

**AN INVESTIGATION OF CHILD SEXUAL ABUSE IN TERMS
OF CONTENT AND EFFECTIVENESS OF 2 MODALITIES
OF GROUP THERAPY TREATMENT.**

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DECLARATION

I declare that the contents of this thesis, unless otherwise
specified, represents my own original work.

JOAN MORGAN

1995

While every precaution has been taken to conceal the identity of the children on
whom this research is based, the entire contents are to be considered confidential.

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ABSTRACT

Within the field of child sexual abuse much of the research concerning initial effects has been obtained from clinical anecdotes and case material. Empirical validation is therefore needed to substantiate research in this area. In addition, research on the outcome and efficacy of different group treatment modalities is lacking. The aim of the study is twofold. The first aim is to investigate the verbalization of negative emotions relating to initial psychological effects of child sexual abuse in a structured and an unstructured treatment group. The second aim is to evaluate the effectiveness of a structured group treatment programme (Sturkie, 1983) versus an unstructured group treatment programme for sexually abused children.

The participants in the study were all female child sexual abuse survivors who ranged in age from 8 years 9 months to 12 years 6 months with a mean age of 10 years 6 months. The subjects were arbitrarily assigned to the structured and the unstructured group. All subjects were individually assessed pre- and post-intervention on the Piers-Harris Children's Self-Concept Scale (1984), the Rutter Teacher's Questionnaire (1967), the Human Figure Drawing Test (1968) and the Kinetic Family Drawing Test (1970).

An analysis of the results reveal that the verbalization of negative emotions relating to initial psychological effects of child sexual abuse accounted for 17.27% of the total verbalizations in the structured group and 20.72% of the total verbalizations for the unstructured group. The unstructured group allowed for greater verbalization of statements relating to anger and the feeling of being unclean, soiled or dirty. There was no significant difference in the verbalization of any of the other emotions relating to initial psychological effects of child sexual abuse. Results of the pre- and post-assessment appear to indicate an increase in self-esteem in relation to the children's attitudes concerning their physical characteristics. In addition, an improvement in attributes such as leadership and the ability to express ideas is indicated. The variable relating to a subject's anxiety, worry, nervousness, sadness,

fear and a general feeling of being left out of things approached significance and indicated a trend to increased self-esteem. No significant differences were noted on any of the other variables measured in the pre- and post-test assessments. In conclusion, there is no evidence to suggest that a structured versus an unstructured group therapy programme appears to be a more effective method of treatment for child sexual abuse survivors, although certain issues pertaining to the different group modalities are discussed.

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List of Terms

To promote clarity the following terms will be employed throughout this study.

The female gender will be assigned to the survivors of child sexual abuse as only female children participated in this study.

The male gender will be assigned to the perpetrator of child sexual abuse.
However, the author recognizes that offenders may be both male and female.

CHAPTER ONE

INTRODUCTION

Research on all aspects of child sexual abuse has grown rapidly during the past decade (Briere, 1992; Finkelhor, 1990; Shapiro, 1991; Sturkie, 1992; Wolfe & Gentile, 1992). Breines and Gordon (1983; cited in Adams, Trachtenberg & Fisher, 1992) claim that the current interest in child sexual abuse must be seen as part of a much larger social concern about women, children, and families and the role that they play in society. This growing public awareness has resulted in an increase in the number of cases of child sexual abuse reported by parents as well as adults sexually abused as children (Brosig & Kalichman, 1992; Lyra, 1987). The current reported figures on child sexual abuse vary greatly, but large scale research on non-clinical populations report that the incidence of child sexual abuse is high. Approximately 1/3 to 1/5 of adult women have had an experience of sexual abuse during childhood or adolescence (Lyra, Russel & Trocki, 1986).

Accurate statistics concerning incidence and prevalence rates of child sexual abuse are closely related to problems with definitional issues (Wyatt & Peters, 1986; Levett, 1994). When considering the definition of child sexual abuse O'Donohue (1992) states that there is no definition that sharply demarcates this phenomenon. Problems that arise with the definition are related to: The degree of sexual contact (Alexander, 1992; Wyatt & Peters, 1986); the age of the victim and perpetrator when the abuse occurred (Russel, 1984); the nature of the relationship between perpetrator and survivor, and the classification of the type of acts which constitute child sexual abuse (Wyatt & Peters, 1986).

Incest, which can be seen as a sub-category of child sexual abuse, is legally defined. In South Africa, Snyman (1989; cited in Russel, 1994) defines incest as:

unlawful and intentional sexual intercourse between male and female persons who are prohibited from marrying each other because they are related within the prohibited degrees of consanguinity, affinity or adoptive relationship (p.17).

However, this definition is restrictive as it refers primarily to the relational context of the abuse and the degree of severity of the abuse. For the purposes of this research a definition of child sexual abuse in its widest context has been adopted. This is in keeping with the current trend of a broad definition of child sexual abuse (Levett, 1994). Killian and Bobat (1986) define child sexual abuse as:

any act with sexual overtones, perpetrated by a needed and/or trusted adult, whom the child is unable to refuse because of lack of age, lack of knowledge or the context of the relationship (p.2).

Two of the other main areas of research in the field of child sexual abuse are those concerning the effects of abuse (Briere, 1992) and the methods of treatment for survivors of abuse (Sturkie, 1992). Despite arguments to the contrary, it is now widely recognized that child sexual abuse has both initial and long-term effects for the child. Browne and Finkelhor define initial effects as "those occurring within two years of the termination of the abuse" (1986, p.144). Initial effects most commonly documented include fear, anxiety, depression, anger, aggression and sexually inappropriate behaviour (Beitchman, Zucker, Hood, daCosta & Akman, 1991; Finkelhor, 1990). The long-term effects include depression, anxiety, self-destructive behaviour, feelings of isolation, low self-esteem, difficulty in trusting others, somatic disturbances, eating disorders, a tendency toward revictimization, substance abuse, social isolation and sexual maladjustment (Grand & Alpert, 1993; Finkelhor, 1990).

Finkelhor (1990) acknowledges the advances made with regard to determining the effects of abuse, claiming that the new research "has simply reinforced and consolidated what earlier research had found" (p.325). However, Finkelhor (ibid) calls for further attempts at conducting detailed empirical studies as much of the research on the effects of abuse has been derived from clinical anecdotes and case examples and has not been of a longitudinal nature. These views are substantiated by Briere (1992) and Beitchman et al. (1991) who both reiterate methodological problems inherent in previous studies of initial and long-term effects of child sexual abuse.

The research on methods of treatment for child sexual abuse survivors has focused on crisis intervention, individual therapy, group therapy, marital and family therapy (Berliner & Ernst, 1984; Damon & Waterman, 1986; Lubell & Soong, 1982; Sturkie, 1983). Arising out of this research, there appears to be a growing recognition that groups are the preferred method of treatment both for the survivor and the abuser (Sturkie, 1992). However, there is no consensus regarding the type of group treatment that provides the most beneficial results. Sturkie (1992) reports that most group models are far more striking in their similarities than in their differences. Most groups deal with the same issues, but may vary according to differences in the basic organization and treatment processes. The literature therefore lacks definitive statements about outcome specifically related to the group model (Sturkie, 1992).

The aim of this study is twofold. The first aim is to investigate, by empirical means, the verbalization of negative emotions relating to initial psychological effects of child sexual abuse in a structured and an unstructured treatment group. Transcripts of all the sessions are content analyzed in an attempt to ascertain if the participants are verbalizing negative emotions relating to initial psychological effects of child sexual abuse. It is hoped that the data derived from this study will empirically validate previously held assumptions concerning the initial psychological effects of child sexual abuse. The second aim is to evaluate the effectiveness of a structured group treatment programme (Sturkie, 1983) and that of an unstructured group treatment programme, in an attempt to ascertain whether the unstructured programme allows for a greater improvement in the children in relation to the variables measured. The variables investigated are levels of self-concept and behavioural and emotional indicators of disturbance.

CHAPTER 2

THE AETIOLOGY OF CHILD SEXUAL ABUSE

A number of theoretical perspectives have been proposed in an attempt to explicate child sexual abuse. These include psychoanalytic, psychodynamic, sociological, feminist and factor model approaches. The psychoanalytic and the psychodynamic approaches tend to focus on explanations of intrafamilial child sexual abuse (incest). The sociological and feminist perspectives, and the factor model approach attempt to provide an understanding of the broader concept of child sexual abuse. As some of the subjects in this study were survivors of incest and others of child sexual abuse an attempt has been made to provide an understanding of the aetiology of both phenomena.

2.1 Psychoanalytic Perspective

Although psychoanalysis is no longer the most influential theory in the area of child sexual abuse, it has had a profound impact on the conceptualization and treatment of the survivor and perpetrator.

During the period 1893 to 1897 Freud postulated the theory that the presence of hysteria in adulthood was related to the sexual seduction of a child by an adult, usually the father. After analysing the content of patients' sessions, Freud came to the conclusion that 80% of cases of hysteria were rooted in the attempts of the patient to protect herself against the painful memories of childhood sexual trauma (Masson, 1985). Freud described these theories in a paper entitled the "Etiology of Hysteria" (1896). He stated:

that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experiences, belonging to the earliest years of childhood, which can be reproduced through the work of psychoanalysis in spite of the intervening decades (Freud, 1896; cited in Adams, Trachtenberg & Fisher 1992, p.362).

Freud, it is therefore hypothesized, saw sexual abuse as fact and not as fantasy. However, due to the unpopularity of his views and the lack of support from the scientific community, Freud was forced to publicly abandon his original seduction theory. Freud therefore altered his theory claiming that the hysterical patients had suffered from faulty and deceptive memories. He contended that he had been unable to distinguish between his patients' childhood sexual fantasies and their memories of masturbation related to infantile sexual wishes in the Electra phase (Vander Mey, 1992). Freud no longer viewed his patients' reports as accounts of actual events, but instead viewed them as repressed and unfulfilled electra fantasies. This change in conceptualization brought about a reformulation of the seduction theory. Freud then proposed the concept of "infantile sexuality" which attributed unconscious sexual drives and desires to children (Adams et al. 1992, p.379). The emphasis was placed on the role of unresolved Electra conflicts in the aetiology of child sexual abuse. Normal adult sexuality was seen to be largely dependent on the adequate resolution of conflicts encountered during the Electra stages of development (Freud, 1964; cited in Adams et al., 1992). This view is also emphasized by contemporary neo-Freudians (Steele & Pollack, 1969; cited in Adams et al., 1992).

It must be recognized that Freud's psychoanalytic approach to psychosexual development and incest has placed a legacy of "blame" on the survivor. This resulted in the tendency to exonerate the perpetrators who engage in child sexual abuse (Rush, 1980).

2.2 Psychodynamic Perspective

The psychodynamic perspective places its emphasis on the individual psychopathology of the offender, survivor and other family members, and the resultant interaction between the participants.

2.2.1 The Perpetrator

A history of emotional deprivation is regarded as one of the most salient features in men who abuse their children (Meiselman, 1978). This deprivation is a result of disturbed and ambivalent parent-child relationships, which may then set the stage for the perpetrator to emotionally and physically abuse his own children. There is overwhelming evidence that parenting style is influenced by the person's generational style (Calam & Franchi, 1987). For example if a child's parents prescribe and practise violent problem-solving methods then it is likely that the child will identify with parental aggressors and later adopt a similar mode of child-rearing. Furthermore, Meiselman (1978) states that a failure to internalize the correct societal norms regarding sexual behaviour increases the likelihood that subsequent generations will be at risk for abuse.

In addition, previous literature has hypothesized that perpetrators are hypersexual, but this has not been supported by research. Cavallin (1966) claims that perpetrators commit incest in an attempt to resolve unmet dependency needs, rather than purely to fulfil sexual drives. Mrazek (1981) disclaims the notion that sexual offenders are promiscuous, believing that offenders confine the gratification of sexual needs to within the family. He views perpetrators as dependent and ineffectual men who seek love and nurturance from their daughters.

Furthermore, the research literature has focused on the psychological disturbances of offenders. Evidence obtained however appears contradictory. It is generally agreed that severe psychoses are rare in child abusers but clinically diagnosable personality disorders which are characterized by a lack of impulse control may be present in some perpetrators (Spinette & Rigler, 1972; Steele, 1987). In more recent research, Valliant and Blasutti (1992) found no particular psychological disturbance among child sexual abuse offenders.

2.2.2 The Mother

Many of the factors which pertain to the perpetrators are shared by the mother in an abusive family. Factors such as childhood deprivation and sexual or physical abuse are often present (Summit, 1983). De Young (1982) claims that most often mothers have not had appropriate role models and therefore demonstrate poor parenting practises. Their early childhood history is often characterized by disruptive events. As a result they frequently display dependency, insecurity and social isolation in adulthood.

Depression has been identified as contributing to the withdrawal and lack of availability of mothers in sexually abusive families (Browning & Boatman, 1977; Killian & Willows, 1988). Alcoholism, psychotic disturbances and the presence of dependent personality traits have also been identified (Lyra, 1981; cited in Glazer & Frosh, 1988). There is insufficient research evidence however to substantiate these claims.

Marital discord and sexual estrangement is often prevalent in these families and a number of studies report widespread incidence of divorce, separation and marital violence in abusive situations (Deare, 1988; Wolfe, 1985). This may facilitate the development of role reversal between mother and daughter through which the daughter assumes the mother's sexual obligations (Browning & Boatman, 1977).

2.2.3 The Survivor

It is often contended that the eldest child is at most risk for abuse. Due to a particular set of dynamics within a family, the eldest child generally demonstrates pseudomature behaviour. This occurs in association with role reversal. The child assumes a parental role in the family and may become housekeeper and parent to younger siblings. The duties as 'mother' are then often extended into the sexual arena, in the form of father and daughter incest (de Young, 1982; Vogelmann, 1988).

