

A GROUP THERAPY PROGRAM FOR ADULT SURVIVORS OF
CHILD SEXUAL ABUSE:
AN OUTCOME STUDY

CENTRE FOR NEWFOUNDLAND STUDIES

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AMANDA J. GAULTOIS



A GROUP THERAPY PROGRAM
FOR ADULT SURVIVORS OF CHILD SEXUAL ABUSE:
AN OUTCOME STUDY

AMANDA J. GAULTOIS

A thesis submitted in partial fulfillment
of the requirement for the degree of
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Abstract

A three phase group treatment program for women who were sexually abused as children was examined for outcome effectiveness. Standardized evaluation questionnaires were utilized to measure change in self-esteem, locus of control, and level of internalized shame at the end of phases I and II. An informal evaluation discussion was used to determine subject satisfaction and content at the end of phase III.

Results indicate a significant positive change in self-esteem, locus of control, and level of internalized shame after phase I, and a further significant positive change in self-esteem for six of the eight subjects after phase II. All subjects reported feeling more content, more in control of life experiences, and less shameful at the end of phase III.

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Chapter One

Introduction

Child sexual abuse and adult survivors of abuse are currently very important issues in Newfoundland. As these topics are talked about more openly, and as more and more adults finally disclose their lifelong "secrets", the extent of child sexual abuse is becoming more realized. Until recently, many of these reports may have been passed off as "stories".

With this new openness comes the gripping reality that a large number of today's adult population have been abused as children. Carver, Stalker, Stewart and Abraham (1983) reported the findings of surveys which indicated that between 22 and 33% of females and 9% of males in Canada have been subjected to sexual abuse before the age of 18.

Disclosure, however, is only the first step towards healing. The next step is dealing with the feelings that, for so many, have been hindering full participation in society and have left scars such as low self-esteem, feelings of guilt, non-assertiveness and relationship difficulties (Bergart, 1986). Gordy (1983) reported that many adult survivors of childhood incest

she worked with experienced conflicts over trust, difficulties with closeness and sexual dysfunctions.

In Newfoundland, the services for helping adults deal with problems of former abuse are few, while the needs are great. The current group therapy program was designed to help victims of abuse work through some of their feelings, and to assist them through the healing process. In a three phase process, participants were given the opportunity to deal with some of the issues and emotions they found most hindering in their adult lives. The group therapy gave the members the opportunity to disclose their own stories, and realize they were not alone in their feelings. The members set personal goals for themselves at the outset of therapy sessions.

Although there is need for group therapy for both male and female incest survivors, current literature suggests that a higher percentage of females than males are abused at all ages (Carver et. al., 1988). Due to the sensitive nature of the issue, and sensitive feelings towards the sex of the abusers, it is also generally agreed that therapy groups for survivors be composed of same sex members (Underhill, 1986). Gordy (1983), Gagliano (1987), and Faria and Belohlavek (1984), among others, have worked with groups consisting

of females only. This current study also focused on a therapy group involving women survivors of childhood sexual abuse.

This study aimed to discover whether this model of group therapy is effective or ineffective in producing positive change in women survivors of sexual abuse, as measured by indices of self-esteem, shame, and locus of control. The Index of Self-Esteem (Hudson, 1982), Internalized Shame Scale (Cook, 1986), and Locus of Control of Behavior (Craig, Franklin, and Andrews, 1986) were used to evaluate whether the group therapy was effective.

Statement of Significance

Presently, there are relatively few therapy groups aimed specifically at women survivors of child sexual abuse in Newfoundland, and fewer still which have been evaluated as to their effectiveness. This study is important because there is need for both conceptualized group intervention strategies for survivors of sexual abuse, and evaluation of those strategies (Bergart, 1986; Jehu, 1987).

This program was set up as a community based service. The importance of providing service at the community level was summarized by Gordy (1983), who

stated the objectives of community based groups was: "to reach and help other women in the community, to educate and sensitize the community to the complex issues surrounding incest, and most importantly to help prevent further child abuse in the future, beginning within their own families." (p.301). The objective of this group was to assist women in the community to understand and to break the cycle of violence by focusing on their own healing.

Rationale

The rationale for this study was two-fold. First, the group therapy provided an outlet for a group of women to discuss their abuse in a supportive, helping environment as a means towards healing. Second, the study measured the effectiveness of the group. That is, it measured whether the group therapy was effective in producing change as measured by indices of locus of control, self-esteem, and shame.

The independent variable in this study was the group procedure. The topics for the group sessions are outlined in appendix A.

The dependent variables were the factors being evaluated. Those were the factors of shame, self-esteem, and locus of control, as measured by the various

instruments.

Statement of Limitations

The most obvious limitation in this study is the ability to generalize the findings to a broad population. The sample size was small, with eight participants, and members were referred by support agencies. It was believed to be unethical to broadly advertise such a group and then select eight to ten participants from all of those who demonstrated a need for the service.

Carver et al. (1988) indicated this type of group therapy is a painful and difficult experience for many participants, and some depression during or between sessions may be expected. Gordy (1983) suggested each member have access to her own counsellor outside the group. This would assure her somebody with whom to discuss individual reactions and reflections which were stimulated by the group process.

However, since such in-depth counselling was beyond the means of the study group, it was believed the best way to provide support between sessions was to accept referrals from support agencies who were prepared to provide individual counselling. The study group provided the group therapy support basis, while the

agencies provided individual support.

Internal validity may have been affected by the freedom of the participants to seek individual counselling in addition to the therapy group. Some of the study results may be confounded by this factor. To counterbalance this, a group evaluation discussion was held during the last therapy session.

Another limitation was the group leaders' awareness of the goals of the group. They knew, for example, the group was designed to help women improve their self-esteem, help them realize they have control over events in their lives, and reduce their sense of shame. Since these were the goals of the group, the co-leaders were working to improve these areas, which may have influenced the test results. The indices measure whether they have been successful.

The study was further limited by the unavailability of empirical data for phase III. The subjects failed to complete the final questionnaires. Therefore, data was analyzed for phases I and II only. There was an informal evaluation discussion at the end of phase III, and the comments made by the subjects were noted by the co-leaders.

Permission to reproduce the Index of Self Esteem (Hudson, 1982) could not be obtained from the publisher.

Therefore, only two of the measurement questionnaires, the Internalized Shame Scale (Cook, 1986), and the Locus of Control of Behavior (Craig, Franklin and Andrews, 1984) are reproduced in the Appendix (see Appendixes E and F).

Explanation of Terms

Following are some of the terms referred to in this thesis.

Feminist philosophy.

The group studied was run from a feminist perspective. Feminist therapists assume victims of sexual abuse are innocent (Peters & Pierre-Jacques, 1988), and hold the adult perpetrators totally responsible for sexual acts involving children (Working Group on Child Sexual Abuse, 1989). They view problems of child sexual abuse as part of societal sexual stereotypes, and advocate women's rights (Peters & Pierre-Jacques, 1988).

Child sexual abuse.

For the purposes of this thesis, child sexual abuse is any sexual act involving children, by an adult. The acts may range from fondling to sexual intercourse, or the use of a child in the production of pornographic materials (Leger, cited in New Brunswick conference

report, 1986).

Adult survivors.

Survivors are adults who are no longer experiencing sexual abuse, or who are no longer subjected to abusive situations. The term is also used to describe adults who have begun to cope with early abuse, so that they do not feel their lives are controlled by the negative effects of childhood abuse.

Victims.

Victims, for the purposes of this thesis, refer to persons who are experiencing abuse, or who are currently being subjected to abusive situations.

Healing.

Healing, as it relates to adult survivors, is the process of coming to grips with childhood abuse, accepting the past, and letting go of past emotions. It involves improvement of self-esteem and assertiveness, reduction of sense of guilt, and increasing perception of having control over life experiences.

Inner child.

The inner child refers to the emotional part of the person that needs to recover (McClure, 1990). For persons in recovery, it often helps to visualize their emotions as a child, and then work to nurture the child during recovery.

Overview of Chapters

This chapter has highlighted the purposes, significance, and rationale for a study of adult survivors of childhood sexual abuse. Chapter Two contains a review of current literature on this topic. Chapter Three describes the population, methodology, and measurement scales. Results and discussion are presented in Chapter Four, while the conclusion and recommendations are presented in Chapter Five.

Chapter Two

Review of Current Literature

Overview

The literature related to this topic includes two main areas: childhood sexual abuse and adult survivors of abuse. First, the background of child sexual abuse is presented, followed by a discussion of the problem, and the surrounding issues. Next, the topic of adult survivors of childhood sexual abuse is discussed, beginning with the effects of childhood abuse on adults, and followed by discussion of methods used to deal with those effects.

Childhood Sexual Abuse

To understand the trauma experienced by adult survivors of sexual abuse, it is first necessary to understand the issues surrounding the abuse which occurred when those adults were children. This understanding includes the nature of the abuse, the dynamics involved, and the effects the abuse had on the person. A definition of child sexual abuse is presented here, followed by discussion of the issues.

The definition of child sexual abuse, as presented

by Rev. Paul Leger (1986), chairman of a conference on the Prevention of Child Abuse, is accepted for the purposes of this thesis. He defines child sexual abuse as "the exploitation of a child for the sexual gratification of an adult. It may range from exhibition and fondling to intercourse or use of a child in the production of pornographic materials" (p. 6). As such, child sexual abuse is distinct from other forms of abuse, namely, nonaccidental physical injury, physical neglect and emotional abuse. Jehu and Gazan (1983) used the term "sexual victimization" to refer to exploitive sexual experiences between juveniles and older persons. These experiences are exploitive "because of the juvenile's age, lack of sexual sophistication or relationship to the older person" (p. 2). Incest, according to Gagliano (1987), is sexual abuse "when the sexual acts occur between people so closely related that they are forbidden by law to marry and ... incest generally occurs between a child and an adult who is in a position of trust and authority" (p. 105).

Historical context.

Kissner (1989) pointed out the helping professions have only been aware of child sexual abuse as a problem for about fifteen years. Prior to this, although child sexual abuse existed, the magnitude of the problem was

denied for many years (Deighton & McPeck, 1985). Rush (1980) asserted sexual abuse of children has always existed, but was not always viewed as a problem by members of society. According to Watchel (1989), child sexual abuse came to be viewed as a problem by society when laws against it were developed in the seventies. Since then, although there has been a dramatic increase in the reporting of sexual abuse, Badgley (1984) concluded there has not been a sharp increase in the actual incidence of sexual offences in recent years.

McNaron and Morgan (1982) gave credit to the consciousness-raising groups of the sixties for allowing women to share previously unspoken realities. During that time, women began to realize they were not alone with their problems and began to put the situation into perspective. The Indian and Inuit Nurses of Canada, in a Consultation on Child Sexual Abuse (1987), wrote: "Only recently have the victims--many of them now adults--begun to speak of their experience, and to search for solutions that address the complex and interrelated needs of victims, abusers, and their families" (p. 1).

