GROUP TREATMENT OF ADULT WOMEN WHO WERE SEXUALLY VICTIMIZED IN CHILDHOOD

BY

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MARY JANE McCALLUM

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

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Acknowledgments

> Originality is nothing but judicious imitation. The most original writers borrowed from one another. The instruction we find in books is like fire. We fetch it from our neighbors, kindle it at home, communicate it to others and it becomes the property of all.
>
> Voltaire

There are many from whom I have had the privilege of borrowing their knowledge and experience and who have willingly offered their instruction, guidance, and support. For this, I would particularly like to thank the members of my committee. Derek Jehu, my advisor, provided a stimulating environment in which to observe and practice the art of clinical research. His wholehearted personal support is appreciated and valued. Marjorie Gazan volunteered her time and expertise to act as my co-facilitator for the therapy group which not only gave me moral support but allowed me to experience working alongside a very highly skilled clinician. Her belief in my ability to carry out this practicum has been beneficial to its completion. Kathryn McCannell encouraged and enriched my pursuit of the graduate program in Social Work. Her example and instruction has helped me to gain a greater understanding of how women view and experience their world.

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Introduction

The pervasiveness of child sexual abuse is no longer a secret. Frequent and often sensational reports in the media have alerted the public to this problem. Recently an exhaustive study detailing sexual offences against children and youth in Canada (Badgley, Allard, McCormick, Proudfoot, Fortin, Olgivie, Rae-Grant, Gelinas, Pepin, Sutherland, 1984) found that 34% of female children and 13% of male children in Canada are victims of child sexual abuse. Although this study used a broad definition of sexual abuse, these figures are nevertheless staggering. More conservative estimates of prevalence rates that report 15% of female and 6% of male children suffer sexual victimizations (Finkelhor, 1984) are also alarming.

Increasing numbers of child sexual abuse cases began to surface in the 1970's. Since then social scientists have attempted to determine the full extent of the problem and to shed some light on the prevalence, causes, and consequences. With each new finding, old myths are shattered. For example, the notion that perpetrators of child sexual abuse are strangers to their victims has proven false. The majority of child victims are abused within the context of their families or other close relationships and societal taboos against intrafamilial sexual abuse only serve to maintain the secret, not to prevent the behavior. Another shattered myth, that only female children are

sexually abused, results from increasing disclosures by male victims. This raises speculation as to whether or not the consequences are the same for both sexes. The answers to these sorts of questions are important for the development of successful intervention strategies.

One assumption about child sexual abuse that has been supported by recent studies is that the offenders are almost always males (Finkelhor, 1984; Russell, 1983).

Until the recent flood of disclosures, child sexual abuse was thought to be relatively rare (Finkelhor, 1986, Chap. 1) as the subject has always been surrounded by secrecy and taboos. But the sexual victimization of children is not rare and its presence is longstanding. Florence Rush (1980), in her landmark exposé The Best Kept Secret: Sexual Abuse of Children, gives an excellent historical perspective by tracing sexual victimization of children back to the Bible and Talmud and demonstrates how sexual abuse of children has been largely condoned by past and present societies. Even though it has existed throughout history and in all cultures, whether or not the behaviors were defined as abuse depended on societal values at the time (Mrazek, 1981). Reasons for the present intense focus on child sexual abuse are not altogether clear. Certainly individuals such as Sandra Butler in Conspiracy of Silence (1978), Florence Rush (1980) mentioned above, and Louise Armstrong's personal account in Kiss Daddy Goodnight: A

Speak-Out on Incest (1978) can be credited with stimulating action by professionals and policymakers to deal with all forms of child abuse. But the exposure of powerless individuals such as children and women could only have taken place in a social climate that was capable of responding adaptatively. In this regard, many believe that the women's movement in its overall efforts to understand and change the male/female power imbalances and sex role socialization processes in our present society can be credited with the emerging recognition that child sexual abuse is a legacy of our patriarchal social structure with negative implications at both the societal and individual level. Susan Brownmillar (1975) in Against Our Will summarizes the political and societal nature of child sexual abuse:

> The unholy silence that shrouds the intra-family sexual abuse of children and prevents its realistic appraisal is rooted in the same patriarchal philosophy of sexual private property that shaped and determined the historic male attitude towards rape. For if woman was man's corporal property, then children were and are a wholly owned subsidiary (p. 281).

Escalating numbers of disclosures by child sexual abuse victims, including children who are presently being abused and adults who suffered abuse in their childhood, have placed impossible demands on the resources available to deal with the disclosures and consequences. Children and adults who have been

encouraged to disclose their abuse and seek help often meet with the reality of long waiting periods for help from too few resources. Policymakers struggle to determine just where in the abuse cycle intervention and prevention resources should be placed. Many valid choices for intervention exist, such as treatment of the child victims and/or their families, treatment of offenders, or treatment of adult victims.

The focus of this practicum is the development, implementation and evaluation of a group treatment program that addresses the needs of adult women who were sexually abused in childhood. This victim population is often overlooked in the allocation of treatment resources as the system attempts to direct it's attention to the immediate crises of child victims. As outlined in the following review of the literature, the long-term consequences of child sexual abuse are often counter-productive and even destructive forces in the lives of adult women victims thus underlining the importance of allocating attention and resources to this client group.

Another purpose of this practicum report is to fulfill in part the requirements for the Master of Social Work degree. Several educational benefits ensue from undertaking the task of developing, implementing and evaluating a treatment program for adult women who were sexually abused in childhood. First, the student's knowledge and understanding of the many aspects of child

sexual abuse is increased by reviewing the relevant literature. Becoming familiar with the literature also allows the student to discover some of the missing pieces in the present state of knowledge about child sexual abuse and to determine a particular area of study on which to focus.

Developing the intervention program adds to research skills and implementing the therapeutic intervention enhances clinical skills in general, and in this case, group therapy skills in particular. By evaluating the intervention the student has the opportunity to determine whether or not the research design was effective in yielding the desired information and if the treatment program was effective in resolving the stated problems. In addition, this exercise allows the student to see what changes should be made to the overall implementation of the program in the future. Finally, the student can in some way add to the general knowledge base by demonstrating further support or non-support for current theories on the treatment of the long term consequences of child sexual abuse.

Literature Review

Definition and Prevalence

One of the problems facing researchers is the definition of child sexual abuse. Technicalities such as age limits, nature of the relationship between adult abuser and child victim, presence or absence of certain sexual activities, duration, and severity of consequences make it difficult to arrive at a definition that is satisfactory to all. For example, some of the confusion stems from the term "incest" which by the legal definition requires the presence of genital intercourse between blood relatives prohibited from marrying. Increasingly this definition is seen as too narrow and insufficient to characterize the full concept of sexual abuse. However, the term "incest" and "child sexual abuse" are often used interchangeably in the literature, while they may not always mean the same thing.

Sandra Butler (1978) does not limit her definition of incest to sexual intercourse. She includes "...any sexual activity or experience imposed on a child which results in emotional, physical or sexual trauma. The forms of incestuous assault are diverse, the acts are not always genital and the experience not always a physical one" (p. 5). Rather than focusing specifically on sexual intercourse child sexual abuse may be interpreted as ranging from exhibitionism to genital manipulation, to intercourse, to child pornography (Mrazek, 1981). Some authors place sexual abuse on a continuum with overt sexual contact being

only an extreme end. Naida Hyde (1986) refers to covert incest, abuse without actual physical sexual contact, as a point on this continuum which represents the coersion, control, domination and subjugation of female children by male offenders. In a chapter on "seductive fathers" Herman (1981) also describes this form of covert incest.

In addition to presence or absence of overt sexual behaviors, another important element in the definition of child sexual abuse is the relationship of the offender to the child. Finkelhor (1986) holds that the two essential criteria for determining abuse are (1) forced or coerced sexual behavior imposed upon a child, and (2) sexual behavior between and an older person in a caretaking role. What become the important issues then are the misuse of adult authority over a powerless child, a breach of normal childhood trust in adults, and the emotional incapability of a child to give informed consent to sexual relations with an adult.

The dimension of the problem of child sexual abuse has been difficult to determine. Reliable studies were rare, and only recently researchers have begun to collect data on the extent to which abuse occurs. Part of the difficulty in collecting reliable figures is the longstanding secret nature of child sexual abuse: "There is certainly good reason to believe that many or most cases of incest are never reported to any social authority, least of all

the police, but are kept as skeletons in the family closet" (Meiselman, 1978, p. 29). When reports are taken from clinical populations, much depends on the willingness of the clinician to consider the possibility of its presence (Swanson & Biaggio, 1985). As mentioned previously, definitions vary widely and terminologies are often confusing.

Finkelhor (1986) makes an important distinction between incidence studies, that is the number of new cases occuring within a given time period, and prevalence studies, the proportion of a population that has been sexually abused in childhood.

Early researchers believed in the rarity of child sexual abuse in families. For example Weinberg (1955) suggested it was a one-in-a-million phenomenon while Kroth (1979) rated the occurrence of child sexual abuse at one in ten thousand. Burgess, Growth, Holmstrom, and Sgroi (1978) however believe that this type of abuse has been severely underestimated and that it actually occurs in one out of every ten families. An often cited research study into prevalence rates of child sexual abuse is that of Finkelhor (1979) who reported that 19% of females and 9% of males had had sexual experiences with older partners prior to age 17. The subjects were male and female college students. In a later study involving a random sample of males and females in Boston, Finkelhor (1984) found that 15% of females and 6% of males had sexual experiences with older partners prior to age 17. Russell

(1983) reports that 54% of a random sample of San Francisco women experienced intrafamilial and extrafamilial sexual abuse, including non contact, prior to the age of 18 years of age. A study of prevalence rates in Great Britain (Baker, 1985) indicated that 10% of adults in a nationally representative sample had been sexually abused before the age of 16.

The reality, as Finkelhor (1986, Chap. 1) points out, is that since 1980 the number of prevalence studies has increased dramatically and the results are often conflicting: "Reported rates range from 6% to 62% for females and from 3% to 31% for males. The lower rates indicate that child sexual abuse is far from an uncommon experience, the higher reported rates would point to a problem of epidemic proportions" (p. 19).

Researchers speculating on the reasons for the dramatic rise in the reporting of sexual abuse incidence rates are hard pressed to determine if there has indeed been an actual increase of abuse or merely an increase in the reporting of child sexual abuse. Many authors believe that it has always been there in large numbers (Rush, 1980) but that changes in social conditions (e.g. sexual norms, female role expectations, family forms) and changes in definitions of child sexual abuse are contributing to these increases in reports. Although still met with shock, horror, and disgust in many quarters, increased public awareness of the reality and extent of child sexual abuse creates a safer

environment for victims, both past and present, to disclose their secret. Human service professionals increasingly recognize the presence of sexual victimization in the histories of their adult clients and need to understand the effects of this victimization on these women and men. Indeed, in Baker's (1985) study, 51% of abuse victims subjectively reported feeling harmed by the experience. Sandra Butler (1978) succinctly states why it is so important to deal with child sexual abuse and its effects:

> Whatever form the assault takes, the scarring of the child can be deep and lasting. Unlike physical abuse, the damage cannot always be seen but the scars are there nonetheless. The most devastating result of the imposition of adult sexuality upon a child unable to determine the appropriateness of his or her response is the irretrievable loss of the child's inviolability and trust in the adults in his or her life (p. 5).

Long Term Consequences

Current literature on child sexual abuse leaves little doubt that victims suffer a range of long term psychological effects from the abuse well into adult life and that many require professional intervention to deal with them (Briere, 1984; Finkelhor, 1986; Gelinas, 1983; Herman, 1981; Jehn, Gazan & Klassen, 1984/5; Meiselman, 1978). However, not all psychosocial problems experienced by an adult victim of child sexual abuse can

be directly attributed to that experience, nor do all victims suffer negative long term effects. Meiselman (1978), for example, stresses the importance of not labelling the abuse trauma as a cause and effect relationship. There may have been other contributory factors in the victim's history that account for present difficulties. These could include "disruption of family of origin, insensitive handling of the abuse by parents, police, courts, and social agencies, a self destructive lifestyle and exploitative relationships with partners" (Jehu, Gazan & Klassen, 1984/5).

Another consideration is whether or not the severity of the abusive experience is positively correlated to the severity of later symptomatology. It does not seem that severity per se of the abuse is a predictor as much depends upon the psychological makeup of the victim as well as pre-abuse and post-abuse experiences. For example, if a child's disclosure of abuse was met with belief and protection this could effect a positive outcome as trust is restored. Or, as Briere (1984) points out "the relative presence of absence of a specific abusive incident or incidents may be of less overall significance than the child's global experience of violation, exploitation, and powerlessness during her early years" (p. 10). According to Summit (1983) disbelief and lack of protection on the part of the adult caretakers are the factors that lead to an increase in

helplessness, hopelessness, isolation and self blame that are the most damaging aspects of child sexual victimization as these ultimately lead to the guilt, self-hate and rage that victims carry with them into adulthood. "Victims looking back are usually more embittered toward those who rejected their pleas than toward the one who initiated the sexual experiences" (Summit, 1983, p. 178).

Unless the trauma of sexual victimization is dealt with properly in her childhood, the victim's vulnerability to later negative consequences is increased. This is not to say that negative consequences are guaranteed as some victims manage to deal with the abuse on their own thus avoiding painful consequences or they simply psychologically bury the experience. Gelinas (1983) argues that the negative consequences of child sexual abuse have a certain "time-bomb" quality and a delayed reaction may be brought about by some sort of trigger. Often these triggers are related to developmental occurrences that contain elements of or structural similarity to the traumatic situation; such as marriage and/or the initiation of a sexual relationship where intimacy and trust, which have been violated in the past, become issues. Another example of a developmental trigger is the birth of a child which could highlight the intergenerational risk of incest occurring.

Until more information becomes available concerning the long term consequences of child sexual abuse for male victims, the knowledge gained from clinical reports pertains to the consequences for adult female victims.

Many victims in clinical populations do not identify child sexual abuse as a source of their problems. Possibly, many are unaware of this as they may have blocked memory of the trauma or alternatively do not attribute present difficulties to a past event. Courtois and Watts (1982) suggest that some victims will be afraid to disclose their sexually abusive experience fearing rejection and a judgmental reaction. It therefore becomes important for mental health professionals to familiarize themselves with symptoms and presenting complaints that could indicate a history of child sexual abuse.

Mood Disturbances

Negative long term consequences related to feelings about self are almost universally reported by victims. In a series of 51 women treated for long term effects of childhood sexual victimization, Jehu, McCallum, Klassen & Gazan (1987) found that 92% of the clients presented with some sort of mood disturbance, 47 (92%) had clinically significant levels of low self esteem, 45 (88%) suffered from feelings of guilt, and 36 (70%) were clinically depressed.

Low self esteem. Feelings of worthlessness, of being different and set apart from other people, and of not being normal are common complaints of sexual abuse victims (Herman, 1981). Abused children internalize messages that they must somehow be worthless and bad persons who do not deserve protection. This inability to form a positive self identity is carried through to adulthood. According to Herman: "Many women felt that what set them apart from others was their own evilness. With depressing regularity, these women referred to themselves as bitches, witches, and whores. The incest secret formed the core of their identity" (p. 97).

Low self esteem was documented by Jehu, Klassen and Gazan (1987a) who reported that on a Belief Inventory 39 (78%) of 50 female abuse victims answered partly, mostly, or absolutely true to the statement "I am worthless and bad." Similar responses were given by 45 (88%) of 50 victims to the statement "I must have been an extremely rare woman to have experienced sex with an older person when I was a child" and by 45 (90%) of 50 victims to the statement "I am inferior to other people because I did not have normal experiences." In this study 24 (80%) of 27 victims and 22 (91%) of 30 victims had clinically significant levels of low self esteem as measured by the Battle Self Esteem Inventory (1981) and the Hudson Index of Self Esteem (1982) respectively.

The pervasiveness of feelings of worthlessness, isolation and stigmatization is supported by other empirical studies such as that of Courtois (1979) in which 87% of a community sample reported that their sense of self had been moderately to severely affected by their experience of sexual abuse by a family member. Herman (1981) found that in a clinical sample of incest victims 60% had a predominantly negative self-image.

Guilt. The feelings of worthlessness just described are associated with and stem from victim's feelings of guilt about their abuse. This misattribution of blame is often caused by the victim's belief that because as a child they reacted with passive compliance, kept the secret, or experienced emotional and/or physical pleasure from the sexual abuse, they must have wanted the abuse to happen, when in fact they were responding to adult authority and a desire for the nurturance that abuse victims so often lack.

Feelings of guilt associated with compliance are demonstrated by the response of partly, mostly, or absolutely true to the Belief Inventory statement "I must have permitted sex to happen because I wasn't forced into it" by 42 (84%) of 50 victims (Jehu, Klassen & Gazan, 1987a). A similar rate of response was found for a statement regarding secrecy. Forty-three (86%) of 50 victims felt that "I must have been responsible for the sex because it went on so long."

Belief in their own childhood seductiveness very often leads to an assumption of guilt by sexual abuse victims and cultural messages reinforce this erroneous belief. As Herman (1981) points out "The Modern American version of the Seductive Daughter is familiar to everyone. She has been immortalized in the popular literature as Lolita" (p. 37). Belief Inventory responses of partly, mostly, or absolutely true were given by 31 (62%) of 50 victims to the statement "I must have been seductive and provocative when I was young" (Jehu, Klassen & Gazan, 1987a).

With regard to the question of blame, Herman (1981) states: "Children do have sexual feelings and do seek out affection and attention from adults. Out of these undeniable realities, the male fantasy of the seductive father is created. But...it is the adult, not the child, who determines the sexual nature of the encounter, and who bears the responsibility for it" (p. 42).

Depression. Finkelhor (1986, Chap. 5) comments that in the clinical literature depression is the most commonly reported symptom of adults sexually abused as children and that this is confirmed by empirical findings. Although causes of depression are complex, it is often associated with some sort of major loss. For the sexual abuse victim the losses are many: the loss of childhood innocence, the loss of a nurturing and protective family that is every child's right, the loss of a sense of control over one's environment, and the loss of self worth.

Herman (1981) reports that in a sample of 40 father-daughter incest victims 60% suffered from major depressive symptoms. Sexual abuse victims were more likely to be experiencing depressive symptoms than non abused subjects in a study by Briere and Runtz (1985). Meiselman (1978) also found significant levels of depression (48%) in a psychotherapy sample of incest victims but found a similar rate of depression in a psychotherapy control group of non-abused women. According to Gelinas (1983), when the effects of child sexual abuse are untreated "the most frequent secondary elaboration is chronic depression, accompanied by guilt, poor self esteem and feelings of powerlessness. Learned helplessness may be evident and suicidal ideation and attempts are not uncommon" (p. 317). A high incidence of suicide attempts among victims of child sexual abuse has been found by clinical researchers (Finkelhor, 1986, Chap. 5). Briere (1984) reports that 51% of abuse victims had attempted suicide, versus 34% of non abused clients, in an extensive study of 153 walk-ins to a community health centre.

Interpersonal Problems

An inability to form healthy interpersonal relationships is often the legacy of child sexual abuse. The victim, unable to trust other people, becomes set apart and isolated. Feelings of shame surrounding the abuse secret make it difficult to enter into close relationships for fear of rejection. The element of trust

ideally forms the basis of all healthy relationships, but for the victim of child sexual abuse, that trust has been violated in a very fundamental way, that is, by his or her family of origin, which by its dysfunctional structure, set the stage for abuse to occur and could not provide protection. The outstanding long term effect according to Gelinas (1983) is that of "relational imbalances" brought about by the exploitive relationships that typically exist in families where child sexual abuse occurs. Even if the abuse was not by a family member, the imbalances account for creating an environment in which a child is unprotected and therefore vulnerable to victimization. One important relational imbalance is role reversals whereby a child becomes "parentified" and takes on adult responsibilities in the family. If a child never experiences healthy relationships within her family of origin, and if she also experiences sexual abuse, she is likely to end up in adult relationships that are also imbalanced and in which she may also be exploited and abused simply because this has been her only experience of the nature of intimate relationships. Often treatment is sought, in adulthood, for the consequences of these relational imbalances rather than specifically for the sexual abuse. Gelinas sums up the effects of these imbalances as (1) missed benefits of childhood (e.g. development of self-system, social skills, personal talents), (2) impaired self esteem as a result of being taught by their families that they have no rights

to have their needs met, (3) feelings of guilt for somehow causing their victimization, which are in part an expression of their loyalty and parentification, (4) difficulty in interpersonal relationships, (5) parenting problems, and (6) continued exploitation by the family of origin that persists into the victim's adulthood.

Problems with interpersonal relationships were universal in a study by Jehu et al (1987b) of 51 women sexually abused in childhood. General social relationships for these women were characterized by feelings of difference, insecurity, mistrust and isolation/alienation which are often exacerbated by limited social skills. For example "isolation may be maintained by communication difficulties, insecurity may persist because the victim is unable to handle stress or be assertive, and discord may continue because the necessary problem solving skills are lacking" (Jehu, Gazan & Klassen, 1987b, p. 13). Women with a history of child sexual abuse frequently report problems in relationships with men. Some fear getting involved in intimate relationships with men since their experience of intimate relationships is one of pain and exploitation. On the other hand, many victims oversexualize relationships with men, having learned this style of relating from an early age. In the Jehu et al (1987b) study, 46 (90%) of women had problems in their relations with men and of those who were married or living as married, 100% had problems in relations with

their partners, including discord, oppression and physical abuse. It seems that these women are more vulnerable than non abused women to revictimization and continued exploitation in their adult relationships, especially those with men. Forty-nine % of victims in Briere's (1984) study had experienced battering in adult relationships compared to 17% of non-victims. Herman's (1981) study similarly reports on difficulties sexually abused women experience in relationships with men. Due to feelings of their own low self worth, these women tend to choose partners that they themselves do not respect and who in turn do not respect them. This often results in an abusive relationship from which the woman feels she cannot escape and which she thinks she deserves. As one woman said: "I see a clear and definite relationship between my incestuous relationship and my need to punish myself by staying with a man who is such a drain on my life" (Herman, 1981, p. 101). The fact that these women do remain in these abusive relationships with men confirms feelings of helplessness, hopelessness, and powerlessness that recapitulates the sexually abusive relationship of their childhood.

The majority of incest victims tend to overvalue and idealize men (Herman, 1981; Jehu et al, 1987b,) while anger and hostility is commonly directed at women. Problems in relating with women stems from the view that sexually abused women have of themselves and other women as weak and useless. This hostility is

particularly directed at mothers for their inability to offer protection from the abuse. According to Herman (1981) this hostility and lack of trust prevents the development of supportive female relationships generally but also masks a deeper longing for a relationship with a caring woman.

Other relationship difficulties often surface for those sexually abused women who are mothers. Not only do these women fear that they will be, as they felt their own mothers had been, bad mothers, but they also fear that they will not be able to protect their own children, specifically daughters, from sexual abuse (Herman, 1981). Never having experienced role models for positive parenting, these women may also abuse their children or experience severe parenting problems. In a study of child abusing families, Goodwin, McCarthy and Di Vasto (1981) found that 24% of mothers reported incest experiences in their childhoods. These authors suggest that since closeness and affection were endowed with sexual meaning for these mothers, they therefore maintained an emotional and physical distance from their children, thus increasing the potential for abuse. Jehu et al (1987b) found that 22 (70%) of 31 victims with children reported that they had physically abused their children in the past and 6 (19%) said that they were doing so at the time of initial assessment for therapy.

