AN EVALUATION OF A GROUP TREATMENT APPROACH FOR
WOMEN SEXUALLY ABUSED IN CHILDHOOD

by

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We accept this thesis as conforming
to the required standard

..............................................................

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ABSTRACT

This study was conducted for the purpose of determining: 1) if changes occurred among sexually abused women who participated in a time-limited group treatment approach from pre-test to post-test on 8 psychological variables including: a) self-esteem, b) body image, c) depression, d) feelings of guilt, e) anger, f) interpersonal sensitivity, g) paranoid ideation, and h) general severity of psychological distress symptoms, 2) if changes on the dependent measures occurred for women in a contrast group, and 3) if the changes were greater among women in group therapy than among women in the contrast group. Twenty-two women who had been sexually abused in childhood participated in this study. Eleven women comprised the experimental group of women who received group treatment, and 11 women comprised the contrast group of women who did not receive group treatment. Participants were administered the SCL-90-R and the Tennessee Self-Concept Scale at three separate intervals: once prior to the commencement of group treatment, once upon completion of the group treatment and once six weeks following the group treatment. A Personal Information Sheet was also administered to both groups prior to group treatment and an (ii)
experimenter-generated Support Group Assessment was administered to the women in the experimental group at the end of the group sessions. Results of the hypothesis testing indicated a significant decrease from pre-test to post-test in the scores of the Paranoid Ideation and Interpersonal Sensitivity subscales of the SCL-90-R for the women in the experimental group. A significant increase was found in the scores of the women in the contrast group on the Overall Self-Concept scale of the TSCS from pre-test to post-test. This increase was significantly greater than the increase in the scores of the women in the experimental group on the Overall Self-Concept scale of the TSCS. In addition, results indicated a significant decrease in the scores of the women in the contrast group on the Feelings of Guilt subscale of the SCL-90-R. The limitations of the study and the clinical and research implications were discussed.
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CHAPTER ONE

Statement of the Problem

In recent years, the sexual abuse of children has commanded a great deal of attention from community members and mental health professionals alike. In part, attention to this social problem has increased in response to apparent reports of a rising incidence of child sexual abuse in our society (James & Nasjleti, 1983; Kosky, 1987; Rush, 1980). Results of a study conducted by Kinsey, Pomeroy, Martin, and Gebhard (1953) indicated that one in four American women and one in ten American men had been sexually abused before the age of eighteen. More recently, the American Humane Association (cited in James & Nasjleti, 1983) cited 53 cases of reported sexual abuse per million children under eighteen years of age. These results clearly dispute earlier reports that the sexual abuse of children occurs at a rate of one child in a million (Weinberg, 1955). Canadian statistics also reflect high incidences of child sexual abuse. Based on a royal commission report, Bagley (cited in Bagley & King, 1990) found that one in two females and one in three males have experienced unwanted sexual acts, and 80 percent experienced these assaults in childhood.
While the results of these studies indicate an alarmingly high incidence of sexual abuse, many clinicians and researchers still consider these new statistics to be conservative estimates, given the great reluctance to acknowledge or discuss child sexual abuse in our society (Brucki, 1986; James & Nasjleti, 1983; Kosky, 1987). Based on his review of statistics for incest, Kosky (1983) suggests that only ten percent of all incest cases are actually reported.

Although in our society people are still reluctant to discuss sexual abuse, there seems to be a growing recognition of this problem as reflected in recent media reports (eg. Macleans, 1989). The breaking of the silence around sexual abuse has largely been attributed to the feminist movement which has placed the sexual abuse of female children within a larger context of violence against women in our society (Armstrong, 1978; Brownmiller, 1975; Butler, 1985; Froula, 1986; Rush, 1980). While many men have reportedly been victims of sexual abuse in childhood, research suggests that the majority of sexual abuse victims are young girls who are abused by older males (Brucki, 1986; Kosky, 1987). From a feminist perspective the sexual abuse of a young girl by an older male is viewed as an extreme example of the power
differential between men and women which is inherent in our patriarchal society (Rush, 1980; Sgroi, 1987). According to Sgroi (1987), sexual abuse "is based upon the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency, and subordinate position"(p.9).

Sexual abuse has been defined in a number of ways. The operationalization of this term has created a debate among researchers and clinicians and has resulted in conflicting incidence reports. There is some disagreement among clinicians over the inclusion of a wide range of sexually related behaviors in the definition of sexual abuse (Kosky, 1987; Sgroi, 1987). Definitions range from the inclusion of overt sexual interaction (sexual intercourse, fondling, oral copulation, etc.) to more covert and suggestive sexual behavior (nudity, inappropriately observing an older child disrobing, bathing, etc.) (Sgroi, 1987). Sgroi maintains that the more covert forms of sexual abuse are insidious and can also be destructive to the victim and therefore argues that these forms of abuse must be included in an accurate definition of sexual abuse. For the purpose of the present study, covert activities such as nudity and exposure will be included in the
definition of sexual abuse in order to encompass the range of possible forms of such abuse. The National Center on Child Abuse and Neglect (cited in James & Nasjleti, 1983) offers the following broad and inclusive definition of sexual abuse:

Contacts or interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person. Sexual abuse may also be committed by a person under the age of eighteen when that person is either significantly older than the victim or when the perpetrator is in a position of power or control over another child (p. xii).

This definition will be used in the present study as it provides a fairly inclusive description of the power dynamics inherent in sexual abuse.

According to recent studies, most of the perpetrators of sexual abuse are known to the victim, and members of the victim's family are the most common offenders (Brucki, 1986; Brunngraber, 1986; Kosky, 1987). Incest is a form of sexual abuse defined by the distinct relationship between the victim and the perpetrator. The crucial psychosocial dynamic in incest is the familial quality of the relationship. According to Sgroi (1987), incest encompasses the
following criteria:

...any form of sexual activity between a child and a parent or stepparent or extended family member (for example, grandparent, aunt or uncle) or surrogate parent figure (for example, common-law spouse or foster parent) (p. 10).

This definition of incest allows for the inclusion of a wide range of sexually abusive behaviors and clearly delineates the familial quality of the relationship between the victim and the abuser. For these reasons, this definition of incest will be used in the present study.

Included in the discussion of incest is the occurrence of sibling incest which involves sexual interaction between individuals who have one or both parents in common (Loredo, 1987). Incestuous sexual abuse involves coercion and power differentials between the perpetrator and the victim and does not include the relatively "normal" occurrence of mutual sexual curiosity between children (Loredo, 1987; Sgroi, 1987).

Of the various possible forms of incest, it is generally agreed that the most common form is father-daughter incest (Brunngraber, 1986; Gil, 1988; Kosky, 1987; Meiselman, 1978). Other common forms of incestuous abuse include stepfather-stepdaughter and
grandfather-granddaughter abuse (Kosky, 1987).

According to Brunngraber (1987), at least one in 100 girls is sexually abused by her father. Similarly, Bagley and Young (1988) report that 50% of all sexual abuse victims were abused by a family member. Given the high incidence of incestuous abuse in our society (Bagley & Young, 1988; Brunngraber, 1986), it is vital to include incest in the broader discussion of sexual abuse. While incest will not be treated separately in this study, it is important to mention that it is a distinct form of sexual abuse distinguished by the familial quality of the relationship between the perpetrator and the victim.

While there are some who maintain that sexual abuse is not always harmful or deleterious to an individual (Henderson, 1983; Rascovsky & Rascovsky, 1950), the majority of research in this area indicates that sexual abuse is quite traumatic and can have extremely negative and far-reaching effects on its victims (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Brunngraber, 1986; Courtois, 1979; Faria & Belohlavek, 1984; Jehu & Gazan, 1983; Maguire & Wagner, 1978; Tsai, Feldman-Summers & Edgar, 1979).

The effects of childhood sexual abuse are diverse both in nature and severity (Brunngraber, 1986). In
addition, research has indicated that the duration and severity of the effects of sexual abuse may be directly related to a number of variables associated with the abuse (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Tsai et al., 1979). These variables include the duration and frequency of the abuse, the relationship of the offender to the victim, the type of sexual act committed, the use of force and aggression in the abusive acts, the age of the victim at the onset of the abuse, and the sex of the offender (Browne & Finkelhor, 1986). While these variables may affect the impact of sexual abuse on an individual, the research suggests that there are a number of short- and long-term effects that are commonly associated with the experience of childhood sexual abuse (Brucki, 1986; Courtois, 1979; Meiselman, 1978; Sgroi, 1987).

Short-term effects of sexual abuse include those that a child experiences during or immediately after the abuse, such as depression, acting-out or aggressive behavior, low self-esteem, age-inappropriate sexual behavior, sleep disturbances, withdrawal, distrust and suicidal feelings (Brucki, 1986; Sgroi, 1987). According to Brunngraber (1986) long-term effects include "those specific behaviors, emotional states, physical symptoms, and qualities of interpersonal
relationships" (p.18) that exist at least six months after the abuse has ended. Symptoms associated with childhood sexual abuse in adulthood range from low self-esteem to self-mutilation and suicide attempts (Browne & Finkelhor, 1986; Brunngraber, 1986; Meiselman, 1978).

Based on their review of the research, Jehu and Gazan (1983) delineate several common emotional and interpersonal problems experienced by adult women who were victims of childhood sexual abuse. Feelings of guilt and shame seem to be universal among these women as they often blame themselves for the abuse and are pressured to keep the abuse secretive. This is particularly true of women who feel they "allowed" the abuse to continue over a number of years, and for those who experienced feelings of physical pleasure during the abuse (Ganzarain & Buchele, 1987; Tsai & Wagner, 1978). Low self-esteem, depression and feelings of inferiority and worthlessness are also commonly reported among victims (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Courtois, 1979; Meiselman).

Internalized rage and hostility have also been strongly associated with the experience of childhood sexual abuse (Deighton & McPeek, 1985; Wheeler, 1981). While anger is usually directed at the perpetrator of
the abuse, it may also be directed at the mothers of the victims for their lack of protection (Haller & Alter-Reid, 1986; Herman, 1981). In most cases, this anger is not given direct expression resulting in depression and internalized anger and self-hatred (Bass & Davis, 1987; Brunngraber, 1986; Wheeler, 1981).

The interpersonal relationships of women who have been sexually abused are often strained and unfulfilling (Tsai & Wagner, 1978; Haller & Alter-Reid, 1986). Mistrust of others and a fear of intimacy in both sexual and nonsexual relationships often lead to feelings of isolation and loneliness (Bergart, 1986; Goodman & Nowak-Scibelli, 1985; Haller & Alter-Reid, 1986; Jehu & Gazan, 1983; Tsai & Wagner, 1978).

Sexual abuse victims may also have a distorted body image, as a result of the physical violation that occurs during the abuse (Bass & Davis, 1987). Negative self-image and self-loathing are commonly found among women who have been sexually abused, and many experience feelings of dissociation or psychological distancing from their bodies (Bass & Davis, 1987; Brunngraber, 1986; Fraser, 1987). Eating disorders such as anorexia nervosa, bulimia and compulsive eating are believed to occur frequently among sexual abuse victims (Bass & Davis, 1987; Gil, 1988; Meiselman,
1978).

As sexual abuse is increasingly acknowledged in our society, more and more women are disclosing their own childhood victimization (Bass & Davis, 1987; Fraser, 1987; Rush, 1980). The demand for counselling and treatment is increasing. Consequently, clinicians and researchers have become concerned with the treatment modalities that will be the most effective in meeting the many and varied needs of these clients (Brucki, 1986; Faria & Belohlavek, 1984; Gazan, 1986; Gil, 1988; Hyde, 1987). However, most of the research that has examined the efficacy of treatment approaches for sexual abuse victims has been based upon small, non-random clinical samples and case studies. There has been a noticeable lack of systematic research designed to evaluate the effectiveness of various treatment approaches for adult victims of childhood sexual abuse (Courtois & Sprei, 1988).

To date, many clinicians have recognized group therapy as an important component of the healing process for sexual abuse victims (Deighton & McPeek, 1985; Hays, 1987; Herman & Schatzow, 1984) While individual therapy is often recommended first as a means of initially processing the abuse, Herman and Schatzow (1984) maintain that group therapy is
essential for the resolution of the secrecy, shame, and social stigma that are associated with sexual abuse. Hays (1987) suggests that group therapy decreases interpersonal distrust and isolation, validates the coping skills of the participants, minimizes the occurrence of learned helplessness, helps to develop new coping skills and allows women to gain support from other women who have been sexually victimized.

Group treatment is often recommended to be used after a client has received, or is concurrently receiving, some individual counselling (Gil, 1988; Herman & Schatzow, 1984). The goals of group treatment include decreasing feelings of isolation and stigmatization among individuals who have been sexually abused, validating their experiences and coping skills, gaining new perspectives on their experiences, externalizing responsibility for the abuse and increasing self-acceptance by providing an opportunity for individuals to gain support from others with similar experiences (Courtois & Sprei, 1988; Forward & Buck, 1978; Gil, 1988; Hays, 1987). Group treatment approaches for sexual abuse victims vary according to the theoretical orientation and mandate of the therapists or counselling centers offering the groups. Some treatment approaches are highly structured and
follow family systems (Deighton & McPeek, 1985), transactional interactions (Alexander, Neimeyer, Follette, Moore & Harter, 1989), or contextual (Goodman & Nowak-Scibelli, 1985) models and approaches. Other group treatment approaches are less structured and more process-oriented, allowing the group members to set their own agenda for the discussion of issues stemming from their abusive experiences (Alexander et al., 1989; Gil, 1988; Tsai & Wagner, 1978). Regardless of the specific approach used, it is generally agreed that there must be some degree of structure provided in group therapy in order to adequately address some of the common themes that emerge from the processing and working-through of childhood sexual abuse (Courtois & Leehan, 1982).

The most common group treatment format is short-term therapy where members meet once a week for ten to twelve weeks (Gil, 1988; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Tsai & Wagner, 1978). Goodman and Nowak-Scibelli (1985) maintain that a short-term approach helps to "minimize regression and instead highlights the strengths of the individual" (p.534). Similarly, Herman and Schatzow (1984) believe that the pressure of a time-limited approach to group therapy facilitates early bonding and
disclosure among group members.

In recent years, there has been a rapid increase of therapy and support groups for adult women who were sexually abused in childhood. However, to date, there has been only one controlled study evaluating the effectiveness of this form of treatment (Alexander, et al., 1989). As Alexander et al.'s study is the first to provide empirical data supporting the effectiveness of group therapy for adult survivors of childhood sexual abuse, the authors urge researchers to add to this knowledge by conducting further empirical evaluative studies of treatment approaches to sexual abuse. They state that:

In light of the significance and diversity of problems experienced by sexual abuse victims, it would be useful for future researchers to evaluate a variety of treatment approaches (e.g., group therapy, individual therapy, couples therapy) that may all be germane to the successful treatment of the adult survivor of childhood sexual abuse (p.482).

**Purpose of the Study**

The present study was designed to meet this need by investigating whether involvement in short-term supportive group therapy resulted in significant social
and emotional changes for adult women who were sexually abused in childhood. It was the present author's intent to add to the research in this area by conducting a controlled, quantitative study. The study involved the implementation of a pretreatment/post-treatment design using standardized measures. In the literature a number of long-term effects commonly found among women sexually abused in childhood are identified (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Courtois, 1979; Jehu & Gazan, 1983; Meiselman, 1978). Based on these findings, the variables examined in this study included self-esteem, depression, guilt/shame, hostility/anger, interpersonal relationships, trust, intimacy and body image.

While many clinicians have recognized the importance of group therapy in the treatment of women sexually abused in childhood (Bonney, Randall & Cleveland, 1986; Gil, 1988; Herman & Schatzow, 1984), there has been a paucity of systematic research examining the effectiveness of group treatment approaches for this clinical population. It is the present author's belief that empirical outcome research is essential to increasing our understanding of what treatment approaches will best meet the needs of sexual abuse victims. It is hoped that the present study will
provide an important and much-needed preliminary step in the research process by increasing our knowledge of the effectiveness of this group treatment approach for women who were sexually abused in childhood. In this way, we may better meet the needs of these clients in the counselling setting.
CHAPTER TWO

Review of the Literature

Recently, there has been a great deal of literature on the impact and treatment of childhood sexual abuse (Bagley & King, 1990; Briere & Runtz, 1988; Brunngraber, 1986). Researchers have indicated a wide number of long term effects of sexual abuse ranging from depression, anxiety and low self-esteem to sexual dysfunctions, substance abuse and self-destructive behavior (Browne & Finkelhor, 1986). In response to this new understanding of the effects of sexual abuse on its victims, clinicians have begun to focus their attention on the most effective and beneficial treatment approach for this clinical population (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Gil, 1988; Roberts & Lie, 1989). A number of treatment strategies have been examined ranging from individual to family systems therapies. Recently, group therapy approaches have emerged as an important component in the healing process of women sexually abused in childhood (Gil, 1988; Herman & Schatzow, 1985; Roberts
In this chapter, a review of the literature on childhood sexual abuse will be undertaken. The following three general areas will be addressed: 1) the long-term impact of sexual abuse on adult women; 2) an overview of treatment issues for victims of sexual abuse; and 3) a review of group treatment approaches for women sexually abused in childhood.

The literature being reviewed on the long-term effects of sexual abuse will focus on the emotional impact and the interpersonal impact of sexual abuse. Emotional impact refers to the psychological effect that the sexual abuse has had on the individual, such as depression and low self-esteem, while interpersonal impact refers to the effect of the abuse on the individual's relationship to others, such as difficulty trusting or developing intimacy with others. While it is acknowledged that there are many male victims of childhood sexual abuse, consistent with the focus of the present study, this review will be limited to female victims. In addition, as this review is limited to adult victims, the short-term or initial effects of sexual abuse will not be discussed.

Treatment approaches for victims of sexual abuse
will be reviewed in terms of their prevalence and efficacy. Common therapeutic concerns and interventions will be discussed as they pertain to the treatment of sexual abuse victims. Additionally, this chapter will include a review of group treatment approaches for women sexually abused in childhood. The rationale for this approach will be discussed. This chapter will conclude with a discussion of the limitations involved in sexual abuse research.

The Long-Term Impact of Childhood Sexual Abuse

The long-term impact of sexual abuse has been well documented in the literature (Bagley & Young, 1990; Briere & Runtz, 1988; Brunngraber, 1986; Courtois, 1979; Jackson, Calhoun, Amick, Maddever & Habif, 1990; Jehu & Gazan, 1983). Until recently, however, no conceptual framework existed which specified how and why sexual abuse is traumatic. Recognizing this gap in the literature, Finkelhor and Browne (1985; 1988) proposed a model to understand the impact of sexual abuse based on their review of the research in this area. These authors postulated that sexual abuse experiences could be analyzed in terms of four traumagenic dynamics: 1) traumatic sexualization; 2) betrayal; 3) powerlessness; and 4) stigmatization.
These authors maintain that the traumagenic dynamics, "alter children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities" (p.531).

According to Finkelhor and Browne (1985), traumatic sexualization refers to a process wherein a child's sexual feelings and attitudes are shaped by the sexual abuse in a way that is developmentally inappropriate and interpersonally dysfunctional. An example of this would be when a child is rewarded by an offender for developmentally inappropriate sexual behavior through the exchange of affection, attention and gifts for sexual behavior. As a result of this interchange, the victimized child learns that sexual behavior may be used to manipulate others into meeting her developmentally appropriate needs. Traumatic sexualization may also occur "when certain parts of a child's body are fetishized and given distorted importance and meaning" (p.531). It may also occur when the child is taught misconceptions about sexual behavior and morality by the offender. Finally, this form of trauma may occur when the child associates very frightening memories and events with sexual activity.
Finkelhor and Browne (1985) suggest that the traumatic sexualization resulting from sexual abuse may vary dramatically according to: a) the efforts of the offender to evoke a sexual response from the child; b) incidences where the child is enticed to participate; and c) the degree of understanding of the child. However, these authors conclude that all forms of traumatic sexualization result in: 1) inappropriate sexual behavior by the child; 2) confusion and misconceptions about sexual self-concept; and 3) unusual emotional associations to sexual activity.