Finally, after many years of denial, child sexual abuse has been acknowledged by members of society as not only existing, but as being a problem. This is the

first step in dealing with the problem, as it opens the way for discussion of the issues, and development of plans of action. It is not enough to merely acknowledge the problem. As Kreidler and England (1990) so aptly state:

There are groups of women who are making courageous efforts to turn their lives around and face the consequences of incest on their adult development. They desperately want to be healed and are willing to risk themselves in an attempt to be whole. They... face a resurgence of pain and grief that has often been buried or denied for years. They want to be better mothers; they want to be able to love; they want to be able to feel; they want to be free of destructive lifestyles. (p. 41)

Extent of the problem.

Estimates on the extent of childhood sexual abuse in Canada are varied. The Committee on Sexual Offenses Against Children and Youths, headed by Badgley (1984), reported one in five females and one in ten males as the most widely cited rates of childhood sexual abuse. That is, 20% of females and 10% of males have been or will be sexually assaulted in Canada before they become adults. In certain populations, the incidence may be even

higher. Carver et al. (1988), citing several researchers and health practitioners, reported that 44% of a group of female drug abusers and 43% of a psychiatric inpatient group had been victims of childhood abuse.

Badgley (1984) attributed the problem of gaining accurate estimates of abuse to the underreporting of incidents. He wrote, "known child sexual abuse is a fraction of its true occurrence" (p. 113). He attributed some of this underreporting to health care and social workers who believe the evidence is inadequate to report, the incidents have stopped, or the unity of the family is more important.

There is also a large proportion of sexual abuse which never comes to the attention of workers in the field because the victims remain silent. Runtz and Corne's (1985) analysis of earlier data found only 6% of women who indicated they were sexually abused as children had reported the assault to the police, and 83% remained silent when the perpetrator was known to them.

Thus, the extent of the problem was not only denied in the past, but also remained hidden because of the scarcity of reports to police and other authority figures. Many of the current estimates are based on reports of adults who are willing to disclose they have

been abused in the past. The above statistics suggest that as the topic gains widespread recognition, more and more survivors are willing to disclose their own experiences. However, once those experiences are disclosed, the survivors need assistance to deal with the realities of the experiences. Kreidler and England (1990) recognized the need for services when they stated "the last decade has seen an explosion in need for programs, but only a fraction of victims are receiving services" (p. 36).

Dynamics of sexual abuse.

Although there are male victims of sexual abuse, the majority of victims are female, and the majority of offenders are male family members (Halliday, 1986). As well, most of the victims are less than eight years old at the time of the initiation (Summit, 1983). Runtz and Corne (1985) reported up to 90% of child sexual abuse perpetrators to be male, while 90% of the victims are female. Also, about 80% of the perpetrators are fathers and step-fathers in positions of authority over children (Halliday, 1986). Halliday found only 8.5% of the perpetrators to be strangers to the victim. Furthermore, child sexual abuse occurs in all races, income groups, ethnic groups and religions (Peters & Pierre-Jacques, 1988).

These statistics suggest more sexual abuse of children occurs in the home by persons known to the victim than by strangers. The perpetrators are overwhelmingly in positions of power and authority over the victims, and no single group is free from this type of violence.

Runtz and Corne (1985) suggested since most incest victims are young girls, and most offenders are father figures or other family members, coercion is used more often than physical force to get the victims to comply. Halliday (1986) explained how exploitation of the child's love, trust and innocence are often enough to get them to keep the secret.

There are various reasons why children remain silent about the abuse. These include their feelings of guilt and shame (Rush, 1983, in Bass & Thornton, 1983), low self-worth, helplessness, fear of rejection and disbelief by others, and fear of reprisal by the offender (Badgley, 1984). These feelings, mixed with feelings of love for the perpetrating family member, cause much confusion for the child. The resulting confusion often keeps the child complacent and unable to report.

Initial effects of child sexual abuse.

The initial effects of sexual abuse include the

feelings the child had at the time of the abuse, and the reactions which occur within two years of the termination of the abuse. According to Rush (1983), children gain self-esteem and confidence from being valued by adults whom they trust. When they are sexually exploited, the reactions they need from trusted adults to promote a positive identity do not occur. If they are unsupported in their rights to express themselves, including expression of anger and indignation, they experience feelings of insignificance and shame, rather than feelings of high self-esteem and confidence.

Browne and Finkelhor (1986) listed other initial effects of child sexual abuse. These include fear, expressions of anger and hostility, guilt, shame, depression, sleep and eating disturbances, and adolescent pregnancy.

Often, the effects of the childhood abuse do not become apparent until the child becomes an adolescent. Powers and Jaklitsch (1989) reported a number of psychological and behavioural effects common to adolescents who were maltreated. These include guilt, depression, low self-esteem, loss of trust, anxiety, denial of the abuse, problems with establishing intimacy, feelings of futurelessness, family distortion,

sexual acting out, aggression, problems of control, seeing themselves as victims, and suicide.

Not every child who has been abused displays all of these negative effects, but many experience several of them. Kostash (1987) interviewed teenage girls across Canada, and found many who have experienced a combination of the above effects.

Effects of Childhood Sexual Abuse on Adult Survivors

Many victims of childhood sexual abuse experience negative effects well into adulthood. Gil (1988) explained how, as children, victims of sexual abuse developed coping mechanisms to help them deal with the situation. These methods of coping allowed the child to survive the sexual abuse by enabling them to detach themselves from the pain of the experiences. As adults, however, the ability to detach emotionally or psychologically interferes with building adult relationships, and the adult survivor experiences difficulties as a result. Tomlin (1991) noted the highest level of discomfort for women survivors can be found in the areas of new dating and new parenting.

Clinical workers have often found adult survivors of childhood abuse to seek professional help for problems other than the abuse. These presenting

problems include sexual dysfunctions, depression, marital difficulties, substance (alcohol or other drug) abuse, difficulties establishing relationships, and nervous problems (Bergart, 1986; Evans, 1987; Halliday, 1986; Parker & Parker, 1991). Until recently, many clinicians did not make the connections between childhood sexual abuse and the presenting problems as adults. As a consequence, the presenting problems were often treated in isolation, with little success. Gelinas (1983) pointed to this unawareness, as she became aware of the problems underlying her clients' presenting problems.

Besides the above presenting problems for which past victims seek therapy, clinicians have also identified an array of long term effects attributed to childhood sexual abuse. These may be classified as emotional, physical, behavioural and interpersonal. The following sections give a brief overview of these effects. Methods for dealing with these effects are discussed following the sections outlining the various effects.

Emotional effects.

Cole and Barney (1987) list adult depression as one of the most common emotional effects of childhood sexual abuse. Depression and guilt were the two main

therapeutic targets in their work with adult survivors of sexual abuse. Alexander, Neimeyer and Follette (1991) were able to reduce depression and distress with women survivors in group work. Browne and Finkelhor (1986) targeted low self-esteem, fear, and anxiety as therapeutic goals for adult survivors they worked with. Issues with touch, body shame, and fear of intimacy and abandonment were noted by Evans (1987) as effects of boundary violations in families. The Victoria Women's Sexual Assault Centre Committee (1987) added powerlessness, loneliness, sadness, shame, anger, and loss of trust as other emotional effects of childhood sexual abuse. Nightmares, memory blocks, and the creation of multiple personalities were noted by Gil (1983) and McClure (1990) as results of childhood sexual abuse.

As Steiger and Zanko (1990) pointed out, incest does not have specific, predictable consequences, but it occurs frequently in the backgrounds of psychiatrically disturbed women. Saunders, Villenponteaux, Lipovsky and Kilpatrick (1992) also studied the backgrounds of women who were experiencing mental disorders. They found molestation victims to be overrepresented in adults experiencing compulsive disorder and social phobia.

Physical effects.

Jehu and Gazan (1983) have done research on the physical effects of childhood sexual abuse on adult survivors. Their findings indicated women who were sexually abused as children experience problems in sexual adjustment, impaired sexual motivation, sexual phobias, and sexual dissatisfaction as adults. The Victoria Women's Sexual Assault Centre Committee (1986) also reported pain during intercourse and recurring medical problems as physical effects of childhood abuse. Saunders et al. (1992) found an overrepresentation of adult sexual abuse survivors among women who experience sexual disorders. Most of the physical effects of sexual abuse tend to be manifested in sexual problems, and must be dealt with as part of the treatment for childhood abuse, rather than in isolation.

Behavioural effects.

Danica (1988) related her personal accounts of problems in parenting, substance abuse, and suicide attempts as being associated with early sexual abuse. Beitchman, Hood, DaCosta, and Akman (1991) noted sexual promiscuity, suicidal thoughts, and an increased risk for revictimization are more common among victims of sexual abuse. Powers and Jaklitsch (1989) highlighted aggression and prostitution as behavioural effects of

abuse which need to be dealt with, while Gil (1988) pointed to the connections of childhood abuse with eating disorders, self-mutilation, and prostitution. The behavioural effects of childhood sexual abuse are varied, and differ with individuals.

Treatment for behavioural effects of childhood abuse, such as eating disorders, self-mutilation, and prostitution cannot be effective unless related to the underlying problem--that of the childhood sexual abuse.

Interpersonal effects.

Jehu, Gazan, and Klassen (1984) have identified several effects of childhood abuse which can be classified as interpersonal problems. These include problems with intimacy, avoidance of close relationships, and the tendency to become involved in transient relationships and in relationships in which the partner is abusive. Alexander et al. (1991) also noted the effect on relationships. They attributed child sexual abuse as interfering with the establishment of supportive relationships. The effect on interpersonal relationships was also noted by Carson, Gertz, Donaldson and Wonderlich (1990). They found the current family relationships of female survivors to be disengaging, controlling, conflictual, and lacking in organization and emotional expressiveness.

Many of the interpersonal effects of childhood abuse are among those which, in the past, were often not seen as being connected to childhood abuse. Effective treatment, however, must depend upon the accurate detection and treatment of sexual abuse.

As evidenced by the above discussion, the effects of childhood sexual abuse are many and varied, and they differ with individuals. The severity of the effects of childhood abuse differs with different personalities, but there also seem to be other factors which play a role in the severity of the effects. According to Beitchman et al. (1991), the most harmful factors of childhood sexual abuse in terms of long-lasting effects on the child are: 1) the frequency and duration of the abuse; 2) abuse involving penetration, force, or violence; and, 3) a close relationship to the perpetrator. Edwards and Alexander (1992) also noted the existence of parental conflict and paternal dominance compound the effects of childhood sexual abuse.

Adult Survivors of Childhood Sexual Abuse

Methods to deal with the effects of childhood sexual abuse differ with individual practitioners, and vary according to the severity of the presenting

effects. Healing may be accomplished in different ways, although some elements appear to be common. The following factors are essential to any treatment program of child sexual abuse: 1) the survivors must be believed; 2) the survivors need to be assured they were not at fault; and, 3) the survivors need to know they are not alone (The Working Group on Child Sexual Abuse, 1989).