Sexual Dysfunctions

Given the very nature of the trauma of child sexual abuse, it

is not surprising that victims often suffer from some sort of sexual dysfunction in adulthood. Finkelhor (1986, Chap. 1) comments that the effects of child sexual abuse on later sexual functioning has received much attention in the empirical literature with all clinically based studies showing sexual problems among child sexual abuse victims. The highest percentage (87%) of victims reporting problems with sexual adjustment was found in Meiselman's (1978) sample of 58 incest victims compared to a control group rate of 20%. A somewhat lower percentage (45%) of women reported sexual problems in Briere's (1984) study. The control gorup rate was 15%. Of the 51 women in the Jehu, Klassen & Gazan (1987b) study over three quarters (78%) reported some form of sexual dysfunction with negative reactions to sex such as phobic responses, aversive reactions, and dissatisfaction predominating.

Over half (55%) of Herman's (1981) 40 father-daughter incest victims complained of impairments in sexual enjoyment: "Many of the informants reported that their pleasure in sex was minimal or even entirely absent. The memory of incest was intrusive and often paralyzing. Some women complained of disturbing "flashbacks," or memories of the incestuous sexual acts, in the midst of their lovemaking...Others so thoroughly associated sex with the feeling of being dominated and controlled that they were unable to relax" (p. 105).

Stress Disorders

Symptoms of anxiety and tension are often experienced by adult victims of child sexual abuse. As reported by Jehu, Gazan & Klassen (1987c) these symptoms can include anxiety and phobias, dissociation/depersonalization/derealization, sleep disturbances/nightmares, and obsessions/compulsions. At least one of these problems was experienced by 44 (86%) of the 51 women in their study, mainly anxiety reactions and dissociative phenomena.

Gelinas (1983) describes these long term stress disorders as chronic traumatic neurosis which result from the use of dissociation as a defense against the trauma of the abuse:

> Former victims have related their conscious efforts to induce some type of dissociative defense while the incest was occurring. Most commonly they would attempt to become "part of the wall" or to "float near the ceiling and look at what was happening"...Other patients induced hypnotic anesthesia experiences...In incest victims who consciously use dissociative phenomena in the service of defense, the tendency towards dissociation under stress continues after cessation of incest, often showing up in the presenting picture as "confusion," or as dissociative behavior erroneously interpreted as psychotic. This tendency toward marked dissociation obviously raises questions about a

possible link between childhood incest and later multiple personality disorders (p. 316).

Briere's (1984) study compared adult female victims of child sexual abuse with a control group of clinically distressed non abused women. His findings led to a conclusion that the abused women presented with a specific pattern of symptomatology characterized by multiple dissociative experiences, anger, self-mutilation and self-destructiveness, substance abuse, and alterations in sexual functioning. Briere labels this pattern of symptomatology as a "Post Sexual Abuse Trauma."

A great many behavioral and emotional problems related to a history of sexual abuse can be found in the clinical literature and these findings are being confirmed by an ever increasing number of empirical studies. Finkelhor (1986, pp. 186, 187) attempts to make sense of this long list of negative effects by organizing them into a comprehensive series of four categories which he calls the "Traumatic Dynamics of the Impact of Child Sexual Abuse." The four categories are (1) traumatic sexualization, (2) stigmatization, (3) betrayal, and (4) powerlessness. The author shows the dynamics involved in each of these categories, the psychological impact on the victim and the behavioral manifestations of the traumatic impact. For example, one dynamic of betrayal is the violation of the expectation that others will provide care and protection, and the psychological

impact is one of grief and depression and/or an inability to judge trustworthiness in others. The behavioral manifestations could include, among others, a vulnerability to subsequent abuse and exploitation. The guilt, shame, lowered self esteem, and sense of differentness from others which are so common to child sexual abuse victims are seen as the psychological impact of stigmatization according to Finkelhor's system.

Interventions

A range of treatment interventions for child sexual abuse is described in the literature and the types of interventions include treatment of the entire family where incest occurred, group and individual treatment of children, adult victims, offenders, and mothers of child victims.

One such program entitled "A Comprehensive Child Sexual Abuse Treatment Program" (Giaretto, 1981) offers treatment to sexually abused children and their families and includes the three components of professionals, volunteers, and self help groups. The basic philosophy is that all three components work together to generate a humanistic community-rooted climate in which abused children, perpetrators and other family members are supported during the crisis period and go on to learn the attitudes and skills needed to lead self-fulfilling lives with social responsibility. The emphasis in this program is the supportive healing of the family.

Patricia Phelan (1987) describes a program for families where incest has occurred. Counsellors and "veteran" families create an educational curriculum intended to eliminate confusion, explain what has happened and articulate who is responsible and why. The goal is to impact new knowledge in order to socialize families to adopt the values and norms of the community so that incestuous behavior will be altered.

Other programs differ in their philosophy in that the main goal of intervention is to protect the child from further abuse which usually requires separating the child from the offender until he has received adequate treatment. For example the program at Harborview Medical Centre in Seattle focuses on meeting the long term needs of victims by providing extensive supportive assistance to the child victim as well as to the non-offending parent (Wachtel & Lawton-Speert, 1983). Sgroi and Dana (1982) found that mothers of incest victims tend to be so needy as to require multiple treatment modalities. For this client group, individual therapy was seen as necessary before progressing to group, couples, or family therapy.

Group therapy for adolescent victims is particularly relevant as group affiliation is a normal developmental stage of adolescence. Needs for peer identity, acceptance, approval, and conformity can be met with the group modality (Blick & Porter, 1982).

A long term study on treating the effects of child sexual abuse was undertaken by Jehu et al (1987a) at the University of Manitoba. Fifty one female victims commenced treatment in individual therapy which initially focussed on the mood disturbances of guilt, low self esteem, and depression. Some of these women found it helpful to have their husbands or partners attend therapy sessions with them. Following treatment of mood disturbances, many victims elected to continue treatment within this study for other difficulties such as marital problems, sexual dysfunction, non-assertive behavior, and problems in interpersonal relationships. Jehu and his associates demonstrated a significant reduction in the mood disturbances of this client group, determined by the use of several standardized instruments. Measures were taken at assessment, termination and follow up to determine the efficacy of the treatment program.

Group Treatment for Adult Women

Group treatment of adult women suffering the effects of child sexual abuse is especially appropriate for dealing with the feelings of isolation and stigmatization experienced by these women. A great variety exists in types of groups described in the literature. Some groups focus on specific therapeutic techniques or clinical issues and are led by trained therapists while other groups can be categorized as self-help in nature. Still other groups, described as feminist or consciousness raising, target the

political nature of sexual victimization of children, focusing on the powerlessness of women and children in a patriarchal society.

Several pioneering therapy groups for women sexually molested as children were conducted at University of Washington in Seattle (Tsai & Wagner, 1978). Each group consisted of 4 to 6 members and met for a total 4 weekly sessions. Minimal screening for entry to the group was conducted. Alleviation of sexual guilt and shame, and clarification of emotional and behavioral consequences of molestation were the stated goals of the group. Clinical findings included feelings of guilt and depression, negative self image, and problems in interpersonal relationships associated with an underlying mistrust of men, inadequate social skills and difficulties in sexual functioning. Evaluation by means of a 6 month follow up questionnaire showed that the participants viewed the groups as helpful, had reduced feelings of guilt, and an improvement in interpersonal relationships. Overall, the value of the group experience centered around "being able to share feelings with other women who have gone through similar experiences and could truly understand" (p. 425).

Herman and Schatzow (1984) report on a series of time-limited therapy groups for women with a history of incest. Groups consisted of 5-6 members who attended 10 weekly sessions which focused on resolving the issues of secrecy, shame, and isolation. An important feature of these groups was the condition that each

participant have the on-going support of individual therapy throughout the life of the group. Seventy-three percent of participants returned 6-month evaluation questionnaires and subjectively reported that contact with other victims was the most helpful thing about the group. Additionally, participants reported improved self esteem as the most consistent change six months after termination.

Another model for short-term structured groups for adult female victims of childhood incest (Gordy, 1983) also required that participants have access to individual therapists, mainly prior to the commencement of the group and following termination, in order for each woman to discuss with a trusted counsellor her own individual reactions to the group process. For the participants, the outcome of the group process resulted in decreased social isolation, increased self-esteem, lessened guilt and shame, and insight into how to control their individual lives, gained through the support and understanding of members. An evaluation questionnaire was administered at termination to assure increased accountability to funders.

Using a structured approach with 3 definable stages, Goodman & Nowak-Scibelli (1985) present a model for group treatment for women incestuously abused as children. Prior to the commencement of the 12 weekly sessions, a detailed history of the victimization is obtained along with an assessment of the woman's current life

situation. One purpose of these procedures is to eliminate women who are actively psychotic, suicidal, or in markedly unstable life situations. Three important assumptions form the basis of the treatment approach: (1) in any situation involving sexual contact with a child, the adult is responsible, (2) offenders should be held accountable, but without scapegoating, and (3) the victim has feelings of loyalty toward her family of origin. Specific goals are stated and emphasis is placed on disclosing the details of the incest in a safe environment during the middle phase for the purpose of allowing underlying affect to surface. These authors specify that the type of individual best suited to this group model is a woman who is psychologically minded and has been in individual treatment before the group, as well as having at least one stable interpersonal relationship and some success in work or school. Participants subjectively report that "for the first time in their lives they experienced a true sense of identification and belonging" (p. 544). Pre and post group questionnaires to measure particular changes are presently being developed.

Faria & Belohlavek (1984) outline specific therapeutic goals and treatment approaches for group treatment of female adult survivors of childhood incest. Some of the goals refer to group process issues such as commitment and building a working relationship while others are directed at clinical issues, for example building self esteem, constructive expression of anger,

identifying and gaining control over self-destructive and self-defeating behavior, releasing guilt, and so on. Intervention strategies include cognitive therapy to correct distortions in thinking (e.g. guilt), and gestalt therapy and psychodrama for uncovering feelings. These authors do not report any formal evaluation of this group treatment program.

The frame of reference adopted by Deighton and McPeek (1985) for their therapy groups for adult victims of child sexual abuse is grounded in family therapy theory, particularly that of Murray Bowen and James Framo which focuses on family-of-origin issues in the treatment of young adults. In this regard, the group treatment emphasizes certain issues such as (1) issues dealing with feelings of isolation that maintain the client's victim status, (2) issues facilitating the client's understanding of the generational problems in child sexual abuse, and (3) issues dealing with the client's position in and emotional cutoff from the family of origin as a means of mastering adult relationships" (p. 406). This group differs from some of the others described in that the duration of the group is much longer, typically 30 weekly sessions. As participants frequently report difficulties in their adult relationships with males, a male-female co-therapy team leads these groups. Most other group treatment models favor female co-therapists as male therapists may be too threatening to victimized women (Cole, 1985).

The operational premise for Deighton and McPeek's (1985) groups is that dealing with emotional reactivity in family of origin contacts is the key to resolving the guilt and anger left over from incestuous childhood experiences. Success of the group is evaluated in terms of increased contacts with family-of-origin, and improvement in relationships with extended family members, marital partners, and children.

A treatment program that focuses on the entire family is conducted at the Center Against Sexual Assault (Fowler, Burns & Roehl, 1983). Besides groups for adult incest victims, three other types of groups are conducted for families of incest victims, offenders, and child victims. The adult victims groups led by a male-female co-therapy team, consist of 15 weekly sessions and are somewhat larger than most other groups of this type, with 8 to 10 participants. A structured format is used to cover specified clinical issues such as family rules and roles, shame, secrets, sexuality, new survival skills, and finding joy. No quantitative evaluation is reported. Success is measured by the individual's ability to leave the controlled group setting and establish relationships, or "mainstream."

Very few groups for adult victims of child sexual abuse focus on skill development per se. One such group conducted by Schwab, Jehu and Gazan (1987) concentrated on the development of assertiveness in female victims. The importance of assertiveness

training is based on the fact that a very large percentage of women report difficulties in interpersonal relationships (Jehu et al, 1987b) due in part to social skills deficits such as non-assertive behavior. One conclusion reached following this group intervention was that these women did not necessarily lack the knowledge of or ability to perform assertive behaviors, but lacked confidence in their right to be assertive. Evaluation of this group measured improvements in targeted assertive behaviors which is likely to raise self esteem and the quality of their interpersonal relationships thus reducing the risk of re-victimization in adult relationships.

Limitations

The foregoing discussion of therapy groups for sexually abused women attests to their value, especially for dealing with certain issues such as isolation, guilt, stigmatization, and an understanding of the dynamics of child sexual abuse. Like all treatment interventions, such groups also have limitations. The victim who has never or only recently disclosed her abuse might find doing so in a group setting far too threatening. She may need to develop a trusting relationship with an individual therapist before entering a group. Several authors recommend that women in therapy groups for incest also have access to individual therapists (Gordy, 1983; Goodman & Nowak-Scibelli, 1986; Herman & Schatzow, 1984).

Groups of this nature tend to be short-term which can facilitate the work of the group in one sense, but may also uncover intense emotions such as anger without sufficient time to deal with them appropriately. Tsai and Wagner (1978) reported that a number of women experienced much more anger at the offender following group therapy. Because groups cannot possibly deal with all the issues of each participant, a need for further therapy in either individual, couple, or group format is often indicated. Although a follow-up survey of 15 women who completed short-term groups showed its effectiveness in resolving issues of shame, secrecy and stigmatization, similar improvements were not shown for interpersonal relationships and sexual difficulties (Herman & Schatzow, 1984). Individual or couple therapy would be more effective than groups for the resolution of sexual problems, and it may be that improvements in interpersonal functioning will not be apparent until quite some time after the short-term group ends.

Evaluation of Group Interventions

The majority of reports in the literature on group treatment of adult victims of sexual abuse have described groups for female victims. This is understandable since most of the adult disclosures are by women, even though recent findings (Finkelhor, 1986) indicate a large percentage of males have also been victimized as children.

Some feminist authors argue that women's group which incorporate the characteristics of consciousness raising into traditional group treatment are effective in the resolution of clinical issues such as those resulting from the long-term effects of child sexual abuse or to counteract harmful sex-role socialization (Gottlieb, Burden, McCormick & Nicarthy, 1983). From Walker's (1981) point of view, womens groups differ on structure, goals, leadership, and group development. However, according to Huston (1986) there is no empirical evidence supporting the claims of Walker and others that women's groups are different and more effective. This lack of confirmation on efficacy, especially as it pertains to female groups for sexual abuse victims, is also evident in reviewing the literature on these groups. Almost no formal evaluation has been done although many authors comment on the need for more empirical research on the effectiveness of the various types of group treatments for this client population.

Summary

There can be little doubt that the sexual abuse of children is present in alarming numbers. Not only that, there are many adults who suffer greatly from the devastating consequences of their childhood victimization. In the words of Roland Summit (1983): "In the 1980's we can no longer afford to be incredulous of the basic realities of childhood (sexual) abuse." We are

awakening to the fact that sexual abuse of children does occur and many adult victims need help in dealing with the long-term negative consequences of their abuse. Many intervention and prevention programs are being designed and put into place but it remains to be seen which of these are the most effective.

Group Intervention Program

Rationale

Recent prevalence studies confirm that many adults experienced sexual abuse in their childhood. While many victims have successfully coped with the psychological impact of this abuse, a significant number suffer from a wide range of long-term consequences. Mental health professionals encounter increasing numbers of adult clients, mainly women at this point, seeking treatment for the effects of abuse. The demand for services far outstrips the available resources and the need for efficient and effective treatment programs is apparent. Presently, most of the clinical literature on treatment programs for adult victims of child sexual abuse emphasizes the long term effects and related treatment issues, for example feelings of guilt, low self esteem and isolation, but gives little information on specific treatment strategies or quantitative evidence of their effectiveness.

In an effort to fill this gap Jehu, Klassen and Gazan (1987a) undertook a research study in which the treatment of mood disturbances in adult women sexually abused as children was systemically administered and evaluated. Fifty-one women were assessed for the long term consequences of their abuse and treatment was given on an individual basis although some women took advantage of the option to have their partners join therapy sessions. The focus of therapy was the treatment of mood disturbances, including low self esteem, guilt, and depression.

Standardized measures were used to determine the level of mood disturbances and 92% of the 51 women presenting for therapy had clinically significant levels of low self esteem, 88% suffered feelings of guilt and 70% were considered clinically depressed.

The therapeutic approach for treatment of mood disturbances in this study was Cognitive Behavioral therapy which is based on the work of Aaron Beck and his associates (Beck, Rush, Shaw & Emery, 1979). This approach is directed at the identification and correction of distorted beliefs that contribute to mood disturbances. Encouraging results were reported by Jehu, Klassen & Gazan (1987a). Of the 36 women who completed treatment for mood disturbances and who were available for follow up, 94% had clinically significant levels of distorted beliefs and 58% were depressed at initial assessment. Because of a change in instrumentation, only 15 of the 36 women were evaluated on the self esteem variable and 86% had clinically significant levels of low self esteem at initial assessment. At termination of therapy for mood disturbances 13% had significant levels of distorted beliefs, 8% were depressed and 53% continued to experience low self esteem. Statistically significant changes indicating improvement were reported for all these variables and these changes were maintained at follow up.

The purpose of conducting the short-term therapy group described in this report was threefold. First, to determine

whether or not the cognitive behavioral therapeutic approach successfully utilized by Jehu, Klassen & Gazan (1987a) on an individual level, would be effective when used in a group therapy modality directed at alleviating mood disturbances associated with child sexual abuse.

The second purpose concerned the efficient use of professional resources. In the Jehu, Klassen and Gazan (1987a) study "the mean duration of therapy focused upon mood disturbances was 21.2 weeks with a range of 3-47 weeks, and 75% of clients were treated for between 11-30 weeks" (p. 212). Individual treatment for the sexually abused women in a research setting was important for the identification of clinical issues in this client group and because it is the method of choice for certain psychosocial problems experienced by victims of child sexual abuse. However, since most social service agencies offering treatment to adult victims do not have extensive professional resources available for long term individual treatment, an effective time-limited group approach using the cognitive behavioral model for treatment of mood disturbances commonly found in abuse victims might prove to be a more efficient use of resources.

The third purpose of this group was to directly address the feelings of isolation and alienation so often experienced by women sexually abused as children. Sixty-two percent of women in the Jehu et al (1987) study reported these feelings and Faria and

Belohlavek (1984) report similar findings that sexual abuse victims feel different and distant from ordinary people. These feelings probably stem, at least in part, from the fact that the abuse is very often a secret, not having been disclosed to anyone during childhood or at any other time up until entering therapy. If the abuse was disclosed, it was often met with negative reactions such as blaming the victim, disbelief, or lack of protection (Courtois, 1980; Herman, 1981). For example, 49 (96%) of the 51 women in the Jehu et al (1987) study kept the abuse a secret for some time and of these 49 women, 81% indicated that fear of disbelief, blame or anger by a third party contributed to maintaining the secret. Some of these women eventually did disclose (52%) and 66% met with shock and horror and 63% met with denial of the victimization. As a result of these sorts of reactions, or the expectation of such, many victims are reluctant to share the secret with anyone for fear of negative consequences and thus may develop feelings of shame, stigmatization and isolation.

While many of the negative consequences of sexual victimization, such as guilt, low self esteem and sadness (Jehu, Klassen & Gazan, 1985) can be dealt with very effectively in individual therapy it is difficult to resolve the issues of secrecy, shame, stigma, and isolation in this treatment modality (Herman & Schatzow, 1984). In individual treatment, the victim

has the opportunity to disclose the abuse to a trusted therapist who can then normalize the abusive experience by allowing the client to learn, through discussions, readings and films, for example, that she is not alone in her experience. However, the element of secrecy is still maintained in this one-on-one situation and the incest secret may not be fully laid to rest until the victim is able to disclose and discuss her victimization with someone other than the therapist (Swanson & Biaggio, 1985). Group treatment for adult women who were sexually victimized in childhood would therefore be effective in breaking down the barriers of isolation and stigmatization by allowing these women contact with other victimized women to share their abusive experiences with each other. This sharing of the pain of victimization and its consequences, done in the safe environment of the therapy group, encourages the recognition of the commonality of experiences and fosters the development of a better self concept, assertiveness, and competency in the development of interpersonal relationships (Forward & Buck, 1978).

Evidence that healthy interpersonal relationships and an adequate social support network help an individual maintain physical and mental health and to cope with life stress has been documented in the literature (Anderson, 1984; Saulnier, 1980).

The results of a follow up questionnaire on a time-limited therapy group for adult women incest victims conducted by Judith Herman and Emily Schatzow (1984) indicate that:

> The single most helpful thing was the contact with other incest victims. One woman wrote: "The most helpful feature of the group for me was the sheer access to other incest survivors. It was literally the first time in my life (16 years following the incest) that I saw other physical beings who had been through a similar situation. Their presence proved almost immediately to negate the message that it only happened to me and that it happened because I was me. The group functioned as my first baby-step out of my isolation"...Group members consistently reported improved self esteem, feeling less ashamed and guilty, less isolated, and better able to protect themselves (pp. 12-13).

A further rationale for a group treatment approach is provided by Patricia Gordy (1983). In her clinical experience, women in individual counselling often remarked how alone they felt in their struggle to overcome the consequences of the incest trauma and expressed a wish to share this painful experience with other women victims. As one client said "Incest is not taboo-just talking about it is." Similarly, Tsai and Wagner (1978) report that on follow-up, women in their therapy groups maintained that the most helpful thing about the group experience was the ability

to share with women who have gone through similar experiences and could truly understand. Statements on the effectiveness in reducing isolation of the above mentioned groups are at best subjective and no empirical evidence to support these statements is given.

One task of a therapy group of this nature is to help members cope with the consequences of a shared event, in this case, sexual victimization in childhood. In this sense, the group has some of the characteristics of a situation/transition group as defined by Schwartz (1975) in which one of the key elements is the sharing of information that can lead to a new cognitive framework in which to understand the traumatic experience. In this way a group experience allows for the discussion and understanding of the individual and societal factors that influence the occurrence of child sexual abuse. Explanations for the behavior of individual offenders, for example, comes from the work of Finkelhor (1984) who believes in the importance of considering multi-factored explanations such as a combination of: (1) sexual feelings about the child, and for a variety of reasons, (2) lack of internal inhibitors, (3) lack of external inhibitors, and (4) lack of resistance by the child, as contributing to the offender's behavior.

In a group setting women can share their experiences of victimizations in terms of a social phenomena. With respect to

this Butler (1978) found it imperative to examine child sexual assault as a function of "male dominated family systems and its assumptions about sex-roles and expectations...it is important to understand male sexual aggression as an outgrowth of the patriarchal nature of male/female relationships in every aspect of our lives" (p. 6). In essence sexual abuse has more to do with power than it does with sexuality. The necessity of a feminist orientation to groups for sexually abused women is outlined by Hutchinson and McDaniel (1986) who maintain that "conventional therapies tend to perpetuate the existing belief structure about sexual abuse by isolating and blaming the victim. In contrast, feminist counselling and feminist self-help groups remove the woman's false sense of guilt, validate the woman's experience with sexual violence, and enable the victim to develop an understanding of the social structural context in which sexual assault occurs (p. 2). Hutchinson and McDaniel further state that women in these groups report unconditional acceptance and feelings of belonging not found in other social groups, networking among group members, removal of alienation, and the feeling of being useful and needed by contributing something out of their experience with sexual violence.

