but Liam didn't really understand. He didn't know the meaning behind the playing. Steve would say, 'I'm the problem; make me go away', and he didn't understand or even like doing that noodle fighting. For him he was just beating up on this man. (Parents)

Structural Barriers: (One child did not like his sessions because they excluded any time spent alone with the therapist; this might preclude some children from providing important information regarding their environment. Three children felt that the program's toy-room environment was inappropriateness; this concern could distract C from engaging with T or diminish C's receptivity to T's tasks. In two cases no parent participated in all on-gong sessions along with the child, even though the program design bases its success on parental participation. Five parents experienced feelings of confusion regarding session or program goals that could diminish C's engagement with the process. One biological parent had feelings of abandonment after program termination that could have the potential to damage the maintenance of a problem-gone narrative.)

- This property codes 7 documents out of 14—3children and 5 parents.

Nobody contacted me after the program to see how I was doing. There was no follow-up. I experienced so much support during the program and afterwards I was completely on my own. I felt abandoned. I didn't feel that I had the skills to deal with Dave M. on my own if the sexual touching problem returned. I would have to come back into the program.[15] (Parent)

[15] Represents researcher's memory of parent's comments, as interview tape was not transcribable.

Table 1 (cont.)

CLIENT'S RESTORYING IN RELATIONSHIP (Core Category)

Personal Barriers: (Most clients referenced a history of problematic attachments and social/learning deficits. Such experiences may represent a deterrent to children developing a timely trust in T to accommodates the brief therapy approach and/or the ability to intentionally embrace the restorying process.)
- This property codes 9 documents out of 14—3 children and 7 parents.

My mom [foster] never used to think about me. She doesn't even like me. She knows she doesn't like me. She just acts like it at meetings. She doesn't really like me. She always bugs me at home and she's nice to me at meetings. Like, she'll listen to what I have to say but at home she doesn't. (Child)

Main Category II: The Client / Therapist Collaboration of Co-Authorship

(a) Operations bearing on client's co-authorship with therapist

Alliance with Therapist: (C's experience of a trust/caring and/or empowering relationship with Therapist.)
- This property codes 14 documents out of 14—8 children and 8 parents.

It was hard at first to just tell him [Steve} because it was embarrassing. Then I just decided to do it. I learned it was good to talk to somebody that I knew really well and that I can trust –they would understand. (Child)

Engagement with Therapeutic Task: (Client connects with T to develop story.)
- This property codes 11 documents out of 14—7 children and 5 parents.

I didn't think the activities were too young for my age. It was fine. It made me think that kids of all ages have this problem. That it's not only when you get to this age. That it happens to all different people, different ages. (Child)

Objection to Therapist: (Manner/characteristics/modeling.)
- This property codes 3 documents out of 14—1 child and 3 parents.

I also felt Steve was always waiting to get out for his next smoke. He'd rid down in the elevator with us to smoke and that tended to bother me. I think people have

*T*able 1 (cont.)

CLIENT'S RESTORYING IN RELATIONSHIP (Core Category)

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a job to do and for that one-hour I think you need to be focusing on the child and not thinking of your next smoke (Parents)

Concern about Therapist's Approach: (T's plan of treatment involving C's personal understanding of T's instructions/responses/explanations/subject matter/structuring of sessions.)

- This property codes 4 documents out of 14—2children and 3 parents.

I'm a big kid—don't think I'm stupid. Listen to my side of the story and don't side with someone else. Steve doesn't go with you and then he wants you to say you're sorry after he's telling you that you did it. He makes the story bigger by saying that he believes other people that are not thinking straight. (Child)

Client's metacommunication: (C's conversation about desire to have communicated to T about lack of understanding / appreciation of T's communication / client may feel the need to speak up but finds this difficult to put into effect; C's unwillingness may extend lack of honesty with T even when C is invited to metacommunicate in this way / C may desire the T to explain the program rationale so that the C can better understand and participate in the process.)

- This property codes 6 documents out of 14—3 children and 4 parents.

I should have said—like when he was talking to me he asked me "Could I be part of this team?"—and I'd say "No, and your buddy can't." He'd be like, "You can pick who you want and that's final. Whoever you want for your group." And then he said "Do you want me in your group?" and I had to say "Yes" obviously [but] It would have been funny if I'd said 'No'. He'd be like "You have no choice." (Child)

(b) *Operations bearing on therapist in co-authorship with client*

T's Active Support: (T offers reassurance of a problem-gone solution; reinforces C's strengths.)

- This property codes 12 documents out of 14—6 children and 6 parents.

He was encouraged by Steve to take action. He said "You're the one who has to change your life story—you know how to do it now. You know you accomplished this part. You're the one who has to go to these neighbours and show them you've changed." So now he's writing stories to the parents about how he feels and what he was like then and could he play with their children again. (Parent)

Table 1 (cont.)

CLIENT'S RESTORYING IN RELATIONSHIP (Core Category)

Therapist's Use "Relative Influence Questioning" (White, l988): (Narrative collaborative process of questioning in therapy that invites clients to understand their association with the problem / invites family to participate in construction of a new narrative describing the problem: an externalized description / imbued with a sense of curiosity/wonderment / supports the children's choice making and agency and models this communication tone for parents.)

- This property codes 7 documents out of 14—4 children and 5 parents.

Things are raised after Dan C. has had an opportunity to share why he may have acted like he did or what it is that he thinks he could have done differently. Steve really plays on that. What could you have done differently or what is it you're afraid of? (Parent)

T's Directive Approach: (Direction or instructions of T is experienced by C as authoritarian; perceived by once child who strongly viewed the T/C relationship as lacking equality and real choices; for this child the technique of relative influence questioning was experienced as simulated and lacking in any wonder. Findings suggest that children who do not feel their sense of having real choices may not fully engage in the restorying process.)

- This property codes 2 documents out of 14—1 child and 1 parent.

Well, he [Steve] doesn't know even how to talk to people . . . Like if you didn't know something he would be snobby and be like, oh sure you know it. You just don't want to tell me. He'll dig up stuff that he didn't even know anything about and say he knew a lot about it actually. (Child)

Main Category III – Influence of Program Strategies

(a) Influences on client's sense of agency / reparation

Tools For Life: (Family experiences new strategies to deal with problem after treatment/gains skills such as problem solving / relational skills / psychoeducation.)

- This property codes 11 documents out of 14—7 children and 6 parents.

After the first meeting I got the confidence to talk to him. Before the program I was afraid to discuss the subject with King K and he was hiding his behaviour—he felt I had been shutting him out. Now if there is any inappropriate behaviour I

Table 1 (cont.)

CLIENT'S RESTORYING IN RELATIONSHIP (Core Category)

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*am able to talk about it and deal with it. Steve showed me that this isn't enough to just say no, you're not allowed to do that—you have to talk about it too. (*Parent)

Separation of Client from Problem: (Externalization/narrative therapy technique personifies problem/places problem outside C and within C's control/ encourages C's appropriate choice and their responsibility in gaining a problem-gone narrative.)

- This property codes 11 documents out of 14—7 children and 6 parents.

They named the problem and then we would refer back to it as being the 'touching problem" or the "lying problem" or the "sneaking problem." We talked about how big the touching problem was in measures of this wide, this high …I thought Steve did a great job of getting Dan C. to own up and take some responsibility. I could see that Steve was trying to find out how big Dan C. thought the problem was and to encourage him to take ownership of it and be accountable. (Parent)

(b) Influences on client's sense of identity

Child's Perception of Self: (C experiences changes in self-concept / empowered / self-assured / aware as an outcome of completing the program.)

- This property codes 11 documents out of 14—7 children and 7 parents.

What you do is up to you. Like somebody asks you to touch somebody, you should not do it. You could either hurt the other person and they might not want to be around you. You can lose most of your friends. (Children)

*Parents' Perception of Child: (*Parent experiences the child as multidimensional or, alternatively, is strongly influenced by a problem orientation at program termination. It may be that those who tend to chiefly see the child in light of the problem behaviour will experience less engagement with program and will be less able to support the child toward a problem gone narrative.)

- This property codes 7 documents out of 8—8 parents.

The SHIFT program really helped me understand that I don't have some monster child. With all the activities that we did in the program it gave me insight into what Dave is feeling and now I feel I know ho to help him. (Parent)

Table 1 (cont.)

CLIENT'S RESTORYING IN RELATIONSHIP (Core Category)

Causal Reflections: (C connects with his or her childhood history and etiology of sexual behaviour that offers the C a starting point with which to begin the restorying process.)

- This property codes 7 documents out of 14—3 children and 5 parents.

The very first time I went to the program I talked with Steve at the Mall once—so we would figure out what happened in my past or something. After that we would get together and do the program.

Main Category IV: Client's Experience of Outcomes

(a) Impact of program

Problem Gone: (C has gotten, is getting, or is unsure of getting his or her control over the problem behaviour; while some children felt that the problem was definitely behind them, others felt very positive about a problem-gone solution but appreciated that they were in the process of recovery. One child only expressed definite reservations about his ability to be successful and his parent did not attend the program, seemed unaware of program rationale/strategies/activities, and viewed the child mostly from a problem focus.)

- This property codes 14 documents out of 14—8 children and 9 parents.

I told them that I wasn't doing any of that stuff that I did before. Well, I wasn't sure about it at first but after a while I thought it might come back. I don't know yet. It's better. It's controllable. (Child)

Assimilation: (Metaphoric language of program becomes part of family's world.)

- This property codes 14 documents out of 14—8 children and 9 parents.

I went out in my yard and got a rock and I said "Throw it out that door" and, you know, "Get rid of it because this is the problem here." I identified it, giving it a name and letting him decide how far away he wanted it to go. So it was good to have a reference to be able to handle things that I was doing too. (Parent)

Effectiveness of C/T Operation(s): (C's positive experiences of overall process and activities of program included: diminished guilt and isolation / a heightened sense of self and others / a sense of control of the problem / awareness of thoughts, behaviour, and consequences / problem-solving skills and

Table 1 (cont.)

CLIENT'S RESTORYING IN RELATIONSHIP (Core Category)

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psychoeducation / the understanding of having, with the help of others, changed their story to a new preferred narrative.)

- This property codes 11 documents out of 14—7 children and 6 parents.

It [the program] helped me a lot. I didn't really like them (therapists) but I was learning. Like, I was with the program for some weird things. I started doing better when I as in it and now like people don't bother me . . . Steve was helping me a little bit . . .. Umm, I got a lot off my mind to talk to someone. I started feeling better about the stuff that I'm feeling. (Child)

Lack of Faith in C/T Operation(s): (C is unable to recommend program to others; C experienced process/activities as ineffective.)

- This property codes 3 documents out of 14—1 child and 3 parents.

I think Steve might be effective with the little kids but not these older kids. These kids are already more or less moulded. They can be arrogant and they can be in denial of everything and they don't care. They'll sit there and just watch you and be entertained by Steve instead of him really getting through to them. But then they are colored already (Parent)

(b) Impact of interview

C's View of Program: (Interview process broadened awareness of program effects adding to perceived value of program; clarified program goals to help guide client's future treatment needs.)

- This property codes 4 documents out of 14—5 parents.

He disclosed to us that he was being abused at home after the SHIFT program. So this might have been a plus for the SHIFT program. Now that I think about it, it might have helped him to disclose to us . . . He was being allowed to go for family visits and he was uncomfortable. He did not want it and there e was the list of 10 things on the wall and to tell an adult if someone does this to you. Tell someone you care about . . . So maybe this was part of it because it was very soon after the program finished that he disclosed to us. He felt safe enough to be able to come to us and tell us what was going on. Now that I'm thinking about it might have been a very positive thing that came out of the program . . .. And his behaviour changes since the disclosure have been amazing. It's like he's taken the secrets of the world and just given them away. He's not packing it around anymore. (Parents.)

Table 1 (cont.)

CLIENT'S RESTORYING IN RELATIONSHIP (Core Category)

C's Self-Worth, Hope, Confidence: (Interview process allowed C to revisit their heroism and sense of accomplishment that confirms the narrative therapy concept that the C enjoys additional healing by virtue of having an audience for his or her story; strong observational component to this property.)

- This property codes 5 documents out of 14—6 children.

My team is called the 'Tomb Squad!' It's from an ancient world. Tomb Squad in Egypt means that we are the best! And I know we can all do it as long as we work together.

Allowed Expression of Stalled Dialogue: (Heretofore unexpressed aspects of C's experiences were voiced that may represent deterrents to effectiveness of C's restorying in relationship process and/or the maintenance of a problem-gone narrative. Such experiences included lack of connection with T, developmentally inappropriate implementation strategies, and differential experiences of program design bearing on parental participation and follow-up procedures.)

- This property codes 7 documents out of 14—4 children and 4 parents.

I think they should get another program. I'm a big kid—don't think I'm stupid; listen to my side of the story and don't side with someone else. Steve doesn't go with you and then he wants you to say you're sorry after he's telling you that you did it. He makes the story bigger by saying that he believes other people that are not thinking straight. (Child)

Clarified Conditions Fundamental to Good Program Delivery: (Strong therapeutic alliance / parental involvement / developmentally appropriate intervention strategies / follow-up.)

Core Category

The client's restorying in relationship, the core category, best represents the participants' experience of the program. It must be emphasized, however, that the SHIFT program designers do not describe themselves as engaging in a narrative therapy approach, but rather as a contextual family approach that includes techniques radiating from the narrative philosophy in combination with strategies of other approaches. Perhaps the specific outcomes ascribed to the SHIFT brief therapy design prevent it from being either represented or implemented as a "pure" narrative approach. In narrative therapy each client, problem, and session is considered unique, independent of preconceived understanding. Accordingly, the narrative therapist has a tentative, curious attitude of wonderment. However, in the SHIFT program clients do come for treatment to address a very definite problem as defined by society and a very circumscribed plan of attack is implemented with the SHIFT design. Despite the development of the SHIFT program as a brief directive therapy necessitating the therapist's fixed agenda and structured sessions, the program did appropriate the narrative attitudes of client-therapist collaboration that externalizes the problem through metaphor and role play in plotting to develop the child's story. In keeping with this collaborative narrative process, the SHIFT design was premised on the ongoing participation of parents such that parents could carry on with the restorying process when the program had terminated . The participants related the predominance of narrative strategies throughout their experience of the SHIFT program. With this over-arching narrative approach, children signed on to actively co-author their problem-gone story. Program implementation was structured so as

to symbolize the transformation of the child and the changing of his or her story in collaboration with trusted others through the ongoing actual writing of that story in a huge storybook. The therapist used clients' descriptions to open new spaces for story that included various narrative strategies such as externalization, in which the problem was personified. The children's preferred language was used, creative symbolic drama was implemented, and the sequence of events to increase good outcomes was observed.

The therapeutic team acted as 'co-experts' in plotting an alternative, preferred self-narrative that related to the future and portrayed the child as more powerful than the problem. Initial inquiry was directed to understanding the clients' perspective, focusing on how the problem has been affecting the client's life and relationships. Future possibilities were explored using the narrative relative influence questioning that allowed the client his or her own thought processes in developing understanding of issues. Although children most often appeared to be well aware of their problem-saturated story upon entering treatment, many did not understand society's condemnation or their relationship to the problem. In developing knowledge and externalizing the problem, they no longer viewed the problem as part of themselves, thereby gaining awareness, self-respect, and confidence in the process. Now they were free to develop a new perspective involving a sense of choice, responsibility, and power to change the behaviour that hurt others and engendered society's ostracising responses. In this manner children immersed themselves in the development of their preferred story in collaboration with their therapist and team members. These children

experienced the SHIIFT program as the opportunity to change their life story in co-authorship with others.

Categorical Structure

In view of my foregoing expression of my rationale for the core category, the client's restorying in relationship, we can now continue to address the categorical structure. There are a number of specific aspects that stand out within those areas depicted by the four main categories and their properties, and call for the core category: (a) the relationship the participants developed with the problem along with the factors that appeared to have either fertilized or frustrated that connection; (b) the client-therapist relationship of collaboration experienced by the participants, especially in terms of the client's positive and negative responses to the therapist as well as the helpful and unhelpful aspects of the therapist's role of co-authorship; (c) the extent to which the participants saw themselves changed by the restorying process involving their perceived transfer of skills in having externalized the problem and in having taken responsibility for making appropriate choices toward dissolving the problem, and (d) the outcomes as understood by the participants including those relating to the SHIFT program as well as to the interview process.

Relationship with Problem

The relationship with the problem developed such that children saw it as separate from themselves; as an unwelcome visitor that they needed to keep far away; and as an obstacle that could be dissolved or was controllable, depending on appropriate work of creating relational and structural boundaries with the help of trusted others. The children experienced various implementation strategies in

their development of a problem-gone narrative. Strategies, in keeping with narrative therapy, included externalization techniques that personified the problem by using metaphor, role-play, and rehearsal; the privileging of the clients' language; and a collaborative team approach. As well, cognitive-behavioural strategies were implemented whereby affect, thought, and behaviour were linked with consequences to initiate an awareness process. The family experienced the generalization of their learning to the outside world so that they could continue to gain or to maintain a problem-gone narrative. Possible hindrances to the foregoing strategies were suggested by two children, and by three parents who related their child's experience. These participants found certain of the externalization strategies, as well as the play room environment, developmentally inappropriate. In addition, two families experienced variable parental involvement even though the active participation of a caretaker is a main tenet of the SHIFT design.

Client-Therapist Relationship of Collaboration

Most participants seemed to have experienced the therapist as understanding and accepting. This therapeutic alliance appeared to be augmented through the use of narrative externalization in which the focus was taken off the person as the problem, such that the children felt well supported in their restorying process. As one foster father reported, "King K. can say, 'I'm not a bad guy; it's the problem that's bad and I'm going to remove it myself and throw it away.'" Additionally, the therapist's use of the narrative's "relative influence questioning technique" (White & Epston, l990) both advocated the children's choice making and modelled this communication tool for parents, successfully with some of

them. This ongoing questioning technique also appeared to have assisted the children to maintain continuous responsibility and active participation in plotting a problem-gone narrative. A foster mother observed that, "Issues were raised after Dan C. has had an opportunity to share why he may have acted like he did or what it is that he thinks he could have done differently. Steve really plays on that." Alternatively, participants had general concerns about the therapist in his re-authoring role that appeared to include the clients' lack of acceptance of the therapist's manner and lack of appreciation for, or understanding of, the program as offered.

More specifically, one child in particular appeared to have experienced an unstable therapeutic alliance. This child did not embrace the externalization strategies as he saw the therapist's collaborative offering of choices (i.e., to be able to pick members of his team) as a sham involving little real choice and he said of the therapist "…he just started doing his therapy… ." Also, this child found the therapist's manner "very irritating" and described the therapist as "snobby" and commented that "he doesn't know even how to talk to people." This particular child acknowledged, prior to his expression of these remarks, that "The program helped me a lot because I would have ties for myself with someone instead of being at home and sometimes not get to talk to much people. It got a lot off my mind to talk to someone. It let me feel better about the stuff that I'm feeling." Toward the end of the interview he again acknowledged his learning although he said he really did not like the therapists. Notably, this child had experienced a history of fragile attachments that continued to play out in his present situation. For example, when discussing his foster mother, he reported to

me that she didn't even love him and just pretended to care when at ministry meetings. Of further significance, this child had experienced the first six sessions without parent participation, saying of the second half of the program that "the sessions would be ruined" when the therapist turned his attention away from him and toward his mother. Moreover, it is also possible that this twelve-year-old was sensitive to the therapists' approach, finding it overly directive in nature, as such resistant attitudes to authority are normal in children of this age.