Ways of dealing with the abuse may include reading and writing (Bass & Thornton, 1983; Danica, 1988; McNaron & Morgan, 1982), individual therapy (Cole & Barney, 1987), group therapy led by a professional (Alexander et al., 1991; Peters & Pierre-Jacques, 1988), concurrent individual and group therapy (Alexander et al., 1991; Carver et al., 1988; Taylor, 1989), and self-help or consciousness raising groups (Kissner, 1989; Underhill, 1986). Each of these methods present advantages and limitations, and are discussed in following sections.

The extent of childhood sexual abuse and the negative effects both in childhood and adulthood have prompted community groups to request treatment for clients (Rogers, 1988; Watchtel, 1989; The Working Group on Child Sexual Abuse, 1989). Nortar (cited in New Brunswick Conference report, 1986) also stresses the

need for a community response to fill the needs of prevention, identification, assessment, and treatment services for child sexual abuse victims. These four elements are essential to eliminating the problem of childhood sexual abuse.

The above authors stress the necessity of services being available at the community level, with access for all who wish to avail of them. Isolated clinics and programs will not fulfil this need; nor can they address the need for public awareness and prevention. Kreidler and England (1990), pointing to the need for services, noted only a fraction of victims receive treatment. Clients of therapists represent a fraction of adult survivors who need the service. By offering service at the community level, through community organizations, a wider range of adult survivors will be able to avail of the service.

Individual vs Group Therapy

The question of whether to use individual or group therapy is a point of disagreement among therapists. Some women have had past negative experiences in individual therapy due to non-recognition of the effects of childhood sexual abuse (Peters & Pierre-Jacques, 1988). In those cases, the women were treated for the

presenting problems rather than the underlying abuse, and treatment was neither effective nor beneficial. However, individual therapy can be a first step in the treatment process, and is preferable in some cases. Severe trauma and self-destructive behaviour require intensive individual therapy, and cannot be adequately dealt with in a group setting (Bergart, 1986; Cole & Barney, 1987).

Group therapy has several advantages over individual therapy for the treatment of adult survivors of sexual abuse. Group therapy serves to reduce the members' feelings of isolation, creates a strong sense of mutuality and acceptance, emphasizes empowerment of members, and increases feelings of adequacy and self-esteem (Knight, 1990). Kreidler and England (1990) summarized the advantages of group therapy when they wrote:

Group counseling is well suited to meet many of the needs of incest survivors. Victims can use the group experience as a means of examining feelings, learning to trust, and establishing healthy relationships. A group can provide victims with the opportunity to deal with the destructive behaviors that often plague them. (pp. 36-37)

Because of the unique advantages of both individual and group therapy, several clinicians suggest a combination of the two. Individual therapy can be used as the first step towards healing, followed by group therapy (Bergart, 1986), or can be concurrent with group therapy (Alexander et al., 1991; Carver et al., 1988; Taylor, 1989). Cole and Barney (1987) required group participants to be in concurrent individual therapy so that they could deal with issues which emerged during the group sessions, but which were not adequately addressed during that time. Concurrent individual and group therapy also allowed therapists to deal with emotions which emerged between group sessions. This is reiterated by Alexander et al., who found short term therapy without concurrent individual therapy to be insufficient.

Group Treatment

A decision to provide group treatment, with or without individual therapy, presents issues concerning which therapeutic issues to target, which type of group to run, and which philosophical approach to take. This section reviews some of the current thought.

Therapeutic issues.

Given the large number of long term effects, and

the fact that not every survivor experiences the same effects, a decision has to be made as to which issues should be focussed on in the group. One way to narrow the focus is to have group members set goals at the beginning of treatment, by asking what they expect to gain from the group experience. The therapists may then modify the group treatment process, to ensure that the different needs are met. Goal setting has been used by several clinicians, including Alexander et al. (1991), Apolinsky and Wilson (1991), and Kreidler et al. (1990).

Although survivors experience varied effects from the past abuse, some effects appear to be more common. Anger, loss of trust, low self-esteem, difficulty experiencing feelings, difficulties with interpersonal relationships, guilt, and shame appear to be very common among survivors. Hence, therapists often design a therapy program around a list of common issues, while being prepared to deal with other issues as they are presented by participants. Apolinsky and Wilcoson (1991), for example, targeted anger, trust, self-esteem, interpersonal relationships, guilt, and empowerment as therapeutic issues. Kreidler and England (1990) dealt with issues of healing, destructive thoughts, feelings and behaviours, and control of actions and reactions. It would be unnecessary to deal with all of the possible

negative effects of past abuse, as individuals do not experience every negative effect.

Self-help vs therapy groups.

There are two basic types of groups: those which are led by one or two professionals, referred to here as therapy groups, and those without a group leader (Tamarack & Mountain, 1984). These latter groups may be termed self-help, mutual aid, or consciousness-raising groups. The members meet and discuss their problems in self-help groups, but there is no designated leader.

However, as Cole and Barney (1987) explained, group work with sexual abuse survivors can be traumatic for the participants, as members talk of their own experiences and the impact on their lives. The members may experience overwhelming anxiety as they listen to others and bring forward their own painful memories, especially those who had not previously disclosed the abuse (Alexander et al., 1991).

As Cole and Barney pointed out, the value of using therapist led groups is that therapists can use interventions to assist group members to cope with new anxieties, while resolving past trauma and working on long lasting effects. Other clinicians who have used specific interventions in therapy groups include Alexander et al. (1991), Apolinsky and Wilcoson (1991),

effects of the abuse (Gagliano, 1987). Feminist therapists are basically client centered. They also advocate women's rights, and see the problems of child sexual abuse in a larger context, as part of societal stereotypes (Peters & Pierre-Jacques, 1988).

The family centered approach assumes children have the right to not be assaulted, and focuses attention on the family as a system (Badgley, 1984). Family oriented therapists see sexual abuse as an overall family problem. According to Peters and Pierre-Jacques (1988), family therapists "treat the family as a whole system, and the victim as part of the problem. Often family therapists want to treat the whole family together, as well as offering individual therapy" (p. 17). Family therapists insist that contact with the family is essential to resolve issues with family members (Deighton & McPeck, 1985).

Some feminist and client centered therapists react negatively towards the family systems approach to therapy because of the inclusion of both the perpetrator and the victim or survivor in the same group. They see this as harmful to the survivors in dealing with their problems, and feel the family approach ignores the dynamics involved in male power over women and children (Rush, 1980). Badgley (1984) concluded that the child

Carver et al. (1988), Knight (1990), and Kreidler et al. (1990).

Kissner (1988) suggested mutual aid groups can be an adjunct to individual and group therapy programs. He wrote, "where sufficient financial and population resources exist, there can be little doubt this type of integrated approach offers the best form of intervention for children and adult survivors of sexual abuse" (p. 66). Others suggested mutual aid as a follow-up to therapy groups, or as on-going group support (Bergart, 1986; Gordy, 1983).

Client centered and feminist approach vs family systems approach to therapy.

Among therapists who utilize therapy groups, there is some disagreement about orientation. Client centered therapy assumes the client is innocent in the sexual abuse relationship, holds the adult offender totally responsible for any abuse which occurs, and focuses services on the victim (Badgley, 1984). According to Badgley, this approach usually coordinates treatment between essential medical and child protection services, so the child receives maximum benefits without having to repeat the story to several different agencies. Client centered group therapy focuses on groups of survivors to help them alleviate the guilt, shame, and other negative

centered approach "provides more short-term benefits for sexually abused children" (p. 635) over the family centered approach. These benefits include:

- More promptly undertaken initial assessments.
- More victims receiving medical examinations.
- Broader and more extensive consultation with other disciplines in relation to assessing the child's needs....
- A slightly higher proportion of victims being counselled, and overall, the more frequent provision of a broader range of counselling and treatment services for victims and members of their families. (p. 636)

Gagliano (1987) used a combination of the two approaches in working successfully with abused adolescents. Her clients received the benefits of group work with other survivors in a supportive therapy group. In cases where the fathers wanted to change, they attended individual and group therapy for perpetrators. Family therapy was the final phase of treatment. Deighton and McPeck (1985) also used therapy groups with adult survivors, and during the last phases of treatment, incorporated group sessions for members and their male partners as a way of dealing with some of the

interpersonal issues.

From the above literature, it appears client centered treatment is the most appropriate first step in treating the child victim. Family centered therapy with the family of origin may be beneficial to the child, as a last step, if the perpetrator accepts responsibility for the abuse and wants to change. For the adult survivor, however, feminist counselling appears to be more appropriate. Family counselling, when used with adults, often involves the adult partner and children rather than family of origin (Deighton & McPeck, 1985), and seems to be more effective after client centered or feminist individual and group counselling.

Summary

There is evidence of a widespread problem of childhood sexual abuse, the effects of which cause not only childhood trauma, but also long lasting negative effects well into adulthood. Acknowledgment of childhood sexual abuse as a problem opens the way to the provision of treatment and prevention programs. This new openness also encourages those who have been abused as children to disclose their long held secrets, and to seek assistance.

The treatment programs for survivors of sexual

abuse include individual counselling, group counselling, and long term self-help groups. Group counselling appears to be especially effective, because of the ability to reduce feelings of isolation, while providing peer acceptance and support. It also appears a great number of today's adult population could benefit from survivor's therapy groups.

Current Study

In light of the above literature, the current study involved a therapy group for adult survivors of child sexual abuse. The group was evaluated for outcome effectiveness in the areas of self-esteem, locus of control of behavior, and reduction of shame.

The current study group incorporated the following factors:

1. The study group was made available to clients of several community agencies.
2. Individual therapy concurrent with group therapy was used to deal with emotions which emerged during or between sessions that could not be adequately addressed by the group.
3. The group was led by therapists because of the advantages of using therapeutic interventions.
4. The group was conducted by two female

therapists.

5. The co-leaders were prepared to deal with a number of therapeutic issues common to adult survivors, while individual group members set their own goals.

6. The co-leaders used a feminist counselling approach.

Hypotheses

The questions studied concerned the effects of involvement in a group for sexual abuse survivors on the participants' self-esteem, sense of shame, and perception of control over events in their lives. An attempt was made to measure whether involvement in group therapy had a positive effect on these traits.

The hypotheses studied were as follows :

1. Involvement in this therapy group will improve the participants' sense of self-esteem.
2. Involvement in this group will lessen the participants' sense of shame over past abuse.
3. Involvement in this group will increase the participants' ability to perceive events as being under their personal control.
4. Involvement in this group for a longer period (36 weeks) will produce greater change than short term involvement (12 weeks).

Chapter Three

Methodology

The present research utilized a group undergoing therapy for past sexual abuse. The group therapy sessions were run in three phases, with a three to four week break between each phase. The treatment program was designed by one of the co-therapists, based on current literature as well as input from subjects involved in a trial group, to be discussed below.

Setting

All three phases of therapy took place in a room suitable to accommodate a large group, which was centrally located within the city of St. John's, Newfoundland, Canada. The group therapy was made available to clients of community centres, including The Women's Centre and Patrick House--a shelter for homeless women, as well as private counsellors.