It has been suggested that certain children may demonstrate seductive behaviour, thereby inviting abuse. However, de Young (1982) points out the dangers of attributing the sexual abuse to the survivor. Not only does this minimize the responsibility of the perpetrator, but it serves to depreciate the negative effects and consequences of sexual abuse on children.

There is much debate in the literature regarding the specific characteristics of the survivor. However, it is generally conceded that an important predictor for child sexual abuse is the parents' perception of one specific child as problematic, abnormal or 'different' in relation to the other siblings (Belsky, 1980; Martin, 1976; Calam & Franchi, 1987). Children with minor central nervous system damage or structural delay and those with 'difficult' temperaments are also at risk. Browning and Boatman (1977) view these defects as contributing to the vulnerability of these children. Furthermore, they propose that these children may have sought physical attention from their parents to assure them that they are loved.

It is however important to note that most children who are abused are of normal intelligence. Meiselman (1978) has reported that the majority of child abuse survivors fall within the average intelligence range, but because of the abusive situation at home, they may not perform adequately at school.

In summary, within the psychodynamic perspective the family is viewed as a complex organization or system within which there is an interaction of the intrapsychic dynamics of each family member. Each family member is therefore assigned a role in the dynamics of an incestuous act (Mrazek, 1981).

2.3 Sociological Perspective

The sociological perspective attempts to explain child sexual abuse in terms of a number of sociological phenomena which include low socio-economic status, social isolation, deteriorating socio-cultural mores and external stresses.

Evidence concerning the occurrence of child sexual abuse in low socioeconomic classes is contradictory. Earlier studies (Cavallin, 1966; Mrazek 1981) found a correlation between these two variables, but this has not been substantiated in recent studies. Finkelhor and Baron (1986) found that child sexual abuse and social class were unrelated.

Stress factors such as unemployment, illness, bereavement, disease and injury have been associated with the onset of child sexual abuse (Mrazek, 1981). Divorce and subsequent remarriage also appear to significantly increase the risk of abuse in already vulnerable families (Finkelhor, 1982). This is in keeping with the findings of Russel (1994) who claims that broken homes, with a higher incidence of step-fathers, adoptive and foster fathers, contribute to increased rates of child sexual abuse.

Social isolation has long been thought to be one of the contributing factors in the aetiology of child sexual abuse (Cavallin, 1966). A lack of support structures and social support networks effectively isolate a family, thus creating an environment in which abuse may occur. Finkelhor and Baron (1986) and Mrazek (1981) both found support for the fact that social isolation may constitute a risk factor in the occurrence of child sexual abuse.

Deteriorating socio-cultural values and a high incidence of violence in any country creates a climate for sexual abuse. Russel (1994) states that when the level of violence escalates in a country, men may find it easier to employ force and violence in their personal relationships.

However, because of serious methodological problems, the sociological perspective remains speculative. Mrazek (1981) proposes that future research in this area is required in an attempt to determine the impact of these sociological factors.

2.4 Feminist Theories

Socio-cultural and political factors form the crux of the feminist analysis (Hoff, 1988). A feminist conceptualization of child sexual abuse provides an explanation of why the vast majority of perpetrators tend to be men. In addition, it attempts to explain how the socialization process results in the sexual abuse of female children.

Feminist writers generally view child sexual abuse as a socially created problem originating in and perpetuated by patriarchy. Sexual abuse is seen as another mechanism by which males in a patriarchal society gain control over females. The basic patriarchal premise is that women and children are the private sexual property of men (Brownmiller, 1975) and therefore rape and sexual abuse are their right. Women are viewed as "sexual commodities" to be used by men. Since virtually all known societies are dominated by men, it is contended that all versions of the incest taboo are agreements among men regarding sexual access to women. Men agree as to how these commodities may be distributed. The taboo against child sexual abuse is created and enforced by men, but is also more readily violated by men. In the early socialization practises of children, Lyra and Hirschman (1983; cited in Vander Mey, 1992) state that:

The boy learns that he may not consummate his sexual desires for his mother because his mother belongs to his father, and his father has the power to inflict the most terrible punishment on him: to deprive him of his maleness. In compensation however, the boy learns that when he is a man he will one day possess women of his own (p.262).

Furthermore, Lyra and Hirschman (ibid) postulate that female children are taught that they can only obtain power through their association with, or by being, the possession of a man. They claim therefore that:

The taboo against sexual contact with his daughter will never carry the same force, either psychologically or socially, as the taboo which prohibited incest with his mother. There is no punishing father to avenge father-daughter incest (p.262).

This type of belief clearly results in an asymmetry in the power relationships between males and females. The perpetuation of this imbalance of power in a traditional patriarchal family leads women to accept their subordinate status in society and adds weight to the myth that sexual abuse of females by males is normative.

In further elaboration of this patriarchal societal view, Mackinnon (1987) views society's relative acceptance of sexual violence (eg., rape, battery, sexual harassment and sexual abuse, prostitution and pornography) as evidence that men gain power over women through sex. Russel (1984) supports this view and emphasises the direct relationship between culture, socialization and sexual violence in a patriarchal society. Boys are socialized to believe that men should be tough and in control and that women are weak and controllable. Girls, on the other hand are socialized to believe they are inferior beings who are basically masochistic. In a later stage of development, because of assigned gender roles in families, men assume the breadwinners' role, traditionally more highly regarded than that of the role of homemaker and nurturer. All these factors reinforce the male belief that they have a legitimate right to the attention and sexual favours of the women in the family (Eagle, 1988).

In conclusion, feminist theories attempt to reconceptualize child sexual abuse in terms of the role of patriarchy in the development of abusive sexual behaviour. It is suggested that the greater the degree of male supremacy in any family or culture, the greater the incidence of child sexual abuse.

2.5 Finkelhor's Four-Factor Model

Finkelhor (1984) proposes four preconditions considered important in the explication of child sexual abuse. The model is informed by a general feminist and family systems perspective. It assumes the role of patriarchy and family systems dynamics in the generation of child sexual abuse. In this manner it attempts to document influences of social forces upon personal behaviour (Vander Mey, 1992). Finkelhor (ibid) therefore provides a general theoretical understanding of the interaction of individual and societal factors which may be utilized as a set of preconditions to determine the probability of an occurrence of child sexual abuse. The four preconditions are:

i) Motivation to Abuse a Child Sexually: Emphasis is placed on the factors associated with power gratification in sexual abuse. It is contended that sexual frustration is the primary motivating factor (Finkelhor, 1984). Men may perceive themselves as highly sexed and that gratification of this arousal is their right. A need to dominate may therefore serve as sufficient motivation for abuse, in contrast to Frude (1982) who believes that Oedipal issues may play a role.

ii) Overcoming Internal Inhibitors: Finkelhor (1984) contends that the motivation to abuse a child is coupled with the perpetrator's ability to overcome his inhibitions. Factors which contribute to a lack of inhibition are related to poor impulse control, the eroticization of children through pornography and other media, the lack of empathy with children among males, patriarchal ideology and the use of substances such as drugs and alcohol (Finkelhor, 1984).

iii) Overcoming External Inhibitors: The external inhibitors to commit sexual abuse may be reduced because families in which child sexual abuse occurs are often socially isolated. There is also a "societal presumption of non-interference in family matters" (Vander Mey, 1992) and this contributes to the perpetuation of child

sexual abuse. The role of a mother as an external inhibitor is also recognized, but there is an acknowledgement of the fact that very often these mothers' are absent, withdrawn, or feel powerless to stop the abuse, thus limiting their power to act as an inhibiting factor.

iv) Overcoming the Child's Inhibitors: Individual and societal factors play a role in the presence of a child's inhibitors. Finkelhor (1984) suggests that ignorance regarding sexuality, a psychologically maladjusted child and adult coercion may place the child at risk. Within a patriarchal society children are seen as the property of men. This may lead to children feeling powerless in sexually abusive situations, and thus more likely to be abused.

Vander Mey (1992) claims that this model has much to offer because of its empirical base and because it informs our understanding of the "various embedded, multilevel, and entwined causal factors associated with child sexual abuse" (p.251).

It is further proposed that this type of model:

reflects a strong tendency in the social sciences to rely upon correlation analysis to indicate the relative strength and direction of association among variables and the emphasis placed on indicating under what circumstances these correlations will vary (Vander Mey, 1992, p.239).

In conclusion, it would appear that despite the various attempts to explain the aetiology of child sexual abuse and incest, there is no single theoretical perspective that can adequately explain the aetiology of this phenomena. On-going research is therefore needed in an attempt to understand the complex interaction of factors which contribute to child sexual abuse.

CHAPTER 3

THE EFFECTS OF CHILD SEXUAL ABUSE

The effects of child sexual abuse can usefully be divided into initial and long-term effects of abuse. Browne and Finkelhor (1986, p.144) define initial effects as "those occurring within two years of the termination of the abuse." The term initial or short-term effects can be used interchangeably. However, Browne and Finkelhor (1986) prefer the term initial effects because "short-term" implies that the effects do not persist over time. This fact has not been substantiated by research (Beitchman, Zucker, Hood, daCosta, & Akman, (1991).

When considering the initial and long-term effects of child sexual abuse, certain factors should be taken into account. These include the methodological problems associated with this type of research, the moderating variables which mediate the effects of child sexual abuse and lastly the view that sexual abuse has no lasting consequences for children.

3.1 Methodological Problems

The research relating to the effects of child sexual abuse has methodological difficulties and interpretive constraints. Levett (1994) claims that these problems are partly due to disagreements about definitional issues, different conceptions of childhood, and the significance of age differences between perpetrators and victims. Beitchman, Zucker, Hood, daCosta and Akman (ibid) in their review of the initial effects of child sexual abuse list the following problems with current research:

- i) The literature has been vague in separating effects directly attributable to child sexual abuse from effects that may be due to pre-existing psychopathology in the child, the family or to the stress associated with disclosure.

ii) Most of the studies examined have failed to use a control or comparison group, which seriously limits the degree to which firm conclusions can be drawn.

iii) Much of the research that has been conducted is of a descriptive nature and very little empirical research studying sexually abused children has been conducted.

Alter-Reid, Gibbs, Lachenmeyer, Sigal and Massoth (1986) report similar criticisms: Few empirical studies have utilized large sample sizes, there has been a lack of adequate comparison groups, objective measures and statistical data analysis. Briere (1992) in his research on the methodological issues in the study of child sexual abuse effects claims that:

...such research must be considered first wave: primarily focused on probing the link between childhood molestation and both proximal and more distal psychosocial difficulties (p.219).

These factors should therefore be borne in mind when considering the research on initial and long-term effects of abuse.

3.2 Moderating Variables

When considering the harmful and adverse effects of child sexual abuse, certain moderating variables should be considered. It has been found that the impact of these variables may directly relate to the presence of initial and long-term effects. However, Beitchman, Zucker, Hood, daCosta and Akman (1991) claim that these variables are often intercorrelated and thus more sophisticated research techniques are required to identify the independent effects on the outcome of child sexual abuse.

i) Age of Onset of Child Sexual Abuse

Research relating to age of onset and severity of outcome remains inconclusive.

Initial reports seemed to indicate that pre-schoolers presented with less behavioural disturbances than older children (Gomes-Schwartz, Horowitz & Sauzier, 1985; Adams-Tucker, 1982). However subsequent studies (Friedrich, Urquiza & Beilke, 1986; Goldston, Trunquist & Knuston, 1989) have not supported this finding.

Adams-Tucker (1982) contends that if children were first sexually molested before the age of 10 they were less severely affected than those first molested between the ages of 10 to 15 years. Other studies have postulated that because of the increased understanding of the older child, greater negative consequences are associated with their experience of abuse (Peters, 1976). In contrast to these two studies, other researchers found no relation to age of onset and later disturbance (Briere & Runtz, 1988; Finkelhor, 1984).

Beitchman et al. (1991) provides an explanation for the inconclusive findings. They believe that when children are initially assessed the full extent of the effects of abuse may not be evident. As the child matures however, they may exhibit other symptomatology related to the abuse. Secondly, Beitchman et al. (ibid) believe that most often younger survivors have not been exposed to abuse over a long period of time and that less force is used than with older children and adolescents. These factors will obviously have a bearing on the symptomatology manifested. A need for retrospective studies of adults is therefore required. The variables relating to duration and severity must be controlled before any final conclusions regarding the importance of age of onset are reached.

(ii) Relationship to the Offender

There is a general belief that child sexual abuse perpetrated by a biological father or stepfather causes greater trauma for an abused child. The extent of betrayal involved in this act seems to be the most important factor. These findings are supported by research conducted by Adams-Tucker (1982) and Russel (1984). However, Friedrich, Urquize and Beilke (1986) have found that survivors of

intrafamilial versus extrafamilial abuse display no differences in the type or degree of symptomatology exhibited.

iii) Type of Sexual Contact

Sexual activity involving completed or attempted intercourse, fellatio, cunnilingus, analingus or anal intercourse is thought to be more traumatizing than general fondling or touching of a child. This is supported by Beitchman, Zucker, Hood, daCosta and Akman (1991), and Elwell and Ephross (1979; cited in Beitchman et al., 1991).

iv) Frequency and Duration

Findings concerning the impact of the frequency and duration of child sexual abuse continue to be equivocal. Johnston (1979; cited in Beitchman et al., 1991) found that symptoms of depression were most severe in children who had been abused for more than two years. However, Browne and Finkelhor (1986) do not support these views. Their studies reported no relationship between the duration of the abuse and the negative symptoms displayed.

v) Parental Reaction to Disclosure of the Abuse

The response of parents and adult caretakers to a child's disclosure is thought to be crucial and has direct impact on the child's perception of the incident. The opportunity to ventilate feelings in connection with the abuse has been identified as an important part of the recovery process (Silver & Wortman, 1980; cited in Wyatt & Powell, 1988). The Tufts study (1984; cited in Browne & Finkelhor, 1986) found that there was an increase in detrimental effects on a child following a negative parental reaction to abuse.