One additional point is noteworthy concerning the co-therapy approach. The findings support the value of structuring sessions to include simultaneous individual sessions with the child alone and family members, which are then integrated, as was experienced by many of the participants. However, one child was unhappy that he had not been given time alone with the therapist within the session hour as it had been very difficult for him to relate an incident he had experienced at home in the presence of his mother

Participants' Perception of Change

When we look at how the participants perceived themselves to have changed, all the children as well as most parents said that the program had offered them new ways of looking at their situation and tools that fit for them that they could use outside the therapy room. Most children appeared to demonstrate responsible proactive behaviour that seemed to have been stimulated by the narrative externalization of the problem, to have empowered them to beat off the problem, and to maintain a problem-gone story. There were two parents, one a biological mother and the second a foster parent, who appeared unsuccessful at developing tools from the SHIFT program. The first parent said that she would

not be able to deal with her son's problem on her own if it should come back. The second parent did not appear connected to any aspects of the SHIFT program and had not attended any sessions with her foster child. What made this latter situation particularly meaningful was that the child of this foster parent was the only youth I interviewed who appeared unsure of his abilities and in strong need of appropriate, knowledgeable support in getting the problem under control.

Impact of Program

The last area of understanding has to do with the perceived success of the SHIFT program as experienced by participants as well as outcomes relating to the participants' experience of the research interview. The majority of participants reported that the SHIFT program had been worthwhile. Even the one child mentioned above, with a history of fragile attachments and negative feelings toward the program and therapist both, grudgingly reported, when I drew attention to his incongruity, "Well it did help me. I didn't really like them but I was learning." Also, as mentioned, this youth felt strong irritation toward the therapist for the attention he had given to his foster mother in sessions where he felt dismissed and "… not listened to… ." With regard to the one foster parent who saw no value in the program, this was the same parent who had not attended any program sessions, seemed to be poorly informed about the program and how to manage the problem, and expressed a rather hopeless attitude concerning "…these children… ."

More specifically, all the children, save one, appeared to have conquered the problem or have it well under control with the help of their caretakers. Again, the one child I interviewed who reported being unsure of his ability to control the

problem had not had his caretaker take part in his sessions. Additionally, the children experienced acceptance and support in their opportunity to discuss their feelings and experiences and to externalize the problem. This experience broke their isolation, diminished their sense of guilt, and highlighted their responsibility to battle the problem. One of many exuberant parents effused, "I thought Steve did a great job of getting Dan C. to own up and take some responsibility. I could see that Steve was trying to find out how big Dan C. thought the problem was and to encourage him to take ownership of it and be accountable." Most children, as well as parents, appeared to be confident and hopeful in their clear sense of what they had to do to control the problem. Children appeared to have achieved an increased ability to identify with their feelings, thoughts, and consequences, to reach out to others, and to understand and develop appropriate boundaries. Children and parents were able to transfer the language and tools of the program to their own environment, and increased their problem-solving skills and communication skills in general. There was one parent interviewed who said she had not gained tools from the program to manage the problem. This biological mother expressed, "Nobody contacted me after the program to see how I was doing. There was no follow-up. I experienced so much support during the program and afterwards I was completely on my own. I felt abandoned. I didn't feel that I had the skills to deal with Dave M. on my own if the sexual touching problem returned. I would have to come back into the program."

Lack of faith in the program, as previously related, was reflected by one child and by one parent who had attended no program sessions. In addition to these participants, a foster couple expressed considerable criticism concerning the

developmental appropriateness of program strategies and the minimal length of program sessions. Nonetheless, this couple had learned that their foster child, while attending the SHIFT program, had been experiencing sexual abuse during visits to his biological parent's home. This couple expressed to me, "The SHIFT program could have helped him to feel safe enough to come to us and disclose what was going on. The main de-escalation came with the disclosure … It was like the weight of the world had been lifted from his shoulders. … Since then there have really been some drastic changes to his behaviour. I think that he finally gets it; that the behaviour is not okay. The lying has stopped too."

Impact of the interview

Participants reported experiencing beneficial effects from their interview in a number of ways: children revisited their success in having plotted a success story, children and parents released negative feelings that had concerned them about the program, and parents broadened their awareness of program effects and program goals. It was in the interview that the one couple who had chastised the implemented externalization strategies (i.e., metaphors and role-plays) or certain of the therapist's characteristics came to reflect, "Now that I think about it, the program might have helped him to disclose." It was just after the program finished that this child had communicated to his foster parents that he was experiencing sexual abuse at that time in the home of a biological parent during his regular visits. In addition, I was able to clarify the SHIFT therapist's clear objective to bring about the disruption of the child's sexual behaviour problem, rather than having a mission to either uncover etiological issues or to deal with trauma

associated with children's own experience of sexual abuse. One couple in particular gained information so as to better meet their child's future needs.

On another front, and of utmost significance, by way of the interview process certain conditions were brought to light that appeared to shed light on the SHIFT program delivery including: the nature of the therapeutic alliance, the degree of parental involvement, the implementation of developmentally appropriate intervention strategies, and the follow-up procedures undertaken by program staff. The foregoing areas are elaborated upon in the Discussion chapter.

CHAPTER V: DISCUSSION

My task in this process study has been to develop an understanding derived from the research question asked of the participants: "What is your experience of the program?" In developing an understanding of their reports I have conceptualized a core category, four main categories, eight primary categories and thirty-five descriptive categories. The results as understood demonstrate a vivid, if mixed, portrayal of the SHIFT multi-modal program as experienced by these children and their parents. These children were nine years of age or under when they entered the SHIFT program. The very fact that they were able to recall specifics of their experience during interview close to three years later is a strong reflection on the success that SHIFT had in capturing the hearts and minds of many of these children. Despite the sensitivity of the topic and an initial sense of discomfort experienced by some children, all worked into steadfast integrity in the interview. I interpreted the children's integrity to have been motivated by: (a) their recognition of the task of "doing research", (b) their inclination to help other children, (c) the collaborative nature of the researcher-client relationship, and (d) their desire to have their heroism acknowledged (White & Epston, l990). Moreover, the validity of the children's input concerning their success with the problem was confirmed in the interviews with their parents. It was likely also the case that the children's knowledge that their parents were also interviewed as well would have compelled the children to be honest, to avoid challenges arising from inconsistencies between their reports and those of their parents. Furthermore, since most of parents were foster caretakers they would not carry the sensitivity or embarrassment perhaps faced by biological parents that

might have influenced them to be unrealistically positive about their child's treatment outcome and problem maintenance. In addition, one of the two biological parents interviewed had been a client of mine such that I was privy to a first hand account of her child's success.

The understanding developed from this research is consistent with findings of other studies and clinical experience, showing in particular: the advantages of narrative therapy and externalization (Roth & Epston, l996)**;** the significance of the therapeutic alliance to client's engagement. (Hubble et. al., 1999); the impoverished history associated with these children (Gray et. al., 1999); the relevance of the attachment style of the client to engagement (Strickland-Clark, 2000); the benefits of cognitive-behavioural therapy **(**Burton et al., l996); the possible limitations in the application of the developmental component in programs for children with sexual behavioural problems (Araji, 1997); the centrality of parental involvement in the treatment for these children (Friedrich, 1993); and, the lack of certainty as to whether clients are able to instigate follow-up procedures when required (Wachtel, l995).

This evaluation was a process study and formative in nature. As such, the significant understandings can be best expressed by looking at the implementation strategies as experienced by the participants who went through the program in comparison to the implementation design as reflected in the manual. The key elements of the program as experienced by the participants are reflected in my conceptual construction. In what follows I emphasize selective features of my findings. Nevertheless, I also reflect a sense of the multi-modal therapeutic

approach, described as contextual family therapy. My focus is mainly on the implications of these findings for treatment

The Therapeutic Relationship

Elaboration of the narrative approach concerning the therapeutic relationship seems appropriate here. While the narrative approach emphasizes collegial collaboration between therapist and client, it is also directive by virtue of techniques such as "relative influence questioning" (White & Epston, l990). The SHIFT program model is offered as brief therapy and as such holds to a rather structured format. Indeed, the program implementation design is mandated by an agenda that reflects society's zero tolerance of a person with a sexual behavioural problem. Hence, these children were required to develop a reality that parallels our societal expectations about sexually appropriate behaviours. However, the program is designed such that, true to the narrative approach, children were encouraged to construct their preferred reality based on their strengths and resources and with an emphasis on the future. Consequently, the nature of the therapeutic problem required the SHIFT therapist to maintain a highly focused plan with these children, within which he strove to embrace the philosophy and techniques of the narrative approach. It is conceivable that in working within the given time frame of this program and given the possible serious nature of the child's behaviour, the provider may have judiciously chosen to sacrifice a support posture in order to push for needed change. In this respect, however, I am also cognizant of research that suggests common factors to all counselling process in facilitating healing, rather than the specific methods prescribed by a particular theory (Duncan, Hubble, & Miller, l997; Hubble et al., l999). Such literature

highlights the influential position of the therapeutic relationship, in keeping with what is emphasized in narrative therapy.

Research findings suggest that most children seemed able to collaborate with the therapist in the development of their new preferred story. However, there was the one child, close to 13 years of age, who looked back on the SHIFT experience of almost 3 years earlier with strong concerns. This child perceived the therapist as domineering rather than collaborative. Apparently this child experienced the therapist's questions more in keeping with the traditional therapy: often rhetorical or serving as pedagogic devices, focusing on one aspect of the client's story for a particular purpose, and usually confirming the therapist's knowledge. For example, this client saw the therapist's attempt to offer him choices as a weak attempt that paradoxically seemed to emphasize his lack of real choice. Possible explanations for this youth's response may lie in one or a combination of factors including the therapist's prescriptive approach, the child's history of fragile attachments, and relevant developmental factors such as a natural resistance to authority at this age. Despite this child's criticism, I was left with the impression that he really did value his exchanges with his therapist, Steve. He had admitted that Steve had been some help to him but also appeared to have anger toward Steve and toward his foster mother. He was upset as, in his mind, Steve had sided with others rather than listening to his side of the story. This youth stated that he would be having a really good meeting, but when Steve directed his attention toward his mother "it ruined the whole meeting." According to the foster mother the foster dad had attended the first session, after which the child had asked to attend the meetings on his own. Further, this child expressed to

me off tape that Steve and his dad had had a disagreement over Steve's scheduling of sessions during the daytime and the child was left with the impression that Steve had been rude to his foster father. The child appeared to have taken his father side in this exchange and it is possible that this experience coloured his acceptance of the program provider. It was apparent that the provider's directive approach did not sit well with this youth as he disliked the way Steve talked to him, quoting Steve as saying "you don't want to talk about it eh? Well, you're going to." Nonetheless, despite this troubled start involving the father, in further analyzing the interview data it appears that the child's relationship with Steve was building well until the foster mother entered the picture mid-way through the sessions. It is possible that he felt betrayed by Steve's deference after having been the sole object of the therapist's attention. This child expressed that he did not feel loved and his attachment history and ambivalent style would tend to make him particularly sensitive to the quality or manner of the therapeutic alliance. Also, as suggested, developmental factors could be at play here. This child was working for independence as confirmed in his mother's conversations about his requests in their home. He wanted to feel that he was being offered some real choices. However, he viewed the therapist's efforts to allow him to make choices as a sham and commented that Steve "just started doing his therapy."

Children's Unique Needs

Perhaps this child's unfavourable response points to the need for externalizing conversations that more closely mirror Michael White's (White & Epston, l989) emphasis on curiosity and an attitude of one yet to know. It is conceivable that in developing a stronger therapeutic alliance, this child may have

responded less negatively to therapeutic questions that suggested real choices where none were perceived, and may have felt more validated despite the therapist's directive approach. Consequently, per haps children with problematic attachments need to be drawn into the preferred story more gradually. For example, older children in particular may be more sensitive to the therapist's inclusion of others perceiving it as exclusive and dismissive.

Consideration of the program experience of a child diagnosed with Fetal Alcohol Syndrome (FAS) gives an understanding of the experience relative to younger children in the program. This child was reported to have experienced the activities of role-play, in the personification and metaphoric defeat of the problem, without having any cognitive awareness of the purpose behind the play fighting. Thus, while the repetition inherent in these activities is very helpful to these children, their lack of understanding may cancel out possible beneficial effects. This lack of comprehension resulting in the ineffective use of implementation techniques may be further augmented when the child omits a meaningful label for the problem. One couple recognized that the problem label could be more effective when it more directly described the serious nature of the problem that had come to visit.

Hence, the prevalence of problematic attachments with this client base could represent a challenge to the quick formation of the therapeutic alliance necessitated in this brief therapy program. Furthermore, older children are more discriminating in what they will choose to act upon in good faith such that they will typically be more resistant to the direction of an adult and need to be offered real choices so that their agency is initiated. Younger children or developmentally

challenged children may have difficulty drawing connections so as engage in meaningful role-play in metaphorically defeating the problem.

One addition points to the emphasis the SHIFT program design places on the degree and nature of the intervention fitting the problem. While I am not certain what specific sexual behavioural problems brought any of these children into the SHIFT program but for the one child I treated in co-therapy, there was a child who had a strong reaction to the therapist's "perverted" questions and games. It appears that he was asked to discuss what he would do if a girl wanted to touch him. He said that this was "sick" talk. He explained that he would never even think about doing this because he knew girls but "he didn't know girls in that way and he wasn't old enough". He experienced the therapist as firmly insisting that he had to discuss 'what if'. It seems that the child was disgusted by the topic and, given the nature of his reaction, there is uneasiness whether or not interventions did 'fit' the problem. Alternatively, it is quite conceivable that the therapist was privy to information concerning the child's needs that directed him to initiate this line of questioning.

> The foregoing considerations concerning the nature of the child's problem as well as developmental and psychological demands represent some potential challenges to purposeful treatment of children with sexual behaviour problems. It may be that the SHIFT provider could better meet the unique needs of children by giving further emphasis to the degree and nature of the problem in implementation strategies, as well as developmental needs and attachment history. Such regard may help assure that children are empowered by the experience, form a stable therapeutic

relationship, and more fully engage in the therapeutic process.

Parental Role

Observation of the SHIFT design emphasizing the central role of parental participation to the program's success suggested another area of concern. In recognizing the parent's integral role one mother emphasized, "If he were doing the program by himself he would say that everything was hunky-dory in his book. That's why I feel the parent participation is huge with these kids. Because I was there too, we could talk about issues and get real." In addition to the program focus on contextual family therapy with the accompanying relational domains, parent participation is also closely connected to the program's rationale for providing treatment as a brief therapy approach. As previously described, the period of consolidation of learning is left in the hands of the family upon program termination. However, two parents interviewed experienced the SHIFT program without fully participating, one partially taking part and the other not at all. While it is understandable that it is sometimes in a child's best interests to attend the program on his or her own for a period of time, it is contrary to the principles of the SHIFT contextual family therapy approach to exclude caretakers as a central part of the treatment. This study further supports the need for the ongoing participation of the children's parent(s) in the case of the non-participating foster mother, although well intentioned, had little understanding of the program rationale or problem management. This parent's lack of comprehension was particularly relevant because her child was uncertain of his future success in beating the problem, and so needed parental guidance to consolidate learning.[16]

[16] At the time of the interview, this foster parent had informed the ministry of their need to see another therapist to gain help with the child's sexual behaviour problem.

Follow-up Measures and Maintenance

The SHIFT implementation design has built in follow-up measures to address the progress and needs of the child and the family. The results suggest that follow-up procedures are left up to the program participants themselves to instigate. Wachtel's 1995 study confirmed this. Further Wachtel stated that it was unclear as to whether parents who had completed the SHIFT program did in fact initiate appropriate follow-up procedures. With present-day economic constraints and budgetary considerations experienced by the MCFD, follow-up considerations can represent a difficult if not impossible burden. However, these findings suggest that lack of follow-up may be particularly problematic in at least two situations. The first circumstance concerns a foster parent who had been minimally involved in the program and who was unaware of the on-going demands of her role regarding the child's sexual behaviour and the child's attachment needs. The second situation is the case of a biological parent who appeared highly dependent on the program provider, lacked confidence in her abilities, and who experienced a sense of abandonment at the program's termination. In reflecting on this latter parent who expressed feelings of abandonment as "she was never contacted" after she and he child completed the program she expressed that she had developed no sense of how to deal with the problem if it should return. While this mother herself could have benefited from a follow-up contact, the problem itself had abated. It is quite possible that intentional follow-up procedures could achieve the following benefits: offer support to parents in consolidating learning; clarify most helpful aspects of program; provide a gauge as to consolidated learning, as well as

long term effectiveness of program; and, help assure children do not re-enter the mental health system for sexual behavioural problems.

Program Goals

The SHIFT program designers are clear in stating that implementation does not emphasize treatment to deal with trauma-related issues or to fix a child's broken parts. Rather, the main objective of the SHIFT program is to diminish further trauma for the child and for those that he or she has harmed by stopping or managing the sexual behaviour problem. The experience of the participants suggests that it is important to make the parents aware of the SHIFT program goals and its inherent limitations to treat, for example, trauma associated with abuse. One family I interviewed was waiting patiently to return to the SHIFT program for treatment to deal with trauma related issues when I told them they needed to go through the MCFD staff to seek such treatment. Another family was quite critical of the program because it did not deal with causal issues and would have benefited from a better understanding of the philosophy of the SHIFT approach to better focus their attention where it was most needed. The highly defined program goals are also reflected in the structured format as when the therapist has accomplished his set tasks for that week he drew a close to the session. Not understanding the structural component of his implementation strategies, one couple were highly frustrated as they understood that the provider was short changing them in not providing a full hour of treatment.

One additional point regarding the program goals emphasizes the suggested best practices of the Provincial Consultation Group (Wachtel, l996). This group acknowledges the prevailing movement to 'treat' sexual offenses or

offenders and move away from earlier guidelines for sexual offense programs that encouraged the treatment of 'individuals with psychopathology' where sexual offenses may be related to that pathology. While this submission recognizes that sexual behaviour problems merit intervention in their own right as they can compromise the mental health of the child, they also endorse the importance of addressing other problems in treatment. At this point in time the SHIFT program offers a structured format that directs its treatment to the goal of stopping the sexual behavioural problem.

Overall Analysis Considerations

In appreciating these findings it seems important the reader remain mindful that any critical considerations of the participants' experiences of the SHIFT program model are based on a small number of the total participants: (a) one child and one parent expressed a lack of faith in the program or the therapist as a whole; (b) four children in total expressed opinions bearing on their experience of strategic and structural barriers to re-authorship, although they valued both the program and the therapist in general; and, (c) one couple was censorious of the strategies implemented, the structure of sessions, and the personal habits of the therapist, but also applauded the program for giving their child the sufficient insight to confide a sexual abuse experience.

Furthermore, inasmuch as the program provider may have offended participants and was perceived as sometimes 'off the mark' with implementation strategies, this is not to suggest that participants experienced the program as ineffectual. On the contrary, my understanding suggests that in most cases the program goal was achieved: That of stopping or rendering controllable the sexual

behaviour problem. In general, the children as well as their parents were very thankful for the experience offered them in the SHIFT program. Many families were highly enthusiastic with the narrative restorying process that instilled hope and empowerment and with externalization that personified the problem offering them a common language to continue their work to defeat the problem. An important factor in the maintenance of a problem-gone story, notably for older children, appeared to be their perception of their responsibility in dissolving the problem such that they were the main actor and head writer in the creation and completion of their problem-gone narrative. Understandings pertaining to the degree and nature of the problem, developmental factors and attachment needs in this study further underscore the prevalent need for differential implementation strategies based on the nature of the problem, the developmental age, and the unique psychological needs of children. With children who have a history of problematic attachments and/or are experiencing the age of 'normal' resistance to authority, the findings suggest children will be best supported by externalizing conversations that reflect the provider's openness and curiosity and empowerment in reaping the considerable benefits afforded by the narrative approach. Similarly, a stronger emphasis on forming a stable therapeutic bond with the older children could give them a more rewarding experience and encourage a stronger therapeutic engagement. The significance of emphasizing the central role of parents and giving consideration to follow-up procedures is further supported by these findings. While the program was true to form in demonstrating considerable flexibility and creativity in program implementation strategies, it could benefit from additional consideration in an effort to best meet children's unique needs.