Description of Sample

The group was comprised of eight subjects who had been sexually abused as children or adolescents. The ages ranged from 20 to 48 with a mean age of 27, and

included six employed subjects and two students. All subjects had worked at least a year at some time. There were four single, two divorced and two common-law relationship subjects. One of the divorced subjects was also living in a common-law relationship. Three subjects were living with parents, two lived alone, two lived with a boyfriend, and one lived with both parents and a spouse. All except one of the subjects grew up in St. John's. There were four university graduates, two technical college graduates, and two university students. It is interesting to note that all subjects had post-secondary education. All subjects had previous therapy, and were either in concurrent individual therapy, or had a counsellor available. It is likely that their therapists encouraged the subjects to seek group therapy.

Subject 1 was 26 years old, single, a university graduate, working, and living with her parents. Subject 2 was 27 years old, single, a college graduate, working, and living alone. She grew up in a medium sized town. Subject 3 was 48 years old, divorced, living in a common-law relationship, a university graduate, and working. She had one child. Subject 4 was 33 years old, divorced, a university graduate, working, and living alone. Subject 5 was 38 years old, living in a

common-law relationship, a university graduate, and working. Subject 6 was 19 years old, single, a university student, and living with her parents. Subject 7 was 21 years old, single, a college graduate, working, and living with her parents. Subject 8 was 22 years old, married, a university student, and living with spouse and parents.

Co-leaders

The group sessions were co-led by two female therapists. Both therapists were engaged in private practice in the community, and had masters degrees in Social Work. One of the therapists had additional training in hypnotherapy.

Female therapists were used because of the sensitive nature of the issues being discussed, and because of sensitive feelings towards the gender of the abusers. Although using a male therapist may have been beneficial as a role model, it was felt this was outweighed by the benefits of using female therapists in the process of recalling traumatic memories.

The advantages of using two therapists included sharing of responsibility and added gain for the members from the combined input of two therapists. Lawlor (1992) noted the importance of co-leadership for groups

for adult survivors in allowing therapists to deal with their own anxieties so they do not interfere with the running of the group.

Procedure

The study group was run in three periods of 12 weeks each, for a total of 36 weeks. A trial group was run previous to the study group, but had a dropout rate of 80%. The trial group started with ten members, and had dropped to four by the end of twelve weeks. Three of the subjects who dropped out had not had extensive individual therapy, and found it very difficult to deal with their memories in a group situation. One subject had not previously disclosed, but was encouraged to go by her sister, who was also a group member. Both sisters dropped out. One subject had not resolved an alcohol addiction, and dropped out to deal with that issue first. Two other subjects dropped out without giving reason.

The high dropout rate of the trial group was not surprising, as other researchers also experienced high dropout rates in similar groups. Kissner (1988) attributed the dropout rate to the high anxiety brought on by affect-laden memories. Data from the trial group was used to further develop the current three phase

treatment plan, by having subjects give input as to what their needs were, and how those needs could best be met.

There were no dropouts in the study group until phase III, when three subjects moved out of town for work or family related reasons. All three subjects indicated they would have continued in therapy had they been able to remain in the city. One difference between the trial group and the study group is that for the trial group, individual community therapists suggested group work to their clients. After the trial group started, word spread in the community about group therapy. Clients contacted the group leaders themselves and went on a waiting list for the next group. When the wait list grew to eight women, the current study group was started. The fact that subjects in the study group requested group work themselves is one factor which is different from the trial group. This interest seems to have made a difference between dropping out and remaining in therapy for the completion of the three phases.

Other differences between the trial and study groups were: a) all subjects had been in individual therapy previous to joining the study group; and, b) subjects in the study group were required to have no problems with substance abuse. Subjects were

interviewed by the co-therapists previous to the start of the study group to assess whether they were ready for group work by meeting the above conditions. The necessity of screening clients for suitability for group work was pointed out by Cole and Barney (1987), and Apolinsky and Wilcoson (1991). They suggested women who were current substance abusers, who were going through a current crisis, or who could not speak about the abusive experiences receive individual therapy before moving to group therapy.

The co-therapists invited the group members to participate in the evaluation study by completing questionnaires (see Appendix C). One of the questionnaires was a demographic survey (see Appendix D). The others were the Index of Self-esteem (Hudson, 1982), the Internalized Shame Scale (Cook, 1986), and the Locus of Control of Behavior (Craig et al., 1984) (see Appendixes E and F). These instruments were chosen to measure change as a result of group work with sexual abuse survivors.

Since many of the long-term effects of childhood abuse have a negative impact on the survivor's self-esteem, a measure of self-esteem during and after therapy was deemed appropriate. Shame, and a feeling of not having control over events in life were major

therapeutic targets for the study group. A measure of these traits was included in the assessment. Depression, though not measured in itself, is reflected in one's sense of self-esteem and sense of guilt. Because it was impossible to measure all the traits which were targeted during therapy, these three major ones were chosen to measure, while an evaluation of the other traits was informally carried out through discussion during the last therapy session.

The co-therapists explained to group members that participation in the evaluation study was optional. They were not required to complete the questionnaires, and they could still remain in the group should they decide not to participate. All members agreed to participate in the evaluation study.

The study group met one evening a week for two hours, and continued for three 12 week periods, for a total of 36 sessions. The literature suggests that longer groups are more beneficial to survivors of sexual abuse. Gordy (1983), for example, found eight sessions to be too short a time to deal with all of the issues, whereas Bergart (1986) found it necessary to lengthen group time to six months. Deighton and McPeck (1985) found groups to average about thirty sessions, while Kreidler and England (1990) ran a three phase group

which extended over 56 sessions. These clinicians found the intensive group work needed for survivors of sexual abuse required between 26 to 56 weeks. The traditional group of eight to 12 weeks in length is not sufficient to deal with all the issues involved with sexual abuse survivors.

The first session of phase I and the last session of each of the three phases of the study group were reserved for pre- and post-testing. Testing at the end of each phase allowed the evaluator to determine whether a longer period of therapy was more effective in producing change in the subjects. By measuring change over time, individual subjects' progress could be monitored. This gave a more accurate picture than just measuring before and after therapy. The importance of measuring over time was pointed out by Anton (1978), who cautioned cause and effect would be difficult to determine with just one test before and after the group therapy. Therefore, gradual change as therapy progressed could be more readily attributed to the group therapy, and is a more reliable indicator than just one post-test.

Each subject was instructed to make up a number to use on all questionnaires. This ensured confidentiality of participants, while allowing pre- and post-test

comparisons to be made.

Unfortunately, data could not be collected at the end of the last session because the evaluation discussion went on until quite late in the evening. The subjects were given the questionnaires to complete at home, but they failed to return them. As time went on, it was realized that completing them late would render the results invalid, as other factors would probably have influenced the results. An attempt was made to do a follow-up survey ten months after the group ended, but most of the subjects had moved out of the province and could not be contacted. Thus, standardized evaluation is available for phases I and II only. Despite this, a trend can be seen over time, and this is further discussed in chapter 4.

Analysis of Results

Measurement data was analyzed using a paired samples t-test. Tracey (1983) pointed to the necessity of using statistical tests to analyze data, stating that associational designs do not allow a conclusion of cause and effect. The informal, subjective evaluation was utilized to gather other evaluative information which could not otherwise be tested. Barnsley, Ellis and Jacobson (1986) pointed out the need to include

descriptive and subjective information in evaluation, as traditional evaluation, they contend, does not take into account the innovative structures of women's groups.

Other issues besides guilt, shame, and self-esteem dealt with during the course of therapy are difficult to measure using a standardized questionnaire. For example, much of the first phase of therapy focused on reduction of isolation and identification with others in the group. For some subjects, this was the first time they had ever experienced a true sense of belonging. Although the new sense of belonging would have an effect on self-esteem, it in itself could not be measured. Thus, asking the subjects how they felt after the therapy as compared to before they started therapy would give a truer picture of the impact of the therapeutic intervention.

Group Structure

The group was loosely structured so that there was minimum emphasis on the agenda of the therapists and maximum focus on the needs of the subjects. Subjects had an opportunity to set personal goals at the beginning of group work, and flexibility was maintained within the group sessions to allow subjects to talk about their own issues.

Each of the three therapy phases focused on major

issues which seem to be common among adult survivors. Topics and interventions were introduced by the therapists, though subjects were able to discuss other issues when the need arose. The therapists used interventions such as getting in touch with feelings, journal writing, taking care of the inner child, relaxation, hypnotherapy visualizations, cognitive restructuring, and use of photographs to emphasize the innocence of childhood.

Use of interventions is supported in the literature on group work with survivors. Faria and Belohlavek (1984), for example, used journal writing, reading materials, and cognitive restructuring, while Bergart (1986) used role play, empty-chair techniques, and guided fantasies. The interventions are used to assist the subjects to effectively get in touch with feelings, challenge previous beliefs, reorganize thoughts, and take control over their lives.

Group Process

The first session of phase I was used to set goals, talk generally about some of the issues of child sexual abuse, allow the subjects to get to know each other, and begin to establish trust. Sessions 2 to 11 in each phase were "working sessions", the sessions in which the

therapeutic work took place. Subjects talked about their own experiences and gave each other support. The process of healing in this framework is described aptly by Lawlor (1992):

The sharing of one's stories and experiences of being a victim of sexual abuse is a very difficult process. As each member shares her story of pain and sorrow members begin to accept that they are not responsible for the abuse and had little or no power as a child to stop it. Because of the identification with one another's pain and sorrow, members begin to let go of guilt and shame. (p. 248)

The therapists began to prepare the subjects for termination of each phase by session 10. In the termination stage, the issue of loss was dealt with, and the amount of time between each phase was agreed upon. In the third phase, termination included plans for the future. Some of the subjects expressed a desire to form a support group. However, two of the subjects were going through personal difficulties, and felt they needed to continue in individual therapy instead. Three subjects left the province before the end of phase III, and were not available for a support group. The remaining three subjects decided not to form a formal

support group, but do maintain contact, and occasionally get together for coffee or lunch.

The three basic stages of group process-- introduction, working stage, and termination--were identified by other researchers as well (Gazda, 1983; Gordy, 1983; and Napier and Gershenfeld, 1987). Bergart (1986) noted the termination stage in her groups often led to the development of self-help support groups.

The Group Program

The group therapy program was designed to deal with a limited number of issues that are common to adult survivors of sexual abuse. Members were also given the opportunity to work on their own issues. No attempt was made to deal with all of the possible effects of childhood abuse as a group. Rather, the subjects identified their needs at the beginning of group therapy, and from that, an agenda was established. Identified issues included isolation, body image, learning to feel feelings, trust, anger, rage, depression, shame, and learning to take control of events in their lives.

Common issues dealt with in the three phases include trust, safety, and letting go. The first two sessions of each phase dealt with issues of trust and

safety. In phase I, trust was established, boundaries set, and issues of confidentiality were discussed. Trust and safety had to be re-established in the initial sessions of phases II and III, because of the separation from the group. Letting go was dealt with during the last two sessions of each phase, to prepare subjects for the break, and for the eventual ending of group support.