3.3 The Resilient Child

Before describing the initial effects of child sexual abuse it is important to note that not all authors ~~believe that children will~~ be adversely affected by sexual abuse.

Yates (1976; cited in Adams-Tucker, 1984) appears to be at the extreme end of the "pro-incest lobby" and claims that sexual contact with an adult during childhood can have a positive impact on the psychological development of the child. He proposed the slogan "Sex by age 8 or else its too late," claiming that sexual experiences with compassionate adults can provide a natural and safe avenue for a child to learn about sexual pleasures.

A more moderate view is held by Lynch (1988) who believes that not all abused children have long-term difficulties. Their research concentrated on defining the "problem free abused child" (p.210) by means of objective measures concerned with the child's own health, general development and behaviour. The findings revealed a trend for the children who were problem free. They were usually identified as abused when they were young. Lynch (ibid) also found that these children were unlikely to have experienced perinatal problems or to have accumulated developmental and behavioural abnormalities prior to intervention. Following intervention, factors which contributed to their problem-free recovery included swiftly concluded legal proceedings and few, if any, placement changes. An additional protective factor identified among the abused children was the possession of above-average intelligence.

Finkelhor (1990) reports that almost every study of the impact of child sexual abuse has found a substantial group of survivors with little or no symptomatology. Various reasons are put forward to explain this phenomenon. The inadequacy of current measuring techniques has been cited as a possible explanation. Another factor which has been considered is the fact that children engaged in denial when first assessed. However, this has not always been substantiated by research

(Runyon, 1988; cited in Finkelhor, 1990). Lastly Finkelhor (ibid) states that children who have experienced less severe abuse and who have adequate psychological and social resources to cope with the stress of abuse, may be asymptomatic.

However, despite these views, Beitchman et al. (1991) in their recent review on the effects of child sexual abuse conclude that the majority of researchers are in agreement that sexual abuse during childhood results in harmful and adverse effects.

3.4 Initial Effects of Child Sexual Abuse.

Short-term effects
The initial effects of child sexual abuse can be divided into the following categories: Behavioural problems and problems in social functioning, problems relating to inappropriate sexual behaviour, psychological problems and lastly effects related to self-esteem. These categories are however not discrete and symptomatology may manifest in one or more of the categories.

3.4.1 Behavioural Problems and Problems in Social Functioning

A number of behavioural problems have been identified in sexually abused children. These include sleeping and eating disturbances, poor school performance, running away, withdrawal, antisocial behaviour, aggression, acting-out behaviour and disruptive behaviour in the family (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Friedrich, Urquiza & Beilke, 1986; Morrison, 1989).

Most of the difficulties in interpersonal relationships manifest in behavioural problems. Poor peer relationships, difficulty making friends, a feeling of being different, and social withdrawal are some of the factors which have been noted. Finkelhor and Browne (1985) claim that because of a feeling of mistrust and a

sense of betrayal, sexually abused children often have an aversion to intimate relationships.

Behavioural and academic problems at school are very common problems for child sexual abuse survivors (Adams-Tucker, 1982; Einbender & Friedrich, 1989; Tong, Oates & McDowell, 1987). Tong et al. (ibid) reported that teachers rated sexually abused children as performing significantly less well in their school work. Gomes-Schwartz, Horowitz and Sauzier (1985) found evidence for cognitive deficits and developmental immaturity in a sample of sexually abused pre-schoolers. However they were unable to unequivocally state that these were as a result of the sexual abuse and argued that these symptoms were likely to have predated the abuse. More studies with clinically controlled groups are required for accurate assessment.

Within the adolescent age group "acting-out" behaviours, such as running away, alcohol/drug abuse and promiscuity were frequently reported (Gomes-Schwartz et al., 1985; Runtz & Briere, 1986). Linberg and Distad (1985) studied twenty-seven incest survivors, aged 12-18 years and found that self-destructive behaviours such as alcohol and drug abuse, suicide attempts, self-mutilation, running away and explosive anger were common behavioural problems. Goldston, Trunquist and Knuston (1989) compared sexually abused adolescents with a clinical control group and found that running away was more common for the sexually abused girls than among the control group. However they also found that drug abuse was more common in the controls, and 4 other indices of acting-out did not differentiate the two groups. Briere (1992) states that these types of acting-out and self-destructive behaviours may be an early manifestation of borderline personality disorder.

One of the difficulties encountered regarding behavioural issues is that many of these problems are nonspecific signs of distress. As such they are not necessarily specific to child sexual abuse, but might be indicative of other problems. Moreover, little attention has been paid to their frequency in the population of

children at large. In an attempt to redress this, Hibbard and Hartman (1992) compared the problem behaviours of child sexual abuse survivors with a non-abused comparison sample. They found that sexually abused children, according to parental assessment, were generally more symptomatic than the non-abused comparison subjects. However significant differences between alleged child sexual abuse victims and comparison children on many individual behaviours previously described as indicators of child sexual abuse did not emerge. They also found that other than a greater incidence of generalized difficulties, no specific pattern of behavioural problems was demonstrated. This reiterates the necessity for on-going research in this area.

3.4.2 Inappropriate Sexual Behaviour

Inappropriate sexual behaviour includes such activities as sexual play with dolls, inserting objects into the vagina or anus, masturbation, seductive behaviour, requesting sexual stimulation and inappropriate or precocious sexual knowledge (Mian, Wehrspann, Klajner-Diamond, LeBaron & Winder, 1986). They contend that this behaviour occurs, not as a result of a child having some type of innate hypersexuality, but rather as a result of their premature exposure to adult sexuality.

Friedrich and Grambsch (1992) have found that sexual behaviour problems are a useful discriminating variable between sexually abused and non-sexually abused children. Furthermore, they claim that this finding is becoming an increasingly robust and reliable indicator. Sexualized behaviour appears to be a symptom that is a relatively constant marker of child sexual abuse during the years prior to puberty. Gomes-Schwartz, Horowitz and Cardarelli (1990) state that:

The observation that inappropriate sexual behaviour is one of the most common symptoms in preschool youngsters may offer some insight into the ways in which a cognitively immature child attempts to process an incomprehensible experience (p.86).

Adolescents may also display evidence of sexual acting out, such as promiscuity and homosexual contact (Beitchman, Zucker, Hood, daCosta & Akman, 1991).

It is however important to note that a proportion of sexually inappropriate behaviour may be ascribed to variables other than child sexual abuse. Some children may come from families who observe very relaxed standards with regard to nudity, sexuality and promiscuity. These factors may then be associated with sexualized behaviour.

3.4.3 Psychological Effects

i) Depression and Suicidal Ideation

Symptoms of depression are common and include depressive affect, impaired self-concept and feelings of helplessness (Browne & Finkelhor, 1986). According to Kovacs and Beck (1977) the basic characteristics of childhood depression include changes of cognition in the negative direction, alterations in attitude and motivation, and vegetative and psychomotor dysfunction. Wozencraft, Wagner and Pellegrin (1991) revealed that child sexual abuse survivors described a significantly higher level of depression than was reported by a normative sample of school-age children. Beitchman et al. (1991) in their review of studies reporting symptomatology among sexually abused adolescents revealed evidence of depression, low self-esteem, and suicidal ideation. However, it is important to remember that the depression may be disguised (ie., masked depression). In such instances it may be expressed through somatic complaints or in acting-out behaviour such as truancy, stealing, self-mutilation or suicide attempts.

ii) Guilt

Guilt is another common reaction to sexual abuse (Courtois, 1988; Sgori, 1982). Blick and Porter (1982) claim that this guilt can be related to disclosure of the secret of the abuse and the resultant family disruption which usually occurs. It can also

manifest as a result of victim-blaming societal responses to abuse. From a developmental perspective, Lusk and Waterman (1986) claim that guilt is less likely to be observed among preschoolers. In support of this Conte and Schurmerman (1987) note that guilt has a greater adverse effect on survivors as they mature. The assumption is that preschoolers do not realize the taboo nature of the incest and are therefore protected from guilt because of their innocence.

iii) Anger

Feelings of anger and hostility are common initial effects of sexually abused children. This anger is very often repressed as the child is unable to cope with their angry feelings towards a loved one. Sgori (1982) states:

Sometimes the repressed rage is manifested by depression or withdrawal, sometimes by aggressive fantasies or behaviour, and occasionally as psychotic symptomatology (p.120).

Survivors may initially be angry with the perpetrators who have abused them, then with members of their families who failed to protect them from the abuse. Sturkie (1983) and Meiselman (1978) note that incest survivors are usually most angry with their mothers. They perceive them as their principle caretakers who should have been primarily responsible for their protection.

iv) Fear

Meiselman (ibid) demonstrated that feelings of fear and helplessness were manifested in symptoms such as nightmares, clinging behaviour, somatic complaints and hypervigilance. Heightened anxiety may also be evidenced in impaired impulse control, enuresis and sleep disturbances.

v) Powerlessness

A feeling of powerlessness is also often manifested. This is linked to a sense of violation commonly experienced by abused children. Finkelhor and Browne (ibid) claim a fundamental powerlessness occurs in sexual abuse when a survivor's territory and body space are repeatedly invaded against her will. This sense of powerlessness is exacerbated by the manipulation and coercion that the perpetrator may impose on the survivor. Finkelhor and Browne (1985) claim that powerlessness is one of the four trauma-causing factors in abuse. In addition, it is one of the primary dynamics in the overall conceptualization of abuse.

vi) Stigmatization

Another principal dynamic in the understanding of abuse (ie., traumatogenic dynamic) is that of stigmatization (Finkelhor & Browne ibid). This stigmatization can occur as a result of the child's own knowledge and feelings about the incest or as a result of parental and societal reactions to the abuse. Very often these resultant feelings are then associated with feelings of badness, shame, guilt and a sense of feeling dirty. This may result in a child feeling that she has been permanently damaged or altered, that is, the "damaged goods" syndrome (Finkelhor & Browne, ibid).

vii) Post-Traumatic Stress

The relationship between sexual abuse and post-traumatic stress disorder (PTSD) has also received attention in the literature (Deblinger, McLeer, Atkins, Ralphe & Foa, 1989; Kiser, Heston, Millsap & Pruitt, 1991; McLeer, Deblinger, Atkins, Foa & Ralphe, 1988). Symptoms developed by children thought to be suffering from PTSD include the development of trauma-related and other fears, sleep disturbances, including difficulties in going to bed and falling asleep, nightmares, regressive bed-wetting, eating disturbances, guilt, acting out or withdrawal

behaviour and depressive behaviour. This has led to the belief that the trauma of child sexual abuse can lead to PTSD. Methodological problems still abound in this area, but Beitchman, Zucker, Hood, daCosta and Akman (1991) state that:

the high percentage of children manifesting traits putatively associated with PTSD suggests that the syndrome should be further studied to examine to what extent it is specific to sexual abuse per se or implicates sexual abuse under the general class of severely traumatic events to which children might be exposed (p.547).

Finkelhor (1990) however claims that PTSD is in itself not an adequate conceptualization to understand child sexual abuse. To believe survivors of sexual abuse are primarily experiencing the effects of PTSD will cause researchers to dismiss some of the more specific effects of the abuse.

3.4.4 Effects on Self-Esteem

As a result of their intrinsic developmental egocentricity children will often assume that the abuse was their fault and that they caused it. Finkelhor and Browne (1985) believe self-blame is exacerbated by the "negative connotations ...that are communicated to the child around the experiences and then become incorporated into the child's self image" (p.532). This results in a predicted decrease in self-esteem. Oates, Forrest and Peacock (1985) found that sexually abused children demonstrated significantly lower scores in self-concept on the Piers-Harris Children's Self-Concept Scale (1984). Furthermore, their expressions of the future were less ambitious than the non-abused group. Difficulties in self and social functioning appeared in roughly parallel form over approximately forty studies of child sexual abuse survivors surveyed (Cole & Putnam, 1992). However once again there are conflicting findings regarding the effects on self-esteem. The Tufts study (1984; cited in Browne & Finkelhor, 1986) for instance, found no significant differences in self-esteem across any age group.

3.5 Long term Effects

A review of the literature reveals that the consequences of childhood sexual abuse are far reaching and have been linked to the development of significant impairment in daily functioning and severe psychiatric and medical disorders. Disturbances in emotional reactions, self-perception, difficulties in interpersonal relating, social functioning and sexual problems have been well documented (Browne & Finkelhor, 1986; Glod, 1993; Russel, 1994).

Research has also identified a number of disorders in which the incidence of childhood sexual abuse, particularly incest, significantly exceeds chance. These conditions include: Borderline personality disorder (Brown & Anderson, 1991; Bryer, Nelson, Miller & Krol, 1987; Stone, 1990), multiple personality disorder (Cole & Putnam, 1992), somatoform disorders such as pseudoseizures, pelvic pain and gastrointestinal disturbances (Briere & Runtz, 1988; Lowenstein, 1990), eating disorders (Bulik, Sullivan & Rorty, 1989), and substance abuse disorders in women (Brown & Anderson, 1991; Root, 1989; Young, 1990). However, as with initial effects, it is important to note that not all children who have been sexually abused develop long-term effects and psychiatric disorders.

In summary, there appears to be a large body of research which documents initial and long-term effects of child sexual abuse. However, methodological problems still abound in this area of research. Beitchman et al. (1991) state that the existing body of empirical research on the effects of child sexual abuse is lacking and fails to provide a sound knowledge base for the appropriate provision of treatment services in the field of child sexual abuse. There is therefore an urgent need for on-going research in this area.

