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The Effectiveness of Group Treatment for Women Sexually Abused as Children

by

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "The Effectiveness of Group Treatment for Adult Survivors of Childhood Sexual Abuse" submitted by Elizabeth Mary Jean Westbury in partial fulfilment of the requirements for the degree of Master of Social Work.

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ABSTRACT

The purpose of the current study was to determine the effectiveness of group treatment for women sexually abused as children in improving depression, self-esteem, and trauma symptomatology by comparing the differences between women in group treatment and women in a wait-list comparison group. Between September 1993 and April 1994, 32 women in group treatment and a wait-list comparison group at a non-profit agency in Calgary, Alberta completed a questionnaire, pretest, and posttest measurement instruments. All were in concurrent individual therapy.

On average, both groups of women reported decreased depression and trauma symptoms as well as increased self-esteem. In the treatment group, statistically significant improvement was found in depression and in anxiety, an aspect of trauma symptomatology. Improvement approaching statistical significance was found in levels of self-esteem. Implications of these findings for clinicians working with survivors and recommendations for policy issues are also presented.

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PERSONAL INTRODUCTION

My experience with social work began in Hay River, Northwest Territories as a counsellor at The Women's Centre where I had the privilege of being part of a team that opened a shelter for battered women. When women told me the stories of their lives, they often disclosed childhood sexual abuse. I began to ask my clients if they had experienced any unwanted sexual touching or attention. I learned that many of these women were survivors of childhood sexual abuse.

Each time a movie or a talk show concerning sexual abuse aired locally, more women would disclose their experiences. I learned to work with survivors by reading books and through supervision from Donna Dupuis, who flew in from Yellowknife every two weeks. I realised that I could make a difference and decided to return to university.

During my BSW practicum at Calgary Family Service Bureau I co-facilitated a group for survivors using the same model which was evaluated in this research project. As I learned about the treatment of sexual abuse survivors I noticed a frequent assumption concerning the efficacy of group treatment. There was, however, little empirical evidence to support that assumption.

As a Master of Social Work student, as a private practitioner, and as a group work leader, I am concerned to see such a gap in the knowledge base of the social work profession. I hope this study helps to fill that gap.

DEDICATION

This thesis is dedicated to the childhood sexual abuse survivors whose lives have touched me personally and professionally as they struggled, with courage, to heal.

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CHAPTER ONE

THE PROBLEMS EXPERIENCED BY ADULT SURVIVORS OF CHILD SEXUAL ABUSE

This chapter introduces the range of difficulties often experienced by childhood sexual abuse survivors by first providing a brief presentation of the prevalence rates, and then discussing the two major theoretical explanations for the effects of childhood sexual abuse: the four traumagenic dynamics (Finkelhor & Browne, 1985) and post-traumatic stress theory. The third, and largest section of this chapter presents the long-term effects of childhood sexual abuse: self-esteem; anxiety; depression; suicidality; dissociation; memory difficulties; sleep disturbances; substance abuse; interpersonal difficulties; and revictimization. The impact of each of these long-term after-effects on survivors is presented, as well as the research that supports their applicability to this population.

Prevalence Rates of Child Sexual Abuse

As the topic of childhood sexual abuse became more prevalent in the media, in prevention programs, in the school system, and in the entertainment media, it is apparent that it is of considerable social concern. While statistics regarding the actual prevalence of children being abused cannot be calculated, a number of retrospective studies of adult women who were abused as children suggest that the figures are high. Furthermore, estimates of the prevalence of childhood sexual abuse have been documented by several Canadian and American studies. In one of the earliest studies in the area of childhood

sexual abuse, Finkelhor (1979) noted that 10% of 530 female college students reported sexual abuse by a relative and 13% reported sexual victimization by a non-relative. Later, in a ground-breaking, random sample study in the San Francisco area, Russell (1986) reported that 12% of 930 women had been sexually abused by a family member prior to the age of 14. Before the age of 18, 16% had experienced intrafamilial sexual abuse, while 31% reported extrafamilial sexual abuse.

In a federally-sponsored, national Canadian study of 2,135 respondents, the Badgely (1984) commission estimated that one in three men, and one in two women had been the victim of at least one unwanted sexual act. Eighty percent of the time these unwanted sexual acts occurred prior to age 18. The overall percentage of abused female children was not provided, however, if the rate of women sexually abused as children is 80% of one of two women, then approximately 40% of Canadian women were sexually abused, in some manner, at least once, as children. This study utilized a broad definition of sexual abuse which included "hands off" sexual abuse, which may explain the high prevalence rate, however, it remains the best estimate of the extent of the sexual victimization of Canadian children. Discrepancies in prevalence rates due to sampling differences are discussed by de Chesnay, Stephensen, and West (1990).

Two prevalence studies in the city of Calgary estimate that 21.7% to 32% of women (N=377; N=620) have been sexually abused at least once, in a manner involving genital touching before the age of 17 (Bagley & Ramsay, 1986; Bagley & Young, 1990). In a further prevalence study conducted in Calgary (N=750) with women aged 18 to 27,

Bagley (1991) noted that 32% of these young women had experienced some form of childhood sexual abuse.

A nationally representative American study (N=2,626) estimated that 27% of women and 16% of men had been sexually abused as children (Finkelhor, Hotaling, Lewis, & Smith, 1990). Similarly to other research, most often the children were abused by someone they knew and many did not disclose their sexual abuse experience during childhood.

In summary, if these prevalence rates are accurate, then one in every two or three women in North America has experienced some form of childhood sexual abuse. While the exact prevalence figures have been debated, there is little doubt that a substantial number of women in the general population were sexually abused as children. Many of these women refer to themselves as "survivors," the term that will be used in this thesis.

Theoretical Explanations for the Effects of Childhood Sexual Abuse

There is a substantial body of research that documents both the immediate and the long-term effects of sexual abuse. Browne and Finkelhor (1986) use the term "initial effects" rather than "short-term effects" when referring to reactions to sexual abuse which occur within two years of termination of abuse. They do so "because 'short-term' implies that the reactions do not persist - an assumption that has yet to be substantiated" (p.66). A review of the paediatric literature suggests that within two years of being sexually abused children report a unusually high rate of physical problems such as stomach complaints, eating disorders, headaches, and disturbed sleep (Adams-Tucker,

1982). For the purpose of this thesis, long-term symptoms will be considered as those which last into adulthood, or began in adulthood as a result of sexual abuse in childhood or adolescence.

There are two major theoretical approaches that explain the initial as well as the long lasting and devastating effects of childhood sexual abuse: Finkelhor and Browne's (1985) framework of four traumagenic dynamics or factors, and post-traumatic stress theory upon which the trauma-focused intervention approaches are based. Both theories attempt to explain why childhood sexual abuse would create serious reactions that would persist for many years (Briere, 1989; Courtois, 1988; Finkelhor & Browne, 1985; Herman, 1992).

The four traumagenic dynamics.

Finkelhor and Browne (1985) propose that sexually abused children are traumatized in four ways: experiencing traumatic sexualization; betrayal; powerlessness; and stigmatization. The four dynamics "cause trauma by distorting a child's self concept, world view, and affective capacities" (Finkelhor, 1987, p.348).

The organization of this chapter is based on the conceptualization used by Wachtel and Scott (1991) in their literature review, where each of the effects of childhood sexual abuse are categorised as related to one, or more, of the four traumagenic dynamics. Wachtel and Scott fit the effects of childhood sexual abuse into the conceptual model developed by Finkelhor (1987) to organize the after-effects into the categories of the traumagenic dynamics. In addition, Finkelhor (1987), divided the effects into

psychological impacts and behavioural manifestations. The former refers to those after-effects which have an impact upon the survivor's cognitive or mental processes; the latter, refers to those which affect the actions or the behavioural processes.

Traumatic sexualization refers to the interpersonally improper, and the developmentally inappropriate way in which a sexually abused child learns about sexuality which is thought to significantly affect her sexual self-concept. A child who is manipulated into sexual behaviour in exchange for gifts or attention learns that she must give of herself physically and/or emotionally in order to receive affection. The child often accepts the perpetrator's rationale about sexual behaviour. For example, the perpetrator may rationalize that a child needs to be "taught" about sexuality, or may tell the child that she is at fault, or that she is "bad" and, therefore, deserves this treatment. As adults, any type of sexual activity may become associated with negative memories and emotions (Finkelhor, 1987).

The psychological impact of traumatic sexualization may result in confusion about appropriate behaviour, sexual identity, and sexual norms as well as negative associations with sexual arousal and other activities which can later lead to an aversion to sexual intimacy (Finkelhor, 1987). Wachtel and Scott (1991) suggest that the behavioural effects ascribed to traumatic sexualization are "precocious sex-play, seductiveness, increased affection seeking, promiscuity, sexual acting-out, 'homosexuality', and juvenile prostitution" (p.84).

The long-term effects thought to result from traumatic sexualization include poor sexual identity and sexual self-esteem, sexual dissatisfaction, and sexual difficulties such

as orgasmic dysfunction and difficulties with arousal (Finkelhor, 1987). While some survivors display little interest in sex, others may be over-sexualized and promiscuous, perhaps becoming involved in prostitution or experiencing the "damaged goods syndrome" (Wachtel & Scott, 1991). Finkelhor (1987) notes that some survivors become sexually inappropriate in their parenting behaviours. Interestingly, there is also a high incidence of persons having experienced rape in populations of adult survivors (Wachtel & Scott, 1991).

The second traumagenic factor, the dynamic of betrayal, refers to the betrayal of trust that a child experiences when her well-being is disregarded and she is harmed by someone upon whom she is dependent (Finkelhor & Browne, 1985). A child may also experience betrayal and lose trust in others when she is being treated in an abusive manner by someone upon whom she is not dependent, but has perceived to be trustworthy such as a priest, teacher, friend of the family, or a kind stranger (Finkelhor, 1987).

The dynamic of betrayal is believed to affect such psychological reactions as grief, depression, dependency on others, mistrust, anger, hostility, aggression, and an inability to discern the trust-worthiness of others (Finkelhor, 1987; Wachtel & Scott, 1991). Behavioural manifestations of these psychological difficulties may include impaired judgement about trust-worthiness and an inability to trust, making it difficult for some survivors to establish close relationships.

In children, the behavioural manifestations of the dynamic of betrayal are often seen as withdrawal, depression, separation anxiety, running away, leaving home earlier

than developmentally appropriate, compulsive behaviour, obesity, and a variety of somatic symptoms (Wachtel & Scott, 1991). In adulthood, interpersonal conflicts with spouses and with parents are common problems cited among survivors (Wachtel & Scott, 1991). Finkelhor (1987) reports that some survivors may be vulnerable to abuse and exploitation and may experience difficulty in preventing their own children from being victimized.

The third traumagenic factor, the dynamic of powerlessness, is experienced by a child whose right to control over her own body is disregarded by the perpetrator (Finkelhor, 1987). Most children have little control over what happens in their lives but do experience some control over their bodies. In the case of a sexually abused child, this is no longer the case. Powerlessness may also occur when the child is 'tricked' by the perpetrator, when she cannot prevent the abuse from occurring, or when she cannot stop the abuse once the perpetrator begins to sexually abuse her (Finkelhor & Browne, 1985). This sense of powerlessness "is increased when children feel fear, are unable to make adults understand or believe what is happening, or realise how conditions of dependency have trapped them in the situation" (Finkelhor & Browne, 1985, p.532).

The psychological impact of experiencing powerlessness is thought to include anxiety, fear, a decrease in efficacy, perceptions of self as ineffective, or as victims, or identification with the aggressor (Finkelhor, 1987). The behavioural manifestations of this sense of powerlessness include nightmares, sleep disturbances, somatic symptoms of physical problems, and psychosomatic illnesses, eating disorders, dissociation, extreme passivity, and poor social skills (Wachtel & Scott, 1991) .

In children, the behavioural manifestations resulting from a sense of powerlessness are phobias, school problems, running away, learning difficulties, hyperactivity, sleep disturbance, bedwetting, character disorder, delinquency, acting out, sexual offenses, suicidal behaviour and ideation, in addition to other self-destructive behaviours (Finkelhor, 1987; Wachtel & Scott, 1991). A need to control or to identify with the aggressor is sometimes seen in this population (Finkelhor, 1987).

In adulthood, some survivors report concerns about parenting such as feeling inadequate as a mother or worrying about not protecting their children (Wachtel & Scott, 1991). These may be valid concerns, as some survivors lack adequate parenting skills. Finkelhor (1987) further notes that adult survivors may experience employment problems, difficulties with aggressive behaviour, and, as previously mentioned, may be vulnerable to other types of victimization.

Stigmatization, the fourth traumagenic factor, occurs when a sexually abused child comes to believes that something is wrong with her when she realizes that societal norms do not include sexual contact between children and adults. As such, her personal experience is different from the experiences of most other children (Finkelhor & Browne, 1985). When the perpetrator blames the victim, denigrates the child, or pressures others for secrecy about the abuse the child may also feel stigmatized (Finkelhor, 1987). A child who has been sexually abused may experience guilt or shame as she infers from negative reactions to the sexual activities that she has behaved badly or, even worse, that she is bad (Courtois, 1988; Finkelhor, 1987). Such feelings may be encouraged by the perpetrator to ensure silence and may be further reinforced when a disclosure of sexual

abuse is mishandled by a non-perpetrating parent or authority figure (Finkelhor & Browne, 1985).

Stigmatization is considered to have such psychological impacts as guilt, shame, and a sense of being different from others. This is thought to affect a child's development of her self concept and to lower her self-esteem, even into adulthood (Finkelhor, 1987). The behavioural manifestations that are associated with a sense of stigmatization can include isolation, aggression, and substance abuse (Finkelhor, 1987; Wachtel & Scott, 1991). The sequelae of stigmatization and poor self-concept may also result in other self-destructive behaviours such as criminal involvement, homicidal ideation, suicidal ideation or behaviour, self-mutilation, or masochism (Finkelhor, 1987; Wachtel & Scott, 1991).

To summarize, the traumagenic dynamics are clearly a useful way to organize the after-effects of childhood sexual abuse, contributing to an understanding of why such long-term consequences may occur. The complexity of the four traumagenic dynamics help to make sense of the complicated issues faced by many survivors (Finkelhor, 1987).

Post-traumatic stress theory.

The theory of post-traumatic stress originated from studies of survivors of the Nazi concentration camps (Herman, 1992), Hiroshima, natural and man-made disasters, and the Vietnam War (Colodzin, 1993; Herman, 1992; Lifton, 1976). Lifton (1976, 1979, 1988) described a theory of an individual's trauma experience that explains the long-term effects of such experiences and introduces key concepts such as death anxiety, survival guilt, psychic numbing, disruption of interpersonal relationships, and the need

to find meaning and significance in one's life. The construct that developed from this earlier body of research, Post-traumatic Stress Disorder (PTSD) appears in the DSM IV (American Psychiatric Association, 1994) with diagnostic features which develop, "following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to ones's physical integrity . . ." (p.424). The DSM IV criteria for PTSD include: a response of helplessness, fear or horror, persistent reexperiencing of the traumatic event, avoidance of the trauma stimuli or numbing of responsiveness, symptoms of extreme arousal or hyper-vigilance, these symptoms occur for a month or longer (American Psychiatric Association, 1994).

Post-traumatic stress disorder results in recurrent recollections of the event, and intense psychological or physiological reactions which occur when a person has been exposed to a triggering event that reminds the person of the original trauma. The possibility of a delayed onset of symptomatology is acknowledged (American Psychiatric Association, 1994).

The conceptualization of PTSD encompasses most of the persistent negative effects experienced by sexual abuse survivors (Briere & Runtz, 1987; Courtois, 1988; Dolan, 1991; Gelinas, 1983; Meiselman, 1990). Cognitive difficulties related to PTSD include impaired self-concept and self-esteem, negative perceptions of self and others and the future (Briere, 1989). In addition to the cognitive difficulties many survivors report emotional after-effects which include anxiety, depression, interpersonal difficulties, and

acting-out which includes drug and alcohol abuse, self-mutilation, suicidality (Briere, 1989).

Dissociation is, perhaps, the most common PTSD component seen in sexual abuse survivors (Briere, 1989). Other PTSD symptoms frequently reported by survivors include, "sleep disturbance, difficulties in maintaining concentration, memory problems, irrational guilt, hyperalertness, and an intensification of symptoms when a victim is exposed to situations or stimuli that resemble the original traumatic event" (Briere, 1989, p.9). Briere (1989) noted that the "most common abuse-related cognitive changes appear to be (a) negative self-evaluation and guilt, (b) perceived helplessness and hopelessness, and (c) distrust of others" (p.12).

Cameron (1994) refers to survivors of childhood sexual abuse as "veterans of a secret war" (p.1) drawing a parallel between studies of the brain chemistry of Vietnam veterans which found that trauma survivors were prone to adrenaline surges long after the actual danger had past and the reactions of survivors of sexual abuse. The brains of the Vietnam veterans responded to crisis by releasing hormones activating a stress reaction, that caused an exaggeration of the perceived danger which, in turn, triggered body reactions and emotions of past trauma (Goleman, 1992). These chemical changes in the brain produce the three major symptoms of PTSD which are also common to sexual abuse survivors: reexperiencing the trauma, numbing of sensation and emotion, and arousal or hyper-vigilance.

The research literature on survivors presents some support for the relevance of PTSD to survivors of sexual abuse. In a non-clinical population, Greenwald and

Leitenberg (1990) found that while only 3.4% reported sexual abuse during childhood, of those survivors, 20% currently presented with PTSD symptoms, while another 41% reported such reactions at some time. In a clinical population of sexual abuse survivors, 72% were diagnosed with PTSD while a further 13% reported a number of PTSD symptoms (Rowan et al., 1991, cited in Rowan & Foy, 1993). Similarly, in another clinical sample of adult survivors of childhood sexual abuse, Rowan et al. (1994) found that 69% of survivors met full DSM-III-R criteria for PTSD.

In a survey of childhood sexual abuse survivors, Williams (1990) reported that 93% of 525 subjects had PTSD symptoms (cited in Rowan & Foy, 1993). The sample for this study came from referrals from the researcher's associates and only 10% of the women contacted responded making this finding methodologically weak.

Alexander (1993) speculated that the earlier the age of onset the more devastating the effects of the sexual abuse in adulthood. Most research has found that the severity of trauma increases when the sexual abuse includes penetration or use of force, is more frequent, is of a longer duration, and when the perpetrator has a close relationship to the victim (Beitchman et al., 1991; Greenwald & Leitenberg, 1990; Rowan et al., 1990, cited in Rowan & Foy, 1993; Williams, 1990, cited in Rowan & Foy, 1993).

Finkelhor (1987) noted that applying the PTSD formulation to childhood sexual abuse has been of some benefit, such as providing a description of, and a label for the symptoms experienced by many survivors. In addition, the PTSD formulation suggests that the sequelae of childhood sexual abuse need to be examined in a structured manner.

It normalizes the after-effects of sexual abuse as sharing some of the dynamics of other traumas, and thus, has reduced the stigma felt by some survivors (Finkelhor, 1987).

Nevertheless, Finkelhor (1987) has criticized the conceptualization of PTSD as it does not include consideration of the sexual nature of the trauma nor the inter-personal disturbance in the relationship between the victim and the perpetrator of the trauma. In addition PTSD does not account for all of the symptoms of childhood sexual abuse, does not apply to all survivors, and does not provide a theory to explain how childhood sexual abuse leads to the after-effects experienced by some survivors. Putnam and Trickett (1993) note other differences between violence and childhood sexual abuse; in the case of intrafamilial sexual abuse, disclosure has additional traumatic sequelae, family support for the victim is often absent, and the child's home provides no refuge, but is the setting for trauma.

In a similar vein, Cameron (1994) noted that PTSD is a theory primarily formulated by studying adult men who, in the case of Vietnam veterans, were subjected to trauma for a period of a year or two as a result of chance events. In contrast, survivors of sexual abuse were subjected to trauma, often of long duration, which was intentional as well as sexual in nature, prior to the completion of the developmental tasks of childhood. In addition, childhood sexual abuse often occurs with a person or people with whom the child is in a close relationship.

In spite of these criticisms and the acknowledged differences between war veterans and sexual abuse survivors, PTSD theory provides a framework which offers a way for survivors to integrate their sexual abuse symptoms in a meaningful manner

(Courtois, 1988). However, the four trauma dynamics model helps to explain the after-effects of child sexual abuse as a process (Finkelhor, 1987). Combining the PTSD formulation and the traumagenic dynamics model appears to accomplish the inclusion of both the content (PTSD) and process (the traumagenic dynamics) of the after-effects of childhood sexual abuse.

Long-Term Effects

The effects of childhood sexual abuse commonly persist into adulthood both in terms of the impact of the traumagenic factors (Finkelhor & Browne, 1985) and the symptoms of post-traumatic stress (Rowan & Foy, 1993). Women who have been sexually abused as children are "known to lead more disadvantaged lives than non-abused women" (Bagley & Ramsay, 1986, p.46). While the extent to which this is so is dependent upon many factors, it does appear that a considerable number of sexual abuse survivors experience many challenges.

Briere and Runtz (1993) noted that "research provides strong support for the psychological toxicity of childhood sexual victimization" (p. 324). Research has linked childhood sexual abuse experiences to a number of adult problems and symptoms such as low self esteem, anxiety, depression, suicidality, dissociation, memory difficulties, sleep disturbances, substance abuse, sexual dysfunction, interpersonal difficulties and re-victimization. In this section, each of these long-term symptoms will be discussed in terms of the way in which they affect survivors, and the research that supports their applicability to this population.

Self-esteem.

Negative self evaluation, often referred to as low self-esteem, is considered a common cognitive effect of sexual abuse (Courtois, 1988; Bagley & McDonald, 1984; Bagley & Ramsay, 1986; Briere, 1989; Browne & Finkelhor, 1986). Low self-esteem is believed to result from the dynamics of traumatic sexualization (Wachtel & Scott, 1991) and of stigmatization (Finkelhor, 1987; Wachtel & Scott, 1991). A sequelae of sexual abuse may be the tendency to view oneself as a victim as a result of experiencing powerlessness (Finkelhor, 1987).

One's level of self-esteem is developed through social interactions with significant others and through comparison of self with others (Frey & Carlock, 1989). Children are vulnerable and impressionable, and it is during childhood that self-concept develops, and self-esteem evaluation begins to have an impact on a child's behaviour.

Coopersmith confirmed a positive relationship between healthy self-esteem and effective, satisfying behaviour (Coopersmith, 1967). The conditions in childhood that proved essential in the development of high self-esteem were parental acceptance, defined and enforced limits, and respect for individuality within the limits provided (Coopersmith, 1967). Those with low self-esteem were raised under conditions of "domination, rejection, and severe punishment" (Coopersmith, 1990, p.4), conditions that many survivors of childhood sexual abuse experienced.

The development of a sense of self is an early developmental task (Cole & Putnam, 1992) that is possibly disrupted by childhood sexual abuse (Swink & Leveille, 1986). How well, or how badly a "child is treated early in life is bound to influence his

or her growing self awareness" (Briere & Runtz, 1993, pp. 323). Maltreatment, such as sexual abuse, may interfere with a child's ability to know themselves, thus, disrupting their self-perception, their interpersonal relationships, and ultimately, their self-esteem (Briere & Runtz, 1993).

Children who have been sexually abused are also thought to be injured by inconsistent and damaging appraisals. This is especially so with incest victims where the child internalizes negative parental statements or statements of blame as a basis for self-perception (Briere & Runtz, 1990). Where a child infers that she is unimportant, the experiences of sexual abuse are incorporated into her concept of self (Finkelhor & Browne, 1985).

In terms of research that supports the idea that survivors experience low self-esteem, Herman (1981) reported that 60% of the sexual abuse survivors in her study had predominately negative self images compared to 10% of women in a comparison group, a statistically significant difference. In a community study of adult women, Bagley and Ramsay (1986) measured self-esteem finding that 19% of the women who had been sexually abused as children reported poor self-esteem, compared to 5% of non-abused women, a difference that was statistically significant. Further, Bagley (1991) reported significantly lower self-esteem, as measured by a version of the Coopersmith Self Esteem Scale, in 49% of women who had been sexually abused for a week or more as compared to 22% of non-abused women. Two studies of female university students, compared survivors with non-survivors and found significant differences between the two groups in levels of self-esteem (Briere & Runtz, 1990; Parker & Parker, 1991).

A number of studies were also found that did not demonstrate a statistical relationship between child abuse and poor self-concept or low self-esteem (Briere & Runtz, 1988; DiPietro, 1987; Fromuth, 1986; Runtz, 1987, cited in Briere & Runtz, 1990). The Briere and Runtz (1988a) and the Fromuth (1986) studies were with samples of female college and university students. It is possible that sexual abuse survivors who are functioning well enough to attend a post-secondary educational institution enjoy higher levels of self-esteem. The DiPietro (1987) study concerned adolescents and Runtz' thesis (1987) is unpublished.