Betrayal, as described by Finkelhor and Browne (1985), refers to the trauma resulting when a child discovers that she has been callously manipulated and harmed by a trusted person. Betrayal may also be felt when a trusted person in the child's life does not protect or believe her. Finkelhor and Browne (1985) state that "children who are disbelieved, blamed, or ostracized undoubtedly experience a greater sense of betrayal than those who are supported" (p. 532).

A third traumagenic dynamic postulated by Finkelhor and Browne (1985) is one of powerlessness or disempowerment. This refers to the process in which the child's sense of self-efficacy is continually being
diminished by repeated invasion of her body against her will. This is heightened by coercion and manipulation on the part of the offender. Powerlessness is increased when a child experiences fear and the realization that she cannot stop the abuse from happening.

The fourth and final dynamic in the traumagenic model is stigmatization. According to Finkelhor and Browne (1985), this dynamic refers to feelings of shame and guilt that accompany the experience of sexual abuse and are subsequently internalized as a part of the child’s self-image. Negative connotations may be communicated to the child by an offender who may blame or demean the victim for the sexual activity. Similarly, the enforcement of secrecy on the part of the offender "may convey powerful messages of shame and guilt" (p.533) to the child. Finkelhor and Browne (1985) suggest that stigmatization may also result from societal attitudes that deem sexual abuse as taboo. If people react with shock and horror to a child's disclosure of abuse, that child may feel additionally stigmatized and deviant.

According to Finkelhor and Browne (1985), "these four traumagenic dynamics account in our view for the
main sources of trauma in child sexual abuse" (p. 533). They suggest that while these dynamics lack narrow definitions they may be useful as broad categories for organizing and understanding the effects of sexual abuse. If healing does not occur in childhood, these dynamics may persist in an individual's adult life, resulting in a number of long-term problems.

Haugaard and Reppucci (1988) identify four areas of psychosocial functioning that may be adversely affected by sexual abuse: emotional, sexual, interpersonal, and behavioral. Based on their review of the literature, they report that negative long-term effects commonly found among sexual abuse victims include feelings of guilt and shame, depression, lack of trust, hostility and anger, difficulty in interpersonal relationships, intimacy problems and body image distortion.

Similarly, in their review of the literature Jehu and Gazan (1983) suggest that the problems associated with sexual abuse in childhood can be categorized in terms of emotional, interpersonal and sexual adjustment. These authors found that the emotional problems most commonly cited in the literature include guilt, low self-esteem, and depression. Interpersonal problems associated with sexual abuse include "feelings
of isolation, alienation, and difference from other people, together with much mistrust and insecurity" (p.73). These researchers report that the interpersonal relationships of many sexual abuse victims are characterized by transience, dissonance and a fear of intimacy. Sexually abused women often avoid or sexualize relationships and report a greater tendency toward homosexual relationships. Finally, Jehu and Gazan found that many women who were sexually abused in childhood complain of a number of sexual problems including impaired motivation, sexual phobias, vaginismus, impaired arousal and climax, dyspareunia, and sexual dissatisfaction.

In a more extensive review of the literature Browne and Finkelhor (1986) also identify four general categories of the long-term effects of sexual abuse: 1) emotional reactions and self-perceptions; 2) effects on interpersonal relating; 3) effects on sexuality; and 4) effects on social functioning. According to their review, depression is the most commonly reported emotional reaction to sexual abuse. Other reactions include symptoms of anxiety or tension, feelings of isolation and stigmatization, and low self-esteem. Interpersonal problems reported by these researchers
suggest that victims of sexual abuse experience difficulties relating to both men and women, problems relating with their parents, and difficulty parenting their own children. In addition, Browne and Finkelhor cite a number of studies reporting that victims often complain of difficulty trusting, even fearing others, of hostile feelings and a sense of betrayal. Almost all of the clinical studies reviewed by these authors cite long-term sexual difficulties among victims of sexual abuse, including more sexual guilt, less satisfaction, decreased arousal, and avoidance or abstinence from sexual activity. Finally, Browne and Finkelhor reviewed studies measuring the effect of sexual abuse on social functioning and found that victims were more likely to engage in later prostitution and substance abuse than non-victims.

In reviewing the literature for the present paper, the impact of sexual abuse will be categorized according to emotional and interpersonal impact. While sexual difficulties are commonly reported among victims of sexual abuse, sexual problems are rarely the focus of group treatment and therefore will not be extensively discussed.

Emotional Impact
Recently, researchers have become interested in the emotional impact of childhood sexual abuse on adult victims (Bagley & Young, 1990; Briere & Runtz, 1988; Gold, 1986). Bagley and Young (1990) summarize the results from an extensive study on the mental health and adaptation of adult victims of sexual abuse involving a number of community mental health studies conducted in Calgary from 1981 through 1987. Based on a random sample of 377 women, Bagley and Young report that subjects with a history of child sexual abuse indicated higher levels of depression than women with no abuse history. In addition, abuse victims reported lower self-esteem than non-victims.

Similarly, Stein, Golding, Siegel, Burnam and Sorenson (1988) conducted an extensive epidemiological study of the long-term psychological effects of child sexual abuse among Los Angeles residents. These authors examined the incidence and prevalence of 15 psychological symptoms and 11 psychiatric disorders associated with child sexual abuse in a representative community sample of 3,132 adults from two Los Angeles areas. Participants in this survey were individually interviewed and asked if they had been sexually abused in childhood. The respondents who reported abuse were
then asked about their emotional and behavioral reactions to the abuse. In addition, the NIMH Diagnostic Interview Schedule was employed to assess the prevalence of a number of psychiatric disorders based on the Diagnostic and Statistical Manual (DSM-III) criteria (American Psychiatric Association, 1980).

Results of this survey indicated that over 75% of the respondents who reported sexual abuse in childhood had experienced at least one of the psychological symptoms studied; the most common of which were anxiety, anger, guilt and depression. Other reported symptoms included increased substance use, appetite disturbance, and fear of being alone. Similarly, respondents who had been sexually abused reported higher rates of psychiatric disorders than non-abused respondents, including a higher prevalence of substance abuse, affective disorders, anxiety and panic disorders, major depressive episodes, phobias, and antisocial personality disorders.

Gold (1986) also examined the impact of sexual abuse on adult functioning. In this study, 103 women who had been sexually abused in childhood and 88 women who had not been abused were asked to complete a
battery of instruments designed to assess the participants' present level of functioning. In addition, participants were asked to complete a number of measures designed to assess attributional style. Women who had been sexually abused in childhood were also interviewed about their victimization experiences. Results of this study indicate that women who had been sexually abused in childhood reported higher levels of depression, more psychiatric symptoms and lower self-esteem than women who were not abused.

In another study examining the incidence and long-term effects of childhood sexual abuse on a non-clinical sample of women, Briere and Runtz (1988) administered a "Family Experiences Questionnaire" to 278 female undergraduate students ranging in age from 17 to 40 years. The questionnaire consisted of a variety of items and scales, including a modified version of Finkelhor's survey of childhood experiences, and two versions of the Hopkins Symptom Checklist. Of the 278 participants in this study, 41 (14.7%) reported a history of childhood sexual abuse.

Results of this study suggest that there are a number of significant psychological effects associated with sexual abuse in a non-clinical sample of women.
When compared with non-abused women, the women with a history of sexual abuse reported higher levels of acute and chronic dissociation and somatization, as well as higher levels of anxiety and depression. The authors of this study suggest that these results are especially significant as they were found among a non-clinical sample of university women and "the university screening process may require a certain minimal level of general functioning" (p. 54).

Jackson, Calhoun, Amick, Maddever and Habif (1990) examined how childhood sexual abuse affects subsequent adjustment in young adult women. Twenty-two women who reported sexual abuse by a family member were compared with 18 non-abused women on measures of interpersonal and sexual functioning, self-esteem, and emotional adjustment. Participants in this study completed an extensive battery of self-report assessment instruments. In addition, women who had reported abuse participated in a one hour semi-structured interview containing questions regarding the abusive experience(s), demographic information, family characteristics, traumatic life experiences, and social and psychological adjustment. Results indicated that women sexually abused in childhood reported
significantly greater adjustment difficulties than their non-abused peers, including higher levels of depression, lower self-esteem, poorer body images, less sexual functioning satisfaction, and poorer social and interpersonal adjustment.

In an investigation of the immediate and long-term effects of sexual abuse, Brunngraber (1986) administered the Modified Incest Questionnaire (MIQ) to a sample of 21 women who had been sexually abused by their fathers in childhood. Each participant in this study was individually interviewed using the MIQ which includes information on demographics, nuclear and extended family history, the participant's sense of self and sexual knowledge prior to the abuse, specific details of the abuse and its aftermath, and information regarding the types and severity of the immediate and long-term effects of the abuse.

Results of this study indicate that the women who had experienced sexual abuse reported a number of negative aftereffects including feeling isolated and different from others, less worthy than peers, distrustful and confused. Feelings of shame, guilt and worthlessness predominated and these women commonly reported an extremely negative self-image and low
self-esteem. In addition, when asked to rate the overall psychological impact of the abuse on a five-point scale from positive to negative, 80.9% of the participants rated it in the negative direction.

Based on their clinical observations in their work with therapy groups for women sexually abused in childhood, Tsai and Wagner (1978) cite a number of long-term effects of sexual abuse including guilt, negative self-image and depression. Reporting on ten therapy groups comprising a sample of 50 women these authors state that guilt "was universally experienced by the group participants" (p.421) and was related to three factors. First, the victim was pressured to keep the abuse secret thus conveying the message that she should be ashamed of the experiences. Second, the victim experienced physical pleasure during the abusive episodes despite her repugnance of the acts. Third, the victim felt guilty for not stopping the abuse sooner as the average duration of the abuse was 4.6 years. In addition to these findings, Tsai and Wagner report that feelings of worthlessness and depression were extremely common and highly correlated with guilt. They maintain that these feelings "are lessened as the guilt is reduced and eliminated" (p.422).
In summarizing the results of the literature on the long-term impact of childhood sexual abuse, a number of emotional concerns are commonly cited as resulting from the abuse experiences. Studies consistently report such negative effects as low self-esteem, depression, guilt, anger, anxiety, feelings of worthlessness, and self-loathing including distorted body image. The fact that these negative effects are so lasting among sexual abuse victims has led some researchers to stress the need for further research in this area to help determine what factors may contribute to the development and, ultimately, the treatment of these problems (Browne & Finkelhor, 1986; Brunngraber, 1986).

Interpersonal Impact

In addition to the studies citing the long-term emotional impact of sexual abuse, clinicians and researchers have indicated a variety of interpersonal problems associated with such abuse (Courtois & Watts, 1982; Herman, 1981; Meiselman, 1978; Tsai & Wagner, 1978). Based on her clinical work with a sample of 26 women who had been sexually abused by their fathers and a control group of non-abused women, Meiselman (1978) reports that 64% of the victims and 46% of the controls expressed conflict with or fear of their husbands or
partners. Jackson et al.'s (1990) study of 22 abused and 18 non-abused women, indicates that the abused women reported significantly more difficulty in dating and social activities and more psychological and/or social dysfunction than the non-abused women.

Tsai and Wagner (1978) conducted ten therapy groups for women sexually abused in childhood. Of the 50 women in their sample, the majority reported problems in interpersonal relationships stemming from such factors as a mistrust of men, inadequate social skills and feelings of isolation, compulsive involvement with abusive men, and sexual dysfunction.

Based on their review of clinical work conducted with adult women who were sexually abused in childhood, Courtois and Watts (1982) suggest that sexual abuse often results in a number of concerns pertaining to relationships. According to these authors, these relationship problems can be categorized according to: 1) relationships in general; 2) marital relationships; and 3) parental relationships (either with their own parents, or their children). These authors state that:

Relationships in general are often described as empty, superficial, conflictual, or sexualized. The inability to trust is pronounced. Good or
pleasurable relationships often increase guilt and shame because they are viewed as undeserved or impossible (p.276).

Similarly, based on her clinical experience with 40 adult women who had been sexually abused by their fathers, Herman (1981) maintains that interpersonal problems are common. She states that "all, without exception, felt somehow branded or marked by their experiences" (p.96), and that the most common complaint of the women in her sample was "a feeling of being set apart from other people" (p.96). A marked feeling of isolation compounded by difficulty in developing trusting relationships was commonly reported by the women in this study. According to Herman:

The legacy of their childhood was a feeling of having been profoundly betrayed by both parents. As a result, they came to expect abuse and disappointment in all intimate relationships...At the same time that these women had little hope of attaining a rewarding relationship with anyone, they desperately longed for the nurturance and care which they had not received in childhood (p.100-101).

Upon interviewing 22 women who reported childhood
sexual abuse, Jehu, Gazan and Klassen (1985) identified a number of interpersonal problems associated with abuse. These problems were categorized according to: 1) general social relationships; 2) relationships with men; 3) relationships with a partner; and 4) relationships with women. The majority of the women interviewed in this study reported problems in the realm of general social relationships including limited social skills (82%), feeling different from others (82%), mistrust of others (73%), insecurity in relationships (73%) and feeling isolated or alienated from others (50%).

When asked about their relationships with men, over three quarters (77%) of the women reported a fear of intimate relationships with men, and over half (59%) of the women expressed a general fear of men. Similarly, almost half (46%) of the women interviewed expressed feelings of anger and hostility toward men while approximately one third (36%) reported anger and hostility towards women. Finally, of the women who were married or living with a partner, all reported discord in their relationships, and almost half (44%) reported oppression and/or physical abuse by their partners.
Brunngraber (1986) interviewed 21 women with a history of child sexual abuse and found that most of them experienced marked to severe social difficulties including feeling different from others, difficulty making friends, feeling inferior to others, and feeling insecure in social situations. The majority of the women in this study reported difficulties in their relationships with men. Predominant reactions to men included hostile feelings, distrust, avoidance of emotional or physical relationships, and sexual dysfunction. Few women in this study reported problems in their relationships with other women, although some reported difficulty in establishing close female relationships.

Upon reviewing the literature on the long-term effects of childhood sexual abuse, it seems clear that the impact of such abuse is negative and lasting. In summary, sexual abuse has been linked to a number of emotional and interpersonal problems ranging from depression, low self-esteem and guilt to conflict in relationships, isolation and stigmatization. Few clinicians working in this area dispute the far-reaching negative effects that childhood sexual abuse has on its victims. Consequently, the
development and evaluation of treatment programs for victims of sexual abuse is of primary concern to many researchers and clinicians. In the following section, the literature on the treatment of adult victims of sexual abuse will be reviewed.

Treatment

As we gain more knowledge of the long-term impact of sexual abuse, increasing attention is being paid to the issue of treatment. While treatment approaches for child victims of sexual abuse abound (Blick & Porter, 1982; Delson & Clark, 1981; Hazzard, King & Webb, 1986), less has been written about specific treatment programs for the adult victim. Clinicians have identified two main forms of therapeutic intervention for the adult victim of childhood sexual abuse: individual treatment and group treatment (Courtois & Watts, 1982; Haugaard & Repucci, 1988). To date, treatment has been strongly influenced by the individual therapist’s own theoretical orientation (Giaretto, 1978; Jehu, Klassen & Gazan, 1985). Regardless of their theoretical beliefs, many clinicians suggest that in order to adequately treat victims of sexual abuse, a number of basic therapeutic issues such as resistance to therapy and developing a
trusting relationship, must be addressed (Bass & Davis, 1988; Courtois & Sprei, 1988; Courtois & Watts, 1982; Faria & Belohlavek, 1984; Maltz & Holman, 1987).

**Common Therapeutic Issues**

Women who have been sexually abused in childhood often present a number of issues and dynamics in both individual and group therapy. Courtois and Sprei (1988) believe that it is vital for the therapist working individually with victims of sexual abuse to be aware of these dynamics as they are presented in therapy. These authors maintain that the therapist must understand and be able to interpret transference and countertransference reactions such as "trust/betrayal; negative self-concept; shame and stigmatization; guilt and complicity; loss and mourning; control and power; conflicted and ambivalent feelings; and defenses and survivor skills" (p.290). Similarly, Bergart (1986) believes that transference issues are common when working with sexually abused clients. She suggests that the primary form of transference that clients enact with a female therapist is maternal. According to Bergart (1986), clients may view the therapist as they viewed their own mothers in childhood, and this transference must be interpreted
and processed in order to help clients work through these unresolved feelings.  

Courtois and Sprei (1988) believe that sexual abuse victims have had their trust in others jeopardized and have experienced profound betrayal at many levels through their abuse experiences. According to these authors, sexual abuse victims "will bring this lack of trust to therapy, making the development of a therapeutic alliance a slow and difficult task" (p.290). As a result of this dynamic, Courtois and Sprei suggest that the therapist working with victims of sexual abuse should not assume that trust will develop quickly, even with compliant clients, as crises in trust may surface as the client begins to process the abuse issues more deeply. Similarly, Westerlund (1983) believes that issues of trust must always be considered in the treatment of sexual abuse victims. If trust issues are not addressed, Westerlund feels that a therapeutic relationship cannot be achieved.

Maltz and Holman (1987) maintain that in order for incest resolution to occur, it is important for the therapist to build a strong rapport with the client. According to these authors, "The survivor needs to feel that the therapist is present, listening fully to
her, and trustworthy" (p.124). Courtois & Sprei (1988) feel that a negative self-concept and feelings of isolation and differentness from others may prevent the client from accepting positive regard or caring from the therapist. As a result the client may try to sabotage the therapeutic relationship if the therapist does not closely monitor and process these dynamics.

Courtois and Sprei (1988) maintain that many victims possess an overdeveloped awareness of the reactions and feelings of others. While this dynamic was originally developed in order to survive the sexual abuse, these authors believe that the client may misattribute the responses of the therapist to herself, often by assuming that she has done something to displease the therapist.

Ambivalent feelings of love and hate toward the abuser may also become an issue in therapy, especially if the therapist places too much blame on the perpetrator or expresses anger about the abuse before the client is ready (Maltz & Holman, 1987). Additionally, the relationship of the client with her abuser must be understood as Courtois and Sprei (1988) believe that the client may assume the role of the "parentified child" in therapy by being overly
compliant and by negating her own needs. Accordingly, the therapeutic relationship must be carefully monitored with special attention being paid to preparing clients for any changes in therapy, such as absences and terminations.

Westerlund (1984) suggests that power issues may arise when working with sexually abused clients and can best be dealt with by assuming a non-directive approach and giving control to the client. Westerlund believes that the client may feel attacked if the therapist assumes a confrontational approach. According to this author, "Women with histories of family sexual abuse are extremely sensitive to intrusiveness and need to have their boundaries respected" (p. 25). Courtois and Sprei (1988) maintain that victims of sexual abuse rarely experienced feelings of control and power in childhood, therefore they often arise as issues in therapy. These authors believe that power issues arise as clients begin to exert control in therapy through such means as missing or being late for appointments, silence, or nonpayment of fees. They feel that it is therefore essential for the therapist to set boundaries and limits in therapy.

Finally, Courtois and Sprei (1988) identify a number
of defenses which operate in therapy with victims of sexual abuse such as denial, repression, minimization, projection, and dissociation. They believe that it is crucial for the therapist to understand that these defenses are coping strategies and to be able to convey this to the client.

In summary, issues in the individual treatment of women sexually abused in childhood range from lack of trust and negative self-concept to repression, denial and control. Similarly, group treatment often raises a number of issues that must be recognized and understood by the group facilitators (Bergart, 1986; Courtois & Sprei, 1988; Deighton & McPeek, 1985; Gil, 1988; Haller & Alter-Reid, 1986; Hays, 1987).

Gil (1988) identifies a number of important issues that are common among groups for women who have been sexually abused in childhood. The first of these issues is resistance, as group members may feel the need to protect themselves from the judgements of others. Gil feels that some women may be afraid of negative reactions from the group, or feel that the concerns of other members are more urgent than their own concerns. Additionally, victims of sexual abuse often doubt their own memories of the abuse experiences
and therefore may hesitate to share their memories with the group. Resistance may also occur in the form of tardiness, missing sessions and refusing or forgetting to complete assignments. In addition, Gil (1988) points out that at times the group may participate in a collective resistance by mutually avoiding the expression of feelings, specific topics and intense emotions.