CHAPTER 4

GROUP TREATMENT FOR CHILD SEXUAL ABUSE SURVIVORS

Clinical reports of treatment for sexually abused children have involved the use of a wide range of therapeutic modalities. Individual, family and group therapy have been among the most commonly used approaches. Whilst the benefits of individual and family work cannot be denied, it appears that there is an almost unanimous agreement that group therapy provides the most effective means of addressing the needs of sexually abused children (Blick & Porter, 1982; Gagliano, 1987; Knittle & Tuana, 1980; MacFarlane & Waterman, 1986; Mrazek, 1981; Steward, Farquhar, Dicharry, Glick & Martin, 1986).

Group treatments within the field of child sexual abuse have been aimed at different client groups, for example, preschool children (Carozza & Heirsteiner, 1982; Damon & Waterman, 1986); latency-aged children (Berliner & Ernst, 1984; Sturkie, 1983); adolescents (Blick & Porter, 1982; Knittle & Tuana, 1980); adult survivors of incest and other forms of sexual assault (Courtois, 1988) and parents of sexually abused children (MacFarlane & Waterman, 1986).

4.1 Advantages of Group Therapy

With the growing recognition of the magnitude and severity of the problem of child sexual abuse, the numbers of children who have been referred for treatment has increased dramatically. This has created a strain on inadequate resources and adds weight to the argument for the use of group therapy as an effective method of intervention. The advantages of group therapy in the treatment of sexually abused children are:

- i) Groups provide a support system for the participants outside of the home situation. Following disclosure of sexual abuse a child is often rejected by both...

parents and siblings and the group can provide a child with a stable and supportive environment. Steward, Farquhar, Dicharry, Glick and Martin (1986) claim that the group becomes a surrogate family for the child with the therapists acting as surrogate parents. Berliner and Ernst (1984) and Peake (1987) support this view, but they stress the potential benefits of peer support. It is currently recognized that group treatment with its peer focus is a developmentally appropriate form of intervention for children with a variety of behavioural and emotional difficulties (Johnson, Rasbury & Siegel, 1986).

ii) Groups also provide the participants with an opportunity to interact with others who have been through the same experiences, thus reducing the sense of isolation and alienation reported by many sexually abused children. This enables the participants to universalize their experiences (Knittle & Tuana, 1980) and allows them to identify with other survivors.

iii) Group treatment can provide participants with a wide range of educational opportunities. Sturkie (1983) amongst others, notes the opportunities for sex education. Hazzard, King and Webb (1986) stress the development and enhancement of social skills in the groups. The introduction of techniques such as role-play and psychodrama prepare and assist the participants to gain mastery over difficult situations such as court proceedings (Blick & Porter, 1982; Sturkie, 1983).

iv) Because of the less threatening levels of intimacy and intensity, groups are perceived to provide a safer environment for the participants than that of individual therapy (Hazzard et al., 1986). According to Courtois (1988), in individual therapy there are certain elements which are isomorphic to elements of an abusive relationship (eg., the child is in a 'one-down' position with a significant authority figure and they are required to trust this person). However the child's recent experiences may have taught her that parental and adult trust can be violated. Groups, with their emphasis on peer support and egalitarian rather than authoritarian relationships, are therefore preferable to individual therapy as they can

allow the participants to fulfil their dependency needs in a more secure manner than in individual treatment approaches.

v) Group therapy may be more cost-effective than other interventions (DeLuca, Boyes, Furer, Grayston & Hiebert-Murphy, 1992). Greater numbers are able to be reached at less cost.

vi) Lubell and Soong (1982) discuss the difficulties of involving families in treatment approaches. Very often families deny that the abuse has taken place. They may also fear the consequences of further disclosure. Families may therefore be very resistant to becoming involved in group work. An advantage of group therapy is that it does not require active involvement on the part of the survivor's family.

4.2 Disadvantages of Group Therapy

Despite the many obvious advantages of group therapy, various authors have suggested that group treatment has several disadvantages.

i) Blick and Porter (1982) note that group participants share less with their individual therapists and this sometimes leads to a division of loyalties between the group and the child's individual therapist. However, there was the recognition that this seemed to create more of a problem for the therapists than for the participants.

ii) Sturkie (1992) claims that group involvement may cause some problems for children who still have to appear in court. The possibility exists that the child may inadvertently confuse their own stories with those of other children in the group and this can reduce a child's credibility in court.

iii) Nelki and Watters (1989) warn about the potential dangers of prolonging sexual abuse groups. They claim that children may become identified as survivors of sexual abuse. The groups then continue to perpetuate the survivor role rather than

assisting the child to individuation. However, they do not deny the need at times for longer-term therapy, but believe that these groups do not then necessitate a sexual abuse label.

iv) Webb-Woodard and Woodard (cited in Haugaard & Reppucci, 1988) also contend that groups are not the treatment of choice in incest cases. They maintain that family members may develop different identities and learn different sets of skills within their group settings. Problems then arise in the subsequent reconstitution of the family, when these identities and skills are different for each member.

4.3 Goals of Group Therapy

Typical themes and goals cited in the literature on group therapy with survivors of child sexual abuse include the following (Lubell & Soong, 1982):

- i) Clarifying and validating the ambiguous and conflicting feelings and sensations associated with the molestation experiences and the aftermath of disclosure.
- ii) Facilitating the verbal, physical, and graphic expression of previously intolerable thoughts and feelings.
- iii) Universalizing and detoxifying the experiences through appropriate sharing.
- iv) Offering explanations for the abuse that help the child to organize his or her thoughts about the experiences.
- v) Teaching age-appropriate methods for eliciting, expressing, and receiving physical affection and nurturing.
- vi) Enhancing the child's sense of physical control, body integrity, and individual efficacy.

vii) Establishing and practising a protection plan to minimize the potential for future molestation.

Steward, Farquhar, Dicharry, Glick and Martin (1986) discuss seven goals which relate specifically to working with young sexually abused children. These include: Helping the children translate their thoughts and feelings into words so that they can express themselves and their preferences; supporting the children's ability to say no and ask for help; allowing the children to experience a relationship with caring adults; limiting the children's assumption of their own ability to evoke violence in others as a way of relieving their sense of responsibility for the abuse; supporting the development of peer-interaction skills; supporting an increase in self-worth; and encouraging the attainment of appropriate developmental milestones. Steward et al. (ibid) believes that these goals address "both the wounds of the past and our young patients' needs for the future" (p.268).

4.4 Models of Group Therapy

A variety of different models of group intervention have been proposed, distinguished by, amongst others, the degree of structure provided (Bergart, 1986; Sturkie, 1983), the number of sessions (Courtois, 1988) and the type of medium utilized (Naitove, 1982). Sturkie (1992) outlines five different models of group treatment for sexually abused children.

4.4.1 Traditional Group Model

This method of group intervention is based on the principles of traditional group work (Yalom, 1985). The groups are non-directive and the facilitators merely provide a basic framework for the experience, with emphasis being placed on working with the group process. No specific theme is introduced and the content of the sessions is guided by the issues which come up in the context of the group. However, the facilitators of such a group must have a very good working

knowledge of the dynamics of child sexual abuse. Traditional group models can also be likened to unstructured groups. The best examples of this model in the treatment of child sexual abuse are the groups run by Blick and Porter (1982); Gagliano (1987); Knittle and Tuana (1980) and Lubell and Soong (1982).

4.4.2 Structured Group Model

This model of group intervention for the treatment of child sexual abuse was pioneered by Sturkie (1983) and was initially used with latency-age survivors of sexual abuse. The group meets for a period of nine weeks. Each week a specific theme is introduced which focuses on various effects of the abuse. The themes include: Believability, guilt and responsibility, body integrity and protection, secrecy and sharing, anger, powerlessness, other life crises and tasks and court attendance. Upon completion of this cycle it is recommended that the participants return to the programme at least once more for further assistance in the mastery of the relevant treatment issues.

Berliner and Ernst (1984) also utilize a structured group treatment programme. They suggest a short term programme of six sessions. The focus is largely on the specific consequences of the abusive act. The programme includes an emphasis on drawings and free discussion. Hiebert-Murphy, De Luca and Runtz (1992) combine a structured approach with activities such as diary writing and refreshment times.

Specific advantages to structured group treatment have been identified. Sturkie (1983) claims that the structure allows for the possibility of covering a wide array of treatment themes in a short space of time. The structured format also allows for easier training of the facilitators and can be used when relatively inexperienced health professionals are required to treat sexually abused children.

However, criticism has been levelled against the use of this type of structured format. Haugaard and Reppucci (1988) have expressed concern that the use of the structured group format may suggest symptoms and feelings to the child that he or she did not previously experience. They claim that an emphasis on responsibility or anger may be very confusing to children who have not experienced these feelings. This may result in the participants trusting their own perceptions even less, thereby creating a negative, iatrogenic treatment outcome. The drive towards conformity in a group has also been cited as a problem with group therapy and has been supported by social psychology research (Asch, cited in Haugaard & Reppucci, 1988).

Another criticism, which this study hopes to address, is the fact that the effects which form the focus of the treatment themes lack adequate empirical validation. Sturkie (1983) examined themes that had arisen naturally during previously less structured groups and from these observations he then decided on the thematic content for the current structured format that is proposed.

4.4.3 Developmental-Play Group Model

Sturkie (1992) claims that this model is largely employed with younger children. It emphasizes play, fantasy and games as the major methods of intervention and an attempt is made to return the child to his or her normal developmental course. Less emphasis is placed on abusive issues and an attempt is made to assist the participants in areas of social development and parent-child interactions. Critchley (1982) utilized this format and worked with abused children between the ages of 2 to 4 years. With a combination of group and individual play therapy he attempted to enhance the development of age appropriate skills, peer relationships and interpersonal and social skills.

4.4.4 Group-Arts Model

Rather than concentrating on thematic content, these groups are organized around the use of different types of media of expression. Naitove (1982), and Carozza and Heirsteiner (1982) describe the use of different types of media such as drawings, painting, sculpting and collages. The value of drawings is well recognized in the treatment of sexually abused children (Yates, Beutler & Crago, 1985). Carozza et al. (1982) state that their:

general approach is to utilize art expression to enhance individual and group growth and awareness and to allow the girls to externalise and work through conflict (p.167).

The value of this type of group therefore lies in the recognition that art is an expression of the child's inner reality and thus allows the child the opportunity to symbolically express their inner feelings. The roots of this approach lie in the psychodynamic orientation (Hagood, 1992).

The use of different forms of media are often incorporated into structured or unstructured groups and thus serve as a complement to these groups.

4.4.5 Parallel Group Model

This model of treatment was developed by Damon and Waterman (1986) specifically for treatment of children aged 8 and under. Groups for children and their caretakers are run simultaneously and address the same treatment themes. The rationale behind this type of treatment is that because of the parallel groups the caregivers can respond more appropriately to any material that the children may wish to speak about outside of the group situation (Damon & Waterman, 1986).

Nelki and Watters (1989) ran structured groups over a nine week period in conjunction with a parallel caregivers' group. The groups combined clear

educational goals with an opportunity to explore areas of emotional conflict. The caregivers were also involved in evaluating the effectiveness of the therapy by completing questionnaires which recorded symptomatology. The findings of this research suggest that the group for caregivers was particularly stressful as several of the members had themselves been abused as children. Nelki and Watters (ibid) therefore recommend that only experienced therapists be used for such a group.

Sturkie (1992) claims that this parallel group treatment model "represents a synthesis of the clinical and empirical knowledge that is embodied in the group treatment literature as a whole" (p.337).

4.5 Group Structure and Procedure

Various other factors have to be considered when planning groups for sexually abused children. These include the following:

4.5.1 Criteria for Membership

The criteria for group membership are "straight forward and unsophisticated" (Sturkie, 1992, p.339). The participants involved should have either experienced some form of sexual abuse or be at risk for abuse. Very little work has been done with combining survivors of other abuse (eg., post traumatic stress, children of alcoholic parents and physically abused children) with sexually abused children. While many of the dynamics may be the same, it is nevertheless recommended that separate groups are warranted for the sexually abused population. Sgori (1982) believes that child sexual abuse becomes the "bond between the members" which can be used to advantage in group therapy. However, more research is called for in this area as it may be because of the taboo nature of child sexual abuse that separate groups are required.

When considering group membership, Hazzard, King and Webb (1986) claim that at times children may be too severely disturbed to be able to benefit from group therapy. Behaviourally disruptive children or severely emotionally disturbed children may initially benefit more from individual therapy than group therapy until they are relatively stabilized. Intellectually limited children may need a group that includes other children of similar intellectual functioning.

Sturkie (1992) claims that there is virtually no research relating to the influence of race and class within a group situation. Hazzard et al. (1986) believe that these factors have the potential to isolate some members and as such would become more problematic as the size of the group decreases.

4.5.2 Age of the Participants

There is consensus in the literature that group members need to be functioning at comparable emotional and intellectual levels. Within the child sexual abuse field groups for pre-schoolers, latency-aged survivors and adolescents have been proposed (Sturkie, 1992). However, Levine (1979; cited in Haugaard & Reppucci, 1988) claims that children between the ages of six to thirteen can tolerate a two to three year age range. Blick and Porter (1982) state that an age difference of seven years is acceptable provided that the participants are focusing on the same developmental issues and dilemmas.

4.5.3 Gender of the Participants

Gender is another important variable when considering group membership. Little is known about young male survivors of sexual abuse (Scott, 1992). However Friedrich, Luecke, Beilke and Place (1992), and Schacht, Kerlinsky and Carlson (1990) claim that the preliminary clinical findings suggest that the course and treatment programme of these groups is dramatically different. Scott (ibid) asserts

that "the influence of male socialization dramatically alters the content, process, and management" of groups for male survivors (p.237). He gives attention to gender-specific defense mechanisms and acting out behaviour, which he feels are typical for this population. He therefore does not advocate having males and females in the same groups. This view is supported by work conducted by Berliner and Ernst (1984) and Mandell and Damon (1989).