In summary, while it makes conceptual sense that survivors of childhood abuse would experience low self-esteem the research evidence to date is mixed. More research into the self-esteem of survivors as compared to non-abuse survivors is clearly needed.

Anxiety.

Survivors often exhibit symptoms of anxiety (Bagley & Ramsay, 1986; Browne & Finkelhor, 1986; Jehu, Gazan & Klassen, 1985) which may be a result of the powerlessness they experienced during their childhood sexual abuse (Finkelhor, 1987; Wachtel & Scott, 1991). Clinical experience indicates that women who were sexually abused in childhood often present with somatic, cognitive, and conditioned components of anxiety (Briere & Runtz, 1993). Beck and Emery's (1985) model of anxiety disorder involves hyper-vigilance, preoccupation with control, and misinterpretation of events as evidence of danger or threat of danger. This can be interpreted as a learned response to the sometimes daily danger of childhood sexual abuse. As adults removed from threats

of immediate danger, hyper-vigilant activity or anxiety seem out of context and may be misinterpreted as of psychiatric concern (Briere & Runtz, 1993).

Studies with clinical samples have reported higher rates of anxiety in survivors than in non-survivors. Briere (1984) found that 54% of survivors experienced anxiety attacks as compared to 28% of non-survivors (cited in Browne & Finkelhor, 1986). Similarly, Sedney and Brooks (1984) noted that 59% of survivors reported symptoms of anxiety compared to 41% of non-abused women. Although the statistical significance of these two comparisons were not reported two similar studies using the Trauma Symptom Checklist (TSC) revealed statistically significant differences (Briere & Runtz, 1987; 1989).

Parallel results have been reported in studies with non-clinical populations. Bagley and Ramsay (1986) found that sexually abused women were twice as likely as non-abused women to report serious psychological problems such as anxiety or severe neurosis. Yama, Tovey & Fogas (1993) similarly reported that women who had been sexually abused as children had significantly higher anxiety scores than those who had never been abused. Statistically significant correlations between sexual abuse and anxiety were noted in other studies (Elliott & Briere, 1992; Fromuth, 1986; Gold et al.,1994).

Herman and Schatzow (1987) found that 26% of the outpatient incest survivors in their study had chronic severe anxiety symptoms according to DSM-III criteria. Conversely, high numbers of sexual abuse survivors were found in populations of those diagnosed with an anxiety disorder. Of 66 anxious women, 48.5% had a history of childhood sexual abuse (Murrey et al., 1993). In contrast, Cole's (1986) study of male

and female university students found no statistically significant relationship between anxiety and childhood sexual abuse although there was a trend in that direction (cited in Briere & Runtz, 1989).

In summary, while many studies find anxiety and childhood sexual abuse to be associated, this is not always the case. However, in the one available study where there was no relationship between childhood sexual abuse and anxiety the sample was drawn from a, presumably, high functioning group of college students. Interestingly, even in this study the trend was in the direction of higher anxiety.

Depression.

Survivors often exhibit symptoms of depression (Bagley & Ramsay, 1986; Browne & Finkelhor, 1986; Jehu et al., 1985) which may result from the experience of a betrayal of trust which occurred in conjunction with the experience of sexual abuse (Finkelhor, 1987; Wachtel & Scott, 1991) or during the disclosure of the sexual abuse. Jehu (1989) postulates that sexual abuse victims experience negative thoughts related to their abuse history and these thoughts may lead to depression. Depression may be expressed in various ways, such as lethargic behaviour or a lack of attention to self care (Courtois, 1988). Depression is an after-effect of sexual abuse which has the potential to become chronic (Courtois, 1988).

After a review of the findings of seven studies that utilized standardized measures in non-clinical populations, Cutler and Nolen-Hoeksema (1991) concluded that female sexual abuse survivors experienced significantly higher levels of depression than both

male survivors and non-abused females. In other comparison studies of community samples, sexually abused women were also significantly more depressed than non-sexually abused women (Gold et al., 1994; Yama et al., 1993). Interestingly, a similar finding was reported by Elliott and Briere (1992) in their study of professional women. Furthermore, statistically significant correlations between depression and a history of childhood sexual abuse as measured by the TSC-33 have been reported (Briere, 1989; Briere & Runtz, 1987; Briere & Runtz, 1988; Cole, 1986, cited in Briere, 1989).

To put the rates of depression in sexually abused women and non-abused women into perspective, it is important to examine the rates within the general population. Hammen's 1991 literature review of depression studies suggested that 4% to 8.4% of the general population were depressed. Gold and Morris (1986), in another literature review, reported that 10% to 25% of the general population had experienced depression at least once during their lifetime.

Bagley and Ramsay (1986) reported that 17% of the abused women in their study of a community sample were depressed compared to 9% of non-abused women. While Herman and Schatzow (1987) reported that 57% of the survivors in their research presented with a depression which had lasted for at least two years (Herman & Schatzow, 1987).

In an non-clinical British study, Bifulco, Brown, and Adler (1991) noted that 64% of the sexually abused women had experienced clinical depression in the previous three year period. Conversely, high numbers of sexual abuse survivors were found in

populations of those diagnosed with a depressive disorder; 43.7% of 199 women had a history of childhood sexual abuse (Murrey et al., 1993).

Again, Fromuth's (1986) findings differ from other studies, with no statistically significant differences in depression between abused and non-abused female college students. While 12% of the abused women were moderately to severely depressed, 14% of non-abused women were similarly depressed. A further two studies found no association between childhood sexual abuse and depression (Herman, 1981; Murphy et al., 1988). The Herman study which compared sexually abused women, with women who had "seductive" fathers, found that both groups had equally high rates of depression; 60% of the incest survivors had major depressive symptoms versus 55% of the comparison group.

In summary, there appears to be considerable evidence that women who are sexually abused in childhood experience more depression than those who are not sexually abused. There is some evidence that women with a history of childhood sexual abuse constitute a high proportion of depressed populations.

Suicidality.

Among adult survivors, suicide attempts are relatively prevalent (Jehu, Gazan & Klassen, 1985). Self destructive and suicidal behaviour may be related to low self-esteem resulting from the dynamics of stigmatization (Wachtel & Scott, 1991) or from traumatic sexualization (Finkelhor, 1987). Suicide may be a response to long-term after-effects of abuse such as depression and numbing (Courtois, 1988) and suicide can provide an

option, or an 'out', which, paradoxically, can give survivors a sense of control (Summit, 1986, cited in Courtois, 1988). Those who attempt suicide at a young age may do so to escape their abusive home situation; Briere and Runtz (1986) reported that 93% of the women who had attempted suicide before the age of 13 were survivors.

From a clinical perspective, Courtois (1988) notes that survivors may not value themselves enough to stay alive, as they may not have experienced being treated as a valued person. Suicide may be a way for survivors to punish themselves, as a result of a false sense of responsibility concerning the sexual abuse perpetrated against them during childhood, or it may be a call for help.

Only one early study (Herman, 1981) reported no significant differences in suicide rates between survivors and non-survivors. However, there appeared to be quite a difference between the rates of attempted suicide, such that 37.5% of survivors had attempted suicide compared to 5% of non-abused women.

In contrast, most studies suggest that sexual abuse survivors exhibit more frequent suicidal behaviour than non-abused women. Sexually abused women were twice as likely as non-survivors to attempt suicide according to two reports (Briere & Runtz, 1986; Sedney & Brooks, 1984). A statistically significant difference was noted by Bagley and Ramsay (1986) in rates of suicidal ideation between abused and non-abused women (11% versus 3%), and in rates of suicide attempts (5% versus 0%). Briere and Runtz (1986) also reported statistically significant differences in histories of suicide attempts; 55.9% of survivors had attempted suicide compared to 22.6% of non-abused women. Furthermore, similar findings were reported by Briere and Runtz (1987) with sexually

abused women more likely to have attempted suicide than those who were not abused (50.7% versus 33.7%).

In a clinical study, Briere (1984) found that 43% of those seeking help had a history of sexual abuse before the age of 15 and 51% of those women (versus 34% of non-survivors) had a history of at least one suicide attempt (cited in Briere & Runtz, 1986). Furthermore, a study of psychiatric patients found that women who had experienced suicidal ideation and had attempted suicide were three times more likely to have been physically or sexually abused in childhood than those who were not suicidal (Bryer, Nelson, Miller, & Krol, 1987).

From the findings of these studies, there appears to be a high correlation between childhood sexual abuse and a history of suicidal ideation or suicide attempts. This does not, however, imply a causal effect between childhood sexual abuse and suicidality (Briere & Runtz, 1986).

Dissociation.

Clinical experience suggests that many survivors learn to dissociate "out of their bodies" or to "numb out" during sexual abuse (Briere & Runtz, 1993; Courtois, 1988). Dissociative behaviour includes "trance states, perceptual distortions, feelings of depersonalization or of seeing the self from afar, feelings of derealization, [and] fainting spells. . ." (Courtois, 1988, p. 98). Dissociation is a process which occurs on a continuum from day dreaming to multiple personality disorders (Anderson, Yasenik, & Ross, 1993). Dissociation may serve as an anaesthetic to deal with painful childhood

sexual abuse memories (Briere & Runtz, 1987) and may also function as a contributing factor in the denial process.

Dissociation is believed to be used by many survivors as a coping mechanism initially learned during abusive episodes. Most practitioners have noted that dissociation is a critical factor in treating child sexual abuse survivors. Several authors related dissociation to the traumagenic dynamic of powerlessness (Finkelhor, 1987; Wachtel & Scott, 1991).

In a non-clinical sample, Briere and Runtz (1988) found that sexual abuse survivors scored significantly higher in acute and chronic dissociation. In a non-clinical study, sexually abused women were reported to have significantly higher levels of dissociation, as measured by the TSC-40, than non-sexually abused women (Elliott & Briere, 1992; Gold et al., 1994). In contrast, another non-clinical study using the TSC-33 reported no significant differences between abused and non-abused women (Cole, 1986, cited in Briere & Runtz, 1989).

In a clinical study by Nash, Hulsey, Sexton, Harralson, and Lambert (1993), a statistically significant relationship was reported between a history of sexual abuse and the use of dissociative defences. Further significant differences were found on levels of dissociation between sexually abused women and non-abused women (Briere & Runtz, 1987; 1989). In one of these studies, sexually abused women were 73% more likely to report problems with dissociation than non-abused women (Briere & Runtz, 1987).

In a Canadian clinical sample 88.2% of the sexually abused women reported dissociative experiences (Anderson, Yasenik, & Ross, 1993). Surprisingly, 54.9% had

such high levels of dissociation that they met the criteria for multiple personality disorder diagnosis. In an inpatient study, Swett and Halpert (1993) found that 81% of the women reported a history of childhood sexual abuse, 11.4% a history of physical abuse, and 54.5% a history of both types of abuse. The abused women scored higher, indicating more dissociative behaviour, on a Dissociative Experiences Scale (DES) than those with no abuse history. While the highest scores were reported by women who were both physically and sexually abused: surprisingly, levels of reported dissociation were higher for those who had been only physically abused than for those who had been only sexually abused (Swett & Halpert, 1993).

Chu and Dill (1990) studied 98 female psychiatric patients. Thirty-five had histories of childhood sexual abuse and 50 had histories of childhood physical abuse. Dissociation, as measured on the Dissociative Experiences Scale, was clearly related to childhood abuse history, with higher scores for women abused by a family member. However, slightly higher scores were reported by women who had been physically, but not sexually abused, and the highest dissociative scores, more than three times the score of those only sexually abused, were women with both physical and sexual abuse histories.

As Briere and Runtz (1988) point out, although there are many reports in the clinical literature concerning dissociation little research has yet been conducted on this construct. Nevertheless, there are enough findings to indicate that dissociation is a problem in clinical populations and in some non-clinical populations of sexually abused women. There are no data yet on whether, or not, to attribute dissociative behaviour to

sexual abuse, or to some other variable such as a pathogenic home environment (Nash et al., 1993). Although the etiology of dissociation in sexual abuse survivors is not fully known, there appears to be substantial evidence suggesting that the phenomena presents a significant challenge to many adult sexual abuse survivors.

Memory difficulties.

In a population with a history of trauma and high rate of dissociative behaviour, it follows that difficulties such as intrusive memories, amnesia and memory lapses would occur frequently (Herman, 1992). However, neither Finkelhor (1987) nor Wachtel and Scott (1991) listed memory difficulties as an after-effect of childhood sexual abuse. In addition, these authors did not categorize memory difficulties as resulting from any particular dynamic of traumatization. An in-depth discussion of memory repression and retrieval, along with details surrounding the current controversy regarding the possibility of false memory syndrome (see Dalenberg, 1994; Ofshe, 1994; Olio & Cornell, 1994) is beyond the scope of this thesis. Recently, however, it has become an important debate in the field of child sexual abuse; therefore, a brief overview of the memory difficulties experienced by survivors and current research on the topic is presented.

The phenomena of intrusive recurring memories is commonly described in the post-traumatic stress disorder literature (Herman, 1992; McCann & Pearlman, 1990). The clinical literature suggests that a number of survivors present with symptoms of childhood sexual abuse but no memory of being molested, while others with abuse memories report disturbances in their memory process (Courtois, 1988; Gil, 1988).

Partial amnesia has also been reported as a problem for some survivors (Briere, 1989). Dolan (1991) explains amnesia in survivors as an attempt by the survivor to defend themselves against the pain and trauma arising from the memories. Survivors avoid re-experiencing the abuse by repressing their memories; these memories, however, may return spontaneously (Dolan, 1991).

Early onset sexual abuse may not be recalled due to the possibility that before the age of four or five children are not thought to have coherent and formalized memories (Benedek & Schetky, 1987). In support of this idea Leitenberg, Greenwald, and Cado (1992) reported that respondents in a community sample of sexually abused women relied on emotional suppression and denial to cope with childhood sexual abuse experiences. The more severe the abuse and the earlier the age of onset, the greater was the association with emotional suppression.

Two researchers conducted follow-up studies with women documented to have been abused in childhood (Bagley, 1990; Williams, 1993, cited in Classen, 1995). Bagley (1990) conducted an 18-year follow-up study of English women known to have been sexually abused and others who were known to have not been sexually abused. Of those women known to have been sexually abused 26.3% stated they recalled none or only part of the sexual abuse. Of those women known to have not been sexually abused, 16.6% said that they had been sexually abused during childhood (Bagley, 1990). A higher rate of memory difficulties was reported in William's American study of 129 women with documented histories of childhood sexual abuse wherein 38% reported that they did not

recall abuse that was known to have occurred 17 years previously (1993, cited in Classen, 1995).

Two other studies using self-report measures have also noted memory difficulties with survivors. Herman and Schatzow (1987) found that 33 (64%) of 57 survivors at some time prior to age 18, had not remembered, part, or, all of the details regarding their childhood sexual abuse. Fourteen women (26.4%) were considered to have severe amnesia with very little recall of childhood. Interestingly, some form of corroborating evidence of the sexual abuse was later obtained by 74% of these women. It was not clear how many of those women with severe amnesia recovered memories of sexual abuse nor how many of them had their suspicions of sexual abuse confirmed by others. A strong relationship was discovered between the severity of amnesia and the duration of the abuse and the age of onset (Herman & Schatzow, 1987).

Finally, Briere and Conte (1993) reported a high rate of repression of sexual abuse memories in a clinical sample of 450 adults who had a sexual abuse history which they had recalled by age 18. At some time before that age, 59.3% of the women had no memory of the sexual abuse. Again, memory difficulties were associated with an early age of onset and long duration of abuse. Violent abuse, multiple perpetrators, and death threats by the perpetrator were also associated with memory difficulties (Briere & Conte, 1993).

While there is anecdotal evidence of sexual abuse survivors who recall sexual abuse in adulthood, there is still only early evidence of this phenomenon. Clearly, more research is needed with samples of survivors who are known, through corroborating

evidence, such as medical reports, or social services documentation, to have been sexually abused as children.

Sleep disturbances.

As adults, survivors often experience sleep disturbances such as restless sleep, nightmares, and difficulties falling asleep or staying asleep which may be related to the experiences of powerlessness during sexual abuse (Finkelhor, 1987; Wachtel & Scott, 1991). Sexual abuse often occurs when a child is in bed and, at a young age, some women report that they became light sleepers in an attempt to protect themselves. A number of sexual abuse survivors have recurrent nightmares (Gelinas, 1983) which are a symptom of post-traumatic stress disorder (Briere, 1989). Also associated with the PTSD symptom of increased arousal is restless sleep (Briere & Runtz, 1993). In addition, difficulties falling asleep or staying asleep are symptoms of depression (Beck & Steer, 1987) which, as discussed previously, is a significant problem for some survivors.

Briere (1984) reported that 54% of survivors complained of having nightmares, compared to 23% of non-survivors. Sexually abused men and women had significantly more frequent nightmares than those who had not been sexually abused in childhood (Cuddy & Belicki, 1990, cited in Briere & Runtz, 1993). Furthermore, Briere (1984) noted that 72% had difficulty sleeping compared to 55% of non-survivors (cited in Finkelhor & Browne, 1986). Sedney and Brooks (1984) found that 51% of survivors had trouble sleeping compared to 29% of non-survivors.

Sexually abused women experienced significantly more sleep disturbances than non-abused women as measured by the TSC-33 or the TSC-40. Four studies report statistically significant differences between women who had histories of childhood sexual abuse and those with no history (Briere, 1989; Briere & Runtz, 1987; Cole, 1986 cited in Briere, 1989; Elliott & Briere, 1992). In Briere and Runtz's (1987) clinical study, the women who were sexually abused reported more sleep disturbances than 69% of the non-abused women.

To summarize this information, there appears to be some early evidence that sexually abused women experience more sleep disturbances than non-abused women. Only one study reported contradictory findings: Gold, et al. (1994) found no significant correlation between a history of childhood sexual abuse and sleep difficulties.

Substance abuse.

Another common problem for sexual abuse survivors is alcohol and drug addiction. This is a difficult issue to tease out, however, because many of these women may have a genetic predisposition to substance abuse. Alternatively, substance abuse may be an after-effect of childhood sexual abuse, and a method, albeit negative, of dealing with the psychological and behavioural manifestations of stigmatization experienced in childhood (Finkelhor, 1987; Wachtel & Scott, 1991). Substance abuse can be perceived as a learned coping behaviour to deal with stress and difficulties, while also providing a temporary anaesthetic from post-sexual abuse symptomatology (Briere, 1992).

However, those who use substances to deal with painful memories may, in the process, become alcoholic or drug addicted.

To put the rates of substance abuse in sexually abused women and non-abused women into perspective it is important to examine the rates within the general population. An Alberta study reported that 83% of the general population consume alcohol (AADC, 1989). Researchers estimate that 10% to 12% of those will develop a problem with alcohol or drugs, although men are four times more likely to develop such problems. This means that only 2.5% to 3% of women, generally, develop problems with substance abuse.

By comparison, in two studies sexually abused women were alcoholic 17% and 27% of the time compared to alcoholic non-abused women (4% and 11%) (Briere, 1984; Peters, 1984; both cited in Browne & Finkelhor, 1986). In the same studies, drug addiction was reported in 27% and 21% of survivors while only 12% and 2% of non-abused women were addicted (Briere, 1984; Peters, 1984, both cited in Browne and Finkelhor, 1986). It is not known whether these findings are statistically significant. Herman (1981) reported non-significant differences between 35% of abused women who were alcoholic and 5% of non-abused women who were alcoholic.

Varying rates of childhood sexual abuse survivors, from 36.5% to 90%, have been reported in populations of substance abusers. In some rehabilitation programs the numbers of survivors was as high as 70% to 90% (Ryan & Popour, 1983, cited in Ladwig & Anderson, 1989). A study of chemically dependent women who were involved in the American criminal justice system found that 46.7% of the women had histories of

childhood sexual abuse (Ladwig & Andersen, 1989). Edwards and Donaldson (1989) reported that 36.5% of 104 survivors were alcohol-dependent.

Parental substance abuse is also found in a larger proportion of families where sexual abuse occurs. There may be a family pattern of addictive behaviour and a survivor may be chemically dependent before, as well as after, the abuse (Jelinek & Williams 1987). In a non-clinical study, Yama, Fogas, Teegarden, and Hastings (1993) found a significant correlation between childhood sexual abuse and parental alcoholism.

Edwards and Donaldson (1989) found that 36.5% of 104 survivors reported family histories of alcoholism. Herman (1981) found a similar rate of alcoholism in sexually abusive fathers (37.5%), however, this was not significantly different from the 35% of "seductive" fathers who were alcoholic.

To sum up, in most studies, sexual abuse survivors had a higher rates of substance abuse than non-survivors, even when the differences were not significant. The exception, to date, was in a population of college students in which both abused and non-abused women reported low rates of substance abuse (Sedney & Brooks, 1984).

Sexual dysfunction.

Sexual abuse survivors reportedly experience a wide range of sexual difficulties thought to be related to the dynamic of traumatic sexualization (Finkelhor, 1987; Wachtel & Scott, 1991), as well as to symptoms of anxiety which, as previously discussed are common for many survivors (Courtois, 1988; Maltz & Holman, 1987). Maltz and Holman (1987) noted that flashbacks of abuse, a PTSD symptom, can be triggered during

consensual sexual activity, causing difficulty for survivors and their partners. Difficulties may also develop during sexual emergence into adulthood, through confusion in determining sexual orientation, or preference, and in sexual arousal, response and satisfaction. In addition, survivors may confuse sex with affection which can lead to relationship difficulties (Briere, 1989).

Jehu (1989) found that 94% of the sexually abused women in a clinical sample experienced sexual dysfunction. Bagley and McDonald (1984) reported a significant correlation between sexual abuse in childhood and later aversion to sex in relationships.

Sexual problems often result in low sexual self-esteem. Finkelhor (1984) reported significantly lower levels of sexual self-esteem, measured by Finkelhor's (1979) Sexual Self-Esteem Scale, for both men and women who were sexually abused as children. Sexual abuse survivors reported lower sexual self-esteem, and higher levels of sexual dysfunctional, 45% and 87%, compared to 29% and 20% in non-abused women (Briere, 1984, cited in Browne & Finkelhor,1986; Meiselman, 1978). In contrast, using the same scale, Fromuth (1986) found no relationship between sexual abuse and level of sexual adjustment or self-esteem.

Several other studies reported no significant differences in sexual adjustment between survivors and non-survivors. Herman (1981) noted that while 55% of the survivors in her study had sexual problems, 50% of the comparison group of women with seductive fathers did as well. Clearly, however, inappropriately seductive behaviour, on the part of the fathers could contribute to sexual difficulties in the women. Parker and

Parker (1991) found no differences in sexual adjustment between abused and non-abused college students as measured by the Sexual Adjustment Inventory.

In addition to sexual self-esteem, Fromuth (1986) reported no significant differences between groups of sexually abused women and non-sexually abused women in the age that women started dating, their capacity to be orgasmic, or their sexual desires. This latter finding contradicts the clinical observations of Maltz and Holman (1987) and may be the result of utilizing a non-clinical sample with the, presumably, high functioning required to attend college. Interestingly, while a history of childhood sexual abuse was not related to actual promiscuous consensual sexual behaviour, it was related to a self-rating of promiscuity (Fromuth, 1986). This finding could contradict the suggestion that survivors may be prone to promiscuity and other indiscriminate sexual behaviour (Briere, 1989).

Briere and Runtz (1987) found that the childhood experience of sexual abuse was related to sexual difficulties as measured by the TSC, such that survivors had 79% more sexual difficulties than non-abused women. Elliott and Briere (1992) reported significant differences on the TSC-40 subscale of sexual problems again such that women who had been sexually abused in childhood had more problems than non-abused women. Briere and Runtz (1990) found a statistically significant relationship between sexual abuse and dysfunctional sexual behaviour.

In summary, sexual abuse in childhood appears to result in a range of sexual difficulties for adult survivors. Nevertheless, Fromuth found that some commonly held beliefs about sexual abuse survivors appear to be untrue. For example, Fromuth reported

that compared to non-abused women, survivors are no more or less orgasmic, have similar levels of sexual desire, or are no more promiscuous than non-abused women. The issue of sexual dysfunction appears to be another area in the field of childhood sexual abuse which requires further research.

Interpersonal difficulties.