Journal writing was a major focus in all three phases. Subjects were encouraged to write during the week, as thoughts and feelings surfaced. Homework, or specific journal writing was often assigned, whereby subjects were required to write on a particular topic during the week. This was shared and discussed during the following session.

Phase I was meant to assist the subjects to bond with the group, to deal with issues of isolation, trust, and mistrust, and to get in touch with basic feelings. During phase I, subjects began to write about and share their own experiences and issues. They were asked to recall incidents from their childhoods, and to write about the experiences as if they were the child. This was difficult for some subjects, who could not get in touch with the feelings they had experienced as a child. Those subjects wrote in the third person instead, from an adult perspective. This was acceptable in phase I.

By phase II, all subject had learned to write from a child's perspective.

Phase II consisted mainly of recall of abuse incidents, and getting in touch with feelings. Subjects used journal writing to get in touch with and validate their feelings of shame, guilt, rage, anger, depression, suicide, and sexuality. Each session focussed on one feeling. Subjects shared their journal writings during the sessions. Two sessions each were needed for the issues of anger and shame, as there was a lot of discussion on these issues. This phase assisted subjects to get in touch with feelings, and to deal with many of the issues which were hampering them as adults.

In phase III, subjects were given the opportunity to work on their own issues. They could do more work on whichever feeling still needed to be dealt with from phase II, or work on different feelings. This was done through hypnotherapy. The therapist had the subjects go back in time, through relaxation and suggestion, but did not specify which feeling to focus on. Hypnotherapy was carried out every second week, with debriefing after the hypnotherapy, and discussion of the experience during the following session. One of the therapists was certified in hypnotherapy.

Three types of hypnotherapy were used: a) a

breathing meditation; b) a basic induction; and, c) healing the inner child script. A basic breathing meditation was done at the beginning of each session. The basic induction was used to assist subjects into a deep relaxation, using sun energy as guided imagery. This induction was used three times, in sessions 1, 3, and 5. The time to achieve deep relaxation was reduced from 20 minutes in session 1, to 10 minutes in session 5. The healing the inner child script was used every second session, starting with session 2. The complete therapy scripts are detailed by Lawlor (in press). An outline of the sessions is included in Appendix A. In phase III, subjects learned to take care of the inner child, integrate the inner child with the adult, and let go of the past.

Specifics of phases I and II of the group program have been detailed by Lawlor (1992, in press). An outline of the three phases of the group program is included in Appendix A.

Measurement Instruments

To measure whether the group therapy was effective in producing positive change in the subjects, three measurement instruments were used. The Index of Self Esteem (Hudson, 1982), the Internalized Shame Scale

(Cook, 1986), and the Locus of Control of Behavior (Craig et al., 1984) were chosen to measure the major therapeutic targets. Following is a list of the measurement instruments, with a description of each.

Locus of Control of Behaviour [LCB].

This scale was developed by Craig, Franklin, and Andrews (1984) to measure the extent to which participants perceive events in their lives as being a consequence of their behaviour, and, therefore, under their personal control. Craig et al. also wanted to predict relapse after therapy.

The instrument consists of 17 items to which participants respond "agree" or "disagree", on a six point scale. Items are worded in both the first and third person, and half the items are reverse worded to avoid bias. The scores are added, and may range from 0 to 85. Low scores indicate internal locus of control, or a sense of personal control over events. High scores indicate external locus of control, or a sense that behaviour is controlled by external factors.

Internal reliability is acceptable ($0.23 \leq r \leq 0.61$), as are test-retest reliability ($r = 0.78$, after six months), and construct validity ($r = 0.66$ for females) (Craig et al., 1984).

Index of Self Esteem [ISE].

The Index of Self Esteem (Hudson, 1982) measures a person's self-concept, or sense of esteem. The index consists of 25 self-report questions, marked on a five point scale. Half of the questions are worded in reverse order to reduce bias. The scores are added, and may range from 0 to 100. Scoring was reversed, so that high scores indicate a positive, or high self-esteem, and low scores indicate low self-esteem. Reliability alpha is .93, and content and construct validity is .60 (Hudson, 1992).

Internalized Shame Scale [ISS].

The Internalized Shame Scale (Cook, 1987), measures a person's level of shame. The scale consists of 35 statements of negative experiences, to which participants respond on a scale of 0 to 4. The scores are tallied, and may range from 0 to 140. High scores indicate a high level of shame. Internal consistency reliability coefficient is .95, indicating high internal consistency. Variance for a group of clinically treated female clients is $F(1,62) = 19.93$, $p = .001$ (Cook, 1987).

Summary

This chapter has summarized the methodology and

test instruments used in the group study. It also briefly discussed some of the issues involved in running a group, such as selection of participants, therapy goals, and duration of group work. The following chapters present the data results, discussion of results, and recommendations.

Chapter Four

Results

The measurement instruments were administered during the following times: a) Time 1--the beginning of group therapy (T1), b) Time 2--the end of phase I of group therapy (T2), and c) Time 3--the end of phase II of group therapy (T3). Results are presented in the following sections: (1) Index of Self-esteem (ISE) results, (2) Locus of Control of Behavior (LCB) results, (3) Internalized Shame Scale (ISS) results, (4) individual scores for ISE, LCB, and ISS, (5) ISE for six subjects, (6) LCB for six subjects, and (7) ISS for six subjects.

Index of Self Esteem

The mean score for self-esteem in Time 1 (T1), the beginning of group therapy, was 38.75, with a standard deviation of 9.35. A score below 30 would indicate severe distress, and above 70 would indicate no clinically significant problem in this area (Hudson, 1992). At Time 2 (T2), the end of phase I, the mean score was 45.50, with a standard deviation of 6.70. At Time 3 (T3), the end of phase II, the mean score was

52.88, with a standard deviation of 11.53. The mean score increased by 6.75 points from the beginning to the end of phase I (T2 minus T1), and increased by 7.38 points from the end of phase I to the end of phase II (T3 minus T2). The change in self-esteem is significant ($t = -2.93$, $p < .05$) between T1 and T3, and between T1 and T2 (phase I), but is not significant ($t = -1.75$, $p = .12$) between T2 and T3 (after phase II) (see Table 1).

Locus of Control of Behavior

The mean score for locus of control of behavior in T1, the beginning of group therapy, was 44.50, with a standard deviation of 13.60. The mean score for groups of university students and working nurses was 28.1 (Carver et al., 1984). At T2, the end of phase I, the mean score was 33.25, with a standard deviation of 7.59. At T3, the end of phase II, the mean score was 30.00, with a standard deviation of 12.28. The mean score decreased by 11.25 points from the beginning to the end of phase I (T1 minus T2), and decreased by 3.25 points from the end of phase I to the end of phase II (T2 minus T3).

Table 1

Measures of Self-esteem (ISE), Between the Different Treatment Phases

Time (N=8)	Mean	SD	t value	deg. of freedom	2-tail prob.
T1	38.75	9.35	—	—	—
T2	45.50	6.70	—	—	—
T3	52.88	11.53	—	—	—
T1, T3*	—	—	-2.93	7	.022**
T1, T2	—	—	-2.74	7	.029**
T2, T3	—	—	-1.75	7	.123

* Paired samples t test on the difference in mean scores between T1 and T3.

** Significant at the .05 level.

Table 2

Measures of Locus of Control of Behavior (LCB) Between the Different Treatment Phases

Time (N=8)	Mean	SD	t value	deg. of freedom	2-tail prob.
T1	45.50	6.70	—	—	—
T2	33.25	7.59	—	—	—
T3	30.00	12.28	—	—	—
T1, T3*	—	—	2.91	7	.023**
T1, T2	—	—	3.45	7	.011**
T2, T3	—	—	.78	7	.463

* Paired samples t test on the difference in mean scores between T1 and T3.

** Significant at the .05 level.

The change in locus of control of behavior is significant between T1 and T3 ($t = 2.91$, $p < .05$), and between T1 and T2 (phase I) ($t = 3.45$, $p < .05$), but is not significant between T2 and T3 ($t = .78$, $p = .46$) (see Table 2).

Internalized Shame Scale

The mean score for internalized shame in T1 was 94.75, with a standard deviation of 12.57. The mean score for a sample of female undergraduate university students was 42.8. At T2, the mean score was 80.75, with a standard deviation of 7.76. At T3, the mean score was 72.75, with a standard deviation of 22.46. The mean score decreased by 14 points from the beginning to the end of phase I (T1 minus T2), and decreased by 8 points from the end of phase I to the end of phase II (T2 minus T3). The change in internalized shame is significant between T1 and T3 ($t = 2.45$, $p < .05$), and between T1 and T2 ($t = 2.77$, $p < .05$), but is not significant between T2 and T3 ($t = .86$, $p = .86$) (see Table 3).

Individual Scores for ISE, LCB, and ISS

Because the mean group scores indicate a significant positive change after phase I but not after

Table 3

Measures of Internalized Shame (ISS) Between the
Different Treatment Phases

Time (N=8)	Mean	SD	t value	deg. of freedom	2-tail prob.
T1	94.75	12.57	—	—	—
T2	80.75	7.76	—	—	—
T3	72.75	22.46	—	—	—
T1, T3*	—	—	2.45	7	.044**
T1, T2	—	—	2.77	7	.028**
T2, T3	—	—	.86	7	.421

* Paired samples t test on the difference in mean scores between T1 and T3.

** Significant at the .05 level.

phase II, individual scores for the three instruments were examined.

Table 4 lists the individual scores for all subjects on the ISE, LCB, and ISS instruments. An increase in the scores for ISE indicates an increase in self-esteem. A decrease in the scores for LCB indicates a more internalized locus of control, and a decrease in the scores for ISS indicates a decrease in internalized shame. Graphically, an upward trend in ISE and downward trends in LCB and ISS would indicate continued positive change (see Table 4).