4.6 The Group Therapist/s

The literature generally recommends that groups for sexually abused children should be run by two facilitators (Haugaard & Reppucci, 1988). Sturkie (1992) claims that the mutual support and multiple vantage points of the two therapists are indispensable. The co-therapy model also allows for an increase in resources available to a child. This is supported by Steward, Farquhar, Dichharry, Glick and Martin (1986) who claim that two therapists with different temperaments, perspectives, and levels of attention may offer more resources to the abused children than one therapist working alone.

Other advantages of having two therapists is that the groups can continue if one of the facilitators is unable to attend, thus providing the participants with a sense of permanence and continuity (Kitchur & Bell, 1989). Two therapists also allow one of the therapists to play a more supportive role, while the other can be more confronting (Mayer, 1983). Lastly, the presence of a co-facilitator can assist the therapist to modulate his or her own feelings and countertransference feelings, thereby enabling the therapist to be more genuinely available to the group members.

The gender of the therapists in groups for sexually abused children has led to much debate and controversy. Pescosolido and Petrella (1986) suggest that when a child's relationship with males has been characterized by betrayal and abuse, the use of a

male co-facilitator may provide a corrective emotional experience for the participants. Support for this view comes from Gottlieb and Dean (1981) who believe that a male-female team allows for group members to explore their beliefs about healthy heterosexual relationships and that it serves as a model for a healthy parental relationship.

In contrast to the above views, Blick and Porter (1982), Berliner and Ernst (1984), and Hazzard, King and Webb (1986) have all argued against the initial inclusion of a male co-therapist. This argument seems to be mainly based on the assumption that the participants would feel inhibited in the presence of a male therapist, especially in the early stages of therapy. It has also been found that the presence of a male therapist has led to "sexually stylized and seductive behaviour" (Sturkie, 1992, p. 276) and that the children became focused on the possibility of a sexual relationship between the male and female therapists.

However, despite the above reservations, the use of a male therapist later in the treatment process has been recommended. Hazzard, King and Webb (1986) and Haugaard and Reppucci (1988) claim that the problems relating to male therapists present the participants with important issues to work through.

4.7 Factors Affecting Verbalization in a Group

Various factors appear to influence the ability of participants to share their feelings in a group setting. A basic sense of trust and security first needs to be established by the therapists to create a climate of sharing within the group. This can be done by establishing group norms, encouraging group cohesion and allowing the participants to express conflict openly.

The size of the group appears to provide a limit to the amount and quality of communication that can take place among members as individual persons (Hare, 1982). A large group allows for greater resources to enable the members to problem

solve, but the average contribution of each member may then diminish. Napier and Gershenfeld (1987) maintain that a group of five appears to be an optimal number because it is large enough to allow for diversity of opinions and ideas, yet small enough to allow everyone to be heard. Key (1986; cited in Napier & Gershenfeld, 1987) found that communication and productivity were enhanced when participants sat in a circle. However, sensitivity to "crowding" in a psychological sense is another factor which must be considered. Freedman (1971; cited in Napier & Gershenfeld, 1987) found that females were more likely to feel comfortable in smaller rooms and would thus engage in mutual sharing more readily, whereas men would prefer a larger space. Other more practical factors such as raising the temperature in a room may lead people to react negatively to each other. This may then decrease the overall level of communication within a group setting.

In conclusion, despite the large amount of work conducted in the area of group therapy, studies appear to be lacking in the areas relating to investigation of content and effectiveness of group therapy treatment modalities. This study will partially attempt to address both these issues.

CHAPTER 5

OBJECTIVES AND HYPOTHESIS

5.1 Summary of the Literature Review

Within the literature there has been a growing recognition of the magnitude and severity of the problems associated with child sexual abuse. However, methodological problems still abound in all areas of research. There is a clear need for more empirically based research.

When considering the aetiology of child sexual abuse no single theory can adequately account for this phenomenon, which remains a multifaceted social problem. Many multi-levelled causal factors need to be considered when attempting to explain the occurrence of child sexual abuse.

Initial and long-term effects of child sexual abuse are now well documented and there appears to be a general consensus emerging that child sexual abuse will have lasting negative consequences in many areas of a child's life. However, current research appears to be attempting to differentiate out various inter-correlated variables which may play a role in moderating the effects of child sexual abuse.

The literature indicates that group treatment is the preferred mode of intervention. For children, but more especially for adolescents, it is the developmentally appropriate method of intervention because of its peer focus and emphasis on peer support. However further systematic evaluation relating to the efficacy and outcome of group therapy is required, especially with latency aged children.

5.2 Objectives

The objectives of this study are two-fold.

- (i) The first is to investigate by empirical means, the verbalization of emotions relating to the initial psychological effects of child sexual abuse in a structured and an unstructured treatment group. Transcripts of all the sessions will be content analyzed in an attempt to validate the existing research concerning initial effects of child sexual abuse.

- (ii) The second objective is to evaluate the effectiveness of a structured group treatment programme (Sturkie, 1983) and that of an unstructured group programme, in an attempt to ascertain whether the unstructured programme allows for a greater improvement in the children in relation to the variables measured. The Piets-Harris Children's Self-Concept Scale (1984) has been utilized to measure levels of self-concept. The Rutter Teacher's Questionnaire (1967) measures behavioural factors for general emotional disturbance as well as yielding subscale scores for antisocial and neurotic type behaviours. The Human Figure Drawing Test (1968) and Kinetic Family Drawing Test (1970) measure and yield indicators of general emotional disturbance.

5.3 Hypotheses

The following hypotheses will be investigated:

Hypothesis 1:

The group therapy process will allow for the verbalization of negative emotions relating to the initial psychological effects of child sexual abuse.

Hypothesis 2:

There will be a significant difference in the verbalization of negative emotions relating to initial psychological effects of child sexual abuse in the Sturkie Model of Group Therapy and the unstructured group intervention with victims of child sexual abuse.

Hypothesis 3:

The post-test scores of both groups on the Piers-Harris Children's Self-Concept Scale, the Rutter Teacher's Questionnaire and the Projective Drawings will be significantly different from the pre-test scores. This will indicate an improvement in self-concept and a positive shift in relation to the behavioural and emotional factors measured on completion of the treatment groups.

Hypothesis 4:

The post-test scores of the Piers-Harris Children's Self-Concept Scale, the Rutter Teacher's Questionnaire and the Projective Drawings will be significantly different for the structured than for the unstructured groups with no significant difference at pre-test level. This will indicate that the structured group showed less improvement in self-concept and a less positive shift in relation to the behavioural and emotional factors measured on completion of the treatment groups.

CHAPTER 6

METHODOLOGY

6.1 Research Design

There are two components of this study. In the first component, which is related to hypotheses 1 and 2, the unit of analysis is that of a speech act (i.e., from the period of time that one person starts to speak to the completion of their communication or until they are interrupted). These speech acts are derived from a content analysis of the transcripts of the group sessions and are concerned with verbalizations in group therapy. For the second component, which tests hypotheses 3 and 4, the research design is that of a pre-test, post-test with two groups. One group received the Sturkie Structured Group Treatment Programme (1983) and the other an unstructured group treatment programme run along the lines proposed by Yalom (1985).

6.2 Subjects

Six months prior to the commencement of this study a sexual abuse awareness programme had been undertaken at a local primary school. This had unexpectedly resulted in a number of children revealing that they had been sexually abused. Regrettably, the persons involved with the awareness programme did not have the resources to provide any follow-up for the children. The Psychology Department of the University was therefore approached to assist with this problem and to provide group treatment for these self-identified children. It was these children that were thus included in this study together with two other children with a history of sexual abuse from the local children's home.

Ten subjects were involved in the research programme. The age of the subjects ranged from 8 years 9 months to 12 years 6 months with a mean age of 10 years 6

months (Std. Dev. 1 year 5 months). All subjects were female and all were English speaking children.

A brief history of each child included in the groups is presented in Appendix (A). To protect the confidentiality of the children their identities have been concealed. A summary of the age and nature of abuse of each child is presented below. The first 4 children presented were in the structured group and the remaining 6 in the unstructured group.

Table 1. Name, Age and Nature of Abuse of Subjects

Name	Age	Nature of Abuse
Karin	11 yrs. 5 months	Extrafamilial fondling
Jane	9 yrs. 1 months	Intrafamilial fondling
Tara	9 yrs. 5 months	Intrafamilial fondling
Sharon	9 yrs. 5 months	Intrafamilial fondling
Cindy	12 yrs. 2 months	Extrafamilial oral sex and fondling
Laura	8 yrs. 6 months	Intrafamilial fondling
Leonie	12 yrs. 2 months	Extrafamilial sexual intercourse
Jody	12 yrs. 6 months	Extrafamilial and intrafamilial fondling
Sandy	10 yrs. 9 months	Extrafamilial fondling
Cathy	10 yrs. 9 months	Extrafamilial fondling

6.3 Group Organization

6.3.1 Difficulties in Group Organization

The initial group organization proved to be problematic. Since no follow-up had occurred following the initial prevention programme a few of the parents were not aware that their children had revealed details of sexual abuse or that they had requested help following the programme at the school. In addition, neither of the therapists involved in the study had been part of the previous prevention programme and thus were dealing with information obtained second-hand. This was also compounded by the fact that a time period of approximately 6 months had elapsed since the children had indicated that they were survivors of sexual abuse. It was therefore recognized from the start that this was not an ideal situation, but that the children were in need of help and thus a treatment programme had to be initiated.

Because most parents did not have access to transport (the school serviced a low socio-economic area), the school authorities offered to provide transport to and from the university. However, once the groups commenced they were no longer able to fulfil their commitment and the therapists were left with no choice but to transport the participants, despite the various ethical and practical problems which then needed to be dealt with.

6.3.2 Pre-Group Involvement

Prior to the commencement of the groups each parent or guardian was interviewed by one or both therapists involved in this study. As far as possible, the nature and the purpose of the study was explained and any feelings related to their child's involvement in such a programme were explored. Support was also provided for the parents if required and confidentiality was assured.

Parents or guardians were requested to provide written permission for each child to participate in the study. In addition, consent was obtained to videotape each session.

Prior to the first group session, pre-testing was undertaken on all the children in the study. After some introductory exercises to facilitate rapport with the children, each child completed the Piers-Harris Children's Self-Concept Scale (1984), the Kinetic Family Drawing (1970) and the Draw-a-Person Test (1968). The Rutter Teacher's Questionnaire (1967) was forwarded to the teachers in the relevant classes, for completion. At the time of the pre-test, the teachers would have taught the subjects for approximately four months.

6.3.3 Group Structure

Because of the difficulties involved in the group organization no attempt was made to match the two groups and the methodology utilized was to a certain extent dictated by clinical and ethical considerations. The children were arbitrarily divided into the structured and unstructured groups, following which certain changes had to be made due to illness, school commitments and the fact that one subject withdrew from the study. The data will therefore be analyzed taking this factor into account. The structured group finally had 4 subjects and the unstructured group 6 subjects. The mean age of the structured group was 9 years 11 months and that of the unstructured group was 10 years 11 months.

The groups were held on a weekly basis and each session lasted approximately one hour. The groups were held in the therapy room of the University and each session was video-taped. Eight structured group sessions following the format of the Sturkie Model of Group Therapy (1983) were held and on the ninth session the participants enjoyed a social activity. The basic principles of group therapy proposed by Yalom (1985) were utilized for the unstructured group. Despite the non-directive nature of these groups, structured exercises such as drawing and

story-telling were also utilized if necessary to assist the participants to "get in touch" with their suppressed emotions. Yalom (1985) proposes that these structured exercises can play an important role in brief, specialized therapy groups. An extra group session was held for the unstructured group as it was felt that the children still had a need to deal with certain issues. It was hoped to hold another two groups for the children in the unstructured group, but these had to be cancelled because of school examinations.

6.3.4 Post-Group Involvement

Group post-testing was undertaken after the treatment groups had been completed and the teachers were requested to once again complete the Rutter Teacher's Questionnaire (1967).

6.4 Therapists

Two female therapists conducted the group sessions because of the documented advantages of the co-therapist model for groups (Blick & Porter, 1982). One of the therapists (the researcher) was an intern clinical psychologist and the other was a qualified clinical psychologist. The co-therapist model proved to be particularly advantageous during this research as the qualified therapist was unable to attend some of the groups because of unexpected circumstances and commitments. Her absence was always discussed with the children and any feelings in relation to her absence were explored.

6.5 Group Process

A brief summary of the group process in each session is included in Appendix (B & C). Congruent with Sturkie's Model of Structured Groups (1983) a specific theme was introduced for each structured session, whereas no theme was introduced in the

unstructured groups. In the latter groups the therapists were mostly guided by the issues, themes and crises that were introduced by the children.

6.6 Assessment Instruments

6.6.1 The Piers-Harris Children's Self-Concept Scale

The Piers-Harris Children's Self-Concept Scale (1984) subtitled "The Way I Feel about Myself" is an 80-item, self-report questionnaire designed to assess how children and adolescents feel about themselves. In this context self-concept is defined as "a relatively stable set of self-attitudes reflecting both a description and an evaluation of one's own behaviour and attributes" (Piers, 1984). The scale is concerned with measuring a child's conscious self-perceptions, rather than trying to infer how the children feel about themselves.