Relevance to Counselling Psychology

The therapist's constitution of self is a fundamental aspect of a counsellor's training (Bernstein, l990**).** A thorough discussion of narrative therapy here and its ethical position in light of my affiliation with a person-centered approach (Rogers, l951; 1957) involves much more depth than the scope of this paper allows. However, it seems worthwhile to mention briefly that I experience some uneasiness with regard to the ethical 'positioning' of the therapist in the narrative method. In this regard, when I begin to reflect on the directive nature of the approach and the therapist's use of knowledge, I am left with an awareness of the essentiality of the therapist's ongoing self-scrutiny. To elaborate, as much as the narrative therapist (Freedman & Combs, l996; White & Epston, 1990) strives to identify the preferred outcomes that the client has identified, it is the therapist who decides which meanings will be selected out for focus and 'reconstruction'. It is the therapist who makes judgements in his or her choice of words in determining the 'relative influence' of the problem. In other words, the therapist's moral positioning is very much in attendance. Thus, I see the therapist's attention to his or her ethical positioning as a necessary guideline for using the narrative method.

In this respect, the schema of ethical postures of Karl Tomm (as cited in Bernstein, 1990) offer one understanding of the counsellor's constitution of self as an ethical practice. Tomm has articulated four guidelines that he follows in empowering himself and others: (a) *grounding*—sensitivity including attending to the context and conditions of others, (b) *recursioning*—mindfulness that includes listening to others' listening and assuming that one is assuming, (c) *coherencing*

—congruency including identifying inconsistencies between intent and effect and privileging emotional dynamics in order to seek intuitive consistency; and (d) *authenticating*—being honest including privileging direct experience over explanations, performing one's own explanations, and being open to seeing oneself through others' eyes. What I find particularly engaging about Tomm's ethical position is that he has delineated certain postures through which he wants to constitute himself in relation to others and invented language that will support and remind him to make the ethical choices he wants to make in an ongoing way. This schema provides distinctions that can be used in a generative and loving kind of continual deconstruction and reconstruction of self-in-process.

Those representing the field of counselling psychology need to strive for the ongoing establishment of the therapeutic self in ethical practice. Karl Tomm's ethical postures offer the counselling psychologist a valuable guideline toward such engagement. And across the horizon as a guiding inspiration for all counseling psychologists spreads the immutable value of talk therapy. Is not the counseling psychologist always moving toward what is not yet known? Do not those professionals representing the field of counselling psychology need to consistently question the methods they use with clients such that their practices are congruent with the type of relationship that their techniques ask of them? In responding to these questions with a 'yes', the counselling psychologist is acknowledging that his or her relationships will allow for creative possibilities, of which their methods will make up some. And so it follows that our therapeutic relationships embrace our ethics and an artistic flexibility.

Future Research

The results of this study and theory presented point to a number of research questions in relation to individual and interpersonal processes of the child, the parent, and the therapist. One such area relates to the nature of the child's therapeutic bond. Such research needs to look at program length as it relates to the unique challenges in establish a trusting and collaborative relationship with the children. Further, the attachment needs of the child may hold particular relevance as they influence, for example, the child's differential engagement with a support stance versus a more challenging approach. In this manner, variations in attachment processes assessed in children could provide a basis for better matching of treatment of youth with sexual behaviour problems.

Furthermore, necessary investigation includes exploring the program's implementation strategies in connection with externalizing techniques and the developmental level of the child. Such inquiry may help to insure that the older child in particular is appropriately drawn into collaboration with the therapist as the coach of his or her team. Such collaboration will more likely result in the child developing a relationship to the sexual problem that promotes personal agency.

Research to date suggests that the role of family in the development of children's sexual behaviour as seen from a theoretical perspective is best described as reciprocal such that family characteristics both precede and are influenced by children's sexual behaviour. Generally, it has been found that greater child problems were matched by more problematic parental responses. Research is needed to determine how to best engage families and the type of casework that is possible with the family.

With the considerable reservations among treatment providers in British Colombia concerning the legitimacy of a continuum of sexual behaviour problems in terms of seriousness of offense or difficulty of treatment, this area needs rigorous investigation**.** For example, we do not know that risk factors that can be associated with sexual behavioural problems in children are proportional to the degree of intrusiveness of the sexual behaviour. Further, it is conceivable that 'self-focused' sexualized interests in these children, rather than sexual behaviour that is 'interpersonal' nature, may indicate many problematic areas in the functioning of both the child and the family.

Given the lack of consensus in the study of children's sexual behaviour problems to date there is a need for both qualitative and quantitative studies that can serve to compliment research findings in developing knowledge in this new area. To fully understand the child's experience and to be able to predict which children are at greatest risk for developing problematic sexual behaviour, we need to gather information systematically.

Limitations to the Present Research

Although these participants can be viewed as representative of other children in SHIFT in a similar situation and like conditions, the sample does not capture the experience of all those who have gone through the SHIFT program. Also, it is always possible that material relevant to the study is yet to be expressed or is missing from the participants' awareness. Certain of the children I interviewed did express some discomfort due to the sensitivity of the topic that could have limited their full expression of their experience. Also, the sample was such that as many as 75% of the children were from foster homes, which may

suggest a differential support system in contrast to those children living in their biological home. Furthermore, I did not have access to information on the number of parents contacted by letter and phone who refused participation, on what explanation(s) they gave for their refusal, and on their status as biological parents versus foster parents. Explanations for refusing participation could have shed valuable light on the program as experienced. As well, it would be important to know if biological parents were less inclined to take part and, if so, why. Perhaps biological parents struggle with shame-based reactions to their child's problem and perhaps their refusal to take part suggested they experienced a poor treatment outcome in SHIFT. Moreover, the fact that the children had experienced the program up to 3 years before the interview gave the participants an additional challenge in recalling the specifics of their experience at SHIFT.

Additional consideration is related to the nature of the information acquired. When information is in the form of reports of participants during interview, the method of interviewing can influence the nature of the resulting data. Although I gave my participants few guidelines when asked to focus on an area of interest, I was aware of the need to develop a comfortable relationship with the participants in order to assist their narration of their personal experience. As such, there were times when I had to make a choice between letting the participant struggle for words and helping in bringing expression to the surface. In the first instance important material could have been missed while in the second material could have been co-constructed (Rennie, l995). Having checked to see to what extent if any I might be leading the narration, I am aware I cannot take reassurances received at face value. There is always the chance that the

participants were deferring to me in the same way they might be inclined to defer to a therapist (Rennie, l994). However, as I immersed myself in my data an understanding developed regarding my perception of the children's steadfast integrity of expression throughout the interview process. I interpreted the children's tenacity to include a number of possible processes: (a) their recognized task in 'doing research', (b) their inclination to help other children, (c) the collaborative nature of the researcher-client relationship, and (d) their desire to have their heroism acknowledged.

One final area of deliberation concerns the grounded theory method. The analysis is such that categories have been conceptualized in a hierarchical structure, with a core category colligating four main or 'higher order' categories or clusters, eight primary or 'lower order' categories and thirty-five descriptive categories or properties. These categories are the reflection of the totality of my developed experience in completely immersing myself in the consideration of each inquiry transcript. As such, this overarching conceptualization could represent a limitation for the reader. In order for the reader to achieve a discerning understanding of the many issues that come to bear regarding this complex issue, it is necessary for him or her to become deeply familiar with the full range of categories as conceptualized.

Conclusion

My understanding of the participants' reports of their experience of SHIFT reflects both the value I place on attachment theory and on the therapeutic alliance. I have taken the findings to support the therapeutic relationship as a common factor in psychotherapy. They also point to the gravity of the ethical

position of the self of the therapist in relation to the therapeutic relationship. Moreover, I have understood social learning theory to be mirrored by the absence of appropriate socialization in the lives of many of these children and by their struggles to incorporate culturally appropriate realities into their everyday thinking. These findings defend implementation strategies that reflect greater flexibility in meeting the emotional and developmental needs of children. Further, this research emphasized the powerful effects of narrative therapy and externalization in personifying the problem, in addition to the importance of the relational and environmental factors in reaching and maintaining a problem-gone solution. Narrative therapy initiated the children's agency toward actively restorying a preferred narrative with the help of trusted others. In this manner many participants experienced control and empowerment in understanding and aligning themselves with their culture's values and beliefs. Moreover, this investigation has demonstrated support for programs for these children that give a central position to family involvement. The findings also suggest that, although this brief therapy model is designed to give parents the major responsibility toward consolidating learning and to initiate follow-up procedures when necessary, we do not know if parents indeed do initiate contact with the ministry personnel when the behaviour becomes less manageable.

It is my hope that this study will make a small contribution to this complex and multi-faceted area of research within which very little consensus exists to date. My reflections and understandings have left me with an overall impression of the powerful effect of solutions gained through the narrative therapy approach and externalization techniques that circumscribe the SHIFT program.

Furthermore, the narrative approach lent itself well to the SHIFT contextual family therapy design that integrated effective techniques from various schools most notably experiential cognitive-behavioural. As treatment for these children and their families continues to be accompanied by open minds, clinical curiosity, and compassion, our understanding of them and for them will be enhanced.

> Therapeutic interaction is a two-way phenomenon. We get together with people for a period of time over a range of issues, and all of our lives are changed for this.
>
> —Michael White (1995, p. 7)

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APPENDIX A

Contact Letter to Participants

Name
Address
Address
Date

Dear _____,

This letter is an invitation to participate in a study called WHAT KIDS THINK AFTER TREATMENT FOR SEXUAL BEHAVIOUR PROBLEMS. Not only will future program participants be able to receive this treatment because of your support, but they can also have the benefit of program improvements as a result of your contribution.

The purpose of this study is to obtain descriptions of how the Sexual Health in Family Treatment (SHIFT) program is being put into practice at the Ministry of Children and Family Development (MCFD). We will be asking a number of children and their parents who have taken part in this treatment at the MCFD in the past two years to give of their time to describe their thoughts and feelings connected with their counselling sessions. The researcher is carrying out this investigation in partial fulfilment of her Master's degree in Counselling Psychology at Trinity Western University. The researcher is also presently a Mental Health Clinician with the MCFD, Child & Youth Mental Health Program, in Chilliwack.

Many adults who have been taken part in this type of research find that they gain a stronger understanding and the opportunity to reflect on the benefits of their experience in counselling. The children can be reminded of the fun and positive rewards of problem solving that were introduced to them in the program. In appreciation for your valuable participation, a gift of $10.00 will be given to the children and an honorarium of $20.00 will be given to the parents. Where a couple prefers to be interviewed separately, a $10.00 honorarium will be offered to each parent individually. The researcher will give out all honorariums at the beginning of the participant's interview.

For each interview, participation will involve a time commitment of approximately 60 minutes, with the children being interviewed first, followed by the parents. In cases where parents are no longer living together and both parents wish to participate in the interview separately, the investigator can set up individual times to accommodate these preferences. Where parents are separated and only one parent wishes to take part in the interview, the investigator will be happy to interview the one parent as long as that parent took part in the full treatment program with the child. The investigator would want to interview the child alone for approximately one hour. However, the child is welcome to remain in the room while the investigator interviews the parents for an additional time of approximately one hour. If the child is able to keep busy in an adjoining area of the interview site, the investigator sees no problem with interrupting the interview should the parent need to attend to the child during the course of the parental interview. There may be a brief follow-up interview in person or a telephone interview.

As co-researchers, together you and the researcher will be looking at what meanings you have given to your experiences in counselling. The sole purpose of the study and the interview is to recall how you personally experienced the treatment—for example, the things that were really helpful and not so helpful. Interviews will be tape-recorded and written out. A fictitious name will be given to your audiotape (that you may choose) to make sure that whatever you say is classified information. Only the researcher will be able to match your actual identity with the information you give during the interview. The research team (Supervisor, Second Reader, and Thesis Co-ordinator) and the independent transcriber will not have access to the tapes or written notes unless they are marked with your fictitious name or a coded number. If after taking part in the study you want to talk about your experience you may contact me and a therapist from the Ministry will be

available to you. Further, if you would wish to relate any thinkable ethical concerns regarding your experience of doing this study, your consent form will contain the name of a neutral contact person at the Trinity Western University.

Audiotapes will be stored in a secure office and all procedures and written material concerning the study will be held in the researcher's personal computer and protected by a password. Tapes will be destroyed upon the completion of the researcher's degree, as will the cross-referenced list of the codes and participant's names. Written interview notes will be securely kept on the researcher's computer indefinitely. You would have the right to withdraw this permission for maintaining this data at any time you wish. In the case that you withdraw your permission, your data will be completely and permanently erased from the investigator's personal computer approximately five years after the researcher has defended her Master's degree. Upon the conclusion of the study you will receive the copies of results of the researcher (unless you express your choice not to receive them). After the study is completed the information about access to the results will be sent to you in a letter.

Your involvement is completely voluntary and you are under no obligation to continue the study should you change your mind at any moment. At any time during the study you can pull out and you will not be penalized in any way.

A few days following the receipt of this letter I will be taking the liberty of contacting you by telephone to answer any questions you may have and to find out if you are able to assist us by taking part in this study.

Sincerely,

Dr. Robert Lees, R. Psych.,
Regional Mental Health Consultant,
Upper Fraser Region,
Ministry of Children and Family Development
Voice Message 1-800-782 4138

APPENDIX B

Parental Consent Form

–

STUDY: WHAT KIDS THINK AFTER TREATMENT FOR SEXUAL BEHAVIOUR PROBLEMS

INVESTIGATOR: Suzanne Kerr, (604) 607-0601

SUPVERVISOR OF RESEARCH: Dr. Marvin McDonald, (604) 513-2121, ext. 3223

The researcher is doing this investigation in partial fulfilment of her master's degree in Counselling Psychology at Trinity Western University. The purpose of the study is to explore the meanings of the experiences of clients who took part in the Sexual Health in Family Treatment (SHIFT) approach at the Ministry of Children and Family Development. You will be asked in approximately a 60-minute interview to recall your experiences, both helpful and unhelpful, during the time you were involved in these counselling sessions. The researcher will seek to provide a safe and warm environment for the interview. There are no known harms associated with your participation in this research. However, it is possible that you may find talking about your time in counselling mildly disturbing. You will not benefit directly from this research, though your contribution may give you a stronger understanding of what you got from counselling. Additionally, future participants can benefit as a result of understanding both your experiences in the program.

Interviews will be audiotaped, written out, and assigned a fictitious first name to ensure that such information is kept confidential. Should any data be quoted in the completed study, any identifying information will be removed. In the event that there is any doubt that the quote(s) are not free of recognizable material, privacy of the participant will be further assured by discussion of the quoted material with the research participant in the follow-up interview. The tapes will be erased upon the completion of the researcher's degree as will the cross-referenced list of the codes and participant's names. Written report of the interviews will be securely saved on the researcher's personal computer for five years after publication**,** unless you withdraw your permission for the researcher to keep this data for this period of time. In the event that this consent is withdrawn, your written data will be permanently erased from my computer approximately five years after conclusion of the study. The researcher may schedule a brief follow-up interview or telephone conversation. You can withdraw from the study at any moment without any obligation or penalty and all your data will be destroyed. Should you have any questions or concerns that arise from the experience of participation in this study, please feel free to contact Dr. Robert Lees at 1-800-782-4183 and arrangements will be made for a counsellor to see you. Additionally, if you have any questions about ethical issues involved in this project you may contact Mrs. Candy O'Connor in the office of the Academic Vice President of Trinity Western University at 604-513-2037. Limits to confidentiality during this interview involve discussion of any behaviour that could prove harmful to you or others. If you have any questions, you may ask them at any time before or after the interview. Parents will be offered a $20 honorarium and a single parent will be offered a $10.00 honorarium before the interview.

I UNDERSTAND THAT IF I WITHDRAW MY CONSENT AT ANY TIME DURING THE STUDY, ANY INFORMATION THAT HAS ALREADY BEEN COLLECTED FROM MY CHILD FOR THIS STUDY WILL BE PROMPTLY DESTROYED.

I HAVE READ AND UNDERSTOOD THE COVER LETTER AND THIS CONSENT FORM AND I WILLINGLY AGREE TO BE A PARTICIPANT IN THIS RESEARCH AND I WILLINGLY AGREE FOR MY CHILD _____ TO BE A PARTICIPANT IN THIS RESEARCH.
ALSO, I ACCEPT A COPY OF THIS CONSENT FORM. .

Name of Participant:_____ Signature of Participant _____

I DO NOT CONSENT TO MY CHILD'S PARTICIPATION IN THIS STUDY.
Name of Participant _____ Signature of Participant_____
Date: _____ Researcher: Suzanne I. Kerr

APPENDIX C

Child Consent Form

STUDY: WHAT KIDS THINK AFTER TREATMENT FOR SEXUAL BEHAVIOUR PROBLEMS

INVESTIGATOR: Suzanne Kerr, (604) 607-060.

SUPVERVISOR OF RESEARCH: Dr. Marvin McDonald, (604) 513-2121, ext. 3223

The reason for this study is to find out what you thought about those times you came to see Steve and talked to him. I would like to help you feel safe and comfortable here with me. Here is some information for you to read so that you can know what you and I will be doing together.

- Suzanne and I will spend around 60-minutes chatting about those times I spent with Steve.
- Anything I can tell Suzanne could help other children who will come to see Steve in the future.
- Suzanne and I can talk about what I think and feel about my visits with Steve.
- Suzanne will ask me about things I did with Steve that I think really helped me and about things that maybe I think were not very helpful.
- Suzanne will tape our voices on a machine and later on our talk will be typed out.
- I can choose any make believe name I want for my tape.
- Suzanne will only keep the tape while she needs it to do her special work. After, when she doesn't need it anymore, she will destroy all the information about our chat.
- Suzanne may ask for me to talk with her for a short time another day.
- It is possible that I will become upset as I think about my times with Steve.
- If I do feel even a little upset after our talk, I can tell my parents and ask them to call Dr. Rob for me (1-800-782-4183). Suzanne says that Dr. Rob is a *really* nice man and he will get me a nice counsellor who will talk with me and who can help me feel better.

♦ I can decide to leave the study at any moment and this will be completely okay with Suzanne.
♦ If I tell Suzanne anything that could prove harmful to me or to anyone else, then Suzanne will have to tell someone about this.
♦ If I have any questions I may ask them at any time before we start our talk, or at the end of our talk.
♦ Before we start the interview I know that I will get $10 that is mine to keep. even if I decide I don't want to stay and talk.

I HAVE READ THIS AND I KNOW WHAT THE THINGS IN THIS FORM MEAN. I WANT TO TAKE PART IN THIS PROJECT. I WILL ALSO TAKE A COPY OF THIS FORM WITH ME.

NAME of Participant: _____

SIGNATURE of Participant _____

Date:_____

Researcher: Suzanne I. Kerr

APPENDIX D

Confidentiality Letter to Transcriber

Name

Address

Address

Dear Transcriber,

This is a confidentiality agreement that confirms the highly serious and restricted nature of the tapes that you are transcribing into documents. All information contained in those tapes must remain confidential. Thank you in advance for your valued assistance. I highly appreciate your precise attention to the foregoing considerations. Please do not hesitate to cal me if you have questions at any time.