Figure 1 shows individual score changes over time. Subject 1 had an increased self-esteem score, and decreased locus of control and internalized shame scores at T2, but reversed results at T3. That is, at T3 (end of phase II), subject 1 had a decreased self-esteem score, and increased locus of control and internalized shame scores. Subject 2 had a decreased ISE score at T2 and an increased score in ISS at T3. Subject 2 had increased ISE and decreased LCB scores at T3, and a decreased ISS score at T2. Subject 3 presents with the same pattern of results as subject 1, with increased self-esteem and decreased locus of control and internalized shame scores at T2, and reversed results at Time 3. Subject 4 had increased ISE and decreased LCB

Table 4

Individual Subject Scores for ISE, LCB, and ISS

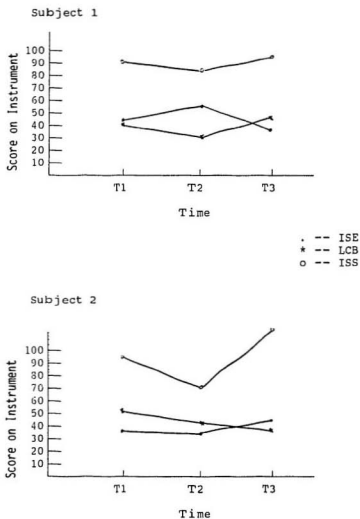
Subjects N=8)	ISE			LCB			ISS		
	T1	T2	T3	T1	T2	T3	T1	T2	T3
1	44	47	38	40	31	48	90	85	94
2	38	37	46	51	43	39	95	71	108
3	51	59	55	53	31	37	93	83	88
4	35	44	74	61	43	22	108	91	46
5	39	49	61	58	33	31	105	68	71
6	19	40	41	34	33	19	104	83	58
7	40	42	53	21	19	10	68	79	47
8	44	46	55	38	33	34	95	86	70

and ISS scores at T2 and T3 (end of phases I and II). Subject 5 had increased ISE and decreased LCB scores at T2 and T3, but a decreased ISS score at T2, and an increased ISS score at T3. Subject 6 had the same pattern of results as subject 4, with increased ISE and decreased LCB and ISS scores at T2 and T3. Subject 7 had results similar to subject 5, except that subject 7 had an increased ISS score at T2 and a decreased ISS score at T3. Subject 8 had increased ISE and decreased ISS scores at T2 and T3, a decreased LCB score at T2, and an increased LCB score at T3 (see Figure 1).

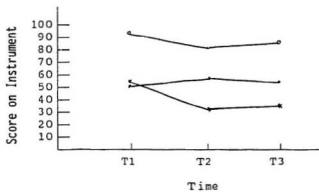
Individual Score Changes for ISE, LCB, and ISS

Table 5 indicates the positive and negative score changes for individual subjects on the self-esteem, locus of control, and internalized shame indices. Subjects 1 and 3 had positive changes in self-esteem, locus of control, and internalized shame scores at T2, but negative changes in all three traits at T3. Subjects 4 and 6 experienced positive changes in all three measured traits at T2 and T3 (end of phases I and II). Subjects 5 and 7 experienced positive changes in self-esteem and locus of control at T2 and T3. However, subject 5 experienced positive change in internalized

Figure 1

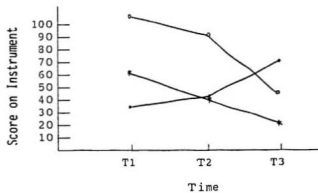
Individual Subject Scores for ISE, LCB and ISS

Subject 3

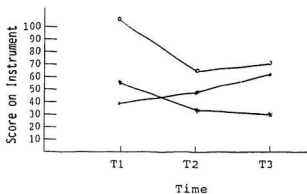


. -- ISE
 * -- LCB
 o -- ISS

Subject 4

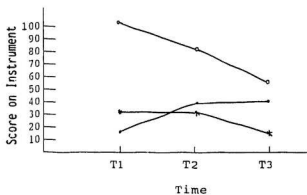


Subject 5

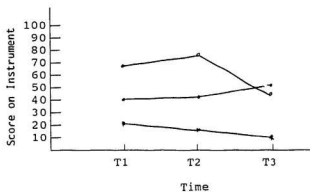


. -- ISE
* -- LCB
o -- ISS

Subject 6

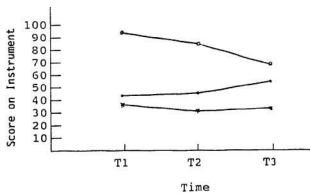


Subject 7



. -- ISE
 * -- LCB
 o -- ISS

Subject 8



shame at T2 and negative change in internalized shame at T3; while subject 7 experienced a negative change in internalized shame at T2 and a positive change in internalized shame at T3. Subject 2 experienced negative change in self-esteem at T2 and negative change in internalized shame at T3. Subject 2 experienced positive change in self-esteem and locus of control at T3, and positive change in internalized shame at T2. Subject 8 experienced positive change in all traits, except for a negative change in locus of control at T3 (see Table 5).

Index of Self Esteem, Excluding Subjects 1 and 3

An examination of individual scores indicates some subjects had positive changes while others had negative changes on the same traits. To test whether the change in scores for the subjects who appeared to have improved was significant, a paired samples t test analysis was done on the group scores again, excluding subjects 1 and 3.

The new mean score for six subjects for the Index of Self Esteem was 35.83 with a standard deviation of 8.75 at T1. At T2, the mean score was 43.00, with a standard deviation of 4.29. This represents an increase of 7.17 points by the end of phase I (T2 minus T1),

Table 5

Direction of Individual Score Changes for ISE, LCB, and ISS

Subjects (N=8)	ISE		LCB		ISS	
	T2	T3	T2	T3	T2	T3
1	+	-	+	-	+	-
2	-	+	+	+	+	-
3	+	-	+	-	+	-
4	+	+	+	+	+	+
5	+	+	+	+	+	-
6	+	+	+	+	+	+
7	+	+	+	+	-	+
8	+	+	+	-	+	+

which is not a significant change ($t = -2.18$, $p = .08$). At T3, the mean score was 55.00 with a standard deviation of 11.64. This represents an increase of 12 points by the end of phase II (T3 minus T2), which is a significant change ($t = -3.05$, $p < .05$) (see Table 6).

Locus of Control of Behavior, Excluding Subjects 1 and 3

When subjects 1 and 3 were excluded from the results and a t -test run on the remaining data, the mean score for Locus of Control of Behavior at T1 was 43.83 with a standard deviation of 15.48. At T2, the mean score was 34.00, with a standard deviation of 8.83. This represents a decrease of 9.83 points by the end of phase I (T1 minus T2), which is not a statistically significant change. At T3, the mean score was 25.83 with a standard deviation of 10.76. This represents a decrease of 12 points by the end of phase II (T2 minus T3), but is not statistically significant. The change is significant from the beginning of phase I to the end of phase II (T1 minus T3) ($t = 3.46$, $p < .05$), but not after each phase individually. To be significant, the 2-tail probability must be less than .05. After phase I, the 2-tail probability was .054, and after phase II, it was .059. This represents a change in the right direction, but is not statistically significant (see

Table 6

Measures of Self-esteem (ISE), Excluding Subjects 1 and 3

Time (n=6)	Mean	SD	t value	deg. of freedom	2-tail prob.
T1	35.83	8.75	—	—	—
T2	43.00	4.29	—	—	—
T3	55.00	11.64	—	—	—
T1, T3*	—	—	-4.15	5	.009**
T1, T2	—	—	-2.18	5	.081
T2, T3	—	—	-3.05	5	.028**

* Paired samples t test on the difference in mean scores between T1 and T3.

** Significant at the .05 level.

Table 7).

Internalized Shame Scale, Excluding Subjects 1 and 3

When subjects 1 and 3 were excluded from the results and a t-test run on the remaining data, the mean score for Internalized Shame at T1 was 95.83 with a standard deviation of 14.66. At T2, the mean score was 79.67 with a standard deviation of 8.85. This represents a decrease of 16.16 points by the end of phase I (T1 minus T2), but is not a significant change ($t = 2.45$, $p = .058$). At T3, the mean score was 66.67 with a standard deviation of 22.92. This represents a decrease of 13 points by the end of phase II (T2 minus T3), but is not statistically significant. There was a significant change between T1 and T3 ($t = 2.80$, $p < .05$) (see Table 8).

Summary

Analysis of the data of the study group indicates a significant change in self-esteem, locus of control, and level of shame after two phases of group therapy, spanning eight months. The change in these traits after phase I of group therapy is significant, though the change between phase I and phase II is not statistically significant.

Table 7

Measures of Locus of Control of Behavior, Excluding
Subjects 1 and 3

Time (n=6)	Mean	SD	t value	deg. of freedom	2-tail prob.
T1	43.83	15.48	—	—	—
T2	34.00	8.83	—	—	—
T3	25.83	10.76	—	—	—
T1, T3*	—	—	3.46	5	.018**
T1, T2	—	—	3.50	5	.054
T2, T3	—	—	2.43	5	.059

* Paired samples t test on the difference in mean scores between T1 and T3.

** Significant at the .05 level.

Table 8

Measures of Internalized Shame (ISS), Excluding Subjects 1 and 3

Time (n=6)	Mean	SD	t value	deg. of freedom	2-tail prob.
T1	95.83	14.66	—	—	—
T2	79.67	8.85	—	—	—
T3	66.67	22.92	—	—	—
T1, T3*	—	—	2.80	5	.038**
T1, T2	—	—	2.45	5	.058
T2, T3	—	—	1.09	5	.327

* Paired samples t test on the difference in mean scores between T1 and T3.

* * Significant at the .05 level.

However, an examination of individual scores on the three measurements indicates that some subjects improved in the measured traits after phase II, while others did not (see Tables 3 and 4). Four subjects (4, 6, 7, and 8) improved in self-esteem, locus of control, and level of shame after phase II. Two subjects (2 and 5) improved in self-esteem and locus of control, but worsened in the level of internalized shame. Two subjects (1 and 3) showed improvement in the three measured traits after phase I, but worsened in all three after phase II.

To test whether the positive changes in scores for the six subjects who improved after phase II were significant, a paired samples t -test was run on the data after excluding the data for subjects 1 and 3 (see Tables 5-7). The results indicate a significant change between phases I and II for self-esteem. The changes for locus of control and level of shame between phases I and II, though in a positive direction, were not statistically significant.

An informal discussion was used as an evaluation of phase III, as data could not be collected. The results of this discussion indicate further positive change in the three measured traits for all subjects. All subjects reported feeling better about themselves, less

shameful, and more in control over events in their lives than before they started group therapy. This is further discussed in the following chapter.

Chapter Five

Discussion of Results and Recommendations

A three phase group therapy program was examined in detail, using standardized measurement scales to determine outcome effectiveness for phases I and II, and an informal discussion evaluation after phase III. Data results indicate positive change after phase I for all subjects, and positive change after phase II for six out of eight subjects. Informal discussion at the end of phase III indicates the group process brought positive changes in the lives of the subjects, though they had to recall painful experiences to achieve that goal.

The four hypotheses of this study were supported by the data. Hypothesis 1 stated that involvement in this therapy group would improve the participants' sense of self-esteem. The self-esteem of the subjects was generally improved by the end of phase I of group therapy. Though there appeared to be a temporary setback for two subjects at the end of phase II, six subjects had improved self-esteem at the end of that phase. By the end of group therapy, there was an overall improvement in self-esteem for all subjects.

Hypothesis 2 stated that involvement in this group

would lessen the participants' sense of shame over past abuse. All but one subject had a reduced sense of internalized shame by the end of phase I of group therapy. Although feelings of shame were increased somewhat for four subjects during phase II as a result of recall of abuse incidents and feelings, four subjects continued to improve. All subjects had a reduced sense of shame by the end of phase III.

Hypothesis 3 stated that involvement in this group would increase the participants' ability to perceive events as being under their personal control. All subjects had an improved sense of internal control at the end of phase I of group therapy. Three subjects experienced a negative change by the end of phase II, though five subjects continued to feel more in control. By the end of phase III, all subjects were feeling more in control over events in their lives.