Children in the age group of 8-18 years respond to statements about feelings with "yes" or "no" as true or not true of themselves. Six cluster scales are scored:

- i) Behaviour: this is a 16-item cluster which reflects the extent to which the child admits to or denies having problematic behaviour.
- ii) Intellectual and School Status: This 17-item cluster reflects the child's self-assessment of his or her abilities as related to intellectual and academic tasks, including general satisfaction with school and future expectations.
- iii) Physical Appearance and Attributes: This cluster includes 13 items and reflects a child's attitudes with regard to his or her physical characteristics. The items also cover issues relating to leadership and the ability to express ideas.
- iv) Anxiety: This 14-item scale taps a variety of specific emotions including worry, nervousness, shyness, sadness, fear and a general feeling of being left

out of things. General emotional disturbance and dysphoric mood are reflected.

v) Popularity: The 12 items in this cluster evaluate a child's popularity with his or her classmates, and their ability to make friends.

vi) Happiness and Satisfaction: This 10-item cluster measures a child's general feeling of happiness and also a child's sense of satisfaction with their life.

6.6.1.1 Administration and Scoring of the Piers-Harris Children's Self-Concept Scale

The Piers-Harris Children's Self-Concept Scale (1984) can be administered either individually or in a group setting. The children are encouraged to answer as truthfully as possible, and it is stressed that there are no right or wrong answers. The instructions are then read aloud to the children and it is emphasized that they are expected to circle either "yes" or "no" for every item. Following this the individual items are then read aloud to the children and care is taken to ascertain that each child understands the questions.

The appropriate scoring keys and tables (Piers, 1984) are used to obtain the total raw scores and also the raw scores for the cluster scales. The items are scored in the direction of positive self-concept, thus the higher the raw score the higher the child's assessed self-concept.

6.6.1.2 Validity of the Piers-Harris Children's Self-Concept Scale

Validity investigations of the Piers-Harris Children's Self-Concept Scale (1984) have supported the scale in terms of content validity, concurrent validity, convergent, discriminant validity and construct validity (Shavelson, Hubner & Stanton 1979; cited in Piers, 1984). They used the Piers-Harris Children's Self-Concept Scale (1984) together with five other self-concept instruments and examined three aspects of self-concept (i.e., definition, instrumentation and empirical data). It was concluded that self-concept interpretations of the total score on the Piers-Harris Children's Self Concept-Scale (1984) are warranted based on convergent validity coefficients.

In another study by Franklin, Duley, Rousseau and Sabers (1981; cited in Piers, 1984) convergent and discriminant validity was investigated. Convergent validity was examined by comparing performance on the Piers Harris Children's Self-Concept Scale and the Coopersmith Self-Esteem Inventory (1967; cited in Piers, 1984). A correlation coefficient of 0.78 was found, indicating convergent validity.

Factor analytic studies (Rich, Barcikowske & Witmer, 1979; cited in Piers, 1984) have upheld the cluster scores and have demonstrated greater within-scale correlations than across scales, although all scales tend to correlate moderately.

6.6.1.3 Reliability of the Piers-Harris Children's Self-Concept Scale

Test-retest reliability coefficients range from 0.42 to 0.96 with a median test-retest reliability of 0.73. The internal consistency estimates for the total score range from 0.88 to 0.93 (Piers, 1984). It is thus contended that the reliability analyses indicate adequate temporal stability and internal consistency.

6.6.2 Rutter Teacher's Questionnaire

This questionnaire was first used as a screening device for psychiatric disorders in the Isle of Wight studies in 1965 (Rutter, 1967; Rutter, Tizard & Whitmore, 1970).

It was developed and used in conjunction with a Parent Questionnaire. The Rutter Teacher's Questionnaire (1967) provides a fairly economical and quick way for teachers to measure behaviour occurring in the classroom situation. It can be used to discriminate between different types of behavioral or emotional disorders (antisocial or neurotic behaviour). It can also discriminate between children who show these disorders and those who do not. It is however important to note that the designation of a psychiatric disorder on this scale (antisocial or neurotic) does not mean that the child (in terms of their basic personality structure) is abnormal. It only infers that their behaviour, emotions or relationships were abnormal at the time of the assessment.

6.6.2.1 Administration and Scoring of the Rutter Teacher's Questionnaire

The scale consists of twenty-six brief statements which concern the child's behaviour in the classroom situation. The teacher has to check whether the statement "certainly applies" (scores 2), "applies somewhat" (scores 1) or "doesn't apply" to the child in question. The scale yields a total, a neurotic score and an antisocial score. Those children with a total score of above 9 and a neurotic score exceeding the antisocial score are designated "neurotic", and those with a total score of 9 and the antisocial score exceeding the neurotic score are designated "antisocial". The children with equal neurotic and antisocial subscores are categorized undifferentiated (Rutter, 1967).

6.6.2.2 Validity of the Rutter Teacher's Questionnaire

The Rutter's Questionnaire (1967) was able to identify 60% of girls and 80% of boys as being disturbed in a clinic sample whereas in a sample of the general

population only 3% of girls and 11% of boys were found to be disturbed (Rutter et al., 1970). The questionnaire was also able to differentiate at a significant level of confidence between the "neurotic" and "anti-social" children. When comparing the clinical diagnosis made from case notes with children who obtained a score of 9 or more on the scale, it was found that there was agreement in 90% of the antisocial children and 80% of the neurotic children.

6.6.2.3 Reliability of the Rutter Teacher's Questionnaire

The inter-rater reliability on this scale was found to be $r = 0.72$. Thus the coefficient of determination equals 0,52 meaning that 52% of the variance in one raters scores is likely to be determined by another's (Rutter et al., 1970). This was obtained by 4 teachers rating seventy children in the last term of infant school and then these same children were once again rated by different teachers 2 to 3 months later in the first term of junior school.

Re-test reliability for teachers filling in the form twice on 70 children within a three-month interval between completions was $r = 0.89$ (Rutter, et al., 1970). Thus the coefficient of determination equals 0,79 indicating that 79% of variance in one raters scores is likely to be determined by the other rater. Similar findings were also reported by Richman (cited in Rutter et al., 1970).

6.6.3 Projective Drawings

Two of the most commonly used projective drawing tests were used in this study: The Koppitz Human Figure Drawing Test (HFD) (1968) and the Kinetic Family Drawing Test (KFD) (1970). The employment of projective drawings has been widespread in psychology for several decades. The most basic assumption underlying projective drawings is that a child's drawing is an expression of their inner reality (Yates, Beutler & Crago, 1985).

6.6.3.1 Development of the Human Figure Drawing Test

The Human Figure Drawing Test (HFD) was first developed by Koppitz (1968) who believed that the Human Figure Drawing Test is one of the most valuable methods for psychometrically evaluating children. It yields a developmental assessment which can be interpreted to give an I.Q. range, as well as giving an indication of the emotional adjustment of the child.

6.6.3.2 Development of the Kinetic Family Drawing

The Kinetic Family Drawing Technique (KFD) was originally based on the principles of the family drawing technique (Hulse, 1951; cited in Klepsch & Logie, 1982) and was introduced by Burns and Kaufman in 1970. An important distinguishing feature of the KFD is that the analysis of these drawings focuses on movement rather than on the analysis of inert figures. This was based on the assumption that the dimension of movement was all important.

6.6.3.3 Administration and Scoring of the Projective Drawings

Both tests can be administered either individually or in a group. The instructions for the Human Figure Drawing (1968) and the Kinetic Family Drawing (1970) are included in Appendix (D). There is no time limit for either test. A child may use an eraser, but this should be noted by the examiner.

For the purposes of this research the scoring system for emotional indicators developed by Koppitz (1968) has been employed. A distinction is made between developmental signs and emotional indicators on the drawings. The former reflect a child's level of cognitive maturity (developmental items), and the latter refers to those drawing indicators which suggest anxiety, interpersonal or intrapersonal attitudes and social-emotional concerns (emotional indicators).

Koppitz (1968) has listed thirty significant emotional indicators and defined these according to three criteria:

- i) They must have clinical utility and differentiate between drawings of healthy and emotionally disturbed children.
- ii) They should occur at a low frequency in the drawings of healthy children (i.e., in less than 6% of the drawings of normal children)
- iii) Their frequency of occurrence should be independent of age and maturation level

Emotional indicators include items or features not usually found on HFD's such as teeth, short or long arms, the omission of items, such as eyes and nose and lastly items that relate to the quality of the drawing, such as the type of integration, shading and use of transparencies.

However, it is important to note that Koppitz (1968; cited in Cummings, 1986) assumes that in order to make a meaningful diagnosis or evaluation of a child's behaviour or difficulties, the significance of emotional indicators is increased by considering their presence in terms of the entire drawing. Koppitz contends that the total drawing and combination of signs should be "analyzed on the basis of the child's age, maturation, emotional status, social and cultural background" (ibid p.55) and should then be evaluated in relation to other available test data.

6.6.3.4 Validity and Reliability of the Projective Drawings

Hagood (1992) stresses the problems of validity and reliability with the use of projective drawings, particularly as an accurate assessment instrument in the field of child sexual abuse. The following problems with the drawings are noted:

- i) In recent years the level of exposure of children to sexually explicit material has increased dramatically. The effects of modern parenting methods, school sex-

education, films and videotapes, dramatically effects a child's perception of sexual matters. Hagood (1992) states:

what is now reflected in children's drawings as 'normal' in 1992 might be considerably different than what was typical of children's drawings at an earlier period of time when the establishment of many children's projective drawings tests was carried out (p.28).

ii) When evaluating drawings no attempt to understand or ascertain immediate prior events in a child's life is made. These events can often help clarify why the child depicts certain elements in his or her drawings.

iii) Very often changes in artwork are considered to be due to therapy, but in actual fact they may be due to developmental maturation which would have occurred without therapy.

iv) There is a danger that therapists read more into the artwork than may actually be there. They sometimes may be inclined to project evidence into the drawings to fit in with existing hypotheses. This will obviously lead to bias in the interpretation of the drawings.

v) Psychoanalytic interpretations appropriate for adults are often extrapolated and used to interpret children's drawings. Clinical experience has demonstrated that interpretations which are appropriate for adults do not apply to the drawings of young children.

The literature appears to contain contradictory evidence in relation to the validity and reliability of projective drawings. Bradshaw (1972; cited in Klepsch & Logie, 1982) investigated the test-retest reliability of the Human Figure Drawing Test with respect to the structural aspects of the drawings. He allowed for a one week interval between the two administrations of the test and found that placement of the figures on the page and the size of the figure appeared to be reliable.

Swenson (1968; cited in Klepsch & Logie, 1982) in his review of the empirical findings, found more support for the reliability and validity of projective drawings. Ogdon (1984) states that the validity studies indicate an increase in the consensual and empirical validity of projective drawings. These findings were attributed to improved research design methodology. Support for this view comes from Roback (1968; cited in Klepsch and Logie, 1985). There appears to be a general consensus that global or overall ratings are more reliable than ratings based on specific signs.

In order to test the inter-rater reliability of the scoring system in this study, the emotional indicators on the drawings were evaluated by two independent raters. The inter-rater reliability was 0.76 and 0.71 respectively. Thus on average the raters scores were determined 61% of the time by the independent raters, indicating adequate reliability.

6.7 Data Analysis

Descriptive statistics yielded means, standard deviations and minimum and maximum scores for all variables (see Appendix E). Further methods of data analysis will be presented in conjunction with the hypothesis that is being tested.

6.7.1 Data Analysis for Hypothesis 1

Hypothesis 1 states that the group therapy process will allow for verbalization of negative emotions relating to initial psychological effects of child sexual abuse.

In order to test these hypotheses each session was video-taped. The content of each session was then transcribed and a content analysis was performed on the transcripts. An important step of content analysis according to Bailey (1987, pp. 304) is to "define the recording unit". The unit of analysis used in this research was that of a speech act (i.e., from the period of time that one person starts to speak to the completion of their communication or until they are interrupted). In order to

establish the categories to be included in the content analysis, the transcripts of all the sessions were studied. It was decided not to impose any pre-existing categories on the data such as those used by Finkelhor and Brown (1986) or Russel (1994). Rather, an attempt was made to allow the categories to emerge from the raw data. The speech units in each category were then grouped together and scored as frequencies of the various verbalizations. Holsti (1969) claims this is the most widely used method of measuring characteristics of content.

In order to test the inter-rater reliability of the content analysis 4 sections of the transcripts representing 154 speech acts were selected. These were rated by two independent raters using the definitions of the various categories specified as a guide. The inter-rater reliability was 0.78 and 0.83 respectively. Thus on average the raters scores were determined 65% of the time by the independent raters, indicating adequate reliability.

6.7.2 Data Analysis for Hypothesis 2

Hypothesis 2 states that there will be a significant difference in the verbalization of negative emotions relating to initial psychological effects of child sexual abuse in the Sturkie Model of Group Therapy (1983) and the unstructured group intervention with survivors of child sexual abuse.

Session 1 to 7 of the structured and unstructured groups were compared to see which group format allowed for greater verbalization of emotions. However, session 8 of the unstructured group was omitted and instead session 9 was compared with session 8 of the structured group. This was because the technique of psychodrama was utilized in both of these sessions (see Group Process in Appendix B & C). No extra therapy session was included for the structured group, therefore session 8 of the unstructured group has not been included in the content analysis. To test this hypotheses a Wilcoxon test was carried out for each category.

6.7.3 Data Analysis for Hypothesis 3

Hypothesis 3 states the post-test scores of both groups on the Piers-Harris Children's Self-Concept Scale, the Rutter Teacher's Questionnaire and the Projective Drawings will be significantly different to the pre-test scores. This will indicate an improvement in self-concept and a positive shift in relation to the behavioral and emotional factors measured on completion of the treatment groups. In order to test this hypothesis a Student t-test for small dependent samples was used to compare the means of the two groups pre- and post-test.