By signing this document I solemnly declare that I will abide by the following considerations in their entirety:

1) To hold all information that I learn through my transcription and all papers having confidential information in the strictest confidence.
2) To keep locked all information that identifies participants for the duration of the time that I have access to such information
3) To under no circumstances type the name of the participant as it is heard on the tape onto the transcript. Only the assigned fictitious name for the participant will be used. I will type the fictitious name as it appears on the outside of the tape in place of the participant's name.
4) Upon completion of the typing of the transcript, I will return the tape, typed transcript, and the computer disk containing the typed transcript to the investigator.
5) Following completion of the transcriptions I will erase all files from my computer and delete my hard drive of all confidential information.
6) I agree to accept a copy of this declaration.

_____ _____

NAME OF TRANSCRIBER SIGNATURE OF TRANSCRIBER

_____ _____

NAME OF WITNESS SIGNATURE OF WITNESS

DATE: _____

Investigator: Suzanne M. Kerr Phone: (604) 607-0601 Email: KerrSue @netcom.ca

Supervisor: Dr. M. J. McDonald Phone: (604) 513-2121, Ext. 3223 Email: mcdonald@twu

APPENDIX E

Continua of Child Sexual Behaviours

Children's sexual behaviours from normal to disturbed behaviours related to sex and sexuality in kindergarten through fourth grade children.

Continua of Child Sexual Behaviours

Continua of Child Sexual Behaviours

Continua of Child Sexual Behaviours

Continua of Child Sexual Behaviours

APPENDIX F

Summary of SHIFT Rationale and Essential Features

SHIFT implementation design includes a wide range of therapeutic and psychoeducational practices, based on the criteria of fit. Conceptually, the program reflects the importance of looking at the family as a whole when assessing the child's behaviours such that all practices are offered within the context of a family-based approach.

Contextual Family Therapy

- Collaborative rather than hierarchical
- Strives to maintain integrity of family: family is child's is most vital support system.
- Assists family to separate from problem story while facing present difficulties
- Elaborates contexts in which behaviour occurs.
- Focus on exceptions and strengths, inviting child and family to discover 'unique outcomes' where child has resisted the sexual behaviour that serves to reinforce child's existing internal controls as well as the 'safety plan.'
- Focus on solutions in present (rather than causal determinants)
- Locates problematic behaviour and major source of influence within the family
- Sees change as taking place in the context of day to day life in family
- Asks questions about how members perceive, think about and respond to problem.
- Builds common language at child's level to discuss story –(e.g. metaphorical vehicles)
- Accepts that family stories about the problem behaviour govern what the family identifies as inappropriate or shameful and how family will respond.
- Understands that family stories about the problem behaviour influence the relative strength of weakness by which the problem presents.
- Helps client separate from a problem filled negative story that obscures victories.
- Addresses related and parallel problems to problematic sexual behaviour.

Variety of Interventions

Structural intervention

- Clarification of boundaries: inter-generational; decision making practices; defines appropriate parent sub-system ; uses contracts.

Strategic intervention

- Problematic patterns: change key sequences of behaviour or create new meaning for behaviour
  - Patterns of interaction in one relationship in family are believed to often represent or symbolize interaction in other relationships
  - Therapist accepts the client's 'world view' and introduces suggestions for change while not disturbing this worldview in any fundamental way.

Inter-generaltional work

- Unresolved emotional issues among generations affect later generations (genograms).

Narrative externalization

- Views language as the fabric of child's social and emotional realities.
- Builds a common language at child's level to discuss story.
- Sees children as 'captured by' enactment of problematic stories and 'recruited into' the problem behaviour.

- Personifies the problem—problem is named and given human characteristics.
- Family and child share the externalized metaphor once developed.
- Defeat of the problem is 'metaphorically enacted' by family.
- Offers the family a 'shorthand' to discuss problem comfortably.
- Focuses on story-making or meaning-creating practices of family and communities.
- Empowers the family through a collaborative and respectful approach that engages the strengths, resources, and responsibility of the family.
- Moves the therapeutic role from that of expert to one of co-creator in the problem-solving process and a 'problem-gone' solution.
- Enhances role of creativity and flexibility for both the family and therapist

Contests and precursors: mapping of contextual interpersonal, and internal—"who, what, when, where and why", "red flag" exercises (e.g.: road maps; *steps* of stairs; identification of feelings).

Cognitive distortions: mapping and correction for thought processes (e.g. stinky thinking) that have fostered or supported the behaviour—discussion, step metaphors, exercises to develop empathy and consequential thought, including 'thought-stopping').

Impulse enhancement: identification of instances when the children have wanted to touch but have resisted the impulse—cartoons, progressive stories, role plays, enactments.

Developing alternative behaviours: enhancement of child's internal controls (when identified) and sharing of them with family and significant others—problem-solving, conflict resolution, guided imagery, role plays, enactments, art work, parent-child homework.

Asking for help: identification of those that can help, and practice asking for help—red flag discussions, plays, role plays, parent-child homework.

Taking responsibility: together with significant others, on-going teamwork to 'fight' the problem, to acknowledge that the behaviour will remain 'sneaky', and to foster periodic family 'check-ins'.

Individual Child Therapy

- Works within the language system of child; offers terminology that is 'user friendly' to children and builds on 'metaphorical vehicles.'
- Integrates cognitive-behavioural theory (CBT) and techniques with narrative therapy.
- Discusses 'Red Flag' feelings and situations: puts behaviour in a situational context by helping child recognize events, feelings, and situations that *precede* incidents of inappropriate sexual behaviour, label these (e.g., 'stinky thinking'), and recognize effects of behaviour on others and themselves (e.g., 'counter-thinking')
- Relies on the cognitive–behaviour (CBT) approach (as previously used in work with adults and adolescents with sexual behavioural problems). But adds experiential CBT elements such as the *steps* notion (Cunningham & MacFarlane, 1991, p. 173) that serve to reconstruct the sequence of problem behaviour and provide a basis for constructing a 'safety plan.'
- Uses board games (e.g., *Talking, Feeling, doing Game,* or *Breakaway,* or *Frustration*) which 'dare' to ask direct questions.
- Helps child manage personal space—teaches boundary setting and 'patterns of respect.'
- Negates the utility of CBT with reactive/impulsive children who lack connection between events; who may be 'acting out' their confusion or heightened impulsivity through sexual behaviour; and who have no patterns and no 'red flags.' Recommends, instead, good information and open frank discussion.

APPENDIX G

Elaboration of Table 1

Categorical Conception of What Kids Think of a Sexual Health Program

CLIENT'S RESTORYING IN RELATIONSHIP (Core Category)

Main Category 1: The Client's (C) Relationship with the Problem

(a) The active pursuit of a 'problem-gone' narrative

Invitation to Re-story: (Talking opens a door; reflects both the children's and the parent's experience of safety/trust/understanding.)

I liked it when we were supposed to talk about what's happened because it made it go away. I felt better after. Now my brothers and I know we can talk about it and we won't get in trouble. Our family understands now and so do we. (Child)

When I kept it inside I just didn't like myself. I felt dumb and weird. Just getting it out, I felt all opened. By telling someone how I felt I didn't feel guilty—like when nobody knew about it. I was happy about my self. I could tell the truth. I knew that that what is said in that room stays in that room. (Child)

Steve and Grace were both great! Grace would speak about how the stinky thinking was a problem and all that and she would ask questions too. (Children)

Talking about it was like getting a door to open and once in there you can work on it. Like getting him to open up and to respect his feelings. Then you can tell him why it's not appropriate. Explain it to him so that he can better understand. (Parent)

Liam felt safe enough to come to us and say, this is what's going on.) His behavioural change since those disclosures are amazing. It's like Liam's taken the secrets of the world and just given them over. He's not packing it around anymore. (Parent)

Issues were raised after Dan C had the opportunity to share about why he may have acted like that or what it is he could have done differently. Steve really plays on that. (Parent)

Steve opened King K up slowly so he was never afraid to say what he wanted. Steve would just come straight out and ask him a question about a sexual behaviour and what age he thought it was allowed. When King K. answered Steve might say just say 'no, not really' and ask him the question again. Steve just kept going like this until King K. got the right answer. (Parent)

- This category codes 13 documents out of 14—7 children and 6 parents.

Understanding of Story Line: (C's awareness/acceptance of problem; willingness to create a new story with the help of others.)

It was hard at first to just tell him because it was embarrassing. Then I just decided to do it. I learned it was good to talk to somebody that I knew really well and that I can trust—they would understand. (Child)
We're getting other things in our brain and we're not just thinking about the problem. So when I can talk about it then it will just go away, and I'll be a normal kid again, and I won't touch anyone or do that stuff anymore. (Child)

The very first time I went to the program I talked with Steve at the Mall once—so we would figure out what happened in my past or something. After that we would get together and do the program. (Child)

Well, Steve said that I learned this from my sister and my family and stuff, and he says I'm going to help you make it stop and I said cool. (Child)

To another kid who was going to take this program I'd say it's okay to talk to Steve about it because they help you. Your mom can help you too because it is a family organization—your family needs to know. Most people will understand. If a family member doesn't understand that you have that problem, the program helps you understand and helps them understand too. (Child)

In my opinion sometimes King K is thinking, "I'm doing it. I don't want to throw the problem away." And Steve said "But it's getting you into trouble. Do you want to get into trouble? This sneaky problem is bad. You want to take it out of yourself and throw it away. You don't want it." King K would say a number of time "But I like it." And then he'd come back again and say "But, it gets me into trouble. I don't want it." And then finally he doesn't want to keep the problem. He just wants it to go away. (Parent)

The SHIFT program could have helped him to feel safe enough to come to us and disclose what was going on. (Parent)

The problem was overwhelming but once you got into the program you didn't think of it as being just Dave's problem any longer. It became a problem that we had to deal with. (Parent)

I thought that Steve asked what the issues were point blank. Steve asked Dan C. did he think the behaviour was a problem, did he want the problem to be far away, and how did he think we could take care of the problem? (Parent)

Kenny learned he could come to us and talk when he started getting these thoughts. Steve kept saying these people are foster parents and they're knowledgeable and they want to help you. (Parent)

What the program really did was allow this child –who was feeling ruined and stupid, that he'd destroyed everybody's life, and that it was all sitting on his shoulders—to understand that he was not alone, that he had support, and that sometimes we need help. We all worked together to help him get rid of the problem. (Parent)

- This node codes 12 documents out of 14—7 children and 5 parents.

Opening Spaces Through Story/Story-Writing: (Collaborative discovery of preferred scenarios and new/alternative behaviours and shifting of fixed meanings; blue-print of the child's construction of a problem-gone solution.)

To me the story meant that we had to get it all written down and this would probably help more with getting the problem away. We wrote about a lot of stuff in there on how to stay away from the problem. I could always look back if I needed to find out something It was about things I have

done wrong, things I am starting to get right, and things that can help me along the way. It's about how I got better. It's a keepsake so that I never forget. I read the story and I feel good about myself for being able to get through the program. (Child)

Well, we did this little story in this yellow construction paper and rectangle thing with blank sheets of paper. We made it into an actual real story of a touching problem that came to visit this kid. He kept saying "No, I got rid of you before and I do not want you to come back." So then we were fighting him and then it was gone and the touching problem never visits the guy again and we can live happily ever after. (Child)

The story is a record of my success. A keepsake, so I never forget. It's how I got better and how I felt when I read the story and it was good. I just felt good about myself for being able to get through that. (Child)

The story writing and discussion really helped Dave with the problem. The story was not about a bad person. Dave made a mistake and now we were going to fix it. So it was a very positive story —there was praise to be given. Dave really looked forward to making the big letters that everybody got to colour. The story writing really stuck in his mind. (Parent)

Talking about it was like getting a door to open and once in there you can work on it. Like getting him to open up and to respect his feelings. Then you can tell him why it's not appropriate; explain it to him so that he can better understand. (Parent)

The story they created was very good. The created a book that was very helpful for us, where we could relate to the word spans. He made up a rule of 10 things he had to read every night on the back of his bedroom door. It listed what was inappropriate to e doing and who to tell if he had inappropriate thoughts. We went through it with him three to five times a night. The consistency of this was what worked for him. (Parents)

- This category codes 12 documents out of 14—7 children and 5 parents.

Portrayal of Problem: (Externalization/personification of problem as invitational reframing/

person not the problem; opens up C's horizon of hope and agency.)

By giving the problem a name King K. is separated from the problem. King K. can say "I'm not a bad guy, it's the problem that's bad and I'm going to remove it myself and throw it away. It's getting me into trouble and I don't want that." (Parent)

They named the problem and then we would refer back to it as being the "touching problem" or the 'lying problem' or the 'sneaking problem'. We talked about how big the 'touching problem' was in measures of this wide, this high. I thought Steve did a great job of getting Dan C. to own up and take responsibility. (Parent)

Steve asked Dan C. did he think the behaviour was a problem, did he want the problem to be far away, and how did he think we could take care of the problem? (Parent)

It helped him to be able to name the problem—to separate from the problem. This is how we work with him at home. It's not about you. It's about your behaviour. (Parents)

Some people were going around saying some stupid rumours about sex. So we had to deal with that in the program and try to get past them because they were all lies. (Child)

- This category codes 13 documents out of 14—7 children and 6 parents.

C's Contact with Feelings: (C connects with emotions that include experiences of remorse/ diminished guilt/ a sense of hope, power and accountability; reflected in restorying.)

I felt that I had the power to get it all away. I felt very, very bad when the touching problem was near me, but as soon as I came here I felt relieved. It was like I knew that Steve and the other person are going to help me get the touching problem away. (Child)

The program helps you get by your problems easier. I felt a lot better about myself for being able to do the session. I feel confident that it is gone. The 'problem gone' team was a strong team. Like we never quit. It helped me to think that kids of all ages have this problem. (Child)

Before [the program} I just kept things inside me until it got me so upset. It made me feel a lot better because I could talk to someone about my feelings and not have to worry about it. Not make me upset inside and stuff. (Child)

We had to yell loud 'Get away Mr. Stinker!' It made me feel braver. (Child)

King K. became pretty confident with everybody there all the time. He felt that he was in control. Anytime he got an idea and he got it right, he felt more confident that he was the one doing the work. Whereas before with me and at school he was just told he couldn't do it without a proper explanation. Now it's explained to him why and that made him feel really good. (Parent)

Kenny G. always thought that he could never be by himself and he could never do anything alone. When he would be by himself before he would think all these bad things and then go and do it. So now he actually believes that he can be on his own and not think bad thoughts about wanting to go and touch somebody. He learned a lot. (Parent)

- This category codes 12 documents out of 14—7 children and 5 parents.

Team Support: (On-going team approach starts with child picking a team name and members including program provider, co-facilitator, parent(s), and appropriate others to0 help in restorying a problem-gone narrative; paves way for the child's role as 'hero' or quarterback both in the therapy setting and in the world.)

My team is called the 'Tomb Squad.' It's from an ancient world. Tomb Squad in Egypt means that we are the best and I know we can all do it as long as we work together. (Child)

My team was the "Problem-Gone" Team. It was a strong team. Like we never quit. We all worked together. (Child)

There was another game with questions and answers and we'd all go around the room to give answers. (Child)

If something happens—like stinky stuff—tell someone and they will help you. We thought we would get in trouble before, but we won't because now they know about it and we know about it. (Child)

*The fact that there was a team that was built around solving the problem was great — like a captain and who would be the players and who would be part of that team. It made it a team effort so Dan C. didn't feel it was just his problem to deal with by himself. He felt he had a support system around him. (*Parent)

Steve gave him the tools and said "Well, how old to you need to be to have sex?" And he started saying 10, 11, 12—going up himself. Then Steve would "Okay you got it right. Well done/" He was really happy. It made him f eel good. He felt he was actually—that he was doing something—that he was part of something. (Parent)

If he were in doing the program by himself, he would say that everything was hunky-dory in his book. That's why I feel the parent participation is huge with these kids so we can talk about issues and get real. (Parent)

- This category codes 11 documents out of 14—6 children and 5 parents.

Team Activity: (Treatment plan involves construction and writing up of structured safety plan to ensure 'safe zones'/environmental controls; development of boundaries/habits of respect/ psychoeducation/ information sharing.)

We learned not to open doors when someone is in the bathroom and not to touch people. And don't go in people's rooms. That's the rule of the house too. Hmmm, like if my brother came up really close to me, I could ask him to move because he's in my bubble space. Like how close Batman and Michael are right now. I could tell them that they're in my bubble. (Children)

I mostly talked about things to avoid to stay out of trouble—like no forts with younger children and no sleepovers. Well, the important thing is that the behaviour will never happen again and I can carry on so that people don't get hurt. The program taught me a lot because I never knew that being disrespectful really hurt people. I pretty much used to only think of what was happening to me but in the program I learned how my behaviour hurt my Mom and my step dad. (Child)

First thing is he asks how I am doing at school. If I'm doing okay, then he gets going with the problem solving. Like I have to do this thing. Like I can beat this problem. And he asks me if I'm doing what it says—like stuff I don't do and places I don't go. Things I don't see. (Child)

Another good thing is we had a film on personal space. It was for Liam's level and he understood this is my personal space. Like we can have family, we can have friends that we are really close with, then there are people we hand shake with, and finally there's the people we don't talk to. (Parent)

He learned self-control. He learned to ask questions and not scream. With me he was very sexually oriented and he would touch me. Kenny learned that he could just put his arms up when he wanted a hug from me—and not be sexual towards me because I would back away. He learned social skills in making friends. (Parent)

Dan C. didn't have any sense of what was okay to do and what wasn't. The program gave him this awareness. We still struggle with his judgement but at least the program taught him a good sense of what's right and wrong. (Parent)

- This category codes 13 documents out of 14—7 children and 7 parents.

Interruption of Behavioural Schema: (Implementation of cognitive-behavioural techniques allow C to connect links between thoughts, behaviour and consequences; sharing of information is encouraged to map internal and external precursors of problem.)

He talks a lot about how the problem would mess up my life if it came back. (Child)

*We talked about what we should do and shouldn't do and what would happen—using this sheet of paper. If we have a stinky thought, what should we do**?** Like somebody asks you to touch somebody, you should not do it. You could either hurt the other person or they might not want to be around you—you could lose most of your friends; you can go to jail. You'd get into lots of trouble*. (Children)

You had to just remember to tell yourself before you are going to do something 'think before you act.' It just kind of clicked in before I did something. I was learning to stop and think before I acted and to think things over and talk about them. (Child)

You'd think about what would happen like losing your stereo and being grounded. I am old enough to go to jail now and it would be that much worse again because my step-mom would never trust me again. I learned how bad people felt because of my behaviour and how good people feel when I respect them and how things go a lot better when there is no disrespect and more respect. (Child)

Well, Steve told me that whenever you think about touching someone, just think more about what you are going to do before your actions. This is super powerful thinking. As soon as the touching problem comes to mind I have to fight it in my head—then I do whatever my mind goes over or then I have to fight with it more. Whatever I agree in my mind not to do I just don't do. I'm thinking Steve told me not to do it. I'm saying to myself if I do this I'm going to get in loads of trouble and if I don't do this *I'm going to be perfectly fine—in the safe zone. I would say, "I think you want to stop doing this. You are not good for my mind—you are very bad and very yucky."* (Child)

Well, if I wanted some stuff to happen more in the program, then I would have to think about it. Then, if there was something going on during the week, if I wanted to, I could either tell Steve or I could write it down on a piece of paper. (Child)

We wrote about a lot of stuff in there on how to stay away from the problem. I could always look back if I need to find out something. It was about things I have done wrong, things I am starting to get right, and things that can help me along the way. (Child)

Like if I have a problem talking to my Mom, he wants to know about it. Unless I tell him he talks to my Mom right away. (Child)

Issues were raised after Dan C had the opportunity to share about why he may have acted like that or what it is he could have done differently. Steve really plays on that. (Parent)

Steve told Dave that he had the control—that his mind can tell him that he's doing something wrong. A 4-year old can't turn and tell you that you're wrong. You're the one with the brains—you have to stop and think. (Parent)

The biggest thing that jumps up for me is that the children weren't aware that their behaviour was a problem. So first they needed to become aware of the problem and then they were able to problem solve and find solutions. They were really good at that. (Parent)

We always talked openly together so Steve always knew how the week was going and he could take it from there in his own private session. If felt very confident that it was all being supported. (Parent)

In my opinion sometimes King K is thinking, "I'm doing it. I don't want to throw the problem away." And Steve said "But it's getting you into trouble. Do you want to get into trouble? This sneaky problem is bad. You want to take it out of yourself and throw it away. You don't want it." King K would say a number of times "But I like it." And then he'd come back again and say "But

it gets me into trouble. I don't want it." And then finally he doesn't want to keep the problem. He just wants it to go away. (Parent)

We set up a chart for David. This way if he was going to touch someone he would stop and think before he did anything. So it took him a few weeks for it to sink into his head and then he started getting much better in that department. (Parent)

Steve told Dave that he had the control—his mind can tell him that he's doing something wrong. He said "Dave, you're the one with the brains—you have to stop and think." I'm finding Dave is using the 'stop and think' in other aspects of his life. He really thinks about what is expected of him at home (Parent)

Kenny had told Steve that I had been staying away from him and Steve said we'll have to change your story. This is when Kenny had asked me to come in for the first time. But he was anxious. He acted all wacky at the table. He wanted to talk about it but could he really talk now that I was there. That is what Steve was explaining to me and Steve spoke for Kenny saying "Kenny doesn't think you like him." I said "Well, up to this point it has been really hard. Kenny has changed. He has been doing really well, but for a child to be sexual towards me I just turn off and back away." Then Kenny said, "I won't do that anymore." So from that point on its been pretty good. We do sideways hugs and it's been really good. (Parent)

- This category codes 13 documents out of 14—7 children and 8 parents.