Women who have been sexually abused as children often report interpersonal problems and disturbed relatedness that may be after-effects of childhood sexual abuse. The contributing factors are considered to be the dynamics of betrayal of trust, powerlessness (Finkelhor, 1987; Wachtel & Scott, 1991) and stigmatization (Finkelhor, 1987). In the clinical literature, survivors report problems with parenting (Gelinas, 1983) and with developing and maintaining relationships (Courtois, 1988; Herman, 1981; Maltz & Holman, 1987). Survivors may also have a poor sense of personal boundaries and difficulty trusting others (Blume, 1990).

Gold (1986) noted that sexual abuse survivors reported having fewer friends and playing less with other children than their peers during childhood. Sexual abuse appears to disturb the developmental tasks of learning intimacy with peer groups and the development of sexual relationships in adolescence (Downs, 1993).

Briere (1984) reported that 64% of the sexually abused women seeking therapy in one study were socially isolated compared to 49% of non-abused women (cited in Browne & Finkelhor, 1986). They also expressed more fear of people, such that 48% feared men and 12% feared women compared to 15% and 4%, respectively, of the non-

abused comparison group. Jehu et al. (1985) found that sexual abuse survivors in treatment experienced interpersonal problems such as limited social skills (81.8%), feeling different from others (72.7%), fear of intimate relations with men (72.7%), fear of men (59.1%), overvaluation of men (50%), anger or hostility toward men (45.5%), and anger or hostility toward women (36.4%). Of those who were married (nine out of 22), four women (44.4%) felt oppressed by their partner, three (33.3%) were abused, and all expressed discord with their partner.

Herman (1981) noted comparable rates of separation or divorce between abused and non-abused women (27.5% versus 25%). In contrast, in their community sample, Bagley and Ramsay (1986) found significant differences in marital status between abused women and non-abused women such that more abused women were divorced (12% versus 5%) and fewer abused women were happy in their marriages (20% versus 40%). Elliott and Briere (1992) also reported statistically significant differences concerning marital status in that more abused women were divorced than non-abused women.

In her college sample study, Fromuth (1986) found that interpersonal sensitivity, measured by the SCL-90, was not significantly correlated to childhood sexual abuse. Similar results were reported by Briere and Runtz (1988) in their non-clinical sample, who found no significant differences between abused and non-abused women on the interpersonal sensitivity subscale.

In summary, compared to non-abused women, sexual abuse survivors most often appear to have more interpersonal problems and are more fearful of others. While there seems to be some evidence of difficulties in marriage, the findings were not unanimous.

Revictimization.

Considering the interpersonal difficulties that survivors experience it is not surprising that many are sexually or physically revictimized as adults. Factors that are believed to contribute to revictimization are traumatic sexualization, betrayal of trust, and powerlessness (Finkelhor, 1987; Wachtel & Scott, 1991). Runtz (1987) considers the main contributing factors to revictimization to be traumatic sexualization combined with learned helplessness, an idealized view of men, an overvaluation of men, and an impaired ability to determine who is trustworthy (cited in Courtois, 1988).

The adult who has been abused approaches adulthood with deficiencies in self-care, in identity, in ability to form interpersonal relationships, in memory, and in cognition (Herman, 1992). Downs (1993) proposed that sexual abuse survivors may not see themselves as worthy of healthy relationships with people that they see as "good." Similarly, Conte and Schuerman (1987) have suggested that survivors may gain a sense of control of their abuse experiences by choosing poor relationships or abusive partners to recreate their childhood experiences. Courtois (1988) calls the phenomena of revictimization a "social effect" of childhood sexual abuse. McCann and Pearlman (1990) state that the literature suggests "a strong association between early childhood victimization and repeated victimization later in life" (p. 268). The two most commonly occurring types of revictimization are physical and emotional abuse in marriage or common-law relationships and sexual assault.

In marital or common-law relationships survivors may not believe that they have a right to be treated well, and may experience a sense of learned helplessness which is

reinforced in their relationship but has its roots in their earlier disturbed relationships. Herman (1992) believes that victims of trauma unconsciously reenact the trauma that they previously experienced, perhaps with the fantasy of changing the outcome. This does not mean that the victim is to blame. As Herman (1992) reminds us, ". . . repeated abuse is not actively sought but, rather, is passively experienced as a dreaded but unavoidable fate and is accepted as the inevitable price of relationship" (p.112).

Varying rates of physical victimization as adults, 18.3% and 49%, were found in studies of women who had been sexually abused as children (Briere, 1984, cited in Browne & Finkelhor, 1986; Edwards & Donaldson, 1989). Conversely, in populations of women who are abused physically, emotionally, and by verbal abuse, 50% had been sexually abused as children (Walker, 1985). Of women physically and sexually abused in their marriages, significantly more (53%) had been sexually abused as children compared to 22% of non-battered women (Shields & Hanneke, 1985). Survivors may also learn as children, that violence within the home is normal. Herman (1982) found that 50% of women who were incestuously sexually abused had violent fathers in comparison to 20% of the comparison group.

The literature suggests that survivors are sexually assaulted more often than other women (Briere, 1989, Fromuth, 1986; Runtz, 1987 cited in Briere, 1989; Russell, 1986). This may be because survivors may present themselves as being unable to speak up to, to be assertive to, or to protect themselves from potential abusers. Additionally, if a women dissociates, as many survivors do, she is unlikely to accurately assess any potential danger, as the reality of a dangerous situation may be out of her awareness

(Herman, 1992). A women in a dissociative state may also have difficulty determining trustworthiness. If the survivor over-estimates the trustworthiness of a friend, or intimate partner, she could be vulnerable to revictimization (Briere, 1989).

In a probability sample of 930 women, Russell (1986) reported that 33% to 65% of sexually abused women had also been raped as an adult. Fromuth (1986) noted a significant relationship between a history of sexual abuse and non-consensual sex, such as sexual assault or coercive sex, as an adult. Runtz (1987) reported that 44% of survivors were also victims of sexual assault as teenagers or young women (cited in Beitchman et al, 1992). Edwards and Donaldson (1989) studied adult women who had been sexually abused as either children or adolescents, finding that 9.6% had been sexually abused by strangers as adults and 18.3% had been sexually abused by an acquaintance.

In contrast, Herman (1981) found that 15% of both the abused and non-abused women had been raped. Similarly, Murphy et al. (1988) found no significant relationship between childhood sexual abuse and later physical abuse or sexual assault. More of the comparison group (30%) had been victimized as adults than the group of sexually abused women (26%).

In summary, although not all of the research suggests a significant relationship between childhood sexual abuse and later sexual assault, many sexual abuse survivors are revictimized in adulthood. Estimates of the number of survivors who have been revictimized physically as an adult range from 18% to 49%; rates for sexual assault as an adult ranged form 15% to 65%. The lower rates of physical and sexual abuse may be

similar to rates of women not abused, however, the higher range is not found in the general population.

Summary

The long-term effects of childhood sexual abuse fit well with Finkelhor and Browne's (1985) conceptualization of the four traumagenic dynamics of childhood sexual abuse. As a result of their childhood abuse adult survivors typically experience traumatic sexualization, betrayal, powerlessness, and stigmatization. The construct of Post-Traumatic Stress Disorder and the trauma symptomatology that is unique to survivors, are also useful in understanding the long-term difficulties seen in this population.

The summarized research supports the notion that childhood sexual abuse is damaging both at the time of the occurrence and in the long-term. The majority of the research indicates that survivors report symptomatology related to low self-esteem, depression, suicidality, dissociation, memory problems, sleep disturbances, substance abuse, sexual difficulties, interpersonal difficulties, and revictimization. As Briere and Runtz (1993) note, this support is inferential as it is not always clear if the psychological manifestations and behavioural difficulties seen in this population are due to the sexual abuse or to other variables. Some research also suggests that these symptoms are not present in all survivors.

Other behavioural difficulties for survivors include aggressive behaviour, parenting difficulties, self-mutilation, and somatic complaints. In addition, the

psychological manifestations include personality disorders such as sociopathic, psychopathic, and multiple personality (Courtois, 1988).

Sexual abuse survivors appear more likely than non-abused women to be diagnosed with personality disorders. Of 21 women diagnosed with borderline personality in Herman, Perry & van der Kolk (1989), 67% had histories of childhood sexual abuse. In another study of 12 women also diagnosed with borderline personality disorder, 75% were survivors (Stone, 1981). In a third study of women diagnosed with borderline personality diagnosis in a psychiatric emergency department of a hospital, 93% of 14 women reported sexual abuse histories (Briere & Zaidi, 1989).

The effects of childhood sexual abuse on survivors indicate that they are at risk for initial and long-term mental health impairment. Although this impairment is not inevitable, there is a considerable likelihood of survivors experiencing at least some of these problems (Browne & Finkelhor, 1986).

CHAPTER TWO

TREATMENT FOR SEXUAL ABUSE SURVIVORS

The literature concerning available treatment for survivors, with a particular focus on group intervention, is reviewed in this chapter. In the first section, a brief overview of recommended therapeutic approaches is presented, followed by a discussion of three therapeutic approaches used in group treatment for survivors: feminist therapy; trauma-focused therapy; and Integrative Body Psychotherapy (IBP). While IBP is not yet widely used in the field of childhood sexual abuse, in combination with feminist and trauma theory, it is the treatment model used in the groups currently under study. The second section of this chapter concerns treatment for survivors discussing in particular the rationale for group treatment and the structure of both short and long-term groups. Also included in this section are a number of therapeutic techniques commonly utilized by practitioners.

The third section presents the findings from outcome studies evaluating various treatment groups for adult survivors. A discussion concerning the variables which achieved statistical significance is presented. The final section of this chapter concludes with the rationale for the current research.

Therapeutic Approaches

Not surprisingly, as the awareness of child sexual abuse has increased so has the demand for treatment services for adult survivors of childhood sexual abuse. The most

commonly recommended therapies in the treatment of adults who have been sexually abused as children include individual psychotherapy, group treatment, and group treatment with concurrent individual therapy. Self help groups for sexual abuse survivors are also available, however, they will not be discussed as they are not commonly utilized within a therapeutic approach and there is no research on their efficacy.

The predominant therapeutic approaches used with survivors are feminist and trauma-focused therapy. Courtois (1988) suggests that various therapies can complement one another and selected elements from each are often combined within one treatment approach. Although Dolan (1991) has recently described the use of a solution-focused approach with adult survivors, feminist and trauma-focused approaches are more commonly utilized at present.

Feminist therapy.

Historically it has been difficult for a woman to have a vote, much less a voice; hence, it should not be surprising that the reality of childhood sexual abuse has been denied for centuries. In the late 1890's, after identifying the phenomena of adults behaving sexually with children, now defined as sexual abuse, Freud, under great pressure from his colleagues and European society, recanted his findings. The women who had confided in Freud about their childhood sexual abuse were labelled hysterics who had fantasized about sexual relationships with adult men (Courtois, 1988; Herman, 1992). Professional and societal denial remained the norm for many years.

In this century, during the 1970's, women began to meet in consciousness-raising groups to normalize and validate their experiences in a patriarchal society. As women began to develop a voice, many also disclosed having been sexually assaulted. Rape crisis centres were opened.

As more women broke the silence, it became apparent that many women had survived rape, battering, and childhood sexual abuse. Diana Russell's (1986) breakthrough research gave substantive support to the reality that women had been disclosing in groups, that one in three women had experienced sexual abuse as a child.

As most of the survivors who came to access counselling were women who were treated by women therapists, it is not surprising, that a feminist approach became common among those who work with survivors. Feminist therapy is a philosophical as well as a methodological approach. Feminist writers and researchers brought violence against women, including childhood sexual abuse, into the open and feminist therapists have contributed much to the effort to displace the psychoanalytic traditions of Freud and to depathologize women's experiences in the world (Courtois, 1988). It became clear that women needed places to heal from the psychological damage that they had experienced, and that the healing should take into account the political and societal context in which the original injuries took place (Laidlaw & Malmo, 1990).

Feminist ideological themes include an end to patriarchy, empowerment, the importance of process, an understanding of the personal as being political, consciousness raising, and validating the non-rational processes such as spiritual and holistic approaches to healing (Bricker-Jenkins & Hooyman, 1986). A differential power analysis and sex-

role analysis is considered essential during therapeutic work with women (Sturdivant, 1980).

Feminist practitioners also believe that helping needs to occur within a collaborative, egalitarian relationship between the therapist or counsellor and the client (Bricker-Jenkins & Hooyman, 1986; Levine, 1976). Group therapy is another modality that decreases the power of the therapist by increasing a client's opportunity to assert her own power. Valentich (1986) notes that "work with groups is a hallmark of a feminist approach to practice" (p.575).

Feminist counsellors generally agree on the need to "emphasize present concerns, and use historical material to facilitate the client's understanding of her oppression" (Valentich, 1986, p.572) as well as considering the client's personal needs within their social context (Palmer, 1991). The issues of denial, minimization, and rationalization of childhood sexual abuse are considered within familial and societal contexts.

Group therapists and facilitators adhering to a feminist model are encouraged to share their personal struggles and victories with the group members as they work together toward empowerment and change. A facilitator can role-model competency, which has been seen by many group members as the most helpful part of feminist group therapy (Johnson, 1976). Avoiding the traditional psychoanalytic role of the therapist who maintains a personal distance and who is thought to "know all" liberates group leaders from the pressure of knowing all. The client is empowered, and remains the expert on her own life.

The use of language is another important feature in a feminist approach, allowing women to be in charge of their process and naming of their experiences. To depathologize the experience of being a sexual abuse victim, the term "survivor" has been used in the feminist therapeutic community to acknowledge the power of the coping skills developed by these women during childhood (Davis, 1990; Anderson & Gold, 1994).

Nevertheless, there are some women who have been sexually abused in childhood who find the term "survivor" presumptuous and pathologizing. They resent the fact that their childhood experience of abuse is being used by others as their main identifying characteristic and find the term "survivor" as limiting as the term "victim" (Anderson & Gold, 1994). Dinsmore (1991), a feminist therapist, believes that sexual abuse survivors can be more than survivors, they can become thrivers who recognise that being a sexual abuse survivor is only one part of their identity.

Feminist therapy techniques include the determination of personal and societal goals, use of problem-solving, and the development of inter-personal and life-management skills (Valentich, 1986). A therapeutic group can provide a safe place for women to discuss the power structure of a patriarchal society and sexual abuse as a violent abuse of power. Within a feminist therapy group, members establish their personal and group goals and discuss social goals. Group members work together to discover and develop life management skills related to their injuries as sexual abuse survivors. Members may be encouraged by the group leaders to take feminist action by

forming networks, being politically involved, and by participating in activities such as the "Take Back the Night" march.

Trauma-focused therapy.

Trauma-focused therapy refers to any theoretical approach which embraces the physiological and psychological sequelae related to post-traumatic stress disorder (PTSD) and addresses the relational and sexual nature of the injuries caused by childhood sexual abuse (Herman, 1992). To provide an effective treatment framework for survivors many clinicians incorporate the philosophy of trauma-focused therapy into their practice (Briere, 1992).

McCann and Pearlman (1990) have referred to theory as a map which guides exploration of an individual's experience. Trauma-focused therapy facilitates the clinician and the client in making connections between symptoms which may have otherwise appeared to be unrelated. Trauma-focused therapy provides a framework for addressing post-sexual abuse symptomatology which allows the survivors' behaviour to be viewed within a context of their past and present experiences.

A salient feature of trauma-focused therapy is the recognition that adults sexually abused as children are survivors who have strengths as a result of living through trauma into adulthood (Briere, 1992; Courtois, 1988; Harvey & Harney, 1995; Herman, 1992). Post-traumatic symptomatology resulting in current difficulties are viewed as learned coping behaviours, defences, and adaptations to toxic conditions present in the survivors'

childhood environment rather than defects of character or pathological mental illnesses (Briere, 1989; Briere, 1992; Courtois, 1988).

In trauma-focused therapy, attention is primarily on the survivors' personal experience, and this experience is viewed within the environmental and societal context in which the trauma occurred (Courtois, 1988; Harvey & Harney, 1995). The context of the original trauma is attended to with the goal of moving beyond mere survival to self-affirmation and integration (Briere, 1989).

A strong rationale for utilizing trauma-focused therapy with childhood sexual abuse survivors is precisely the functionality of addressing the complexities of childhood sexual abuse within the context of PTSD symptomatology which provides a diagnosis, while normalizing reactions and difficulties (Briere, 1992; McCann & Pearlman, 1990). A diagnosis suggests a course of treatment and potential resolution often leading to an instilled sense of hope on the part of the survivor (Courtois, 1988; Herman, 1992).

Trauma-focused therapy moves between establishing safety for the survivors and dealing with traumatic memories (Briere, 1992). Establishing safety includes normalizing the healing process, teaching self-care techniques, and encouraging healthy choices. Dealing with traumatic memories includes witnessing the survivor tell her story, facilitation of emotional discharge, and cognitive restructuring.

A three stage model of recovery from the trauma of sexual abuse is described by Herman (1992) and by Lebowitz, Harvey and Herman (1993). This model acknowledges that trauma emerges from interactions between the person, the event (the sexual abuse), and the environment (Harvey, in press, cited in, Harvey & Harney, 1995). These

interactions produce individual differences in post-traumatic response and, therefore, each survivor will have a different recovery process. Nevertheless, there are three conceptualized stages of recovery from childhood sexual abuse: first, safety; second, remembrance, integration, and mourning; and; third, reconnection with others, regaining complete memory, and enhancement of self-esteem (Herman, 1992).

Symptomatic arousal may still occur after treatment, but the recovering survivor will know "specific healthful routines to cope with and manage such arousal" (Harvey & Harney, 1995, p.80). If a survivor "is prepared for the symptoms of hyperarousal, intrusion, and numbing, she will be far less frightened when they occur" (Herman, 1992, p.157).

As with feminist therapy, trauma-focused therapists ideally have an open and receptive attitude, and consider the survivor as a partner in a therapeutic alliance (Briere, 1989; 1992; Courtois, 1988). An effective trauma-focused therapist recognises the survivors' strengths and makes use of them in therapeutic healing (Harvey & Harney, 1995). Briere (1992) considers the philosophical approach a therapist utilizes with abuse-focused therapy to be as important as their clinical theory and techniques.

To conclude, theorists agree that the PTSD conceptualization provides valid and carefully observed symptomatology gathered from populations of victims of violence. However, the unique nature of the crime of sexual abuse and the young age of the victims adds a further dimension to the reality of challenges facing survivors of sexual abuse. Trauma-focused therapy is one model of treating survivors which considers the social and environmental context in which the sexual abuse occurred, utilizes the PTSD

conceptualization, builds on strengths rather than pathology, and acknowledges that each survivor is unique.

Integrative body psychotherapy.

A body-focused feminist model is used at Calgary Family Service Bureau, where the current study was conducted. This model includes Integrative Body Psychotherapy (IBP), a holistic approach which considers cognitive, emotional, physical and spiritual aspects to be of therapeutic concern for clients (Rand, Rosenberg & Assay, 1985). The need for balance in all aspects of a person's life is recognized, as is the importance of personal boundaries, and a need to be 'present', that is to say, not dissociative (Rand et al., 1985). Each of these are also important issues for sexual abuse survivors (Cole & Barney, 1987; Courtois, 1988; Putnam & Trickett, 1993).

The goal of IBP is to find the "essential self" which is "grounded in the body" (Rand et al., 1985, p.14). According to IBP theory, the essential self emerges once there is an integration of the body, the mind, the emotions, and the spirit. This integration occurs when the self is known and honoured. A healthy person is seen as "a mass of free flowing energy" (Rand et al., 1985, p.23).

As childhood sexual abuse creates an injury which is often physical as well as psychological, IBP has much to offer the healing survivor. The techniques used allow the participant to increase body awareness, clarify their boundaries, and decrease their level of dissociation.

Group and Individual Treatment

In a literature review of treatment for adult survivors Cahill, Llewelyn and Pearson (1991) report that most therapy begins with trust building and with the provision of information about childhood sexual abuse, the family dynamics involved, the after-effects, and the treatment issues. This information helps clients normalize trauma symptomatology and to prepare for the therapeutic work to follow.

Practice wisdom indicates that the preferred treatment in the initial stages of healing is individual therapy followed by group treatment (Bass & Davis, 1988; Briere, 1989; Courtois, 1988; Forward & Buck, 1978; Gannon, 1989; Gil, 1988; Kunzman, 1990; Laidlaw & Malmo, 1990; Maltz & Holman, 1987; Meiselman, 1990; Sgroi, 1988 & 1989; Sprei, 1987) or group treatment with concurrent individual therapy (Abbott, 1995; Briere, 1989; Cole & Barney, 1987; Courtois, 1988; Goodman & Nowak-Scibelli, 1985; Gordy, 1983; Herman & Schatzow, 1984; Maltz & Holman, 1987; Sprei, 1987; Sgroi, 1989). Courtois (1988) believes that group treatment with concurrent individual treatment may be most effective for healing sexual abuse trauma. However, she notes that some survivors may prefer group treatment to individual therapy because in the latter they may be vulnerable to abuses of power or to sexual abuse by the therapist (Courtois, 1988). In addition, individual therapy may, inadvertently, replicate the original dynamic of secrecy between two people when the client was sexually abused in childhood (Bergart,1986; Drews & Bradley, 1989) and repeatedly discussing the trauma in individual sessions may aggravate rather than heal (Dolan, 1991).

Many sexual abuse survivors will not willingly participate in group treatment until they have increased their interpersonal skills and developed an ability to trust others through individual work with a therapist. The client's relationship with their therapist is considered to be the foundation of healing (Olio & Cornell, 1993) as it hopefully addresses the interpersonal damage that sexual abuse survivors have experienced (Cole & Barney, 1987). To be able to begin discussing the abuse, a survivor needs an ability to relate in a secure interpersonal manner. This is ability is developed as a result of healthy relationships with supportive adults during childhood, or with supportive relationships in adulthood, either with a partner, friend, or therapist (Alexander, 1993).

Briere (1989) cautions that some survivors may initially experience intensified and escalated symptomatology as they begin group treatment and will need concurrent individual therapy as there is not always time in group to deal with crisis issues. A number of therapists make individual therapy prior to group treatment and continued concurrent individual therapy a prerequisite to group attendance (Buzzell & Quigley, 1994; Cole & Barney, 1987; Drews & Bradley, 1989; Goodman & Nowak-Scibelli, 1985; Gordy, 1983; Herman, 1992; Herman & Schatzow, 1984). Others are more moderate in their support of individual therapy concurrent with group treatment, however, acknowledge that some clients may need individual therapy while in group (Abbott, 1995; Axelroth, 1991; Courtois, 1988; Roberts & Lie, 1989).

Validation and normalization result from participation in many types of groups (Corey & Corey, 1987; Dimock, 1983). Group treatment is recommended for sexual abuse survivors because it offers an opportunity to recognize, manage, and perhaps

resolve post-traumatic symptomatology. As survivors meet each other, share empathically, and learn safety and trust-building with others in a consistent setting, therapeutic healing is often the result (Courtois, 1988).

Within a supportive group setting, survivors are believed to overcome feelings of stigmatization as their isolation decreases, their silence is broken, and they are heard and believed (Courtois, 1988; Briere, 1989; Herman, 1992; Mayer, 1983; McCann & Pearlman, 1990; Sgroi, 1988; Sprei, 1987). Group therapy allows the survivor the opportunity to heal with supportive witnesses. Secrecy, shame, and guilt are common issues that may be more fully resolved, more quickly, within a group therapy setting than within individual therapy (Sgroi, 1988).

There is no one type of therapy group for sexual abuse survivors as each survivor may be in a different stage of recovery with different therapeutic needs (Herman, 1992). Theoretically during the first stage, group therapy is used to provide support and information about stress management techniques. During stage two, group therapy is thought to normalize trauma responses and to deal with issues of shame and guilt while helping participants to express feelings and access repressed memories. It is suggested by Herman that stage three group therapy should deal with interpersonal issues such as relating to others. Interpersonal issues in intimate relationships could also be dealt with in couples counselling or groups for couples.

Yalom (1985) has previously identified the curative factors of group therapy in general. From this researcher's perspective, the important curative factors for sexual abuse survivors in the early stages appear to be: the instillation of hope, universality,

imparting of information, and cohesiveness. During the second stage of recovery imitative behaviour, catharsis, and corrective recapitulation of the primary family group may be more in the foreground. In the third stage of healing the important factors may be: development of socializing techniques, altruism, existential factors, and interpersonal learning. Participants in group therapy may benefit from these curative factors and these factors can be enhanced or modified according to the individual differences among participants including their stage of therapy and the type of group (Vinogradov & Yalom, 1989).

Group structure.