According to Gil (1988), open hostility and threatening behavior may surface in group treatment, resulting in the withdrawal of other group members and an inability to feel safe. Gil stresses that women who have been sexually abused in childhood have a need for safety in a group and the facilitator(s) must be able to model protective behavior if and when open hostility is expressed. Goodman and Nowak-Scibelli (1985) also found that issues of anger arise in their groups for sexually abused women. These authors found that on occasion, anger will arise between group members and they stress the need to process these feelings in terms of how they relate to the members' interactions with their families of origins.

Another issue which may arise in group treatment is when a group member monopolizes group time. Gil (1988)
believes that this may occur if the group member has problems with boundaries and control, as a result of the abuse. In addition, she feels that some people who talk incessantly may be avoiding their feelings or the discomfort of silence. Gil maintains that the group facilitators must make an attempt to contain the group member who is monopolizing time.

Conversely, Gil (1988) suggests that some group members may be terrified of receiving group time, as they are not accustomed to being seen or heard. These members may try to avoid attention by remaining silent or sharing very little with the group. Gil points out that occasionally a group member may in fact become an elective mute. Again, Gil stresses the need for facilitators to process these issues with the group members. Deighton and McPeek (1985) report similar issues as they found that many women in group treatment tended to "reinforce their own feelings of isolation...by maintaining the family secret" (p.406).

Finally, Gil (1988) suggests that one or more group members may repeatedly elicit rejection from other group members. She feels that this is related to the sexual abuse, as people who fear or anticipate rejection may encourage it to happen in order to
relieve their feelings of anxiety. In a similar but often more destructive vein, Courtois and Sprei (1988) believe that some group members may project their own feelings of self-hatred onto the other group members. Again, these authors feel that these issues must be closely monitored and processed by the facilitators. Other issues that may arise for an individual in group treatment include, feeling too threatened due to shame, secrecy, denial, and mistrust; fear of losing control or going crazy; and feeling unable or unworthy of receiving help from other victims (Courtois & Sprei, 1988; Haller & Alter-Reid, 1986; Hays, 1987).

It is clear that many dynamics are present when working with sexually abused clients, in both individual and group therapy (Courtois & Sprei, 1988; Deighton & McPeek, 1985; Gil, 1988; Goodman & Nowak-Scibelli, 1985). Clinicians must be aware of these issues when designing a treatment program for sexually abused clients. A number of treatment approaches will now be discussed for both individual and group therapy.

**Individual and Group Treatment Approaches**

Faria and Belohlavek (1984) outline a treatment approach for female victims of childhood incest based
on their work in this area. They maintain that treatment must begin with identifying adult incest victims through questioning and an awareness of the indicators of abuse. These authors suggest that when working with incest victims therapists should operate from a special frame of reference involving: 1) desexualizing the incest experience; 2) believing the victim's account of the abuse; 3) recognizing that the incest should not be treated as a crisis as it happened years ago; 4) responding to the client with empathy and sensitivity; 5) learning the necessary details of the abuse at an appropriate pace; and 6) finding outlets for the therapist's own reactions to the intensity of the client's emotions.

These authors outline the following eight treatment goals for working with incest victims: 1) establishing a commitment to the therapeutic process; 2) identifying old patterns by which the client flees from relationships; 3) developing a mutual working relationship; 4) building the client's self-esteem about surviving the incest; 5) developing the constructive expression of anger; 6) helping the client to identify and gain control over self-destructive and self-defeating behaviors; 7) networking with other
support systems and developing other meaningful relationships; and 8) increasing self-esteem through improving body image and understanding human sexual response. Throughout the therapy process Faria and Belohlavek (1984) suggest using tools such as letter writing and journal keeping to help the client keep track of thoughts and feelings between therapy sessions. They believe that principles from a variety of therapies such as cognitive and gestalt therapy, psychodrama, dream work, and hypnosis may be incorporated into treatment.

Based upon their extensive work with sexual abuse victims, Bass and Davis (1988) provide a number of guidelines for mental health professionals working in this area. They maintain that effective treatment of sexual abuse victims must begin with a belief that healing is possible, a willingness to witness great pain and a willingness to believe the unbelievable. In addition, these authors stress the need for therapists to remain nonjudgmental and client-centered. They maintain that the clients' needs must be validated and their stories believed by the therapist in order to work through feelings of guilt and shame. They state that "when children are abused, their power is taken
away. It's essential not to duplicate that dynamic in the counseling setting" (p.346).

Maltz and Holman (1987) outline a model of incest resolution therapy that can occur in individual or group settings. They maintain that incest resolution therapy must encompass a variety of therapeutic interventions designed to help victims process their feelings about the abuse. These interventions include helping the client tell her story, reframing, developing communication skills, rational emotive therapy, visualizations and affirmations, and journal writing. Maltz and Holman stress that in order to be effective with these interventions, the therapist must build a strong rapport with the client. They suggest that the cornerstone of all therapeutic interventions is an emphasis on helping the client to identify and use her own personal power. These authors state that:

While maintaining a supportive, nurturing relationship to the survivor, the therapist must be able to encourage the survivor's own expression of assertive strength and action. Healthy therapist-survivor relationships are indicated when (1) survivors feel free to take the lead in suggesting problem areas that they want to address, (2)
survivors feel comfortable to express feelings such as confusion, anger, and appreciation to the therapist, and (3) survivors feel that their own opinions, judgements, and ideas are as worthy of expression and discussion as those of the therapist (p.124).

Regardless of the therapeutic approach taken, Maltz and Holman (1987) believe that incest resolution therapy is usually long-term, ranging from one to several years depending on the individual and her needs.

Forward and Buck (1978) identify three goals for working with victims of sexual abuse: 1) externalizing guilt, rage, shame, fear and confusion; 2) placing responsibility on the adult, where it belongs; and 3) teaching the client that she does not have to be psychologically crippled for the rest of her life. They believe that these goals can only be pursued if the client has a strong commitment to treatment and a willingness to face the abusive experiences and break the lifelong pattern of silence and secrecy.

Meiselman (1978) identifies several treatment goals based on her clinical sample of 58 women who experienced incest in childhood. She believes that therapy must involve an opportunity for cathartic
release for the client as well as reassurance that she was not to blame for the abuse. Meiselman stresses the importance of helping the adult client to assume responsibility for her present behavior, regardless of the abusive experiences in her past. In addition, Meiselman maintains that the goals of therapy should be the same for all schools of therapy, and should include facilitating the development of competence, assertiveness, personal responsibility, and satisfactory sexual functioning.

Courtois and Sprei (1988) list the following goals for retrospective incest therapy: 1) establishment of a therapeutic alliance; 2) acknowledgement and acceptance of the occurrence of the abuse; 3) exploration of the issues of responsibility and complicity; 4) breakdown of feelings of isolation; 5) recognition, labeling and expression of feelings; 6) catharsis and grieving; 7) cognitive restructuring of faulty beliefs; 8) insight and behavioral change; 9) education and information-giving; and 10) separation and individuation. Due to its reparative nature, Courtois and Sprei believe that therapy with incest victims is long-term, often taking years to complete. Consequently, these authors stress the need to pace the
interventions and interpretations of therapy, with constant attention to the emotional reactions of the client to the material being covered.

In summary, treatment approaches for adults sexually abused in childhood range from believing and validating that the abuse occurred to facilitating the expression of intense emotions and providing new ways of coping with the memories of the abuse. While treatment methods may vary it is generally believed that both individual and group therapy approaches are essential for adequate resolution of issues stemming from child sexual abuse (Courtois & Watts, 1982; Gil, 1988; Haugaard & Repucci, 1988). According to Haugaard and Reppucci (1982), individual therapy is often used as the first step in the therapeutic process. These authors state that "through individual therapy, the client can be introduced to the therapeutic process, issues of immediate concern can be addressed, and the client can be prepared for subsequent forms of therapy" (p. 259). Most commonly, group therapy is recommended to accompany individual treatment, either concurrently or consecutively (Courtois & Sprei, 1988; Gil, 1988). In the following section of this chapter, the literature outlining group treatment approaches will be
reviewed in greater depth and the rationale for using this intervention strategy will be discussed.

**Group Therapy**

Group therapy is a growing form of treatment for victims of sexual abuse. Forseth and Brown (1981) surveyed 36 incest treatment programs and therapists and found that group therapy was cited most often as the preferred form of treatment for both victims and perpetrators of sexual abuse. Many clinicians believe that group therapy is essential for effective resolution of the issues of secrecy, shame and guilt that are associated with sexual abuse, as well as providing an avenue for breaking the victim's sense of isolation and differentness (Courtois & Sprei, 1988; Gil, 1988; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Tsai & Wagner, 1978).

**Rationale**

Yalom (1985) identifies eleven primary factors that make up the therapeutic experience of groups: instillation of hope, universality of experience, imparting of information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis
and existential factors. He believes that these factors exist in varying degrees in all group therapy approaches and contribute to the therapeutic efficacy of this form of treatment. Recently, clinicians have come to recognize that these therapeutic factors may have special relevance in therapy groups for victims of sexual abuse (Bonney, Randall & Cleveland, 1986; Roberts & Lie, 1989).

Forward and Buck (1978) recommend group therapy as the treatment of choice for sexual abuse victims due to the supportiveness of the group and the opportunity for victims to identify with others who experienced abuse. Meiselman (1978) believes that self-help groups contribute to the development of feelings of competence, assertiveness and personal responsibility among victims of sexual abuse. Courtois and Sprei (1988) concur that group therapy provides an opportunity for members to gain new perspectives on their experiences and helps them to externalize responsibility for the abuse.

Gil (1988) sees group therapy as essential for minimizing the adult victim's feelings of freakishness. She believes that involvement in a group experience allows victims to associate with others of similar
background and helps them to feel more normal and less responsible for the abuse. Gil maintains that group therapy provides an opportunity for individuals to receive positive feedback and to develop feelings of trust.

Hays (1987) believes that group therapy is uniquely suited to address the issues of interpersonal distrust and isolation endemic to the experience of incest. According to Hays, groups foster the personal empowerment of the incest victim by allowing her to validate her own experience and coping skills, overcome a history of learned helplessness, increase self-acceptance, develop new skills and supports and take a more active stance in her familial relationships.

Clearly, many clinicians agree that group treatment is an important component of the healing process for women sexually abused in childhood (Courtois & Sprei, 1988; Forward & Buck, 1978; Gil, 1988; Hays, 1987). The most commonly cited reason for recommending group treatment is to reduce the profound sense of isolation and shame that many victims of sexual abuse experience on a daily basis. As clinicians have become increasingly supportive of group treatment, new
programs have been developed. A description of a number of group treatment approaches as outlined in the literature will be discussed in the following section.

**Group Treatment Programs**

In a pioneering study on therapy groups for women sexually molested in childhood, Tsai and Wagner (1978) conducted ten groups comprising a total sample of 50 women. Each group consisted of four to six members and was limited to four weekly or biweekly sessions, lasting 1 1/2 hours per session. The first sessions began with introductions and the confidential nature of the groups was stressed. The women were then requested to discuss their sexual abuse experiences in detail. According to the authors, this task was often the most difficult for the group members, but was necessary for breaking the silence of the abuse and allowing the leaders and fellow group members to help deal with the problem. The emotional responses of members to these detailed disclosures were then discussed and debriefed.

The second and third sessions usually focused on the emotional and behavioral repercussions of the abuse, including the effect on interpersonal relationships and sexual functioning. Tsai and Wagner (1978) note that as a result of these sessions, many
group members became more depressed as more detailed memories of the abuse surfaced and they became preoccupied with the molestation experiences.

The final sessions outlined in this study dealt with any remaining unresolved issues. The authors found that the topics raised by the participants in these final sessions often included how to prevent their own children from being molested, individual stages of recovery and further treatment plans. Feedback concerning the group experience as a whole was elicited and referrals to individual therapists were made in these final sessions.

After the termination of each group, participants were asked to complete a six-month follow-up questionnaire evaluating the group experience. Tsai and Wagner cite results for the first six groups comprising a sample of 23 women. Using a Likert-type scale, participants were asked to rate the overall helpfulness of the group experience, their feelings of guilt and self-acceptance, their feelings toward the molester, their current relationships, and to comment on any other changes resulting from the group experience.

Results of this study indicate that members felt
the group experience played a major role in minimizing the negative effects of the abuse for all of the participants. The reduction of guilt feelings and increased self-esteem were found to be the most therapeutic outcomes of the group experience. According to Tsai and Wagner (1978), this preliminary evidence "suggests that short-term group therapy is profoundly effective in the alleviation of guilt and the palliation of other long-range consequences of childhood molestation" (p.426). However, these authors failed to provide information on whether group members had received individual treatment prior to or concurrently with group treatment making it difficult to clearly attribute their results to the group experience.

Responding to a need for published descriptions of sexual abuse therapy groups, Herman and Schatzow (1984) outline an empirically developed model of time-limited group treatment for incest victims. Twenty-eight women who reported incestuous abuse in childhood participated in 5 groups comprised of 5 to 7 members and 2 co-therapists. Criteria for selection in these groups included an expression of positive feelings about participating in the group with other incest victims, a
reasonable level of day-to-day functioning, and ongoing individual therapy. Herman and Schatzow selected a short-term group therapy model, meeting once a week for 10 weeks. Each session lasted 1 1/2 hours. These authors believe that the pressure of this time limit was necessary in order to facilitate bonding among group members and to reduce resistance to the disclosure of abusive experiences.

The first session in this model focused on introductions of the members to each other and setting ground rules for the group. Sessions two through five consisted of goal definition and disclosure. During these sessions, members were asked to share their personal goals with the group. These goals fell into four categories: the recovery of memories, improved relationships, improved self-esteem, and disclosing the incest experience with a close friend or family member. In addition, group members were encouraged to share their abuse experiences in greater detail. The authors found that this sharing increased the group's cohesiveness.

The sixth through ninth sessions concentrated on encouraging group members to achieve their personal goals. Much time was spent helping individual members
prepare and plan disclosures and other actions that they wished to take. Herman and Schatzow (1984) report that the sharing of successful disclosures and the realization of other goals by individual group members served as a catalyst for more reluctant members to take action. The tenth and final session in this therapy model focused on the issue of termination and feedback.

Approximately 6 months following termination group members were asked to complete an evaluative questionnaire asking them to report what they liked best and least about the group, suggestions for improvement, and personal gains from their involvement in the group. Of the 20 women who returned the questionnaire, all deemed the contact with other incest victims as the most helpful aspect of the group. In addition, the majority of the women reported feeling better about themselves, less ashamed and guilty, less isolated and better able to protect themselves. Based on the results of this follow-up survey, Herman and Schatzow maintain that group therapy is uniquely effective in alleviating feelings of shame, secrecy and stigmatization associated with incest. However, it is unclear as to how the 8 women who did not return the questionnaire felt about their group experience.
Goodman and Nowak-Scibelli (1985) outline a time-limited, structured group treatment approach for women incestuously abused as children, based on their work in a Massachusetts Incest Treatment Program. The group format outlined in this model involved meeting for 1 1/2 hours a week for a duration of 12 weeks. No more than 8 members were admitted to a group and all members met certain criteria including ongoing involvement in individual therapy.

According to these authors, the therapy groups typically proceeded through a number of group stages. The beginning stage of treatment was characterized by high anxiety among group members and the fear that they will be unable to talk in the group. The middle stage of treatment focussed on the details of the abuse and was characterized by strong emotions such as depression, loss and anger. The final stage of treatment was considered the most difficult by these authors as it focussed on termination. Goodman and Nowak-Scibelli (1985) believe that during this stage group members must be allowed to grieve the loss of the group and to express angry feelings toward the group leaders. However, they feel that this natural expression of anger must be balanced with a focus on
the changes made by the group members throughout the course of therapy.

Based on their group facilitation experience, Goodman and Nowak-Scibelli conclude that short-term therapy groups are useful in meeting the unique needs of incest victims. They believe that these groups allow victims to acknowledge that other women were not to blame for the abuse and therefore to recognize their own innocence. However, these authors failed to report on whether any formal assessment of the group treatment program was completed by group members, making it difficult to conclude that the groups were meeting the needs of these women.

Gil (1988) offers a description of a time-limited group therapy approach based on her clinical experience. She suggests guidelines for a 12 week support group for adult survivors of childhood sexual abuse, including scheduling a check-in time for each group session, discussing specific topics of concern to group members, conducting a closing exercise after each session, and providing homework for group members. According to Gil, the initial sessions of this group treatment model are spent prioritizing individual and group goals and establishing group rules. The middle
sessions may focus on specific topics such as self-image, self-esteem and trust, while later sessions focus on developing group intimacy and cohesion, and recounting the abuse experiences.

Gil (1988) stresses the importance of providing an opportunity for all group members to disclose their abuse experiences to the group, while allowing them to say as much or as little about the abuse as they deem necessary. The final sessions in this group therapy model focus on termination, review and feedback. According to Gil, group members should be encouraged to discuss separation, loss and endings of all kinds. In addition, she feels that group members must be given the chance to review what they have achieved from their participation in the group and to set goals for their future.

Roberts and Lie (1989) evaluated an empirically-based group therapy model for adult survivors of childhood incest. Participants in this study were 53 women who were assigned to one of 9 therapy groups offered by a Rape Crisis Center in Wisconsin over a 14 month period. It is unknown if these women had received previous individual treatment for sexual abuse issues. Membership for each group
varied between 5 and 6 members, with 2 co-therapists. During the intake and assessment process, demographic information was gained through a self-administered structured questionnaire. In the first session, group members were asked to complete a pretest evaluation package comprised of the Beck Depression Inventory (BDI), and an experimenter-generated Self-Assessment Scale (SAS) designed to measure overall psychosocial, physical and sexual functioning.

The initial stages of this group model focussed on increasing self-awareness and promoting trust among group members. Later stages focussed primarily on "reclaiming the inner child", disclosure of the abuse and ventillation of the strong emotions accompanying the memories of the abuse. The final session was devoted to termination, reflection and evaluation. Group members were asked to complete the BDI and the SAS as well as a Group Dynamics Evaluation Scale designed to evaluate the impact of curative factors of the group on individual outcomes.

Results of this study suggest that participants in the group treatment approach outlined by Roberts and Lie (1989) reported significantly lower levels of depression and improved self-assessment. In addition,
the lowered levels of depression were maintained at a six-month follow-up. While this study offers data on the outcomes of one group treatment approach, it fails to provide a contrast group making it difficult to determine if the outcomes were due to the treatment effects or other factors.

In summary, the literature on group therapy programs for adult victims of child sexual abuse indicates that this form of treatment appears to play an important role in alleviating a variety of symptoms associated with sexual abuse. In particular, group treatment is believed to facilitate healing for sexual abuse victims by: 1) alleviating feelings of guilt and shame; 2) minimizing the sense of isolation and stigmatization; 3) improving self-esteem; 4) reducing depression and internalized anger; and 5) improving the quality of interpersonal relationships (Gil, 1988; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Roberts & Lie, 1989; Tsai & Wagner, 1978).

While many clinicians strongly support the use of group treatment for sexual abuse victims, the literature evaluating the effectiveness of such groups is sparse and often suffers from methodological difficulties such as small sample sizes, the lack of
comparison groups and standardized instruments, and inadequate information on treatment history. The following section consists of a summary of the research on sexual abuse as well as a discussion of its limitations.

Summary and Limitations

Upon reviewing the literature on the impact and treatment of sexual abuse, a number of points emerge. Repeatedly, studies have indicated that sexual abuse in childhood can have a negative impact on its victims that is extensive and enduring. The experience of adult victims of childhood sexual abuse is often characterized by depression, low self-esteem, and feelings of guilt. Difficulties in interpersonal relationships due to hostility toward others, a pervasive lack of trust and a fear of intimacy are also common among sexual abuse victims. Studies have indicated that victims feel a profound sense of isolation and differentness from their peers, adding to their feelings of worthlessness and shame. Self-loathing, body image distortion and low self-esteem are also commonly cited among adult sexual abuse victims.