Metaphoric Defeat of Problem: (C's experiences the C/T's use of metaphors in process of separating problem from person (externalization) to enact the defeat of the problem behaviour.)

If the problem came towards us we had to yell for it to fly away. We had to yell loud: "Get away Mr. Stinker!" . . . We felt very brave . . . we drew Mr. Stinky to see how it looked. It was very, very ugly. Mr. Stinky had dots all over his face and ears that went wooooh. We actually drew the problem. That's how it looked. Of the pictures, I think we only cut up one. And we put it in the shredding machine and it never came back. (Children)

We worked with the noodles. Steve got me very, very excited with the program. Steve was supposed to be the person that was trying to make me touch him and I was the person who was trying to fight it. (Child)

Well, we did activities when we were, like, fighting in this room. It was like a little touching business. Like sometimes my friends touch me and I touch them right back. So me and Steve, we were playing this game working with two noodles. Sometimes Steve was the person that was trying to make me touch him. "Like touch me!" And I would say "No" and he's like "Touch me David!" And I say "Oh No!" (Children)

He'd say he's the problem and the person had to hurt the problem or get rid of it or whatever. So we'd take noodles and beat each other. (Child)

With the story Liam and Steve coloured together and they talked about the problem and how to make it smaller. Each time we'd come for a visit, Steve would ask how many incidents went on during the week and we'd talk about how it was getting smaller. (Parents)

- This category codes 9 documents out of 14—6 children and 5 parents.

Clients' Metaphors: (C's uses metaphorical language to speak of his or her program experience—stinky thinking / tomb squad team / space invaders / bubble space / safe zones and so on.)

If the problem came towards us we had to yell for it to fly away. We had to yell loud, "Get away Mr Stinker!" (Child)

We talked about what we should do and shouldn't do and what would happen—using this Mr. Stinko paper. If we have a stinky thought, what should we do? (Child)

Hmmm, like if my brother came up really close to me, I could ask him to move because he's in my "bubble space." (Child)

Steve and Grace were both great. Grace would speak about how the stinky thinking was a problem and all that and she would ask questions too. (Children)

My team is called the "Tomb Squad." It's from an ancient world. Tomb Squad ion Egypt means that we are the best and I know we can all do it as long as we work together. (Child)

We had a list of things we couldn't do on the Mr. Stink paper—like lots of stuff on it that you shouldn't do anymore. Michael read this list every day. (Child)

My team was the "Problem-Gone" team. It was a strong team—like we never quit. (Child)

I felt like I had the power to get it all away. I felt very, very bad when the touching problem was near me, but as soon as I came here I felt relieved. (Child)

As soon as the touching problem comes to mind I have to fight it in my head—then I do whatever my mind goes over and then I have to fight with it more. (Child)

I'm saying to myself, if I do this I'm going to get in loads of trouble and if I don't do this I'm going to be perfectly fine—in the "safe zone." (Child)

So then we were fighting him and then it was gone and tee touching problem never visits the guy again and we can live happily ever after. (Child)

They named the problem and they would refer back to it s being the "touching problem" or the "lying problem" or the "sneaking problem". We talked about how bit the touching problem was in measures of this wide, this high. (Parent)

- This category codes 12 documents out of 14—8 children and 7 parents.

Observational Factors: (C's spontaneous joy and excitement/anger at power relationships / uncertainty as to one's strength to beat the problem / discomfort with talking specifically about problem; needing assurances about confidentiality in expressing criticism.)

(b) Disconnection with story-building solutions

Strategic Barriers: (C's experienced a dilemma over implementation of program strategies/interventions/techniques such as the story-writing process/the use of metaphors/the

program activities. For some participants the experience represented a major disjunction in treatment while others perceived the experience as merely unhelpful or unpleasant.)

What I didn't like about the program was sitting there and listening. I would want to write the story but we didn't even get to write it. Steve wrote it. (Child)

Steve and Dan C. started the story in the last three sessions. He started the story in the beginning, but I think maybe Dan C got a little bit lost in it. (Parent)

The label for the problem was too general. It needs to be labelled clearly as in "This is my inappropriate sexual behaviour—I'm the thoughts that come into your head." Liam did not even recognize what he was doing—he knew nothing about the problem. (Parents)

Liam saw the program as more of a game than understanding that the story was reality. He got a certificate saying that he had graduated his problem. So Liam thought I've graduated and I'm okay—now I can go places with kids where my foster parents can't see me. Liam was confused and so were we. He didn't feel like he was getting his just rewards. Steve referred to it as the problem is now gone and the reality is, it wasn't gone. (Parents)

The noodle exercise was supposed to beat up on the problem and beat it down—but Liam didn't really understand. He didn't know the meaning behind the playing. Steve would say, "I'm the problem; make me go away." And he didn't understand or even like doing that noodle fighting. For him he was just beating up on this man. (Parents)

I didn't like the hitting with the noodles back and forth in the playroom. Liam didn't see that he was supposed to be fighting the problem. I didn't think the fighting was good for him because he can be very aggressive and it looked like it was okay to do this stuff. Liam doesn't have the forethought and cognitive ability to think things through, as in—"This is a game, you are the problem, I'm going to get rid of you, and I'm going to beat you until you are gone." (Parents)

Steve does a lot of pervert talk in the program—sick things like him wanting me to talk about what I would do with girls. I say "Shut up fag" to my brother and my mom thinks her son's becoming a pervert. (Child)

And the puppet thing—I thought I was kind of old to be learning with little puppets. Like when we were running around with puppets and stuff. I didn't really like that. You know for my age he should have something different than that. With a little kid I could understand this might be a way of making it more fun for them so that it's easier to talk about it. For me, I would like to see him act normal and just be himself and not use puppets and stuff. (Child)

With this program we could take something wrong and make something right. We could make the children talk more by using a talking stick—something like a teddy bear. They can cuddle and look at it and talk about it. Then when the next person wants to talk then they could have it. It would help people like Michael because he's so shy— it would help people of all ages. (Children)

- This category codes 6 documents out of 14—5 children and 3 parents.

Structural Barriers: (One child did not like his sessions because they excluded any time spent alone with the therapist; this might preclude some children from providing important information regarding their environment. Three children felt that the program's toy-room environment was inappropriateness; this concern could distract C from engaging with T or diminish C's receptivity

to T's tasks. In two cases no parent participated in all on-gong sessions along with the child, even though the program design bases its success on parental participation. Five parents experienced feelings of confusion regarding session or program goals that could diminish C's engagement with the process**.** One biological parent had feelings of abandonment after program termination that could have the potential to damage the maintenance of a problem-gone narrative.)

Well, what I didn't like is that Steve didn't ask me to talk to him alone at all. Anything like that. Just about things at home. (Child)

Well, umm, maybe the room could be different instead of being just toys. Just change the room. Maybe use it for something else and have a room instead for discussing more of what you are supposed to in it. I thought we were just going to talk about it the whole time—not play around. There wee too many toys and stuff like that. We're here to talk right, but we're in a toy room. It was the wrong surroundings. The talking was the important part and the fact that we were in a playroom wasn't I think a good idea. (Child)

Liam didn't seem to have the ability to trust Steve—and not in that awful setting sitting in a family room with all these adults staring at him. (Parents)

The process would have been good to know ahead of time. I do think the first appointment should really be made with the parents or caregivers alone. (Parent)

I went once to see it and observe. After that I said I would come back with Daffy and Steve said, "No, it's only for Daffy." I was never called to go back except the time they finished. (Parent)

My attending the program wasn't expected and it wasn't explained afterwards. I concluded that maybe Steve was explaining it to the social worker rather than me. I don't know what Steve said because we were never present. We were never told what he did. (Parent)

It was probably the sixth or seventh session because I only went to the last, I think, four or five sessions because Steve was working with a partner and Kenny. (Parent)

I guess it's not considered important that somebody take ownership of what's going on as long as the children understand that the behaviour is wrong—but this issue was a struggle for me. I was thinking 'come on guys, who's going to be responsible for this?' This issue of accountability got confusing for Dan C. —he didn't want to be taking the label as the bad guy in the whole thing where he may be just going along. (Parent)

The first session really threw me off, as I didn't understand the process at that point. I wish that I could have gone in first and discussed the program with Steve to understand the steps he planned on taking. If this opportunity had been offered my husband and I would both have gone. After the first session Steve sort of went over what Kenny had been writing with his permission. I understood the process a little better then. (Parent)

I was expecting a little change or expecting that we could get to the root of the problem—see why it happened or what was wrong. Why did Daffy become sexually aggressive? (Parent)

I think instead of us doing all the talking that we find a way to get Liam to open up so the program can get into depth with the problem. The program needs to get more in-depth. It was too shallow. They need to get into the reasons this is happening; we had to do the probing and find out ourselves that Liam was being abused. Otherwise, he would still be doing the behaviours. (Parents)
The older brother accused Dan C and Dan C accused him. The youngest brother also has some

intrusive behaviour. So where does it all come from? I felt they could have put all the brothers in a room and said "Okay guys, what's gone on here?" It seems—as long as everyone involved knows the behaviour is wrong—it's not important that someone take ownership. But in my way of thinking it would be good to find out what is going on with whom. (Parent)

Nobody contacted me after the program to see how I was doing. There was no follow-up. I experienced so much support during the program and afterwards I was completely on my own. I felt abandoned. I didn't feel that I had the skills to deal with Dave M. on my own if the sexual touching problem returned. I would have to come back into the program.[17] (Parent)

I would come home and tell Gloria that we were in and out of the session in 15 or 20 minutes. I wondered what Liam could have been getting out of this. Steve would come in and ask how our week had been. I'd say something to the effect that it had been great—Liam hasn't done anything this week. Then Steve would take Liam into the playroom for a 15 or 20 minute period and I would wait in the family room. The next thing I know we were heading out the door. Liam displays a lot of compulsive behaviours besides the sexual activity. The program wasn't enough sessions to really get in-depth with these problems. (Parent)

- This category codes 7 documents out of 14—3 children and 5 parents.

Personal Barriers: (Most clients referenced a history of problematic attachments and social/learning deficits. Such experiences may represent a deterrent to children developing a timely trust in T to accommodate this brief therapy approach and/or the ability to intentionally embrace the restorying process.)

My mom [foster] never used to think about me. She doesn't even like me. She knows she doesn't like me. She just acts like it at meetings. She doesn't really like me. She always bugs me at home and she's nice to me at meetings. Like, she'll listen to what I have to say but at home she doesn't. (Child)

Dan C. just needs to be taught all of these things that he's missed because, very literally, he was locked in a room with his brothers and that's where he spent his time. (Parent)

The problem with David started because of his father's stepson touching him. I guess David thought if this guy can touch me then it's okay to do it to other people—to my sister and to her friends. (Parent)

His mom had these movies and they'd sit and watch them together. I said that you aren't allowed to do that. That's not appropriate at your age. You have to be 18 to watch those movies. I had to explain to him again and again for him to understand that what happened at his mom's was not appropriate. But he had a hard time understanding when his mom said it was okay. (Parent)

Only a year ago Dan C. undressed right there in front of my teenaged daughter and her friends. He didn't know that this wasn't all right. I don't see Dan C as a predator. He is very young emotionally and he needs to be taught all these things he's missed. (Parent)

Liam doesn't understand the concept of consequences to his behaviour. He is developmentally delayed and he has ADHD. He is very impulsive. With FAS children it's really important to label lots of different things and use repetition. Liam has problems with impulsivity and compulsions in other areas also. (Parent)

[17] Represents researcher's memory of parent's comments, as interview tape was not transcribable.

He was very sexually oriented and he would touch me. Kenny learned that he could just put his arms up when he wanted a hug from me—and not be sexual towards me because I would back away. (Parent)

The way it started was at his biological father's, the stepson . . . he is the one that started touching David and that's, I guess, what sunk into David's head. (Parent)

In coming and watching the kids in the program, the biggest thing that jumps up for me is that they weren't aware that the behaviour was a problem. So the kids needed to first become aware and then they were able to problem solve or find solutions. (Parent)

Daffy wouldn't talk about the program because he doesn't understand about it—his comprehension is very low. He's been assessed at grade 2-3 level and could be in grade 9. I think he has dyslexia. Daffy is a very creative person, but very impulsive and not understanding of consequences. (Parent)

Liam doesn't understand the concept of consequences to his behaviour. He is developmentally delayed and he has ADHD. He is very impulsive. With FAS children it's really important to label lots of different things and use repetition. Liam had problems with impulsivity and compulsions in other areas also. (Parents)

It's so hard for children who come into the world without a parent who is an educator and a good example. I've had so many foster kids that have had to do a lot of private counselling. With Daffy you see if you can mend the broken pieces and erase some hurts. (Parent)

- This category codes 9 documents out of 14—3 children and 7 parents.

Main Category II: The Client / Therapist Collaboration of Co-Authorship

(a) Operations bearing on client in co-authorship with therapist

Alliance with Therapist: (C's experience of a trust/caring and/or empowering relationship with Therapist.)

I was happy about my self. I could tell the truth. I knew that that what is said in that room stays in that room. (Child)

Steve opened King K up slowly so he was never afraid to say what he wanted. (Parent)

I felt that these people are pretty nice trying to help me and stuff. (Child)

I just got to know Steve and I felt I could tell him about it. (Child)

Steve and Grace were both great. Grace would speak about how the stinky thinking was a problem and all that and she would ask questions too. (Children)

It was hard at first to just tell him [Steve} because it was embarrassing. Then I just decided to do it. I learned it was good to talk to somebody that I knew really well and that I can trust; they would understand. (Child)

Think

I felt like I really changed. Steve said let's get down to business—we started working on it and we worked so well that all this stuff just stopped. (Child)

I'd tell another kid how nice Steve is. That he is a really nice guy. Like what is said in that room stays in that room. Like it's totally secret to anybody else. (Child)

Well, I felt really happy for me and I felt really thankful for Steve helping me get the touching problem away from me. (Child)

It was hard at first to talk about things but it kind of got easier as we went along. I didn't know him at first but I got to know him. I knew he was not going to do anything to me. He was not going to be mean or anything. That made it easier. (Child)

Before I just kept things inside me until it got me so upset. It made me feel a lot better because I could talk to someone about my feelings and not have to worry about it. Not make me upset inside and stuff. (Child)

The pace as great—the transition of moving through things was really good. Steve's sense of humour and his ability to do things and to be able to have fun and get to the place where the kids understood was just phenomenal. He brought stuff out in the kids that I didn't think would happen —the sessions when they were able t open up and talk. So that was great. (Parent)

The SHIFT program could have helped him to feel safe enough to come to us and disclose what was going on. (Parent)

I felt very, very bad when the touching problem was near me, but as soon as I came here I felt relieved. It was like I knew that Steve and the other person are going to help me get the touching problem away. (Child)

It might have been Steve just taking the time and talking to me about things, working them over, and trying to find out what the problem is and why I do it. Before I kept it inside me until it got me so upset. Now I feel a lot better because I can talk to someone about my feelings. (Child)

He could relate to what Steve was saying—they were going to write it al out and work on it at each session. (Parent)

We always talked openly together so Steve always knew how the week was going and he could take it from there in his own private session. If felt very confident that it was all being supported. (Parent)

I think that he really understood what he had done and that he wouldn't be doing that anymore if he chose to. It's good that he can trust now and I trust him now. (Parent)

Then Steve would say "Okay you got it right. Well done!" He was really happy. It made him f eel good. He felt he was actually—that he was doing something—that he was part of something. (Parent)

- This category codes 14 documents out of 14—8 children and 8 parents.

Engagement with Therapeutic Task: (C connects with T to develop story.)

I didn't think the activities were too young for my age. It was fine. It made me think that kids of all ages have this problem. That it's not only when you get to this age. That it happens to all different people, different ages. (Child)

Steve and Grace were both great! Grace would speak about how the stinky thinking was a problem and all that and she would ask questions too. (Children)

The program helps you get by your problems easier. I felt a lot better about myself for being able to do the sessions. (Child)

I felt like I really changed. Steve said let's get down to business—we started working on it and we worked so well that all this stuff just stopped. (Child)

We worked with the noodles. Steve got me very, very excited with the program. Steve was supposed to be the person that was trying to make me touch him and I was the person who was trying to fight it. (Child)

It was hard at first to talk about things but it kind of got easier as we went along. I didn't know him at first but I got to know him. I knew he was not going to do anything to me. He was not going to be mean or anything. That made it easier. (Child)

Dave went in to the program craving to be helped. When he came out he was 'party bait.' He thought "Great! I know what to do now! I know what I'm allowed to do and what I'm not allowed to do." Dave really needed this in his life. (Parent)

I think I would love to see Steve just counsel him all the time because it seems like we were able to really, you know—not even just the touching problem—Steve did a great job of getting Dan C. to own up and take some responsibility. I could see that Steve was trying to find out how big Dan C. thought the problem was and to encourage him to take ownership of it and be accountable. (Parent)

The pace was great—the transition of moving through things was really good. Steve's sense of humour and his ability to do things and to be able to have fun and get to the place where the kids understood was just phenomenal. He brought stuff out in the kids that I didn't think would happen —the sessions when they were able t open up and talk. So that was great. (Parent)

If he were in the program by himself everything would be hunky-dory in his book and that's why I feel the parent participation is huge with these kids so we can talk about issues and get real. (Parent)

Any time he got an idea and he got it right he felt more confident. He knew he was the one that was doing it. Steve would say "Okay you got it right. Well done!' He was really happy. It made him feel good. He felt he was actually—that he was doing something; that he was part of something. (Parent)

- This category codes 11 documents out of 14—7 children and 5 parents.

Objections to Therapist: (Manner/characteristics/modelling.)