There appears to be considerable agreement concerning the structure of groups for adults sexually abused as children. Commonly mentioned structural recommendations are conducting groups with same-sex members, using co-facilitators, including five to eight participants, and offering one and a half to two hour sessions that meet weekly (Briere, 1989). These recommendations parallel the suggestions in the group psychotherapy literature (Vinogradov & Yalom, 1989). Some differences in this general approach have also been suggested such as mixed- gender groups (Knight, 1993) and mixed-gender co-leadership of female sexual abuse survivor groups (Threadcraft & Wilcoxon, 1993).

A review of the literature suggests that common goals in group treatment include acknowledging that the perpetrator is responsible for the sexual abuse, breaking the denial concerning the long term effects of sexual abuse, sharing the secret of the sexual

abuse, and adapting coping behaviours to be useful in adult life. Dolan (1991) recommends that sexual abuse survivors have the therapeutic goal of "reducing potential vulnerability to future stress" (p.3). Some groups also aim to improve interpersonal communication and interactions (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Courtois, 1988; Gold-Steinberg & Buttenheim, 1993; Hazzard, Rogers & Angert, 1993; Hughes, 1992; Mennen & Meadow, 1992; Sultan & Long, 1988). There is also general agreement among these authors regarding the themes within groups for survivors such as denial, safety, trust, anger, rage, grief, assertiveness, and interpersonal and intrafamilial difficulties.

Most of the groups described in the literature are short-term, from eight to sixteen weeks in duration, which meet weekly. The process allows survivors to establish a sense of safety in the group, learn coping mechanisms, and disclose their sexual abuse experiences. In time-limited therapy, group members give and receive practical support, practice changes in behaviour, and learn coping skills to address post-traumatic stress symptomatology. Members address such practical issues as setting limits with abusive family members and preparing to confront a perpetrator or to report them to the police (Goodwin & Talwar, 1989).

Closed short-term groups have been described and recommended by most authors (Apolinsky & Wilcoxon, 1991; Axelroth, 1991; Cole, 1985; Cole & Barney, 1987; Drews & Bradley, 1989; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Kelly-Garnett, 1989; Knight, 1990; McEvoy, 1990; Tsai & Wagner, 1978). These

therapists report that their particular approach has been effective in the treatment of sexual abuse survivors; however, few outcome studies have supported their claims.

There is considerable support for the use of short-term, time-limited groups as they are economically feasible for most agencies to offer. Goodman and Nowak-Scibelli (1985) propose that offering a short-term group role-models clear boundary setting. Short-term groups can diminish participants' resistance to sharing (Herman & Schatzow, 1984). Clients can make the commitment to participate more easily, the work is goal-oriented, the focus on interpersonal relationships is minimized, anxiety is reduced, and dependency on the group or the therapist is reduced. Furthermore, bonding is encouraged between the group members, the structure is clear, and themes and feelings that can be explored in later individual or long-term group work are identified by the participant (Sprei with Unger, 1986 cited by Courtois, 1988).

In contrast, two types of long-term groups have been developed for adult survivors. Longer time-limited closed groups are typically offered for a period of six months to one year, while time-unlimited groups are open to new members when old members leave. Long-term groups address issues similar to those addressed in short-term groups such as disclosure, safety, trust, anger, and loss. The difference is, however, that these issues can be explored at greater depth.

Longer time-limited groups have been described and recommended by Bergart (1986), McBride and Emerson (1989), and Gold-Steinberg and Buttenheim (1993). Mennen and Meadow (1992) and Abbott (1995) recommend time-unlimited groups and Courtois (1988) also offers such groups. Hazzard et al., (1993) have outcome data on

their year-long group which is presented in the research section. These authors consider that the interpersonal difficulties experienced by survivors resulting from earlier breaches of trust can best be dealt with in long-term groups that specifically address interpersonal issues.

Common interpersonal processes that occur in groups are inclusion, control, and intimacy (Dimock, 1987). The opportunity to feel included and to develop intimacy in a group are thought to assist a survivor to deal with their issues of stigmatization and betrayal of trust. Control issues are common to group members (Dimock, 1987) and are of particular importance to survivors who been impacted by the traumagenic dynamic of powerlessness due to their childhood sexual abuse experiences.

In longer-term groups and in time-unlimited groups for survivors, interpersonal issues can be addressed in a way that is not possible within short-term groups. There are increased opportunities to observe behaviours and experience interactions which may develop into transference issues to be addressed within the group (Courtois, 1988; Mennen & Meadow, 1992). Clients may feel misunderstood or exhibit contextually inappropriate behaviour due to cognitive distortions in any type of therapy, however in a long-term group there could be an opportunity to address these transference issues. For example, a female survivor, abused by her father, may perceive a female therapist as non-protecting and uncaring, similar to her own mother (Elliott & Briere, 1995). The client will have the opportunity to work through this type of issue, hopefully learning that not all women are like her mother.

Long-term groups allow participants the "support and challenge they need to make life changes" (Corey & Corey, 1987, p.87). Time is available to practise new behaviours and to gain new insights as the group serves as a social microcosm (Yalom, 1985). Courtois (1988) reported that in one therapy group she co-facilitated it was only in the fourth year of therapy that the members trusted each other enough to be confrontative. Other advantages of longer-term groups for sexual abuse survivors are the increased amount of time available for participants to resolve their sexual abuse issues, an emphasis on strengths rather than pathology and individuation, increased cohesiveness, a greater level of safety and trust, and more opportunity for cathartic release (Goodwin & Talwar, 1989; Mennen & Meadow, 1992). Given the pervasive nature of the effects of childhood sexual abuse, long-term therapy may have much to offer the recovering sexual abuse survivor.

Techniques used in group treatment of survivors.

The treatment techniques used in group treatment for survivors depend significantly upon the theoretical perspective of the group leaders. An eclectic mix of techniques and interventions are utilized in groups for sexual abuse survivors (Apolinsky & Wilcoxon, 1991; Cole & Barney, 1987; Courtois, 1988; McBride & Emerson, 1989). The techniques most often used are drawn from cognitive, gestalt, and occasionally from psychodrama approaches including, but not limited to, visualization, art therapy, and role-playing.

Cognitive techniques are utilised in all the survivor groups described in the literature, to restructure distorted beliefs, to normalize and legitimize learned coping behaviours, and to teach logical analysis, decatastrophizing, the reattribution of blame from the victim to the perpetrator, self-nurturing and creating a safe and secure environment for themselves (Courtois, 1988). Some therapists use the provision of information in a safe environment as their main method (Axelroth, 1991; Drews & Bradley, 1989). Information is commonly provided on the long-term effects of sexual abuse, family systems theory, normalization of the recovery process, and how to express anger appropriately.

Written homework is commonly assigned to group members (Courtois, 1988). Keeping a personal journal is often recommended as homework for survivors and there are entire books of writing exercises for survivors (e.g., Davis, 1990). Other interventions used include stress management techniques such as relaxation and breath control, assertiveness training, anger management techniques, role playing, and social networking (Courtois, 1988).

In group work for sexual abuse survivors, Gestalt therapy techniques have been utilized by a number of practitioners (Apolinsky & Wilcoxon, 1991; Bergart, 1986; Cole & Barney, 1987; McBride & Emerson, 1989; Threadcraft & Wilcoxon, 1993). Gestalt therapy can bridge "the gap between cognitive therapies and behaviour modification" (Blugerman, 1986, p.80). The focus of Gestalt therapy is increasing the client's level of awareness (Perls, Hefferline & Goodman, 1969). Gestalt techniques may include the use of body-focused awareness, role-plays, and empty chair work where a group member has

an opportunity to confront someone in a symbolic manner or to practice some other new behaviour. An outcome study comparing groups that use symbolic confrontation of perpetrators compared to groups with no symbolic confrontation found statistically significant increases in self-esteem in the former group (Apolinsky, 1990, cited in Threadcraft & Wilcoxon, 1993).

Psychodrama, an action therapy first developed by Moreno (1946), has been applied to a variety of special populations (Fuhlrodt, 1990; Jennings, 1992; Williams, 1989) and is being used with sexual abuse survivors in day-long therapy groups in New York city (personal communication with Louise Lipman, 1993) and six-month long therapy groups in Chicago (Bergart, 1986). Drama therapy is an offshoot of psychodrama, in which stories involving fictional characters are acted out (rather than personal experiences). This model has been applied in group work with adolescent sexual abuse survivors (MacKay, Gold & Gold, 1987).

An important process that is incorporated into the content of many groups for survivors is a structured opportunity for group members to "tell their story" (Buzzell & Quigley, 1994; Gold-Steinberg & Buttenheim, 1993; Herman & Schatzow, 1984; Hughes, 1992; Knight, 1990; Roberts & Lie, 1989; Tsai & Wagner, 1978). This experience is considered important to change the dynamic of secrecy which is common to the experience of most survivors (Courtois, 1988; Bass & Davis, 1988; Briere, 1989).

Practising new behaviour in group therapy can be a powerful intervention (Courtois, 1988) and provides opportunities for personal growth (Yalom, 1985). Homework is often assigned so that the participants can return to the group and

experience encouragement for their attempts at behaviour change (Corey & Corey, 1987).

Therapists incorporate a range of skills and techniques including guided imagery, art therapy, and the use of metaphor in the treatment of survivors (Courtois,1988). Wilderness therapy, including camping and mountain climbing to face fears and accept challenges, has been utilized to address the difficulties that survivors experience (Goodwin & Talwar, 1989). Also, bringing childhood photographs to session can facilitate discussions of early sexual abuse in therapy groups (Buzzell & Quigley, 1994; Carver, Stalker, Stewart & Abraham, 1989; Cole & Barney, 1987; Roberts & Lie, 1989).

There are as many variations of group therapy techniques and approaches as there are therapists leading them. Practitioners utilize techniques guided by their expertise, their intuition, and by anecdotal reports about what works and what does not work.

Research on Group Treatment for Sexual Abuse Survivors

The few published group therapy outcome studies include seven journal articles and one doctoral dissertation (Alexander et al., 1989; Carver et al., 1989; Fisher, Winne & Ley, 1993; Hazzard et al., 1993; Hughes, 1992; Roberts & Lie, 1989; Sultan & Long, 1988; Threadcraft & Wilcoxon, 1993). Two of the studies focused solely on groups for those who had experienced intrafamilial sexual abuse (Alexander et al., 1989; Roberts & Lie, 1989) while others evaluated groups for those who had been sexually abused by family members and by non-family members (Carver et al., 1989; Fisher et al., 1993; Hughes, 1992). In addition, one study also included a subgroup of participants who had

been physically abused (Sultan & Long, 1988). Finally, two studies did not make it clear whether the participants had been sexually abused by family members, non-family members, or both (Hazzard et al., 1993; Threadcraft & Wilcoxon, 1993).

A pretest/posttest one group design was used in four of the eight studies (Carver et al., 1989; Fisher et al., 1993; Hazzard et al., 1993; Threadcraft & Wilcoxon, 1993). Carver et al. (1989) however, used two pretests, one during screening interviews and one at the beginning of group treatment. Another pretest/posttest design combined groups using three different therapeutic models (Hughes, 1992). Other variations of the pretest/posttest design include study with two posttests (Roberts & Lie, 1989), and another study with a pretest, three intermediary measurements during treatment, and an interview style posttest (Sultan & Long, 1988). Details of the structure of these groups and the number of participants can be seen in Table 1.

Only Alexander et al., (1989) used an experimental design with study participants randomly assigned to three conditions, two types of therapy groups, and a wait-list comparison group. Comparison of pretest and two posttest measurements of participants in both types of treatment group and the wait-list were conducted.

The use of a wait-list comparison group is important. While changes in groups from pretest to posttest can be statistically significant, without a comparison group there is no way to clearly attribute the changes to the treatment. The possibility remains that the changes could be due to some other variable such as re-testing or maturation or the client's involvement with individual therapy. This is especially so if clients are concurrently in individual therapy, since the changes could be because of the individual therapy rather than the group treatment.

Table 1. Details of Groups Studied in Outcome Research

STUDY	DESCRIPTION	N
Alexander et al. (1989) Memphis, USA	Time limited (10 week) Closed Random assignment to 3 groups -Interpersonal transaction -Process group -Wait-list comparison	57
Carver et al. (1989) London, Ont.	Time limited (10-15 week) Closed	29
Fisher et al. (1993) Maple Ridge, BC	Long term (6 months) Closed	32
Hazzard et al. (1993) Georgia, USA	Long term (1 year) Closed Process group	78
Hughes (1992) USA	3 types of groups -Time limited (24 week) Closed with concurrent individual therapy -Long term (24 sessions measured) Open -Time limited (20 week) Closed	31
Roberts & Lie (1989) Wisconsin, USA	Time limited (10 week) Closed	53
Sultan & Long (1988) USA	Time limited (16 week) Closed Female inmates	15
Threadcraft & Wilcoxon (1993) USA	Time limited (10 week) Closed Male & female leaders	7

In these outcome studies, the variable most often measured was depression (five studies). Self-esteem and psychiatric symptomatology were both measured in four studies whereas self concept, social adjustment, and social behaviour were evaluated in three. Trauma symptomatology was a variable in two studies as was locus of control and trust. Each of the other variables were measured in only one study. A breakdown of the variables that were examined in each study is presented in Table 2.

Table 2. Variables Studied in Group Treatment Outcome Research.

STUDY	VARIABLES
Alexander et al. (1989)	Depression Social adjustment Fearlessness Psychiatric Symptoms
Carver et al. (1989)	Depression Social Behaviour Psychiatric symptoms
Fisher et al. (1993)	Psychiatric symptoms
Hazzard et al. (1993)	Self-esteem Psychiatric symptoms Trauma symptoms Locus of control Sexual symptoms
Hughes (1992)	Depression Self-esteem Trust Assertiveness Trauma symptoms Cognitive beliefs
Roberts & Lie (1989)	Depression Self-esteem
Sultan & Long (1988)	Self-esteem Locus of Control Trust Alienation
Threadcraft & Wilcoxon (1993)	Depression Self concept

The measurement instrument utilized and the improvements in the variables in each study can be seen in Table 3. In the best-designed research, Alexander et al. (1989) recruited 65 incest survivors through newspaper advertisements and therapist referrals to participate in their American study. The women were randomly assigned to one of three conditions: a ten-week interpersonal transaction group, a ten-week process group, or a wait-list condition. The group members reported a statistically significant improvement in levels of depression, fearlessness, and psychiatric symptomatology in participants of both the interpersonal transaction group and the process group. Only subjects in the process group reported statistically significant improvement in social adjustment. Results of the analysis of the follow-up scores showed that both types of groups were successful in maintaining treatment gains for a follow-up period of six months (Alexander et al., 1989).

Twenty-nine women participated in the Carver et al. (1989) study of ten and 15 week long survivors' groups at a Canadian outpatient psychiatry clinic. Statistically significant improvement was found in psychiatric symptomatology except for paranoid ideation. However, no statistically significant improvements were reported on either depression or social behaviour. The authors of this study hypothesized that there was no change in paranoid ideation because the trauma that sexual abuse survivors have experienced in the area of trust suggests that it would take a longer time for them to show improvement in this category.

Fisher et al. (1993) studied a group which met weekly for six months at a Canadian community mental health clinic. Thirty-two women completed therapy and

participated in the study. The researchers reported statistically significant improvement in psychiatric-symptomatology as measured by the Million Clinical Multiaxial Inventory (MCMI). The available information concerning the pretest/posttest improvement was limited.

Table 3. Statistically Significant Improvement in Variables Studied in Outcome Research of Survivor's Groups

VARIABLE	MEASUREMENT	STATISTICALLY SIGNIFICANT IMPROVEMENT
Depression	Beck Depression Inventory	Alexander et al. (1989) Hughes (1992) Roberts & Lie (1989) Threadcraft & Wilcoxon (1993)
Self-esteem	Index of Self Esteem	Hazzard et al. (1993) Hughes (1992)
	Self Assessment Scale	Roberts & Lie (1989)
	Rosenberg	Sultan & Long (1988)
	Global Self Concept	Threadcraft & Wilcoxon (1993)
Trauma Symptomatology	Trauma Symptom Checklist-33	Hazzard et al. (1993) -except for dissociation Hughes (1992) -except for dissociation & anxiety
Psychiatric Symptomatology	Symptom Checklist-90	Alexander et al.(1989) Carver et al. (1989) -except for paranoid ideation Hazzard et al. (1993)

Hazzard et al. (1993) studied year-long process-oriented psychotherapy groups that met weekly at an American non-profit agency. Recruitment of the 78 women who participated in the study was through newspaper advertisements and therapist referrals. Hazzard and her colleagues reported statistically significant improvement on self-esteem,

psychiatric symptomatology, locus of control, and trauma symptomatology except for the dissociation subscale which showed no statistical improvement. The measurement of sexual symptoms showed mixed improvement; the pretest to posttest average scores on the sexual avoidance subscale improved while differences from pretest to posttest on the sexual problems subscale did not show improvement.

Hughes (1992) combined the results of three different types of groups (see Table 1 for details) at three American rape crisis centres, and compared variables from pretest to posttest. Statistically significant improvements were reported in levels of depression, self-esteem, and trauma symptomatology except on the dissociation and anxiety subscales. While there were no statistically significant changes in cognitive beliefs, there was change in a positive direction as negative beliefs decreased. Assertiveness also decreased, however, Hughes notes that the scores of group members were, on average, higher that the scores of assertiveness for the normative population.

Roberts and Lie (1989) conducted a study of groups for survivors at an American rape crisis centre. Fifty-three women participated in the ten-week long groups which focused on the group members telling their story. The researchers reported statistically significant improvements in depression and self-esteem. These improvement were maintained at the six month follow-up.

A 16-week long treatment group for 15 women inmates in the American penal system was studied by Sultan and Long (1988). This group included women who had been physically abused only, sexually abused only and both physically and sexually abused. Statistically significant improvements were found in self-esteem, trust, and

alienation. There was no improvement in locus of control which the researchers believe was attributable to one incident of a night-long, prison wide search for a stolen kitchen knife, which reminded the group participants how little control they had in their environment. However, it is also possible that there was no change, or that locus of control may not be an appropriate variable. Statistically significant improvements were found in self-esteem, trust, control, and reduction of anger. These changes were reported by group participants, during follow-up interviews, to have been maintained.

Threadcraft and Wilcoxon (1993) studied a single ten-week long structured therapy group for survivors with a mixed-gender co-leadership team in the United States. The number of respondents was very small (N=7). Statistically significant improvements were reported in measures of depression and self-concept.

In summary, in a number of studies statistically significant changes were found from pre-test to post-test in depression, self-esteem, general psychiatric symptomatology (except for paranoid ideation in one of three studies), and trauma symptomatology (except for dissociation in two studies and anxiety in one of those two studies). Only the 1989 Alexander et al. study reported improvements in depression and general symptomatology, in comparison to a wait-list comparison group.

Although the findings of the majority of these studies report statistically significant improvement, the improvements cannot be attributed to the treatment due to the lack of comparison groups in all but one study. Confused methodology such as combining the results of three different types of treatment groups also confounded the results of at least one study (Hughes, 1992).

Rationale for the Current Study

While practice wisdom indicates that group therapy may be the most effective method of treatment for sexual abuse survivors, there is limited research evidence that groups are, in fact, effective, almost no information about the relative effectiveness of different types of group therapy, and apparently, no research to date about long-term, open-ended, groups.

Cost benefit analyses of services are becoming standard practice in social service agencies (Posavac & Carey, 1989) and there is a belief that short term group therapy can be a cost effective way to provide service to an increased number of clients (Yalom, 1995). However, little empirical evidence is currently available to support the effectiveness of any type of group treatment. Such evidence is necessary to justify the expense of group therapy to funders and to consumers. It is important to know, rather than merely believe, that group work is an effective and efficient treatment modality for survivors of childhood sexual abuse.

In 1984, Finkelhor identified a "pressing need to evaluate the effectiveness of various intervention strategies" (p.231). Later, Alexander et al. (1989) made the same recommendation. Others specifically recommended further research into the effectiveness of group therapy with concurrent individual therapy (Follette, Alexander & Follette, 1991; Roberts & Lie, 1989). Roberts and Lie (1989) also recommended research into the long term psychosocial changes which clients may experience as a result of therapy. In addition, Beutler (1993) had suggested that tests of treatment efficacy, while fostering theory development, is needed. Pilkonis (1993) encouraged clearer methodology,

particularly the use of control groups, in researching treatment for sexual abuse survivors. It is also recommended that due to the long-term effects of sexual abuse, longitudinal studies would be useful.

There appears to be general agreement on what variables should be measured, with the most commonly measured being depression, self-esteem, and psychiatric symptomatology. However, more recent studies have utilized Briere and Runtz's (1989) Trauma Symptom Checklist to measure trauma symptomatology instead of psychiatric symptomatology (Hazzard et al., 1993; Hughes, 1992).

The groups that have been studied demonstrated statistically significant improvement on most variables. Furthermore, in the one study with a comparison group the improvements were maintained six months later during a follow-up measurement (Alexander et al., 1989). Except for this one study, however, the significance of the improvement is questionable as we do not know whether the group is responsible for the improvement.

Further study of the effectiveness of group treatment for adult female survivors of childhood sexual abuse using standardized measurement instruments and a wait-list comparison would provide data to advance empirical knowledge. The results could guide clinical practise, inform agency policy, and contribute to the knowledge base of the social work profession.

To conclude, as few methodologically sound studies have been directed at the question of the effectiveness of group treatment it seems clear that effort in this direction is warranted. It is also clear that there is some consensus on what variables are common

to sexual abuse survivors and might be improved as a result of group treatment. Future research should include these variables, use reliable measurement instruments, and include a wait-list comparison group.

CHAPTER THREE

METHODOLOGY

The methodology used in the current research is presented in this chapter. The purpose of the current study is to determine the effectiveness of group treatment for women sexually abused as children in improving depression, self-esteem, and trauma symptomatology by comparing differences between women in group therapy and women from a wait-list comparison group.

The first section of this chapter introduces the conceptual definitions of child sexual abuse, and the dependent and independent variables. The dependent variables include depression, self-esteem, and trauma symptomatology, and the independent variable is time-limited therapeutic group treatment. The second and third sections present the research design and the hypotheses used in the current study.

The fourth section concerns the instrumentation utilized in this study: the Beck Depression Inventory, the Coopersmith Self-esteem Inventory, the Trauma Symptom Checklist-33, and the demographic and abuse history questionnaire. The fifth and sixth sections introduce the research participants and address ethical issues. The final section documents the limitations and strengths of the current study.

Conceptual Definitions.

Child sexual abuse was defined as "any unwanted exploitative sexual contact or attempted sexual contact experienced before the age of eighteen" (Russell, 1986, p.41).

Such sexual contact could include but was not limited to the following: exhibitionism; voyeurism; fondling; fellatio; cunnilingus; sodomy; attempted intercourse; intercourse; French kissing; showing of pornographic materials; insertion of objects into the vagina or rectum; taking sexually explicit photographs of the person (Roberts & Lie, 1989). For the purposes of this study anyone who said they had been sexually abused as a child was considered to have experienced such abuse.

The dependent variables included in the current study were depression, self-esteem, and trauma symptomatology. The following definitions were employed:

Depression is a mood with "feelings of sadness, despair, and discouragement (Werner, Campbell, Frazier, Stone, & Edgerton, 1984, p.28)" with the presence of at least two of the following: "poor appetite or overeating, insomnia or hyposomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions and feelings of hopelessness" (DSM-IV, p.345, 1994).

Self-esteem is the level at which one regards oneself in a positive manner. In the context of measuring self-esteem the following definition was utilized:

> . . . the evaluation a person makes, and customarily maintains, of him- or herself. "Self-esteem" expresses an attitude of approval or disapproval and indicates the extent to which a person believes him- or herself capable, significant and worthy. . . . It is a subjective experience conveyed to others by verbal reports and other overt expressive behaviour (Coopersmith, 1990, p.5).

Trauma symptomatology includes cognitive, psychological and physical stress indicators, such as symptoms of depression, anxiety, dissociation, sleep disturbances, and hypothesized post-sexual-abuse-trauma (including, nightmares, flashbacks, sexual problems, fear of men, a sense of 'unreality' and memory problems) which are indicative of symptoms that sufferers of post-traumatic stress disorder experience (Briere, 1989; Colodzin, 1993). The construct post-sexual abuse trauma refers to:

> . . . "symptomatic" behaviours that were initially adaptive responses, accurate perceptions, or conditioned reactions to abuse during childhood, but that elaborated and generalized over time to become contextually inappropriate components to the victim's adult personality (Briere & Runtz, 1987, p.374).