6.7.4. Data Analysis for Hypothesis 4

Hypothesis 4 states that the post-test scores of the Piers-Harris Children's Self-Concept Scale, the Rutter Teacher's Questionnaire and the Projective Drawings will be significantly different for the structured than for the unstructured group, with no significant difference at the pre-test level. This will indicate that the structured group showed less improvement in self-concept and a less positive shift in relation to the behavioral and emotional factors measured on completion of the treatment groups.

To test this hypothesis a Student t-test for small independent samples was used. Depending on the variance pre- and post-test, the t-test for equal or unequal variance was used. In order to test the interaction of pre-test/post-test and structured/unstructured a 2 Way Analysis of Variance with one repeated measure was used.

CHAPTER 7

RESULTS

The results in this chapter will be presented in relation to each hypothesis tested.

7.1 Results of Hypothesis 1

The unit of analysis for hypothesis 1 is that of a speech act (i.e., from the period of time that one person starts to speak to the completion of their communication or until they are interrupted).

7.1.1 Categories of the Content Analysis

The results of the content analysis revealed a need for the following categories: Negative emotions relating to initial psychological effects of child sexual abuse; positive emotions generally reflective of therapeutic experiences; defense mechanism; narrating the facts of child sexual abuse experiences; statements not directly related to child sexual abuse; and therapist input. The categories, together with definitions and quotations from the transcripts to illustrate the different speech units, are presented:

(i) Negative Emotions Relating to Initial Psychological Effects of Child Sexual Abuse

Anxiety: This category includes all expressions by the children which relate to feelings of uneasiness and concern.

Example:- "I felt very anxious and did not know what to do."

Anger: This category relates to expressions of anger, rage and displeasure.

Example:- "I want a hand-grenade to throw at him".
"I felt very angry with him".

"Disbelief": This category includes the negative experiences of people not believing, not giving credence to and being sceptical of experiences that the children have related.

Example:- "When I tell the truth nobody believes me. Because I told my Dad something and he did not believe me and he said I must go to my bedroom and stay in your bedroom and it was the truth".

Fear: This category includes the experiences of fright, terror and fear.

Example:- "You start getting scared when you think of your problems".
"It was also very scary because it was my mother's father".

Feeling Dirty: This category includes feelings the children have of being unclean or soiled or spoilt in some way as a result of the sexual abuse.

Example:- "I felt dirty.
(Therapist) Like you wanted to wash it all away.
No, you can't. You feel clean when you get in the bath, but when you get out you start feeling dirty".

Guilt: This category includes experiences when the children have felt that it was their fault that the sexual abuse had taken place.

Example:- "I did think it was my fault because I did not say no".
"He just carried on so I thought it was my fault".

Isolated: This category includes statements relating to a sense of isolation or loneliness.

Example:- "There was nobody I could trust and nobody that I could talk to."

Low Self Esteem: This category includes feelings of lack of self worth.

Example:- "That time I could not feel good about myself."

Powerlessness: This category includes statements relating to lack of power or feelings of being wholly unable to bring about changes.

Example:- "I did not know what to do and I did not think I could stop him."

Peer Problems: This category includes problems in relating to peers.

Example:- "Whenever I try to be their friends they push me aside."
"It is because my friends say I must not come, so I had to quit."

Sadness: This category includes feelings of sorrow or mournfulness that the children have experienced.

Example:- (Commenting on her drawing the child said) "This little girl called Julie-Sophie looks happy but she is sad. She feels sad."
"I feel miserable and I cry and feel sad".

Upset: This category refers to references of a child's composure being disturbed.

Example:- (Child describing her drawing) "This is Mr. X and this is Mr. X, my uncle. X says he is coming for me and my uncle says I will molest you. This is me and I am very upset."

Unspecified Negative: This includes all negative emotions that do not fit into any of the above categories.

Example:- "I do not want to come back to the groups. I do not enjoy them."

(ii) Positive Emotions Generally Reflective of Positive Therapeutic Experiences

"Believed": Includes all positive experiences the children have had of being believed when they have told someone about their being sexually abused.

Example:- "My Mom started to explain that I must never be scared to tell her what happened and she told me it was not my fault."
"I told my mother and she believed me and then went to tell my principal. It felt good."

Blameless: Includes all statements relating to a child's realization of their innocence.

Example:- "It was not my fault. I could not stop him."

Happy: This category relates to all expressions by the children of feeling lucky, fortunate or contented with one's lot.

Example:- "I feel happy because we can say the things we want to say."

Positive Self Esteem: This category includes all statements indicating a positive self worth.

Example:- "I know deep in my heart it does not matter what you look like outside. It is what is in your heart that is important."

Unspecified Positive: Relates to all expressions of positive emotions that do not fit into any of the above categories.

Example:- "I feel as if I have got all the bad things off my chest and I can carry on."

"I learnt that if you have got bad things on your chest it is good to talk about them."

(iii) **Possible Defense Mechanisms (Resistance, Boredom, Unwillingness to Participate).** Note: Because of its nature, this category is loosely defined.

Denial: Includes statements relating to a denial of the fact that the sexual abuse ever took place.

Example:- "My mouth is zipped. I have nothing to say, because I have never been sexually abused."
"It never happened to me."

Boredom: This category includes all references to being bored.

Example:- "The group is boring."
"I feel bored."

Difficulty in Expressing Emotion: Refers to all expressions relating to difficulty in talking about issues. It also includes a child's refusal to answer questions by remaining silent.

Example:- "It is difficult to talk about."
"I am not going to speak about it."

(iv) Narrating the Facts of Child Sexual Abuse Experiences

Ability to Narrate Story or Fact: This category includes all factual statements relating to the childrens' experiences of the abuse.

Example:- "It was my Oupa and he was showing me the costume and he tried it on me and when he did this he moved his hand down here and he started to touch me in my private parts."

"The person who did it to me did not give me sweets and chocolates. He was my friend's cousin and I had to go and stay there for the holidays."

(v) Process Related Verbalizations not Directly Related to Child Sexual Abuse.

Discussion of Group Process: This category includes all statements relating to the group process, group content and group rules.

Example:- "How many more groups have we got."
"What are we going to do to-day."

Miscellaneous: This category includes statements that do not fit into any of the other categories, and are concerned with various other issues, most of which are impossible to classify due to their rarity.

Example:- "I keep hearing voices in my brain. When I keep quiet I hear these sounds in my brain and they always tell me to do things."
"There is a spider in the corner of the room."

(vi) Therapist Input

Therapist Input: These statements include all the contributions made by the therapists.

Example:- "Remember we said it is difficult to speak about. It took some of us a long time to be able to speak about it."

The following table contains the means and standard deviations of the proportions of speech acts in all the categories of the content analysis. First the overall mean and standard deviation of the groups is presented followed by that of the structured and unstructured group.

Table 2. Means and Standard Deviations of the Categories of the Content Analysis.

Category	Overall Groups		Structured Group		Unstructured Group	
	Mean	Std.Dev	Mean	Std.Dev	Mean	Std.Dev
Negative Emotions	19.06	20.75	17.27	18.89	20.72	19.56
Positive Emotions	3.38	4.1	2.83	3.11	3.86	4.66
Defense Mechanisms	5.51	5.62	3.03	3.01	7.73	6.23
Narrating Facts of Abuse	18.10	6.44	19.76	7.50	16.41	6.01
Not Related to Abuse	12.27	9.3	13.73	10.46	10.94	7.46
Therapist Input	41.77	4.77	43.37	3.69	40.34	5.34

Figure 1a. The Total Mean Verbalization of Statements in the 6 Categories of the Content Analysis in the Structured Groups

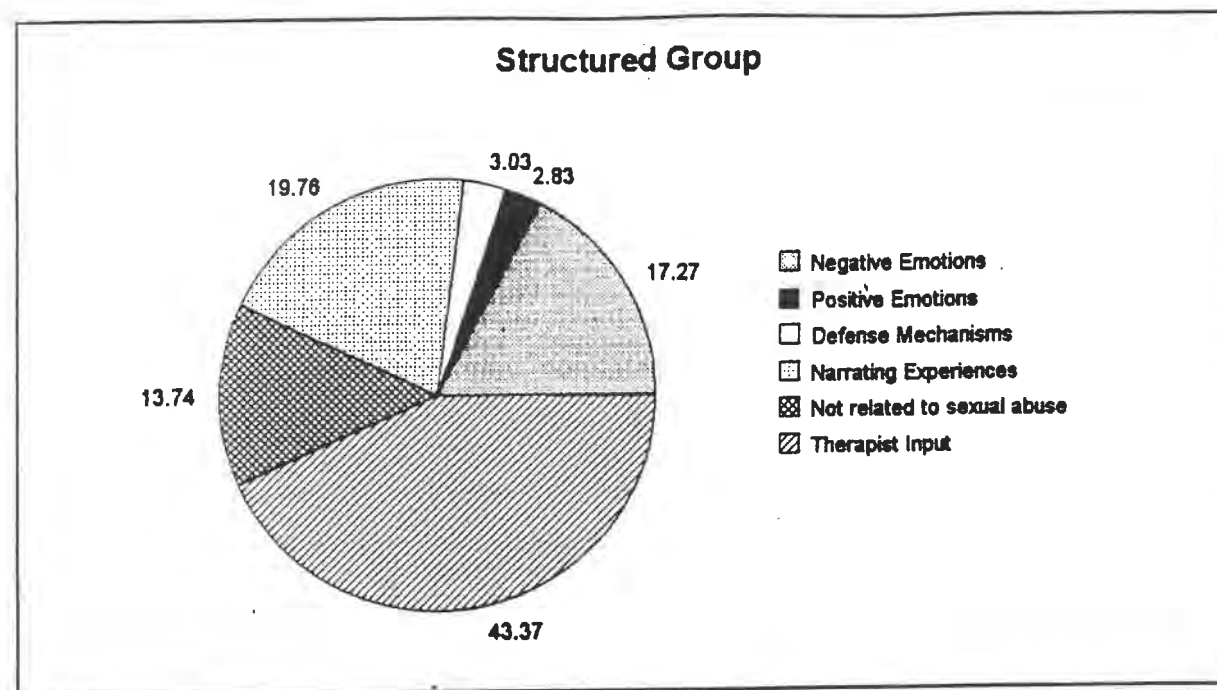
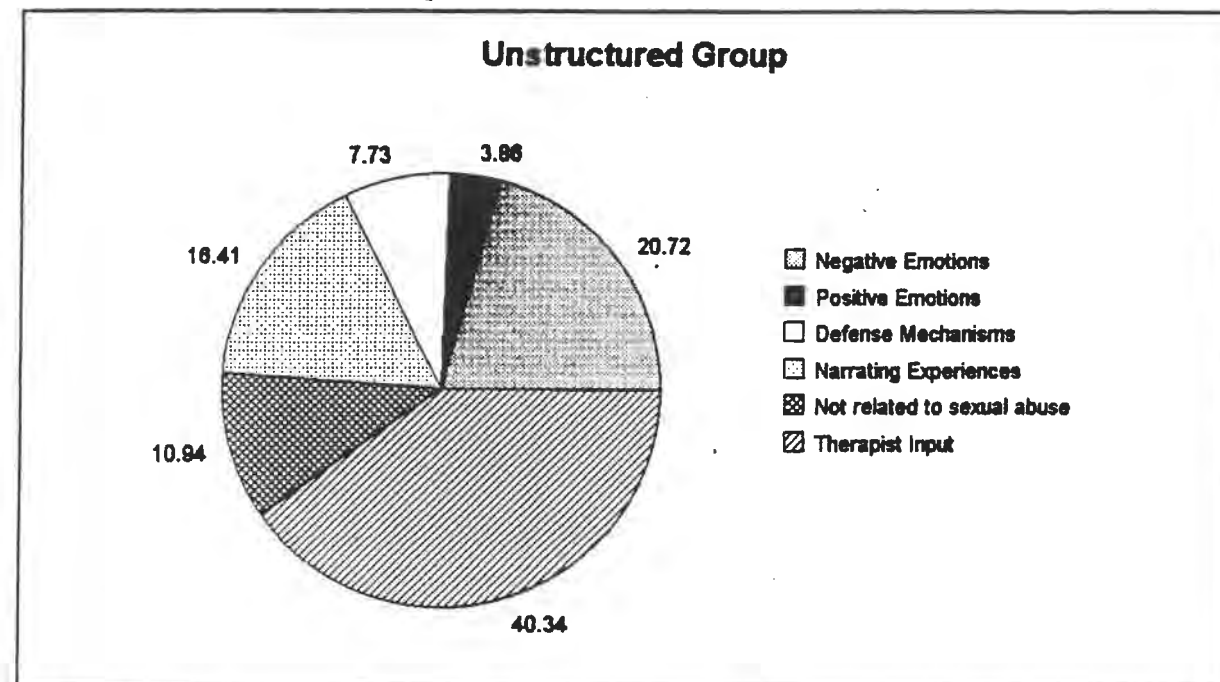


Figure 1b. The Total Mean Verbalization of Statements in the 6 Categories of the Content Analysis in the Unstructured Groups



From these results it would appear that there is support for Hypothesis 1. The group therapy process allows for verbalization of negative emotions relating to initial psychological effects of child sexual abuse. In the structured group 17.27% of the total communication was related to the participants expressing negative emotions relating to initial psychological effects of child sexual abuse. In the unstructured group 20.72% was related to this category.

7.2 Results of Hypothesis 2

The unit of analysis for hypothesis 2 is that of a speech act (i.e., from the period of time that one person starts to speak to the completion of their communication or until they are interrupted).

7.2.1 Significant Differences In The Verbalizations of the Structured and Unstructured Group Treatment Programmes

The following table contains the means and standard deviations of the proportions of speech acts in the category of negative emotions relating to initial psychological effects of child sexual abuse. First the overall mean and standard deviation of the groups is presented followed by that of the structured and the unstructured group. Finally, the conclusions of the Wilcoxon test are presented.