I didn't like the story because it was none of his business. I would have preferred not to go there. Like if I didn't feel like talking about the problem-solving thing, then he'd get mad. (Child)

I don't think that Liam liked Steve or that Steve was the best man for the job. In our home I am the more authoritarian one and Gloria is the nurturer. I believe that Liam especially works better with a woman. (Parents)

The Ministry and the foster home preach no smoking you know It's a health hazard and Kenny would always see Steve outside there smoking and when he would come back in he'd say that Steve was smoking of cigarettes. Kenny pointed out to me several times. That was the only downside. Kenny couldn't understand why a doctor would be smoking. (Parent)

I also felt Steve was always waiting to get out for his next smoke. He'd rid down in the elevator with us to smoke and that tended to bother me. I think people have a jot to do and for that one-hour I think you need to be focusing on the child and not thinking of your next smoke. (Parents)

I wasn't impressed with the first time I saw Steve . . . I don't want to really say he didn't have control of the situation—but he was so laid back. So if I had been aware of the process in the beginning I might have known that sometimes he just lets the kids do whatever. (Parent)

- This category codes 3 documents out of 14—1 child and 3 parents.

Concern about Therapist's Approach: (T's plan of treatment involving C's personal understanding of T's instructions / responses / explanations / subject matter / structuring of sessions.)

I'm a big kid—don't think I'm stupid. Listen to my side of the story and don't side with someone else. Steve doesn't go with you and then he wants you to say you're sorry after he's telling you that you did it. He makes the story bigger by saying that he believes other people that are not thinking straight. (Child)

Steve does a lot of perverted talk in the program—sick things like him wanting me to talk about what I would do with girls. Steve would ask me what I'd do if I ever encountered a girl and she wanted to touch me. I felt like I don't even want to talk about it buddy. Then he says "You don't want to talk about it; well you're going to," I'd say I wouldn't touch a girl because I don't know much still because I'm too young. Then he goes "Oh, what if"". And I'm like "I don't care about what if, I wouldn't do it". He goes on it and on it until he's trying to make me talk when I'm not going to talk because I don't think of doing that. (Child)

He would help me out a lot…. But you don't want to play games with him because he has some weird games. Like he had these gross games. Like he talks about sick stuff. Like that's what he has to do. That's his job. (Child)

Well as I mentioned the smoking bothered Kenny . . . Umm, but I would say that he thinks Steve wouldn't talk to him at an appropriate age level—stuff like that. (Parent)

The first session really threw me off, as I didn't understand the process at that point. I wish that I could have gone in first and discussed the program with Steve to understand the steps he planned on taking. If this opportunity had been offered my husband and I would both have gone. After the first session Steve sort of went over what Kenny had been writing with his permission. I understood the process a little better then. (Parent)

They need to find a way to get Liam to talk to Steve about what's going on instead of our having to tell Steve. We might have a certain part to play in that but I think it should be coming more from the child. (Parents)

I felt a little ripped off a few times with the short sessions . . . We weren't even getting 50 minutes —sometimes only 15 or 20 . . . I would come home and tell Gloria that we were in and out of the session in 15 or 20 minutes. I wondered what Liam could have been getting out of this. Steve would come in and ask how our week had been. I'd say something to the effect that it had been great—Liam hasn't done anything this week. Then Steve would take Liam into the playroom for a 15 or 20 minute period and I would wait in the family room. The next thing I know we were heading out the door. (Parent)

- This category codes 4 documents out of 14—2 children and 3 parents.

Client's Metacommunication: (C's conversation about wish to have communicated to T about lack of understanding or appreciation of T's communication / C may feel the need to speak up but finds this difficult to put into effect / C's unwillingness may extend to lack of honesty with T even when C is invited to metacommunicate in this way / C may want T to explain program rationale concerning process so that the C can better understand and participate in the process.)

They'd have a puppet and then you'd think 'What's with the puppet?' (Child)

He would always be fairly annoying. Like mom with say something and then he'll just talk about it and then I won't get to say anything that I want to talk about…. I didn't get to speak a lot because my mom was making up stupid weird things to say about school. Then he'd bring that up. He would always say, I'm trying to talk to your Mom about this. I already heard your side of the story. (Child)

Like if you didn't know something he would be snobby and be like, oh sure you know it. You just don't want to tell me. He'll dig up stuff that he didn't even know anything about and say he knew a lot about it actually. (Child)

I should have said—like when he was talking to me he asked me "Could I be part of this team?" And I'd say "No, and your buddy can't." He'd be like, "You can pick who you want and that's final. Whoever you want for your group." And then he said "Do you want me in your group?" and I had to say "Yes" obviously. It would have been funny if I'd said "No" [to him]. He'd be like "You have no choice." (Child)

It was annoying the way he talks and that he always has to have a partner in the room. I don't mind of one person hears about it, but I don't need two people hearing. Plus he'll bring my mom in and she'll say some stupid things, then he'll start talking about that and that would ruin my whole meeting (Child)

Well, what I didn't like is that Steve didn't ask me to talk to him alone. Anything like that . . . just about things at home. Like when my step-dad threw me into the chair, like I as thinking my Mom would deny it and I knew she would. So I just wanted to talk to him alone, but I did not want to say 'Can I talk to you alone?' because she would be awfully suspicious and would be asking me stuff. (Child)

Umm, but I would say that he thinks Steve wouldn't talk to him at an appropriate age level—stuff like that. (Parent)

I do think the first appointment should really be made with the parents or caregivers alone. I started to understand the process a little bit better, but it would have been good to know the whole plan ahead of time, or even just the steps he planned on taking. So the first session really threw me off. . . I wish I could have gone in first and discussed the program with Steve to understand the steps he planned on taking. If this opportunity had been offered my husband and I would both have gone. After the first session Steve sort of went over what Kenny had been writing with his permission. I understood the process a little better then. (Parent)

- This category codes 6 documents out of 14—3 children and 4 parents.

(a) Operations bearing on therapist in co-authorship with client

Think

Therapist's Active Support: (T offers reassurance of a problem-gone solution; reinforces C's strengths.)

Steve told me that he worked with lots of children with problems like mine. I felt better knowing that I wasn't the only one. (Child)

The story writing and discussion really helped Dave with the problem. The story was not about a bad person. Dave made a mistake and now we were going to fix it. So it was a very positive story —there was praise to be given. (Parent)

King K became pretty confident with everybody there all the time. He felt that he was in control. Anytime he got an idea and he got it right, he felt more confident that he as the one doing the work. Now it's explained to him why and that made him feel really good. (Parent)

Kenny G. always thought that he could never be by himself and he could never do anything alone. Now, [with Steve] he actually believes that he can be on his own and not think bad thoughts about wanting to go and touch somebody. Steve said you're the one who has to change your life story—you know how to do it now. (Parent)

Steve made it a team effort so David didn't feel it was just his problem to deal with by himself. He felt he had a support system around him. (Parent)

He was encouraged by Steve to take action. He said 'you're the one who has to change your life story—you know how to do it now. You know you accomplished this part. You're the one who has to go to these neighbours and show them you've changed. So now he's writing stories to the parents about how he feels and what he was like then and could he play with t heir children again. (Parent)

The story was not about a bad person. Dan C. made a mistake and now we were going to fix it. So it was a very positive story---there was praise to be given. (Parent)

Before he had a sexually foul mouth and once Steve told him that you're going to be okay, you know, you'll get through this, but we have to work on it. We have to work on changing the story about you. That was a 'light bulb' moment. (Parent)

His mom was a big problem at the beginning of the program because she was telling him "You're changing. You're different." So Kenny would take this as bad, but in the times he would talk to Steve he would assure him that he was doing good work and that maybe his mom meant that it was a good change. (Parent)

Any time he got an idea and he got it right he felt more confident. He knew he was the one that was doing it. Steve would say 'okay you got it right. Well done!' He was really happy. It made him feel good. He felt he was actually—that he was doing something. –that he was part of something. (Parent)

I thought it was a great program. Steve spent a lot f time and did a lot f good work. (Parent)

- This category codes 12 documents out of 14— 6 children and 6 parents.

Therapist's Use of "Relative Influence Questioning" (White, l988): Narrative collaborative process of questioning in therapy that invites clients to understand their association with the problem / invites family to participate in construction of a new narrative describing the problem—l

an externalized description / imbued with a sense of curiosity/wonderment / supports the children's choice making and agency and models this communication tone for parents.)

Issues were raised after Dan C. has had an opportunity to share why he may have acted like he did or what it is that he thinks he could have done differently. Steve really plays on that. What could you have done differently or what is it you're afraid of? (Parent)

Steve opened King K up slowly so he was never afraid to say what he wanted. Steve would just come straight out and ask him questions about a sexual behaviour and what age he thought it was allowed. When King K answered, Steve might just say "No, not really" and ask King K the question again. Steve just kept going like this until King K got the right answer. (Parent)

Steve and Grace were both great! Grace would speak about how the stinky thinking was a problem and all that and she would ask questions too. (Children)

I thought that Steve asked what the issues were point blank. Steve asked Dan C. did he think the behaviour was a problem, did he want the problem to be far away, and how did he think we could take care of the problem? (Parent)

If he were in doing the program by himself he would say that everything was 'hunky-dory in his book.' That's why I feel the parent participation is huge with these kids. Because I was there too, we could really talk about issues and get real. (Parent)

- This category codes 7 documents out of 14—4 children and 5 parents.

T's Directive Approach: (Direction or instructions of T is experienced by C as authoritarian; experienced by once child who strongly viewed the T/C relationship as lacking equality and real choices; for this child the technique of relative influence questioning was experienced as simulated and lacking in any wonder. Findings suggest that children who do not feel their sense of having real choices may not fully engage in the restorying process.)

Well, he [Steve] doesn't know even how to talk to people . . . Like if you didn't know something he would be snobby and be like, oh sure you know it. You just don't want to tell me. He'll dig up stuff that he didn't even know anything about and say he knew a lot about it actually. (Child)

He was really rude a lot. If I didn't tell him something that he doesn't like, he'd use his therapy. He goes, are you sure that's true? Like if I tell my side of the story. He doesn't listen to it. He never sticks with the person's side of the story. He goes with their parents because that's his job and he can get fired. (Child)

Like if I didn't feel like talking about the problem-solving thing, then he'd get mad. Like if I did not want to talk about something because I felt uncomfortable, he would always get mad and then he would talk to my Mom. (Child)

He'd talk about some pretty stupid crap. It's annoying and he always says gross things. He'd be like if I ever encounter a girl and she wanted to touch me. I felt like I don't even want to talk about it buddy. Then he says "You don't want to talk about it. Well you're going to." I'd say "I wouldn't touch a girl because I don't know much still because I'm too young." Then he goes "Oh, what if?" And I'm like "I don't care about what if. I wouldn't do ii." He goes on it and on it until he's trying to make me talk when I'm not going to talk because I don't think of doing that. (Child)

Steve pushed him to talk about his mom and all sorts of things. So, as much good as the program did, he will have some bad memories about it. But Kenny G. does know how good he's doing. (Parent)

- This category codes 2 documents out of 14—1 child and 1 parent.

Main Category III – C's Experience of Therapist's Operations

(a) Operations bearing on client's sense of agency / reparation

Tools For Life: (Family experiences new strategies to deal with problem after treatment/gains skills such as problem solving / relational skills / psychoeducation.)

I learned about how to know if somebody likes you and what age I should hold hands and have a kid and stuff. I learned to behave better around my Mom and Chuck and I am actually getting along really well now. (Child)

The program helps you get by our problems easier I felt a lot better about myself for being able to do the sessions. (Child)

Well, the program taught me a lot cause I never knew how much it hurt people being disrespectful. I pretty much only thought of what was happening to me and not how people felt. But when I came to see Steve, I learned how much it hurt people. I felt really bad for not being respectful to my Mom. (Child)

Steve said 'You're the one who has to change your life story. You know you accomplished this part. So now he's writing stories to the parents about how he feels and what he was like then and could he play with t heir children again. (Parent)

King K became pretty confident with everybody there all the time. He felt that he was in control. Anytime he got an idea and he got it right, he felt more confident that he was the one doing the work. (Parent)

He was encouraged by Steve to take action. He said you're the one who has to change your life story—you know how to do it now. You're the one who has to go to these neighbours and show them you've changed. (Parent)

He has come home and written stories about things that he would like to change at our house. Doing these stories really helped us understand what he wanted—like a little chart on the wall to remind him what to do rather than our always telling him. (Parent)

*He learned self-control. He learned to ask questions and not scream. With me he was very sexually oriented and he would touch me. Kenny learned that he could just put his arms up when he wanted a hug from me —and not be sexual towards me because I would back away. He learned social skills in making friends. (*Parent)

The language the therapists used here in this room is what we use at home all the time to continue to work with the problem. When people come to our house we can refer to the problem and nobody else knows what we are talking about. The program helped Michael at school to be able to talk to kids and solve problems and the proper way to behave. (Parent)

After the first meeting I got the confidence to talk to him. Before the program I was afraid to discuss the subject with King K and he was hiding his behaviour—he felt I had been shutting him out. Now if there is any inappropriate behaviour I am able to talk about it and deal with it. Steve showed me that this isn't enough to just say no, you're not allowed to do that—you have to talk about it too (Parent)

The SHIFT program really helped me understand that I don't have some monster child. With all the activities that we did in the program it gave me insight into what Dave is feeling and now I

feel I know how to help him. Am also finding that Dave is using the 'stop and think' idea in other aspects of his life by thinking about what is expected of him in the home. (Parent)

I don't feel that I would be able to handle things on my own if Dave M. started having these touching problems again. I would have to come back and see Steve in order to deal with it. (Parent)

- This category codes 11 documents out of 14—7 children and 6 parents**.**

Separation of Client from Problem: (Externalization/narrative therapy technique personifies problem / places problem outside C and within C's control / encourages C's appropriate choice and their responsibility in gaining a problem-gone narrative.)

They named the problem and then we would refer back to it as being the "touching problem" or the "lying problem" or the "sneaking problem." We talked about how big the touching problem was in measures of this wide, this high …I thought Steve did a great job of getting Dan C. to own up and take some responsibility. I could see that Steve was trying to find out how big Dan C. thought the problem was and to encourage him to take ownership of it and be accountable. (Parent)

By giving the problem a name King K. is separated from the problem. King K. can say "I'm not a bad guy, it's the problem that's bad and I'm going to remove it myself and throw it away. It's getting me into trouble and I don't want that*."* (Parent)

The problem was overwhelming but once you got into the program you didn't think of it as being just Dave's problem any longer. It became a problem that we all had to deal with (Parent)

I went out in my yard and got a rock and I said "Throw it out that door" and, you know, "Get rid of it because this is the problem here." I identified it giving it a name and letting him decide how far away he wanted it to go. (Parent)

Steve really worked hard with him. In my opinion sometimes King K is thinking "I'm doing it. I don't want to throw the problem away." And Steve said "But it's getting you into trouble. Do you want to get into trouble? This sneaky problem is bad. You want to take it out of yourself and throw it away. You don't want it." King K would say a number of times "But I like it." And then he'd come back again and say "But, it gets me into trouble. I don't want it." And then finally he doesn't want to keep the problem. He just wants it to go away. (Parent)

He'd feel that it was two separate things. He'd say, "It's not my friend because it gets me into trouble." Then he wants to get rid of it. He'd say, "I don't want it back. It's dirty." It's a separate thing to him—not part of him. (Parent)

The fact that there was a team that was a team built around solving the problem was great—like a captain and who would be the players and who would be part of that team. It made it a team effort so Dan C. didn't feel it was just his problem to deal with by himself. He felt he had a support system around him*.* (Parent)

I think he first thing was that he realized that what he did wasn't okay but that he wasn't a bad person. That was a 'biggy'. (Parent)

- This category codes 11 documents out of 14—7 children and 6 parents.

(b) *Influence* on client's sense of identity.

Child's Perception of Self: (C experiences changes in self-concept / empowered/self-assured / aware; outcome of completing the program.)

What you do is up to you. Like somebody asks you to touch somebody, you should not do it. You could either hurt the other person and they might not want to be around you. You can lose most of your friends. (Children)

I pretty much only thought of what was happening to me and not how people felt. But when I came to see Steve, I learned how much it hurt people. (Child)

After fighting off the problem I felt really good. It actually got it off my chest and so it stopped. I knew that I had the power to get it all away. (Child)

If the problem came towards us we had to yell for it to fly away. We had to yell loud "Get away Mr. Stinker!" . . . We felt very brave . . . (Children)

Well it was the inappropriate behaviour that was the problem or it was half-and-half. It was half me and it was half the inappropriate behaviour. (Child)

I felt like I had the power to get it all away. I felt very, very bad when the touching problem was near me, but as soon as I came here I felt relieved. (Child)

That felt good you know. I felt that I had done the right thing and stuff. It made me feel better because I was in control. (Child)

I just felt good about myself for being able to get through that [the program]. (Child)

I felt all opened up. I was happy about myself. I told the truth a lot. (Child)

Well the important thing is that the behaviour will never happen again and that I can carry on so that people don't get hurt. The program taught me a lot because I never knew how much it hurt people being disrespectful. I felt really bad for not being respectful to my mom. (Child)

Any time he got an idea and he got it right he felt more confident. He knew he was the one that was doing it. Steve would say "Okay you got it right. Well done!" He was really happy. It made him feel good. He felt he was actually—that he was doing something—that he was part of something. (Parent)

At first King K. said '"I was dared to do it and I did it." And he said "I'd do it again if somebody asked me to do it" and "Why should I get in trouble?" But his outlook was different towards the end of the sessions. Like the situation at school. I talked to him a few times and he understood that what he did was not right and he had to get rid of the behaviour. (Parent)

- This node codes 11 documents out of 14—7 children and 7 parents.

Parents Perception of Child: (Parent experiences the child as multidimensional or, alternatively, is strongly influenced by a problem orientation at program termination. It may be that those who tend

to chiefly see the child in light of the problem behaviour will experience less engagement with program and will be less able to support the child toward a problem gone narrative.)

I have really seen a change in Dave. He seems to be more comfortable with himself. (Parent)

The problem was overwhelming but once you got into the program you didn't think of it as being just Dave's problem any longer. It became a problem that we all had to deal with. (Parent)

It made it a team effort so David didn't feel it was just his problem to deal with by himself. He felt he had a support system around him. (Parent)

The story was not about a bad person. Dave made a mistake and now we were going to fix it. So it was a very positive story—there was praise to be given. (Parent)

He didn't have any sense of what was okay to do and what wasn't. The program gave him this awareness. (Parent)

At first I didn't want to have anything to do with him because he kept touching me. I wasn't able to be affectionate with him. My husband would play with him or take him for bike rides. You know I realize that it was a cry for a hug. It wasn't a sexual thing towards me, but it was how he related to getting his needs met. (Parent)

King K. can say "I'm not a bad guy; it's the problem that's bad and I'm going to remove it myself and throw it away. It's getting me into trouble and I don't want that." (Parent)

The SHIFT program really helped me understand that I don't have some monster child. With all t he activities that we did in the program it gave me insight into what Dave is feeling and now I feel I know ho to help him. (Parent)

Only a year ago Dan C. undressed right there in front of my teenaged daughter and her friends. He didn't know that this wasn't all right. I don't see Dan C as a predator. He is very young emotionally and he needs to be taught all these things he's missed. (Parent)

In coming and watching the kids in the program, the biggest thing that jumps up for me is that they weren't aware that the behaviour was a problem. So the kids needed to first become aware and then they were able to problem solve or find solutions. (Parent)

Liam doesn't understand the concept of consequences to his behaviour. He is developmentally delayed and he has ADHD. He is very impulsive. With FAS children it's really important to label lots of different things and use repetition. Liam has problems with impulsivity and compulsions in other areas also. With Liam 16 weeks of therapy is not going to cure him. It's going to take years and years of repetition and appropriate behaviour and consistency. (Parents)

I've had so many foster kids that have had to do a lot of private counselling. With Daffy you see if you can mend the broken pieces and erase some hurts. (Parent)

These kids are already more or less moulded. They can be arrogant and they can be in denial of everything and they don't care. They'll sit there and just watch you and be entertained by Steve instead of him really getting through to them. But then they are coloured already. (Parent)

He didn't particularly like the whole program. He didn't want to go. He was embarrassed buy it, because of what it was and rightfully so. I mean, if I had to go I'd be embarrassed. (Parent)

- This category codes 7 documents out of 8—8 parents.