Clinicians have noted that as the taboo surrounding
the discussion of sexual abuse weakens, increasing numbers of sexually abused women are seeking treatment. As the demand for treatment increases, the need for the development of effective therapeutic intervention also increases. Researchers have begun to focus their attention on documenting and evaluating treatment approaches for this clinical population. Recently, group therapy has emerged as an important component in the treatment of women sexually abused in childhood due to its unique ability to combat the isolation and shame that so often accompanies the sexual abuse experience.

While sexual abuse research is expanding, a number of methodological difficulties must be considered when reviewing the literature in this area. Much of the research on the treatment of sexual abuse victims purport successful outcomes while failing to provide adequate information on the treatment history of the group participants (Deighton & McPeek, 1985; Goodman & Nowak-Scibelli; Gordy, 1983; Hays, 1987; Herman & Schatzow, 1984). For much of the research reviewed, it is often unclear as to whether the subjects in these studies had received prior individual or group treatment for sexual abuse issues which may have confounded the results. Furthermore, information
regarding the nature and extent of abuse experienced by the group participants and demographic information is often not provided, making generalizations of the findings difficult. In many cases, a clear working definition of sexual abuse is not provided, again hampering the generalizability of the findings.

While the literature describing group therapy programs for victims of sexual abuse has increased in recent years, little research has been conducted evaluating the effectiveness of such programs. Several studies claiming to provide evidence of the effectiveness of their group treatment programs have relied exclusively on post-treatment evaluations and have failed to provide adequate assessment data such as pre-to post-test information (Deighton & McPeek, 1985; Goodman & Nowak-Scibelli, 1985; Gordy, 1983; Haller & Alter-Reid, 1986; Hays, 1987; Herman & Schatzow, 1984; Tsai & Wagner, 1978). Furthermore, none of these studies provided comparison groups to support their claims that group treatment contributed to the changes in the symptoms of their clients. To date, only one study evaluating the effectiveness of group treatment for women sexually abused in childhood has provided a contrast group to validate their findings (Alexander,
Neimeyer, Follette, Moore & Harter, 1989).

In addition to not providing comparison groups, many studies exhibit further methodological problems that hamper the validity of their findings. There has been a noticeable lack of the use of standardized measures in sexual abuse research (Deighton & McPeek, 1985; Goodman & Nowak-Scibelli, 1985; Gordy, 1983; Haller & Alter-Reid, 1986; Hays, 1987; Herman & Schatzow, 1984; Tsai & Wagner, 1978). Most of the studies reviewed used subjective, non-standardized measurements of the variables in question. While some studies have employed standardized measures (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Roberts & Lie, 1989) Browne and Finkelhor (1986) that these instruments may not have measured factors directly related to the abuse. This has led these and other researchers to call for the development of instruments designed specifically to measure the impact of childhood sexual abuse on its victims (Asher, 1988; Browne & Finkelhor, 1986).

To date, there is only one controlled study evaluating the effectiveness of group treatment approaches (Alexander, Neimeyer, Follette, Moore & Harter, 1989). Alexander and her associates (1989)
randomly assigned 65 women who had been abused by a father, stepfather, or other close relative to one of three treatment conditions. The first treatment condition was an interpersonal transaction group which involved dyadic interaction and disclosure among group members focusing on issues that are common to incest survivors. The second treatment condition was a process group format which followed Yalom's (1985) guidelines for group interaction and personal sharing. Finally, there was a control condition which consisted of women on a wait list.

Using a pretreatment-posttreatment design, as well as a six month follow-up, Alexander et al. (1989) evaluated subjects on measures of social adjustment, depression, fearfulness, and general distress. Utilizing four objective, standardized measures, these authors found that "both group formats were effective relative to the wait list condition in reducing depression and in alleviating distress as measured by the SCL-90-R" (p.481), and that no significant differences were found between the two different types of group treatment. Clearly, a need for further research in this area is indicated, as it is vital to the continued development and growth of much-needed
treatment programs for so many victims of childhood sexual abuse.

The present study was designed to add to this research by evaluating the effectiveness of a group treatment approach for women sexually abused in childhood. In the literature a number of symptoms commonly associated with the experience of childhood sexual abuse are identified. These include low self-esteem, depression, feelings of guilt and shame, anger or hostility, difficulties in interpersonal relationships, inability to trust, fear of intimacy and distorted or negative body image. These symptoms were identified as the dependent variables in the present study. Based on the clinical literature forwarded to date, it was hypothesized that involvement in the supportive group treatment program would result in significant changes in these symptoms in women who had been sexually abused in childhood. More specifically, the following hypotheses were tested:

Hypothesis I:
Ho The scores obtained by the treatment group participants will not significantly decrease from pre-test to post-test, on the General Severity Index of
the SCL-90-R.

H1 The scores obtained by the treatment group participants will significantly decrease from pre-test to post-test, on the General Severity Index of the SCL-90-R.

Hypothesis II:

Ho The scores obtained by the contrast group participants will not significantly decrease from pre-test to post-test, on the General Severity Index of the SCL-90-R.

H1 The scores obtained by the contrast group participants will significantly decrease from pre-test to post-test, on the General Severity Index of the SCL-90-R.

Hypothesis III:

Ho The scores obtained by the treatment group participants will not significantly decrease from pre-test to post-test, on the following subscales of the SCL-90-R:

a). Interpersonal Sensitivity
b). Depression
c). Hostility
d). Paranoid Ideation
e). Feelings of Guilt
H1  The scores obtained by the treatment group participants will significantly decrease from pre-test to post-test, on the following sub-scales of the SCL-90-R:

   a). Interpersonal Sensitivity
   b). Depression
   c). Hostility
   d). Paranoid Ideation
   e). Feelings of Guilt

Hypothesis IV:

Ho  The scores obtained by the contrast group participants will not significantly decrease from pre-test to post-test, on the following sub-scales of the SCL-90-R:

   a). Interpersonal Sensitivity
   b). Depression
   c). Hostility
   d). Paranoid Ideation
   e). Feelings of Guilt

H1  The scores obtained by the contrast group participants will significantly decrease from pre-test to post-test, on the following sub-scales of the SCL-90-R:

   a). Interpersonal Sensitivity
b). Depression

c). Hostility

d). Paranoid Ideation

e). Feelings of Guilt

Hypothesis V:

Ho    The scores obtained by the treatment group participants will not significantly increase from pre-test to post-test, on the Overall Self-Concept Index of the Tennessee Self-Concept Scale.

H1    The scores obtained by the treatment group participants will significantly increase from pre-test to post-test, on the Overall Self-Concept Index of the TSCS.

Hypothesis VI:

Ho    The scores obtained by the contrast group participants will not significantly increase from pre-test to post-test, on the Overall Self-Concept Index of the TSCS.

H1    The scores obtained by the contrast group participants will significantly increase from pre-test to post-test, on the Overall Self-Concept Index of the TSCS.

Hypothesis VII:

Ho    The scores obtained by the treatment group
participants will not significantly increase from pre-test to post-test on the Physical Self Index of the TSCS.

H1  The scores obtained by the treatment group participants will significantly increase from pre-test to post-test on the Physical Self Index of the TSCS.

Hypothesis VIII:

Ho  The scores obtained by the contrast group participants will not significantly increase from pre-test to post-test on the Physical Self Index of the TSCS.

H1  The scores obtained by the contrast group participants will significantly increase from pre-test to post-test on the Physical Self Index of the TSCS.

Hypothesis IX:

Ho  There will be no significant differences between the scores obtained by the treatment group participants and the contrast group participants from pre-test to post-test on the Overall Self-Concept and Physical Self-Concept indices of the TSCS.

H1  There will be a significant difference between the scores obtained by the treatment group participants and the contrast group participants from pre-test to post-test on the Overall Self-Concept and Physical
Self-Concept indices of the TSCS.

Hypothesis X

H0 There will be no significant differences between the scores obtained by the treatment group participants and the contrast group participants from pre-test to post-test on a) the General Severity, b) Depression, c) Interpersonal Sensitivity, d) Paranoid Ideation, e) Hostility and f) Feelings of Guilt indices of the SCL-90-R.

H1 There will be a significant difference between the scores obtained by the treatment group participants and the contrast group participants from pre-test to post-test on the a) General Severity, b) Depression, c) Interpersonal Sensitivity, d) Paranoid Ideation, e) Hostility and f) Feelings of Guilt indices of the SCL-90-R.
Participants

The participants in this study included 22 adult women (over age 18 years) who experienced sexual abuse in childhood. Eleven women comprised the experimental group and eleven women comprised a contrast group. Women in the experimental group had voluntarily sought group treatment for issues resulting from sexual abuse. Participants in the experimental group were recruited from a wait list and, based on a first come - first serve policy, they were included in the group treatment program. Participants in the contrast group were recruited from the community through advertisements requesting voluntary participation in the study. Eight of the women in the contrast group and five women in the experimental group had received or were currently receiving individual treatment for issues stemming from sexual abuse at the time of the study.

Experimental Group

The mean age for the experimental group was 36 years old, and the range was 19 to 44 years. One woman (9%) had received some schooling, 9 women (82%) completed high school, 1 woman (9%) received a
bachelor's degree, and none had post-graduate education.

The mean age of onset of the abuse for the women in the experimental group was 3 years old and the mean duration of the abuse was 11 years. However, 5 (45%) of the women in this group were unsure as to the duration of the abuse. Of the experimental group members, 4 had been sexually abused by their natural fathers, 3 by their step-fathers, 3 by their mothers, 4 by their brothers, 2 by their sisters, 4 by their grandfathers, and 2 by their uncles. One woman did not remember who had sexually abused her. Additionally, 6 of these women had been abused by a male family friend or neighbour. One woman reported abuse by someone other than the offenders listed but did not specify who had abused her. Nine of these women had been multiply abused by different perpetrators.

The most frequently reported forms of abuse for this group were fondling (82%), exposure (64%), kissing (64%), masturbation (64%), fellatio (46%), cunnilingus (46%), and vaginal intercourse (46%). Additionally, 18% of the women in this group reported experiencing anal intercourse and 10% experienced other forms of abuse such as choking, suffocation and bondage. Over 90% of the women in the experimental group described
their parents' marriage as unhappy.

**Contrast Group**

The mean age for the contrast group was 32 years old, and the range was 19 to 55 years. The highest level of education completed by these women was as follows: 4 women (36%) had some schooling, 1 woman (9%) had completed high school, 2 women (18%) had received a bachelor’s degree, and had 4 women (36%) had some post-graduate education.

The mean age of onset of the sexual abuse for the women in this group was 6 years old with a mean duration of 9 years. Three (27%) of the women in this group were unsure of the duration of the abuse and 3 (27%) reported being abused for less than a year. The remaining 5 (46%) women had been abused for more than 5 years. Four of the contrast group members had been sexually abused by their natural fathers, 1 by her natural mother, 2 by their brothers, 1 by her grandfather, and 2 by their uncles. In addition, 5 of the women in this group had been abused by a male family friend or neighbour and 1 woman had been abused by someone other than the offenders listed but did not specify who had abused her. Two of these women had been victims of multiple abuse by different perpetrators.
The most frequently reported method of abuse was fondling (91%), followed by exposure (55%), fellatio (55%), vaginal intercourse (46%), masturbation (36%), kissing (27%), and cunnilingus (27%). In addition, 9% of these women reported other forms of abuse including suffocation, choking and bondage. Over 80% of the women in the contrast group described their parents' marriage as unhappy.

**Instrumentation**

Two standardized instruments were used in the present study to measure pre-test to post-test changes in the dependent variables among the women in both groups: the Tennessee Self-Concept Scale and the Symptoms Checklist-90-Revised. Standardized tests are distinguished by the uniformity of their administration and scoring procedures, making it possible to compare scores between different individuals (Anastasi, 1988). In addition, standardized tests provide norms based on scores obtained by a large, representative sample of the type of individuals for whom it was designed, thereby providing a referent for the comparison of scores for each individual completing the test.

**Tennessee Self Concept Scale (TSCS)**

The Tennessee Self Concept Scale is a 100-item, self-report measure developed by Fitts (1965) to assess
the multidimensional nature of self-concept. Fitts' originally developed the TSCS as a research instrument that might contribute to more accurate clinical diagnosis of psychological disorders. The TSCS was derived from a compilation of the self-descriptive statements of other self-concept measures as well as self-written, self-descriptions of a sample of patients and nonpatients.

The TSCS measures five externally referenced aspects of self-concept (i.e., moral-ethical, social, personal, physical, and family) and three internally referenced aspects of self-concept (i.e., identity, behavior and self-satisfaction). These combined frames of reference form a $5 \times 3$ matrix of items containing 15 cells. According to Fitts (1965), each of the external self-concept traits can be manifested in relation to the three internal frames of reference. Identity refers to the private, internal self-concept (e.g., what I am), whereas Behavior is that part of the self that is observable to others (e.g., what I do or how I act). The Satisfaction frame of reference examines the discrepancy between the actual and ideal self (e.g., how I feel about myself). According to Fitts, an individual may have very high Identity and Behavior scores but still score low on Satisfaction due
to "very high standards and expectations of himself" (p.2).

The TSCS is an extremely popular and widely used instrument (Marsh & Richards, 1988). In their review in the most recent Mental Measurements Yearbook, Marsh and Richards (1988) found that, "the TSCS ranked 18th in total number of references compared with all tests, 12th among personality tests, and 1st among self-concept instruments" (p.613).

The test-retest reliability of the TSCS is generally high, ranging from .60 to .91 (Fitts, 1965). Fitts (1965) maintains that the TSCS is also high in content and construct validity, and is able to discriminate differences in self-concept between various groups (Fitts, 1965).

The TSCS is widely used within counselling. This instrument has been used in research with sexual abuse victims, therefore the test results may have comparative clinical relevance. The TSCS uses a Likert type scale that is easy to administer and takes approximately 15 minutes to complete.

The Symptoms Checklist-90-Revised (SCL-90-R)

The Symptoms Checklist-90-Revised is a self-report instrument designed by Derogatis (1983) to provide a global measure of symptomatic psychological distress as
indicated by nine primary symptom dimensions: somatization, obsessive-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoia and psychoticism. In addition, there are three global indices of distress which reflect distinct aspects of psychopathology: the General Severity Index (GSI) which measures numbers of symptoms and quantities of distress, the Positive Symptom Total (PST) which reflects only the numbers of symptoms, and the Positive Symptom Distress Index (PSDI) which reflects only the intensity of distress.

The SCL-90-R is comprised of 90 items, each of which is measured on a 5-point scale of distress, where (0) represents "not at all" and (4) represents "extremely". Derogatis (1983) clearly states that the SCL-90-R is not a measure of personality, but rather one of "current, point-in-time, psychological symptom status" (p.4). Norms are provided for men and women in four populations including psychiatric outpatients, psychiatric inpatients, adult non-patients and adolescent non-patients (Derogatis, 1983).

High levels of internal consistency (ranging from .77 to .90) and test-retest reliability (ranging from .78 to .90) have been reported for the SCL-90-R (Alexander, Neimeyer, Follette, Moore & Harter, 1989;
Derogatis, 1983). Edwards, Yarvis, Mueller, Zingale and Wagman (1978) report test-retest coefficients ranging from .81 to .94 for the SCL-90. In addition, the SCL-90-R has high criterion and convergent validity when compared with the MMPI (Derogatis, 1983). Upon administering the SCL-90 to a sample of 1,002 psychiatric outpatients, Derogatis and Cleary (1977) report high construct validity on all nine of the symptom constructs of this instrument. The SCL-90-R is also widely used in clinical settings which may add to the clinical relevance of the findings of the present study (Alexander et al., 1989; Derogatis, 1983; Derogatis & Cleary, 1977).

The SCL-90-R was chosen, in part, for its ease of administration and clarity. It takes approximately 15 minutes to complete and, while unobtrusive, it assesses a wide range of symptoms, several of which relate closely to the experience of sexual abuse. In addition, the SCL-90-R has recently been used in sexual abuse research (Alexander, Neimeyer, Follette, Moore & Harter, 1989). The depression, hostility, interpersonal sensitivity, anxiety, and paranoia subscales of the SCL-90-R will be used to measure the following variables in the present study: depression, guilt/shame, anger/hostility, interpersonal
relationships, trust and intimacy.

The SCL-90-R is highly sensitive to changes in the presence or alteration of symptoms, as well as differences in severity of symptoms between groups (Derogatis, 1983). In addition, while the standard time referent for the SCL-90-R is "the past seven days including today" (Derogatis, 1983, p.2), the time window is left flexible so that other time referents may be used, as in the present study. The time referent of "the past four weeks" was chosen for the present study as the symptoms being measured that are associated with sexual abuse are often long-term and were not expected to fluctuate much in a seven day period. A four week time span was believed to be more likely to assess the changes in the symptoms if any were to occur.

Support Group Assessment

In order to elicit subjective responses to the group treatment, an experimenter-generated questionnaire was administered to the women in the experimental group at the end of the therapy sessions (see Appendix E). This questionnaire was divided into two parts. Part one of the questionnaire consisted of 13 items to be rated on a Likert-type scale. Subjects were asked to rate each item in terms of its value,
with (1) indicating the "least valuable" response and (3) indicating the "most valuable" response. The items included specific group format variables such as large group work, small group work, homework assignments, lectures/information, films and resources. In addition, five of Yalom's (1985) client-perceived therapeutic factors were included in the Likert-type scale: cohesiveness, hope, guidance, self-understanding and inclusion. These items were included based on Bonney, Randall and Cleveland's (1986) findings that Yalom's curative factors were rated highly by a sample of incest victims in group treatment. Some of Yalom's factors were excluded as they were determined to be irrelevant to the type of group approach to be examined in the present study. Finally, two items measuring the women's perception of support from other group members as well as from the facilitators was included.

The second part of the questionnaire consisted of two open-ended questions concerning the effectiveness of the group at meeting the needs and goals of each participant, as well as providing an opportunity for comments and suggestions regarding future groups of this nature.

Discussion of the Group Treatment Approach

The group treatment approach evaluated in the
present study was based on the model adopted by Support, Education and Prevention of Sexual Abuse of Children (SEPSA) (McEvoy, 1990). This group approach was designed to help survivors of childhood sexual abuse focus on common issues and gain information and support. An outline of the group treatment approach is presented in Appendix A.

Similar to the sexual abuse groups evaluated in previous research (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Goodman & Nowak-Scibelli, 1985; Gordy, 1983; Herman & Schatzow, 1984; Tsai & Wagner, 1978) this group treatment approach was time-limited, lasting for 10 weeks, with each weekly session lasting 2 1/2 hours. While time-limited groups are believed to increase pressure to facilitate bonding among group members and diminish resistance to sharing emotionally painful material (Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984), it is possible that an adequate resolution of sexual abuse issues may not be attained within 10 weeks. This problem seems to have been reflected in the responses of the members in the present group to the Support Group Assessment, suggesting that more time was needed to process their issues.

In accordance with the SEPSA model, the group had
two facilitators: one who was a survivor of child sexual abuse, and one who had not experienced child sexual abuse, but who had experience in group facilitation. This model of facilitation was also used in the group discussed by Gordy (1983).

Screening interviews lasting one hour were conducted with each prospective member in order to ensure that members were ready for group work. Readiness was based on the prospective member’s ability to talk about the abuse, the absence of current alcohol or drug problems, and the member’s ability to state her goals for joining the group. While members in this group were not required to be in individual therapy for sexual abuse issues, other researchers suggest that involvement in individual therapy concurrent with group therapy is essential in order to process the intense emotions that may arise from group therapy (Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Roberts & Lie, 1989). It is possible that some of the women in the group evaluated in this study who had not received individual counselling did not fare as well as those who were receiving individual counselling, thereby affecting the outcomes of this study.

Once an individual was accepted into the group, she was required to develop a contract stating her major
goal for being in the group. According to McEvoy (1990), it is important for members to be able to state a personal goal for group work as "A woman who is not clear about what she hopes to get out of the group runs the risk of absorbing the other members' stories and pain..."(p.69).