Women who were sexually abused in childhood no longer need to feel isolated and stigmatized because of their experience. When they come together in groups the secrecy and myths surrounding

sexual abuse are shattered and these women will hopefully make the transition from victim to survivor.

Subjects

Recruitment of group members was done by means of a letter sent to various social service agencies and hospital social work departments. Many of these were aware of the individual treatment program for women who had experienced abuse then being conducted at the Psychological Service Centre, University of Manitoba, and made referrals. All referrals were screened as possible candidates for the group using the criteria outlined below. The purpose of criteria for group entry was to provide guidelines for suitability to the group and to achieve some sort of homogeneity would be achieved. Those women considered inappropriate for group therapy would have been referred elsewhere but this eventuality did not materialize. For the purposes of subject selection the definition of child sexual abuse provided by Goodman and Nowak-Scibelli (1985) was followed:

> Sexual abuse is any inappropriate sexual stimulation between a parent or parent surrogate and a child. This includes oral, anal, and genital contact, as well as genital exposure, but does not include verbal seduction when it alone is the only form of sexual inappropriateness. Sibling incest is also included when there is an unequal power relationship

> between the two siblings by virtue of differences in age, size, family position, etc. (p. 534).

The term parent surrogate includes non-family members such as family, friends or neighbors with whom a child would normally have an adult-child trust relationship.

Criteria

The following criteria were used as guidelines to determine suitably for inclusion in the therapy group.

Legal age in Manitoba. The rationale for this is fairly evident as offering treatment to minors poses special problems in obtaining permission from parents or guardians. More importantly, participants should have, developmentally, reached at least the adult stage and if possible no longer be living with their family of origin.

Possess at least grade 8 education. One aspect of the treatment program utilized bibliotherapy and cognitive behavioral techniques that require a certain level of cognitive ability in order to grasp the concepts. In addition, much of the work in the group was by means of verbal communication which requires some communication ability. This requirement of grade 8 education was not meant to imply a lack of intelligence or ability in those who do not possess it, but provided a guideline for assessment.

Non-crisis status. Many sexually abused women have experienced suicide attempts and substance abuse in the past.

Since the nature of the therapy group was to address stressful issues it was assumed that there would be less risk of the re-occurrence of these problems if the women were not currently in crisis. Coping with a crisis would have been a distraction at a time when each woman needed energy to devote to group work and a crisis in one individual's life would potentially disrupt the dynamics of the group. Crises that developed once the group commenced would be dealt with and would not require the participant experiencing a crisis to leave the group.

Five-year interval from last incidence of victimization. When there has been a significant interval between the present time and the trauma of victimization it is more likely that any adverse consequences of the victimization such as guilt, depression and low self esteem are more or less stable and on-going problems that the victim has thus far been unable resolve on her own.

Age difference between victim and offender. The offender/victim relationship is essentially one in which a breach of childhood trust in adults and a misuse of power has occurred. An age difference where the offender was at least 5 years older was the guiding principle in this instance to ensure that the relationship was not construed as a romantic relationship.

Voluntary participation. It is advisable that group members participate in therapy primarily because they want to. So often

abused women describe themselves as "people pleasers" and the danger exists that a woman may agree to attend because another person, say her partner, doctor, or therapist, thinks it is advisable. Abused women do however experience ambivalence about joining the group, especially if they are unfamiliar with groups, or fear rejection, but a voluntary commitment will help alleviate some of these feelings and is necessary for group work. In other words, a woman who does not want to be there will not benefit from the group experience and runs the risk of feeling re-victimized and controlled.

Summary of Demographic Characteristics

The seven women who commenced group treatment ranged in age from 30 to 51, with the mode being in the 35-39 age group. Five of these women were divorced, one was married, and one had never been married. Six women had children. Four group members had completed grade 12 education, one had graduated from university, one had post-secondary professional training, and one had completed grade 10 education. All of the women were caucasian and had been brought up in Christian religions. Two women presently practice their religion. Two of the women were employed in professional occupations, four women were employed in clerical positions of which three were part-time, and one woman was a homemaker.

In general, the characteristics of the families of origin for all of the women included male supremacy, social isolation and role reversals. Three of the women were sexually abused by older brothers, two were abused by their father and one by her step-father. One woman was abused by her paternal uncle. With the exception of one woman, all the group members maintained the secret of the abuse until adulthood. The one childhood disclosure was met with disbelief and non-protection by the family.

Following are case vignettes of the women who comprised the therapy group. These are presented for the purpose of giving some insight into the unique character of this particular group of women. To protect confidentiality, the names used are pseudonyms.

Case Vignettes

Eight previously sexually abused women completed the assessment phase of the intervention. Of this number, six women formed the core group and remained in the group until its completion. One woman decided to withdraw prior to the commencement of the series of group sessions. During the assessment process this woman expressed apprehension and ambivalence about entering the group and was unable to overcome these feelings sufficiently during the assessment. She was therefore referred for individual counselling. Another woman, Susan, dropped out of the group after attending two sessions, the second and fourth. She felt that the group members were not "in

the same place" as she was since she had attended some individual counselling previously which had a feminist orientation. Also, Susan was in the process of confronting her mother for not having protected her, adjusting to a recent marital separation, and publicly disclosing her lesbianism. The occurrence of these two withdrawals confirms the importance of two of the subject criteria previously discussed, that is, voluntary commitment to group therapy, and a non crisis state.

Following are case vignettes of the seven women who commenced the group treatment program.

Martha

Martha is a 49 year old professional woman who has one adult child and is divorced from her alcoholic, emotionally abusive husband. Martha's parents adopted her when she was an infant and she characterizes her family-of-origin as one of male supremacy and social isolation. Her father emotionally abused his spouse and her mother was non-nurturing and emotionally abusive towards the victim and her older brother, who was also adopted.

Martha was victimized by her older brother. The victimization commenced at approximately age 3 and continued until Martha was 14 years old. Sexual activities included genital intercourse. Martha was very fond of her brother and was induced into the victimizations by the opportunity for attention and affection, and through the exercise of adult authority. The

offender used threats to maintain the secret and Martha never disclosed the abuse until approximately one year ago when she sought counselling from her minister and his wife.

The long term consequences of the victimization for Martha have been generalized anxiety, feelings of guilt for having experienced emotional pleasure from the abuse, low self esteem and feelings of difference from others, and a long history of depression for whch she is currently taking anti-depressant medication. She overvalues men, disparages women and is non assertive, and occasionally aggressive. Her relationships with men are over-sexualized although she has never enjoyed a satisfactory sexual relationship. Martha describes herself as always having been "grown-up," as never having had a childhood, or "fun."

Gwen

Gwen is 37 years old and works part-time in a clerical position. She is presently divorced and has an 18 year old son who lives in another city and an 8 month-old son from a former relationship. Gwen was raised by her mother and step-father in a family of 5 children characterized by male supremacy, physical violence, social isolation, and role reversals. Gwen recalls constantly seeking affection and approval from her emotionally distant and critical mother.

Gwen's step-father sexually abused her commencing when the victim was aged 8 until she was 13 years old. Sexual activities included vaginal sexual intercourse. The offender used threats of physical violence and the exercise of adult authority to induce Gwen's participation in sexual activities. She felt helpless and ashamed and believed that if she disclosed to her mother she would encounter disbelief, anger and blame. The victimization was kept secret until Gwen disclosed to her girlfriend's mother at the age of 13 and subsequently to her own mother. Because of her mother's negative reaction, Gwen later denied the abuse as she feared her mother would miscarry the baby she was carrying, however the abuse did not continue.

In the long term, Gwen has suffered from feelings of guilt because she received emotional pleasure in the form of attention and affection from the offender and physical pleasure from the sexual activities of the abusive incidents. Feelings of low self esteem stem from her childhood experiences of being told she was "fat, dumb, and ugly" by her step-father and other family members. Gwen has suffered periods of depression during which she would take drug overdoses, and on one occasion was hospitalized for this. She feels isolated and alienated from people and her lack of assertiveness and need to please others to prove her self worth results in others taking advantage of her. She mistrusts others, and avoids intimate relationships with men, and

oversexualizes those relationships she does have. Gwen described herself as a physically and emotionally abusive parent to her first son. She suffers from many health problems related to her obesity.

Heather

Heather is 30 years old and works full time in a clerical position. She is single and has never been in an intimate relationship with a man. Her family-of-origin consisted of her natural parents and five children of which she and her twin brother are the youngest. She described her parents as strict disciplinarians who did not openly demonstrate affection to each other or to the children. They were absent from the home much of the time as both were involved in running a family business and many household responsibilities fell to Heather. She feels she was the family "scapegoat," the "ugly duckling" who got blamed for everything.

Heather's older brother sexually abused her from the time she was 9 years old to the age of 14. The abuse ceased when she physically fought him off. Sexual activities ranged from exhibitionistic display of the offender's genitals to the victim to penile penetration of the victim's vagina by the offender. Threats of physical violence, use of adult authority, bribery, and the opportunity for attention and affection were used by the offender to induce the victim to engage in sexual activities. The

victim felt helpless to stop the abuse and kept the secret until well into her adult life when she disclosed to a psychiatrist. She feared disbelief, blame and anger from her parents. She also feared the offender would be jailed and this would break up the family, which she felt responsible for keeping together.

The long term effects of Heather's victimization include guilt for somehow causing the abuse, and very low self esteem as she feels she wears a label saying "damaged goods." She suffers from social evaluation anxiety and has a history of depression for which she is presently under psychiatric care. At age 14 Heather attempted suicide by taking a whole bottle of aspirin. She experiences sleep disturbances and abused alcohol in the past. Heather's social relationships are characterized by mistrust of others, especially men, and she has been hurt many times by people taking advantage of her willingness to please. Heather is obese and feels that this makes her unattractive to men.

Louise

Louise is a 51 year old married homemaker. She has 3 daughters ranging in age from 17 to 32. She grew up in a family in which the father was authoritarian, domineering, physically violent towards his spouse and children, and an alcoholic. Louise's mother is described as a quiet, passive woman who showed little affection and nurturing towards her two children and left much of the responsibility of caring for the younger child to

Louise. Both parents were described as excessively religious and moralistic.

Louise's father sexually abused her from the time she was 10 years old until she was 16. He did this by insisting on examining her genitals to see if she had been "fooling around with boys." On one occasion he attempted sexual intercourse but the victim was able to fight him off. The offender used threats of physical punishment and exercise of adult authority to induce Louise's compliance and she kept the abuse a secret until adulthood believing that her mother would not believe her or protect her.

The long term consequences of the abuse for Louise have been feelings of guilt, low self esteem and periodic episodes of depression. She feels isolated from people due to a lack of trust in others and has suffered repeated victimizations, particularly by her husband who is emotionally abusive, as well as sexual fondling by a priest when she was a child, and by a psychiatrist and a medical doctor as an adult. She feels she wears an invisible sign by which abusers can single her out.

Mary

Mary is 46 years old and has one daughter aged 11 years. She is presently divorced from her second husband and both marriage partners were physically and emotionally abusive. Ten years ago, a second daughter died at the age of seven months of Sudden Infant

Death Syndrome. Mary works as a stenographer but is currently unemployed while recovering from a hysterectomy.

There were 16 children in Mary's family of origin. Her father is described as promiscuous, alcoholic, physically abusive, often unemployed, and often absent from home. Her mother is described as overburdened, sharp-tongued and non-nurturing. Mary was never able to trust either of her parents. The family was socially isolated, with much role confusion as older siblings, including Mary, took on parenting responsibilities for younger children. Other characteristics of the family included male supremacy, a milieu of abandonment, and oversexualization.

Mary's paternal uncle sexually abused her from the time she was 5 years old to the time she was 12. The abuse ceased when Mary's family moved away from proximity to this uncle. Sexual activities included erotic fondling of the victim's body by the offender and manual stimulation of the victim's genitals by the offender. He used bribes of food and gifts, the exercise of adult authority, threats, and the opportunity for attention and affection to induce Mary to participate in sexual activities. Mary kept the abuse a secret for fear of disbelief and blame and because she enjoyed the gifts of food and the attention and affection she received. At the age of 30, Mary disclosed the abuse to her mother at the time of the offender's death. Her mother's blaming reaction was "why didn't you tell me."

In the long term Mary has suffered from extreme guilt for having taken food in exchange for participation in sexual activities and does not consider herself a victim because of this. She has very low self esteem and is obsessed with cleanliness, bathing up to three times a day and excessively cleaning her home. Mary has suffered periodic depressions for which she has taken anti-depressants and, at age 34, attempted suicide by slashing her wrists. She abused alcohol for five years during her second marriage and continues to experience sleep disturbances. Mary distrusts people, feels insecure in social relationships and is non-assertive. She overvalues men and has had many transient, casual, and promiscuous relationships. She now fears intimate relationships with men. Because of her guilt feeling over having accepted food in exchange for sex as a child, Mary is adamant about not accepting anything from others unless she is able to reciprocate. Mary has recently experienced some parenting problems as she tends to be very over protective of her daughter.

Peggy

Peggy is a 36 year old woman who is employed part time in a clerical position. She has three adolescent children from her first marriage which she left because of her husband's physical and emotional abuse towards her. Peggy had recently ended a common-law-relationship when she discovered that her partner was sexually abusing her three children. There were six children in

Peggy's family of origin and as the oldest female child, she was responsible for many household tasks and caring for younger siblings. She described her father as a man who regarded women as sexual objects and her mother as an emotionally distant woman. Other siblings were also sexually abused, although this was never disclosed until their adult years.

Peggy was sexually abused by her older brother. The abuse began when she was 9 years old and continued until she was 14. Her brother used physical force as a method of inducement and sexual activities included penile penetration of the victim's vagina. The offender used threats to maintain Peggy's silence and the abuse was never disclosed to her parents. She feared that she would not be believed and that nothing would be done to protect her. The abuse ended when she ran away from home at age 15.

Peggy "blocked out" the victimization for a long period of time, until the victimization of her own children. In adulthood, the victim feels extreme guilt over her own victimization believing that she was provocative, and because she experienced sexual pleasure during molestation. She has a feeling of being "dirty," experienced bouts of depression for which she was occasionally prescribed anti-depressants, and has sleep disturbances. Although warm and friendly on the surface, Peggy feels isolated from others, mistrusts people, especially men, and feels that people take advantage of her willingness to please.

She has been experiencing some parenting problems, particularly with her 15 year old daughter who disclosed the sexual abuse by Peggy's common law husband.

Susan

Susan is a 38 year old professional woman who is employed full-time. She has two female children and has been separated from her husband for one year. She is currently in a lesbian relationship. Susan has one younger brother and she described her family of origin as a "non-family"; four people living together with many secrets and socially isolated. Her father was alcoholic, non-nurturing and emotionally abusive. Her mother was described as "emotionally flat," non-nurturing, and a "martyr."

Susan's father victimized her from her earliest memory. The victimization is characterized as non-physical in nature, but a constant oversexualization of the father/daughter relationship. Her father attempted to have sexual intercourse with Susan on one occasion when she was 18 years old.

Although she does not experience feelings of guilt for the victimization, Susan suffers from very low self esteem, feeling that she must have been unworthy of protection from her mother. She is extremely distrustful of people, especially men, and disparages women. Susan abused drugs and alcohol in her early 20's and was once hospitalized for psychiatric care during this time. She is presently experiencing strong feelings of anger,

particularly towards her mother for not having protected her. She has chosen a lesbian lifestyle as she feels that men are incapable of providing her with the intimate, supportive, and understanding type of relationship that she needs. Susan had previously attended feminist-oriented peer support counselling for issues concerned with her sexual victimization and it was through this process that she began to identify herself as a legitimate victim.

Therapists

Two female therapists led the group, myself, as an M.S.W. student conducting the group as a practicum requirement and another therapist (M.G.) who was experienced in group therapy and in particular the treatment of adult women sexually abused in childhood. I undertook primary responsibility for the group.

The emphasis of the co-therapists' role was that of co-facilitators rather than task oriented leaders although as Yalom (1975) points out: "most co-therapy teams deliberately, or more often unwittingly, split roles: one therapist assumes a more provocative role, much like a Socratic gadfly--while the other serves as a harmonizer in the group." Provision of a safe atmosphere to facilitate disclosure and discussion together with setting up a therapeutic relationship within the group fostering mutual liking, acceptance, respect, and trust were regarded as an important task of the co-therapy team as a prerequisite to implementing therapeutic change through specific procedures.

Means by which this task is accomplished are (a) suggestion and influence, (b) permission giving and sanctioning, (c) support and encouragement, (d) therapist modeling, (e) therapist self disclosure, and (f) praise and other forms of social reinforcement (Jehu, Gazan & Klassen, 1987a).

The co-therapists were not personally victims of child sexual abuse as defined previously however it is fair to say that all women in our patriarchal culture are victims of a system that allows women and children to remain powerless and to be regarded as possessions and sexual objects. By having worked with other victims of child sexual abuse, and by their experience of the culture, the co-therapists were able to validate and normalize the victimization experience of the women in this particular group as a method of resolving feelings of isolation and stigmatization.

Some authors (Cole, 1985; Gordy, 1983; Yassen & Glass, 1984) recommend co-therapy for this type of group given the intensity of feelings and issues exchanged within the group process. The co-therapists act as a support for each other in managing the stress that each may experience. Yalom (1975) considers the co-therapy format particularly advantageous for the beginning therapist, as in my own case, to lessen anxiety and for the provision of valuable feedback.

Therapist gender has generated some debate in the literature on child sexual abuse. Frequently, male-female co-therapy teams

are used in groups for female victims with the assumption that this provides positive sex role modeling. Female therapists may however overidentify with the victim and express anger at the offender which the victim does not share. It is important for female therapists to come to terms with their feelings about child sexual abuse so that the issue can be approached matter-of-factly (Herman, 1981). Some problems encountered by male therapists as outlined by Herman (1981) include (1) a natural tendency to identify with the offender that interferes with permitting the victim to express anger at the offender, (2) exacerbating feelings of guilt by excusing the offender's behavior, and (3) the risk of responding sexually to the victim even though he may not act upon it, which would evoke the feelings of shame, guilt and disappointment associated with her victimization. As Cole (1985) points out: "Male therapists may quite inadvertently revictimize incest survivors due to their own male inculturation and the victim's lack of knowledge and skill in setting emotional and physical boundaries with men" (p. 81).

The arguments described above guided the decision to have a female co-therapy team for the group. At the initial stages of therapy, which this group addressed, female therapists are less threatening. The opportunity for interaction with a positive male role model can be provided at a later stage in therapy, possibly through assertive training (Schwab et al, 1987).

Procedures

Size, Space and Time

It is difficult to know the ideal number of participants for this type of group. If there are too many members, some participants may be inhibited in sharing the secret of their victimization. However, a larger number affords a measure of safety to members who are not ready to disclose and can still gain from listening to the experiences of others. While there should be no pressure placed on victims to "tell their story" in the group it should be encouraged from a therapeutic viewpoint. When disclosure does occur "a victim's sense of shame may be so intense that she reacts to the revelation of the incest secret by running from therapy" (Swanson & Biaggio, 1985). Therapists need to be sensitive to the possibility of this happening and not put undue pressure on victims. Also, if a number of victims choose not to self-disclose to any degree, the other members who have disclosed may feel put upon or may feel alone in their disclosure causing them to retreat from any further sharing. A delicate balance needs to be achieved in the amount, nature, and rate of self disclosure by group members. Too few participants can be equally as damaging as too many since this may put undue pressure to disclose upon a victim who is not yet ready, once again recreating an experience of victimization.

Given these considerations, and based on reports in the literature, eight women were selected for the group. Experience indicates that in groups, dropouts are likely to occur and, for a variety of reasons, not all members will be completely faithful in their attendance. Non attendance may occur, for example, if disclosures of the victimization secret precedes the development of trust within the group whereby the victim disclosing fears rejection and experiences ambivalence about returning to the next session. Following initial assessment, one woman decided not to attend the group and another group member dropped out following the fourth session. Six women remained in the group until its conclusion.

Sessions were conducted at the Psychological Service Centre, University of Manitoba. This facility has appropriate space for holding group therapy sessions and is easily accessible to clients by car and bus. The weekly sessions, held during evening hours, were of two hours duration with a 10 minute break. Evening sessions were more feasible as several group members were employed during daytime hours and/or had small children in which case daytime babysitting presented problems. Adhering to the scheduled place and time becomes important when working with child abuse victims who have experienced life as chaotic and unpredictable. Receiving what is expected contributes to establishing the trust and security necessary for group work.

The group was limited in its duration to 15 sessions plus a follow up session held six weeks later. In addition each group participant individually attended three assessment sessions prior to commencement of the group, a mid-group check-up session, and a termination session with the co-therapists.

The value of time-limited therapy for victims of child sexual abuse has been well documented (Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984). When participants are aware of the time frame they are mobilized to face the issues that brought them to the group (Tsai & Wagner, 1978). Herman and Schatzow (1984) outline three reasons for a time limited group. First the pressure of a time limit would facilitate bonding amongst group members and diminish resistance to self-disclosure. Secondly, given the stressful and regressive aspects of the treatment, a time-limit would provide a structure within which this regressive aspect could be contained. Thus, group members can feel more in control of their anxiety. Third, a time-limit encourages a focus on the common theme of childhood sexual victimization with a minimum of distractions.

Following termination of the scheduled sessions group participants can be encouraged to meet with one another on a self help basis. A formal time-limited therapy can only begin to touch on some of the basic issues regarding long term consequences of

abuse but hopefully can provide victims with the skills needed to resolve these issues for themselves.

Members were encouraged to arrange their affairs so that they could attend the group and focus on its tasks without interruption or distractions, but if missing a session was unavoidable, they were asked to contact the co-therapists. If a member failed to make contact before or soon after a missed session, the co-therapists attempted to find out the reasons. This seemed especially important as something may have happened in the previous session that was upsetting to the victim thus discouraging her return. These procedures were outlined in the initial session so that members knew what was required of them.

The group was considered "closed" so that no new members were added once sessions had begun. Since the development of mutual trust and comfort with each other is essential to facilitate self disclosure, it seemed appropriate to have a closed group especially with women sexually abused as children for whom secrecy and mistrust is usually a way of life. Continually adding new members would threaten the development of security and trust.

Although not formally documented many therapists working with sexually abused women have observed that these victims tend to give themselves a "holiday" from the intensity of therapy by missing appointed sessions. The timing of the group was planned so that a break could be taken over the Christmas period. In the

interim, each group member was seen individually by the co-therapists to review goals and to deal with individual issues that may have arisen.

The group members did not have access to individual therapists. The rationale for this procedure lies first in the desire to demonstrate whether or not this approach could be effective particularly in view of the limited resources of many social service agencies which makes simultaneous group and individual therapy unfeasible. Secondly, as Blick and Porter (1982) point out, having an individual therapist can cause loyalty conflicts for a woman as she becomes more and more connected with the group as part of the natural process of group dynamics.