Causal Reflections: (C connects with his or her childhood history and etiology of sexual behaviour that offers the C a starting point with which to begin the restorying process.)

The very first time I went to the program I talked with Steve at the Mall once—so we would figure out what happened in my past or something. After that we would get together and do the program. (Child)

Well, Steve said that I learned this from my sister and my family and stuff, and he says I'm going to help you make it stop and I said cool. (Child)

Steve pushed him to talk about his mom and all sorts of things. So, as much good as the program did, he will have some bad memories about it. But Kenny G. does know how good he's doing. (Parent)

- This category codes 7 documents out of 14—3 children and 5 parents.

Main Category IV: Client's Experience of Outcomes

(a) Impact of program

Problem-Gone: (C has gotten, is getting, or is unsure of getting his or her control over the problem behaviour; while some children felt that the problem was definitely behind them, others felt very positive about a problem-gone solution but appreciated that they were in the process of recovery. One child only expressed definite reservations about his ability to be successful and his foster parent did not attend the program, seemed unaware of program rationale/strategies/activities, and viewed the child mostly from a problem focus.)

I started doing better when I was in the program and now people don't bother me. They even gave me a certificate at the end. I think the problem went away. (Child)

I 'm not doing the things that I was doing before anymore. It made me better, yeah, because I was in control. (Child)

Well like the important thing is that it will never happen again and that I can carry on so that people don't get hurt. I feel confident that it is gone. (Child)

I like it when we were supposed to talk about what's happened because it made it go away and I just felt better after and it never came back. (Child)
It felt pretty good because I was able to accomplish what I was supposed to do. The touching problem just wore off and it didn't come back. (Child)

I told them that I wasn't doing any of that stuff that I did before. Well, I wasn't sure about it at first but after a while I thought it might come back. I don't know yet. It's better. It's controllable. (Child)

There's no more ripping up toys in anger and doing sexual things with them. The main de-escalation came with the disclosure. There have really been some drastic changes to his behaviour. I think that he finally gets it—that the behaviour is not okay. The lying has stopped too

. . . But 16 weeks [the program] is not going to cure him. It's going to take years and years of repetition and appropriate behaviour and consistency. (Parent)

Dan C. didn't have any sense of what was okay to do and what wasn't. The program gave him this awareness. We still struggle with his judgement but at least the program taught him a good sense of what's right and wrong. (Parent)

I think that he really understood what he had done and that he wouldn't be doing that anymore if he chose to. It's good that he can trust now and I trust him now. The behaviour has just changed so drastically and it's because of the program. Absolutely a hundred percent! (Parent)

I have really seen a change in Dave. He seems to be more comfortable with himself. He hasn't run into any problems except for some of the kids in the neighbourhood using 'boy's' language—he tells me it's uncomfortable for him to hear this language. (Parent)

I don't see any improvement with the problem, but Daffy could if he knows what he has to improve. There was one incident that showed that he was on the upswing again. I asked the social worker to find somebody who can help him because the program with Steve it was not effective. (Parent)

Assimilation: (Metaphoric language of program becomes part of family's world.)

We had the list of things we couldn't do on the Mr. Stinko paper—like lots of stuff on it that we shouldn't do anymore. Michael read this list every day. (Children)

The language that Steve and Grace used in this room is what we use at home all the time to continue to work with the problem. Nobody knows what these words mean except for us. (Parent)

Before the program I was afraid to discuss the subject with King K and he was hiding his behaviour—he felt I had been shutting him out. Now if there is any inappropriate behaviour I am able to talk about it and deal with it. Steve showed me that this isn't enough to just say no, you're not allowed to do that—you have to talk about it too. (Parent)

We are able to continue with the different words and ways of talking about the problem. It didn't just stop here. It was helping Michael at school to be able to talk to kids and solve problems and the proper way to behave. (Parent)

I went out in my yard an got a rock and I said "Throw it out that door" and, you know, "Get rid of it because this is the problem here." I identified it giving it a name and letting him decide how far away he wanted it to go. So it was good to have a reference to be able to handle things that I was doing too. (Parent)

We set up a chart for David. This way if he was going to touch someone he would stop and think before he did anything. So it took him a few weeks for it to sink into his head and then he started getting much better in that department. (Parent)

- This category codes 14 documents out of 14—8 children and 9 parents

Effectiveness of Client/Therapist Operation(s): (C's positive experiences of overall process and activities of program included diminished guilt and isolation / a heightened sense of self and others / a sense of control of the problem / awareness of thoughts, behaviour, and consequences /

problem-solving skills and psychoeducation / the understanding of having, with the help of others, changed their story to a new preferred narrative.)

Steve helped me get through it. To another kid taking the program that I'd say the program will help you—you'll be able to control it a little bit and you'll like the feeling of getting rid of it. (Child)

The program helped me a lot because I would have ties for myself with someone [therapist] instead of being at home and sometimes not get to talk to much people. It got a lot off my mind to talk to someone. It let me feel better about the stuff that I'm feeling. (Child)

Before [the program} I just kept things inside me until it got me so upset. It made me feel a lot better because I could talk to someone about my feelings and not have to worry about it. Not make me upset inside and stuff. (Child)

I felt like I really changed. Steve said, "Let's get down to business". We started working on it and we worked so well that all this stuff just stopped. (Child)

The program let me tell someone how I felt. Just getting it out, I did not feel so guilty—like nobody knows about it. Stuff like that. It's hard to explain. (Child)

When I passed the things that Steve taught me not to do, then I graduated and I got a certificate and we had our party. Steve got me really, really, excited with the program. (Child)

I thought Steve did a great job of getting Dan C. to own up and take some responsibility. I could see that Steve was trying to find out how big Dan C. thought the problem was and to encourage him to take ownership of it and be accountable. (Parent)

You know I wouldn't have expected this from Kenny for years and years and years. When I think of when he first came to us. He's is a very intelligent child—to be able to, in only a year, to change his from life from upside down to right side up. (Parent)

The main de-escalation came with the disclosure. There have really been some drastic changes to his behaviour. I think that he finally gets it—that the behaviour is not okay. The lying has stopped too. (Parent)

But his outlook was different towards the end of the sessions. Like the situation at school. I talked to him a few times and he understood that what he did was not right and he had to get rid of the behaviour. (Parent)

It [the program] helped me a lot. I didn't really like them (therapists) but I was learning. Like, I was with the program for some weird things. I started doing better when I as in it and now like people don't bother me . . . Steve was helping me a little bit . . .. Umm, I got a lot off my mind to talk to someone. I started feeling better about the stuff that I'm feeling. (Child)

I thought it was a great program. Steve spent a lot f time and did a lot f good work. (Parent)

The SHIFT program really helped me understand that I don't have some monster child. With all t he activities that we did in the program it gave me insight into what Dave is feeling and now I feel I know how to help him. (Parent)

If he were in doing the program by himself he would say that everything was hunky-dory in his book. That's why I feel the parent participation is huge with these kids. Because I was there too, we could talk about issues and get real. (Parent)

Think

The fact that there was a team that was built around solving the problem was great—like a captain and who would be the players and who would be part of that team. It made it a team effort so Dan C. didn't feel it was just his problem to deal with by himself. He felt he had a support system around him. (Parent)

I found that in King K's case, the program was pretty useful for him and for me too. I'm able to deal with him and confront him directly and discuss it where I wouldn't have done that before. (Parent)

He could relate to what Steve was saying—they were going to write it all out and work on it at each session; then we could look back to see his progress. The story writing was just excellent—Kenny was able to change his life story. (Parent)

When he had talked to people before he hadn't done these stories or anything. I mean he couldn't think of any other way other than sexual or swearing. So people repelled from he. He's come such a long way. (Parent)

The behaviour has just changed so drastically and it's because of the program—absolutely a hundred percent. (Parent)

He has come home and written stories about things that he would like to change at our house. Doing these stories really helped us understand what he wanted—like a little chart on his wall to remind him what to do rather than our always telling him. (Parent)

I couldn't believe how well Kenny was doing when I came to the sixth session or so because he didn't want to come to these appointments but once he got there he was fine. He didn't appear to like Steve but he would talk. So Steve was hitting the right buttons. (Parent)

He even wants to start rewriting thins that he's done with is friends that he made a few years ago and their parents said they could not play with him because f his mouth. He's writing stories to these people abut how he feels and what he's like now and could he play with them again. (Parent)

- This category codes 11 documents out of 14—7 children and 6 parents.

Lack of Faith in C/T Operation(s): (C is unable to recommend program to others; C experienced process/activities as ineffective.)

No, I don't think they [other kids] should come either. I think they should get a new program. That's what I think . . . Stop the program. Find another way. Either listen to my side of the story and don't listen to someone else. Don't listen to that side. He doesn't go with you. He goes the other way and then he wants you to say you're sorry after he's telling you that you did it. (Child)

I think Steve might be effective with the little kids but not these older kids. These kids are already more or less moulded. They can be arrogant and they can be in denial of everything and they don't care. They'll sit there and just watch you and be entertained by Steve instead of him really getting through to them. But then they are colored already (Parent)
Liam didn't seem to have the ability to trust Steve—and not in that awful setting sitting in a family room with all these adults staring at him. I don't think that Liam liked Steve or that Steve was the best man for the job. In our home I am the more authoritarian one and Gloria is the nurturer. I believe that Liam especially works better with a woman. (Parents)

- This category codes 3 documents out of 14—1 child and 3 parents.

(*b) Impact of interview*

C's View of Program: (Interview process broadened awareness of program effects adding to perceived value/outcomes of program; clarified program goals to help guide client's future treatment needs.)

He disclosed to us that he was being abused at home after the SHIFT program. So this might have been a plus for the SHIFT program. Now that I think about it might have helped him to disclose to us . . . He was being allowed to go for family visits and he was uncomfortable. He did not want it and there e was the list of 10 things on the wall and to tell an adult if someone does this to you. Tell someone you care about . . . So maybe this was part of it because it was very soon after the program finished that he disclosed to us. . He felt safe enough to be able to come to us and tell us what was going on. Now that I'm thinking about it might have been a very positive thing that came out of the program . . .. And his behaviour changes since the disclosure have been amazing. It's like he's taken the secrets of the world and just given them away. He's not packing it around anymore. (Parents)

- This category codes 4 documents out of 14—5 parents.

C's Self-Worth, Hope, Confidence: (Interview process allowed C to revisit their heroism and sense of accomplishment that confirms the narrative therapy concept that the C enjoys additional healing by virtue one having an audience for his or her story.)

My team is called the "Tomb Squad." It's from an ancient world. Tomb Squad in Egypt means that we are the best and I know we can all do it as long as we work together. (Child: delivered very proudly)

- This category codes 5 documents out of 14—6 children

Allowed Expression of Stalled Dialogue: (Heretofore unexpressed aspects of C's experiences were voiced that may represent deterrents to effectiveness of C's restorying in relationship process and/or the maintenance of a problem-gone narrative. Such experiences included lack of connection with T, developmentally inappropriate implementation strategies, and differential experiences of program design bearing on parental participation and follow-up procedures.

- This category codes 7 documents out of 14—4 children and 4 parents.

I think they should get another program. I'm a big kid—don't think I'm stupid. Listen to my side of the story and don't side with someone else. Steve doesn't go with you and then he wants you to say you're sorry after he's telling you that you did it. He makes the story bigger by saying that he believes other people that are not thinking straight. (Child)

Clarified Conditions Fundamental to Good Program Delivery: (Strong therapeutic alliance/parental involvement/developmentally appropriate intervention strategies/follow-up.)

APPENDIX H

Provincial Consultation Group (Wachtel, 1996) and The Revised Report from the National Task Force (1993)

In 1990, with the establishment of the Sexual Abuse Interventions Program (SAIP) in British Columbia, Canada, mental health centers contracted with community agencies to provide general sexual abuse counselling for children and youth throughout the province. With agency staff reporting increasing numbers of children under 12 who were exhibiting intrusive sexual behaviour, pilot programs were established by Child and Youth Mental health Services (CYMHS) to deliver counselling services to these children 1993. The pilot project staff was asked to produce an update of knowledge in the field. The resulting update was received as highly informative such that these therapists were asked to form the core of a Provincial Consultation Group to extend this work. The final product of this extensive endeavour was a report submitted to the CYMHS (1996) entitled *Best Practice Issues and Suggested Practice Standards in Working with Children with Sexual Behaviour Problems* (Wachtel). This report incorporates advice on clinical practice, research, training and policy development in this field. It represents the 'state of the art' in treatment programs acknowledged in current clinical practice in British Columbia. This major report is organized around another seminal report, as outlined below.

Revised Report from the National Task Force (1993). The Task Force report is a function of the US-based National Adolescent Perpetrator Network (NAPN), a group of individuals from more than 800 programs involved in intervention with sexually abusive youth. In the fall of 1986, a survey of NAPN members gave unanimous agreement for the creation of the National Task Force. The first goal was defined as consensus building along with the articulation of the basic assumptions upon which current practice was

based. The second goal was to incorporate the entire system's response that includes and supports the assessment and treatment of children with sexual behaviour problems. Additionally, the survey covered specific suggestions of representatives as well as defining the characteristics necessary to represent the entire field. With multiple disciplines, theories, professions, programs, methods, techniques, and settings defined and compiled**,** 20 participating and 20 advisory Task Force positions were appointed, representing specific task areas. Despite the huge variance in membership, preliminary findings showed strong consensus. In early 1987 a review was made of all related documents and literature available to the field. There were 167 NAPN members who responded to the first working draft, with a second draft that required a written response circulated in the fall of 1987. Participating members compiled the Preliminary Report (1988) with some 8,000 copies circulated from 1988 to 1993. Active solicitation of membership feedback along with yearly meeting to consider additional research has resulted in a Revised Report in l993, which continues to base itself on a consensus building process. Throughout this paper, references will be made to these two documents outlined above as the Provincial Consultation Group and the Task Force. Additionally, the reader will find The National Task Force's review of theoretical approaches in Appendix M.

APPENDIX I

Characteristics of Children with Sexual Behaviour Problems

Although treatment for children who appear to have problematic sexual behaviours has existed for several years, little research exists to document its efficacy. Nevertheless, there is a growing body of literature that focuses specifically on children with sexually behaviour problems and the characteristics of these children and their families. Such works include both empirical research (Bonner, Walker & Berliner, l997; Friedrich & Luecke, l988; Gray, Pithers, Busconi & Houchens, l999; Pithers, Gray, Busconi & Houchens, l998) and astute clinical knowledge (Cantwell, l988; Cunningham & McFarlane, l991, 1996; Friedrich, l990; Gil & Johnson, l993; Johnson, l988, l989; McFarlane & Cunningham, l991). Moreover, the literature gives us clinical-based discussion on standards and best practices (National Task Force Revised, l993; Provincial Consultation Group, l997) and on family dynamics, etiology, and treatment approaches (Araji, l997; Burton & Rasmussen, l998; Cunningham & McFarlane, l991, l996; Gray & Pithers, l993; Gil & Johnson, l993; Johnson, l995, l999; Johnson & Berry, l989; Lane, l991, l997; Provincial Consultation Group, l996; Ryan, l991, l997a; National Task Force Revised, l993). Additionally, a few resources have been developed to help parents (Gil, l987; Johnson, l995; Pithers, Gray, Cunningham, & Lane, l993; Ryan & Blum, l994). Although the empirically based treatment literature on children with sexual behaviour problems is scant, more recently the systematic evaluation of the efficacy of various treatment approaches with these children has been undertaken in the United States (Bonner et. al., l997; Gray et. al., 1999; Pithers et. al., 1998) and Canada (Wachtel, l995). Two of these studies are summarized in this paper under ‘treatment programs’.

APPENDIX J

Labelling Children with Sexual Behaviour Problems

The literature lacks agreement on what to call children with sexual behaviour problems. Cunningham and MacFarlane (1991, 1996) have used 'causal' terminology to refer to children who act out sexually as 'abuse-reactive' although it does not appear to be the case that all children with sexual behaviour problems are reacting to a history of sexual victimization. Some have called them 'sexualized children' (Gil & Johnson, l993) while others have referred to them as 'sexually aggressive/reactive' (Araji, l998; Friedrich &Luecke, l988; Gray & Pithers, l993). While the term 'sexualized' does *not* suggest the presence of an aggressive component that *may* be present, the term 'sexually aggressive' *does* imply an aggressive component that may *not* be present.[18] Other labels used to describe these children include 'child perpetrators' (Johnson, l988; Lane, l991) and 'children who molest' (Cunningham & MacFarlane, l991; Johnson, l995) as well as 'children with sexually abusive behavioural problems' and 'sexually abusive children' (Burton & Rasmussen, l998). Such names were adapted from the adult and adolescent sex offender field. However, the prepubescent children we speak of here are not involved in the judicial system; it is note worthy that children in some states enter the judicial system at ten years of age. Other labels prevalent in the literature are 'children with sexual behaviour problems or disturbances' (Berliner, Gray, Friedrich & Pithers, l996; Gray & Friedrich, l996; Lane, l997; Wachtel, l995) and 'sexually intrusive children' (Wachtel, l992).

While some researchers have taken a hard line in describing these children such as not to minimize the abusive nature of the behaviour, other researchers have preferred the other end of the continuum in choosing a label that is essentially descriptive and minimally stigmatizing to these children. In British Columbia, Canada, the term

[18] Dispute on the sexual *nature* of children must recognize that children *do* hav*e* a sexual nature; our culture's denial of this denotes systemic issue in addressing children's needs.

'sexually intrusive' is now being used to represent the extreme end of Johnson's continuum (1994, see Appendix E). This term is intended to describe children who use manipulation or coercion to obtain sexual contact, who tend to pair sexuality and anger or aggression, and who may plan their sexual victimization in some detail. Initially coined the term 'sexually intrusive' was seen as essentially descriptive and minimally stigmatizing, replacing terms originally adapted from the adult and adolescent sex offender field. However, this term was seized upon and came to be applied to *any* child whose behaviour was at all sexually problematic or even questionable (Wachtel, l996). The Provincial Consultation Group (Wachtel, 1996) believes that the general use of this term labels children, threatens to make them social outcasts, and generates caregiver alarm rather than leading to solution-focused action. With the understanding that these children are not all reacting to a history of sexual victimization, the Provincial Consultation Group (Wachtel) believes that 'causal' terminology can lead to both fruitless attempts to secure a disclosure from the child in treatment and to 'non-directive' victim-focused treatment that fails to address the sexually problematic behaviour. Generally, the members of the Provincial Consultation Group (Wachtel) believe that the child's own victimization experience can be dealt with (where it *is* an issue) within a program aimed at controlling and reducing problematic sexual behaviour. One demand members express here is the need to carefully balance treatment since victim-oriented work tends to be 'expansive' and open up the child's feelings, while therapy oriented towards mitigating problem behaviour tends to involve containment and direction (Act II, l995).