Each group meeting began with a check-in, where members briefly described how they were feeling that day and shared any major events that occurred that week. At this time, group members were also able to ask for "problem-solving time" where they could process personal issues during that session. This was followed by the exploration of an educational topic through minilecture, group discussion, or group exercise. The educational topics were decided by the group members at the first session, based on their personal needs and goals. The topics included such issues as developing personal boundaries, depression, anger and rage, shame and guilt, sexuality and body image, and self-esteem. Finally, each group session ended with a closing round where members briefly shared how they were feeling. This group format was similar to those outlined in previous research (Gordy, 1983; Herman & Schatzow, 1984; Roberts & Lie, 1989; Tsai & Wagner, 1978).
Procedure

The present study evaluated a ten week (2 1/2 hours/week) group treatment program for adult women who had been sexually abused in childhood (see Appendix A). Two groups were conducted consecutively at a local counselling and resource center for women, by two trained female facilitators experienced in running such groups. Participants in this study were 22 adult women over the age of 18 who had been sexually abused in childhood. Eleven women who had voluntarily requested group treatment for issues stemming from childhood sexual abuse comprised the experimental group. The contrast group included eleven women who had been sexually abused in childhood but who had not received group treatment for issues stemming from the abuse.

The Tennessee Self-Concept Scale (TSCS), developed by Fitts (1965), was administered to women in the experimental and contrast groups, prior to and following the group therapy sessions. This instrument was utilized to determine whether the group treatment approach would facilitate significant changes in self-esteem and perceived body image among the women in the treatment group, when compared with the contrast group.
The Symptoms Checklist-90-Revised (SCL-90-R) (Derogatis, 1983) was also administered to women in the experimental and contrast groups, before and after the group therapy sessions. This instrument was used to determine whether the group treatment approach would facilitate significant changes in the level of depression, guilt/shame, anger/hostility, difficulty in interpersonal relationships, trust and intimacy reported among women in the experimental group when compared with the contrast group. These variables were measured according to the following subscales of the SCL-90-R: the general severity index, interpersonal sensitivity, depression, hostility, paranoid ideation and guilt.

Finally, an experimenter - generated Support Group Assessment was given to the women who completed the group treatment program. This questionnaire allowed the women the opportunity to subjectively evaluate the group treatment, and to comment on their experiences in the group. In addition, the questionnaire allowed the women to make suggestions for the design of future groups of this nature.

Subjects for the experimental group were selected from a wait list at the counselling center by the group facilitators and staff, two weeks prior to the
beginning of the group sessions. The first eight women from the wait list received a verbal invitation from the center's staff to participate in the support group beginning in October, 1990. Upon acceptance to the group, each woman met with the group facilitators individually, in a pre-therapy interview prior to the start of the group sessions. At this interview, each woman was given both a verbal and a written description of the purposes and procedures of the study (see Appendix B). Each woman was asked to be involved in the study and, if she agreed, she was then asked to sign a consent form (see Appendix C) and complete a demographic information sheet (see Appendix D), the TSCS and the SCL-90-R. Finally, the TSCS, the SCL-90-R and the experimenter-generated Support Group Assessment (see Appendix E) were completed by each participant at the end of the last group session and were collected by the group facilitators.

At the final session, each subject was asked to participate in a six-week follow-up which involved completing the SCL-90-R and the TSCS again (see Appendix F). Participants who agreed to complete a follow-up were mailed a package including the SCL-90-R and the TSCS and a self-addressed, stamped envelope to be mailed back to the experimenter. This procedure was
then repeated for the women in a second group which commenced in February, 1991. Seven women in the first group and four women in the second group completed the pre- and post-test packages. Only two women in the first group and three women in the second group also completed the 6 week follow-up questionnaires. Given the small numbers of women who completed the 6 week follow-up, no statistical analyses were conducted on this component of the study. However, the mean scores of the dependent measures for all of the women in the experimental group were calculated and compared to determine if there were any differences at a glance between those women who completed the follow-up and those who did not.

Subjects for the contrast group were obtained through voluntary response to advertisements for the study which were posted at various local community and counselling centers (see Appendix G). Fourteen women contacted the experimenter and agreed to participate after receiving a full verbal description of the study. Each woman was then mailed an experimental package including a written description of the study (see Appendix H), two copies of an ethical consent form (one copy to be kept for herself and one to be mailed back to the primary investigator), a demographic information
sheet (See Appendix D), the Tennessee Self-Concept Scale and the Symptoms Checklist-90-Revised. A self-addressed, stamped envelope was also included so that each participant could mail the completed questionnaires back to the experimenter.

Once the information was received by the experimenter, another package including the SCL-90-R and the TSCS was mailed back to the participant ten weeks later. Again, once that information was received, a third package was mailed to the participants six weeks later. This was done in order to coincide with the length of the groups and their follow-ups. Eleven women completed the pre- and post-test information and only 8 of these women completed the 6 week follow-up information. Again, given the small rate of return of the follow-up packages, no statistical analyses were conducted on this component of the study. Instead, the mean scores of the dependent measures for all of the women in the contrast group were calculated to determine if any differences could be seen between those women who completed the follow-up component of the study, and those who did not.

Treatment of the Data

Exploratory data analyses were conducted on the
categorical and continuous variables. This included calculation of the frequencies of the categorical variables and mean values of the continuous variables. Statistical significance testing was conducted on the categorical variables using chi-square statistics. The means, standard deviations and standard errors for the continuous variables were calculated and were tested for statistical significance using t-tests. Correlations were conducted on both categorical and continuous variables to determine if they impacted on the pre-test scores or the changes in the scores from pre-test to post-test.
CHAPTER FOUR
RESULTS

Introduction

The results obtained from the statistical and descriptive data analysis are presented in the present chapter. Raw scores were used on the Overall Self-Concept and Physical Self-Concept scores of the TSCS, and on the General Severity Index and the sub-scales of the SCL-90-R in order to compare differences in the scores from pre-test to post-test for the participants in both groups. The null hypothesis rejection is based on a significance level of $p \leq .05$.

Tests of the Hypotheses

Hypothesis I

One-tailed, paired t-tests were conducted to determine whether the scores obtained by the experimental group participants on the General Severity Index (GSI) of the SCL-90-R significantly decreased from pre-test to post-test. A summary of the mean scores, the standard deviations and the probability levels for the GSI from pre-test to post-test for both groups is presented in Table 1. A summary of the mean
Table 1
Within Group Comparisons - One-Tailed Paired T-Tests on Mean Score Differences of Dependent Measures from Pre-test to Post-test for Contrast and Experimental Groups

<table>
<thead>
<tr>
<th></th>
<th>Contrast Group (n=11)</th>
<th></th>
<th></th>
<th>Experimental Group (n=11)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\bar{x}$ S.D. p</td>
<td></td>
<td></td>
<td>$\bar{x}$ S.D. p</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GSI</td>
<td>-0.06 0.41 0.32</td>
<td></td>
<td></td>
<td>-2.81 0.60 0.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>0.07 0.62 0.39</td>
<td></td>
<td></td>
<td>-0.29 0.75 0.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoid Ideation</td>
<td>-0.12 0.58 0.25 **</td>
<td></td>
<td></td>
<td>-0.59 0.90 0.03 **</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal</td>
<td>-0.27 0.57 0.08 *</td>
<td></td>
<td></td>
<td>-0.62 0.67 0.0003 *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitivity</td>
<td>-0.72 0.91 0.01 *</td>
<td></td>
<td></td>
<td>0.00 1.00 1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guilt</td>
<td>0.18 0.75 0.22</td>
<td></td>
<td></td>
<td>-0.35 0.81 0.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostility</td>
<td>7.73 9.53 0.01 *</td>
<td></td>
<td></td>
<td>3.82 27.81 0.33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Self-Concept</td>
<td>1.36 7.69 0.29</td>
<td></td>
<td></td>
<td>1.82 11.61 0.31</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*** denotes p<0.01
**** denotes p<0.05
pre-test, post-test and follow-up scores and the range of scores on the dependent measures for the experimental group is presented in Table 2.

The GSI scores obtained by the eleven participants in the experimental group were not found to decrease significantly from pre-test to post-test, at a $p < .05$ level of significance. Therefore null Hypothesis I was accepted and the alternate Hypothesis I was rejected.

Hypothesis II

One-tailed, paired t-tests were conducted to determine whether the scores obtained by the contrast group on the GSI significantly decreased from pre-test to post-test. Table 1 (p. 95) presents a summary of the mean scores, standard deviations and the probability levels for the GSI scores for both groups. A summary of the mean pre-test, post-test and follow-up scores and the range of scores on the dependent measures for the contrast group is presented in Table 3.

No significant differences were found on the GSI scores for the contrast group participants from pre-test to post-test, at a $p < .05$ level of significance. Therefore, null Hypothesis II was accepted and the alternate Hypothesis I was rejected.

Hypothesis III
<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings of Guilt</td>
<td>1.73</td>
<td>1.73</td>
<td>2.00</td>
</tr>
<tr>
<td>Paranoid Ideation</td>
<td>1.76</td>
<td>1.17</td>
<td>1.13</td>
</tr>
<tr>
<td>Depression</td>
<td>2.18</td>
<td>1.89</td>
<td>1.71</td>
</tr>
<tr>
<td>GSI</td>
<td>1.82</td>
<td>1.54</td>
<td>1.27</td>
</tr>
<tr>
<td>Hostility</td>
<td>1.68</td>
<td>1.33</td>
<td>0.90</td>
</tr>
<tr>
<td>Interpersonal Sensitivity</td>
<td>2.18</td>
<td>1.56</td>
<td>1.42</td>
</tr>
<tr>
<td>Overall Self-Concept</td>
<td>304</td>
<td>308</td>
<td>336</td>
</tr>
<tr>
<td>Physical Self-Concept</td>
<td>54</td>
<td>56</td>
<td>62</td>
</tr>
</tbody>
</table>
Table 3  
Mean Pre-test, Post-test and Follow-up Scores and Range of Scores  
of the Dependent Measures for the Contrast Group

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings of Guilt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-test</td>
<td>2.27</td>
<td>0.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Post-test</td>
<td>1.55</td>
<td>0.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Follow-up</td>
<td>2.25</td>
<td>0.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Paranoid Ideation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-test</td>
<td>1.00</td>
<td>0.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Post-test</td>
<td>0.88</td>
<td>0.00</td>
<td>3.17</td>
</tr>
<tr>
<td>Follow-up</td>
<td>0.83</td>
<td>0.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-test</td>
<td>1.70</td>
<td>0.92</td>
<td>3.62</td>
</tr>
<tr>
<td>Post-test</td>
<td>1.80</td>
<td>0.39</td>
<td>3.77</td>
</tr>
<tr>
<td>Follow-up</td>
<td>1.80</td>
<td>0.62</td>
<td>3.77</td>
</tr>
<tr>
<td>GSI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-test</td>
<td>1.20</td>
<td>0.41</td>
<td>2.61</td>
</tr>
<tr>
<td>Post-test</td>
<td>1.13</td>
<td>0.37</td>
<td>2.39</td>
</tr>
<tr>
<td>Follow-up</td>
<td>1.22</td>
<td>0.27</td>
<td>2.60</td>
</tr>
<tr>
<td>Hostility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-test</td>
<td>0.88</td>
<td>0.17</td>
<td>2.17</td>
</tr>
<tr>
<td>Post-test</td>
<td>1.06</td>
<td>0.17</td>
<td>2.83</td>
</tr>
<tr>
<td>Follow-up</td>
<td>1.13</td>
<td>0.17</td>
<td>2.67</td>
</tr>
<tr>
<td>Interpersonal Sensitivity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-test</td>
<td>1.55</td>
<td>0.33</td>
<td>3.56</td>
</tr>
<tr>
<td>Post-test</td>
<td>1.28</td>
<td>0.33</td>
<td>3.22</td>
</tr>
<tr>
<td>Follow-up</td>
<td>1.53</td>
<td>0.11</td>
<td>3.67</td>
</tr>
<tr>
<td>Overall Self-Concept</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-test</td>
<td>325</td>
<td>267</td>
<td>382</td>
</tr>
<tr>
<td>Post-test</td>
<td>332</td>
<td>271</td>
<td>388</td>
</tr>
<tr>
<td>Follow-up</td>
<td>326</td>
<td>260</td>
<td>393</td>
</tr>
<tr>
<td>Physical Self-Concept</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-test</td>
<td>61</td>
<td>46</td>
<td>68</td>
</tr>
<tr>
<td>Post-test</td>
<td>62</td>
<td>52</td>
<td>76</td>
</tr>
<tr>
<td>Follow-up</td>
<td>59</td>
<td>42</td>
<td>73</td>
</tr>
</tbody>
</table>
In order to determine if there was a significant decrease in the scores from pre-test to post-test on the five subscales of the SCL-90-R for the experimental group participants, one-tailed, paired t-tests were conducted. See Table 1 (p.95) for a summary of the mean scores, standard deviations and the probability levels for the subscales for both groups.

No significant decreases were found on the scores of (b) the Depression scale, (c) the Hostility scale, or (e) the Feelings of Guilt scale of the SCL-90-R, at a significance level of $p \leq .05$. Therefore null Hypothesis III was accepted for components (b), (c), or (e). However, significant decreases in the scores were found at a $p \leq .01$ level on (a) the Interpersonal Sensitivity scale, and at a $p \leq .05$ level on (d) the Paranoid Ideation scale of the SCL-90-R from pre-test to post-test. Therefore, components (a) and (d) of the alternate Hypothesis III were accepted.

Hypothesis IV

One-tailed, paired t-tests were conducted to determine if there were significant decreases in the scores on the five subscales of the SCL-90-R, from pre-test to post-test, for the contrast group participants. The mean scores, standard deviations and the probability levels for the subscales for both
groups are presented in Table 1 (p.95).

A significant decrease was found in the scores for (e) the Feelings of Guilt subscale of the SCL-90-R, at a significance level of $p < .01$. Therefore, the null Hypothesis IV for component (e) was rejected and the alternate Hypothesis IV for component (e) was accepted. However, no significant decreases were found in the scores for (a) the Interpersonal Sensitivity scale, (b) the depression scale, (c) the Hostility scale, or (d) the Paranoid Ideation scale of the SCL-90-R from pre-test to post-test. Therefore components (a), (b), (c) and (d) of the null Hypothesis IV were accepted.

Hypothesis V

One-tailed, paired t-tests were conducted to determine if the scores on the Overall Self-Concept Index of the TSCS significantly increased from pre-test to post-test for the experimental group participants. The mean scores, standard deviations and the probability levels for this scale for both groups are presented in Table 1 (p.95).

A significant increase from pre-test to post-test on the Overall Self-Concept Index scores for the experimental group participants was not found at a significance level of $p \leq .05$. Therefore, the null Hypothesis V was accepted and the alternate Hypothesis
V was rejected.

Hypothesis VI

In order to determine if the scores on the Overall Self-Concept Index of the TSCS significantly increased from pre-test to post-test for the contrast group participants, one-tailed, paired t-tests were conducted. The mean scores, standard deviations and the probability levels for this scale for both groups are presented in Table 1 (p.95).

A significant increase from pre-test to post-test on the Overall Self-Concept Index scores for the contrast group participants was found at a significance level of $p \leq .01$. Therefore, the null Hypothesis VI was rejected and the alternate Hypothesis VI was accepted.

Hypothesis VII

One-tailed, paired t-tests were conducted to determine if the scores on the Physical Self-Concept Index of the TSCS significantly increased from pre-test to post-test for the experimental group participants. The mean scores, standard deviations and the probability levels for this scale for both groups are presented in Table 1 (p.95).

A significant increase from pre-test to post-test on the scores of the Physical Self-Concept Index was
not found for the experimental group participants, at a significance level of \( p < .05 \). Therefore, the null Hypothesis VII was accepted and the Alternate Hypothesis VII was rejected.

Hypothesis VIII

One-tailed, paired t-tests were conducted to determine if the scores on the Physical Self-Concept Index of the TSCS significantly increased from pre-test to post-test for the contrast group participants. The mean scores, standard deviations and the probability levels for this scale for both groups are presented in Table 1 (p.95).

A significant increase from pre-test to post-test on the scores of the Physical Self-Concept Index was not found for the contrast group participants, at a significance level of \( p < .05 \). Therefore, the null Hypothesis VIII was accepted and the alternate Hypothesis VIII was rejected.

Hypothesis IX

One-tailed t-tests were conducted to determine if the mean scores differences obtained by the experimental group participants were significantly higher than the mean score differences of the contrast group participants from pre-test to post-test on the Overall Self-Concept and Physical Self-Concept indices
of the TSCS. The mean differences in scores, standard deviations and probability levels for these scales for both groups are presented in Table 4.

A significant difference in the mean score differences of the experimental and contrast group participants from pre-test to post-test on the Overall Self-Concept and Physical Self-Concept indices was not found at a significance level of $p < .05$. Therefore null Hypothesis IX was accepted and the alternate Hypothesis IX was rejected.

**Hypothesis X**

One-tailed t-tests were conducted to determine if the mean score differences obtained by the experimental group participants were significantly lower than the mean score differences obtained by the contrast group participants from pre-test to post-test on (a) the General Severity index, (b) the Depression scale, (c) the Interpersonal Sensitivity scale, (d) the Paranoid Ideation scale, (e) the Hostility scale and (f) the Feelings of Guilt scale of the SCL-90-R. The mean differences in scores, standard deviations and probability levels for these scales for both groups are presented in Table 4 (p.104).

A significant difference in the mean score differences of the experimental and contrast group
Table 4

Between Groups Comparisons - One-Tailed T-Tests on the Differences of the Mean Score Differences (from pre-test to post-test) of the Dependent Measures Between the Contrast and Experimental Groups

<table>
<thead>
<tr>
<th></th>
<th>Contrast Group (n=11)</th>
<th>Experimental Group (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( \bar{x} )</td>
<td>S.D.</td>
</tr>
<tr>
<td>GSI</td>
<td>-0.06</td>
<td>0.41</td>
</tr>
<tr>
<td>Depression</td>
<td>0.07</td>
<td>0.82</td>
</tr>
<tr>
<td>Par. Ideation</td>
<td>-0.12</td>
<td>0.58</td>
</tr>
<tr>
<td>Interpers. Sens.</td>
<td>-0.27</td>
<td>0.57</td>
</tr>
<tr>
<td>Guilt</td>
<td>-0.72</td>
<td>0.91</td>
</tr>
<tr>
<td>Hostility</td>
<td>0.18</td>
<td>0.75</td>
</tr>
<tr>
<td>Overall S.C.</td>
<td>7.73</td>
<td>9.53</td>
</tr>
<tr>
<td>Physical S.C.</td>
<td>1.36</td>
<td>7.69</td>
</tr>
</tbody>
</table>

* \( p \leq .05 \)
participants was found on (f) the Feelings of Guilt scale of the SCL-90-R, at a significance level of \( p \leq .05 \). The mean score differences for the contrast group participants were significantly lower than those for the experimental group participants. Therefore, component (f) of the null Hypothesis X was rejected and the alternate Hypothesis X was accepted. Significant differences in the mean score differences of the experimental and contrast group participants were not found on (a) the General Severity scale, (b) the Depression scale (c) the Interpersonal Sensitivity scale, (d) the Paranoid Ideation scale and (e) the Hostility scale of the SCL-90-R, at a significance level of \( p < .05 \). Therefore, components (a), (b), (c), (d) and (e) of the null Hypothesis X were accepted and components (a) through (e) of the alternate Hypothesis X were rejected.

**Descriptive Statistics**

In order to determine if the participants in this study were similar to those in other sexual abuse studies, and to determine if the contrast and experimental groups were similar to each other, the means, frequencies and probability levels of the categorical demographic variables were calculated for both the experimental and contrast groups and are
presented in Tables 5 through 10. Chi square statistics were conducted on the frequencies of responses to the categorical variables to determine if any significant differences existed between the experimental and contrast groups.

The results of two-tailed t-tests comparing the mean scores of the two groups indicated that no significant differences were found between the two groups on age, number of siblings, age at onset of the abuse, or duration of the abuse (see Table 5 for a summary of the mean scores, standard deviations and probability levels). The results of chi-square statistics on the frequencies of responses to the demographic variables indicated that no significant differences existed between the two groups on the type of abuse experienced (see Table 6), yearly income (see Table 7), marital status (see Table 8), ordinal position in family of origin (see Table 9), or perceived happiness or unhappiness of their parents' marriage (see Table 10).