Therapeutic Goals

Alleviation of the mood disturbances of guilt, low self esteem and depression together with decreasing feelings of isolation constituted the basic therapeutic goals of this therapy group. Essentially, this was done by providing a safe place for victims to share their experience without fear of negative consequences, education about the causes and consequences of child sexual abuse, and specific therapeutic techniques directed towards:

1. Building self esteem by (a) receiving assurances from group on personal value, (b) focusing on strengths, (c) becoming a

survivor, (d) examining automatic negative thoughts that lower self esteem, and (e) improving body image.

2. Alleviating guilt by (a) returning responsibility for the abuse to the adult offender, (b) granting absolution to self and other group members, and (c) understanding human sexual response and the psychological, social, sexual development of the child.

3. Building trust by (a) making the group a safe place for disclosure, and (b) learning to take risks and deal with consequences.

4. Dealing with anger by (a) identifying source and direction of anger, (b) validation of right to anger, (c) acceptance and support of intense feelings, (d) externalizing rather than internalizing anger, and (e) learning constructive methods of expressing anger.

5. Changing interpersonal relationships by (a) reducing feelings of isolation and alienation, (b) learning appropriate ways to show affection, (c) identifying old patterns of fleeing from relationships, and (d) networking with support systems.

6. Taking control by (a) changing self-destructive, self defeating behavior, (b) letting go of learned helplessness, (c) gaining control through assertive behavior, and (d) developing coping strategies.

The strategies just described represent the process for achieving the stated goals. Addressing each completely in 15

sessions would have been a far too ambitious task. The issues that emerge and receive emphasis differ with each grouping of women.

Assessment Scheme

Each participant attended three preliminary individual interviews with the co-therapists. These interviews were used to provide information about the group such as purpose, format and goals. Many of the women had not previously disclosed their victimization or had only recently done so and understandably may have been anxious and fearful of disclosing in a group setting. Most had never experienced group therapy previously so that meeting with the co-therapists individually allowed them to ask questions and develop a relationship with the co-therapists while receiving reassurances that anxiety is normal. Yalom (1975) emphasizes the importance of pre-group interview(s) for the purpose of building a rapport that may prove helpful in keeping the client in the group during periods of distress that occur early in the course of the group. The client seen in pre-group sessions is less likely to terminate prematurely. He also advises that clients meet with both co-therapists simultaneously to avoid developing rapport with one and not the other which can lead to a group splitting into two factions.

An assessment of each victim was conducted during the pre-group interviews so that clinical issues and long term

consequences for each individual member could be identified. The information collected from the assessment helps the therapist to anticipate issues that will emerge in the group sessions. The assessment scheme consisted of a modified version of the "Protocol for Initial Assessment Interviews" developed by Jehu, Gazan and Klassen (1987a) in the research program "Therapy with Women who were Sexually Abused in Childhood." The following information was collected during assessment:

1. Demographic data
2. Relationship with partner (if applicable)
3. Victim's family of origin:
   (a) description of and relationship with father and mother
   (b) relationship with siblings
   (c) family functioning--past and present
4. Victimization:
   (a) description of experience
   (b) relationship of offender
   (c) issues of secrecy and disclosure
5. Psychosocial adjustment:
   (a) emotional
   (b) interpersonal

In addition to information gathered according to this assessment scheme, the co-therapists sought any additional

information that would further their understanding of each individual.

Measures

Four standardized measures were used repeatedly to measure self esteem, depression, and negative beliefs that contribute to mood disturbances and feelings of loneliness. Based on research and clinical experience, problems in these areas are commonly found in previously sexually abused women who present for therapy (Finkelhor, 1986; Jehu, Klassen & Gazan, 1987a). As well as providing a clearer assessment picture of each group member, scores on these repeated measures formed the basis for determining whether or not any change in the level of the problems measured had occurred as a result of the intervention. Also, specific responses on each questionnaire were helpful indicators of specific target areas for work within the group. A client satisfaction questionnaire was administered following termination of the group.

Beck Depression Inventory (BDI)

This well established instrument was developed by Aaron Beck (1978). Since this 21 item scale assesses the presence and severity of affective, cognitive, motivational, vegitative, and psychomotor components of depression (Corcoran & Fischer, 1987) it is a comprehensive measure of mood disturbances in victims of child sexual abuse. The BDI has been shown to have good levels of

test-retest reliability (.74 for graduate students after 3 months) and strong concurrent validity. It has shown in several studies to be sensitive to clinical change (Corcoran & Fischer, 1987).

The BDI was completed once during the assessment phase, at termination of the intervention, and at follow-up. The score is determined by adding the scores, which range from 0 to 3, on each item and a score of 21 or above is the recommended cut-off point indicating a clinically significant level of depression (Beck & Beamesderfer, 1974). A score obtained during assessment that indicated severe depression (i.e. 40 or above) would have been cause to reconsider the advisability of this person entering the therapy group, thus the measure acted as an additional screening mechanism.

<u>Hudson Index of Self Esteem (ISE)</u>

This 25-item scale was developed by Hudson (1982) and is one of the few instruments that has been designed to be used as a repeated measure expressly for single system research (Bloom & Fischer, 1982). Responses are on a five-point Likert scale ranging from 1 (rarely or most of the time) to 5 (most or all of the time). The recommended cut-off point of 30 or above indicates a significantly low level of self esteem.

Bloom and Fischer (1982) state that the scale has internal consistency reliability and test-retest reliability (stability) of 0.90 or better. Furthermore, it has high face, concurrent and

construct validity as well as clearly measuring what it is intended to measure. Its main limitation centers upon potential reactivity which should be minimized by its high reliability. The Hudson ISE was administered in the same manner as the BDI, that is, once during assessment, at termination of group intervention, and at follow-up.

Belief Inventory (BI)

This inventory was developed by Jehu, Klassen and Gazan (1984/5) in their research study "Therapy with Women who were Sexually Abused in Childhood" and is a measure of the common distorted beliefs associated with childhood sexual abuse. The 17 items on the Belief Inventory (Appendix A) address negative beliefs concerning guilt, self-esteem and trust. Response categories on the 5 point Likert scale range from 0 (absolutely untrue) to 4 (absolutely true). The total score is derived by adding the scores for each item and a total score of 15 or above indicates a clinically significant level of distorted beliefs.

The test-retest reliability of this instrument was obtained from the responses of 25 previously sexually abused women over an interval of one week during their initial assessment. The Pearson correlation was .93, $p < .001$. The inventory has face validity and because of the alleged association between the distorted beliefs and mood disturbances one might expect it to have reasonable concurrent validity with the Beck Depression Inventory.

This was supported by a Pearson correlation of .55, $p < .01$, between the scores of 25 previously sexually abused women on the two instruments (Jehu, Klassen & Gazan, 1984/5).

The Belief Inventory was administered at the three assessment interviews, at each group session, and at follow-up.

Revised UCLA Loneliness Scale (Short Form) (RULS)

Since a decrease in feelings of isolation and alienation was one of the desired outcomes it was necessary to obtain some measure as to what extent feelings of isolation were experienced by this particular group of women. The four item short form of the Revised UCLA Loneliness Scale (Russell, Peplau & Cutrona, 1980) was used for this purpose. The scale contains an optimal subset of the longer RULS which has a high reliability of .90+ and encouraging content, criterion and construct validity. This short form has been used mainly for survey purposes and there is no clinical cut-off score provided, but norms and standard deviations are provided for various age groups (Russell, 1982). The scale was administered on 3 occasions--at assessment, termination and follow up.

Client Satisfaction Questionnaire (CSQ)

The Client Satisfaction Questionnaire (Larsen, Attkinson, Hargreaves, Nguyen, 1979) was administered on one occasion, that is the individual termination session. The purpose was to give group members an opportunity to evaluate the treatment program in

terms of its acceptibility to themselves. The CSQ is an 8-item measure which is easily administered and scored. Scores are obtained by adding the scores on individual items with higher scores indicating higher-levels of satisfaction. Norms are reported to range from 26.35 to 27.23. The measure has excellent internal consistency but test-retest correlations are not reported (Corcoran & Fischer, 1987). The measure has the potential of obtaining biased responses as clients may answer in a socially desirable manner. However, group members were encouraged to be forthright in their responses.

In summary, four standardized instruments were used to measure depression, self esteem, negative beliefs, and loneliness. These instruments are all short, easily administered and scored, and in addition provided information regarding specific therapeutic target areas for work within the group. These measures have been shown to have acceptable levels of reliability and validity. In addition to the four repeated measures, a consumer evaluation questionnaire (CSQ) was administered at termination to measure each group member's perception on the value of services received.

Evaluation Design

Evaluation of the group treatment combined two research designs, the A-B single system design (Bloom & Fischer, 1982) and the one group pretest-posttest design (Cook & Campbell, 1979).

A-B Single System Design

The scores from the Belief Inventory measures are evaluated for each group member individually constituting an AB single system design. Baseline data collected during the three assessment interviews form the A phase while the B phase consists of scores measured during the implementation of the group treatment program, that is the 15 sessions. Bloom and Fischer (1982) recommend the use of at least 3 data points for the A phase of the AB single system design where the client acts as her own control. Evaluating the data using the AB design indicates if treatment has been accompanied by any changes in the level, stability or trend of the target problems. It was anticipated that scores on all measures would show a reduction in beliefs indicating feelings of guilt and low self esteem once the therapeutic intervention was commenced. Reduced scores maintained at follow up, are further indication of the efficacy of the intervention. Since there is no control group, changes in intervention strategy could be made if this was indicated by general movement of group scores in an undesirable direction.

Bloom and Fischer (1982) identify several strengths of the AB design. First, it allows for ongoing monitoring of changes in target events and thus lets the practitioner know whether to continue with the planned intervention or to make some modifications. Secondly, it is a good accounting device providing

information not only to the practitioner and client but to agencies and society at large. Third, information can be gathered during the assessment phase that can be helpful in seeking an understanding of the presenting problem and planning the intervention strategy. Finally, any differences found between baseline and events after intervention act as a tentative indication of causal factors and suggest areas for further more rigorously designed research.

The limitation of the AB design is that it does not control for threats to internal validity such as history, maturation and reactivity. Using an experimental design that withdraws intervention to control for threats to validity is not appropriate first because the process of changing false beliefs, once identified and corrected, is irreversible and secondly it seems unethical to remove and reintroduce treatment to this client group of sexually abused women. However, some control over threats to internal validity can be achieved since AB designs with two or more subjects, as in the case of this group, constitute a natural baseline design. This design avoids the effects of history by showing changes in two or more clients following onset of intervention thus suggesting that change is due to the intervention process (Bloom & Fischer, 1982).

<u>One Group Pretest-Posttest Design</u>

This quasi-experimental design (Cook & Campbell, 1979) was

used to evaluate data collected from the BDI, the Hudson ISE, and the Revised UCLA Loneliness Scale (short form). It was also used to evaluate results from the Belief Inventory. A comparison of the scores of each group member taken at assessment and at termination of the intervention indicates what proportion of clients have shown changes and in which direction those changes occur. Threats to internal validity are similar to those for the AB design mentioned above.

The threat to history can be reduced by observation and recording pertinent events in the lives of the group members for the duration of the group. Provision for this was built into the group sessions. Practice effect should be reduced by limiting the number of times the questionnaires are administered. In general, threats to validity can be controlled for by replication of the treatment program over time. Because the group participants were not randomly selected it will not be possible to generalize any results obtained from this intervention to all women sexually abused in childhood.

Treatment Procedures

The goals of the group intervention, as previously discussed were the alleviation of depression, low self esteem, and negative beliefs contributing to these mood disturbances. As well, the goals included reduction of feelings of isolation and alienation commonly experienced by women sexually abused as children. The

assumptions made for choosing these particular therapeutic targets primarily rests with the fact that these are amongst the most common problems found in adult victims. Furthermore, the alleviation of one problem would interact with the alleviation of the other targeted problems. For example, changing negative beliefs regarding guilt and self esteem would have a positive effect on alleviating depression symptoms. When victims' self esteem improves and they recognize that they are not alone in their experience or stigmatized by it, this has positive effects on the development of interpersonal relationships thus reducing feelings of isolation and alienation.

The strategy for achieving the stated goals was the implementation of the group treatment program using a cognitive behavioral treatment modality and a variety of therapeutic tools as described below.

Cognitive Restructuring

Women who have been sexually abused as children commonly hold negative or faulty beliefs about the victimization that contribute to feelings of guilt, low self esteem and sadness. For example, abuse victims frequently come to the conclusion that they are the cause of their abuse (guilt) and therefore they must be bad persons (low self esteem). Although simply stated here, this process exemplifies the premise on which the principles of cognitive restructuring are based, i.e. "that beliefs have a

significant influence on feelings and actions. If beliefs are distorted or unrealistic then feelings and actions are likely to be distressing and inappropriate. It follows that the correction of distorted beliefs is likely to be accompanied by the alleviation of such problems" (Jehu, Klassen & Gazan, 1987a). This therapeutic approach, used in the above mentioned authors' treatment program for sexually abused women is derived from the work of Aaron Beck and his associates (Beck, Rush, Shaw & Emery, 1979).

The correction of these distorted beliefs requires that victims (1) become aware of their beliefs, (2) recognize the distortions, and (3) substitute more accurate beliefs. This task was undertaken in the group by first introducing the concept of cognitive restructuring (CR) in general terms, followed by a written description handout (Burns, 1980, Ch. 3) for the group members to refer to while learning this technique. Negative beliefs such as those on the Belief Inventory (Appendix A) were identified and restructured throughout the group process using both a verbal and written approach.

It was anticipated that the technique of cognitive restructuring would become an acquired coping skill that each member could continue to use after group termination, initially to restructure negative beliefs about her own victimization and eventually to use this skill to restructure negative beliefs about

herself and life situations that have the potential for causing a reoccurrence of mood disturbances.

Films and Readings

An educational component was included in the group structure. Increased knowledge about the causes and consequences of child sexual abuse are likely to help resolve feelings of guilt and stigmatization associated with the secret nature of this form of abuse. Thus, group members viewed the film It's not like scraping your knee (Krause & Hirsh, 1983) which depicts adult women who experienced sexual victimizations in their childhood describing their abuse and discussing the consequences to themselves. The value of this film lies in the fact that it normalizes the abuse experience for victims by allowing them to see that they are not alone, their reactions to the abuse are common and normal, and that other abuse victims are normal, attractive and functioning persons--they are not weird or stigmatized. Thus, a victim entering therapy can be given an element of hope. In addition, many painful issues common to victims are brought out and showing this film fairly early in the life of the group serves as an impetus to the discussion of these issues at a later stage.

Books and articles that discuss the causes and consequences of child sexual victimization have also proven to be helpful therapeutic tools for increasing clients' understanding of this phenomenon. Some of the benefits include alleviation of feelings of guilt and abnormality. A bibliography (Appendix D) of books

generally available in libraries and bookshelves was provided for each group member as well as Summit's (unpublished) article Typical characteristics of father-daughter incest. Other handouts became appropriate as various issues arose within the group and these are commented upon in the report on group sessions.

Exercises

A variety of exercises were utilized during the group sessions. In the initial session, when group members do not know one another, group "ice-breaker" exercises that allow for the exchange of basic personal information are usually helpful to the development of cohesion and an atmosphere for safe disclosure. While members were asked to share personal information of a general nature, they were also reassured that they need only disclose to the level of their own comfort (e.g. name, marital status, number of children, occupation, interests). At this point, any pressure, or perception of pressure, to disclose details of her victimization, or even to openly admit being a victim, would have been far too threatening. As the level of trust within the group begins to develop, these kinds of disclosures are more likely to occur spontaneously. Throughout the pre-group interviews and duration of the group the co-therapists emphasized the therapeutic value of disclosing the victimization or "telling the story" but there was no mandatory pressure to do so.

At the beginning of each session the co-therapists and group members gave a "weather-report." In this way participants tuned in to themselves and each other by describing their internal state in terms of a weather condition. Someone who is experiencing a lot of turmoil might describe her state as stormy, or cloudy with sunny patches if distressed but feeling hopeful. At this time, group members could bring up issues that were bothering them and that they would like to discuss in the group. An additional benefit of this exercise in each session was the provision of an opportunity to speak for those members who were less verbal or initially had difficulty speaking in the group. For this reason, the weekly weather report, however brief, was a requirement rather than a voluntary exercise.

On several occasions a "go-round" exercise was utilized. This consists of posing the same question to each group member to elicit individual responses. For example, the question "What is your definition of self-esteem?" could be answered by each woman individually thus enhancing the group's understanding of self-esteem issues.

Other exercises focused on the development of self-esteem, for example reading aloud Virginia Satir's "Declaration of Self-Esteem" (Satir, 1975), and the "Self Esteem Tree" (Elkin, 1983) in which victims identify personal strengths, abilities,

talents and accomplishments in a concrete manner, thus enhancing feelings of self worth.

Most if not all women entering therapy for childhood sexual victimization suffer from low self esteem and this affects every aspect of their lives. The task of improving self-esteem was carried on by members throughout the life of the group and, hopefully, afterwards.

The ending phase of a group of this nature can be stressful for members who have by that time developed a sense of caring for one another and a sense of belonging they may never have experienced before. The realization that the group is ending may give rise to feelings of abandonment and loss that recapitulates their childhood experiences (Goodman & Nowak-Scibelli, 1985). It is important to address this ending directly and help members to identify the positive aspects of their group experience. An exercise that accomplished this is called the "toast" (Elkin, 1983). Each member holds a paper cup and fills it symbolically with her own accomplishments--how she has changed and grown--and does the same for her co-members. This exercise allows members to see that each of them has the potential for taking control of her life.

Homework. Group members were asked to keep a journal recording their thoughts and feelings between therapy sessions. Members were invited to share their journals with the group if

they felt comfortable in doing so. In addition to being a good record of growth and progress, the journal also serves as a means of expression for those members who have difficulty speaking in the group (Faria & Belohlavek, 1984).

Letter writing is another technique that is often therapeutic for incest victims. Many choose to write letters to the offender or the non-protective family of origin. This option was suggested to group members, possibly as part of their journal keeping activities. It is advisable that the consequences of actually sending such a letter be thoroughly explored. The value lies in the actual writing of the letter as it gives recognition to many painful feelings. As Swanson and Biaggio (1985) point out:

> The victim's motives and goals for confrontation as well as the possible outcomes should be anticipated in therapy before the victim acts on her wishes. In all probability the family reaction will be one of fear and hostility, for while the daughter may have changed from her former role, the parents most likely have not, and the daughter's repudiation of her identity as "guardian of the family secret" (Herman, 1981) is a real threat to the family structure.

Between sessions, group participants were encouraged to do something nice for themselves (e.g. physical exercise, time-out from responsibilities, reading an enjoyable book). The point of this exercise was to reinforce the notion that they are deserving

of and need self-care, thus enhancing self esteem. It was also meant to serve as a distraction from the anxiety of therapy. This exercise was called "goal of the week" and members were asked to disclose their goals to each other each week in order to receive the reinforcement to "do it" or positive feedback for "having done it."

Towards the end of the series of group sessions it became apparent that many group members were experiencing anxiety following group sessions characterized mainly by sleep disturbances. A deep muscle relaxation (Goldfried & Davison, 1976) exercise was conducted in the 14th session and many members acquired copies of the relaxation tape for home use.

Structure

The series of group sessions was structured in terms of therapeutic strategy, didactics, films, and exercises. The clinical issues (e.g. guilt, self-esteem, isolation) emerged at a rate determined by the group members themselves. The co-therapists' task focused on facilitating the definition of issues important to this particular group of women sexually abused in childhood rather than imposing what they thought, by their experience with other victims, to be the important clinical issues. The sessions were more tightly structured in the initial stages of the group to allow for security, cohesion, and trust to develop with the expectation that towards the mid phase, group

members themselves would take more responsibility for the content and theme of sessions. The structure acted as a guideline, however, rather than something to be rigidly imposed.

From their experience conducting therapy groups for sexually abused women several authors have emphasized the importance of structure for this particular client group (Cole, 1985; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984). Courtois and Leehan (1982), for example, contend that structure and boundaries are essential for this kind of group since chaos has been a way of life for most abuse victims. Yalom (1975) also espouses structure for specialized therapy groups as a means of relieving anxiety by providing clear and firm expectations for behavior in a new setting.

Report on Sessions

A series of 15 therapy sessions was conducted on a weekly basis with the exception of a 4 week interval between the 7th and 8th sessions to accommodate the Christmas break. During this break each group member was interviewed individually to review progress and goals. A follow-up session was held six weeks following termination.

The series of sessions are conceptualized in distinct phases. The purpose of the initial session was to allow group members an opportunity to get to know each other, to establish group goals, and to review procedural guidelines. The following two sessions had an educational component, with a film and didactic presentation on child sexual abuse. The purpose of this was to lay the foundation for the remainder of group sessions. The next several sessions were used to introduce the concept of cognitive restructuring and to learn its application to the restructuring of negative beliefs about sexual victimization. Following this, the main focus of the sessions were on the identification, discussion, and evaluation of clinical issues, such as guilt, low self esteem, isolation, and trust, that were pertinent to this particular group of sexual abuse victims, using the information and skills acquired in previous sessions. While group termination was discussed in several sessions in the ending phase, the last session was devoted specifically to termination issues.

The description of each group session that follows gives a brief outline of the activities and important issues that emerged in the process of each particular session.

The women who participated in the series of group therapy sessions have been described previously in case vignettes in the Subjects section of this report.

Session 1

Outline. The facilitators welcomed the group members and formally introduced themselves giving information on professional background and experiences, reasons for interest in working with victims of child sexual abuse, and some personal information. Additional remarks were made with the aim of developing an atmosphere of acceptance and safety and acknowledging everyone's initial feelings of anxiety. The women then formed pairs for an "ice breaker" exercise. Each woman interviewed her partner and obtained information such as name, age, marital status, occupation, children, and interests, followed by introducing each other to the group.

Group members completed the Belief Inventory and were then given a handout of the procedural guidelines of the therapy group (Appendix B). These guidelines were reviewed in detail to ensure understanding and agreement. There were no limitations placed on member's contacting each other outside the group, especially since one goal was decreasing feelings of isolation. However the women

were cautioned for the sake of group cohesion to bring to the attention of the rest of the group any issues pertaining to the group that they had discussed amongst themselves. After the break, the remainder of the session was devoted to a discussion of goals for the group. Essentially these goals include alleviation of mood disturbances such as guilt, low self esteem, and depression by the use of specific therapeutic techniques together with reducing feelings of isolation and stigmatization through the group process.

Members were asked to keep a journal as a voluntary homework assignment.

Content. This session was structured so that the facilitators directed the group process and very little expectations were placed on group members. During the discussion of procedural guidelines, Mary became very emotional and disclosed feeling inadequate because she felt, at age 46, she should have dealt with the childhood abuse by now, but that it still affected her greatly. She later revealed being embarrassed by her emotional expression and the other group members spontaneously assured her that they also shared these feelings. Mary's embarrassment was checked out further with the concern that this would prevent her from returning to future sessions.