APPENDIX K

Sexual Development and Sex Play in Children

Literature on children with sexual behaviour problems highlights the importance of clinicians exercising caution such that they distinguish natural and healthy childhood sexual behaviours from those that would be cause for concern or that clearly reflect problems (Araji, 1997; Johnson, 1999; Gil, 1993). Adults may face many difficulties today in distinguishing childhood behaviours that are consistent with natural, healthy childhood sexual development from behaviours that may reflect sexual abuse or that are themselves abusive. This distinction is important because some children have begun to equate touching private parts with abuse, sexual exploration sometimes gets mislabeled as sexual molestation, and sexual touch is often equated with 'bad touch' (Johnson, 1999). The confusion that adults experience around touch in general may also reflect and reinforce these unsound perceptions. Masturbation is common among infants, toddlers, and pre-schoolers (Martinson, l991, l997). Once they discover their genitals, toddler may attempt to see or touch the genitals of others. It is not unusual for young children to take their clothes off, look at one another's bodies, and sometimes touch one another. This can be normative sexual behaviour (Friedrich, l991), age-appropriate sex play (Gil, l993**),** or expectable sexual development (Gil and Johnson, 1993) for children who do not have a history of sexual trauma or exposure to explicit sexual material. Curiosity may motivate this typically naïve experimentation. Additionally, activities such as 'playing house' or 'playing doctor' are common games among young children. However, the sexual content of their play is likely based on what they have observed or experienced (Gil, l993). Unless the children involved have been previously exposed to sexuality play, activities are generally limited to undressing, looking, and touching. These activities are typically between same-age peers, spontaneous, playful, or embarrassed (Gil, l993; Johnson, 1998). When adults discover children engaged in age-appropriate sex play they

may ”educate, redirect, or limit behaviour, but the behaviour itself is not deviant” (Ryan, l997b, p. 439). Furthermore, some children engage in sexual behaviour that is problematic for themselves but not necessarily problematic to others. Excessive masturbation and explicit sexual talk are examples of such behaviour. These behaviours may involve disruptions of a child’s normal development progression, rejection from others, heightened risk for victimization, and anxiety for the child (Task Force Revised, l993). Individual therapy and psychoeducation can be sufficient interventions for these children.

APPENDIX L

Sexually Intrusive versus 'Normal' Sexual Behaviour

The Task Force (1993, p. 27) declares that "classification of sexually abusive youth avoids the disservice of treating them all the same and, ultimately, typologizing offenders can humanize our response to the individual." In responding to this issue the Provincial Consultation Group (Wachtel, l996) is not convinced that there *is* currently an adequate classification scheme for children with sexual behaviour problems. Further, they comment that even if we can talk usefully about common issues, it is critical to assess and treat each child as unique. Consequently, the Provincial Consultation Group members (Wachtel) believe that even useful typologies can lead to mechanical rather than individualized response to these children.

In distinguishing developmentally appropriate sexual behaviours from behaviours that are sexually intrusive, there are a number of clinicians who provide guidelines and a context and perspective to address these issues (Gil, l993**;** Johnson, 1999; Martinson, l991, l997; Ryan, l991, 1997b; Sgroi, Bunk, and Wabrek, l988). For example, from ages 0-5, touching self or others' genitals is normal and results from curiosity while the same behaviour may be considered abnormal or intrusive when the exploration becomes an enactment of specific adult sexual activity (Cunningham & MacFarlane, l991). The type of sexual behaviour exhibited helps to discriminate intrusive sexual interactions from age –appropriate sex play. Friedrich, Grambsch, Broughton, Kuiper & Beilke (1991, as cited in Burton & Rasmussen, 1998, pp. 8) studied normal sexual behaviour in children. Of their sample 880 children ages two to twelve, 46% were reported to have touched their own sexual parts and 6% were reported to have touched others' sexual parts. Only one-tenth percent of this normative sample were reported to have put their mouth on another's sexual parts. Friedrich and colleagues reported that other sexual behaviours rarely noticed by the caretakers of these

children (e.g., asks others to engage in sexual acts, inserts objects in vagina/anus, imitates intercourse) tended to be behaviours that were more aggressive or imitative of adult sexual behaviour. More specifically, a sexually abusive child is one who initiates sexual behaviour in a manipulative or coercive manner. The actual behaviour may encompass anything from fondling to sexual intercourse and include object insertion, oral-genital contact, and bestiality. Other less intrusive sexual behaviours can be highly problematic if they are repetitive and invasive. Examples of such behaviours include exposing genitals, window peeping, grabbing others' breasts or buttocks, looking up skirts and so on.

Ryan (1997) breaks children's sexual behaviours down into four categories as normal, yellow flags, red flags, and no question behaviours. Red flag behaviours considered problematic that force an adult response and potential treatment would include explicit sexual talk between differing age children; touching another's genitals; debasing of self/others' genitals; touching or forcing exposure of another's genitals; debasing of one's own or another's genitals; communication of sexually explicit threats of force; repetition and chronicity in behaviour such as peeping, exposing, obscenities, pornographic interests, and frottage; compulsive masturbation that may include vaginal or anal penetrating; and the simulation of intercourse with dolls, peers, or animals. 'No question' behaviours that demand treatment due to their highly intrusive nature include: actual penetration of dolls, children, or animals; forced touching of genitals; stimulating intercourse with peers without clothing; and any sign of unexplainable genital injury.

Similarly, the highly influential work of Cavanagh Johnson (1994) includes an in-depth and detailed classification system that represent a continuum of sexual behaviour problems in children (see Appendix E for Johnson's complete classification system). SHIFT designers were strongly influenced by Johnson's typology but presently express some reservations as to whether it represents a true continuum of sexual

behaviour problems in children. Generally, the Provincial Consultation Group (Wachtel, l996) reports the continued use of a Johnson style typology of sexual behaviour problems, while also expressing reservations on whether these categories do in fact constitute a continuum either in terms of 'seriousness' or 'difficulty of intervention'.

The Task Force (1993) describes the abuse dynamics that help to define sexually intrusive interactions between children as *power differential,* involving differences in age, size, intelligence as well as physical ability; *intimidation,* involving status or authority; *manipulation,* involving a child's deliberate actions to secure his or her victim's cooperation and participation; and *coercion,* involving the use of tricks or bribes, threats or control, secret planning and coercing victims to silence, power differential, intimidation, manipulation, and coercion.

Suggesting a systems perspective, Ryan (1997b) stresses the contextual nature of the relationship and interaction in defining behaviour as sexually abusive. Similarly, treatment literature in general indicates that the heterogeneous nature of the problem requires attention to the whole person. Although agreement today remains a problem in distinguishing between children's normal and sexually problematic behaviour, it seems important to reference a continuum of sexual behaviour when assessing sexual behaviour problems in children. Such an endeavour can help to ensure that appropriate terms or labels are used to describe children's diverse sexual behaviour and misbehaviours, as well as to ensure appropriate treatment and risk assessment.

APPENDIX M

Theoretical Explanations for Children with Sexual Behaviour Problems

With the growing recognition that some sexually abusive children and their families require intensive intervention, a number of different theories or models have been proposed as explanations for the development of sexually offending behaviour. Johnson (1988, 1989) in choosing what to describe about her clinical population implicitly acknowledged various hypothesis about the etiology of sexually intrusive behaviour. In any examination of the theoretical literature it is important to remain cognizant that, for the most part, these theories have undergone no systematic empirical validation and prevail chiefly as the opinions of practitioners in the field. Additionally, most models comprise bits and pieces of a number of theories woven together that serve to reflect the multidimensional aspects of children with sexually behaviour problems. Generally speaking, these theories are driven by a trauma based paradigm as is represented by the victimizer-victim understanding and they often assume that the child has been sexually abused.

The National Task Force (1993) set out the most systematic review of treatment theories and issues. This review recognizes that historically many different assumptions have been related to the development and treatment of sexual offending. While the Task Force listed fourteen theories upon which treatment has been based, the first nine of these are influential in the treatment of children with sexual behaviour problems. These theories are presented here as inscribed and cited references are those of the report. The descriptors are simplistic and incomplete and meant to include the Task Force biography for complete references.

1. That deviant arousal patterns develop in response to victimization or as the result of learned behavior and social interactions over time (Abel & Blanchard, l984; Becker & Hunter, 1991; Groth, 1979; Longo, l982).

2. That feelings of powerlessness and lack of control may trigger a sexual assault cycle with identifiable precursors, progressions, and antecedents; that the cycle can be identified and intervention strategies developed to stop it (Lane & Zamora, 1985; Ryan, Lane, Davis, & Isaac, 1987).
3. That sex offences may be the outcome of an antisocial way of looking at life and irrational thinking patterns (Yochelson & Samenow, 1976).
4. That developmental problems may contribute to sexually aggressive behavior leading to a fixated or regressive pattern (Groth, l978; Piaget & Kohlberg).
5. That because there is psychological and physiological reinforcement in sexually aggressive behaviors, it may become an addictive (Carnes, 1983) or compulsive (Freeman-Longo, 1989) disorder.
6. That the sexually abusive behavior may be symptomatic of intrapsychic conflict (Groth, 1977).
7. That masturbation to deviant fantasies may increase the likelihood of sexually deviant behavior (Abel & Blanchard, 1984; Marshall, 1980).
8. That the family and environment are essential influences in the development of sexuality and, therefore, family trauma, physical and sexual abuse, neglect, scapegoating, undefined boundaries between individuals, and exposure to sexually traumatic material in the environment may contribute to the development of sexually abusive behavior (Longo, l982; Steele, 1985).
9. That the offender may have learned a distorted confused view of sexuality.

Current thinking has considered all of these theories, and now incorporates elements of many theories into a multi-modal, multifactorial theoretical model (Task Force, l993). These hypotheses are not incompatible; indeed some can be translated one into the other. Most notable, the dominant treatment model, the abuse cycle (#2), is based on thinking errors (#3); assumes that victimization and inappropriate modeling (#1

and #9) are often the case historically; presumes that a dysfunctional and traumatizing family environment (#8) is generally the facilitating context; and incorporates the remaining theories (developmental delay or arrest, intrapsychic conflict, deviant arousal, and sexual reinforcement) as conditions (Ryan, l989). As mentioned previously, it would be fair to say that few of these hypotheses singly or in combination have been tested rigorously. However, researchers in the field are now addressing an agenda to maintain ongoing systematic information on a number of variables that have been clinically implicated, but never empirically investigated in a controlled fashion (see Bonner et al., l997; Gray et al., l999; Pithers et al., (1998)).

The design of a treatment program for children with sexual behaviour problems will often comprise a theory of etiology and model of treatment that are one and the same. The many relevant treatment issues addressed within treatment models are outlined by the Task Force (1993). These topics are presented here as inscribed with the Task Force citations rather than the author's and are represented using the arrow symbol (i.e.⇒).

⇒ *Cycle:* The sexual abuse cycle (assault cycle, offense cycle) describes the 'process' of sexually offending behaviour. It is used as a framework to understand the interrelationship of situations, thoughts, feelings, and behaviors, which lead up to and follow a sexual assault. The situations which trigger the cycle are identified in order to recognize risk and avoid or react differently; the thinking errors are corrected; feelings are accurately labeled and alternate methods of non-exploitive expression are explored; and behavioral methods such as covert sensitization are used to counter fantasy and planning. The cycle is then applied to other dysfunctional areas which result in violence, substance abuse, self-destructive behaviors, and other negative outcomes, and the offender learns to identify and

interrupt the cycle by: avoiding high risk situations, thinking rationally, expressing feelings without being abusive, etc.[19]

⇒ *History:* The client's psychosocial, familial, sexual, and behavioral history holds many keys to current functioning; the client's view of the world, behaviors, attitudes, self-image, and level of empathy. Early childhood history may reveal a progression of dysfunctional thinking, antisocial behaviors and exploitive patterns. Socialization and development may be impacted by early childhood traumas such as physical or sexual abuse, abandonment, rejection, and/or loss which illuminate the client's sense of self and others, values, relationships, and communication. Family history reveals dysfunctional learning and exploitation, role reversals, and, most important, patterns of denial and minimization. The secrecy of the past must be given up, functioning re-evaluated, issues resolved, and contributing factors addressed to assist the youth in returning to more normative development.

⇒ *Consequences of Sexually Abusive Behavior:* The consequences of abuse include negative impacts on victims, perpetrators, and families in personal, social, psychological, economic, and legal areas. While the legal system imposes its own consequences, personalization of consequences comes from victim empathy and self-esteem building. Covert sensitization addresses the offender's need to consider the negative consequences of abusive behavior as a deterrent to relapse. (See 'Special Techniques' section.) Empathy may be the most effective deterrent to prevent the aggressive behavior associated with sexual arousal to sexually aggressive stimuli (Malamuth, 1986; Deardorff, 1975; Kaplan-Reiss, 1987).[20]

⇒ *Family Dysfunction:* Family dysfunctions revealed in the juvenile's history can undermine the treatment process if left untreated. It is, therefore, important

[19] 'Abuse cycles' can be conceptually difficult for young children; 'linear' metaphors such as 'ladders' or 'stairs' are more effectual in doing cognitive work with children (See Lane, l994).

[20] Empathy is not a developmentally appropriate goal for young children. Awareness of consequences for oneself (i.e., getting into trouble) may be all that is achievable.

(especially for juveniles who are or will be living at home) to identify and address those patterns of family dysfunction which trigger, support, or fail to inhibit offending. Family systems often share the same dynamics as the offenders and support the offending behavior by their denial and resistance to change. Confused role boundaries, power imbalances, distorted attachments, poor communication, sexual issues, and denial and minimization by family members must be confronted. In some cases, family dysfunctions may be a key factor in the development and maintenance of sexually abusive behaviors and family therapy may play an important role in facilitating therapeutic change (Henggler, 1989). It is also sometimes evident that bad things happen in relatively functional families. In such instances, family components may help the family with the crisis of an event, which is dissonant with their prior life experience. In every case, family therapy components and parent groups work to create an environment, which supports the treatment process.

⇒ *Denial and Minimization:* Confrontation is a treatment technique used strategically by the therapist to point out negative, destructive behaviors or to counter minimization or denial in the offender's thinking. Confrontation must be direct, firm, and responsible; and at the same time be supportive, never becoming condescending, humiliating, or derogatory. Confrontation should be framed as an act of caring to aid the offender's understanding of self and should not include shouting [a few members saw value in shouting]. Police reports and victim statements are often used to confront denial and minimization associated with the abusive behavior. Daily reports from the offender and others may be used to confront thinking errors and high-risk behaviors during treatment.

⇒ *Cognitive Distortions:* The irrational or rationalizing thought processes, which support or justify sexual offending are referred to as cognitive distortions or

thinking errors. Cognitive restructuring is used to counter irrational thinking with rational thoughts, which produce the desired internal feeling without exploiting others.

⇒ *Addiction/Compulsion:* Because of the psychological and physiological reinforcements associated with sexual behavior, sexually abusive behaviors can take on a life of their own over time. Treatment addresses the issues of addictive/compulsive patterns of behavior.

⇒ *Positive/Pro-Social Sexuality:* Sexually abusive youth often have not completed their sexual development and if encouraged to develop pro-social relationships and realistic sexual expectations, their tendency to return to deviant behavior is lessened. Sex education and sexual identity issues are addressed in pro-social terms and sexual fantasies are explored and restructured to support positive sexuality. Sexuality must be understood in the context of other development. Information on sexually transmitted disease prevention should be included.

⇒ *Sexual Identity and Gender Issues:* Gender confusion is approached without bias, acknowledging the diversity of our culture. Homophobia and homosexual impulses are explored to resolve confusion and support self-esteem and pro-social thinking.

⇒ *Impulse Control:* Combinations of cognitive approaches and relaxation techniques are used to foster greater tolerance for frustration and delayed gratification and to develop internal controls. Monitoring thoughts, learning problem solving and stress management skills, and taking responsibility for choices and decisions supports the expectation of impulse control. External controls provide temporary restraints until the client consistently demonstrates internal sources of restraint.

⇒ *Developmental Deficits:* Competency based programming addresses developmental deficits. Recognizing the pervasive neglect and disruptions of childhood characteristic of many of these youth, basic developmental tasks are often delayed. Trust, autonomy, and psychosocial competence are necessary elements for successful human functioning.

⇒ *Attachment Disorders:* Abusive relationships are characterized by dysfunctional boundaries, which are often the product of distorted attachments, (i.e., either enmeshed, unattached, sexualized, etc.). Patterns of attachment in relationships are learned in infancy. Therapists model respectful boundaries and connectedness in their own relationships with clients and work within the family system to promote more respectful boundaries and healthy attachments.[21]

⇒ *Skill Deficits and Educational Deficits:* Dating skills, assertiveness training, social skills, communications, problem solving, expression of feelings, anger management, stress management, values clarification, sex-role stereotyping, as well as academic functioning may be addressed in the treatment process or may be covered in specific didactic modules or adjunct services.

Developmental Approach. Many practitioners and writers use developmental theory to identify guidelines for what is considered normal sexual development at various ages (Friedrich, 1990, 1991; Johnson, l990; Ryan, l997b)**.** These guidelines are then used as a yardstick to measure sexual behaviours that deviate from these expectations. However, although most treatment models imply the overall use of the developmental approach, clarity around its implementation is lacking, Besides focusing on stages of normal development patterns, the developmental approach encompasses the notion of disruptions that occur during children's development and how these disruptions help explain sexually intrusive behaviours. Such disruptions are the focus of many

[21] The Provincial Consultation Group (1996, p. 26) stresses the family context and finding of family issues (insecure attachment/boundary issues) that may trigger sexual behaviours.

theories framed in the context of traumatic events that comprise absent or disrupted attachments, sexual abuse, physical abuse, neglect, and emotional abuse. These experiences are viewed as having the potential to change the normally expected physiological, psychological, and sociological developments in children's lives.

William Friedrich (1990) serves as a good example of a practitioner and researcher who uses developmental theory and the accompanying notion of disruptions to guide his practice and research. Friedrich contends that the age at which a disruption occurs must be considered because this is the stating point for determining long-term, developmental consequences. In his view, disruptive events may predispose children to interpersonal difficulties by damaging their parent-child relationships and inhibiting social contact with their peers. In discussing sexual abuse as a disruptive element Friedrich relates it to the way children appraise and respond to stressful situations; how they at various cognitive stages are more or less prone to particular coping styles, among which repression, denial, and increased aggression may be present. Furthermore, this researcher notes that families contribute to all aspects of the child's development; that families themselves go through developmental stages of organization and disorganization, thus making the family an important variable in any analysis of children's behaviours**.** Friedrich further notes that the ability of children to manage critical developmental tasks depends heavily on the security provided by their primary caregivers. He refers to research and clinical observations that have shown that children with insecure attachments have an impaired sense of self, are less communicative of their feelings, and frequently form interpersonal networks that reinforce their poor self-images. In perceiving the role of family in the development of children's sexual behaviour from a theoretical position, Friedrich stresses that the impact of the family is best described as reciprocal such that family characteristics both precede and are influenced by children's sexual behaviour.

Consequently, knowledge of developmental theory is considered fundamental in order to identify sexual behaviour in children that requires intervention. Sexual behaviour needs to be viewed on a continuum from normal to problematic within a developmental framework and assessed with reference to the context in which it occurs, the context in which the child lives, and the social norms appropriate to that context. Furthermore, it is worth reiterating here that the trauma outcome process model is the underpinning of theoretical approach used by the SHIFT program. Please see the section under the SHIFT theoretical framework for an outline of this approach.

Additional theories and practices, some of which have already been mentioned as they apply to the etiology of children with sexual behaviour problems, found in one or both of the reviews of Araji (1997) and Gil (1993) include: PTSD model (Cunningham and MacFarlane, l991, l996); traumagenic dynamics model (Finkelhor and Browne, l985, l988); adaptation perspective and coping theory (Friedrich, l990); four preconditions of abuse model (Araji & Finkelhor, l986; Cunningham & MacFarlane, l991, l996); and the addiction model (Breer, l987; Carnes, l983; Cunningham & MacFarlane, l991, l996).