In addition, one-tailed t-tests were conducted to determine if the two groups differed significantly on the initial scores of the dependent measures. Results of the t-tests indicated that the two groups differed significantly on the initial scores of three of the
Table 5

T-Tests Comparing Contrast and Experimental Groups on Demographic Variables (p values are 2-tailed)

<table>
<thead>
<tr>
<th></th>
<th>Contrast Group (n=11)</th>
<th>Experimental Group (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\bar{x}$</td>
<td>S.D.</td>
</tr>
<tr>
<td>Age (years)</td>
<td>31.82</td>
<td>9.89</td>
</tr>
<tr>
<td>No. of children</td>
<td>0.46</td>
<td>0.69</td>
</tr>
<tr>
<td>No. of brothers</td>
<td>1.73</td>
<td>1.49</td>
</tr>
<tr>
<td>No. of sisters</td>
<td>1.36</td>
<td>1.63</td>
</tr>
<tr>
<td>Age at onset of abuse (years)</td>
<td>6.36</td>
<td>5.12</td>
</tr>
<tr>
<td>Duration of abuse</td>
<td>4.19</td>
<td>7.52</td>
</tr>
</tbody>
</table>

*p ≤ .01
Table 6
Comparison of Contrast and Experimental Groups on Frequencies for Type of Abuse Using Chi Square Statistics (p values are two-tailed).

<table>
<thead>
<tr>
<th></th>
<th>Contrast Group (n=11)</th>
<th>Experimental Group (n=11)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Exposure</td>
<td>6</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>(54.55%) (45.45%)</td>
<td>(63.64%) (36.36%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kissing</td>
<td>3</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>(27.27%) (72.73%)</td>
<td>(63.64%) (36.36%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fondling</td>
<td>10</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>(90.91%) (9.09%)</td>
<td>(81.82%) (18.18%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masturbation</td>
<td>4</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>(36.36%) (63.64%)</td>
<td>(63.64%) (36.36%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fellatio</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>(54.55%) (45.45%)</td>
<td>(45.45%) (54.55%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cunnilingus</td>
<td>3</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>(27.27%) (72.73%)</td>
<td>(45.45%) (54.55%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal Int.</td>
<td>5</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>(45.45%) (54.55%)</td>
<td>(45.55%) (54.55%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anal Int.</td>
<td>0</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>(100%) (18.18%)</td>
<td>(81.82%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>(9.09%) (90.91%)</td>
<td>(9.09%) (90.91%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 7

Chi-Square Statistics for Frequency Table of Group by Yearly Income (p = 0.56)

<table>
<thead>
<tr>
<th>Contrast Group (n=11)</th>
<th>Experimental Group (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$10,000</td>
<td>5</td>
</tr>
<tr>
<td>(45.45%)</td>
<td>(45.45%)</td>
</tr>
<tr>
<td>$10-20,000</td>
<td>1</td>
</tr>
<tr>
<td>(9.09%)</td>
<td>(27.27%)</td>
</tr>
<tr>
<td>$20-30,000</td>
<td>2</td>
</tr>
<tr>
<td>(18.18%)</td>
<td>(18.18%)</td>
</tr>
<tr>
<td>$30-50,000</td>
<td>2</td>
</tr>
<tr>
<td>(18.18%)</td>
<td></td>
</tr>
<tr>
<td>&gt;$50,000</td>
<td>1</td>
</tr>
<tr>
<td>(9.09%)</td>
<td>(9.09%)</td>
</tr>
</tbody>
</table>
Table 8

Chi-Square Statistics for Frequency Table of Group by Marital Status (p = 0.199)

<table>
<thead>
<tr>
<th></th>
<th>Contrast Group (n=11)</th>
<th>Experimental Group (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(36.36%)</td>
<td>(36.36%)</td>
</tr>
<tr>
<td>Common-Law</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(27.27%)</td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(36.36%)</td>
<td>(18.18%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(18.18%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(9.09%)</td>
<td>(18.18%)</td>
</tr>
</tbody>
</table>
Table 9

Chi-Square Statistics for Frequency Table of Group by Family Position ($p = 0.222$)

<table>
<thead>
<tr>
<th>Contrast</th>
<th>Group (n=11)</th>
<th>Experimental Group (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Born</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(27.27%)</td>
<td>(9.09%)</td>
</tr>
<tr>
<td>Middle</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>(36.36%)</td>
<td>(45.45%)</td>
</tr>
<tr>
<td>Last Born</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>(18.18%)</td>
<td>(45.45%)</td>
</tr>
<tr>
<td>Only Child</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(18.18%)</td>
<td></td>
</tr>
</tbody>
</table>
Table 10

Chi-Square Statistics for Frequency Table of Group by Parents Marriage (p = 0.534)

<table>
<thead>
<tr>
<th>Contrast</th>
<th>Happy</th>
<th>Unhappy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group (n=11)</td>
<td>Group (n=11)</td>
</tr>
<tr>
<td>Happy</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>(18.18%)</td>
<td>(81.82%)</td>
</tr>
<tr>
<td>Unhappy</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>(9.09%)</td>
<td>(90.91%)</td>
</tr>
</tbody>
</table>
scales of the SCL-90-R: the GSI (p < .05), the Hostility subscale (p < .05) and the Paranoid Ideation subscale (p < .05). Table 11 presents a summary of the mean initial scores for both groups and the probability levels.

In addition, the two groups differed significantly on three of the demographic variables. The women in the experimental group reported sexual abuse by their step-fathers (p < .05) and abuse by more than one person (p < .003) significantly more often than women in the contrast group (see Table 12). In addition, significantly more women in the contrast group had received a university education than women in the experimental group (p < .01) (see Table 13).

Further analyses in the form of two-tailed t-tests were conducted to determine if these variables significantly impacted on either the pre-test scores or the changes in the scores from pre-test to post-test of the dependent measures. Two significant effects at the p < .05 level were found for the pre-test scores and the pre-to post-test changes in the scores of the dependent measures. Women in either group who had not received a university education reported significantly (p < .04) higher initial scores on the Hostility sub-scale of the SCL-90-R (see Table 14) than women in
Table 11
Comparison of Mean Pre-test Scores of Dependent Measures Between Contrast and Experimental Groups Using T-Tests
(p values are one tailed)

<table>
<thead>
<tr>
<th>Dependent Measure</th>
<th>Experimental Mean</th>
<th>Contrast Mean</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSI</td>
<td>1.82</td>
<td>1.20</td>
<td>0.04 *</td>
</tr>
<tr>
<td>Depression</td>
<td>2.18</td>
<td>1.70</td>
<td>0.20</td>
</tr>
<tr>
<td>Hostility</td>
<td>1.68</td>
<td>0.88</td>
<td>0.03 *</td>
</tr>
<tr>
<td>Paranoid Ideation</td>
<td>1.76</td>
<td>1.00</td>
<td>0.04 *</td>
</tr>
<tr>
<td>Interpersonal Sensitivity</td>
<td>2.18</td>
<td>1.55</td>
<td>0.13</td>
</tr>
<tr>
<td>Guilt</td>
<td>1.73</td>
<td>2.27</td>
<td>0.42</td>
</tr>
<tr>
<td>Overall Self-Concept</td>
<td>304</td>
<td>325</td>
<td>0.13</td>
</tr>
<tr>
<td>Physical Self-Concept</td>
<td>54</td>
<td>61</td>
<td>0.10</td>
</tr>
</tbody>
</table>

"*" denotes p<0.05
<table>
<thead>
<tr>
<th></th>
<th>Experimental</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Father</td>
<td>4</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(36.36%)</td>
<td>(63.64%)</td>
<td>(40%)</td>
</tr>
<tr>
<td>Step-Father</td>
<td>0</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(100%)</td>
<td>(30%)</td>
<td>(70%)</td>
</tr>
<tr>
<td>Mother</td>
<td>1</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(9.09%)</td>
<td>(90.91%)</td>
<td>(30%)</td>
</tr>
<tr>
<td>Brother</td>
<td>2</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(18.18%)</td>
<td>(81.82%)</td>
<td>(40%)</td>
</tr>
<tr>
<td>Sister</td>
<td>0</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(100%)</td>
<td>(20%)</td>
<td>(80%)</td>
</tr>
<tr>
<td>Uncle</td>
<td>2</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(18.18%)</td>
<td>(81.82%)</td>
<td>(20%)</td>
</tr>
<tr>
<td>Grandfather</td>
<td>1</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(9.09%)</td>
<td>(90.91%)</td>
<td>(40%)</td>
</tr>
<tr>
<td>Male Cousin</td>
<td>0</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(100%)</td>
<td>(10%)</td>
<td>(90%)</td>
</tr>
<tr>
<td>Male Family Friend</td>
<td>3</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(27.27%)</td>
<td>(72.73%)</td>
<td>(30%)</td>
</tr>
<tr>
<td>Male Neighbor</td>
<td>2</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(18.18%)</td>
<td>(81.82%)</td>
<td>(30%)</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(9.09%)</td>
<td>(90.91%)</td>
<td>(10%)</td>
</tr>
<tr>
<td>Multiple Offenders</td>
<td>2</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>(18.18%)</td>
<td>(81.82%)</td>
<td>(80%)</td>
</tr>
</tbody>
</table>

* p \leq .05
** p \leq .01
Table 13

Chi-Square Statistics for Frequency Table of Group by Education (p = 0.006*)

<table>
<thead>
<tr>
<th>Education</th>
<th>Contrast Group (n=11)</th>
<th>Experimental Group (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some High School</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(36.36%)</td>
<td>(9.09%)</td>
</tr>
<tr>
<td>Completed High School</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>(9.09%)</td>
<td>(81.82%)</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(18.18%)</td>
<td>(9.09%)</td>
</tr>
<tr>
<td>Post-Graduate Education</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(36.36%)</td>
<td></td>
</tr>
</tbody>
</table>

* p ≤ .01
Table 14

Comparison of the Mean Pre-test Scores on the Dependent Measures by University Education using T-tests (p values are two-tailed)

<table>
<thead>
<tr>
<th></th>
<th>No University Education</th>
<th>University Education</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( \bar{x} )</td>
<td>( \bar{x} )</td>
<td></td>
</tr>
<tr>
<td>GSI</td>
<td>1.79</td>
<td>1.27</td>
<td>.10</td>
</tr>
<tr>
<td>Depression</td>
<td>2.17</td>
<td>1.79</td>
<td>.40</td>
</tr>
<tr>
<td>Paranoid Ideation</td>
<td>1.65</td>
<td>1.15</td>
<td>.19</td>
</tr>
<tr>
<td>Interpers. Sens.</td>
<td>2.22</td>
<td>1.57</td>
<td>.12</td>
</tr>
<tr>
<td>Guilt</td>
<td>1.70</td>
<td>2.25</td>
<td>.42</td>
</tr>
<tr>
<td>Hostility</td>
<td>1.70</td>
<td>0.93</td>
<td>.04*</td>
</tr>
<tr>
<td>Overall S.C.</td>
<td>300</td>
<td>325</td>
<td>.07</td>
</tr>
<tr>
<td>Physical S.C.</td>
<td>53</td>
<td>61</td>
<td>.07</td>
</tr>
</tbody>
</table>

* p \( \leq .05 \)
either group who had received a university education. In addition, women in either group who had received a university education reported a significant \( (p < .04) \) decrease on the Feelings of Guilt subscale of the SCL-90-R from pre-test to post-test while women in either group who had not received a university education did not show a decrease in their scores.

No significant effects were found at the \( p < .05 \) level for abuse by more than one offender or abuse by a step-father and the pre-test scores of the dependent measures. Similarly, no significant differences were found between abuse by more than one offender or abuse by a step-father and the differences in the scores of the dependent measures from pre-test to post-test. The initial mean scores of the dependent measures reported by women in either group who had been abused by their step-fathers or by multiple offenders did not significantly differ from the initial mean scores reported by women in either group who had not been abused by their step-fathers or by multiple offenders. In addition, the changes in the scores from pre-test to post-test were not significantly different for the women who had been abused by their step-fathers or multiple offenders and those who had not been abused by their step-fathers or by multiple offenders.
Pearson correlations were calculated to determine if the age of the participant at the onset of the abuse and the duration of the abuse significantly correlated with the initial scores as well as the differences in scores from pre-test to post-test on the dependent measures overall and for the contrast and experimental groups separately (see Tables 15 and 16 for a summary of the results).

Significant positive correlations were found for the age of onset of the abuse and the initial score of the Overall Self-Concept scale ($p < .007$) of the TSCS for both groups. Similarly, a significant negative correlation was found for the duration of the abuse and the initial score of the Overall Self-Concept scale ($p < .04$) for both groups (see Table 15). In addition, among the contrast group participants, significant negative correlations were found for the variable 'age of onset of the abuse' and the difference in the scores from pre-test to post-test on the GSI ($p < .02$), Hostility ($p < .05$), and Paranoid Ideation ($p < .01$) sub-scales of the SCL-90-R (see Table 16). As the age of the participant at the onset of the abuse increased, the differences in the scores of the GSI, Hostility and Paranoid Ideation subscales from pre-test to post-test significantly decreased. No significant correlations
Table 15

Pearson Correlation Coefficients and Probability Levels for the Mean Scores of Age at Onset of the Abuse, Duration of Abuse and the Initial Mean Scores of all of the Outcome Variables (p values are two-tailed)

<table>
<thead>
<tr>
<th></th>
<th>Age of Onset</th>
<th></th>
<th>Duration of Abuse</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>r</td>
<td>p</td>
<td>r</td>
<td>p</td>
</tr>
<tr>
<td>GSI</td>
<td>-0.16</td>
<td>0.48</td>
<td>0.28</td>
<td>0.20</td>
</tr>
<tr>
<td>Depression</td>
<td>-0.15</td>
<td>0.49</td>
<td>0.30</td>
<td>0.17</td>
</tr>
<tr>
<td>Hostility</td>
<td>-0.19</td>
<td>0.38</td>
<td>0.21</td>
<td>0.35</td>
</tr>
<tr>
<td>Guilt</td>
<td>-0.03</td>
<td>0.89</td>
<td>0.37</td>
<td>0.08</td>
</tr>
<tr>
<td>Interpers. Sens.</td>
<td>-0.11</td>
<td>0.63</td>
<td>0.17</td>
<td>0.45</td>
</tr>
<tr>
<td>Par. Ideation</td>
<td>-0.24</td>
<td>0.28</td>
<td>-0.03</td>
<td>1.00</td>
</tr>
<tr>
<td>Overall S.C.</td>
<td>0.56</td>
<td>0.01*</td>
<td>-0.44</td>
<td>0.04*</td>
</tr>
<tr>
<td>Physical S.C.</td>
<td>0.17</td>
<td>0.44</td>
<td>-0.40</td>
<td>0.06</td>
</tr>
</tbody>
</table>

* p ≤ .01
** p ≤ .05
Table 16

Pearson Correlation Coefficients and Probability Levels for the Mean Scores of Age at Onset of Abuse and the Pre-Test to Post-Test Differences in the Mean Scores of the Outcome Variables for the Contrast Group (p values are two-tailed)

<table>
<thead>
<tr>
<th>Age of Onset of Abuse</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DGSI</td>
<td>-0.67</td>
<td>0.02**</td>
</tr>
<tr>
<td>DDepression</td>
<td>-0.28</td>
<td>0.41</td>
</tr>
<tr>
<td>DHostility</td>
<td>-0.61</td>
<td>0.05**</td>
</tr>
<tr>
<td>DGuilt</td>
<td>-0.45</td>
<td>0.16</td>
</tr>
<tr>
<td>DInterpers. Sens.</td>
<td>-0.43</td>
<td>0.19</td>
</tr>
<tr>
<td>DPar. Ideation</td>
<td>-0.71</td>
<td>0.01*</td>
</tr>
<tr>
<td>DOverall S.C.</td>
<td>0.82</td>
<td>0.81</td>
</tr>
<tr>
<td>DPhysical S.C.</td>
<td>0.16</td>
<td>0.47</td>
</tr>
</tbody>
</table>

* p \leq .01

**p \leq .05
were found between the duration of the abuse and the differences in the scores of the dependent measures from pre-test to post-test.

At the conclusion of the group sessions, participants in the experimental group were asked to complete an experimenter-generated Support Group Assessment (SGA) designed to evaluate how well the group experience helped the women. The results are presented in Table 17. The majority of the women (82%) cited feeling a sense of belonging or inclusion and increased self-understanding as the most helpful components of the group experience. In addition, many of the women (73%) cited developing resources, the instillation of hope and support from other group members and the facilitators as the most helpful components of the group experience. Homework assignments and lectures or information giving were most commonly (27%) cited as the least helpful components of the group experience.

When asked to comment on what their individual needs and goals were upon entering the group, the most common responses included the need to decrease feelings of isolation and differentness, to reduce denial by acknowledging and telling their stories of the abuse experiences, and to gain insight and self-awareness. All of the women who responded felt that the group was
Table 17

SGA Responses of the Women in the Experimental Group

<table>
<thead>
<tr>
<th></th>
<th>Least Helpful</th>
<th>Helpful</th>
<th>Most Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large Group Work</td>
<td>9%</td>
<td>46%</td>
<td>46%</td>
</tr>
<tr>
<td>Small Group Work</td>
<td>18%</td>
<td>46%</td>
<td>18%</td>
</tr>
<tr>
<td>Homework Assignments</td>
<td>27%</td>
<td>36%</td>
<td>36%</td>
</tr>
<tr>
<td>Lectures/Information</td>
<td>27%</td>
<td>18%</td>
<td>55%</td>
</tr>
<tr>
<td>Films</td>
<td>18%</td>
<td>55%</td>
<td>9%</td>
</tr>
<tr>
<td>Resources</td>
<td>18%</td>
<td>9%</td>
<td>73%</td>
</tr>
<tr>
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<td>9%</td>
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helpful to very helpful in meeting these personal needs and goals.

Finally, the women in both the experimental and contrast groups were asked to participate in a six-week follow-up to determine if the outcomes were consistent over time. Only 5 women in the experimental group and 8 women in the contrast group participated in the follow-up component of this study. The individual mean scores for each participant on the pre-, post- and follow-up testing times are presented in Tables 18 and 19. A review of these scores suggests that there were no distinguishing differences in the scores of the women who completed the follow-up and those who did not complete the follow-up. The scores obtained by the women in the experimental group who completed the follow-up component of the study indicated that the changes in the scores suggesting improvement were sustained or continued at follow-up. There was less consistency among the scores of the contrast group as the follow-up scores did not reflect any specific trends.
Table 18

Mean Scores of Dependent Measures at Pre-test, Post-test and Follow-up For Experimental Group Members

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"*" denotes no follow-up.
Table 19

Mean Scores of Dependent Measures at Pre-test, Post-test and Follow-up For Contrast Group Members

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*** denotes no follow-up.
CHAPTER FIVE  
DISCUSSION  

The present chapter will include a restatement of the purpose of the study, a discussion of the participants, a brief discussion of the group treatment approach evaluated in this study, and a summary and discussion of the results obtained from testing the hypotheses. The results obtained from the Support Group Assessment will also be reviewed and discussed. Finally, the limitations, as well as the research and counselling implications of this study will be discussed.  
Restatement of the Purpose  

The present study was designed to evaluate the effectiveness of a group treatment approach for women who had been sexually abused in childhood. The evaluation of the group treatment approach was carried out by determining: 1) if changes occurred among women who participated in group treatment from pre-test to post-test on 8 psychological and interpersonal variables including: a) self-esteem, b) body image c) depression, d) feelings of guilt/shame, e) feelings of anger or hostility, f) interpersonal sensitivity, g)
paranoid ideation, and h) the general severity of symptomatic psychological distress, 2). if changes on these measures occurred for women in a contrast group, and 3). if the changes among the women in the experimental group were greater than those among the women in the contrast group. These variables were measured through the use of the Overall Self-Concept and Physical Self-Concept scales of the Tennessee Self-Concept Scale and the 6 scales of the Symptoms Checklist-90-Revised.