Three group members did not attend. One woman notified the facilitators that she was ill, another had a family matter to

attend to, and the third was misinformed about the starting date.

Session 2

Group members completed the Belief Inventory after which the "ice-breaker" exercise from last session was again conducted since there were three new members in this session. This time, the women were given a handout (Appendix C) of questions to guide their interviews and introductions of each other. Group members who were present for the first session briefed new members on the procedural guidelines and group goals.

The film Its not like scraping your knee (Krause & Hirsh, 1983) was viewed prior to the break. Following the break a "go-round" exercise was conducted in which each woman was asked to identify one significant thing that she remembered about the film. Handouts included a schedule of dates for remaining sessions and the article "Typical characteristics of father-daughter incest" (Summit, unpublished). Group members were reminded to keep their journals.

Content. For many women in the group, viewing the film validated their feelings about the abuse experience and permitted them to express these feelings. The film also created anxiety for the group members. Many identified the fear of disclosing the abuse when they were children and some began to recall details of their own abuse which they described as disturbing; Louise commented "I feel like a child still," and Peggy stated "The movie

brings out stuff that I don't want to remember." Several women identified with the anger toward the offender expressed by the victims in the film.

Mary again expressed ambivalence about "belonging" in the group since she had accepted food as a reward for participating in sexual activities with the offender, thus increasing her guilt. Secondly, she felt that she was not a legitimate victim since sexual intercourse was not part of her victimization experience. Thus, it became important for the group to define victim status. In contrast, the film helped several other women to recognize themselves as victims whereas they had not done so previously.

Session 3

Outline. The "weather report" exercise was introduced in this session followed by completion of the Belief Inventory. The facilitators then gave a brief didactic presentation outlining the definition, causes, and long term consequences of child sexual abuse.

Following the break, the discussion of child sexual abuse continued. A handout listing several well known books on sexual abuse was provided for each group member (Appendix D). Homework included (1) journal keeping, (2) reading the handout describing cognitive restructuring (Burns, 1980, Ch. 3), and (3) practicing the self esteem exercise "goal-of-the-week." For a closing exercise, Virginia Satir's (1975) poem on self esteem was read

aloud by one of the facilitators and each woman was provided with a copy and encouraged to read it periodically.

Content. The weather reports on internal feelings were primarily negative, possibility indicating the anxiety being experienced as a result of recalling painful memories and feelings associated with each woman's sexual victimization.

During the group discussion of child sexual abuse both Susan and Peggy expressed their anger at male offenders which was clearly uncomfortable for others. Heather responded to this anger by stating that it was more important to "protect children than punish offenders." These sentiments reflect the strong loyalty to offenders often experienced by victims as well as a fear of losing control through the expression of anger. Mary felt that the discussion reminded her that sexual victimization by men continued into adult heterosexual relationships and that she has not known how to protect herself. The other women also voiced their distrust of heterosexual relationships, their confusion between sex and love, and their belief that there are no good men. Another important issue identified in this regard, was that women get their identity through men; as Mary stated "if you're not having a relationship with a man you're labelled as weird." Feelings of unworthiness of having a good relationship, sex-role socialization and power imbalances between men and women were identified as causes for these relationship problems.

Session 4

Outline. The group members completed the Belief Inventory then gave their internal "weather reports." Based on the information in the Burns (1980) article, handed out as homework reading last session, the facilitators explained the technique of cognitive restructuring giving examples (Appendix E). Following the break the group restructured an example of negative beliefs provided by Peggy. Homework assigned included journal keeping and "goal-of-the-week" self esteem exercise. In closing a piece written on risk taking was read to the group. This piece was written anonymously and brought to the group by Heather.

Content. More positive internal weather reports indicated increasing levels of comfort with the group experience. During the introduction to cognitive restructuring both Peggy and Martha provided examples of negative thoughts that contributed to feelings of incompetence and worthlessness in themselves.

For example, Peggy was feeling that she was a failure as a mother because she had granted her 15 year old daughter's wish to live with her father in another province. Her negative messages to herself were: "She doesn't care about me--she doesn't love me--I don't exist--I wasted my time--I had no impact on her--I failed her, maybe there was one more thing I could have done--Did I do the right thing in letting her go?" Peggy was experiencing distress from coping with an acting out adolescent daughter who

had been sexually abused by Peggy's common-law husband. The group helped her to restructure her negative statements so that she was able to state "maybe for her it wasn't the right thing but I know it's right for me--right now I'm important."

Learning to identify negative messages also helped Heather to recognize that her guilt feelings about her victimization stemmed from her need for attention and affection. This she received from the offender but she therefore blamed herself for the abuse. Recognizing that all children need attention and affection and that she sought these things rather than the abuse helped Heather and others begin to resolve their feelings of guilt.

Session 5

Outline. Completion of the Belief Inventory was followed by the internal "weather report." A group discussion was held on assertiveness and relationships with women. Following the break, the women participated in a "go-round" exercise in which they discussed the questions (a) What is your definition of self esteem, (b) how can you achieve it, and (c) what gets in the way of achieving it. The facilitators checked out what each woman was doing for her self esteem homework assignment. For homework, group members were asked to continue with their "goal-of-the-week" and journal keeping.

Content. During the weather report exercise it became apparent that all the women attending the session had experienced

feelings of having been taken advantage of which gave rise to a discussion of assertive behavior. The women felt that they were unable to say no to unreasonable requests by their children, family-of-origin, and friends. For example, Heather was expected to take on the role of peacemaker in her family of origin. She had, since childhood, always taken on the task of family caretaker, thus becoming the "parentified" child (Gelinas, 1983) and Heather had maintained this role in adulthood although she was becoming resentful of her family's continued demands.

Lack of assertiveness was identified as a problem in interpersonal relationships, particularly those with other women. Feelings of unworthiness and a continual need to prove that they were "nice" by always pleasing others contributed to the inability of these sexually abused women to assert their rights. The women recognized that they were being re-victimized in their adult relationships.

The development of trust within the group became apparent in this session. During the previous sessions, Louise had contributed very little to group discussions, however in this session she was able to identify her lack of assertiveness and low self esteem and participate fully in the discussion of these issues.

Session 6

Outline. Completion of the Belief Inventory and weather

report was followed by a didactic presentation on assertive and non assertive behavior focusing on personal rights as outlined on handouts on assertion (Appendix F). A "go-round" (What is your usual response to aggressive behavior?) and cognitive restructuring exercises on assertive behavior were held after the break. Assigned homework consisted of continuing the "goal-of-the-week" exercise.

Content. Negative internal weather reports by many group members were indications of a rise in feelings of isolation and loneliness brought about by the approaching Christmas season. The myths of "the perfect happy family" associated with Christmas created much distress for the women as they had never experienced a "happy family." Some cognitive restructuring was done to help the women recognize their ability to change their negative perceptions and to take control over whether or not they would enjoy the Christmas season.

The discussion and exercises on assertion revealed that basically the group members did not feel that they were worthy of any personal rights in interaction with other people and thus could not assert these rights. It was a revelation to the group members that each person has the personal right to express beliefs, opinions, needs, and feelings. They had been giving this privilege to others but not to themselves.

Session 7

Outline. When the Belief Inventory and weather report were completed, the group viewed the film "Responsible Assertion" (Baxley, 1978). Following the break, the women discussed the film, then completed the Self Esteem Tree exercise (Elkins, 1978). For homework over the Christmas break, the women were asked to continue to practice the "goal-of-the-week" whereby they would take time to do something nice for themselves in order to reinforce the notion that they are worthy of having their own needs met.

Content. Although the film Responsible Assertion was not originally scheduled to be shown in the series of group sessions, it seemed appropriate to do so in view of the continued concern of the group members with assertiveness issues. The film identifies negative beliefs about rights to assertive behavior and restructures these. As well, the film shows good examples of passive, aggressive, and assertive behaviors in a variety of situations. After viewing the film, Mary and Heather both identified their lack of assertive behavior in their relationships with sisters as stemming from a fear of rejection and a need for approval from their families-of-origin. The group helped these two women to restructure some of their negative beliefs concerning this issue.

Gwen and Heather had a great deal of difficulty in identifying their abilities (roots) and accomplishments (branches) in the Self Esteem Tree exercise, consequently the other women helped them to fill it out. Sharing the contents of their trees with each other elicited a very positive reaction in the group, as each woman had concrete evidence of her talents and accomplishments validated by the group. For example, Heather was surprised and pleased to learn that the other women thought she had a "good sense of humor."

Session 8

Outline. Completion of the Belief Inventory and weather report was followed by a group discussion of revictimization, secrecy, guilt, confrontation, and forgiveness. Homework assigned was to continue with self esteem exercises.

Content. Louise's disclosure that her adult daughter was having difficulty ending a relationship with a physically abusive boyfriend led to a discussion of re-victimization in adulthood. The women identified several reasons why women stay in abusive relationships, including feelings of low self esteem and powerlessness. Mary had been in an abusive marriage and told the group "I never felt good about myself, I thought I deserved the beatings--it wasn't the beatings I enjoyed, it was the fear of going out and being alone--I tried to commit suicide--that's when I hit bottom and started fighting to survive."

The secret of their sexual abuse was maintained by the women in childhood because of a fear of the consequences of disclosure, thus generating guilt feelings. Martha believed that she would have been blamed as her mother "blamed her for everything." Martha carried this expectation of blame into adulthood, "I grew up feeling afraid of people." Identifying the source of her negative belief that she is responsible for everything "bad" that happens in her adulthood relationships was helpful for Martha to resolve her guilt feelings. Gwen's fear of disclosing the abuse originated in her feelings of guilt about having experienced sexual pleasure during molestation by her step-father. This negative belief was restructured by the group. The alternate belief being that physiological response to stimulation is a normal bodily function that the child cannot control. Another source of guilt feelings identified by several group members was their feeling of having wasted a lot of time in getting around to dealing with the effects of their childhood sexual abuse. Anger towards the offender began to surface in this session and Gwen revealed a need to confront her offender step-father, "the anger and hatred is still there--I wish I could get rid of it, it's destroying me." Reasons for and possible consequences of confronting the offender were discussed. Ambivalence about feeling angry was expressed by Louise who felt it was important to "forgive" her father offender. In this session the women began to

express concern about what would happen to them when the group ended.

Session 9

Outline. Following completion of the Belief Inventory and weather report, the group progressed to a cognitive restructuring exercise on issues of self esteem. Goal-of-the-week was assigned for homework.

Content. Feelings of low self esteem contributed to "cloudy" weather reports by several women. One group member, Gwen, continually refers to herself as "dumb." When confronted with this by the facilitators she recognized the safety of this label as she had so often been criticized for any display of intelligence. Many of the other women, particularly Mary and Louise, also identified this as a coping strategy to avoid blame and criticism, but noted that it serves to maintain feelings of inferiority and worthlessness. Through the cognitive restructuring exercise these women were able to substitute the negative belief "Everybody is better than me" with the alternative belief "Some people can do some things better than me, but nobody *is* better than me." Evidence of the acquisition and use of the cognitive restructuring skills was provided by Louise who reported that recognizing her negative beliefs was like "a load off" and has given her a sense of self worth: "I used to feel guilty about feeling good, now I've started to let myself feel good."

Session 10

Outline. The Belief Inventory and weather report were completed. A discussion followed on feelings of isolation and problems in interpersonal relationships, especially those with women. Negative beliefs were then restructured. A handout on Hug Therapy (Keating, 1983) and a schedule of remaining sessions were distributed. The women were reminded to continue with their self-esteem homework exercises.

Content. Martha disclosed to the group that she was feeling lonely and needed to make some social contacts but didn't know how to do so. This led to a general discussion of the difficulties these women had in interpersonal relationships as they had so often been exploited in these relationships. A statement by Mary sums up the difficulty in relating to other women: "How can you have a relationship with a girlfriend or the next door neighbor when you've learned that the only thing you have to offer is your sexuality--you become isolated from women--because you have nothing to offer--I always felt that in relationships with other women you had to do something for them." Peggy added to this by commenting: "With all my relationships, men and women, it was always me giving 100% and being happy with the little scrap I got back--I just stopped doing that." The women identified low self esteem and a lack of trust as reasons for their difficulties in relationships and listed several negative beliefs in this regard

including (a) I don't need people, (b) I feel people won't want to be around me, (c) I'm not worthy unless I'm giving, and (d) I feel I might be used. Alternative beliefs provided were (a) I need people, everyone does, and (b) I'm worthy of taking as well as giving. At this point the women were unable to come up with alternative beliefs for their lack of trust and fear of betrayal.

A handout on "Hug Therapy" (Keating, 1983) was provided for the group members as the issue of giving and receiving physical affection was brought up, particularly by Heather who expressed her difficulties in this area. In this session, the members exchanged telephone numbers, urging each other to call if they needed to "talk," and from this point on began to greet each other with hugs. By receiving a schedule of the remaining five sessions, the women were reminded that the group was entering its ending phase.

Session 11

Outline. Completion of the Belief Inventory and weather report was followed by a brainstorming session on issues of trust.

Content. The issue of lack of trust in interpersonal relationships was continued from last session. Heather, for example, expressed a great deal of hurt and anger when she stated: "I find that if I trust people they eventually do something untrustworthy--I've gotten to the point where I don't trust anybody anymore." The consequences of not trusting people was

noted by Martha: "you tend to build a wall around yourself when you don't trust people." With further discussion of the trust issue, the group members were able to list their criteria for trusting (Appendix G).

Session 12

Outline. The Belief Inventory and weather report were completed followed by a continued discussion of trust issues.

Content. The group identified the fact that they had misjudged someone (the offender) as a major source of their difficulties in trusting their judgment of others' trustworthiness. The women listed the maladaptive methods by which they had handled untrustworthy behavior in the past and how they should handle it now, in a more effective manner (Appendix H).

Session 13

Outline. The women completed the Belief Inventory but the usual weather report was omitted in this session. Instead, a discussion of the function and value of the weather report exercise was held. The issues of forgiveness and anger were discussed.

Content. The group members reported that they have found it useful to identify their inner emotional states by relating it to a weather condition and to look for the source of these feelings. Louise brought up the issue of forgiving the offender which seemed

important for her to do. In general, the other group members did not feel the need to forgive the offenders as many of the women were just beginning to recognize and permit themselves to feel anger towards the offender. Previously, these victims had, as Gwen stated " buried their anger" or directed it at themselves and others in inappropriate ways such as destructive outbursts. Heather disclosed fear of her anger. She described herself as the family peacemaker or glue that kept her family of origin together and was fearful of becoming so angry at her offender brother that the secret would be out and would have a devastating effect on her parents and family. The facilitators pointed out that resolving these feelings of responsibility and loyalty to families, including the offender, together with feelings of guilt about their anger at the offender and at the family for their lack of protection, was often a very difficult dilemma for many sexual abuse victims. Others in the group felt that their anger and hurt had forced them to distance themselves from their families of origin and there was a sense of unfinished business and a need to re-connect. Gwen expressed this by stating "I have cut myself off from my family because of the hurt--and that's why I'm alone now--I'm so angry because of this (cutting-self off)--I missed my younger brothers and sisters growing up."

For the majority of women in the group, the receipt of attention and affection from the offender was an element of their

sexual abuse and served to ensure preservation of the secret and loyalty to the offender. Four of the group members disclosed that they had experienced feelings of jealousy when the offender turned his attention to another woman. For example Heather told the group--"I was really jealous and upset when my brother (offender) got married." The women also disclosed their feelings of shame and guilt for having had these feelings of jealousy, and their anger and hurt at the realization that they had been exploited as sex objects.

Many of the women reported difficulty in sleeping following group sessions and requested some relaxation exercises.

Session 14

Outline. Belief Inventories were completed and internal weather conditions were reported followed by a continued discussion on the issue of anger. To end the session a relaxation exercise was conducted.

Content. Feelings of anger about their abuse continued to surface and create distress for many group members. The following comments by Peggy reveal this process: "I didn't remember any of the details for 20 years, now I can remember it all--very angry feelings are coming out. I'm directing anger at males more than others lately...I didn't feel so angry when I was divvying up the blame."

In order to help the group members relieve some of the tension and anxiety they were experiencing from their recognition and expression of anger, a group relaxation training exercise was conducted. The members practiced deep muscle relaxation by listening to audiotaped instructions (Goldfried & Davison, 1976) and this was also assigned for homework.

Session 15

Outline. The group members completed four measures, the Belief Inventory, the Beck Depression Inventory, the Hudson Index of Self Esteem, and the Revised UCLA Loneliness Scale (Short Form). The discussion of anger was continued from last session together with a discussion of methods for coping with anger. The last half of the session was devoted to a farewell party and an ending exercise, The Toast (Elkins, 1978).

Content. Feelings of anger, and concern over the consequences of losing control over anger continued to be the main theme of the session.

Handouts outlining a "Specimen Coping Plan for Provocations" (Jehu, Gazan & Klassen, 1987c) and "Common Coping Statements" (Novaco, 1975) were given to the women. These formed the basis of a discussion of ways to effectively handle anger.

The conclusion of the series of group sessions was celebrated by sharing party fare that each woman had brought. Included in this celebration was an ending exercise, called the Toast (Elkins,

1978) in which each woman, starting with the facilitators, held a paper cup and toasted each person in the room, symbolically filling her cup with the qualities she identified in each person. For example, one woman might say to another: "Peggy, from you I take your insight and your humour, I put it in my cup, and I toast you." In this way, each woman's contribution to the group was acknowledged and this exercise proved to be a very moving experience for all participants.

Follow Up

A follow up session was held six weeks following the termination session. The purpose was for group members to check-in with each other and to collect follow-up data. The women filled out the Belief Inventory, the Beck Depression Inventory, the Hudson Index of Self Esteem and the Revised UCLA Loneliness Scale (Short Form). Two group members, Peggy and Louise were unable to attend as they had moved to other cities by this time.

A go-round exercise was conducted in which each group member discussed the following: (1) where is my life at right now?, (2) one thing that I like about myself, and (3) my personal goals for the next year.

The women reported increased use of assertive behavior and some changes in their interpersonal relationships in that they were beginning to be able to judge the trustworthiness of others. All of the women had set some personal goals for the short term.

Gwen, for example, is planning to finish her high-school education. With the exception of Heather, all of the women were able to articulate one thing they liked about themselves. With the assistance of the group members, Heather was subsequently able to do this as well. Martha, Mary and Gwen were all given a cheer for some specific assertive behavior they had exhibited outside the group and the women left the session with many demonstrations of affection for each other and promises to keep in touch.

Results

Analysis of Data

Belief Inventory (Jehu, Klassen & Gazan, 1984/5)

The results from this repeated measure are shown by means of graphs for each individual group member and are analyzed by means of visual inspection in order to compare changes occurring between the A and B phases of the intervention design. There are three elements to be considered during visual inspection: (1) level, (2) trend, and (3) stability (Bloom & Fischer, 1982). Level refers to the magnitude or extent of the problem and whether or not there is room for change. Trend refers to the direction of the pattern of data; that is whether it is increasing or decreasing and if change takes place, whether or not the pattern is generally maintained in the same direction. Stability refers to predictability, that is, whether the score on one data point predicts the score on succeeding data points. Several assumptions are made with regard to visual inspection. First that the level of the problem would be maintained or would escalate over time unless an intervention to promote change was implemented (Bloom & Fischer, 1982). Secondly, that the intervention program implemented would decrease the level of the problem and this change would be indicated by the desired direction in the trend of the data. Third, it was assumed that the changes would be continued and maintained in the desired direction.

The Belief Inventory measures the problem of negative beliefs that contribute to mood disturbances in women who were sexually abused in childhood. A total score of 15 or above indicates a clinically significant level of negative beliefs. The desired outcome of the intervention program is for the level of negative beliefs to decrease, therefore the trend would be in a downward direction.

Beck Depression Inventory (BDI) (Beck, 1978)

The results from pre-test, post-test and follow up measures on the BDI were compared to determine changes in scores for each individual. A score of 21 or above indicates clinically significant levels of depression. The intervention program of cognitive restructuring of negative beliefs was directed at reducing levels of mood disturbances including depression. Therefore a decrease in BDI scores was expected between pre-test and post-test measures.

Hudson Index of Self Esteem (Hudson, 1982)

Comparison of pre-test, post-test, and follow-up scores on this inventory indicates any changes in levels of self esteem for each group member. The cognitive restructuring of negative beliefs was aimed at increasing levels of self esteem. This increase is indicated by a decreasing score on the Hudson ISE. The cut-off point is 30 and a score above 30 is considered to be a clinically significant level of low self esteem.

Revised UCLA Loneliness Scale (Short Form) (Russell, Peplace & Cutrona, 1980)

Pretest, post-test and follow-up measures were administered and the results compared to indicate changes. The experience of contact in a group setting with other women who had been sexually abused in childhood is believed to relieve some of the feelings of loneliness and isolation these victims feel. Thus a reduction in overall feelings of loneliness was expected. Based on group norms, a score of 8 or above would indicate undesirable levels of feelings of loneliness, thus group scores were expected to change in a downward direction.

Individual Results

Martha

Belief Inventory. The highest score on the Belief Inventory during assessment was 15 which is the cut off point for a clinically significant level of negative beliefs. Two items were scored absolutely true (4): #7 "Anyone who knows what happened to me sexually will not want anything to do with me," and #15 "It must be unnatural to feel any pleasure during molestation." These responses indicate feelings of low self esteem and guilt respectively. The BI score at termination was 3 and at follow-up it was 4 (Figure 1). Item #15 continued to be scored either mostly true (3) or absolutely true (4) indicating that feelings of guilt persisted.

Beck Depression Inventory. At assessment, termination and follow-up Martha's scores on the BDI were 20, 5, and 3 respectively as shown in Figure 8. These scores do not indicate clinically significant levels of depression as they fall below the cut-off point of 21.

Hudson Index of Self Esteem. A score of 59 during assessment indicates very low self esteem. Termination and follow-up scores of 49 and 46 respectively, as shown in Figure 9, show that Martha continued to experience low self esteem at a clinically significant level well above the cut-off point of 30.

Revised UCLA Loneliness Scale (Short Form). Martha's scores on this measure, shown in Figure 10, were 9 at assessment, 10 at termination, and 9 at follow-up. These scores indicate above average levels of loneliness.

Summary. At termination and follow-up, overall negative beliefs about sexual victimization were not a problem as the scores were well below the cut-off. However, feelings of guilt for experiencing pleasure during molestation (item #15) continued to be a concern for Martha. Levels of depression were never high enough to be clinically significant. Initially, this may have been due to anti-depressant medication taken by Martha. Mid-way through the series of group sessions, Martha reported that she had discontinued this medication and the termination and follow-up scores indicated that an increase in depressive feelings did not

result from this. Martha's feelings of low self worth continued to be indicated by the measures although she verbally reported to the group on several occasions that she felt much better about herself and her improved physical appearance indicated this changed disposition. Feelings of isolation continue to be problematic for this client. The longstanding feelings of being different and isolated from others is compounded by the fact that Martha recently moved to the city from a small rural town and has had difficulty in making connections with others. She also reported that the group experience has made her realize the extent to which she has isolated herself from others for self-protection and this knowledge may have contributed to increased feelings of loneliness. However Martha also reported during her individual termination session with the co-facilitators that she feels more comfortable with her own company.