The fourth hypothesis stated that involvement in this group for a longer period (36 weeks) would produce greater change than short term involvement (12 weeks). The scores on the measurement instruments indicate a greater change over time for the six subjects who continued to improve in the measured traits during phase II. Unfortunately, scores for the end of phase III are unavailable, though subjects reported feeling better

about themselves and more in control of their lives at the end of phase III than previously.

To understand some of the possible reasons for the mixed results after phase II, it is necessary to examine the group dynamics during the three phases, and the evaluation discussion.

According to the group therapists' observations, the results may be explained, in part, by the topics discussed in phases I and II. Phase I dealt mainly with the subjects identifying with the group--dealing with isolation, validation of feelings, bonding with the group, and so on (see Appendix A). Although subjects were asked to identify feelings from their childhoods, they were not forced to do that if they did not feel ready. Apparently, Phase I was effective in achieving its goal of bonding, as seven out of eight subjects experienced positive change in self-esteem and internalized shame, while all subjects experienced positive change in locus of control at the end of Phase I. The subject who had a negative change in self-esteem at the end of Phase I had a difference of only one point, which is not a significant decrease.

Phase II focused on feelings through recall of specific childhood abuse incidents. Shame, guilt,

anger, depression, suicide, and sexuality were some of the issues and feelings which were brought to the surface. Participants were required to get in touch with the inner child. They perceived their feelings as a hurt child inside themselves, and were required to validate those feelings through relaxation and guided imagery. Many of the subjects had denied or shut out their deep feelings over the years, and getting in touch with them proved to be a painful and traumatic experience. Subjects 1 and 3, in particular, had traumatic experiences while recalling painful memories. In addition, both subjects were experiencing difficulties with relationships in their lives at the time, which caused them even more trauma. The anxiety they were experiencing is reflected in the scores on the self-esteem, locus of control and internalized shame scales.

Subjects 2 and 5 improved in self-esteem and locus of control in phases I and II, but the reduction in internalized shame after phase I was increased by the end of phase II. Again, this may be explained, in part, by the recall of painful childhood memories which the subjects perceived as shameful.

As discussed above, empirical data is not available for the end of phase III. However, the informal

discussion at the end of phase III provides valuable subjective information not available through standardized questionnaires. Phase III involved learning to take care of the inner child, and integrating the inner child with the adult. Issues included safety, comforting the inner child, dealing with feelings that needed more work from phase II, and taking control. The flexibility of phase III to allow subjects to work on their own issues at their own level was beneficial to the subjects. As a result, subjects learned to face issues as adults, instead of dealing with issues as they did in the past. They were able to see themselves as survivors, no longer victims.

According to the informal final discussion, many of the negative effects brought on by the recall of affect-laden memories in phase II had dissipated by the end of phase III. By hearing the stories of other participants, subjects realized they were not alone in their trauma, but one of many who had been traumatized. Previous to therapy, many of the subjects had felt that this had happened only to them, and that other children were not abused. It appeared that for many subjects, this may have been the first time in their lives they had felt a true sense of identification.

The shame had been reduced in two ways. One way

was through learning that others had also been abused, which appeared to help the subjects realize they were not at fault. The second method for reducing shame and realizing the subjects were not to blame for what happened was through sharing photographs of themselves when they were children. As each subject observed the photographs of the others, they were overcome by the reality that these were indeed children who had been hurt. As they gave comfort to each subject in turn, acknowledging that these were innocent children who were not at fault, they had to acknowledge that they, themselves, were also not at fault.

In a safe and supportive place to talk, the subjects were able to break down emotional barriers and allow buried feelings to surface. They were able to explore how the abuse was affecting their lives, and come to an understanding of why they felt trapped as adults. They learned to take care of the inner child, and to deal with issues as adults. As a result of the group intervention, the subjects experienced fewer nightmares, panic attacks, and flashbacks. They had learned to relax, to replace negative images of themselves with positive, affirming images, and to take control of events in their lives.

By the end of phase III of group therapy, which had

spanned almost a year, most subjects were ready to let go. After phases I and II, the group stopped for a breather, with unfinished business still on the agenda. As traumatic as phase II was for subjects, phase III required a lot of difficult work. Phase II merely got subjects in touch with feelings. In phase III, they had to deal with those feelings, and let go of them. They did this through the assistance of hypnotherapy, whereby they met, comforted, took care of, and then said goodbye to the inner child. Six of the eight subjects felt they had done as much work as they needed to, and felt ready to leave the group. Even though subjects 1 and 3 felt much better about themselves, they felt they could still not let go of some of the feelings, and wished to continue in individual therapy. All subjects did, however, feel more assured of themselves, less guilty and shameful about what had happened to them as children, and more in control of their lives by the end of phase III.

An attempt was made to do a follow-up study ten months after the termination of the group. Unfortunately, most of the subjects had moved out of the province, and their addresses could not be obtained.

Conclusion and Recommendations

This research supports the theory that group therapy can improve the lives of women who have been sexually abused as children. Although it is painful for survivors to recall traumatic memories, this can be a therapeutic process, whereby the women can acknowledge the pain and then let go of it. The result is women who feel better about themselves, who do not feel guilty about the past abuse, and who feel more in control over events in their lives.

The three phase group treatment program for women who were sexually abused as children was the first of its kind to be offered in St. John's, and possibly, in Newfoundland. It was developed by one of the co-leaders, and was based on current literature as well as input from women involved in a pilot group.

Based on the need for research and service in the area of treatment for survivors, the following recommendations are made:

1. The current study group therapy program is unique because of the extensive use of hypnotherapy. Therapists conducting such a group should be skilled in hypnotherapy methods, as well as thoroughly familiar with the lasting effects of childhood sexual abuse.
2. Standardized evaluation should be carried out

on all three phases of a treatment group for survivors. There is very little standardized evaluative information available on group treatment programs, though this kind of information would greatly assist therapists who offer group treatment. Other traits which were not measured in this study, such as Depression, may be included as study targets.

3. There is a need for more group therapy treatment programs for survivors of abuse.

4. There is a need for prevention strategies in the area of child sexual abuse. Community prevention programs should include: support programs for new parents, education for parents, child and family screening and treatment, child care opportunities, programs for abused children and adults, life skills training, self-help groups, family support services, community organization activities, and public information and education (Leger, 1986), and finally

5. There is need for treatment for offenders, to break the cycle of violence. Poling (1989) found a strong connection between childhood abuse and perpetration as adults. This has implications for the need for intervention at all levels: the child victims; the adult survivors; and the adult perpetrators.

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Appendix

Appendix A

The Group Treatment Program

Outline of Issues Dealt With in Group Treatment Phases

Phase I

- Dealing with isolation
 - validation of feelings
 - no longer feeling alone
 - the importance of having safety nets
 - bonding / becoming part of the group
- Dealing with body image
- Leaving behind the "victim" image
- Understanding the "Inner Child" on a feeling level
- Getting in touch with feelings: crying, sadness, and hurt
- Dealing with the issues of trust and mistrust

Phase II

- Focus on feelings through recall of specific incidents: body image, shame, guilt, rage, anger, depression, suicide, and sexuality
- Getting in touch with the Inner Child and validating the feelings, through relaxation and guided images

Phase III

- Learning to take care of the Inner Child
- Integrating the Inner Child with the adult, through relaxation and visualizations
- Assertiveness and taking control: facing issues today, instead of dealing with as in the past (no longer victims)

Outline of Group Therapy Program

Phase I--Isolation and Survival.

Session 1: Setting boundaries.

Subjects and co-therapists set guidelines, ground rules, and boundaries. Issues of confidentiality were discussed, and subjects set personal goals. Therapists talked about common feelings and experiences that survivors share, and gave information about the recovery process. Questionnaires were completed. Homework assignment: bring a "safe" toy or stuffed animal to the next session.

Session 2: Safety issues.

To foster a climate of trust and commitment among subjects, issues of trust were discussed. Subjects brought a reminder of a safe time in their childhood--a safe toy or plush animal. Subjects shared their animals, and described why they made them feel safe. Homework assignment: journal writing--focus on a feeling and how you felt as a victim.

Session 3: Feeling safe with a feeling.

Subjects shared their journal writings on focussing on a feeling, and how they felt as victims.

Session 4: Feeling comfortable with your body.

Subjects were encouraged to share their feelings and "hangups" about their bodies. An understanding of how each person feels about her body, and an acceptance of those feelings as real was begun. Focus was on the positive. Homework: write a story to yourself as a child, describing one feeling when you were hurt or victimized as a child.

Session 5: Inner child.

Subjects shared their stories to themselves as a child. Homework: write another story to yourself as a

child, describing another feeling when you were hurt or victimized as a child.

Session 6: Inner child.

Subjects shared their stories. Homework: bring pictures of yourself as a child, around the time of the abuse. If possible, also bring a picture of the perpetrator.

Session 7: Inner child.

Subjects brought and shared their photographs. This gave subjects permission to validate the experience, focus on feelings, and accept that they were children and not responsible for the abuse. The support of the group helped subjects to cope with the trauma of reliving their childhoods. Homework: journal writing on one incident of past abuse.

Session 8: Inner child.

Subjects were required to tell their story in detail, and relive one incident of sexual abuse.

Session 9: Inner child.

Subjects were assisted to go back to the inner child through hypnotherapy.

Session 10: Inner child.

Subjects were assisted to go back to the inner child through hypnotherapy.

Session 11: Letting go.

Subjects were assisted in saying goodbye to the inner child, and once again, to get in touch with their feelings.

Session 12: Letting go.

Subjects dealt with issues related to separating from

the therapists and the support of the group. There was an examination of what goals were met, and the length of the break was determined. Questionnaires were completed.

Comment: Even though subjects were required to write about their own experiences and issues, some subjects had difficulty writing as if they were a child. They wrote in the third person instead, and appeared almost detached from their feelings. This was acknowledged by the therapists, who allowed each subject to work from where they were, in terms of feelings. Some of the subjects were not able to write as if they were a child until phase II.

Phase II--Feelings.

Journal writing was assigned as homework, to be discussed during the following session.

Session 1: Trust and safety.

Trust and safety were again issues, as the group was apart for about three weeks.

Session 2: Safety.

Issues around safety were discussed, and subjects identified feelings to work on. Homework: journal writing on a feeling--guilt.

Session 3: Guilt.

Subjects shared stories, and discussed the issue. Journal writing--shame.

Session 4: Shame.

Subjects shared stories; this was continued during the next session.

Session 5: Shame.

Continuation of session 4. Journal writing--anger

Session 6: Anger.

Subjects shared stories; this was continued during the next session.

Session 7: Anger.

Continuation of session 6. Journal writing--depression.

Session 8: Depression.

Subjects shared stories and discussed. Journal writing--suicide.

Session 9: Suicide.

Subjects shared their stories and feelings. Journal writing--sexuality.

Session 10: Sexuality.

Subjects shared their stories.

Session 11: Letting go.