**Discussion of the Sample**

Demographic information on the participants in this study was obtained in order to determine a) if the experimental and contrast groups were comparable to each other, and b) if the women in this study were comparable to the subject samples used in previous sexual abuse research. A review of the demographic information in Tables 5-13 (pp. 107 - 116) suggests that the two groups were similar on most of the demographic characteristics including age, socioeconomic status, marital status, ordinal position in their family of origin, perceptions of the happiness or unhappiness of their parents’ marriages, and number of siblings. Additionally, the two groups were similar
in terms of the type of abuse they experienced, their relationship to the offender, their age at the onset of the abuse, and the duration of the abuse. Finally, the women who participated in the present study seem to be similar to the women involved in previous sexual abuse research.

An overview of the demographic information indicates that the women in both of the groups were in their early to middle thirties, with a mean age of 31.82 years for the contrast group and a mean age of 36.34 years for the experimental group. These age ranges were similar to those found among the women in Alexander, Neimeyer, Follette, Moore and Harter's (1989) study whose mean age was 36 years.

Over one third (36.36%) of the women in both groups were single at the time of the study, almost half (45.45%) of the women in the experimental group and over one third (36.36%) of the women in the contrast group were married or living common-law. Only 2 women (18.18%) in the contrast group and no women in the experimental group were divorced. Again, these findings are similar to those of Alexander et al.'s (1989), who reported that of the women in their study, 39% were single, 36% were married and 20% were
divorced. These findings suggest that the two groups were comparable with regards to age and marital status and were similar to the women in previous sexual abuse research.

The two groups were also similar to each other and to women in previous sexual abuse research with respect to their abuse history, including the age of the participant at the onset of the abuse, the duration of the abuse, the types of abusive behaviors experienced, and the relationship of the participant to the offender. The average age of onset of abuse was 6.36 years for the contrast group and 3 years for the experimental group. While these ages are somewhat younger than what some of the earlier research has suggested (Bagley & King, 1990; Briere & Runtz, 1988) they still concur with research suggesting that sexual abuse most often begins when the victim is prepubescent (Alexander et al., 1989; Bagley & King, 1990; Brunngraber, 1986; Tsai, Feldman-Summers & Edgar, 1979).

The duration of the abuse was similar for the women in both groups, ranging from less than a year to more than 20 years. The mean duration of the abuse was 6.91 years (S.D. = 7.85) for the experimental group and 4.18
years (S.D. = 7.52) for the contrast group. These findings are similar to those of Alexander et al. (1989) who reported that the mean duration of the abuse among the women in their study was 7 years, with a range of one month to 16 years. Tsai and Wagner (1978) report a mean duration of 4.6 years among the women in their study. Again, these results indicate that the women in the present study seem to be similar to women involved in previous sexual abuse research.

The women in the two groups also reported having similar relationships to their offenders, as 36.36% of the contrast group and 40% of the experimental group reported abuse by their natural fathers. This finding is consistent with Tsai, Feldman-Summers and Edgar's (1979) findings that 43% of their clinical sample had been abused by their natural fathers. The offender for both groups of women was almost always male, with the exception of three (30%) women in the experimental group and one (9.09%) woman in the contrast group reporting abuse by their natural mothers. In addition, two (20%) women in the experimental group reported abuse by their natural sister. Again, these findings concur with previous sexual abuse research (Briere & Runtz, 1988; Brunngraber, 1986; Haugaard & Repucci,
suggesting that the women in the present study were similar to the women in previous studies with regard to their relationship to the offender.

The women in both groups were also similar to each other and to women in previous sexual abuse research with regard to the type of sexually abusive behaviors they experienced. The most common form of abuse experienced by women in both groups was fondling, with exposure, fellatio and vaginal intercourse also being common (see Table 6, p. 108). These findings are remarkably similar to findings by Brunngraber (1986) and Roberts and Lie (1989) who cite fondling, fellatio and vaginal intercourse as the most common forms of abuse among the women in their studies.

Upon reviewing the demographic information and abuse history of the participants in the present study, it would appear that the women in both groups were similar to each other and to the women in other sexual abuse research on most of the variables (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Briere & Runtz, 1988; Brunngraber, 1986; Roberts & Lie, 1989; Tsai & Wagner, 1978). However, a number of differences were found between the two groups that must be
considered when reviewing the results of the present study.

A comparison of the scores of the women in this study with standard norms for the TSCS and the SCL-90-R indicated that women in both groups reached "caseness" on the scales of the SCL-90-R (Derogatis, 1983). According to Derogatis (1983) an operational definition of caseness is fundamental to screening and consists of a value or score that serves to define a positive case. The operational rule for caseness for non-patient norms on the SCL-90-R states that if a respondent has a GSI score or any two primary dimension scores greater than or equal to T-score 63, then the individual is considered a positive diagnosis or a case (Derogatis, 1983). These findings suggest that the women in this study were functioning at a level below the norm for female non-patients with regard to psychological symptom distress. In addition, the scores of the women in the experimental group on the overall self-concept scale of the TSCS were below the standardized norms, suggesting that these women reported lower self-esteem than is normally reported by most adults. The scores of the women in the contrast group on the overall self-concept scale of the TSCS fell within the normal
range. However, the women in both groups reported scores on the physical self-concept scale of the TSCS that fell below the norm. These results imply that women in this study were generally lower functioning than a normal population of adult women, with the exception of overall self-concept among the women in the contrast group.

The majority of the women in both groups were in a middle to lower socio-economic class with 72.72% of the contrast group and 90.91% of the experimental group earning less than $30,000 a year. Almost half (45.45%) of the women in both groups were earning less than $10,000 a year. Only 2 women (18.18%) in the contrast group and no women in the experimental group earned more than $30,000 a year, and only 1 (9.09%) woman in each group earned greater than $50,000 a year. These findings suggest that while the two groups were comparable to each other in terms of socio-economic status, the women in this study may not be representative of women in a higher socio-economic class, which may hamper the generalizability of the findings of this study. It is possible that women who are employed in white-collar jobs may be higher functioning in general and may have scored higher on
the TSCS and the SCL-90-R.

More important to note, however, was that the two groups were found to differ significantly on three variables including abuse by a step-father, abuse by more than one offender, and whether or not they had received a university education. Significantly more women in the experimental group reported abuse by their step-fathers than women in the contrast group. Further statistical analyses using t-tests indicated that this difference did not significantly relate to the pre-test scores or the changes in the scores of the dependent measures. These results suggest that the women in the experimental group who were sexually abused by their step-fathers were not significantly different from the women in the contrast group in terms of their general psychological functioning as measured by the TSCS and the SCL-90-R. In addition, the changes in the scores from pre-test to post-test were not significantly different between the women who were abused by their step-fathers and those who were not abused by their step-fathers, suggesting that this variable did not affect the impact of group treatment among women in the experimental group.

The women in the experimental group also reported
abuse by more than one person significantly more often than women in the contrast group. While some research evidence suggests that abuse by more than one offender is more traumatic than abuse by a single offender (Briere & Runtz, 1988), the results of further statistical analyses using t-tests indicated that the experience of abuse by multiple offenders did not significantly affect the initial scores or the pre- to post-test changes in the scores of the dependent measures. These findings suggest that the experience of abuse by multiple offenders did not seem to distinguish the two groups in terms of their general psychological functioning prior to the study, nor did it affect the changes in their scores following group treatment on the TSCS and the SCL-90-R from pre-test to post-test.

The women in the contrast group reported receiving a university education significantly more often than the women in the experimental group. Further comparisons indicated that the women who did not receive a university education reported significantly higher pre-test scores on the Hostility sub-scale of the SCL-90-R and a significant decrease in their feelings of guilt scores from pre-test to post-test.
While Briere and Runtz (1988) suggest that individuals in university may be better adjusted and higher functioning than those who do not attend university, the results of the present study suggest that there were few major differences on psychological functioning between those women who attended university and those who did not, other than their feelings of hostility and guilt.

Finally, a comparison of the mean pre-test scores of the dependent measures obtained by the women in the contrast and experimental groups was made using t-tests to determine if the two groups were comparable. Results indicated that the contrast group members scored significantly lower on the GSI ($p < .05$), Hostility ($p < .05$) and Paranoid Ideation ($p < .05$) subscales of the SCL-90-R than the women in the experimental group (see Table 11, p. 110). These findings suggest a possible source of bias in the sample as the women in the contrast group may have been slightly higher functioning than women in the experimental group at the time of the study.

While a number of differences were found between the two groups, it is evident from the findings that the two groups were similar to each other on most of
the variables. In addition, the women in the present study seem to be generally similar to women in previous sexual abuse research. These findings support the premise that the women in the present study are fairly representative of the general population of women who have been sexually abused in childhood.

Discussion of the Results

A number of findings emerge from this study. First, in accordance with the majority of the research and literature on the effectiveness of group treatment for women sexually abused in childhood (Bass & Davis, 1988; Gil, 1988; Herman & Schatzow, 1984; Tsai & Wagner, 1978; Roberts & Lie, 1988), the women in group treatment reported significant decreases in interpersonal sensitivity, as measured by the Interpersonal Sensitivity subscale of the SCL-90-R. This finding suggests that these women felt decreased uneasiness and discomfort in their interactions with others. Much of the research to date has indicated that group treatment is essential in reducing feelings of alienation, stigmatization and isolation among adult victims of childhood sexual abuse (Deighton & McPeek, 1985; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Roberts & Lie, 1988; Tsai & Wagner,
Herman and Schatzow (1984) report that 72% of their sample of women cited contact with other sexual abuse victims as the single most helpful thing about their group experience. Similarly, Tsai and Wagner (1978) found that the women in their groups rated the opportunity to share their experiences with other victims to be the most helpful component of the group experience. The responses of the women who had received group treatment in the present study concur with these findings. When asked to comment on the the most helpful aspect of the group, 82% of the women reported that interaction with other victims was the most helpful. While these results seem to support the belief that involvement in group treatment decreases feelings of interpersonal sensitivity among women who have been sexually abused, caution must be taken when interpreting these findings, given the small sample sizes.

The second significant finding was a decrease in the scores on the Paranoid Ideation subscale of the SCL-90-R among the women in the treatment group. As this subscale is designed to measure an individual's feelings of suspicion and distrust of others, it may be
assumed that the group treatment approach was helpful in alleviating feelings of distrust and guardedness among the group participants. These findings concur with other research findings which suggest that group treatment is helpful in increasing levels of trust among victims of sexual abuse (Hays, 1987). Hays (1987) maintains that the development of trust is a central issue in therapy groups for victims of sexual abuse.

While these findings seem to suggest that the group treatment approach used for the present study resulted in decreased interpersonal sensitivity and decreased paranoid ideation among the group participants, they are not conclusive. No significant differences were found on these measures between the experimental and contrast groups. It may be speculated that larger sample sizes would show greater differentiation between the groups.

Due to the limitations of this study, individual counselling was not controlled for and may also have contributed to these findings. As some of the women in the contrast and experimental groups were receiving individual counselling for sexual abuse issues, it is possible that this involvement in individual therapy
might also have resulted in a decrease in interpersonal sensitivity and paranoid ideation, as these women learned to trust their therapists. Since it is unknown to what extent this factor impacted the scores of the women in either group, it cannot be stated conclusively that group treatment was the only factor in these changes.

In addition to these expected findings, a number of unexpected findings emerged from this study that do not concur with previous literature on group treatment for sexually abused women. Participants in the contrast group showed a significant improvement in overall self-concept from pre-test to post-test. While these results were not statistically different from those of the experimental group, they raise some questions regarding the significant improvement shown among the contrast group members compared to the experimental group members. An examination of the pre- and post-test scores of the experimental group, indicates that the Overall Self-Concept scores ranged from those who showed great improvement to those who showed a deterioration in their general self-concept (see Table 2, p.97). One may assume then, that group treatment may not be conducive to building a positive
self-concept or increasing self-esteem for all women who have been sexually abused. Perhaps self-esteem decreased for some women at various stages of the therapeutic process as they began to recall specific painful memories. It is also possible that some women compared themselves to other group members and felt inferior in terms of their rate of improvement or their abuse histories. If so, indepth interviews may be necessary in order to screen out members who may not benefit from, or may not be ready for the group experience due to low self-esteem or feelings of intimidation and inferiority.

Another plausible explanation for the significant increase in the Overall Self-Concept scores among the women in the contrast group may be due to individual counselling. As the present study did not control for individual counselling, it is difficult to know whether the improvement shown by the women in the contrast group was due to this factor. Again, it is possible that the women in the contrast group who received individual counselling for sexual abuse issues began to resolve these issues and as a result, their feelings of self-esteem increased.

Perhaps even more surprising were the results on
the Feelings of Guilt subscale of the SCL-90-R. It was found that the contrast group members showed a significant decrease in their feelings of guilt from pre-test to post-test, while the experimental group members showed no changes. An examination of the mean scores for both groups from pre-test to post-test indicates that all but one of the women in the contrast group reported that their feelings of guilt decreased or remained the same. Conversely, three women in the experimental group reported an increase in their guilt feelings and four women reported no change in their feelings of guilt. It is possible that involvement in group treatment may actually increase feelings of guilt as members begin to acknowledge the sexual abuse in their lives. Furthermore, if not carefully processed, some members may feel guilty if they perceive their abuse experiences to be less significant than those of other members, or if they experienced feelings of physical pleasure from the abuse that were not shared by other group members. While this factor has not been examined in the research on sexual abuse treatment groups, some clinicians have noted this possible reaction among their observations of the women in their therapy groups (Gil, 1988; Hays, 1987). Hays (1987)
notes that some members of sexual abuse treatment groups may avoid sharing or minimize their abuse experiences if they feel that they were somehow to blame. She cites an example of a group member who "never did more than allude to her subsequent relationship with her uncle, some of which had been sexually pleasureable" (p.154).

Support Group Assessment

The responses to the SGA seem to support the notion that the group treatment approach was perceived as helpful in reducing feelings of isolation, stigmatization and in increasing feelings of trust and intimacy among the group members. The majority of the women in the group (82%) rated Yalom's (1985) Sense of Belonging /Inclusion factor as the most helpful component of the group, along with Self-Understanding (82%), Instillation of Hope (73%), Guidance (64%), and Cohesiveness (46%). Support from other group members and the facilitators (73%), and the development of resources (73%) were also considered helpful by the group members.

When asked to comment on the extent to which the group had met their individual needs and goals, the majority of the women felt that the group was helpful
or very helpful in meeting their need to decrease their sense of isolation and feelings of "differentness", to tell their stories among other women who would understand, to gain insight and to express their feelings about the abuse. These results seem to support the findings of previous research that group treatment helps to reduce feelings of isolation and alienation among women sexually abused in childhood (Goodman & Nowak-Scibelli, 1985; Gordy, 1983; Herman & Schatzow, 1984; Tsai & Wagner, 1978). In addition, these results seem to support the findings of the present study that group treatment seems to have been helpful in decreasing interpersonal sensitivity and paranoid ideation among the women in the experimental group.

Finally, of particular interest from a clinical perspective, all of the women in the treatment group suggested that future groups be longer in duration. These women felt that groups lasting 12 weeks or more would provide a better opportunity to process their sexual abuse issues in greater depth. This finding has important implications for the changes on the dependent measures among the women in the experimental group. Perhaps if the groups were longer in duration, as
suggested by these women, the changes in the scores would have been greater. It is possible that the ten week format provided by the group treatment approach evaluated in this study was not enough time to adequately resolve issues related to sexual abuse such as self-esteem, body image, interpersonal sensitivity, guilt, anger, and feelings of trust.

Follow-Up Results

Only 8 women in the contrast group and 5 women in the experimental group agreed to participate in this component of the study, making it difficult to statistically compare these findings with the pre- to post-test results in a meaningful way. Instead, the follow-up results were examined in a more qualitative manner by recording the mean scores of all of the women in this study and noting any differences in the scores among those who did not participate in the follow-up and those who did participate in the follow-up. The mean scores are presented in Tables 18 and 19 (pp. 125-126).

Based on a review of the mean scores for the women in the experimental and contrast groups, there did not appear to be distinguishing differences between the scores of the women who completed the follow-up
component of the study and those who did not complete the follow-up. This finding suggests that completion of the follow-up was not dependent on the level of psychological functioning of the women in the experimental and contrast groups as reflected in their scores on the TSCS and the SCL-90-R. In addition, for most of the women in the experimental group, any changes toward improvement in the scores of the dependent measures were maintained or continued at follow-up, suggesting that the changes reported by these women seem to have been maintained six weeks following group treatment. However, given the fact that so few women completed the follow-up, no statistical analyses were conducted, therefore caution is advised when interpreting these findings.

Limitations of the Study

Several factors limited the present study. The lack of randomization of the sample and the voluntary nature of participation in the study may have affected the results. This may be especially true for a sample of sexual abuse survivors given the social stigma and shame that is still associated with this issue. It may be argued that only those women who have already begun to deal with their sexual abuse experiences would
volunteer to participate in a study such as the present one, excluding those women who may still be struggling with feelings of denial and shame about the abuse. As a result of this factor, the generalization of the findings of the present study to other groups of women who have been sexually abused in childhood should be made with caution. In addition, the generalizability of the results of the present study is limited by the fact that all of the women who made up the experimental group were recruited from the same counselling center in a small community.

Finally, in accordance with ethical guidelines, involvement in the present study was voluntary. As a result, four women in the therapy group chose not to participate in the study which precluded the use of a true random sample. As no information was obtained from those women who refused to participate in the study, it is unknown if they differed from the women who did participate in the study. Similarly, as few women participated in the 6 week follow-up component of this study, it was difficult to assess the longer-term benefits of the group treatment approach.

The sensitive nature of the topic of sexual abuse made recruitment of participants for this study
difficult and time consuming. As a result, relatively small sample sizes were obtained making it difficult to draw conclusions and make generalizations from the results. Also, given time and ethical constraints, and the limited number of therapy groups available for sexually abused women, the present study did not include a control group. Only one counselling center consented to an evaluation of their therapy groups and, as the women who might have made up a wait-list control group were eventually used as participants in the experimental group, a contrast group was used in the place of a control group.

While the contrast group provided a way of comparing the scores of women who had received group treatment with women who had not received group treatment, the contrast group was limited in a number of ways. First, due to the voluntary nature of participation in the study, it is possible that the women who participated in the contrast group were not fully representative of sexually abused women in general. As mentioned earlier, given the stigma and shame often associated with sexual abuse, it is possible that the women who volunteered to participate in this study were generally higher functioning than
some women who may have been less willing to admit that they were sexually abused in childhood. It is also possible that the women in the contrast group had not sought group treatment for sexual abuse issues because they felt relatively more resolved in these issues than the women who had sought group treatment. This possibility seems to be reflected in the initial scores of the dependent measures as the women in the contrast group reported better scores than the women in the experimental group (see Table 11, p. 114).

While the participants in this study were distinguished according to whether or not they received group treatment, individual counselling was not controlled for in order to obtain a minimum number of women for each sample group. As a result, some women in both groups had received individual counselling for sexual abuse issues which may have confounded some of the findings of this study. In addition, experiential factors such as the amount of other forms of support and/or stresses that the women in this study had prior to, and during the length of the research were not controlled for, but may have impacted on the results.

The difficulties experienced by the experimenter in finding an organization willing to allow an evaluation
of its therapy groups made it necessary to combine two groups in order to obtain an adequate number of participants for the experimental group. While the treatment model and facilitators were the same for both groups, it could be argued that the qualitative component of therapy groups often differs from one group to another group. The present study was unable to control for the possibility of a qualitative difference between the two groups used to make up the experimental group. However, as the group format was quite structured and the facilitators were the same for both groups, the two groups were comparable in terms of the issues raised and the way in which these issues were processed.

As self-report instruments were used in the present study to measure the dependent variables, the results may have been influenced by possible response bias. In addition, while the test instruments utilized in the present study were designed to measure general psychological and symptomatic constructs, they may not have been able to assess emotional and social components specific to the experience of sexual abuse. For instance, while one might expect levels of anger as measured by the Hostility subscale of the SCL-90-R to
decrease following treatment, it could be argued that an increase in anger may in fact be more therapeutically beneficial. The Hostility subscale was not able to measure the differences between anger at self and anger at others, such as the offender. A standardized instrument designed to measure those symptoms associated specifically with sexual abuse would conceivably be more informative.