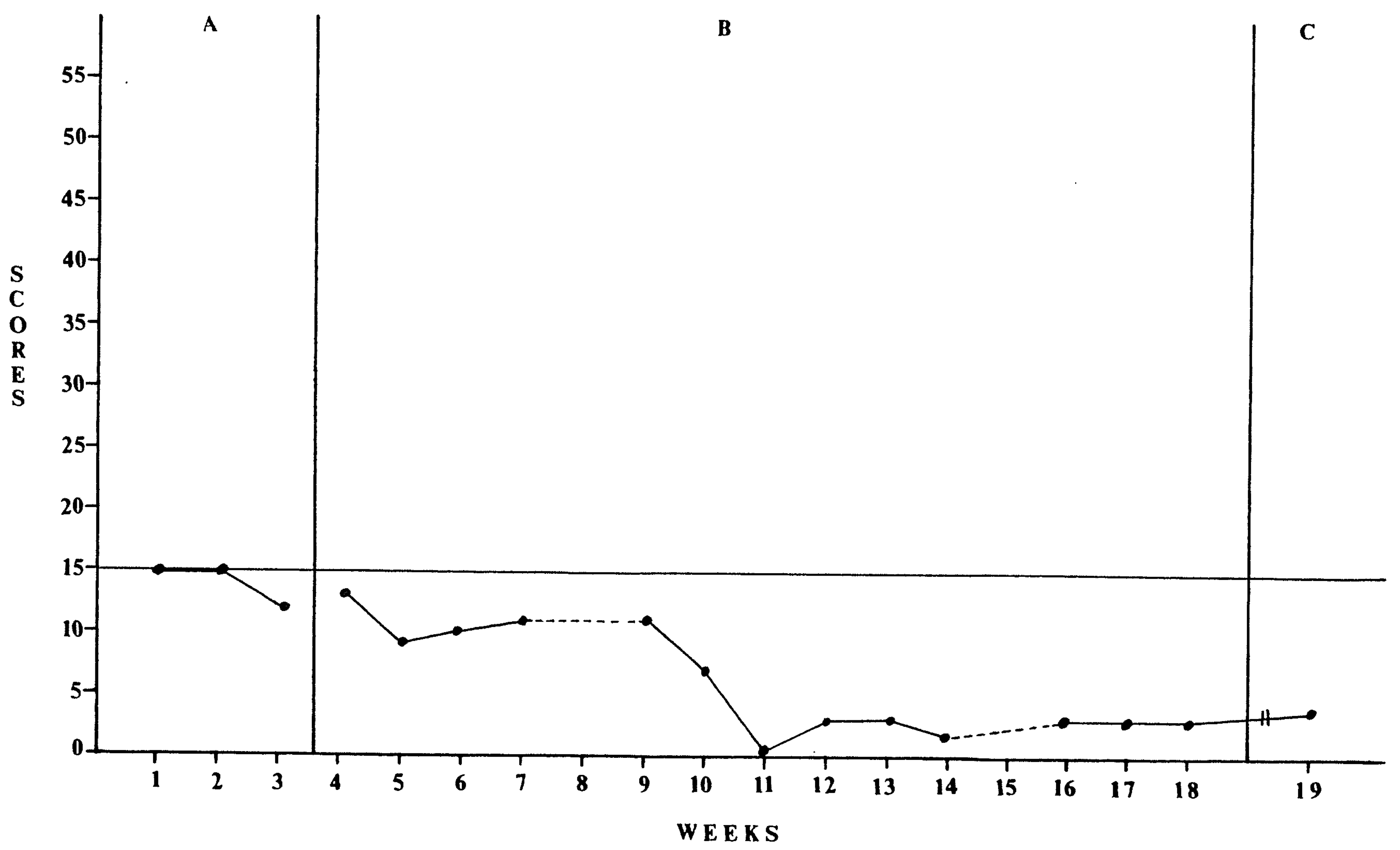
Figure 1

Belief Inventory Scores: Martha

A — Assessment

B — Treatment

C — Follow-Up



Gwen

Belief Inventory. As previously stated, this client received individual therapy in which negative beliefs were cognitively restructured and BI measures were given repeatedly. For purposes of collecting baseline data for the group, one BI measure was given during a pre-group interview and the score was 10. This score does not indicate a clinically significant level of negative beliefs, however some items indicating low self esteem and lack of trust were scored partly, mostly, or absolutely true. Termination and follow-up scores, illustrated in Figure 2, were 10 and 8 respectively indicating little change in negative beliefs.

Beck Depression Inventory. At assessment, termination and follow-up, scores on the BDI were 10, 9, and 6 respectively as shown in Figure 8. These scores do not indicate clinically significant levels of depression.

Hudson Index of Self Esteem. Gwen's score at assessment was 65 (Figure 9) which indicates very low self esteem. Termination and follow-up scores were both 54 which indicates a change in the desired downward direction, however the level remained well above the cut-off point of 30.

Revised UCLA Loneliness Scale (Short Form). Assessment, termination and follow-up scores were 12, 10, and 10 respectively, as illustrated in Figure 10. These scores indicate that Gwen experiences feelings of loneliness and isolation that are well

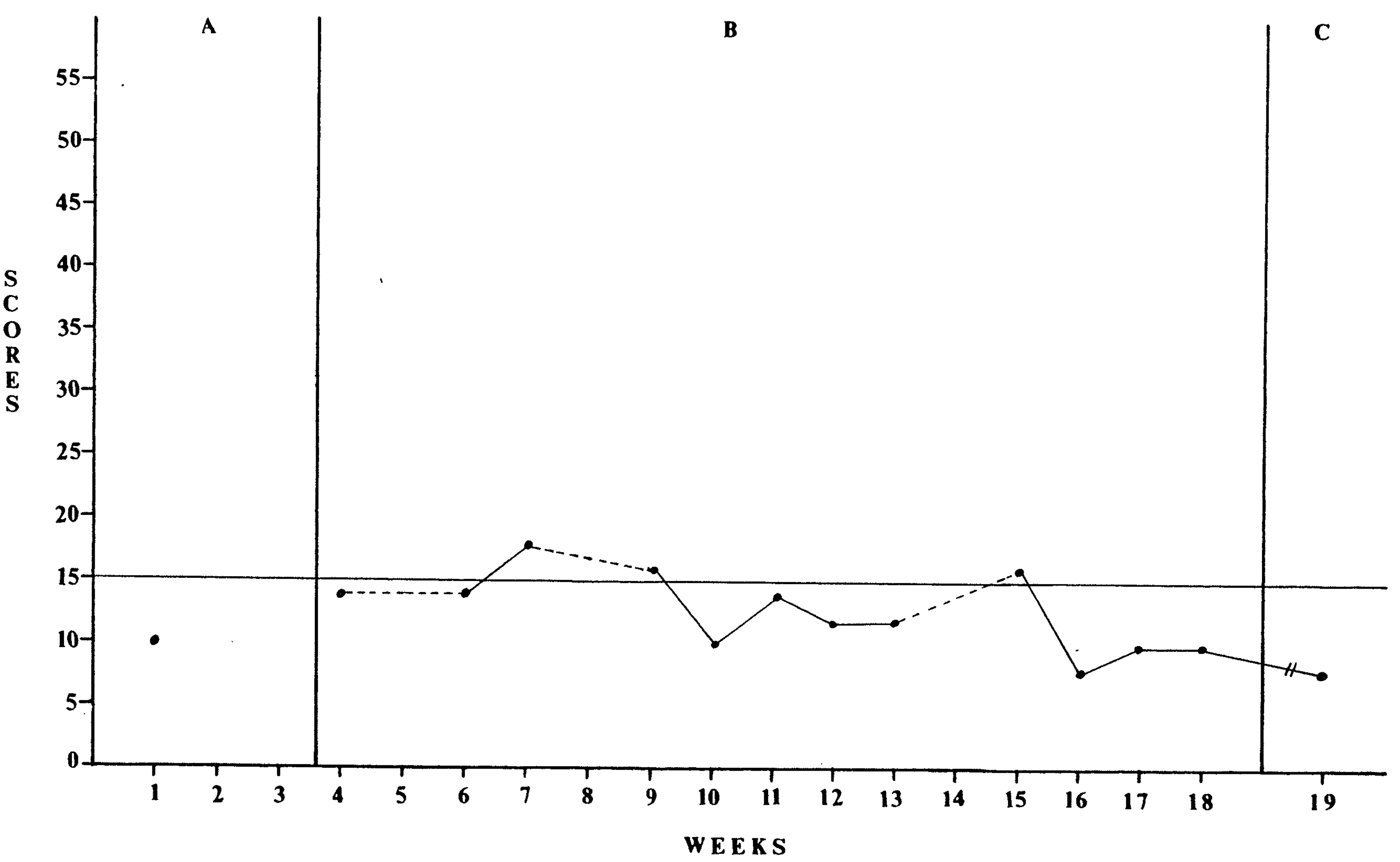
above the norm score of 8 and that these feelings persisted throughout group treatment and follow-up.

Summary. Gwen maintained scores well below the cut-off on all Belief Inventory measures (Figure 2). However, her self esteem remained very low and there appears to be a lack of consistency when the Hudson ISE is compared to the BI which contains self esteem items. It may be that Gwen feels that because she had received previous cognitive restructuring therapy, she *should* be scoring lower on the BI. Another explanation is that Gwen has restructured the negative beliefs at a cognitive level, thus the low score, but has not yet sufficiently assimilated the alternative beliefs at an affective level. Indeed, at the termination of the series of group therapy sessions, Gwen continued making self-denigratory statements such as "I'm so stupid" for which she was challenged by the group members and facilitators to restructure and to recognize how these statements contribute to her low self esteem. Depression is not a concern as evidenced by low BDI scores however Gwen feels quite lonely and isolated. Although she appears to have many friends and acquaintances, she perceives that people are "around me but not with me" (UCLA Loneliness Scale, item #2). As long as feelings of low self worth persist, Gwen will have difficulty in establishing satisfying egalitarian relationships with others.

Figure 2

Belief Inventory Scores: Gwen

A — Assessment
B — Treatment
C — Follow-Up



Heather

The highest score during assessment was 39 indicating a high level of negative beliefs about sexual victimization. General items measuring the variables of guilt, low self esteem and trust were scored absolutely true (4), for example, item #12 which states "I must have been responsible for sex when I was young because it went on for so long." At termination the score on the BI was 15, the clinical cut-off point, and at follow-up the score had risen to 20. Figure 3 illustrates the series of BI scores for this group member.

Beck Depression Inventory. The assessment score of 24 on the BI indicates mild depression. The score dropped to 15 at termination which is below the cut-off of 21 but again rose to 25 at follow-up (Figure 8).

Hudson Index of Self Esteem. The assessment score of 80 (Figure 9) indicates extremely low self esteem and although the score dropped considerably at termination to 61 and 66 at follow-up, these scores are well above the cut-off point of 30, thus for Heather, feelings of low self worth were only mildly reduced and continue to be problematic.

Revised UCLA Loneliness Scale (Short Form). High levels of feelings of loneliness were maintained throughout assessment, termination and follow-up as a score of 13 was recorded across all three measures as illustrated in Figure 10. The intervention of

group therapy did not produce any change in Heather's feelings of loneliness.

Summary. Figure 3 shows a progressive decrease in the level of negative beliefs during the group intervention phase indicating the determined efforts made by Heather to learn cognitive restructuring techniques and apply them both within the group and on her own outside of the group setting. Feelings of guilt were replaced with feelings of anger at the offender and her family of origin which were very unsettling for Heather as shown by the rise in the BI score at the follow-up. These feelings began to emerge towards the termination of the series of group sessions and escalated during the follow-up period. These angry feelings may also have contributed to a rise in the BDI score. Heather had been gradually decreasing her dosage of anti-depressant medication during the treatment phase but had increased dosage by the follow-up session.

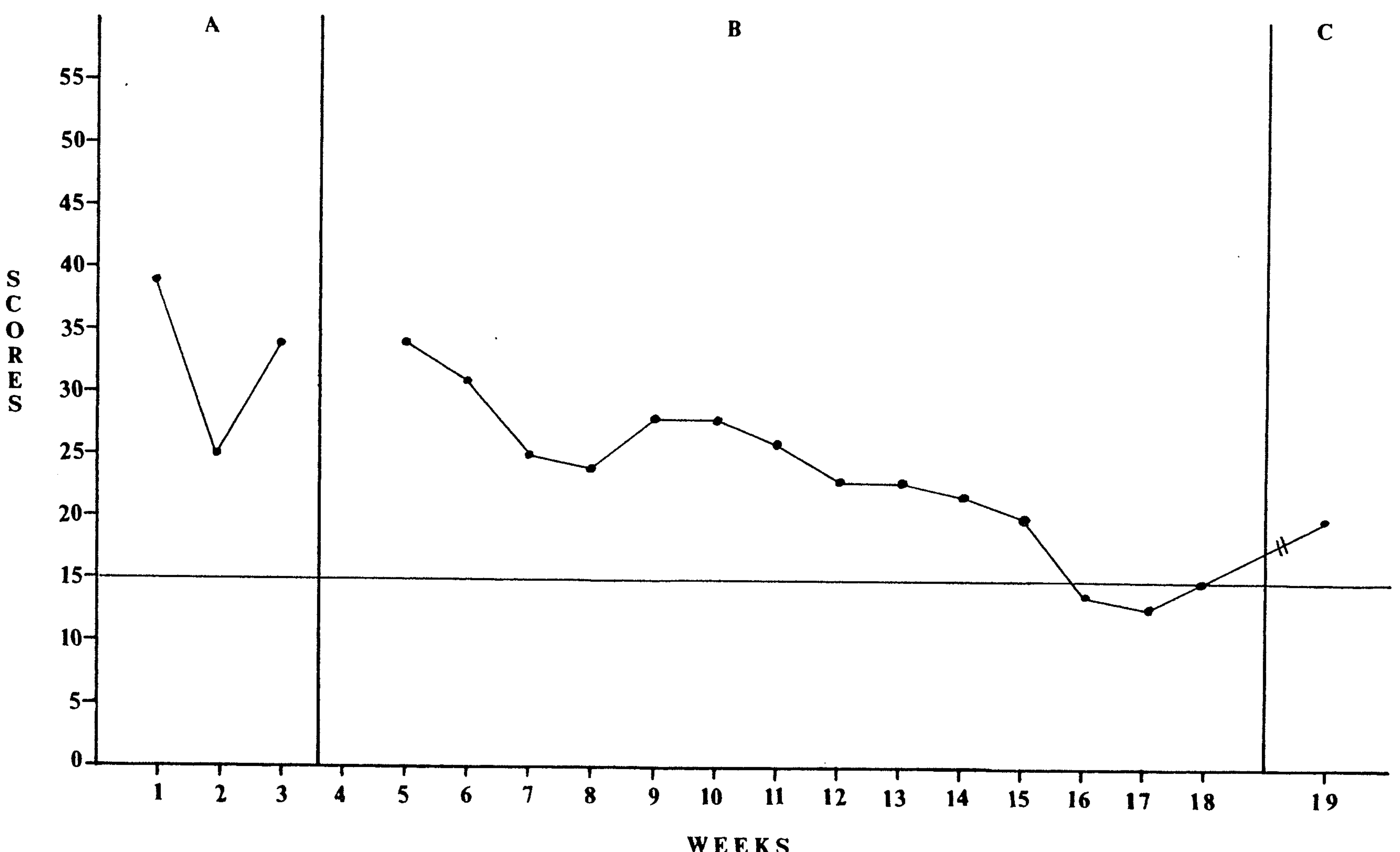
Feelings of low self-worth continued to be problems for Heather throughout all phases of the group although a lower score was achieved at termination. The slightly higher score at follow-up can possibly be explained by the fact that Heather was a very hard working and conscientious individual and her failure to resolve all her problems in one short therapy group may be contributing to increased levels of poor self esteem. The rise in the Hudson ISE at follow-up is also consistent with the rise in

the BI and the BDI as discussed above. Feelings of loneliness and isolation were maintained at the same level throughout all measures. During the course of group therapy that addressed interpersonal relationships Heather began to recognize that many of her relationships were exploitative, in the sense that people take advantage of her non-assertive behavior and her reluctance to make demands for reciprocity. This knowledge may have contributed to her inability to change perceptions about her isolation, her feeling that "nobody really knows me well" (UCLA Loneliness Scale, item #4). Heather reported increased use of assertive behaviors at the follow-up session and in time this will allow her to achieve satisfying interpersonal relationships. Following the termination of group therapy, Heather sought individual treatment to continue to work on resolving the long-term consequences of her sexual victimization.

Figure 3

Belief Inventory Scores: Heather

A — Assessment
B — Treatment
C — Follow-Up



Louise

Belief Inventory. During assessment, the highest score on the BI was 49 indicating a very high level of negative beliefs. The scores decreased steadily during the intervention phase in which cognitive restructuring was used as a therapeutic strategy to resolve the effects of negative beliefs and subsequent scores on the BI were 2 at termination and 1 at follow-up as illustrated in Figure 4.

Beck Depression Inventory. At assessment, a score of 26 on the BDI indicated mild depression. At termination the BDI score was 4 and at follow-up it was 1. Figure 8 illustrates the BDI measures for this group member.

Hudson Index of Self Esteem. The assessment score of 54 indicated that Louise suffered from very low self esteem. By termination of the series of group sessions, the Hudson ISE score was 31 which is one point above the clinical cut-off point thus indicating that a clinically significant change in self esteem had occurred during the therapeutic intervention and this change continued during the follow-up period as the follow-up score was 14. This is illustrated in Figure 9.

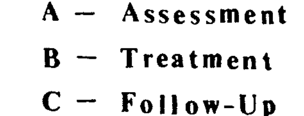
Revised UCLA Loneliness Scale (Short Form). The assessment score of 10 and termination score of 12 are both quite well above the norm of 8. As Figure 10 shows, the feelings of loneliness

decreased considerably in the follow-up period so that a score of 7 was obtained at follow-up.

Summary. Clinically significant changes occurred across all variables as scores were reduced to below the cut-off points on all measures. Louise worked very hard in the group to overcome her feelings of low self esteem by restructuring negative beliefs about herself and thus permitted herself the right to assertive behavior. For Louise, the most significant value of the group experience was to give her increased confidence in her own abilities and in general to have, at the age of 51, an opportunity to share and have validated thoughts and feelings kept to herself for so long. Louise tends to use denial to cope with the many stresses in her present life and this coping strategy is possibly reflected in the decreased scores on all measures. Further decreases on the follow-up measures may be a result of Louise's positive feelings about moving to another province with her husband and settling into a new life there.

Figure 4

Belief Inventory Scores: Louise



A

B

C

SCORES

55
50
45
40
35
30
25
20
15
10
5
0

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19

WEEKS

Mary

Belief Inventory. During assessment, the highest score was 37, a clinically significant level of negative beliefs thus verifying information obtained from the assessment interview that Mary holds negative beliefs about her responsibility for the abuse, her self worth, and trust in people. The score at both termination and follow-up was three indicating that clinically significant changes in the reduction of negative beliefs took place during the intervention phase and were maintained in the follow-up period. This process is illustrated in Figure 5.

Beck Depression Inventory. Scores well below the clinical cut-off point (21) for depression were recorded at assessment (13), termination (1), and follow-up (0), indicating that this client did not suffer from clinically significant depression and some depressive feelings were reduced over the intervention and follow-up period, as shown in Figure 8.

Hudson Index of Self Esteem. Very low self esteem was indicated at assessment by the score of 66 which is well above the cut-off point (30) for clinically significant levels of low self esteem. Following the therapeutic intervention of cognitive restructuring of negative beliefs contributing to feelings of low self esteem, Mary's Hudson ISE score was 20 at termination and 15 at follow-up, as illustrated in Figure 9, indicating clinically significant change.

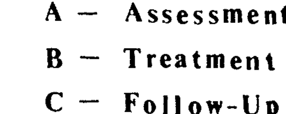
Revised UCLA Loneliness Scale (Short Form). Feelings of loneliness were measured above the norm during assessment when a score of 9 was recorded. At termination the score was 6, and this score was maintained at follow-up (Figure 10) suggesting that following group intervention, Mary did not experience feelings of loneliness.

Summary. Mary's already high level of negative beliefs rose even further to a score of 41 at the first group session (Figure 5). This was due in part to increased distress as a result of self-disclosure during assessment which brought to the surface thoughts and feelings that Mary had successfully kept suppressed for a long time. Because Mary had accepted food from the offender she felt very guilty about the abuse and these feelings were very entrenched and remained so until approximately the mid-point of the series of group therapy sessions when she was directly challenged by the co-facilitators to conclude that there was no rational basis for this false belief. Letting go of these guilt feelings seemed to be the key to increased self esteem. Mary's feelings of loneliness were not as great at assessment as many of the other group members (Figure 10) and these feelings were further decreased at termination and follow-up. This may be due, in part, to Mary's increased feelings of control in interpersonal relationships. Once she recognized her personal worth and her right to equality in relationships she felt better able to define

the nature of and seek the relationships she desired thus decreasing her perception of isolation and loneliness.

Figure 5

Belief Inventory Scores: Mary



A B C

SCORES

55 50 45 40 35 30 25 20 15 10 5 0

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19

WEEKS

Peggy

This group member moved from the city prior to the follow-up meeting and follow-up data is unavailable.

Belief Inventory. The highest score during initial assessment was 49 which indicates a clinically significant level of negative beliefs. After some fluctuations following assessment and first several group sessions, the BI scores show a downward trend, as shown in Figure 6, and the score of 5 at termination is well below the clinical cut-off point of 15.

Beck Depression Inventory. A moderate level of depression was indicated by a score of 35 at assessment. At termination of the group, the BDI score was 4 indicating a clinically significant change and that depression was no longer a problem for Peggy.

Hudson Index of Self Esteem. The score of 42 at assessment indicated that Peggy experienced feelings of low self esteem. As shown in Figure 9, this score was reduced to 18 at termination, which is well below the cut-off point of 30 for this measure.

Revised UCLA Loneliness Scale (Short Form). A relatively high score of 12 was recorded at assessment which subsequently dropped to 7 at termination which is below the norm of 8.

Summary. Peggy's Belief Inventory scores were fairly high and remained so during much of the intervention phase of the group as illustrated in Figure 6. During the time period Peggy was coping with the crisis of her 15 year old daughter, who had

disclosed the sexual abuse of herself and her siblings, moving to another province to live with her father. Peggy interpreted this as a failure on her part. This also contributed to the high levels of depression Peggy was experiencing. Although this crisis state was of concern because of its possible effect on Peggy's functioning in the group, she very much wanted to go through with the group experience and this motivation was a definite asset in helping her to restructure negative beliefs and develop a more positive evaluation of her self worth. Peggy felt very supported by the group process and the women in the group and reported that this was the key factor in giving her the confidence to seek and attain a managerial position in another city. This support also seems to be a factor in Peggy's ability to change her perceptions of loneliness and isolation but since follow-up data is unavailable, it is unknown whether these positive changes have been maintained over time.