The independent variable is whether study participants attended or did not attend time-limited group treatment. For the purposes of this study the following definitions were employed:

Time-limited Therapeutic Group Treatment - a therapy group that was limited to 10 to 12 weekly two hour sessions led by two co-facilitators. The group used a structured format to build trust, a sense of commonality, and to facilitate an understanding of the healing process. The effects of sexual abuse were discussed and each participant was provided the opportunity to 'tell their story' in a supportive group setting. The group was closed to new members after the first session and members were asked to make a commitment to remain in the group for its duration. Exclusion criteria included women

who were in a state of crisis, were currently suicidal, mentally ill, or active substance abusers. Membership in the group was defined as those participants who attended at least 80% of the number of planned sessions and no one was excluded on the basis of low attendance. For a more detailed description of the group model used in this study see Appendix A.

Research Design

A quasi-experimental pretest-posttest comparison group design was utilized in this study.

O_i X O_2

O_1 O_2

Where: O_1 = First measurement of the dependent variables: depression; self-esteem; and trauma symptomatology (pre-test).

O_2 = Second measurement of the dependent variables: depression; self-esteem; and trauma symptomatology (post-test).

X = Independent variable: time-limited therapeutic group treatment.

This design allowed for a contrast of women who were participating in group therapy to a comparison group of women on the waiting list at the agency. Random selection to the different groups was not feasible as group assignment was determined by the clients themselves, based on convenience or wishing to work with a certain team of facilitators.

Hypotheses

The three hypotheses tested in the current research were that: Women who experienced childhood sexual abuse, who participate in a structured time-limited therapeutic treatment group and concurrent individual therapy will experience (1.) a significant decrease in depression in comparison to women who experienced childhood sexual abuse, who remain on a waiting list for group treatment, and participate in concurrent individual therapy, (2.) a significant increase in self-esteem in comparison to women who experienced childhood sexual abuse, who remain on a waiting list for group treatment, and participate in concurrent individual therapy and (3.) a significant decrease in trauma symptomatology in comparison to women who experienced childhood sexual abuse, who remain on a waiting list for group treatment, and participate in concurrent individual therapy.

Instrumentation

Three standardized measures were utilized to operationalize the dependent variables: the Beck Depression Inventory (Beck, 1978), the Coopersmith Self-Esteem Index (Coopersmith, 1981), and the Trauma Symptom Checklist-33 (Briere & Runtz, 1989).

The Beck Depression Inventory.

The Beck Depression Inventory (BDI) is a self-administered scale developed from clinical observations and descriptions of symptoms in psychiatric patients. The 21-item

inventory is rated on a four-point Likert scale which is designed to measure the severity of depression and to assess the presence and severity in the past week "of affective, cognitive, motivational, vegetative and psychomotor components of depression" (Corcoran & Fischer, 1987, p.107). The norms of the BDI included both in-patients and out-patients in a psychiatric hospital, as well as a non-clinical group of college students.

The test-retest reliabilities ranged from $\underline{r}$= .60 to $\underline{r}$=.90 in nine studies of non-psychiatric patients in contrast to the range of $\underline{r}$=.48 to $\underline{r}$= .68 for psychiatric patients (Beck & Steer, 1987). A test-retest correlation of $\underline{r}$= .90 was reported from a sample of 204 college students which suggests that the scores were stable over time (Lightfoot & Oliver, 1985). The non-psychiatric samples, thus appeared to exhibit more stable scores than the psychiatric sample.

The concurrent validity of the BDI is reported by Corcoran and Fischer (1987) to be good to excellent and Kramer and Conoley (1992) found the BDI was substantially supported. There was significant concurrent validity reported in 25 studies, with correlations ranging from .60 to .76, indicating that the respondent's scores on the BDI compare in an equivalent manner to those respondent's scores on other measures of depression (Kramer & Conoley, 1992). Beck and Steer (1987) reported mean correlations between the BDI and other depression scales of .81 in 15 studies of non-psychiatric subjects and .86 in nine studies with psychiatric subjects. In six studies with a total sample of 944, the BDI was correlated to the Hamilton Psychiatric Rating Scale for Depression Scale, and the Hopelessness Scale at a significance level beyond $p < .001$ (Beck, Steer, & Garbin, 1988; Hedlund & Vieweg, 1979). In two other studies

(psychiatric inpatient, N=101 and inpatient drug abusers, N=99) the BDI was correlated to the MMPI-Depression Scale, and the Zung Self Rating Scale of Depression at a statistically significant level (Schaefer et al., 1985).

The content validity of the BDI appears to be moderate as the scale completely measures only six of the nine symptoms of depression as outlined in the DSM-IV criteria. The symptoms of change in sleep and appetite are only partially measured as only a decrease in sleep and decreases in appetite are scored. Increases in sleep and appetite were excluded from the BDI to avoid false positives, as these were symptoms which Beck identified as occurring frequently in normal adults (Steer & Beck, 1985). Furthermore, the clinically diagnosed symptom, agitation, was excluded because Beck and Steer (1987) did not consider that it could be accurately measured through self assessment. Although the content validity of the BDI may initially appear only moderate, the explanations of the exclusion of these specific symptom groups on the BDI seem quite appropriate.

In summary, the Beck Depression Inventory is a tool that is uniform, easily scored, and is stable over time. The choice of response to each item on the BDI is clear and easily understood. The scale is widely used; the 11th Mental Measurements Yearbook (Kramer & Conoley, 1992) reported 1,900 articles with references to the BDI.

Furthermore, the BDI has also been utilized in clinical reports to measure the effects of sexual abuse in adult survivors (Fromuth, 1986; Morrow & Sorell, 1989) and to identify therapeutic targets for survivors (Jehu et al., 1985). Furthermore, the Beck Depression Inventory has been utilized in previous studies of the treatment effectiveness

of sexual abuse survivors groups (Alexander et al., 1989; Follette et al., 1991; Hughes, 1992; Roberts & Lie, 1989; Threadcraft & Wilcoxon, 1993) as well as in individual treatment outcome studies (Fromuth, 1986). One limitation of the BDI may be that this measure asks only about symptoms present in the last week and does not give a long-term indication of mood. As such, the BDI was chosen as it has been widely utilized and is considered a valid and reliable measure of depression in clinical and non-clinical populations and in populations of adult sexual abuse survivors.

The Coopersmith Self-Esteem Inventory.

The Coopersmith Self-Esteem Inventory (CSEI) is a 25-item scale which was designed to measure "in any individual those evaluative attitudes toward the self that one holds" (Adair, 1984). Coopersmith initially designed this inventory to measure children's overall self-esteem, later developing a short form for adults. The adult norm group consisted of 103 college students studied in 1977 (Adair, 1984) and 226 college and university students studied in 1988 (Coopersmith, 1990). The mean age of the latter group of students was 21.5 (s.d.=3.5) with a range from 16 to 34 years; the mean score was 70.0 (sd 19.0) with an alpha reliability of .81 (range .78 to .85). Participating in this research were 114 males and 112 females; 148 students were Caucasian; 24 were black; 13 were Hispanic and 28 were Asian. The Coopersmith 1977 testing (N=103) calculated reliability estimates, KR-20s of .80 for males and .82 for females which are acceptable for research purposes (Coopersmith,1990).

Coopersmith (1990) mentions a study by Crandell which compared the Coopersmith and the Rosenberg Scale of Self-Esteem which reported a correlation of .59 and of .60 for college students (N approximately 300). This finding suggests that the Coopersmith has an adequate relationship with other measures of self-esteem.

The items on the inventory seem to measure common signs of self-esteem such as opinion of self, attitude toward self and tasks, and others' opinions of one's self, providing some support for the content validity of the measure. Other investigations of the psychometric properties of the CSEI suggest significant concurrent validity, meaning that respondents' scores on the BDI compare in an equivalent manner to the scores on other measures of self-esteem. One limitation with this measure is that respondents are asked to indicate how they usually feel without being provided a time frame which may make it difficult for respondents to indicate changes that they have noticed recently.

The Coopersmith Self-Esteem Inventory is a widely used scale which has relatively strong evidence of reliability and validity (Adair, 1984). As well, an adapted version of the adult Coopersmith has been used in research studies with sexual abuse survivors (Bagley & Evan-Wong, 1975; Bagley & King, 1990; Bagley & McDonald, 1984; Bagley & Ramsay, 1986; Bagley & Young, 1987). The Coopersmith was chosen for inclusion in the current research study as it is a standardized measurement instrument that requires little time to complete, is well researched, and is easily scored.

The Trauma Symptom Checklist. (see Appendix B)

Briere and Runtz (1989) developed the Trauma Symptom Checklist (TSC-33) as an abuse-oriented, self-assessment measure of the impact of childhood sexual abuse on long-term adult functioning. This scale was developed from the Briere and Runtz (1987) Crisis Symptom Checklist and from the long-term symptomatology reported by other researchers in the sexual abuse field (Briere, 1989; Briere & Runtz, 1989).

Previous to the development of the TSC-33, researchers utilized scales that were primarily developed for the use in psychiatric or clinical populations. However, Browne and Finkelhor (1986) suggested the importance of developing an instrument specifically designed to measure the after-effects of childhood sexual abuse. In addition, some professionals who work extensively with survivors perceived the experience of childhood sexual abuse and the resulting trauma symptomatology differently from psychiatric conditions (Briere, 1989; Herman, 1992). Although many women who have been sexually abused exhibit psychiatric diagnoses, the true nature of their difficulties is not considered organic, but as a result of their experiences. As such, the TSC-33 was developed to reflect the experience of sexual abuse survivors while psychiatric measurement instruments assess a broad range of symptoms, many of which are not representative of the experience of survivors.

The TSC-33 is a 33 - item scale that measures sexual abuse-related symptomatology on a four point Likert scale. The items are scored on five symptom subscales: "Dissociation," "Anxiety," "Depression," "Sleep Disturbance," and a summary subscale, "hypothesized Post-Sexual-Abuse Trauma (PSAT-h)" (Briere, 1989,

pp.182). Scores range from 0 to 102 with higher scores reflecting greater trauma. An analysis of the internal consistency of the five subscales indicates reasonable reliability; the average subscale score was .71 and the average total score was .89 (Briere & Runtz, 1989).

While still a relatively new instrument, the TSC-33 has been previously utilized in several studies of sexual abuse survivors in non-clinical populations (Bagley, 1991; Briere & Runtz, 1988; Briere & Runtz, 1988b; Briere & Runtz, 1989; Cole, 1986, cited in Briere & Runtz, 1989) and in clinical populations (Briere, Evans, Runtz & Wall, 1988; Briere & Runtz, 1987; Hazzard et al., 1993; Hughes, 1992). The TSC-40, an updated version of the TSC-33 which includes a new sexuality subscale, was utilized in research of a large (N=2,963) non-clinical population of professional women (Elliott & Briere, 1992).

As evidence of the construct validity of the TSC-33 in Briere's 1989 study (N=195) at a crisis centre, the measure significantly differentiated women who had been sexually abused as children from women who were not (Briere & Runtz, 1989). Those respondents with a history of childhood sexual abuse were accurately identified approximately 79% of the time. Similarly, Cole's 1986 study (cited in Briere & Runtz, 1989) of a non-clinical population (N=113) and Briere et al.'s 1988 study (N=80) found significantly higher scores for sexual abuse survivors than for those not sexually abused.

In a non-clinical study of 2,963 professional women, Elliott and Briere (1992) also reported statistically significant differences between survivors and non-survivors. Non-sexually abused participants had average total TSC-33 scores of 16.00, compared

to average total score of 19.85 for abused women. The average sexually abused women in the study had a higher score than 68% of the non-abused women in the study.

In contrast, women in a clinical sample had much higher TSC scores, such that of 195 women at a crisis intervention centre, the non-abused women had average total TSC-33 scores of 27.97 while abused women had average scores of 39.97 (Briere & Runtz, 1989). The differences between groups was statistically significant.

Bagley (1991) concluded that the TSC-33 has good concurrent validity, with significant correlations, compared to other mental health measurements. The TSC was also more effective, compared to other scales, in identifying sexual abuse survivors (Bagley, 1991).

The TSC-33 was used to measure changes in post-sexual abuse trauma symptomatology in two other studies (Hazzard et al., 1993; Hughes, 1992). The TSC-33 certainly provides information about an individual's symptomatology which would not be provided by the BDI or the CSEI. The original scale asked about symptoms in the last two months, but for the purposes of the current study the instructions were modified to reflect symptoms experienced in the last month to avoid overlap with the start of the group.

In summary, the TSC-33 was included in the current research as it is a standardized measurement instrument that requires little time to complete, is easily scored, and is stable over time. Bagley (1991) notes that it is an non-intrusive instrument. Furthermore, its subscale on depression can be correlated with the scores of the BDI. Most important, the TSC-33 was designed specifically for sexual abuse survivors.

The demographic and abuse history questionnaire. (see Appendix C)

This questionnaire was developed by the author to gather demographic data and information on possible extraneous variables such as therapeutic history and abuse history including childhood sexual abuse, adult abuse experiences, suicide attempts, and substance abuse. The questionnaire utilized concepts from the incest history questionnaire designed by Courtois (1988).

Wachtel and Scott (1991) have noted similarities in patterns of data collection in the field of sexual abuse research. Data are commonly gathered from survivors concerning four areas: the nature of the abuse; the socio-demographics; how the sexual abuse was handled on disclosure; and the attributes of the victim and their personal experience of the abuse. It was this researcher's intention to gather data about the first three areas: to determine the nature of the abuse; the socio-demographics of the survivor; and the reaction they experienced if they disclosed their sexual abuse. Due to the limited scope of this quantitative study, however, it was not feasible to gather data concerning the participants' subjective experiences of the abuse.

The demographic questionnaire was organized into three sections. The first section of the questionnaire concerns the therapeutic history, the second concerns abuse history and last section asks about demographic characteristics. Presenting the questions in this order was intended to engage the participants in thinking about their therapeutic experiences first, then moved to the more sensitive area of abuse history after they had become accustomed to the format of the questionnaire. Placing the demographics

questions after the questions concerning childhood sexual abuse was intended to give participants a chance to re-focus on the present as they completed the questionnaire.

The demographic questionnaire consisted of a total of 40 questions: 22 questions were pre-coded; 12 questions required short answers; four questions were open-ended; and two concerning therapeutic history requested that the participants complete a table of information (see Appendix C).

The therapists from the Calgary Service Bureau, who developed the group model evaluated in the current study suggested that the first section of the demographic questionnaire be administered during the group pretest and the last two sections be administered at the group condition posttest. The purpose of this procedure was to reduce anxiety and to increase a sense of cohesiveness prior to introducing possible demographic differences. Further, it was intended to provide the opportunity for support from the group at the posttest at which time the sensitive abuse history would be recorded.

In contrast, the entire questionnaire was mailed to the wait-list comparison group at pretest. It was hoped that any difficulties a participant experienced would be addressed in their individual therapy sessions.

Research Participants

The study population were women sexual abuse survivors who received treatment or were waiting to receive treatment at the Calgary Family Service Bureau. As recommended by several authors (Cole & Barney, 1987; Drews & Bradley, 1989; Goodman & Nowak-Scibelli, 1985; Gordy, 1983; Herman, 1992; Herman & Schatzow,

1984) all of the respondents were concurrently receiving individual therapy to address child sexual abuse issues. This criterion was part of the agency's screening process for participation in the women's sexual abuse survivor group: all participants were to have received individual therapy to address issues of sexual abuse for a minimum of six months prior to group participation.

Potential group participants were informed about the research at the screening interview and again during the first group session. Interested women were invited to meet with the researcher after the first group if they had any questions or concerns before deciding if they would participate in the study. The standardized measures and the demographic questionnaire were administered to the group participants after the initial group session and prior to the last group session.

Potential wait-list comparison condition participants were telephoned by the agency intake worker to describe the research process. Once permission was granted, the measures and the questionnaire were mailed to those willing to participate.

Ethical Issues

The ethical concerns addressed in conducting the current study include informed consent, confidentiality, coercion, and deception. A letter from the researcher (see Appendix D) was provided to potential respondents during their pre-group interviews by the group therapists. A similar letter was sent to potential wait-list comparison group respondents after the agency intake worker received consent from women on the wait-list

to receive the package including the letter, a consent form (see Appendix E) and the package including the standardized scales and the demographic questionnaire.

The letter from the researcher invited adult survivors to participate in the evaluation of the effectiveness of the groups, discussed the need for the study, and described the pretest and the posttest procedure and time frame. A reassurance that confidentiality would be maintained was included with a note that responses to questionnaires would be kept in a locked filing cabinet, all identifying information would be removed from questionnaires and all questionnaires would be destroyed at the end of the research.

Participants were also provided with information concerning the researcher's clinical experience in the area of childhood sexual abuse and were provided with a contact phone number in case they had any questions or concerns. It was emphasized verbally by the intake worker during the pre-group screening interviews by the group facilitators, and in writing by the researcher that participation in this study was completely optional and that respondents could withdraw at any time without affecting their present treatment, in the case of group members, or future treatment, in the case of wait-list comparison group members. All of this information was reiterated in a letter of thanks (see Appendix F) which was given to the women in the treatment group and was mailed to women in the wait-list comparison group. Respondents were asked to sign a consent form (see Appendix E) which included another reminder that they were free to withdraw their consent at any time.

The researcher was available by phone before the groups started and in person at the end of the first group session to answer questions and by phone and mail throughout the duration of the study. The researcher was similarly available to the wait-list comparison group members.

To address the potential risk of re-traumatization considering the severe symptomatology sometimes found in this population, every effort was been made to ensure the safety of participants; all group participants were concurrently in individual therapy. Potential wait-list comparison group members included only those who were in individual therapy. As mentioned previously, the researcher was available to the group members as they answered the pretests and posttest so that if difficulties had occurred a therapist was available to them. The posttest (BDI, CSEI, TSC-33 and demographic questionnaire on abuse history and demographic information) was administered prior to the last group session.

Ethically, it was impossible to limit the length of time or the frequency of the individual therapy sessions which group participants attended concurrent to the group sessions for the duration of the therapy group. It would also have been unethical to force participants to attend individual therapy; however the requirement for participation in this group model required clients to have completed a minimum of six months of individual therapy focusing on sexual abuse issues, thus controlling for the possible intervening variable. As such, the group participants were required to arrange that their individual therapist be available for weekly sessions for the duration of the group. Before the groups

began, a case conference took place, between the individual therapists and the group leaders, with the client's consent.

The ethical concerns of informed consent, confidentiality, coercion and deception were addressed as completely as possible. The University of Calgary, Faculty of Social Work Research Ethics Committee reviewed the ethical consideration incorporated into the current study and granted a Certificate of Approval to proceed with the current research (see Appendix G).

Limitations and Strengths of the Study

The limitations of the current study include the fact that the subjects are volunteers from one specific agency and cannot be considered an accurate representation of abuse survivors in Canada. Due to the lack of random assignment to conditions, the results of the evaluation are not generalizable to other treatment programs. Further replications of this study utilizing random sampling and assignment to research conditions would be necessary before any generalizable conclusions can be formulated.

Several possible intervening variables include differences in therapeutic history and the type and frequency of the concurrent individual therapy. Other potential differences included varying cultural backgrounds, different severity, frequency, and duration of childhood sexual abuse, as well as differing relationships of the victims to the perpetrators of the sexual abuse and differing levels and types of coercion used by the perpetrators.

Many of the factors that affect the internal validity of research designs such as history, maturation, testing, selection, and mortality are controlled for in the current research. However, research factors affecting the external validity of the design such as the interaction of testing and treatment, the interaction of selection and treatment and reactive arrangements are not controlled because the participants were not randomly selected or assigned to condition.

A major strength of the current research is the use of the wait-list comparison group. If the two groups prove to be relatively equivalent to begin with, any intervening variable would have affected each group similarly and, thus, differences between the two groups at posttest are more likely to be a result of the group treatment. Another strength is the use of reliable and valid measuring instruments at pretest and posttest. A particular strength, as stated previously, is the use of, the TSC-33 (Briere, 1989) since it was specifically designed for this population. There has been little outcome research on the effectiveness of group treatment and only one other study (Alexander et al., 1989) published to date has used a wait-list comparison group.

CHAPTER FOUR

RESULTS

The first section of this chapter documents the demographic characteristics of the participants including information on the nature of the sexual abuse experienced. The therapeutic history of these women was also of interest as was their history of physical and sexual abuse as adults, suicidality, and substance abuse. In each sub-section, data are first presented on the entire study population; second, any differences between the demographic characteristics of the treatment group and the wait-list group are presented.

The second major section of this chapter concerns the statistical analyses of the data gathered by the standardized measures. In the first part of the analysis section, these data are analyzed to determine if the characteristics of the women in the treatment group and the wait-list comparison group were similar at pretest. As mentioned earlier in the methodology chapter, due to the lack of random assignment to condition, it is important to identify whether or not there are significant differences in both the demographic characteristics and in the pretest measurement scores between groups.

The second part of the analysis section presents the results of the analysis of covariance on the posttest scores of the standardized measures to determine if there were differences between the treatment group and the wait-list comparison group. These analyses assess whether the women who participated in the treatment groups improved significantly more than the wait-list participants.

Demographic Characteristics of Research Participants

Thirty-two women participated in the study during the period from September 1993 to April 1994 at the Calgary Family Service Bureau, a non-profit community counselling agency, in Calgary, Alberta. Twenty-two (69%) of these women were in the group therapy condition, while the remaining ten women (31%) had been placed on a waiting list to later attend group. Further details concerning the inclusion of participants the data set can be seen in Appendix H.

The average age of study participants was 36.6 years (s.d. = 9.5), the youngest woman being 24 and the oldest 65. Twenty-eight (87.5%) of the women were born in Canada, two in Great Britain, one in the United States and one in Germany. Over half of the women (59.4%) were married or living with partners. Almost three quarters of the respondents (23 or 71.9%) had children.

Almost all of the women (93.7%) had at least a high school education. Twenty-five per cent were professionals or worked in business, while another 31.3% were skilled tradespeople. Four women (12.5%) worked in unskilled or service occupations, while a further eight (25%) worked in the home. One woman (3.1%) was a full-time student and one did not provide information about her occupation. Ten women (31.3%) were employed full-time, eight (25%) were employed part-time, and two (6.3%) were employed part-time in addition to being partially supported financially by their partners.

There were some differences in the demographic characteristics of the treatment group in comparison to the wait-list comparison group. As can be seen in Table 4, statistically significant differences were documented between the two groups on the

variables of education, income, and number of children. Compared to women in the wait-list condition, women in the treatment group had, on average, two more years of education and annual incomes higher by approximately $10,000. Furthermore, women in the treatment group had, on average, 1.5 fewer children than those in the treatment group which is partly explained by the fact that 37% of the women in the treatment group had no children. In summary, the women in the wait-list condition were less educated, earned less money, and had more children than those in the treatment group. This could be interpreted to mean that as a group they were more disadvantaged than those in the treatment group.

Table 4. The Demographics of the Treatment Group as Compared to the Wait-list Group

VARIABLE	TREATMENT GROUP (N=22)	WAIT-LIST GROUP (N=10)	STATISTICAL TEST
Average Age	36.3 years (sd=9.4)	36.6 years (sd=10.5)	t-Test= -.08 df= 15.90 p= .93
Place of Birth	Canadian - 20 (90.9%) Non-Canadian - 2 (British & German) (9.1%)	Canadian - 8 (80.0%) Non-Canadian - 2 (British & American) (20.0%)	Fisher's Exact Test p= .37
Marital Status	Married or lives with partner - 14 (63.6%) Single - 8 (36.4%)	Married or lives with partner - 5 (50.0%) Single - 5 (50.0%)	Fisher's Exact Test p= .36
Average # of Children	1.2 (sd=1.05) range 0 to 3	2.7 (sd=1.64) range 0 to 6	t-Test= -2.69 df= 12.51 p= .02*
Average Years of Education	14 years (sd=1.93) (20 cases)	12 years (sd=2.05)	t-Test= 2.60 df= 16.51 p= .02*
Average Annual Income (approx.)	$28,000 (sd=15.4) (20 cases)	$17,000 (sd=10.87)	t-Test=2.16 df=24.49 p= .04*

* $p < .05$

Child Sexual Abuse Histories of Research Participants

In contrast to the complete response to most of the items related to demographic characteristics, some items in the section of the questionnaire that inquired about the history of sexual abuse elicited a low rate of response, particularly the item questioning the frequency of the sexual abuse. In addition, three women did not answer any part of their sexual abuse histories and explained the reason for this was that they had "no specific memory of the abuse", "lack of memory", and having only "body/sensation memories". A fourth woman wrote that, while her mother and father had both perpetrated sexual abuse acts against her, she was unable to report other details of her abuse due to "amnesia".