Finally, the results of this study had to be interpreted with caution as they were based on the statistical analysis of mean scores. As mean scores only represented average scores, they did not account for the complete range of individual responses to the test questions. In addition, as t-tests were the primary method of analysis, there was an increased vulnerability of finding significance by chance alone.

In summary, the present study was limited by a number of design and sampling difficulties. As the recruitment of participants for this study was arduous, the representativeness of the sample was limited, thereby hampering the generalizability of the findings. In addition, the inconsistency of the findings with previous sexual abuse research may be attributed to a combination of design and treatment factors such as the
limited availability of therapy groups and participants, the lack of control over individual counselling, the use of one agency for the recruitment of the treatment group, the training and expertise of the facilitators, and the psychoeducational nature of the group therapy format.

Implications for Further Research

The most problematic component of the present study was the small sample size, making it difficult to generalize and interpret the findings. In addition, the randomness of the sample could be called to question given the voluntary nature of participation and the fact that the women in the treatment condition were all recruited from the same counselling agency. In the future, the generalizability of the results of the present study may be increased by using larger sample sizes recruited from a variety of counselling agencies. Related to this, the present study was limited to providing a contrast group to serve as a comparison to the experimental group. In future, a control, or delayed treatment group would enhance the validity and generalizability of the findings.

Another limitation of the present study is that individual counselling was not controlled for among the
participants. As a result, it was difficult to assess to what extent the group treatment was instrumental in promoting changes in the women. A more informative approach would be to screen for individual counselling when admitting women to group therapy and to use a control group who was also receiving individual counselling for sexual abuse issues. An even greater control would be achieved by assessing the type of individual therapy being received by subjects and matching them accordingly. Alternatively, an evaluation of the effectiveness of group treatment could be assessed by using participants who have not received any counselling for sexual abuse issues prior to involvement in the study. In addition, it would be helpful to gain information regarding the perceived level of support and/or stresses existing among the participants in the study. It is conceivable that the presence or absence of supports and other life stressors could affect research outcomes. By controlling for these variables, confidence in the outcomes associated with the treatment approach would increase.

The results of the present study suggest that not all of the women benefitted from their involvement in
group treatment. Future research is necessary to
assess the emotional and psychological characteristics
of women who benefit from group therapy and those who
do not benefit. This information would be helpful for
the development of pre-group screening assessments that
would determine the appropriateness of group treatment
for prospective members.

In addition, the mean pre-test scores of the
dependent measures suggested that the members of the
contrast group were generally higher functioning than
the members of the experimental group. While many
clinicians believe that group treatment is the
treatment of choice for sexually abused women (Deighton
& McPeek, 1985; Herman & Schatzow, 1984; Goodman &
Nowak-Scibelli, 1985), it is possible that not all
women who have been sexually abused feel the need for
involvement in group treatment. Further research
comparing the psychological characteristics of women
who seek group treatment and those who do not seek
group treatment would provide some useful insights into
the treatment needs of sexually abused women.

While standardized measures were employed in the
present study, it is unclear as to how well the
instruments used actually assessed the psychological
and/or emotional constructs that were specifically related to the experience of sexual abuse. There is a strong indication that the development of a standardized instrument designed to assess constructs specific to sexual abuse is vital to the accurate evaluation of treatment approaches for adults sexually abused as children.

In addition, the assessment of changes resulting from group treatment would be enhanced by incorporating a qualitative component asking the participants to identify and rate the behavioral changes that have occurred in their lives as a result of treatment. It is not unlikely that participants may indicate emotional changes on self-report measures while not making any changes behaviorally. Furthermore, these changes should be assessed again at 6 month to one year follow-up intervals to evaluate whether the changes were lasting.

The results of this study suggest that group treatment may be helpful in reducing isolation and increasing trust among sexually abused women. However, group treatment was not found to significantly change the group members feelings of guilt, anger, depression, self-esteem, or their perceived body image as measured
by the TSCS and the SCL-90-R. While many clinicians (Deighton & McPeek, 1985; Gil, 1988; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Tsai & Wagner, 1978) have provided valuable qualitative information supporting the use of groups with sexually abused women, few studies have provided quantitative data to support this belief (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Roberts & Lie, 1989). The present study was designed to help fill this gap in the literature. However, as this study was exploratory in nature, and suffered from a number of limitations, the need for further research on pre-test to post-test evaluations of group treatment approaches is indicated.

Implications for Counselling

The results of the present study suggest that group treatment was perceived as helpful in decreasing interpersonal sensitivity characterized by feelings of isolation, stigmatization and shame and increasing trust among women who have been sexually abused in childhood. Although not completely supported by the quantitative data, it seems clear that the women who participated in the group treatment felt that it was very helpful in meeting their personal needs and goals. This qualitative data supports the need for providing
groups for adult survivors of childhood sexual abuse in order to decrease the profound sense of isolation felt by these women. Additionally, the responses of the women in this study suggest that therapy groups for sexually abused women should run for a minimum of 12 weeks in order to adequately meet the needs of all group members.

While some of the results of the present study seem to support the need for sexual abuse groups, a number of findings indicate a need for more effective pre-therapy interviews and screening procedures before admitting an individual into a treatment group. Not all members appear to fare better from involvement in a sexual abuse group. Perhaps of particular importance is the assessment of an individual's psychological and emotional status as well as their previous therapeutic experiences, including individual counselling and involvement in therapy groups.

Finally, given the wide range of abuse experiences reported by the women in the present study, when planning future groups specific attention may need to be paid to the sex of the offender and his/her relationship to the victim and the type of sexually abusive behavior experienced. As many of the women in
the present study reported feeling different from others due to their abuse, it is possible that this feeling may be heightened in a group experience if group members feel their experiences are too different from those of other members.

Conclusion

In conclusion, the results of this study suggest that group treatment was helpful in reducing feelings of interpersonal sensitivity and paranoid ideation among sexually abused women. These results concur with the findings of previous research suggesting that group treatment helps to reduce feelings of isolation and increase trust among sexually abused women (Goodman & Nowak-Scibelli, 1985; Gordy, 1983; Herman & Schatzow, 1984; Tsai & Wagner, 1978). However, the results of this study do not concur with previous research findings that group treatment, 1). reduces feelings of guilt, depression, anger, and the general severity of psychological distress symptoms, and 2). increases feelings of self-esteem and the development of a positive body image among sexually abused women (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Deighton & McPeek, 1985; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Roberts & Lie, 1989;
Tsai & Wagner, 1978).

While all of the women in the present study felt that the group treatment approach was very helpful in alleviating their feelings of aloneness, shame and stigmatization, the results of this study indicated that not all benefitted from their involvement in the group. This finding raises important questions about the appropriateness of group treatment for all victims of sexual abuse. The need for careful screening of potential group members seems to be indicated. As more and more women disclose sexual abuse in their childhoods, the demand for appropriate therapeutic interventions increases. Many women are seeking out groups to share their experiences with other sexually abused women. As waiting lists for these groups increase, there is added pressure to provide more therapy groups to meet this need. The empirical results of the present study and the responses of the women involved in the group, appear to support the need for clinicians and researchers to continue to develop and evaluate group treatment approaches that will best meet the needs of the growing numbers of women seeking treatment.
References


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Neglect, 12, 51-59.
Occupational Therapy in Mental Health, 5, 63-76.
Advances in Nursing Science, 86, 15-35.


Hays, K. F. (1987). The conspiracy of silence revisited: Group therapy with adult survivors of


APPENDICES
APPENDIX A

DESCRIPTION OF THE GROUP TREATMENT PROGRAM
Appendix A

OUTLINE OF THE GROUP TREATMENT APPROACH

Duration: 10 weeks, 2 1/2 hours/week
Place: South-Surrey/White Rock Women's Place

Session One
- Introductions of group facilitators and group members
- Brief check-in
- Review group rules, format, and personal contracts
- Presentation of educational topics
  - Definitions of sexual abuse
  - Communication skills
- Exercise - Split into pairs and complete the sentence
  "If I thought you wouldn't judge me, I'd tell you..."
- Sharing appreciations of group members
- Closing round

Session Two
- Centering and breathing warm-up
- Check-in
- Presentation of educational topic
  - Repairing personal boundaries
- Exercise - Visualization on finding your "inner guide"
- Sharing appreciations
- Closing round

Session Three
- Centering and breathing warm-up
- Check-in
- Presentation of educational topic
  - "Healing the inner child"
- Problem-solving time - for members to share personal issues
- Exercise - "Building a container" for management of intense emotions
- Sharing appreciations
- Closing round

Sessions Four through Nine
- Centering exercise
- Check-in
- Dealing with unfinished business from previous session
- Presentation of educational topic (topics for each session included)
  - Assessing the damage of child sexual abuse
  - Grief and loss
  - Shame and guilt
  - Anger and rage
- Sexuality and body image
- Depression
- Memories and flashbacks
- Fears
- Co-dependency and interpersonal relationships
- The offender and non-offending parents

- Exercises - included art therapy, working with clay, letter and journal writing, gestalt body work, and psychodrama
- Sharing of appreciations
- Closing round

Session Ten
- Centering and breathing exercise
- Check-in
- Review personal contracts in order to assess personal goals
- Presentation of educational topic
  - How to network and access other resources
- Completion of group evaluation form
- Exercise - Completing a "Stroke Sheet" where everyone acknowledges and appreciates other group members
- Celebration with food and beverages
- Sharing of appreciations
- Closing round
APPENDIX B

DESCRIPTION OF THE STUDY FOR THE EXPERIMENTAL GROUP
AN EVALUATION OF A GROUP TREATMENT APPROACH
FOR WOMEN SEXUALLY ABUSED IN CHILDHOOD

This is a University of British Columbia research project intended to look at how group therapy may meet the needs of women who have experienced sexual abuse in childhood. In order to assess how well group therapy works, you will be asked to complete two instruments, the Tennessee Self-Concept Scale and the Symptoms Checklist. These tests measure how you feel, both emotionally and socially, they are not measures of your ability. You will be asked to complete these instruments twice, once at the beginning and once at the end of group therapy. The tests will take approximately one hour in total to complete.

Your answers to these instruments will be compared with those of a group of women who have not received group therapy for issues around child sexual abuse. In addition, you will be asked to fill out a personal information sheet. Finally, you will be asked to fill out a brief questionnaire at the end of the group therapy sessions that will assess how you felt about the group therapy.

Please keep in mind that all of the tests and questionnaires will be completely anonymous and
confidential. You will not be required to put your name on any of the materials, and the results will only be seen by myself and my thesis supervisor.

If, at any time in the project you decide that you do not want to participate, you may decline to do so without penalty. You do not need to participate in the project in order to receive treatment and you will not lose any of your rights as a group member if you chose to decline participation.

This project will be conducted by Louise Blanchard, an M.A. candidate in Counselling Psychology at UBC, and will be supervised by Dr. Judith Daniluk. If you have any questions, comments or concerns about this project, please feel free to contact me at 733-9177 or write to:

Louise Blanchard
#9-1645 West 11th Avenue
Vancouver, B.C.
V6J 2B8

Thank you for your consideration of this project.

Principal Investigator: Louise Blanchard, M. A.
Candidate

Thesis Supervisor: Dr. Judith Daniluk
APPENDIX C

ETHICAL CONSENT FORM
Consent Form

I_________________________ have read the description of the research project entitled An Evaluation of A Group Treatment Approach for Women Sexually Abused in Childhood and I understand the procedures as outlined. I understand that, at any time, I may withdraw from participation in the project without penalty and it will not affect my treatment. I also understand that all of the information that I give is anonymous and will be held strictly confidential.

I hereby consent to being involved in this project.

(Please sign both copies of this consent form and keep one copy for your records)

__________________________
Signature

__________________________
Date
APPENDIX D

PERSONAL INFORMATION SHEET
Section A: Personal Information

Age: ____________

Present Occupation: _______________________________________

Indicate last level of education completed or presently being completed: _______________________________________

<table>
<thead>
<tr>
<th>Present Yearly Income</th>
<th></th>
<th></th>
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<td></td>
</tr>
<tr>
<td>$10,000 - $20,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$20,000 - $30,000</td>
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<td></td>
<td></td>
</tr>
<tr>
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</table>

<table>
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<tr>
<th>Relationship Status</th>
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</thead>
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<tr>
<td>Single</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commonlaw</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How Long?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Number of Children (if any): ____________________________
Section B: Background Information

How many children were in your family?
   Brothers____  Sisters____

What was your sibling position in your family?
   First Born____  Last Born____
   Middle____  Only____
   Other________

Indicate your father's occupation:_____________________

Indicate your mother's occupation:_____________________

How would you rate your parent's marriage?
   Happy____  Unhappy____

Section C: Information on Abuse

Please indicate your age when abuse first occurred:____

Please indicate the duration of the abuse:
   ______days  ______weeks
   ______months  ______years
   Other (please specify):________

Please indicate the relationship of the abuser to you:
   Father____  Mother____
Uncle _____  Aunt _____ 
Grandfather_____ Grandmother_____ 
Brother_____ Sister_____
Male Cousin_____ Female Cousin_____ 
Male Family Friend_____ Female Family Friend_____ 
Male Babysitter_____ Female Babysitter_____ 
Male Neighbour_____ Female Neighbour_____ 
Male Stranger_____ Female Stranger_____ 
Other (please specify): _______________________

Please indicate the type(s) of abusive behavior(s) that you experienced:

Genital Exposure/Nudity _____ 
Kissing _____ 
Fondling _____ 
Masturbation _____ 
Fellatio _____ 
Cunnilingus _____ 
Vaginal Intercourse _____ 
Anal Intercourse _____ 
Other (please specify) ________________

Have you received individual counselling for issues related to sexual abuse? Yes _____ No _____ 
If yes, how long? _____ years  _____ months  
_____ weeks  _____ other  
(please specify a number)
APPENDIX E

SUPPORT GROUP ASSESSMENT
Support Group Assessment

In order to assist in the future development of this type of group therapy, please respond to the following questions:

**PART A:** On a scale from 1 to 3, with 3 indicating the most helpful response and 1 indicating the least helpful response, please rate the group sessions on the following dimensions by circling the response that most accurately reflects your perceptions.

<table>
<thead>
<tr>
<th>Least Help.</th>
<th>Most Help.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**Large group work**

(group discussions, exercises)

1 | 2 | 3

**Small group work**

(working in dyads, triads, etc.)

1 | 2 | 3

**Homework assignments**

1 | 2 | 3

**Lectures/Information**

1 | 2 | 3

**Films**

1 | 2 | 3

**Resources**

1 | 2 | 3
Sense of belonging/inclusion  
- felt I belonged and was accepted by the group  
- felt I was no longer alone/isolated  

Cohesiveness of the group  
- had close contact with other group members  
- felt understood by group  

Instillation of hope  
- feeling encouraged/inspired by the improvement of other group members  

Guidance  
- advice/feedback from group members and group leaders  
- suggestions from group for solving a problem
Self-understanding
1  2  3
- learning why I think and
feel the way I do
-discovering and accepting
previously unknown or unacceptable
parts of myself

Support from other group members 1  2  3

Support from group facilitators 1  2  3

PART B
1a). Have you received individual counselling for
issues stemming from sexual abuse: Yes____  No____

1b). If Yes, how long have you been in individual
counselling?____________________________________

2a). What were some of your personal goals for
involvement in the group?__________________________
__________________________________________
__________________________________________

2b). How helpful was the group in meeting your goals?
   Very Helpful ________
   Helpful ________
   Not Helpful ________
3a). What were some of your personal needs before entering the group? 

3b). How helpful was the group in meeting your needs? 
   Very Helpful ________
   Helpful ________
   Not Helpful ________

4). Comments or suggestions for future groups:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
APPENDIX F

REQUEST FOR SIX WEEK FOLLOW-UP
AN EVALUATION OF A GROUP TREATMENT APPROACH
FOR WOMEN SEXUALLY ABUSED IN CHILDHOOD

Thank you for your participation in this project. As an additional component of the research, we would like to ask you for your continued participation in the project in the form of a 6 week follow-up to the group treatment.

If you agree to participate in the follow-up, you will be asked to complete the Tennessee Self-Concept Scale and the Symptoms Checklist-Revised six weeks after the end of the group sessions.

You may have these instruments mailed to you by January 15, 1991 or you may choose to pick these instruments up at the South Surrey White Rock Women's Place on January 15, 1991. The instruments will be enclosed in a self-addressed, stamped envelope so that you can send them back in the mail upon completion.

Again, all of the information received will be anonymous and confidential. You will not be required to put your name on any of the materials, and the results will only be seen by myself and my thesis supervisor.

If you choose to have the materials mailed to you, your assigned code number will be placed on the
envelope in the place of your name.

If you are willing to participate in this final component of the project, please sign two copies of the enclosed ethical consent form and return it to your group leaders.

Please indicate if you are willing to be involved in the six week follow-up component of this project:

Yes_____  
No _____

If Yes, please indicate how you would like to receive your materials:  
a). Pick up at Women's Place_____  
b). Have materials mailed to me_____  

Mailing Address:__________________________________________

__________________________________________

__________________________________________

If you have any questions or concerns about this component of the project, please feel free to contact me at 733-9177 or write to:

Louise Blanchard
#9-1645 West 11th Avenue
Vancouver, B.C.
V6J 2B8
APPENDIX G

ADVERTISEMENT FOR THE STUDY
I am an MA candidate in Counselling Psychology who is looking for volunteers to participate in a University of British Columbia research project for completion of my thesis. I am looking for women (age 18 and older) who were sexually abused in childhood and who have not received group treatment for issues resulting from the abuse to serve as a contrast group for women who are currently receiving group treatment for issues stemming from child sexual abuse.

If you are interested in participating in this project or would like more information, please call,

Louise Blanchard, MA Candidate

733-9177
APPENDIX H

DESCRIPTION OF THE STUDY FOR THE CONTRAST GROUP
AN EVALUATION OF A GROUP TREATMENT APPROACH
FOR WOMEN SEXUALLY ABUSED IN CHILDHOOD

This is a University of British Columbia research project intended to look at how group therapy may meet the needs of women who have experienced sexual abuse in childhood. While you are not involved in a group at this time, it is important for us to gain information from you in order to compare it with individuals who are in a group. In this way, we will better be able to determine whether group therapy is in fact effective in bringing about therapeutic changes.

In order to assess how well group therapy works, you will be asked to complete two instruments, the Tennessee Self-Concept Scale and the Symptoms Checklist. These tests measure how you feel, both emotionally and socially, they are not measures of your ability. You will be asked to complete these instruments three times; once at the time you receive the instruments, once 10 weeks later, and once sixteen weeks later. The tests will take approximately one hour in total to complete. In addition, you will be asked to fill out a personal information sheet.

Please keep in mind that all of the tests and questionnaires will be completely anonymous and
confidential. You will not be required to put your name on any of the materials, and the results will only be seen by myself and my thesis supervisor.

If, at any time in the project you decide that you do not want to participate, you may decline to do so without penalty.

This project will be conducted by Louise Blanchard, an M.A. candidate in Counselling Psychology at UBC, and will be supervised by Dr. Judith Daniluk. If you have any questions, comments or concerns about this project, please feel free to contact me at 733-9177 or write to:

Louise Blanchard
#9-1645 West 11th Avenue
Vancouver, B.C.
V6J 2B8

Thank you for you consideration of this project.

Principal Investigator: Louise Blanchard, M. A.
Candidate

Thesis Supervisor: Dr. Judith Daniluk
APPENDIX I

LETTER OF CONSENT FROM THE AGENCY
August 7, 1990

To Whom It May Concern;

This is to verify that Louise Blanchard has been in touch with our center (The South Surrey/White Rock Women's Place) on several occasions regarding her research project on adult survivors of child sexual abuse and incest. I have met with Louise personally and have had contact over the phone several times. Also Louise's proposal was discussed and approved with our board of directors and the facilitators of our adult survivors of sexual abuse support groups.

We look forward to working with Louise on this project and hope that in some way it will be beneficial to our clients and to other women who are dealing with this very complex issue.

Yours Sincerely,

[Signature]

Women's Place.