Figure 6

Belief Inventory Scores: Peggy

A — Assessment
B — Treatment
C — Follow-Up

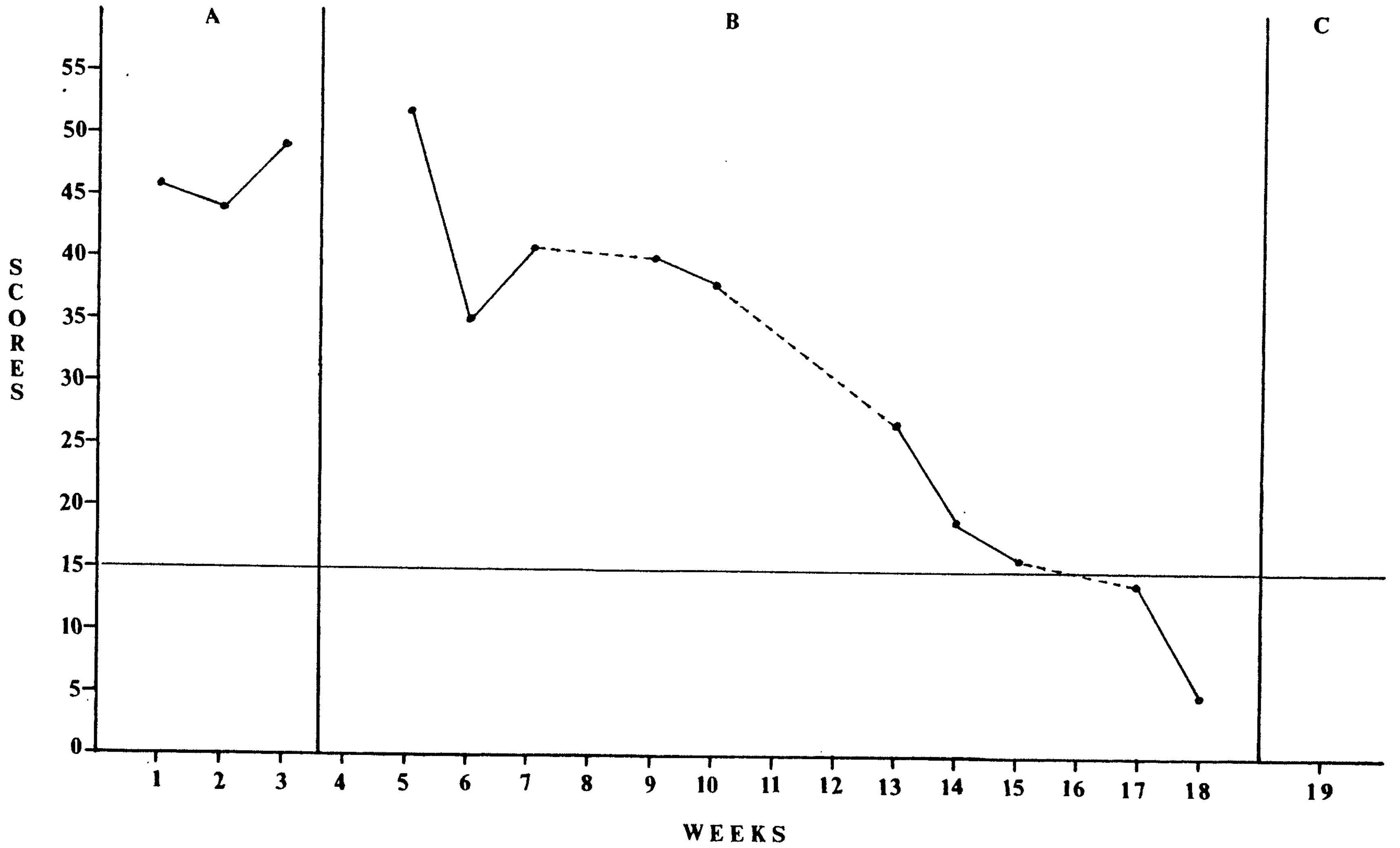
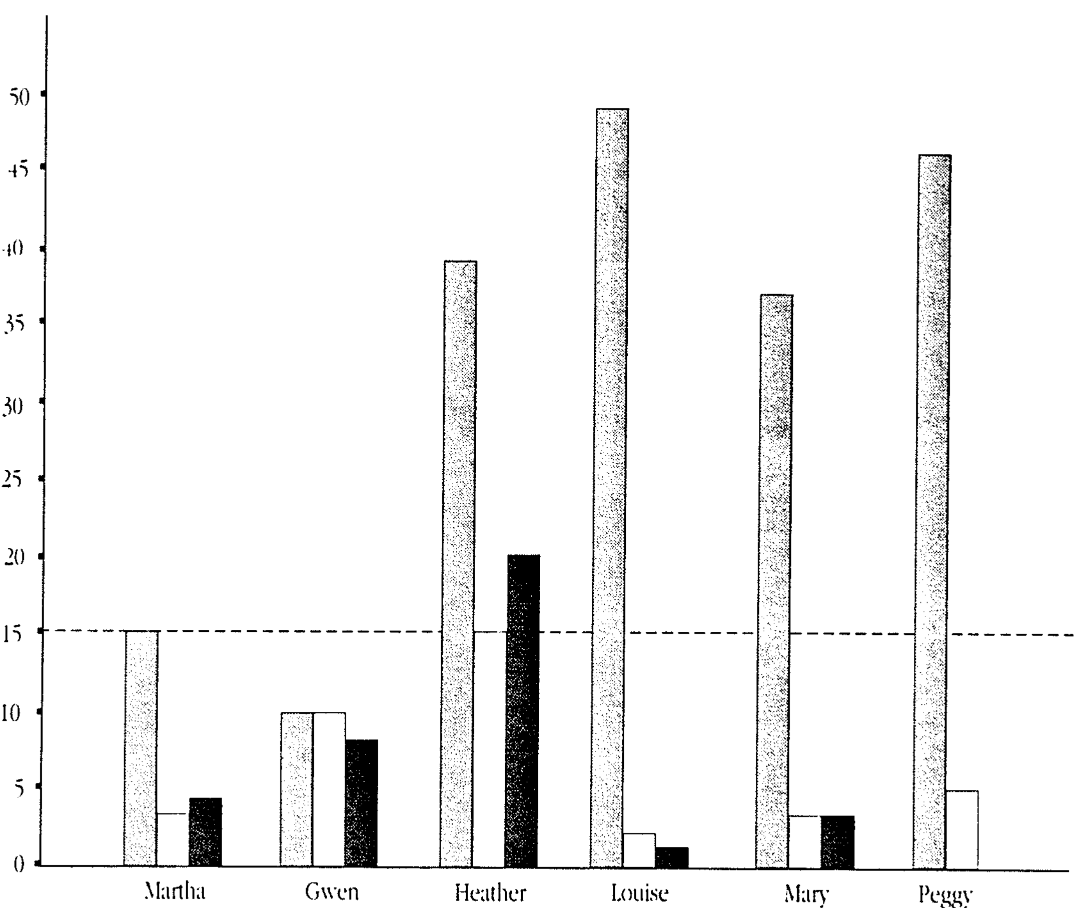


Figure 7

Individual Results: Belief Inventory



Assessment

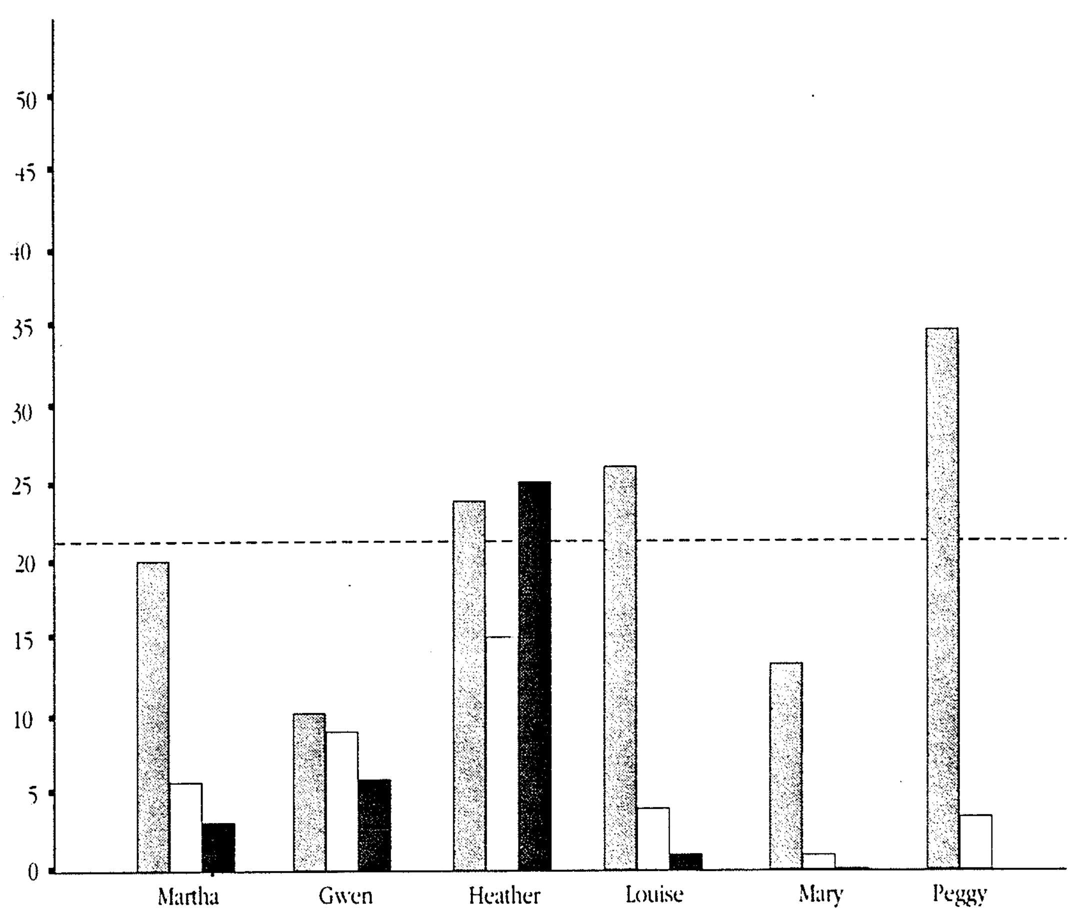
Termination

Follow-up

--- Clinical Cut Off

Figure 8

Individual Results: Beck Depression Inventory



Assessment

Termination

Follow-up

--- Clinical Cut Off

Figure 9

Individual Results: Hudson Index of Self Esteem

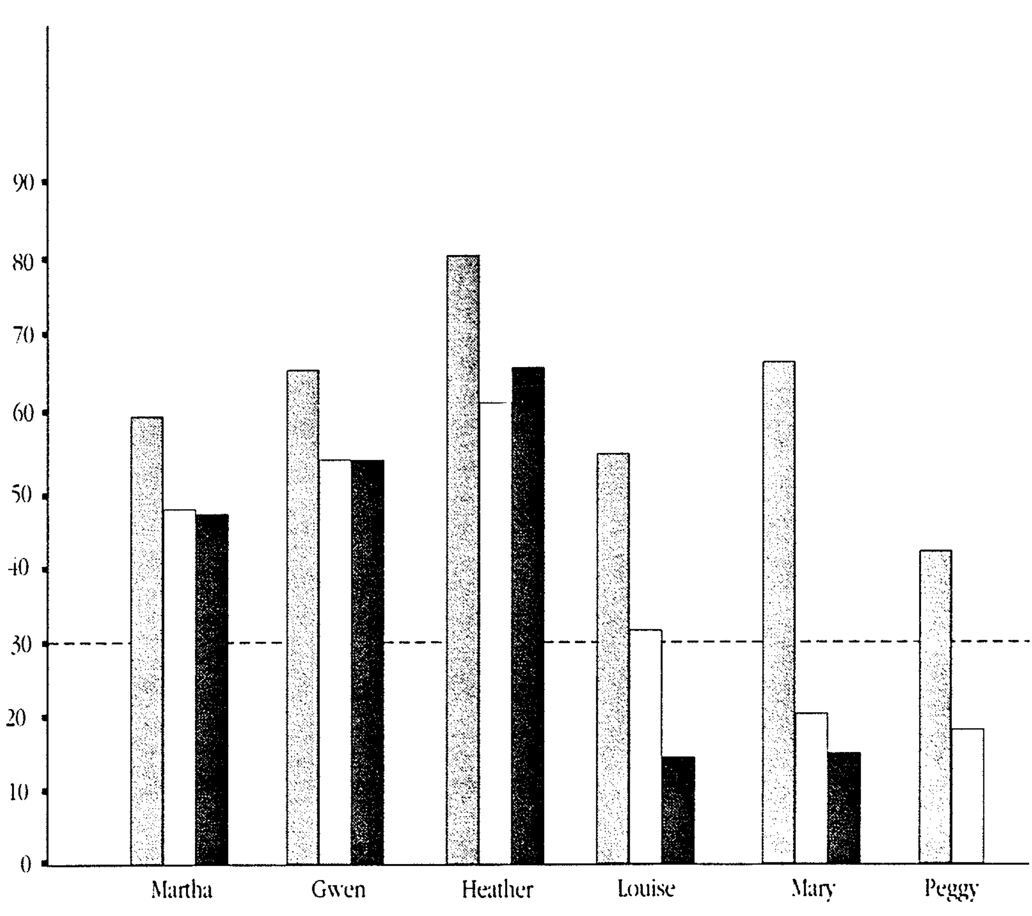
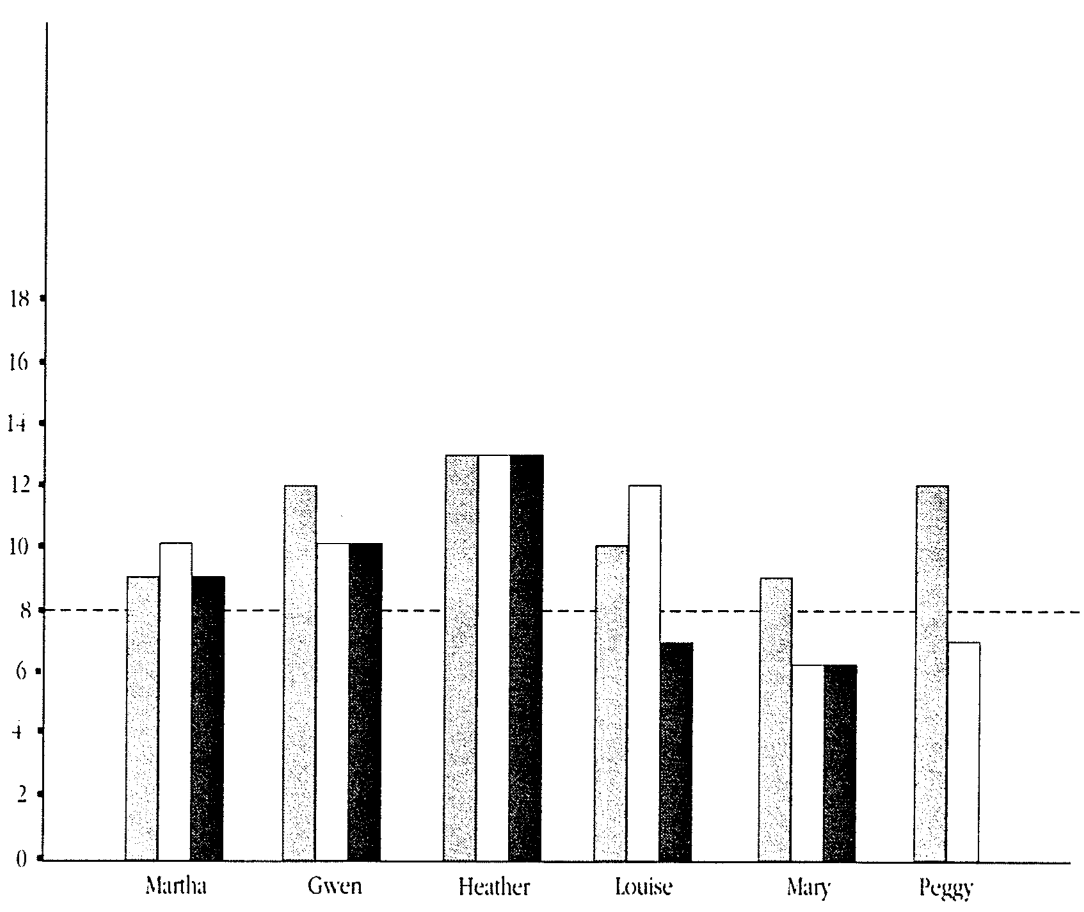


Figure 10

Individual Results: Revised UCLA Loneliness Scale (Short Form)



Assessment

Termination

Follow-up

--- Clinical Cut Off

Group Results

The group results are analzyed for five individuals as follow-up data is not available for one group member, Peggy, who had re-located to another city prior to the follow-up session.

Belief Inventory (BI)

At assessment four (80%) individuals had clinically significant levels of negative beliefs and one (20%) individual scored below the cut-off point of 15. Group responses to each item on the Belief Inventory are shown in Table 1. These are taken from the highest scored BI measure at initial assessment.

Table 1

Distorted Beliefs Among Victims (N = 5)

Belief	Responding as partly, mostly or absolutely true n	%
I am worthless and bad	4	80.0
No man can be trusted	4	80.0
Anyone who knows what happened to me sexually will not want anything to do with me	4	80.0
No man could care for me without a sexual relationship	4	80.0
Only bad worthless guys would be interested in me	4	80.0
It must be unnatural to feel any pleasure during molestation	4	80.0

I am inferior to other people because I did not have normal experiences	4	80.0
I must have permitted sex to happen because I wasn't forced into it	3	60.0
It is dangerous to get close to anyone because they always betray, exploit or hurt you	3	60.0
I must have been responsible for sex when I was young because it went on so long	3	60.0
I will never be able to lead a normal life, the damage is permanent	3	60.0
I must be an extremely rare woman to have experienced sex with an older person when I was a child	1	20.0
You can't depend on women they are all weak and useless creatures	1	20.0
I don't have the right to deny my body to any man who demands it	1	20.0
I must have been seductive and provocative when I was young	1	20.0
It doesn't matter what happens to me in my life	1	20.0
I've always been used so it doesn't matter if other men use me	1	20.0

At termination of the series of group sessions the scores on the BI for four (80%) of the individuals indicated that the level of negative beliefs was no longer clinically significant and one individual (20%) scored 15, the cut-off point. For the four individuals who scored below 15, their scores were maintained below this point at follow-up and the other individual's score

rose to 20 (Figure 3). The group results for the Belief Inventory, shown in Table 2 indicate that at follow-up four (80%) individuals had improved the level of their negative beliefs by decreased scores on the BI representing a clinically significant change and one (1) individual continued to experience a clinically significant level of negative beliefs although the termination and follow-up scores were considerably lower that the highest assessment score for this individual (Figure 7).

Table 2

Group Results for Belief Inventory (N = 5)

	Assessment		Termination		Follow-up	
Score	n	%	n	%	n	%
15 or above	4	80%	1	20%	1	20%
14 or below	1	20%	4	80%	4	80%

Beck Depression Inventory (BDI)

At assessment two (40%) of the individuals in the group had scores indicating clinical depression and three (60%) of the women scored below the clinical cut-off point of 21. At termination of the series of group sessions, all five (100%) of the women had scores on the BDI below 21 indicating that depression was not a problem at this time (Figure 8). One (20%) individual's score was again

above 21 at follow-up. Group results on the BDI are shown in Table 3.

Table 3

Group Results for Beck Depression Inventory (N = 5)

	Assessment		Termination		Follow-up	
Score	n	%	n	%	n	%
21 or above	2	40%	0	%	1	20%
20 or below	3	60%	5	100%	4	80%

Hudson Index of Self Esteem (ISE)

At initial assessment five (100%) women had clinically significant levels of low self esteem as measured by the Hudson ISE. At termination of group intervention procedures all the women showed lowered scores but four (80%) scored above 30 indicating that feelings of low self esteem continued to be problematic for the majority of group members. At follow-up three (60%) of the women continued to experience clinically significant levels of low self esteem and for two (40%) women, low self esteem was no longer a problem and these changes were clinically significant. The group results for the Hudson Index of Self Esteem are shown in Table 4.

Table 4

Group Results of Hudson Index of Self Esteem (N = 5)

	Assessment		Termination		Follow-up	
Score	n	%	n	%	n	%
30 or above	5	100%	4	80%	3	60%
29 or below	0	0%	1	20%	2	40%

Revised UCLA Loneliness Scale (Short Form)

Assessment scores on this scale indicate that five (100%) of the women felt more lonely than the average adult woman. At termination of the group intervention four (80%) of the individuals continued to experience above average feelings of loneliness and the score for one (20%) woman fell below the norm score. At follow-up three (60%) of the women felt more lonely than most women and two (40%) felt less lonely than most other women in the same age range. These results are shown in Table 5.

Table 5

Group Results for Revised UCLA Loneliness Scale (Short Form) (N = 5)

Score	Assessment		Termination		Follow-up	
	n	%	n	%	n	%
8 or above	5	100%	4	80%	3	60%
7 or below	0	0%	1	20%	2	40%

Consumer Evaluation

Client Satisfaction Questionnaire (CSQ)

At termination of the series of group sessions each woman was interviewed individually by the co-facilitators at which time the Client Satisfaction Questionnaire was completed. In general the responses on the CSQ are very favourable indicating that the five group members who completed the CSQ perceived that the therapy group had been a worthwhile experience for them. Responses to individual items on the CSQ are shown in Appendix I. Group results for the CSQ are shown in Table 6.

Table 6

Group Results for Client Satisfaction Questionnaire (CSQ)

Score	n	%
27 or above	5	100%
26 or below	0	0%

Evaluation Questionnaire (Appendix J)

In addition to the Client Satisfaction Questionnaire the group members were also asked to evaluate their group experience by written comments on specific aspects of the group intervention.

Personal goals. Identification of personal goals was undertaken during the assessment phase and first group session. For the most part, the women were unable to specify goals other than "to feel better about myself" and at termination all of the women subjectively reported that they had achieved this by some measure.

Format. The women reported feeling comfortable with the number of group members, length of sessions and location. However, each woman felt that 15 sessions were not enough and would like to have had the group continue longer.

Content. Very positive responses were given regarding the value of films, readings and exercises. For example, Heather commented "very helpful, they put into words what I couldn't" about the video It's not like scraping your knee (Krause, 1983). Cognitive restructuring exercises were reported to be helpful and several women felt they would like to have done more exercises in group sessions. Some women felt that the amount of discussion about their own sexual abuse experience was adequate while others would like to have had more discussion of this.

The final question stated "How do you feel about your group experience?" Evaluations were very favourable and all group

members reported the experience as beneficial in some way as illustrated in the following comments.

Martha. For me the group experience has been very worthwhile. I feel more confident about myself and my ability to cope with life. I feel much better now than when the group started.

Gwen. It has been a good experience for me. I needed someone to discuss my feelings and experiences with and who better to talk with than other women who have experienced the same things and feelings as I have. At times I feel a whole lot better about myself--but I still feel a need to go on from here but where do I go to now? What do I do now?