Subjects did a relaxation, and discussed issues around letting go.

Session 12: Letting go.

Issues of letting go, establishment of next start-up date, and completion of questionnaires.

Phase III--Inner Child.

Session 1: Trust and safety.

Trust and safety issues were discussed again, the breathing meditation was introduced, and the basic induction was introduced. Debriefing.

Session 2: Healing a wound.

Breathing meditation, healing script on healing a wound, debriefing.

Session 3: Healing a wound.

Discussion of previous week's work, basic induction relaxation, and debriefing.

Session 4: Looking deeper.

Healing script to assist subjects to look deeper into their childhoods. Some subjects were able to unlock blocked memories. Debriefing.

Session 5: Looking deeper.

Discussion of previous week's work, basic induction relaxation, and debriefing.

Session 6: Focus on the house.

Healing script to encourage subjects to go back to the house, and look for a safe place. Debriefing.

Session 7: Focus on the house.

Discussion of previous week's work.

Session 8: Feelings as a child.

Healing script to assist subjects to get in touch with the inner child and her feelings. Debriefing.

Session 9: Feelings as a child.

Discussion of previous week's work.

Session 10: Healing.

Healing script to assist subjects to focus on the inner child and to comfort her. Debriefing.

Session 11: Letting go.

Healing script to assist letting go, and saying goodbye to the inner child. Debriefing.

Session 12: Letting go.

Healing script on letting go and freedom. Debriefing. Discussion of the group in general, and how the subjects saw themselves. Making plans for the future: moving on.

Comment: the therapists had intended to administer the measurement questionnaires for the final time, but the last session went on for over three hours. The questionnaires were given to the subjects to be completed at home.

Appendix B

Request to Co-Leaders to Evaluate Group Effectiveness

REQUEST FOR GROUP STUDY

TO: Denise Lawlor and Betty McKinna, Co-therapists of
Group for Adult Survivors of Childhood Abuse
FROM: Amanda Gaultois, Master's Student, Dept. of Ed.
Psych., MUN
RE: Evaluation of group effectiveness

I am studying the area of Adult Survivors of Childhood Sexual Abuse as part of the requirement for my master's degree in Educational Psychology at Memorial University. My research is to study the effects of group therapy on participants who have experienced sexual trauma in childhood or adolescence.

Because the group you are preparing to run is a pilot project and the first of its kind in Newfoundland, I request permission to administer questionnaires allowing me to evaluate whether the group was effective for the participants.

One of the questionnaires is to gather general information about the participants, (eg. marital status). The other questionnaires are designed to give an indication of how participants feel about themselves. These questionnaires would be filled out at the beginning of the group therapy sessions, and at the end of each of the three therapy phases.

The participants will be asked to select a number to be used on all questionnaires, instead of names, to ensure confidentiality. Should you agree to administer the questionnaires, please sign the attached consent form.

Thank you for your assistance in this matter.

Amanda Gaultois

ADMINISTRATION OF QUESTIONNAIRES

We agree to allow Amanda Gaultois to administer questionnaires to our group participants, related to the evaluation of the effectiveness of group therapy. We understand numbers instead of names will be used on the questionnaires so that pre and post questionnaires may be matched.

Co-leader

Co-leader

Appendix C

Request to Group Members to Participate in Group Evaluation

REQUEST TO EVALUATE GROUP EFFECTIVENESS

TO: Participants of Group for Adult Survivors of
Childhood Abuse
FROM: Amanda Gaultois, Master's Student, Dept. of Ed.
Psych., MUN
RE: Evaluation of group effectiveness

I am studying the area of Adult Survivors of Childhood Sexual Abuse as part of the requirement for my master's degree in Educational Psychology at Memorial University. My research is to study the effects of group therapy on participants who have experienced sexual trauma in childhood or adolescence.

Because the group in which you are participating is a pilot project and the first of its kind in Newfoundland, I request permission to administer questionnaires allowing me to evaluate whether the group was effective for you.

One of the questionnaires is to gather general information about the participants, such as marital status, whether or not you have been in therapy before, and so on. The other questionnaires are designed to give an indication of how you feel about yourself. These questionnaires would be filled out at the beginning of the group therapy sessions, and at the end of each of the three phases of sessions.

Should you agree to participate, you will be asked to select a number to ensure confidentiality. This number will be used on all questionnaires instead of your name. If you decide not to participate in the study, your participation in the group will not be affected.

Should you agree to complete the questionnaires, please sign the attached consent form. Thank you.

Amanda Gaultois

COMPLETION OF QUESTIONNAIRES

I agree to complete questionnaires related to the evaluation of the effectiveness of group therapy. I understand that my name will not be used on the questionnaires or in the evaluation, though I will use a number so that pre and post questionnaires may be matched.

Group Member

Appendix D

Demographic Survey

Demographic Survey

ID. Number: _____

Date: _____

DIRECTIONS

- ** To protect your privacy, please DO NOT write your name on this questionnaire. Make up a number, and use this number on all questionnaires.
- ** Please try to answer all questions on your own. Just give one answer for each question.
- ** If you have any questions, feel free to ask.
- ** Your answers will be held in STRICT CONFIDENCE.

PART 1

Please answer by CIRCLING the number or WRITING in the correct response for each question.

GENERAL BACKGROUND:

Age: _____

- Marital Status:
- 1= Single, never married
 - 2= Married
 - 3= Widowed
 - 4= Divorced
 - 5= Separated
 - 6= Common-law relationship

Where have you lived most of your life?

- 1= In a large city (250,000 or more)
- 2= In a small city (less than 250,000; St. John's)
- 3= In a medium size town (eg. Gander, Grand Falls)
- 4= In a small town

OCCUPATIONAL BACKGROUND

Are you currently employed? 1= Yes 2= no

Have you ever been employed in an occupation which paid more than what you currently earn?

1 = YES 2 = NO

If yes, what was the position? _____

What is the longest period of time you have ever held a steady job?

Years _____ Months _____ Weeks _____

EDUCATIONAL BACKGROUND

What is the highest level of education you have completed?

FAMILY

Indicate number, ages and sex of children, if appropriate.

<u>Age</u>			<u>Age</u>		
<u>1st</u> _____	M F		<u>2nd</u> _____	M F	
<u>3rd</u> _____	M F		<u>4th</u> _____	M F	

CURRENT STATUS

Please indicate your present living situation.

1= With parents

2= Alone, single

3= Sharing with a friend(s) (not spouse or boyfriend)

4= Single parent

5= With spouse or boyfriend

Please indicate any previous therapy. 1= No previous

therapy 2= Private counselling 3= Group therapy

Appendix E

Internalized Shame Scale

Internalized Shame Scale

Directions: Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had these feelings and experiences for a long time. These are all statements of feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have had many or these feelings and experiences. Everyone has had some of these feelings at some time, but if you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and mark the number in the space to the left of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. DO NOT OMIT ANY ITEM.

SCALE		
Never-----0	Seldom-----1	Sometimes--2
Frequently--3	Almost Always--4	

- ___ 1. I feel like I am never quite good enough.
- ___ 2. I feel somehow left out.
- ___ 3. I think that people look down on me.
- ___ 4. Compared to other people I feel like I somehow never measure up.
- ___ 5. I scold myself and put myself down.
- ___ 6. I feel insecure about others' opinions of me.
- ___ 7. I see myself as being very small and insignificant.
- ___ 8. I feel intensely inadequate and full of self doubt.
- ___ 9. I feel as if I am somehow defective as a person, like there is something basically wrong with me.

Never-----0 Seldom-----1 Sometimes--2
 Frequently--3 Almost always--4

- _____ 10. I have an overpowering fear that my faults
will be revealed in front of others.
- _____ 11. I have this painful gap within me that I have
not been able to fill.
- _____ 12. There are different parts of me that I try to
keep secret from others.
- _____ 13. I feel empty and unfulfilled.
- _____ 14. When I compare myself to others I am just not
as important.
- _____ 15. My loneliness is more like emptiness.
- _____ 16. I always feel like there is something missing.
- _____ 17. I really do not know who I am.
- _____ 18. I replay painful events over and over in my
mind until I feel overwhelmed.
- _____ 19. At times I feel like I will break into a
thousand pieces.
- _____ 20. I feel as if I have lost control over my body
functions and my feelings.
- _____ 21. Sometimes I feel no bigger than a pea.
- _____ 22. At times I feel so exposed that I wish the
earth would open up and swallow me.
- _____ 23. I become confused when my guilt is
overwhelming because I am not sure why I feel
guilty.
- _____ 24. I seem always to be either watching myself or
watching others watch me.
- _____ 25. I see myself striving for perfection only to
continually fall short.
- _____ 26. I think others are able to see my defects.

Never-----0	Seldom-----1	Sometimes--2
Frequently--3	Almost always--4	

- _____ 27. When bad things happen to me I feel like I deserve it.
- _____ 28. Watching other people feels dangerous to me, like I might be punished for that.
- _____ 29. I can't stand to have anyone look directly at me.
- _____ 30. It is difficult for me to accept a compliment.
- _____ 31. I could beat myself over the head with a club when I make a mistake.
- _____ 32. When I feel embarrassed, I wish I could go back in time and avoid that event.
- _____ 33. Suffering degradation and distress seems to fascinate and excite me.
- _____ 34. I feel dirty and messy like no one should ever touch me or they'll be dirty too.
- _____ 35. I would like to shrink away when I make a mistake.

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Appendix F

Locus of Behavior Scale

Locus of Control of Behavior Scale

Directions: Below are a number of statements about how various topics affect your personal beliefs. There are no right or wrong answers. For every item there are a large number of people who agree and disagree. Could you please put in the appropriate bracket the choice you believe to be true. Answer all the questions.

Strongly disagree---0

Generally disagree--1

Somewhat disagree---2

Somewhat agree---3

Generally agree--4

Strongly agree---5

1. I can anticipate difficulties and take action to avoid them..... ()
2. A great deal of what happens to me is probably just a matter of chance..... ()
3. Everyone knows that luck or chance determines one's future..... ()
4. I can control my problem(s) only if I have outside support..... ()
5. When I make plans, I am almost certain that I can make them ()
6. My problems(s) will dominate me all my life..... ()
7. My mistakes and problems are my responsibility to deal with..... ()
8. Becoming a success is a matter of hard work, luck has little or nothing to do with it..... ()
9. My life is controlled by outside actions and events..... ()
10. People are victims of circumstance beyond their control..... ()
11. To continually manage my problems I need professional help..... ()
12. When I am under stress, the tightness in my muscles is due to things outside my control..... ()

Strongly disagree---0
Generally disagree--1
Somewhat disagree---2

Somewhat agree---3
Generally agree--4
Strongly agree---5

13. I believe a person can really be the master of his fate..... ()
14. It is impossible to control my irregular and fast breathing when I am having difficulties..... ()
15. I understand why my problem(s) varies so much from one occasion to the next..... ()
16. I am confident of being able to deal successfully with future problems..... ()
17. In my case maintaining control over my problem(s) is due mostly to luck..... ()

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