Only two thirds of participants (N=32) responded to both items asking about the age of onset and the age at the end of the sexually abusive experience. The age that the sexual abuse had been initiated ranged from less than a year of age to 12 years. The age that the sexual abuse ended ranged from five to 18 years. The average duration was 7.9 years with a range from three to seventeen years as can be seen in Table 5.

Table 5. Duration of Participant's Childhood Sexual Abuse

VARIABLE	TREATMENT & WAIT-LIST GROUPS (N=32)
Average Age Abuse Started	4.9 years (sd=3.67) (25 cases)
Average Age Abuse Ended	13.0 years (sd=3.61) (24 cases)
Average Duration	7.9 years (sd=4.53) Range 3-17 yrs (21 cases)

Twenty-eight women responded to a request to specify details of their abuse history by listing the range of sexually abusive acts that they experienced. As can be seen in Table 6, of those who responded, 15 women (53.6%) experienced vaginal and/or anal penetration, the most severe category of sexual abuse. Of note is the fact that the majority, 22 women (78.6%), reported experiencing, at a minimum, attempted vaginal/anal penetration or oral penetration.

In addition to other types of abuse experienced, 16 women (57.1%) experienced "hands off" sexual abuse such as sexual comments or being forced to watch perpetrators masturbate or expose themselves. Four women (14.3%) reported that, as children, they experienced such sexually abusive experiences as being subjected to bondage, the use of sex toys, "breast-feeding games," participating in group sex and being the subject of pornographic photos and films.

It was considered of interest that, of 28 women who responded to the item regarding the number of different types of sexual abuse, 26 (92.9%) had experienced more than one type of sexual abuse, while 17 women (60.7%) reported more than three types of sexual abuse. Twenty-six women commented on the degree of force used in connection with their sexual abuse. Nine women (34.6%) experienced verbal or psychological threats, while 13 women (50%) reported experiencing physical force or injury.

Responding to an open-ended question concerning the frequency of their childhood sexual abuse, only one of the 13 women (7.7%) reported only a single incident of sexual abuse and two (15.4%) reported intermittent sexual abuse. The majority, ten women

(76.9%), were sexually abused at regular intervals ranging from once or twice a month, to weekly and in one case, daily.

Table 6. Severity, Force, and Frequency of Participant's Childhood Sexual Abuse

VARIABLE	TREATMENT & WAIT-LIST GROUPS (N=32)
Severity*	Fairly intrusive - 6 (21.4%) (e.g.:fondling; genital contact) Very intrusive - 7 (25%) (e.g.:oral penetration; attempted vaginal/anal penetration) Most intrusive - 15 (53.6%) (e.g.:vaginal/anal penetration) (28 cases)
Number of Types of Abuse	mean= 3 different types (sd= 1.22) range 1-6 types (28 cases)
Force Used in Childhood Sexual Abuse**	No force - 4 (15.4%) Verbal/psychological - 9 (34.6%) Physical force/injury - 13 (50%) (26 cases)
Frequency of Childhood Sexual Abuse	Once - 2 (10.5%) Intermittently - 4 (21.1%) Regularly - 2 (10.5%) 1-2 times/month - 2 (10.5%) 1-3 times/ week - 8 (42.1%) Daily - 1 (5.3%) (19 cases)

*SEVERITY: Severity was coded from least intrusive to most intrusive. The category "least intrusive" included exposure to pornographic material and "hands off sexual" abuse such as leering, suggestive comments and inappropriate sexual behaviour in front of a child. "Fairly intrusive" was a category that included fondling and/or genital contact. The "very intrusive" category included oral penetration, attempted vaginal and/or attempted anal penetration. The "most intrusive" category included vaginal and/or anal penetration.

**FORCE: The degree of force used in the sexual assaults was coded from no force to most forceful. Where the perpetrator did not use threats or physical injury the category "no force" was available. The category "least forceful" included verbal and psychological threats. The "most forceful" category included physical force and /or physical injury.

Importantly, there were no statistically significant differences between the childhood sexual abuse histories (duration, severity, force and frequency) of the women in the treatment group as compared to those in the wait-list comparison group as can be seen in Table 7.

Table 7. Duration, Severity, Force, and Frequency of Treatment and Wait-list Group Participant's Child Sexual Abuse

VARIABLE	TREATMENT GROUP (N=22)	WAIT-LIST GROUP (N=10)	STATISTICAL TEST
Age Abuse Started	mean= 5.4 yrs (sd=3.45) (19 cases)	mean= 3.2 yrs (sd=4.12) (6 cases)	t-Test=1.21 df= 7.36 p=.26
Age Abuse Ended	mean= 13.5 yrs (sd=3.04) (15 cases)	mean= 12.2 yrs (sd=4.47) (9 cases)	t-Test= .78 df= 12.53 p=.45
Duration	mean= 8 yrs (sd=4.58) Range 3-17 yrs (15 cases)	mean= 7.5 yrs (sd=4.81) Range 3-15 yrs (6 cases)	t-Test= .22 df= 8.88 p= .83
Severity	Fairly-4 (22.2%) Very- 3 (16.7%) Most- 11 (61.1%) (18 cases)	Fairly- 2 (20%) Very- 4 (40%) Most- 4 (40%)	t-Test= .59 df= 19.96 p= .48
Number of Types of Abuse	1 type- 1 (5.6%) 2 types- 6 (33.3%) 3 types- 5 (27.8%) 4 types- 3 (16.7%) 5 types- 2 (11.1%) 6 types- 1 (5.6%) (18 cases)	1 type- 1 (10.0%) 2 types- 3 (30.0%) 3 types- 3 (30.0%) 4 types- 3 (30.0%)	t-Test= .69 df= 22.85 p=.49
Force Used in Childhood Sexual Abuse	None- 3 (17.6%) Least- 7 (41.2%) Most- 7 (41.2%) (17 cases)	None- 1 (11.1%) Least- 2 (22.2%) Most- 6 (66.7%) (9 cases)	t-Test= -1.06 df= 16.94 p = .306
Frequency of Childhood Sexual Abuse	Once- 1 (7.7%) Intermittently- 2 (15.4%) Regularly- 2 (15.4%) 1-2x/month- 2 (15.4%) 1-3 x/week- 5 (38.5%) Daily- 1 (7.7%) (13 cases)	Once- 1 (16.7%) Intermittently-2 (33.3%) 1-3x/wk- 3 (50.0. %) (6 cases)	t-Test= .61 df=8.03 p=.56

Characteristics of the perpetrators.

Twenty-two women (68.8%) responded to an item asking if there was any extenuating circumstance in the family situation which the participants felt was related to their sexual abuse. Of these women, seven (31.8%) reported no extenuating circumstances while another seven reported the absence of the non-offending parent at the time of the abuse(s). Five women (22.7%) reported that they lived with alcoholic family members; two women (9.1%) reported high stress and violence between family members; and one women (4.5%) reported that one of her parents was the product of an incestuous marriage.

As can be seen in Table 8, 29 women responded to an item regarding the number of abusers. The total number of perpetrators was 89 with an average of 3.1 (sd=2.4) for each survivor. More than two thirds of the women (69%) reported having been sexually abused by more than one perpetrator. Of these, six women (20.7%) reported a second perpetrator, while almost half (14 or 48.3%) were victimized by three or more abusers.

In response to an item inquiring whether their perpetrator resided with them, 22 of 27 survivors (81.5%) noted that their abuser had lived in the same household. Importantly, 21 of 26 women (80.8%) also reported that another family member was sexually abused as a child. Only 17 women responded to the item inquiring if sexually abused family members had been abused by the same perpetrator: 12 of these (70.6%) responded in the affirmative.

As children, slightly over half (55.2%) of 29 participants had not disclosed their sexual abuse to anyone. Upon disclosure, six children (46.2%) were lectured and/or

physically punished, two children (15.4%) were not believed, one child (7.7%) was told to avoid the perpetrator, and nothing happened in three cases (23%).

Table 8. Characteristics of Perpetrators and Family Data of All Participants

VARIABLE	TOTAL SAMPLE (N=29)
Number of Perpetrators	1 perp.-10 2 perp.-5 3 perp.-5 4 perp.-4 6 perp.-1 7 perp.-2 8 perp.-1 10 perp.-1 total= 89 perps. mean= 3.1 (sd= 2.4) (29 cases)
1st Perpetrator Resided in Home	No - 5 (18.5%) Yes - 22 (81.5%) (27 cases)
Others in Family Sexually Abused as Children	No others S.A. - 5 (19.2%) Others S.A. - 21 (80.8%) (26 cases)
Abused by Same Perpetrator	No - 5 (29.4%) Yes - 12 (70.6%) (17 cases)
Disclosed Sexual Abuse as a Child	No - 16 (55.2%) Yes - 13 (44.8%) (29 cases)

In only one case (7.7%) was a child placed in foster care as a result of her disclosure. Although social services was involved in this one case, the abusing father faced no consequences. Only one perpetrator was ever prosecuted and found guilty, a

legal action that resulted after the survivor reported the sexual abuse, as an adult, to police. Ninety-nine percent of the known perpetrators have never been prosecuted.

Of the 13 women (44.8%) who did disclose, five women (17.2%) received therapy as children. However, in only two (6.9%) of these cases was sexual abuse addressed in therapy. Two women who did not disclose also attended therapy. Sexual abuse issues were not addressed.

There were no statistically significant differences between the childhood sexual abuse histories (perpetrators and family data) of the women in the treatment group as compared to those in the wait-list group as can be seen in Table 9.

Table 9. Characteristics of Perpetrators and Family Data of Treatment and Wait-list Participants

VARIABLE	TREATMENT GROUP (N=22)	WAIT-LIST GROUP (N=10)	STATISTICAL TEST
Number of Perpetrators	mean=3.11 sd=2.28 range 1 to 8 (19 cases)	mean=3.00 sd=2.79 range 1 to 10 (10 cases)	t-Test=.07 df= 13.01 p= .95
1st Perpetrator Resided in Home	No- 4 (22.2%) Yes- 14 (63.6%) (18 cases)	No- 1 (11.1%) Yes- 8 (88.9%) (9 cases)	Fisher's Exact Test p= .09
Others in Family Sexually Abused as Children	No - 4 (23.5%) Yes - 13 (76.5%) (17 cases)	No -1 (11.1%) Yes- 8 (88.9%) (9 cases)	Fisher's Exact Test p= .42
Abused by Same Perpetrator	No- 4 (33.3%) Yes-8 (66.7%) (12 cases)	No- 1 (20.0%) Yes- 4 (80.0%) (5 cases)	Fisher's Exact Test p= .53
Disclosed Sexual Abuse as a Child	No- 11 (57.9%) Yes-8 (42.1%) (19 cases)	No- 5 (50.0%) Yes-5 (50.0%) (10 cases)	Fisher's Exact Test p= .49

Relationship of victim to perpetrator.

As seen in Table 10, most of the sexual abuse was incestuous; the first or only sexually abusive experience was incestuous 91.3% of the time. Seventeen women (58.6%) were initially sexually abused by their biological fathers, step-fathers or adoptive fathers.

Table 10. Relationship of Perpetrators to Sexual Abuse Survivors

RELATIONSHIP OF PERPETRATOR TO VICTIM	1st OR ONLY PERPETRATOR (N=29)	2nd PERPETRATOR (N=20)	3rd PERPETRATOR (N=14)
Not Remembered or Missing Data	none	3 (15%)	2 (14.3%)
Father Figures (biological, step & adoptive fathers)	17 (58.6%)	1 (5%)	none
Grandfather Figures (grandfather, step-grandfather & great grandfather)	none	none	3 (21.4%)
Other Male Relatives	6 (20.7%)	7 (35%)	4 (28.6%)
Mother	2 (6.9%)	4 (20%)	none
Other Female Relatives	1 (3.4%)	1 (5%)	none
Family Acquaintance	3 (10.3%)	3 (15%)	4 (28.6%)
Stranger	none	1 (5%)	1 (7.1%)

Mothers perpetrated sexual abuse against six women while other female relatives perpetrated against two other survivors. Although abuse by a stranger appears only twice in Table 10, three more women who had been abused more than three times had also been abused by a stranger. Strikingly, though, of the total 89 perpetrators, only five (5.6%) were strangers.

In addition to the three previously mentioned women who have no cognitive memory of their sexual abuse, it is of interest to note that another three women (15%) who reported a second perpetrator did not identify the second abuser. Another woman (7.7%) who reported a third perpetrator did not identify who this was. Also mentioned previously, although one woman reported amnesia concerning details of her sexual abuse, she did identify her mother and father as the perpetrators.

Therapeutic histories and adult abuse experiences.

As can be seen in Table 11, during their first therapeutic relationship, which commenced at an average age of 31 years, 14 (43.8%) of the women did not address their sexual abuse issues. It is important to note that when the question of sexual abuse was raised in therapy, 80.6% of the time the issue was initiated by the client, not the therapist.

In terms of the number of different therapists seen for individual therapy, two thirds of the women (19 or 59.4%) reported working with only one therapist, four (12.5%) had worked with two, eight (25%) had worked with three or four, and one (3.1%) respondent had worked with eight therapists. Before attending the current group program, almost two thirds of the study respondents (59.4%) had not previously participated in any type of support group or therapy group.

As adults, one quarter (25.8%) of the women had been sexually assaulted and many (41.9%) were physically abused. Almost half (46.7%) had attempted suicide at least once and one third (35.5%) have a history of substance abuse.

Table 11. Therapeutic and Adult Abuse Histories of All Participants

VARIABLE	TREATMENT GROUP & WAIT-LIST GROUP (N=32)
Age Therapy Started	mean= 31.0 yrs (sd=16.1)
Sexual Abuse Addressed in First Therapy	No- 14 (43.8%) Yes- 18 (56.3%)
Sexual Abuse Question Asked by Therapist	No- 25 (80.6%) Yes- 6 (19.4%) (31 cases)
Therapy as a Child Addressing S.A.	No- 29 (93.5%) Yes- 2 (6.5%) (31 cases)
Previous Group Therapy	No- 19 (59.4%) Yes- 13 (40.6%)
Sexually Abused as Adult	No- 23 (74.2%) Yes- 8 (25.8%) (31 cases)
Physically Abused as Adult	No- 18 (58.1%) Yes- 13(41.9%) (31 cases)
Suicide Attempts	No- 16 (53.3%) Yes- 14 (46.7%) (30 cases)
Substance Abuse	No- 20 (64.5%) Yes- 11 (35.5%) (31 cases)

In the treatment group, only three women (13.6%) had been sexually assaulted as adults, while five of the nine women (55.6%) wait-list respondents had been sexually abused as adults as can be seen in Table 12. This represents a statistically significant difference between the two groups (Fisher's Exact Test; $p = .03^*$). No other statistically

significant differences were found with respect to therapeutic and abuse histories of the women in the treatment group as compared to the waiting list control group.

Table 12. Therapeutic and Adult Abuse Histories of Treatment and Wait-list Group Participants

VARIABLE	TREATMENT GROUP (N=22)	WAIT-LIST GROUP (N=10)	STATISTICAL TEST
Age Therapy Started	mean= 32.3 yrs (sd= 18.75)	mean= 28.2 yrs (sd= 7.78)	t-Test= .87 df= 29.91 p= .39
Sexual Abuse Addressed in First Therapy	No- 9 (40.9%) Yes- 13 (59.1%)	No- 5 (50%) Yes- 5 (50%)	Fisher's Exact Test p= .46
S.A. Question Asked by Therapist	No- 17 (77.3%) Yes- 5 (22.7%)	No- 8 (88.9%) Yes- 1 (11.1%) (9 cases)	Fisher's Exact Test p= .42
Therapy as a Child Addressing S.A.	No- 20 (95.2%) Yes- 1 (4.8%) (21 cases)	No- 9 (90%) Yes- 1 (10%)	Fisher's Exact Test p= .60
Previous Group Therapy	No- 14 (63.6%) Yes- 8 (36.4%)	No- 5 (50%) Yes- 5 (50%)	Fisher's Exact Test p= .36
Sexually Abused as Adult	No- 19 (86.4%) Yes- 3 (13.6%)	No- 4 (44.4%) Yes- 5 (55.6%) (9 cases)	Fisher's Exact Test p= .03*
Physically Abused as Adult	No- 14 (63.6%) Yes- 8 (36.4%)	No- 4 (44.4%) Yes- 5 (55.6%) (9 cases)	Fisher's Exact Test p= .28
Suicide Attempts	No- 13 (65.0%) Yes- 7 (35.0%) (20 cases)	No- 3 (30%) Yes- 7 (70%)	Fisher's Exact Test p= .08
Substance Abuse	No- 15 (68.2%) Yes- 7 (31.8%)	No- 5 (55.6%) Yes- 4 (44.4%) (9 cases)	Fisher's Exact Test p= .40

*= $p < .05$

Summary of demographics, child sexual abuse history and perpetrator information.

To summarize the characteristics of the study participants, almost all were Canadian women, who were, on average, in their mid-thirties. More than half had at least a grade 12 education. Although reasonably well educated, only a third worked full time and two thirds had annual incomes less than $25,000. Most of the women had children, and almost two thirds were married or lived with a partner.

The women in this study, on average, were severely sexually abused as children having experienced long term, extremely intrusive abuse that started when they were quite young. Most of the women had experienced, at minimum, oral penetration or attempted vaginal/anal penetration. More than half had experienced other forms of severe sexual abuse, including vaginal/anal penetration. Two thirds of the women were victimized by more than one abuser (with regular frequency) for an average duration of 7.9 years.

During childhood, the majority resided with at least one of their perpetrators. Strikingly, a large number of participants reported that their siblings had also been sexually abused, many by the same perpetrator. Less than a half of these women had disclosed their sexual abuse as children and only one child who was incestuously abused was placed in foster care. For the most part these women experienced very negative reactions, including beatings, when they did disclose their sexual abuse. With the low rate of disclosure it should not come as a surprise that only one of the 89 perpetrators had been prosecuted.

Although all of these women eventually received therapy, only two were offered treatment for sexual abuse as children. Furthermore, their therapists did not assess for childhood abuse; clients reported that they raised the issue of sexual abuse four times more often than therapists. Several statistically significant differences were found between the women in the treatment group and those in the wait-list group for education, income, number of children, and sexual abuse as an adult.

Statistical Analysis

The pretests of the standardized measures (the Beck Depression Inventory, BDI; the Coopersmith Self-esteem Inventory, CSEI; the Trauma Symptom Checklist-33, TSC-33) for the treatment and wait-list comparison groups were first compared using independent t-tests. This procedure was conducted to ensure that the sample was similar, one of the assumptions of the analysis of covariance. The test was necessary since random assignment to treatment or comparison group was not possible. If differences had been found on some of the standardized tests at pretest, it may have been that the differences between groups could be associated with some of the demographic differences between the two groups.

The results of the t-Tests (see Table 13) indicated no statistically significant differences on the pretest scores between the treatment group and the wait-list comparison group on any of the standardized measures. According to Fitz-Gibbon and Morris (1987) it is necessary to show that the groups "are so alike that the groups are as-good-as random anyway" to meet the conditions for utilising an analysis of covariance.

As such, the requirements to proceed with an analysis of covariance (ANCOVA) were met.

Table 13. Results of t-Tests on the Pretest of the Standardized Measures

STANDARDIZED MEASURE	TREATMENT GROUP (N=22)	WAIT-LIST GROUP (N=10)	t-TEST	p LEVEL
Beck Depression Inventory	24.3 (sd=8.6)	22.7 (sd= 13.6)	.34	.74
Coopersmith Self-Esteem Inventory	38.3 (sd=15.1)	31.9 (sd= 27.1)	.70	.50
TSC-33: Dissociation	9.4 (sd=4.1))	7.8 (sd= 4.6)	.94	.36
TSC-33: Anxiety	12.4 (sd=4.7)	10.6 (sd= 4.5)	1.04	.31
TSC-33: Depression	14.1 (sd=4.2)	13.3 (sd= 5.6)	.40	.70
TSC-33: Sleep Disturbance	6.7 (sd=3.6)	7.8 (sd= 2.3)	-1.02	.32
TSC-33: Post Sexual Abuse Trauma Hypothesized	8.5 (sd=3.7)	9.0 (sd= 3.4)	-.41	.68
TSC-33: Total Score	48.4 (sd=15.5)	44.5 (sd=16.3)	.64	.53

An analysis of covariance was used to compare the posttest scores of the treatment and the wait-list comparison group. The ANCOVA is a powerful statistical test (Posavac & Carey, 1985) which is considered preferable to a comparison of the gain scores between the two conditions (Campbell & Stanley, 1963). The test compares the posttest scores of the treatment group and the wait-list comparison group, taking into consideration the pretest scores of each. This analysis thus equalizes any pre-treatment differences between conditions (Fitz-Gibbon & Morris, 1987; Williams, 1992). The results of the analysis of covariance are displayed in Table 14. The results of each of the standardized measures will be described separately.

Table 14: The Results of the ANCOVA Test on the BDI, the CSEI and on the TSC-33

STANDARDIZED MEASUREMENT	CONDITION	PRETEST SCORE	POSTTEST SCORE	F Value	p
Beck Depression Inventory	Treatment (N= 22)***	24.3 (sd=8.6)	11.0 (sd=7.8)	7.82	.009**
	Wait-list (N=10)	22.7 (sd=13.6)	20.0 (sd=10.4)		
Coopersmith Self-Esteem Inventory	Treatment	38.3 (sd=15.1)	58.9 (sd=21.4)	3.94	.057
	Wait-list	31.9 (sd=27.1)	40.7 (sd=25.9)		
TSC-33: Dissociation	Treatment	9.4 (sd=4.1)	6.8 (sd=4.8)	.40	.535
	Wait-list	7.8 (sd=4.6)	6.2 (sd=3.6)		
TSC-33: Anxiety	Treatment	12.4 (sd=4.7)	8.1 (sd=4.7)	4.23	.049*
	Wait-list	10.6 (sd=4.5)	9.3 (sd=4.2)		
TSC-33: Depression	Treatment	14.1 (sd=4.2)	11.0 (sd=4.8)	1.71	.202
	Wait-list	13.3 (sd=5.6)	11.9 (sd=4.2)		
TSC-33: Sleep Disturbance	Treatment	6.7 (sd=3.6)	5.3 (sd=2.8)	.13	.726
	Wait-list	7.8 (sd=2.3)	6.2 (sd=3.1)		
TSC-33: Post Sexual Abuse Trauma Hypothesized	Treatment	8.5 (sd=3.7)	6.5 (sd=3.7)	.56	.462
	Wait-list	9.0 (sd=3.4)	7.5 (sd=3.5)		
TSC-33: Total Score	Treatment	48.4 (sd=15.5)	35.3 (sd=15.7)	1.12	.299
	Wait-list	44.5 (sd=16.3)	35.8 (sd=13.0)		

* p <.05; **p <.01

Note: p= probability level; sd= standard deviation; ***treatment group N=22 at pretest for all scales, and N=21 for all TSC-33 subscales and total scales at posttest.

Depression

As can be seen in Table 14, improvements in depression as rated by the Beck Depression Inventory are highly significant (F = 7.822; p= .009) for women in the treatment condition as compared to women in the wait-list condition. See Appendix I for the frequencies of participants' levels of depression at pretest and posttest. At pretest, the participants were, on average, experiencing moderate to severe depression according to

Beck's clinical cut-off scores (Beck & Steer, 1987) with an average score of 23.8 (sd= 10.2).

The treatment group participants had a mean score of 24.2 (sd=8.6) at pretest (moderate to severe depression); the range being mildly depressed to extremely severe depression. Similarly, the women in wait-list condition reported a mean score of 22.7 (sd=13.6) at pretest, indicating moderate to severe depression on average. However, in contrast to the treatment group, the wait-list comparison group had three members who were asymptomatic at the time of pretest. Nevertheless, the most depressed were similar to the treatment group members with extremely severe depression.

At posttest, the treatment group members had improved to, on average, mild depression as indicated by a mean score of 11 (sd=7.8), with a range of scores of 1 to 30. Fourteen of the women (63.6%) in the treatment group were asymptomatic by posttest, while only one was experiencing extremely severe depression. Notably, though, her score of 30 was just one point over the range indicating moderate to severe depression.

In contrast, at posttest the women in the wait-list group remained, on average, moderately to severely depressed as indicated by a mean score of 20 (sd=10.4). The range of scores, in the wait-list condition, at posttest was from 6 to 41. Only one participant in the wait-list condition was asymptomatic at posttest while 90% were still clinically depressed with half in the mild to moderate range, one third (30%) in the moderate to severe range, and one woman was experiencing extremely severe depression.

Self-Esteem

Although the direction of change was in the desired direction for both groups, the women in the treatment group had, on average, higher self-esteem than those in the wait-list comparison group both at pretest and posttest. Improvements in self-esteem as measured by the Coopersmith Self-Esteem Inventory approached significance at the .05 level ($F = 3.94$, $p = .057$) for women in the treatment group as compared to women in the wait-list group (see Table 14).