Heather. There were times when I wish I had never got into the group, some weeks it was almost too painful to remember all the hurt and shame. It would have been so much easier to stay the way I was before instead of making the changes. There are times when I feel a lot more mixed up now than I did prior to the group. Wouldn't it have been easier to try and forget about what happened instead of rehashing everything week after week when I got home from the sessions? I now realize that the group was exactly what I needed and I am glad I made myself see things through. I wouldn't let myself back out! This was for me and I deserved the help and if I didn't keep coming I would be hurting myself. (I'm tired of hurting me!) The group has helped me so much to realize that I wasn't alone, there were other women that had had the same

experiences. I wasn't the freak I had always considered myself to be. I might be an oddball but I'm not a freak.

Louise. When the group started I felt scared and did not know if I would be able to participate with the group. It surprised me that I was able to do so. I feel that this was because of the rapport that was formed with this group. There was a great amount of trust that seemed to have been there from the beginning, perhaps these feelings were there because we all shared the same experiences. There was at last someone to talk to. I feel that I have become more assertive and can now deal with problems in a more positive than negative way. I also feel a lot calmer, at peace from within--a great load is gone.

Mary. I must say when I first started the group I did not think I belonged. But I just wanted to get rid of all guilt of my sexual abuse. It was so hard to go back week after week after I let the group know things about me...Guilt for me is something that interfered with my everyday life. But this was something I felt I had no control of and would stay with me for life. Through the group I found out that wasn't so. I feel free today for the first time in my life. It is one of the greatest feelings one can have. I am not saying that everything is perfect because that is not true. I still have to deal with problems and feel people out. I also learned that there are people I can trust...the world sure is a better place to live in.

Discussion

Increasingly, adult victims are disclosing childhood experiences of sexual abuse. A certain portion of these victims suffer from the consequences of this trauma and seek help to deal with a range of long term effects of their victimization.

This study sought to implement a group treatment program that would alleviate distressful long term consequences of child sexual abuse. Based on evidence in the current literature it was assumed that most adult victims presenting for therapy would suffer from mood disturbances such as guilt, low self esteem and depression, and would have a history of difficulties in interpersonal relationships resulting in feelings of isolation and alienation. Thus, a group of female sexual abuse victims would share some commonalities.

A group treatment intervention using a cognitive behavioral therapeutic approach formed the foundation of the study. Cognitive behavioral strategies were successfully employed by Jehu, Klassen & Gazan (1987a) in treating individually victims of child sexual abuse who suffered from mood disturbances. One purpose of the present study was to evaluate the effectiveness of this same treatment approach in a group treatment modality for adult women who were sexually abused in childhood. While individual treatment has been shown to be very effective in resolving a wide range of clinical issues, among them mood disturbances, a group approach was assumed to be more advantageous

for breaking down interpersonal isolation and alienation by providing a safe atmosphere for victims to share the commonalities of their painful experiences and to recognize that they are not alone.

Additionally, the study sought to alleviate mood disturbances and isolation in a group treatment modality without each group member having access to the support of an individual therapist.

Effectiveness of Intervention

Three standardized measures were used to measure mood disturbances. The Belief Inventory (BI) measured negative beliefs contributing to guilt and low self esteem and these negative beliefs were the target of the cognitive behavioral intervention. The Hudson Index of Self Esteem (ISE) measured levels of self esteem and the Beck Depression Inventory (BDI) measured levels of depression. The Revised UCLA Loneliness Scale (Short Form) (RULS) was used to measure feelings of loneliness thought to be associated with isolation and alienation commonly experienced by child sexual abuse victims.

Resolution of Negative Beliefs

Of the five group members for whom assessment, treatment, and follow-up data is available four (80%) had clinically significant levels of negative beliefs regarding sexual victimization. The one group member who scored below the cut-off point of 15 had previously received individual treatment for resolving negative

beliefs using a similar therapeutic approach as the present group intervention. At termination all of the scores were at or below the cut-off point and at follow-up one (20%) score was above (see Figure 7). Since there were clinically significant changes in the reduction of negative beliefs in 60% of individuals and at least some reduction in all individuals as measured by the BI there is evidence that a cognitive behavioral approach that restructures negative beliefs may be one factor in successfully reducing these negative beliefs and thus contribute to alleviating mood disturbances such as guilt and low self esteem.

Alleviating Depression

On the whole, depression was not rated as a problem of serious concern as only two (40%) of the women for whom assessment, termination and follow-up data is available scored above the clinical cut-off point on the Beck Depression Inventory and these scores were in the mildly depressed range (see Figure 8). At termination, all (100%) of the women scored below the cut-off (21) and at follow-up one woman who had initially measured as mildly depressed again scored in this range. The intervention program cannot be said to have produced clinically significant changes in levels of depression since the scores remained close to or below the cut-off, however as shown in Figure 8 the repeated measures indicate that scores generally moved in a downward direction which

for the purposes of the group intervention was the desired and expected outcome.

Increasing Self Esteem

All five (100%) women for whom assessment, termination and follow-up data is available had very low self esteem scoring well above the cut-off point of 30 on the Hudson Index of Self Esteem at assessment (Figure 9). At termination of the series of sessions all of the scores had moved in the desired downward direction but with the exception of one (20%) woman, the scores were still indicative of clinically significant levels of low self esteem. Scores continued the downward trend and at follow-up three (60%) of the women continued to experience low self esteem while two (40%) showed clinically significant change, achieving scores well below the cut-off point of 30. Lifelong feelings of low self esteem commonly experienced by child sexual abuse victims appear to be very resistant to change in the short term and while some positive changes were observed in group members as indicated by lowered ISE scores, these changes were not of a clinically significant nature although the continued downward trend (Figure 9) offers some expectation that continued improvements in self esteem may be an ongoing process initiated by the group intervention.

The Belief Inventory contains several items that pertain specifically to self esteem and it is interesting to note that

although scores on the Hudson ISE remained in the clinically significant low self esteem range for four (80%) of the women at termination and three (60%) at follow-up, the Belief Inventory scores were below the cut-off point for all five (100%) of the women at termination and for four (80%) at follow-up. This suggests that self esteem issues are resolved more quickly at the cognitive level as a result of the acquisition of cognitive restructuring skills practiced in the group sessions, but may take longer to resolve at the affective level. A longer follow-up period may have been more useful to determine whether or not the effects of the group intervention would indicate continued improvements in self esteem that could be expected from the downward trend of the scores on the Hudson ISE.

Alleviating Isolation

All five (100%) of the women for whom complete data is available had feelings of loneliness that were above the norm as measured by the Revised UCLA Loneliness Scale (Short Form). At termination four (80%) of the women continued to feel lonely and at follow-up three (60%) continued to do so.

The issue of developing and maintaining interpersonal relationships was discussed in the group sessions as indicated in the Report on Group Sessions. As a result of these discussions, many women began to realize that although they had a number of friends and acquaintances these relationships were often

exploitative. The women also identified lack of ability to trust others as a major impediment to the development of intimate relationships with others. The realization that their relationships lacked the desired qualities of reciprocity and trust may have contributed to continued feelings of loneliness for these women. The issue of trust emerged as one of the most significant themes in this particular group, with three sessions devoted to defining trust and dealing with untrustworthiness.

Non-assertive behavior was also identified as one reason why these women tended to develop relationships with exploitative individuals. Lack of assertiveness was related to low self esteem and through group discussion the women identified the negative belief that because they were "damaged-goods" or "worthless and bad" individuals they had no personal rights to assert themselves. Consequently cognitive restructuring exercises were conducted around this issue. Hopefully a raised sense of self worth, the ability to identify trustworthiness, and a belief in personal rights will, over time, allow these women to take some risks towards developing quality interpersonal relationships which will alleviate their current feelings of loneliness.

The group members subjectively reported that one of the important benefits of the group was the contact with other women who had experienced sexual abuse in their childhood. The women felt relief to discover they were not the only ones who had been

abused and they felt less alone. However, feelings of loneliness were not alleviated for these women as indicated by scores on the Revised UCLA Loneliness Scale (Short Form). One explanation of this discrepancy may reside in the instrument itself. The short form of the RULS consists of only four items and as such may not cover a wide enough range to be sensitive to changes in feelings of loneliness. The longer form of the Revised UCLA Loneliness Scale (Russell, 1982) which contains 20 items may have been a better instrument to use in this instance. Another explanation may be that alleviating isolation by means of a group intervention may only be effective within the group itself and does not generalize to relationships outside of the group.

Clearly the issues of isolation and loneliness commonly found with victims of child sexual abuse requires further investigation that would include a more distinct definition of the variables so that an appropriate fit can be made with measuring instruments.

Future Planning

Consideration should be given to a number of points in order to enhance the functioning of future group interventions for adult women who experienced childhood sexual abuse and who suffer from the long term consequences of this victimization.

Therapists

The experience of this group intervention supports the evidence in the literature that a female co-therapy team is

appropriate for facilitating such a group. The majority of group members identified being exploited in interpersonal relationships, many of which were with other women. Therefore, provision of two female co-therapists who attempted to provide a safe non-exploitative environment was important to the identification and development of trust not only within the group itself but in relationships outside the group. Whether a mixed co-therapy team would be equally acceptable and effective remains a question for further research.

Both facilitators perceive that they functioned well as a team, carrying out the tasks and roles as planned. The most important personal benefit of co-therapy lies in the mutual support that is so necessary in a group of this nature which can become emotionally intense at times.

Absence of Individual Therapist

One purpose of the group intervention was to demonstrate that effective group intervention could be carried out without the additional support of individual therapy for each group member. Based on individual and group results positive gains were made by all the women without this additional support. The reason for this may be that the group facilitators maintained a low key non-threatening approach as promised to the group members at the outset. A more confrontative group process might require additional supports for each individual. Secondly the interim and termination interviews conducted individually with each group

member proved to be a valuable resource for several of the women who at mid-group seemed to be stuck. For example, Mary could not progress in resolving other issues until she dealt with her guilt. Although this was openly discussed in several group sessions, she required some individual time focused on the particular circumstances maintaining her guilt. Several women required some future planning and referrals for ongoing treatment and the termination interview allowed the facilitators to do this without consuming group time.

Assessment Interviews

Although the assessment interviews were valuable for developing trust and alleviating concerns regarding entering the group, many women found the assessment process distressing, particularly any discussion of details of their victimization such as sexual activities. To avoid creating undue anxiety and the risk of drop-out prior to the commencement of group sessions, a more general assessment scheme could be used. This would serve the purpose of screening individuals to determine their suitability for the group by focusing on the long term consequences.

Structure

The planned structure of the group intervention proceeded with only some minor changes that should be incorporated into future groups as discussed below.

The weather report exercise proved to be valuable in helping the group members learn to identify their internal emotional states. This was aptly demonstrated by Heather who in the last session brought in a picture entitled "How do you feel today" which had faces depicting 70 different emotional states. The nature of the weather report changed as the group progressed through the series of sessions. The time spent on the weather report lengthened as the women explained the reasons for their emotional states. Although some important clinical issues came out of the weather report exercise, the discussion tended to focus on current problems. In retrospect, the weather report exercise should be more specifically focused on getting in touch with emotional states as a pre-condition to discussion of issues of sexual victimization and to check out the effects of the group intervention on individual functioning. Facilitators should be aware that group members may tend to focus on current problems in order to avoid discussion of deeper, more painful issues (Leehan & Wilson, 1985).

Towards the end of the series of group sessions it became apparent that the women in the group were experiencing a certain amount of stress as a result of the group intervention which was typically characterized by sleep disturbances. At this point a deep muscle relaxation exercise was introduced which would have been more beneficial if it had been introduced at the beginning of the series of sessions so that group members could have early

access to the relaxation tape if they so desired, and would have learned some technique for reducing stress and tension following group sessions.

The initial plans for group structure included provision of homework assignments such as journal keeping, readings, and practice of cognitive restructuring techniques. In general, very few of the women carried out homework assignments which may be because these assignments were optional or because dealing with sexual abuse issues outside of the supportive group environment was too threatening. To ensure that cognitive restructuring skills are learned, future groups should incorporate more formal restructuring exercises within group sessions rather than rely on group members to practice these skills on their own time.

In some therapy groups for child sexual abuse, victims are strongly encouraged to disclose details of their victimization as part of the therapeutic process. With the intent of creating a non threatening environment, the women in this group were advised of the benefits of such a disclosure but were also promised that there would be no pressure to do so, and that they should find their own level of comfort in disclosing details that they often perceive as shameful. Many women commented on the evaluation questionnaire that they would like to have had more discussion of their own sexual abuse. This leads to the conclusion that once sufficient trust has developed in the group, some emphasis can be

placed on the importance of self disclosure. If the facilitators can do this with sensitivity then a balance can be maintained between pushing individuals beyond their limits on the one hand and giving the message that the sexual abuse is still a shameful secret on the other.

The co-therapy team acted to facilitate the group process with the understanding that clinical issues that were important to this particular group of adult victims of child sexual abuse would emerge naturally. In a certain sense this did occur and the issues of guilt, low self esteem, assertiveness, and trust in interpersonal relationships were significant themes throughout the series of group sessions. Intense feelings of anger began to surface for several of the women in the ending phase of the group leaving an insufficient number of sessions to deal with this anger. A longer series of sessions would have been beneficial. Although facilitators should avoid overcontrolling the group process, it is also necessary to ensure that certain clinical issues are dealt with. It would seem appropriate, then, to put important clinical issues, such as anger, on an agenda rather than depend solely on group process to identify certain issues.

Conclusion

Belief Inventory results provide encouraging evidence that the cognitive behavioral approach, used in this group intervention, was successful in resolving negative beliefs

contributing to mood disturbances in adult victims of child sexual abuse. However, low self esteem and feelings of loneliness continued to be problems for the majority of group members and it is unclear whether the positive changes that did occur to some degree in these areas would continue over time.

It is difficult to capture the essence of the present therapy group by visual examination of tables and graphs. Certainly the subjective reports of the women on perceived group benefits were extremely positive leaving the impression that the group intervention was a very good experience for all concerned. These sentiments are most thoughtfully expressed by the author Elaine Westerlund:

> Although tremendously difficult, the treatment of women with histories of incest is enormously rewarding. They are highly resourceful, tested as children in ways few of us will ever be tested as adults. The many strengths that have served them in the past they bring to you, the therapist.
> Their strengths are gifts to recognize, applaud, and take comfort in. They are women who have survived already; they are no longer dependent, no longer helpless, and no longer silent. This often comes as a surprise to them. For the therapist, what could be more exciting than to facilitate such a discovery (Westerlund, 1983, p. 29).

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APPENDICES

Appendix A

Belief Inventory

Reproduced by kind permission of

Derek Jehu

Psychological Services Center

University of Manitoba, Winnipeg

NAME: ______________________

DATE: ______________________

Belief Inventory

Please check (√) one column from 0 to 4 that best indicates how strongly you believe each statement to be true in your own case. Please answer according to what you really believe yourself, not what you think you should believe.

	Absolutely Untrue 0	Mostly Untrue 1	Partly True Partly Untrue 2	Mostly True 3	Absolutely True 4
1. I must be an extremely rare woman to have experienced sex with an older person when I was a child.					
2. I am worthless and bad.					
3. You can't depend on women, they are all weak and useless creatures.					
4. No man can be trusted.					
5. I must have permitted sex to happen because I wasn't forced into it.					
6. I don't have the right to deny my body to any man who demands it.					
7. Anyone who knows what happened to me sexually will not want anything to do with me.					
8. I must have been seductive and provocative when I was young.					

(OVER)

	Absolutely Untrue 0	Mostly Untrue 1	Partly True Partly Untrue 2	Mostly True 3	Absolutely True 4
9. It doesn't matter what happens to me in my life.					
10. No man could care for me without a sexual relationship.					
11. It is dangerous to get close to anyone because they always betray, exploit, or hurt you.					
12. I must have been responsible for the sex when I was young because it went on so long.					
13. I will never be able to lead a normal life, the damage is permanent.					
14. Only bad, worthless guys would be interested in me.					
15. It must be unnatural to feel any pleasure during molestation.					
16. I am inferior to other people because I did not have normal experiences.					
17. I've already been used so it doesn't matter if other men use me.					

Appendix B

PROCEDURAL GUIDELINES
for
Therapy Group

* Be on time

* Attend each session **

* Observe confidentiality

* Commit to work with group members and facilitators

* Respect safety zone of group members and yourself

* No smoking - except at break

* No alcohol or drugs

** If you are unable to attend the group session please call Jane McCallum or Marjorie Gazan at the Psychological Services Center.

474-8232
474-9222 (leave message)

Appendix C

Ice Breaker Exercise

What is your life situation right now?

(Tell whatever you _want to_ about partner, children, whatever is going on in your life)

How are you feeling right now?

(Use a weather condition to describe your feeling - for example: sunny with cloudy periods, stormy, foggy)

What is one significant thing about yourself that you want to share with the group?

(For example, a talent, hobby or interest)

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University of Manitoba - Book Store
University of Winnipeg - Book Store
Winnipeg Public Library

McNally-Robinson Booksellers - 1875 Grant, Wpg.

Bold Print - 478A River Ave (River & Osborne)

Appendix E

Example: Cognitive Restructuring of Negative Beliefs

Reproduced by kind permission of

Derek Jehu, Carole Klassen, and
Marjorie Gazan

(Source: Jehu, Klassen, Gazan, 1985/6)

Table 1

Client Record of Beliefs

Negative beliefs	Cognitive distortions	Alternative beliefs
I must have been responsible for sex when I was a child because I wasn't forced into it and it went on so long.	Personalization. Jumping to conclusions.	In a sense I was forced into it and could not stop it because (a) the offender kept persuading me by saying "what's the matter, don't you want to help an old man?" I had been indoctrinated with the belief that nice little girls were supposed to help and please people, especially old people, and did not want to hurt him by not continuing to participate; (b) I desperately wanted attention from someone outside my family and he gave me this; (c) I could not refuse to take his lunch out to the fields where the abuse often happened, because I would have to explain to his wife why I was refusing; (d) I did not want to upset her; (e) I feared that if I told my mother she would do nothing to protect me; and (g) I could not consider telling my father because I hated him, I feared that he would blame or punish me or not do anything.

Table 2

Client Record of Beliefs

Negative beliefs	Cognitive distortions	Alternative beliefs
I am weak for making such a big thing out of the abuse, especially when I know that many women have been abused in degrees far more severe than me. I should be able to handle it better and not let it interfere with the lives of myself and others.	All or nothing thinking.	Like everyone else, I am not completely weak or completely strong.
	Overgeneralization.	The fact that I have difficulty coping with the abuse does not mean that I have difficulty in coping with everything.
	Mental filtering.	There are many areas of my life in which I function quite satisfactorily. The problem I have with the abuse is only one part of my life.
	Mislabeling.	Having difficulty in coping with the abuse does not mean I am a weak person.

TABLE 2, continued

Negative beliefs	Cognitive distortions	Alternative beliefs
	Emotional reasoning.	The fact that I feel helpless does not mean that I am helpless. I have got myself into therapy and am working on coping better with the abuse.
	Should statement.	It is not very realistic or productive to expect better coping from myself. I'm only human and many women have difficulty in coping with the long-term effects of sexual abuse.

Appendix F

Assertion Bibliography

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1. Handout displaying the difference between passive, aggressive, and assertive behavior (p. 127).
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TRUST

Criteria for trusting:

A trustworthy person is:

Someone who will protect you when you need it.

Someone who does what they say they will do.

Someone who has good body language when you're confiding in them (calm, direct, attentive).

Someone who doesn't talk negatively about others - doesn't gossip.

Someone who can be a friend without always expecting something in return.

Someone who allows distance - not pushy.

Someone who gives unconditional love, positive regard.

Someone who knows what you're feeling and can ask.

Someone who is honest about being available or not.

To be able to trust:

You must know and trust yourself and your judgment first.

To receive trust you must give trust.

Dealing With Untrustworthiness

In the Past

Anger

Desire to hurt back

Hide - don't give another opportunity to hurt

Hurt for a long time

Fear of being hurt further by negative judgments

Test more

Ignoring

Feeling rejected and used

Feeling "no good" - not useable any more

Hyper observant

Not allowing self to trust - don't get self into the position

Now

1. Accept having been hurt
2. I don't have to hurt forever
3. Allows us to trust again
4. Know your personal worth - that is - "I am deserving of respect"

Trust your own judgment

Tell person you've been hurt

Withdraw your trust in the person who hurt you

Know that you have the right and the power to withdraw trust and to test.

Deliberate testing without guilt

Differentiate between close friends and acquaintances/ associates and determine your level of trust in each.

Appendix I

Responses on Client Satisfaction Questionnaire (N = 5)

	n	%
1. How would you rate the quality of service received?		
Excellent	5	100.0
Good	0	0.0
Fair	0	0.0
Poor	0	0.0
2. Did you get the kind of service you wanted?		
Yes definitely	4	80.0
Yes generally	1	20.0
No not really	0	0.0
No definitely not	0	0.0
3. To what extent has our program met your needs?		
Almost all my needs have been met	2	40.0
Most of my needs have been met	3	60.0
Only a few of my needs have been met	0	0.0
None of my needs have been met	0	0.0
4. If a friend needed similar help would you recommend our program to him/her?		
Yes definitely	5	100.0
Yes I think so	0	0.0
No I don't think so	0	0.0
No definitely not	0	0.0

Appendix I continued

	n	%
5. How satisfied are you with the amount of help you received?		
Very satisfied	4	80.0
Mostly satisfied	1	20.0
Indifferent or mildly dissatisfied	0	0.0
Quite dissatisfied	0	0.0
6. Have the services you have received helped you to deal more effectively with your problems?		
Yes they have helped a great deal	5	100.0
Yes they have helped somewhat	0	0.0
No they really didn't help	0	0.0
No they seemed to make things worse	0	0.0
7. In an overall, general sense how satisfied are you with the service you received?		
Very satisfied	5	100.0
Mostly satisfied	0	0.0
Indifferent or mildly dissatisfied	0	0.0
Quite dissatisfied	0	0.0
8. If you were to seek help again would you come back to our program?		
Yes definitely	4	80.0
Yes I think so	1	20.0
No I don't think so	0	0.0
No definitely not	0	0.0

Appendix J

In order to plan future groups for sexually abused women we need your help. Please answer the following questions to the best of your ability so that we can learn from your own personal group experience. Thanks!

1. At the beginning, we discussed setting your own personal goals for the group. (For example, improving self esteem) In what way have your goals been met or not met?

2. Please give us your comments about some of the following: (For example, were these helpful, not helpful, distressing)

Weather reports:

Journal:

Homework (doing something nice for yourself):

Cognitive restructuring exercises:

Films: (1) It's Not Like Scraping Your Knee

(2) Responsible Assertion

Self Esteem Tree:

Relaxation Exercise:

3. What did you like or not like about the group format. That is, the number of meetings, place (U of M), time, number of women in the group, etc.?

4. What did you like best about the group?

5. What did you like least about the group?

5. Would you be willing to spend some time doing homework if it had been assigned and expected?

6. Would you like to have had more discussion of sexual abuse (in a general sense, or of your personal experience)?

7. Are there any topics you feel should have been discussed more?

8. Were the group facilitators helpful or not helpful? In what ways?

9. In what ways would you have liked the group to be different?

10. In general, how do you feel about your group experience? (That is, has it been a good experience; have you noticed any changes in yourself; do you feel worse than when the group started?