There are no clinical cut-off scores for the CSEI; however, Coopersmith (1981) states that scores in "the upper quartile generally can be considered indicative of high self-esteem, the lower quartile generally as indicative of low self-esteem, and the interquartile range generally as indicative of medium self-esteem" (p.8). The frequencies of participants level of self-esteem at pretest and posttest can be seen in Appendix J.

The average pretest Coopersmith scores of both the treatment group and the wait-list group are considered medium/low with a mean of 32.3 (sd=19.4). At posttest, the treatment group scores had improved, on average, to a medium/high level (mean=58.9; sd=21.4) while the wait-list group scores remained, on average, at the medium/low level (mean=40.7; sd=25.9).

Trauma Symptomatology

The creators of the Trauma Symptom Checklist-33 (Briere & Runtz, 1989) have not developed cut-off scores for the measure. The data analysis of the Trauma Symptom Checklist-33 subscales (dissociation, anxiety, depression, sleep disturbance, post sexual

abuse trauma-hypothesized) and the total score all show change in a positive direction for both the treatment group and the wait-list comparison group. The average pretest total score for all participants in both groups was 47.19; posttest total TSC-33 score was 39.97 (see Table 14). However, this change did not reach statistical significance.

The only statistically significant change for the women in the treatment group in comparison to the wait-list group was on the anxiety subscale ($F = 4.23$, $p = .049$). The mean score on the anxiety subscale at posttest, for the treatment group was 8.1 ($sd = 4.7$) while the mean wait-list score, at posttest, was 9.3 ($sd = 4.2$) which indicated a higher level of anxiety.

Summary of Statistical Analyses

The t-test analyses indicated no statistically significant differences in the pretest scores between the treatment group and the wait-list comparison group which was required, as previously discussed, to proceed with the analysis of covariance. Statistically significant changes were found in depression and anxiety. Improvement approaching statistical significance was evident with respect to self-esteem. While the results of the Trauma Symptom Check-list anxiety subscale were significant, no other significant results were found in the other subscales nor in the total score.

Nevertheless, the women reported consistent improvements in a reduction of their trauma symptoms. Interestingly, positive change occurred for women within both groups on all measurements, possibly because all of them were receiving concurrent individual therapy. Overall, it appears that participation in the treatment group assisted the women

to decrease their depression and anxiety. Furthermore, group treatment participants improved their self-esteem to levels approaching significance.

CHAPTER FIVE

DISCUSSION

This chapter discusses the results of the current study and their implication for social work practice. The first section includes a comparison of the results of the current study with those of other research. The second section introduces the implications of the findings for clinical social work practice, issues related to assessment for childhood sexual abuse at intake and, ethical and policy issues concerning clients without cognitive memory of childhood sexual abuse who, nevertheless, believe they are survivors.

The third section addresses directions for future research. Included in this section are methodological issues in the study of group treatment for survivors with respect to recommendations for the study of a variety of group treatment models, documenting drop-out rates and, examining individual predictors. Concluding this section are recommendations for future research. The fourth and final section of this chapter presents a conclusion to the current study with a discussion of the hypotheses which were rejected and those which were accepted. When considering the results of the current study in comparison to other research it is important to remember that this study, with only one other (Alexander et al., 1989), included a wait-list comparison group, an important design consideration.

The Results of the Current Study in Context

The demographic characteristics and sexual abuse histories of the study participants appear to be similar to the descriptions of survivors participating in other group outcome studies. The average age of the 32 women in the current study was 36 years, the same average age as the women who participated in the Alexander et al. (1989) study. In addition, the women in the current study had, on average, almost the same number of years of education, 12.8 years vs. 13.7 years, as the women in that study. Participants in the other group evaluations were more often single or divorced compared to women in the current study (Alexander et al., 1989; Carver et al., 1989; Fisher et al., 1993; Roberts & Lie, 1989). The exception was the Hughes (1992) research where more participants were married (68%), compared to the number of women in the current study who were married or who lived with partners (59.4%).

The average duration of childhood sexual abuse for women in the current study was 7.9 years. This was similar to the average of 7 years reported in three other studies (Alexander et al., 1989; Hazzard et al., 1993; Hughes, 1992). Reported rates for severity were also comparable. Vaginal or anal penetration was reported by 53.6% of the women in the current study, while those in other studies reported similar proportions (Alexander et al., 1989; Roberts & Lie, 1989; Hazzard, 1993; Hughes, 1992).

Approximately two-thirds of the women in the current study were sexually abused by father figures, as were women in two other studies (Hazzard et al., 1993; Roberts & Lie, 1989). In other research a smaller proportion, only a third to one half of the women, were abused by their fathers or step-fathers (Carver et al., 1989; Hughes, 1992).

Abuse by more than one perpetrator was reported by 53% of the women in the current study, while fewer women had multiple abusers (32% and 50%) in other studies (Carver et al., 1989; Fisher et al., 1993).

The current research measured changes in three areas: depression, self-esteem, and trauma symptomatology. The first hypothesis, that women who experienced childhood sexual abuse, who participate in a structured time-limited therapeutic treatment group, and concurrent individual therapy will experience a significant decrease in depression in comparison to women who experienced childhood sexual abuse, who remain on a waiting list for group treatment, and participate in concurrent individual therapy, was verified. Statistically significant differences between the treatment group and the wait-list comparison group indicated that the women in the treatment group were, on average, less depressed after treatment than those in the comparison group. This finding parallels the statistically significant results of other group studies utilizing the Beck Depression Inventory (Alexander et al., 1989; Hughes, 1992; Roberts & Lie, 1989; Threadcraft & Wilcoxon, 1993).

The average pretest level of depression in women in the current study was greater than the level of depression reported in three other studies (Alexander et al., 1989; Hughes, 1992; Roberts & Lie, 1989). By the time the posttest was conducted, women in the treatment group study were, on average, experiencing less depression than those in other studies (Hughes, 1992; Roberts & Lie, 1989; Threadcraft & Wilcoxon, 1993). The women who received treatment in the current study, as well, were less depressed than women in the year-long process group of the Alexander et al.(1989) study although

the depression scores remained in the clinical range. In only one instance, the interpersonal transaction group of the Alexander et al.(1989) study, did the average posttest score fall within the asymptomatic range. Nevertheless, in summary, group therapy for survivors may have been effective, on average, in significantly decreasing depression levels as measured by the Beck Depression Inventory (BDI) in the current study as well as four others (Alexander et al., 1989; Hughes, 1992; Roberts & Lie, 1989; Threadcraft & Wilcoxon, 1993).

The second hypothesis, that women who experienced childhood sexual abuse, who participate in a structured time-limited therapeutic treatment group, and concurrent individual therapy will experience a significant increase in self-esteem in comparison to women who experienced childhood sexual abuse, who remain on a waiting list for group treatment, and participate in concurrent individual therapy, was not verified, although the results approached significance. Using the Coopersmith Self-Esteem Inventory (CSEI), women in both the treatment and the wait-list groups reported an average pretest score which indicated medium/low self-esteem (Coopersmith, 1990). While the women in the wait-list comparison group remained at the same level by posttest, the women in the treatment group had, on average, increased self-esteem to a medium/high level.

Other studies of short term groups (10 to 16 weeks) reported significant improvement in self-esteem although each utilized different measures of self-esteem and did not include a wait-list comparison group (Hughes, 1992; Roberts & Lie, 1989; Sultan & Long, 1988; Threadcraft & Wilcoxon, 1993). In a year-long process group, statistically significant improvements in self-esteem were also reported (Hazzard et al.,

1993). Again, the interpretation of the findings of these studies is difficult as none included a wait-list comparison group.

The third hypothesis that women who experienced childhood sexual abuse, who participate in a structured time-limited therapeutic treatment group, and concurrent individual therapy will experience a significant decrease in trauma symptomatology in comparison to women who experienced childhood sexual abuse, who remain on a waiting list for group treatment, and participate in concurrent individual therapy was not verified as a whole. However, on the Trauma Symptom Checklist (TSC-33) anxiety subscale, a statistically significant difference was found between the treatment group and the wait-list comparison group. Although the total TSC-33 score and the remaining subscales showed no statistically significant improvement, there was nevertheless, change in a positive direction.

The lack of a statistically significant difference between the treatment and the wait-list group on the TSC subscale depression did not parallel the improvement on the BDI in the current study. However, the TSC-33 is a relatively new test with only 9 items measuring depression symptomatology, while the BDI consists of 21 items and is known to be a psychometrically sound test.

Statistically significant improvement were reported in the only two other studies, to date, that used the TSC-33 as a pretest/posttest measurement (Hazzard et al., 1993; Hughes, 1992). Hughes (1992) reported significant improvement on the total TSC-33 and all of the subscales with the exception of dissociation and anxiety, in a study combining participants of short-term groups with participants of a long-term group over a 20 to 24

week period. Hazzard et al. (1993) found statistically significant improvements on the total score and on all of the subscales except dissociation in research on a year-long group. Although these other studies reported more statistical significance on the TSC-33, it must be remembered that those women received treatment of a longer duration than that received by women in the current study. Additionally, neither of the significant changes were in comparison to a wait-list control group.

The average TSC-33 total score, at pretest, was greater, indicating a higher level of trauma symptomatology, than the average score reported in two other studies (Hazzard et al., 1993; Hughes, 1992). Although the total TSC-33 score decreased by posttest, indicating decreased trauma symptomatology, this difference was not statistically significant. By posttest, the level of trauma symptomatology in the current study was still greater than the reported levels in the other evaluations of longer groups (Hazzard et al., 1993; Hughes, 1992).

At pretest, the average level of anxiety in the women in the treatment group, as measured by the TSC-33 subscale, was higher than the reported level in the Hughes (1992) study. However, by posttest, the level of anxiety in the current study was slightly lower than what was reported by Hughes and a statistically significant difference was found between the treatment group and the wait-list comparison group. Hazzard et al. (1993) did not report the findings on the anxiety subscale.

In summary, promising results were reported by women in the treatment group with statistically significant improvements in depression and anxiety and improvements in self-esteem that approached significance. Change in a positive direction was reported

in trauma symptomatology. The women in the wait-list comparison group also reported, on average, improvement on all variables. As such group treatment seems to be an effective treatment for survivors of childhood sexual abuse.

Implications for Social Work Practice

This study raises a number of issues for social workers and other professionals who work with sexual abuse survivors. Two main clinical and policy issues arising from this study concern whether all clients should be assessed for a history of childhood sexual abuse and whether to include clients in group treatment who believe that they are survivors of sexual abuse but who have no cognitive memory of sexual abuse.

Assessing for childhood sexual abuse at intake.

In this study, sexual abuse was most often raised as an issue by the client (80.6% of the time) rather than by the therapist during the client's first therapeutic relationship. It is not known how often the client raised the issue as the presenting problem or how often the client presented with other issues which would have been affected by, or a result of, childhood sexual abuse. Nevertheless, it is this researchers opinion that routinely assessing for childhood sexual abuse is be an essential part of an intake interview and should be standard policy for clinicians in private practice, social agencies, and hospitals.

Due to the wide range of post-sexual abuse symptomatology, a history of childhood sexual abuse may be masked by other issues and symptoms (Gelinas, 1983).

For example, childhood sexual abuse is prevalent in clinical populations of clients presenting with issues of depression (Murrey et al., 1993), anxiety (Murrey et al., 1993) and those with histories of family violence (Walker, 1985). Women diagnosed with borderline personality disorder have frequently also had a history of childhood sexual abuse (Briere & Zaidi, 1989; Herman et al., 1989). In addition, compared to non-abused women, sexually abused women more often experience low self-esteem (Bagley, 1991; Bagley & McDonald, 1984; Bagley & Ramsay, 1986; Parker & Parker, 1991); suicide attempts (Bagley & Ramsay, 1986; Briere & Runtz, 1986), substance abuse (Briere & Runtz, 1987), and sexual difficulties (Briere & Runtz, 1987). Survivors may access therapy with any of these issues and, therefore, to ensure effective treatment, it is critical that the therapist assess these existing issues within the context of an experience of childhood sexual abuse. Assessment for childhood sexual abuse should, therefore, be included as an overall part of any assessment process (Briere, 1989).

Issues concerning clients without cognitive memory of childhood sexual abuse.

As previously mentioned, in the field of childhood sexual abuse the issue of recovered memory is a matter which is currently garnering a significant amount of controversy. In the current study, four women (12.5%) in the treatment group condition, had no cognitive memory of childhood sexual abuse. In addition, one other woman with no memory did receive treatment; however, she did not participate in the current study. In considering this issue it is important to examine the research concerning forgotten memories of childhood abuse. As discussed previously, there is some early empirical

research supporting the phenomena of repressed memories in childhood sexual abuse survivors. In follow-up studies of women known, through documentation, to have been abused in childhood, some of the women did not, or reported that they did not, remember childhood sexual abuse that had occurred 18 and 17 years previously (Bagley, 1990; Williams, 1993, cited in Classen, 1995). Other research, using self-report measures, also found a number of sexually abused women, who did not remember their sexual abuse for at least some period of time (Briere & Conte, 1993; Herman & Schatzow, 1987).

Nevertheless, to include women in group treatment who have no memory of the abuse raises three questions. First, are such clients psychologically ready to remember the sexual abuse? Second, what is the effect on the group process when a participant in a sexual abuse survivors group has no cognitive memory of sexual abuse? Third, what are the consequences if the client was not actually sexually abused but experienced other childhood trauma which resulted in similar symptomatology?

The first issue deals with repressed memories. It has been suggested that suppression of memory is an adaptive coping mechanism which is learned by some survivors in childhood (Herman, 1992). Other theorists have noted the self-hypnotic capacities that childhood victims develop as a protective device, which they continue to use in adulthood (Maldonado & Spiegel, 1995). If memory suppression and hypnotic capacities, along with dissociation, are used as protective coping strategies then it seems to follow that other coping strategies must replace these before the conscious mind can deal with the sexual abuse memories. It may be that the best interests of the client will

be served by continued individual therapy or group therapy that focuses on issues other than sexual abuse until she is psychologically ready. A possible indicator that the client is psychologically prepared, then, may be the recovery of memory. Once the client has memory of childhood sexual abuse it would be appropriate to assess for participation in group treatment.

The second issue deals with the effect women without memories of childhood sexual abuse may have on the group dynamics in a survivors' treatment group. The level of cohesion may be affected as commonality is reduced. Members without cognitive memory may experience stigmatization if they do not feel accepted. Other participants may be concerned that a member without memory is in the group for voyeuristic reasons. If these types of difficulties did occur, the group cohesiveness could be adversely affected.

In the current study, the co-facilitators of groups that included a woman who had no memory reported differing experiences (see Appendix K). The facilitators of Group #2, with two members with no memories reported low cohesion, low levels of trust, and a number of struggles. However, these difficulties could also be attributed to the participation of two women who were diagnosed with the psychiatric disorder of multiple personality disorder or dissociative identity disorder. In contrast, the facilitators of Group #3,reported that the group was able to achieve a level of cohesiveness although one women had no memory. Similarly, in another group, where there were two women with no cognitive memory but with corroborating reports, the facilitators reported a high level of group cohesion.

No literature was found on the inclusion or exclusion of women without cognitive memory of childhood sexual abuse in groups for survivors. However, Abbott (1995) recommends that clients be able to discuss their sexual abuse experiences before they are included in group therapy and screening out clients who have borderline personality disorders or dissociative identity disorders. From his perspective, these clients pose a potential management problem in group therapy once the emotional intensity increases, as they often experience difficulties dealing effectively with their emotions.

The third issue relates to the presence of symptomatology similar to the sequelae experienced by sexually abuse survivors but when no such abuse has occurred. If the client was not sexually abused, but experienced other childhood trauma, inclusion in group treatment for survivors is likely inappropriate as it may be damaging to the client's self-image and their relationships with family members. The possibility exists that she may be impeded from receiving appropriate therapeutic assistance. In addition, the agency or the practitioner may also be in a vulnerable legal position if a client or a family member who claims to be falsely accused, decides to take legal action and sue for damages as has recently happened in the United States (Yalom, 1995; Maldonado & Spiegel, 1995).

Agencies should consider if the best interests of the client are served if those with no cognitive memory of childhood sexual abuse are included in group treatment for survivors. Clinicians are invited to carefully consider whether the lack of cognitive memory is a contra-indication for participation in a sexual abuse survivor group treatment. This researcher would recommend that those women without memory be

provided with other appropriate treatment. If group treatment is the most appropriate, they then could be assessed for participation in a multiple issue therapy group.

Community clinics, psychiatric hospitals, and private practitioners may consider developing clear policies regarding how to deal with clients who present with no memory of childhood sexual abuse, but do have post-traumatic stress disorder or other symptoms possibly attributable to sexual abuse. To limit potential damage to the client, and also reduce the possibility of future legal action, the clinician must proceed with caution, ask non-leading questions, and keep careful notes while remaining open to the possibility that the client may have been abused (Courtois, 1995). It is important for clinicians to remain equally open to the possibility that the client was traumatized in some other manner.

Directions for Future Research

There has been so little research concerning the efficacy of group treatment for childhood sexual abuse survivors that almost any addition to the knowledge base is of benefit. There are some methodological issues which become apparent in the review of the literature such as the absence of wait-list comparisons in most of the studies. The findings of this study lead to other questions which will be discussed concerning the different types of treatment provision which are effective for survivors, why the drop-out rate was so low in the current study and recommendations for future research.

Methodological issues in the study of group treatment for survivors.

The absence of studies using wait-list control groups is the most glaring methodological problem in the published research on group treatment for sexual abuse survivors. In the current study, the use of a wait-list comparison group clarified which variables were significantly changed after group treatment since many of the women in the wait-list also reported improvements. All variables, on average, showed improvement. However, without a wait-list comparison group the findings of this study would likely have shown more statistically significant change for those women who participated in the treatment group.

As such, when possible researchers should also make the effort to include wait-list comparison groups in their studies as this approach can further the accuracy of results. This is especially true if the members of the wait-list group are already in individual therapy, representing a multiple treatment effect.

It is recommended that agencies and private practitioners make regular use of standardized instruments in order to measure treatment efficacy. Less than half (43.8%) of 553 American treatment programs for sexual abuse victims and perpetrators, utilized standardized measurements at pre-treatment and post-treatment for client assessment (Keller, Cicchinelli & Gardner, 1989). Perhaps so few agencies utilize standardized measurements because clinicians are disinclined to utilize these measures. The current fiscal reality, however, calls for justification and verification of the efficacy of treatment programs. The more data that agencies can gather using standardized measurements, the

more opportunities there are to conduct research, and, hopefully, the more effective the treatment for survivors.

It is recommended that this study be replicated with a larger sample, and with an equal number of participants in the treatment group and the wait-list comparison group. A larger sample can increase the statistical power of a test and reduce the risk of rejecting the null hypothesis when it is false (Briere & Elliott, 1993).

Recommendations for the study of a variety of group treatment models.

As has been discussed previously, some merit exists in tailoring treatment for sexual abuse survivors relative to their current stage of recovery (Herman, 1992; Lebowitz et al., 1993). The group model in the current study appears to be appropriate for the first two stages of recovery. The main issue during the first stage of recovery is thought to be safety, while, second stage issues relate to remembrance, integration, and mourning. While these issues continue to be important throughout recovery, third stage issues are thought to concern reconnecting with others, improving memory, and increasing self-esteem. To address these latter concerns, long-term group treatment may be more effective than short-term.

Although short-term groups are most often recommended for survivors, professionals must recognize that short term groups may not address all of the sequelae related to childhood sexual abuse trauma. Long-term groups provide opportunities to address interpersonal issues and to practise new skills such as assertiveness, expressing anger, and dealing effectively with dissociative responses.

More research is required on the effectiveness of different types of group treatment and to identify, for example, the best treatment for each stage of recovery from childhood sexual abuse. To determine which type of group treatment is the most effective, comparisons of different group models must be conducted. Hughes (1992) had an opportunity to do this since her study included three different types of groups; however, she chose to combine the data from all groups resulting in an insufficient response to this important question.

Finkelhor (1984) recommends evaluating the effects of various intervention strategies to help policy makers determine, objectively, which programs and/or models are most effective. The treatment of child sexual abuse is a relatively new field which requires data analysis and process information concerning the effectiveness of a variety of treatment modalities and technique (Courtois, 1988).

Drop-out rate and individual predictors in group therapy.

The drop-out rate in the current study was very low in comparison to other studies of group treatment. Only three (6.8%) of the 44 women who began group therapy did not complete the course of treatment. One dropped out due to a personal crisis, another because of family pressure, and the reason for the third women dropping out is not known. Alexander et al. (1989) also reported a fairly low drop-out rate (13.3%) while others reported higher rates ranging from 26.3% to 40.7% (Carver et al., 1989; Fisher et al., 1993; Hazzard et al., 1993; Hughes, 1992; Threadcraft & Wilcoxon, 1993).

It is not clear why the model assessed in the current study reported a lower drop-out rate than other treatment models. One explanation may be that participants were required to attend individual therapy for six months prior to group treatment and concurrently during the course of group treatment. Such individual concurrent treatment may provide survivors with opportunities to deal with personal crises, which may not be addressed in group therapy. Unattended crises may lead a survivor to withdraw from group prior to completion of treatment.

There is some support in the literature for this idea. Follette, Alexander, and Follette (1991) found that previous therapy was associated with more positive group outcome for their process group treatment. Hazzard et al. (1993) reported a similar positive relationship between previous therapy and group outcome. In contrast, Carver et al. (1989) found that women concurrently in group and individual therapy were more likely to drop out of group. To conclude, further research is required as insufficient data are available concerning factors which contribute to women continuing to participate in group treatment as opposed to those who drop out.

Methodological recommendations for future research.

The inclusion of the wait-list comparison group in the current study was an important factor which enhanced the interpretations of the improvement on outcome variables for those in the treatment group. However, other considerations would have made this a more effective study. Three recommendations for future group treatment studies are: one, a more limited definition of sexual abuse survivors; two, an improved

design of the demographic questionnaire; three, a survey questionnaire for the participant's individual therapist to gather data on the type and frequency of their concurrent individual therapy. A discussion of these three recommendations follows.

For the purposes of this study, the conceptual definition of child sexual abuse was defined as "any unwanted exploitative sexual contact or attempted sexual contact experienced before the age of eighteen" (Russell, 1986, p.41). The agency which offered these groups uses the following definition for survivors who are referred to group treatment: "anyone who said they had been sexually abused as a child was considered to have experienced such abuse." In retrospect it would have been useful, for the purpose of this study, to have defined survivor as "anyone who had experienced any unwanted exploitative sexual contact or attempted sexual contact before the age of eighteen, and had cognitive memory of the abuse". It is recommended that researchers not include the data of participants without cognitive memory in outcome studies conducted at agencies where such participants are included. Inclusion of such data may confound the findings, and raises the question, where there is no corroborating evidence, of whether, or not, women with no memory are sexual abuse survivors.

Two, some of the data gathered concerning the frequency of abuse, extenuating family circumstances, and therapeutic history was missing or unclear due to design difficulties with the questionnaire utilized in this study. Open-ended questions inquiring about the frequency of abuse netted only a 38.2% response rate. It is suggested that researchers develop forced answer categories to encourage a greater response.

More detailed inquires should have been made into family histories. Information concerning pre-existing stressors and conditions are particularly important as these are factors may further complicate the after-effects of childhood sexual abuse (Nash et al., 1993). Forced answer questions could inquire about such issues as parental absences, childhood physical abuse, violence between parents, parental alcoholism, and other family stressors.

Participants were asked to fill out a table-type section of the questionnaire in answer to an inquiry about previous therapy (see Appendix C). A clearer format may have facilitated the gathering of more data concerning the duration, frequency, and type of therapy that each women had previously received.

Three, a questionnaire could be administered, with the participant's permission, to the individual therapists who work with the women in the treatment and the wait-list groups. Such a questionnaire could be used to gather data on the type and frequency of individual therapy participants receive while attending group treatment. An analysis of this data could provide important information about the relationship individual therapy and the outcome of the variables studied.

Conclusion

In summation, women who participated in this study had demographic characteristics, childhood sexual abuse histories, and adult abuse histories which were similar to those of other women who participated in group treatment outcome studies. However, on average, at pretest, the women in the current study were more depressed

than women in four studies (Alexander et al., 1989; Hughes, 1992; Roberts & Lie, 1989; Threadcraft & Wilcoxon, 1993) and had more trauma symptomatology than women in two studies (Hughes, 1992; Hazzard, 1993). At pretest the women in both the treatment and the wait-list group had, on average, medium/low self-esteem.

As previously stated, the verified hypotheses in the current research were that: women who experienced childhood sexual abuse, who participated in a structured time-limited therapeutic treatment group and concurrent individual therapy experienced: (a) a significant decrease in depression in comparison to women who experienced childhood sexual abuse, who remained on a waiting list for group treatment, and participated in concurrent individual therapy and; (b) a significant decrease in anxiety, on the TSC-33 which measured trauma symptomatology, in comparison to women who experienced childhood sexual abuse, who remained on a waiting list for group treatment, and participated in concurrent individual therapy.

Hypotheses which were rejected were that: women who experienced childhood sexual abuse, who participated in a structured time-limited therapeutic treatment group and concurrent individual therapy experienced: (a) a significant increase in self-esteem in comparison to women who experienced childhood sexual abuse, who remain on a waiting list for group treatment, and participated in concurrent individual therapy and; (b) a significant decrease in trauma symptomatology, except anxiety, on the TSC-33 which measured trauma symptomatology, in comparison to women who experienced childhood sexual abuse, who remained on a waiting list for group treatment, and

participated in concurrent individual therapy. The increases in self-esteem approached statistical significance for the treatment group women.

Again, the use of a wait-list comparison group in this study provided confidence in these findings. However, the findings cannot be generalized to other sexual abuse survivors as there was no random sampling although statistical analysis showed that the sample was as good as random. It is recommended that this study be replicated with a larger sample if possible. Also recommended is the continued use of psychometrically sound standardized measurements in quantitative studies and that wait-list comparison groups be included in the research designs.

The social work implications which arose from this study concern the importance of professionals assessing for childhood sexual abuse and a need to consider the ethical and legal implications of including clients with no memory of childhood sexual abuse in groups for survivors. Directions for future social work were discussed and included a call for more research into the effectiveness of different types of treatment modalities and interventions for survivors, research concerning the reasons for decreased drop-out rate, and some logistical considerations for future outcome studies.

To conclude, the women in this study experienced, on average, severe sexual abuse over a long period of time during childhood. It appears that these women became survivors who could, with effective treatment, overcome post-traumatic symptomatology, such as depression and anxiety, arising from traumagenic dynamics of traumatic sexualization, betrayal of trust, powerlessness, and stigmatization (Finkelhor & Browne, 1985). Group therapy seems to provide opportunities for survivors to address these

issues, to begin to trust again, to reclaim personal power, and to let go of stigmatization. More information is needed concerning which treatment modality and which techniques are best suited to survivors at different stages in their healing. Around the world, across Canada, women who have been sexually abused are healing individually and in groups. I thank them for sharing their history. I am grateful to be a part of their journey.

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APPENDICES

Appendix A: Group Format Utilized in Current Study
(Buzzell & Quigley, 1994).

At Calgary Family Service Bureau, the women's survivors groups are short-term, closed structured groups led by 2 co-therapists, with six to eight participants. Each group meets 2 1/2 hours weekly, over 10 to 12 weeks. The focus of the group is for each group member to "tell their story" in a supportive safe environment where they will be believed.

The pre-requisite to group participation is six months of individual therapy focused on childhood sexual abuse issues, and concurrent individual therapy as needed during the course of the group. Facilitators meet with prospective group members during a pre-group screening session. Contraindications for group participation include women who are in crisis, suicidal, or actively alcoholic or drug addicted.

Session #1

During the first session ground rules are set by the members, establishing the norms of behaviour in group sessions. The members are asked to think about their personal goals and these are discussed. This process increases identification with the other member and therefore, increases group cohesion. The facilitators discuss what expectations are realistic, while normalizing the possible difficulties and rewards of participating in group treatment.

Facilitator make role expectations and responsibilities explicit. Each person is responsible for getting their own needs met. Members are encouraged to ask for the

support they need. Group members are invited to create a phone list so they can call each other between group sessions. This encourages members to begin to support to each other rather than relying on their therapist or the group facilitators for support. Each woman is also asked to bring a meaningful personal object to the next group meeting. In addition the women are assigned a written exercise on the impact of their childhood sexual abuse experiences. Written homework is assigned at the completion of each session.

Session #2

The session begins with a body-focused relaxation exercise and a check-in. This process is repeated during each subsequent session to encourage members to be present in their bodies, to identify feelings, to discuss current life events, and to raise any unfinished business from the previous session. Members are then asked to introduce themselves, with the personal object they have brought to the group. A discussion of the impact of sexual abuse utilizes information members gathered from their homework assignment.

A "brain-storming" exercise is used to facilitate the identification of individual strengths in the physical, social, emotional, mental, and spiritual realms. Each women is asked to give herself a nurturing gift during the next week to acknowledge her ability to survive.

This purpose of this session is to increase cohesion as members begin to know each other better, and to identify with each other as survivors. In addition the women

begin to learn relaxation and self-care techniques, and to identify their personal survival strengths.

Session #3

The third session focuses on themes of self care and safety building. The facilitators lead a personal boundary exercise. Group members then identify their individual boundary style, and if necessary, discuss how to develop more appropriate styles. The facilitators lead a guided visualisation. Participants visually create a safe place, a wise women guide, and a container for memories of sexual abuse. These concepts are presented as "safety tools," to increase a sense of control, during times of stress or crisis. A writing exercise is assigned which addresses the process of denial and its role as a survival skill.

Session #4

During the fourth session the processes of denial, minimization, and rationalization, at the individual, family and societal level are discussed. Each women learns to get out of dissociation and "flashbacks" in this way: stop, breathe deeply, and focus on the here and now by using all five senses. Healing as the process of moving from victim to survivor to warrior is presented (Butler, 1985, cited in Buzzell & Quigley, 1994).

Each woman is encouraged to move from victim to survivor by breaking the silence and speaking her truth. Members are prepared for the process of telling their

stories. Common feelings, such as fear apprehension are normalized. To prepare for telling their stories, writing exercises are assigned to assist each women to identify her feelings and clarify what she will tell the group. Members decide among themselves in order in which they will share their stories.

Group sessions #5 through #8

During the next few sessions, each woman will tell her story, after showing a childhood photograph to the group. Two women, per session, will tell their story. Each women tells her story the way she chooses. Some methods utilized include: reading a written account of her sexual abuse; speaking about what happened with or without written notes; presenting her life history on a time line; using photographs or artwork.

Each woman has 30 minutes to tell her story without interruption. For 20 minutes after the story group members give feedback, identify similarities, and process the experience. The purpose is to create a safe and structured environment where each women may experience being heard and believed in a supportive community of her peers.

Sessions #9 through #11

The focus of the next sessions are themes chosen by the group members. Commonly chosen themes are: anger; self-esteem; sexuality. Other themes can include: family of origin; assertiveness; relationships; spirituality; perpetrators and confrontation.

During one session, two themes may be addressed. Didactic information is presented and the facilitators utilize appropriate brain-storming exercises and visualizations.

At the end of each session written homework, related to the theme of the next session, is assigned. During each session issues related to process and content the homework is discussed and normalized.

Session #12

The final session addressed the themes of spirituality and closure. Group members have an opportunity to take care of unfinished business with each other through a structured exercise where members use sentence completion. For example, "One thing I never told you is . . . ; One thing I want to let go of is. . . ." Rituals are used to help the participants acknowledge where they have come from. For example, a stone is passed from woman to woman, and each states something that she wants to "let go of." The rock is then washed in a container of water. Latter the water is poured into the ground to symbolically purify whatever was released into the rock.

In another closing exercise, juice is poured into glasses and everyone, including the facilitators, name a "gift" they wish to give the group members. The juice is then poured back into the container, and mixed together, symbolically blended the gifts. The juice is then re-poured. As each member drinks the juice, they symbolically receive the gifts to take the gifts of the group with them at the end of the group.

Members are invited to choose someone to be a contact person for the group; the contact people will be contacted by the agency when there are marches or rallies with

themes relating to sexual abuse survivors. The women are reminded that they can be politically active. They are encouraged to become "warriors" in the cause of prevention and healing of sexual abuse. At the conclusion of the group each person shares how they are feeling. A small celebration, with food the women have brought from home occurs after the group.

Appendix B: Briere's Trauma Symptom Checklist-33

How often have you experienced each of the following in the last month?

		Never	Occasionally	Fairly Often	Very Often
1)	Insomnia (trouble getting to sleep)	0	1	2	3
2)	Restless sleep	0	1	2	3
3)	Nightmares	0	1	2	3
4)	Waking up early in the morning and can't get back to sleep	0	1	2	3
5)	Weight loss (without dieting)	0	1	2	3
6)	Feeling isolated from others	0	1	2	3
7)	Loneliness	0	1	2	3
8)	Low sex drive	0	1	2	3
9)	Sadness	0	1	2	3
10)	"Flashbacks" (sudden, vivid, distracting memories)	0	1	2	3
11)	"Spacing out" (going away in your mind)	0	1	2	3
12)	Headaches	0	1	2	3
13)	Stomach problems	0	1	2	3
14)	Uncontrollable crying	0	1	2	3
15)	Anxiety attacks	0	1	2	3
16)	Trouble controlling temper	0	1	2	3
17)	Trouble getting along with others	0	1	2	3

		Never	Occasionally	Fairly Often	Very Often
18)	Dizziness	0	1	2	3
19)	Passing out	0	1	2	3
20)	Desire to physically hurt yourself	0	1	2	3
21)	Desire to physically hurt others	0	1	2	3
22)	Sexual problems	0	1	2	3
23)	Sexual overactivity	0	1	2	3
24)	Fear of men	0	1	2	3
25)	Fear of women	0	1	2	3
26)	Unnecessary or over-frequent washing	0	1	2	3
27)	Feelings of inferiority	0	1	2	3
28)	Feelings of guilt	0	1	2	3
29)	Feelings that things are "unreal"	0	1	2	3
30)	Memory problems	0	1	2	3
31)	Feelings that you are not always in your body	0	1	2	3
32)	Feeling tense all the time	0	1	2	3
33)	Having trouble breathing	0	1	2	3

Appendix C: Questionnaire

GROUP TREATMENT EFFECTIVENESS FOR SEXUAL ABUSE SURVIVORS QUESTIONNAIRE

PART I

1. First name and last initial (e.g., Liz W.)_____

2. Date: _____

3. Date of birth (month/day/year):___ ___ ___

4. Place of birth: _____

A. THERAPEUTIC HISTORY: Please circle your answer(s).

5. Have you ever attended individual therapy ?
   01 Yes
   02 No

   If yes, please answer the following questions.
   If no, go to section B.

6. Describe the therapy:

Age at start?	Age at end?	How often did you attend?	Type of therapy	Sexual abuse issues addressed?

7. What type of therapist did you work with?
   01 Social worker
   02 Psychologist
   03 Psychiatrist
   04 Nurse practitioner
   05 Other

8. If your sexual abuse issues were addressed in therapy who first brought up the issue of sexual abuse?
   01 You
   02 Your therapist

9. Was your individual therapeutic experience
   01 Positive
   02 Negative
   03 Neutral
   04 Other

10. Have you previously been in a therapy group or a support group?
    01 Yes
    02 No

11. If yes, describe the group:

Type of group	Age when attending?	How often did group meet?	How long did you attend?

12. Overall, was your group experience:
    01 Positive
    02 Negative
    03 Neutral
    04 Other (please comment)_____
    _____
    _____

THANK YOU FOR PARTICIPATING IN THIS EVALUATION PROCESS

Appendix C: con't.

GROUP TREATMENT EFFECTIVENESS FOR SEXUAL ABUSE SURVIVORS QUESTIONNAIRE

First name and last initial (e.g., Liz W.): _____

Date of birth:(month/day/year) ___ ___ ___

Place of birth: _____

Number of group sessions attended? ____

PART II

B. ABUSE HISTORY

Please answer the following questions to the best of your ability. I am aware not all sexual abuse survivors know exactly what happened to them in childhood.

13. How old were you when the sexual abuse started? _____

14. How old were you when the sexual abuse ended? _____

15. Were you abused by more than one person?
    01 Yes
    02 No

16. If yes, how many people sexually abused you? ____

17. What is the relationship between you and the person (or people) that sexually abused you (circle appropriate response)?

    01 Biological father: his age when abuse started ___
    02 Biological mother: her age when abuse started ___
    03 Step-father: his age when abuse started ___
    04 Step-mother: her age when abuse started ___
    05 Adoptive father: his age when abuse started ___
    06 Adoptive mother: her age when abuse started ____
    07 Brother: his age when abuse started ___
    08 Sister: her age when abuse started ___
    07 Grandfather: paternal __ maternal __: age at start___
    09 Grandmother: paternal __ maternal __: age at start___
    10 Uncle: father's brother __ or mother's brother__
    :age at start ____

11 Aunt: father's sister __ or mother's sister__
:age at start ___
12 Cousin: male ___ or female ___ : age at start ____
13 Friend of the family: male __ or female __
:age at start ___
14 Teacher: male ___ or female ___:age at start ____
15 Stranger: male __ or female ___:age at start ____
16 Other (please describe) _____
_____

18. Did the perpetrator(s) reside in your home?
01 Yes
02 No
Comments:_____
_____
_____

19. How often did the sexual abuse occur? _____
_____
_____

20. Were there any patterns or particular circumstances surrounding the occurrences of sexual abuse (e.g., drunkenness, violence, parents working nights)? _____
_____
_____

21. Did you ever disclose the sexual abuse to anyone?
01 Yes
02 No

22. If yes, who did you tell? _____

23. If yes, how old were you when you disclosed? ____

24. If yes, What was the result of disclosing?_____
_____
_____

25. Was anyone else in your family sexually abused?
01 Yes
02 No

26. If yes, who else was sexually abused and by whom? _____
_____
_____

27. Please indicate what happened (circle anything that you experienced):
    01 fondling
    02 genital contact
    03 oral penetration
    04 attempted vaginal/anal penetration
    05 vaginal/anal penetration
    06 exposure to pornographic material
    07 "hands off sexual abuse" (e.g., staring, comments, etc.)
    08 other (please state) _____
    _____
    _____

28. The degree of force used was:
    (circle more than one category if it applies)
    01 none
    02 verbal threats
    03 psychological threats
    04 physical force
    05 physical injury

29. As an adult have you ever been sexually assaulted?
    01 Yes
    02 No

30. As an adult have you ever been in a physically abusive relationship?
    01 Yes
    02 No

31. Have you ever attempted suicide?
    01 Yes
    02 No

32. Do you have a history of substance abuse?
    01 Yes
    02 No

C. DEMOGRAPHIC INFORMATION

33. How many brothers and sisters do you have? _____

34. What is your birth order or position in your family if you are adopted.
    01 First
    02 Second
    03 Third
    04 Fourth
    05 Other (please comment) _____
_____ _____

35. Marital status (circle one only):
    01 Married
    02 Living with partner
    03 Divorced
    04 Widowed
    05 Single

36. Do you have any children?
    01 Yes
    02 No

If yes:

	Age	Sex	*Status	Living with you?
1.				
2.				
3.				
4.				
5.				

(* Status: 1= Natural, 2= Step-child,
3= Adopted,4= Foster, 5=Other)

37. Do you currently work outside the home?
    01 Yes
    02 No

38. If yes, do you work:
    01 Full time
    02 Part time

39. If yes, what is your occupation? _____

40. If no, How are you supported?
    01 Spouse/Partner
    02 Social assistance
    03 U.I.C.
    04 Other (Please specify)_____

41. What is your highest level of education (circle one only)?
    01 Elementary school
    02 Junior high school
    03 Senior high school
    04 College Diploma
    05 Trade school
    06 University undergraduate degree
    07 University masters degree
    08 University doctorate

42. What is your income range (circle one only):
    01 less than $15,000
    02 $15,000 - $25,000
    03 $25,000 - $40,000
    04 more than $40,000

43. Please state anything that was not in this questionnaire that you think may be important to this evaluation:_____
    _____
    _____

40. What do you think of this questionnaire?_____
    _____
    _____
    _____
    _____

THANK YOU FOR PARTICIPATING IN THIS EVALUATION PROCESS

Appendix D: Letter to Participants

2500 University Way
The Faculty of Social Work
The University of Calgary
Calgary, Alberta

September 8, 1993.

Dear Group Participant:

This is an invitation to participate an evaluation of the effectiveness of the Sexual Abuse Survivors Group which I will conduct at Calgary Family Service Bureau this fall and winter. I have worked with survivors for six years and have chosen to dedicate my Masters of Social Work thesis to learning more about the effectiveness of group treatment for sexual abuse survivors.

Many therapists believe that group therapy is a healing and empowering experience for survivors. Unfortunately there have been very few studies in this area. I believe it is important to document the change that occurs for participants in sexual abuse survivors groups so therapists can become more knowledgable and effective in their work and clients, as consumers, may make more informed choices about their healing process.

If you choose to participate you will be asked to fill out a package of questionnaires at the beginning of the group and again at the end of the group. All responses will be kept completely confidential and any identifying information will be removed. The questionnaires will be kept in a locked filing cabinet and will be destroyed at the end of the project.

I will come to Calgary Family Service Bureau at the end of your first group session so you can meet me and I can answer any questions you may have. At that time, with your consent, I will give you the questionnaires to fill out. I estimate that it will take 30 to 40 minutes of your time.

Your signature on the consent form indicates that you have understood to your satisfaction the information regarding your participation in the research project and that you agree to participate in the study. In no way does this waive your legal rights nor release the investigator (Liz Westbury) or involved institutions from their legal and professional responsibilities. If you wish to reach me for any reason you may call me at my private practise (283-6733).

Please understand that participation in this project is completely optional and that you may withdraw at any time, without affecting your participation in the Sexual Abuse Survivors Group in any way.

Sincerely,

Liz Westbury, BSW, RSW.

Appendix E: Consent Form

GROUP TREATMENT EFFECTIVENESS FOR SEXUAL ABUSE SURVIVORS

CONSENT FORM

I agree to participate in the research of the Sexual Abuse Survivors Group at Calgary Family Service Bureau, to be conducted by Liz Westbury of the Faculty of Social Work, University of Calgary.

I understand that I will be asked to fill out a package of questionnaires at the beginning of the group and again after three months when the group ends. All responses will be kept completely confidential and any identifying information will be removed. The questionnaires will be kept in a locked filing cabinet and will be destroyed at the end of the project. Further, I understand that I may withdraw from this research at any time, without affecting my participation in the Sexual Abuse Survivors Group in any way.

Signature: _____ Date: _____

Witness: _____ Date: _____

Appendix F: Letter of Thanks

2500 University Way
The Faculty of Social Work
The University of Calgary
Calgary, Alberta

December 20, 1993

Dear Group Participant,

Thank you for your participation in the evaluation of the effectiveness of the Sexual Abuse Survivors Group at Calgary Family Service Bureau. I understand it may have been difficult for you to participate and I appreciate your efforts to complete the evaluations.

In the next few months I will complete this evaluation comparing the difference in changes that women in group therapy experience with the changes women on the waiting list experience. My Masters of Social Work thesis should be completed by June, 1994 and I will compile a summary of the results which will be available at Calgary Family Service Bureau. Please contact Lorna Pepper (233-2370) in July, 1994 if you would like a copy.

If you wish to reach me for any reason you may call me at my private practise (283-6733). Please remember that participation in this project is completely optional and that you may withdraw at any time, without affecting your future participation in therapy at Calgary Family Services Bureau in any way.

I wish you well on your journey of healing.

Sincerely,

Liz Westbury, BSW, RSW.

Appendix G: Certificate of Approval to Conduct Research

THE UNIVERSITY OF CALGARY

Faculty of SOCIAL WORK

2500 University Drive N.W., Calgary, Alberta, Canada T2N 1N4

Telephone (403) 220-5942
FAX (403) 282-7269

CERTIFICATE OF APPROVAL

by

THE RESEARCH ETHICS COMMITTEE
FACULTY OF SOCIAL WORK

The PROJECT/THESIS entitled:

Group Treatment Effectiveness for Sexual Abuse Survivors.

of Ms. Liz Westbury (student)

In the judgement of this Committee, has met The University of Calgary ethical requirements for research with human subjects.

93-09-13
Date

Michael Rothery, Ph.D.
Research Services, Faculty of Social Work

Appendix H: Research Participants Inclusion in Data Set

The final data set consisted of a sample of 22 women from five treatment groups, and a sample of 10 women who were on the waiting list at the agency. Twenty-nine women (65.9%) completed the pretest scales of a total possible 44 who attended six groups. Twenty-four women (82.8% of the respondents) also completed the posttest, however, since two of these women had previously been involved in the wait-list comparison group, their scores were not included in the sample due to a possible multiple-testing interference which would likely have affected the validity of those results. In total, 22 women (50% of group members) were included in the group treatment condition.

There were two wait-list periods: one from September 1993 to December 1993, and another period from January 1994 to April 1994. The first set of wait-list participants had remained on the list for some time. Of 15 women on the wait-list in the fall, the intake worker was able to contact 11 women, of whom nine (81.8%) agreed to receive the questionnaire in the mail. Only five of these women (55.6%) responded to the pretest; one women did not return her posttest leaving four women (36.4%) as participants from the first set.

Of the 19 women on the second wait-list, 14 were contacted, all of whom agreed to receive the measures and the questionnaire. Eight of these women responded to the pretest; two women did not return their posttest leaving six women (42.9%) as participants from the second set. Thus, the total number of study respondents in the wait-list comparison condition was ten (40%) of a possible 25 participants.

For inclusion in the final data set it was necessary that respondents complete both pretest and posttest measures. Furthermore, the respondent could not have been previously tested because they were included in the wait-list comparison group. The total number of study respondents, including those in the group condition and those in the wait-list condition, was 32 women (46.4%) of a possible 69 participants.

Appendix I: Frequencies of Participants' Levels of Depression at Pretest and Posttest

CONDITION	PRETEST LEVEL OF DEPRESSION	POSTTEST LEVEL OF DEPRESSION
Treatment Group (n=22)	Normal or asymptomatic- 0	Normal or asymptomatic-14 (63.6%)
	Mild to moderate- 5 (22.7%)	Mild to moderate- 4 (18.3%)
	Moderate to severe-12 (54.6%)	Moderate to severe- 3 (13.6%)
	Extremely severe -5 (22.7%)	Extremely severe- 1 (4.5%)
Wait-list Group (n=10)	Normal or asymptomatic- 3 (30%)	Normal or asymptomatic- 1 (10%)
	Mild to moderate- 1 (10%)	Mild to moderate-5 (50%)
	Moderate to severe- 1 (10%)	Moderate to severe- 3 (30%)
	Extremely severe- 5 (50%)	Extremely severe- 1 (10%)

Appendix J: Frequencies of Participants' Levels of Self-esteem at Pretest and Posttest

CONDITION	PRETEST LEVEL OF SELF-ESTEEM	POSTTEST LEVEL OF SELF-ESTEEM
Treatment Group (n=22)	Low -6 (27.3%) Medium/low -12 (54.5%) Medium/high -4 (18.2%) High -0	Low -1 (4.5%) Medium/low -6 (27.3%) Medium/high -10 (45.5%) High -5 (22.7%)
Wait-list Group (n=10)	Low- 5 (50%) Medium/low -1 (10%) Medium/high- 2 (20%) High- 2 (20%)	Low -4 (40%) Medium/low -3 (30%) Medium/high -2 (20%) High -1 (10%)

Appendix K: Details of Treatment Groups in the Current Study

GROUP	LEADER EDUCATION	# COMPLETE TREATMENT	# IN STUDY	LEADER COMMENTS
#1 FALL 1993	1-M.Ed. Psych. student 1-MSW student	7/7	4	-High functioning -Well educated -Didn't want spirituality -Worked on cognitive level -Cohesive -Still meeting Apr.'94
#2 FALL 1993	2-MSWs	7/8 1 Drop-out due to personal life crisis	2	-2 no memory -Poor group cohesion -Low trust -Lots of dissociation -2 MPD (1 diagnosed before group) -Several did not show for the last group session
#3 FALL 1993	1-MSW 1-PhD.	7/8 1 Drop-out due to?	7	-1 no memory -Cohesive -Diverse ages & socio/economic -Still meeting Apr.1994
#4 SPRING 1994	1-MSW student 1-MSW	8/8	6	*Leader changed after 3 sessions -Changed meeting time & place -Low cohesion -Low trust -1 completed pre & posttest but was not included as had been previous wait-list
#5 SPRING 1994	2-MSW students (1 male)	6/7 1 Drop-out due to family pressure	3	-2 no memory in group only 1 with no memory participated in study -Cohesive
#6 SPRING 1994	2-MSW students	6/6	0	-2 subgroups -power struggle changed after stories told -Cohesive -1 completed pre & posttest but was not included as had been previous wait-list