Table 3. Means and Standard Deviations of the Expression of Negative Emotions Relating to Initial Psychological Effects of Child Sexual Abuse.

Category	Overall Groups		Structured Group		Unstructured Group		Sig.*
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	
Anger	4.99	3.71	2.63	1.69	7.31	3.67	P<0.05
Fear	3.13	2.57	3.43	2.90	2.87	2.39	NS
Sadness	2.55	2.43	1.93	2.11	3.10	2.69	NS
Peer Prob.	1.59	2.73	1.70	2.34	1.49	3.17	NS
Upset	1.42	1.20	1.89	1.40	1.00	.87	NS
Unspec. Neg.	1.30	1.19	1.23	1.08	1.35	1.34	NS
Disbelief	1.22	1.48	1.36	1.83	1.08	1.19	NS
Powerless	.63	.98	.68	1.26	.60	.73	NS
Guilty	.61	1.30	.96	1.64	.30	.90	NS
Anxiety	.57	.77	.69	.86	.46	.71	NS
Dirty	.63	1.40	.18	.54	.89	1.26	P<0.05
Isolated	.26	.45	.31	.45	.22	.48	NS
Low Self Esteem	.16	.54	.28	.79	.05	.16	NS
Totals	19.06	20.75	17.27	18.89	20.72	19.56	N/A

Level of Significance: *p<0.05

The results reveal that there was a significant difference in the verbalization of statements relating to anger and the feeling of being unclean, soiled or dirty as a result of the abuse.

The unstructured group allowed for a greater verbalization of these emotions relating to

initial psychological effects of child sexual abuse. There was no significant difference in the verbalization of any of the other emotions relating to initial psychological effects expressed. It would therefore appear that there is support for Hypothesis 2. The method of group intervention appears to have been a significant factor in the verbalization of negative emotions relating to initial psychological effects of child sexual abuse.

Results of the Wilcoxon test also reveal that there were no significant differences between the structured and the unstructured groups in the verbalizations of statements in the following categories: Positive emotions generally reflective of therapeutic experiences; narrating the facts of child sexual abuse experiences; statements not directly related to child sexual abuse; and therapist input. However, the unstructured group allowed for a greater expression of boredom, which is included in the defense mechanism category. 1.1% of the total communications in the unstructured group were related to boredom, whereas there was no expression of this emotion in the structured group.

7.2.2 Negative Emotions Category

The expression of negative emotions relating to initial psychological effects of child sexual abuse accounts for 17.27% of the total expressions in the structured group and 20.72% in the unstructured group. The following figures graphically represent the various emotions contained in this category.

Figure 2a. The Mean Verbalization of the Negative Emotions Relating to Initial Psychological Effects of Child Sexual Abuse in the Structured Group.

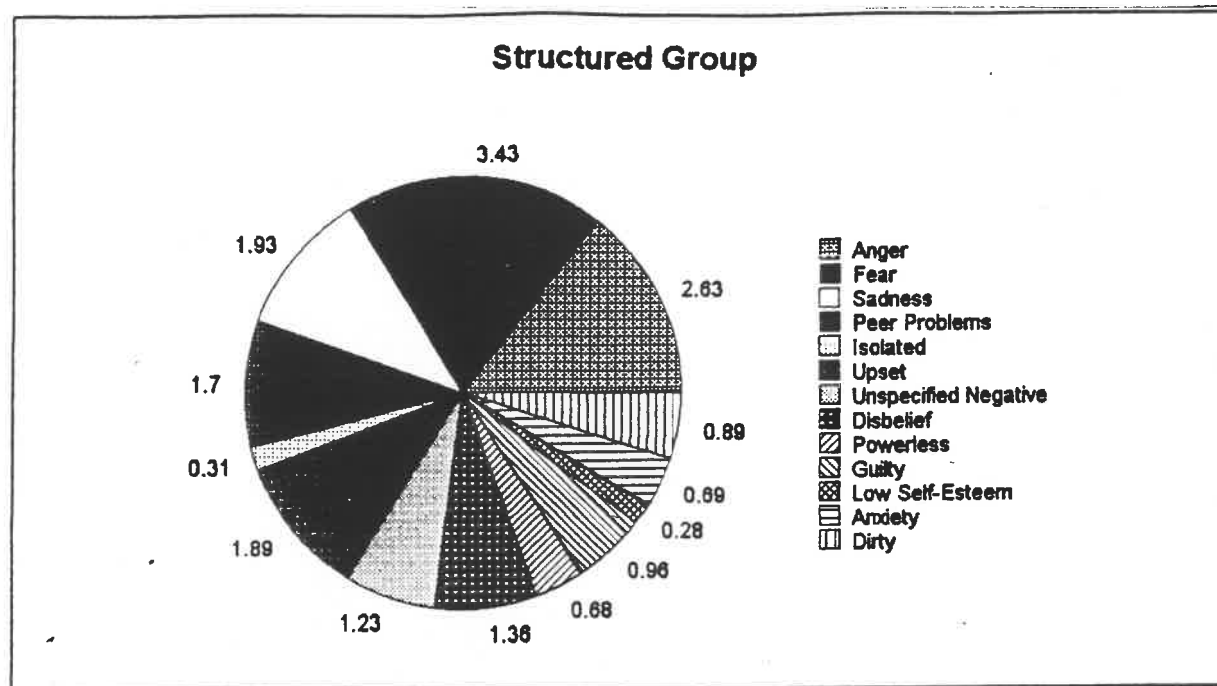
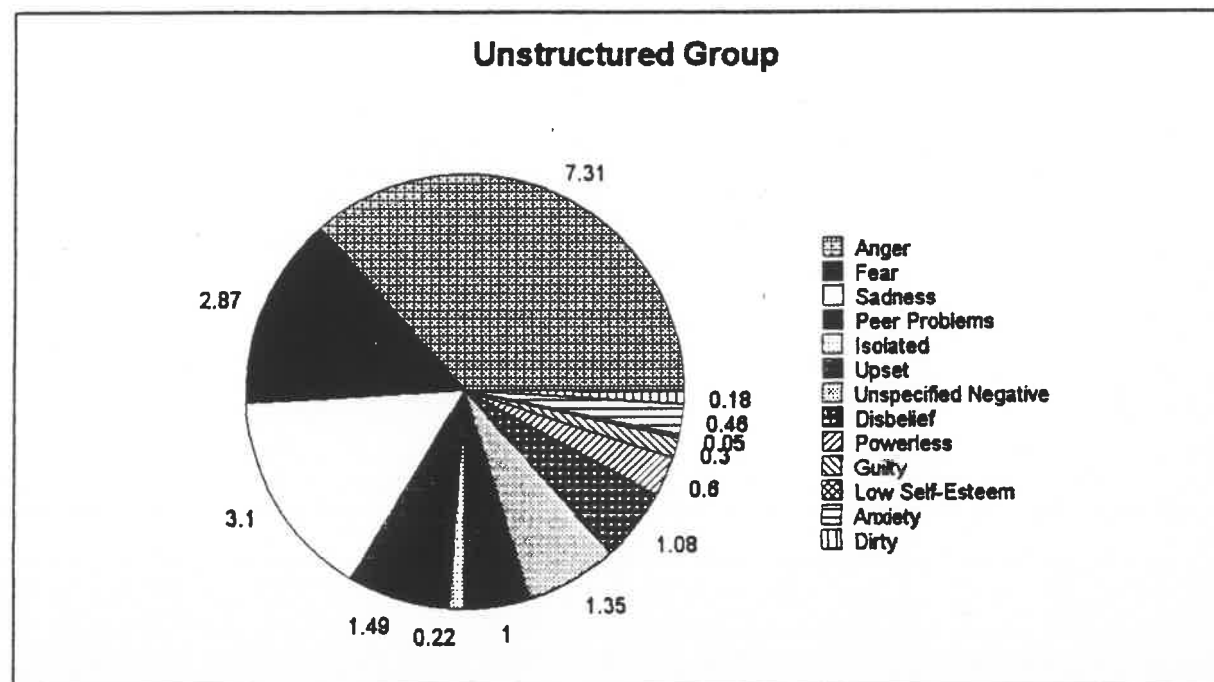


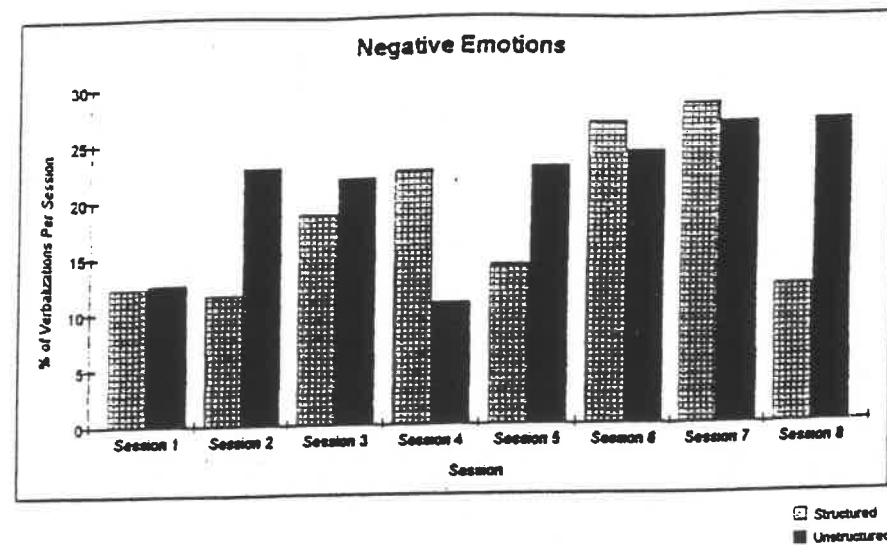
Figure 2b. The Mean Verbalization of the Negative Emotions Relating to Initial Psychological Effects of Child Sexual Abuse in the Unstructured Group.



7.2.3 Trends in The Verbalization of Emotions

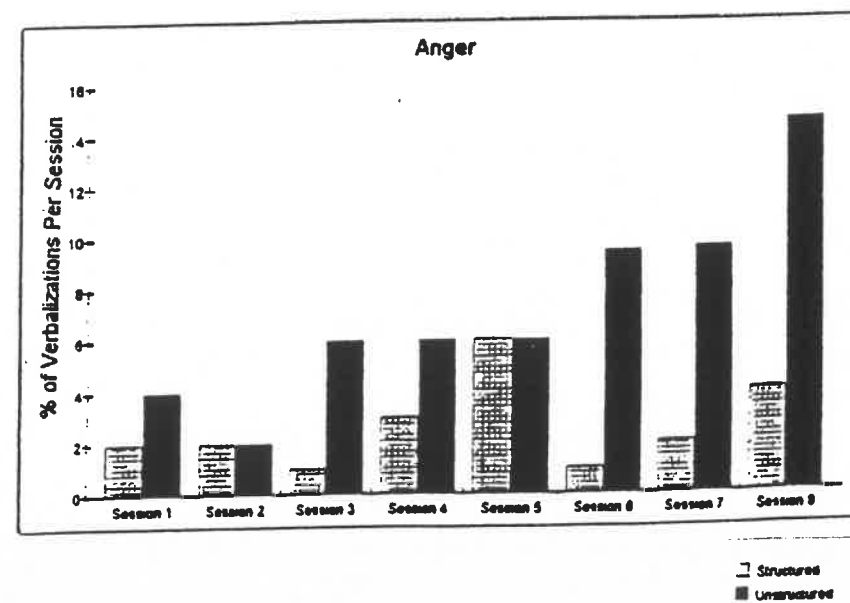
The overall trend in the expression of all the negative emotions relating to initial psychological effects of child sexual abuse is presented.

Figure 3a. Trend in The Verbalization of All Negative Emotions in each Group Session



The expression of all negative emotions relating to initial effects of child sexual abuse appears variable in the structured groups. In the unstructured groups it is variable in the first four sessions and then escalates.

Figure 3b. The Trend in the Verbalization of Statements Relating to Anger in each Group Session



The expression of anger is significantly different between the structured and the unstructured groups. The pattern of expression appears variable in the structured group and escalates in the unstructured group over the last three sessions.

The expression of "feeling dirty" and boredom was also significantly different between the structured and the unstructured groups. The unstructured groups appeared to allow for a greater expression of these emotions. However, the total mean verbalization of statements in both groups relating to "feeling dirty" was only 0.63% and the total expression of boredom was only 0.58%. The trend in the verbalization of these two emotions are therefore not presented in a graphic form.

7.3 Result of Hypothesis 3

The means obtained in the pre- and post-intervention on the sub-scales of the Rutter Teacher's Questionnaire, the subscales of the Piers-Harris Children's Self-Concept Scale, the Human Figure Drawing and the Kinetic Family Drawing are presented below. The significance level calculated using the Student t-test for small dependent samples is included in the right hand column.

Table 3. Means, Standard Deviations and Significance Levels of the Pre- and Post-Test Scores

Scale	Pre-Test		Post-Test		One-Tailed P
	Mean	Std.Dev	Mean	Std.Dev	
Rutter Antisocial	2.3	2.93	2.3	2.41	0.5
Rutter Neurotic	2.8	2.03	2.7	2.7	0.434
Piers-Harris 1	12.3	12.3	12.2	12.2	0.445
Piers-Harris 2	10.0	3.89	11.1	4.54	0.190
Piers-Harris 3	6.4	2.45	8.2	3.57	0.040 *
Piers-Harris 4	6.7	2.14	7.7	2.32	0.069 *
Piers-Harris 5	6.0	2.68	6.0	2.76	0.323
Piers-Harris 6	7.5	2.37	8.3	1.41	0.140
HFD	2.5	1.91	2.5	1.43	0.5
KFD	3.8	2.04	4.0	1.82	0.434

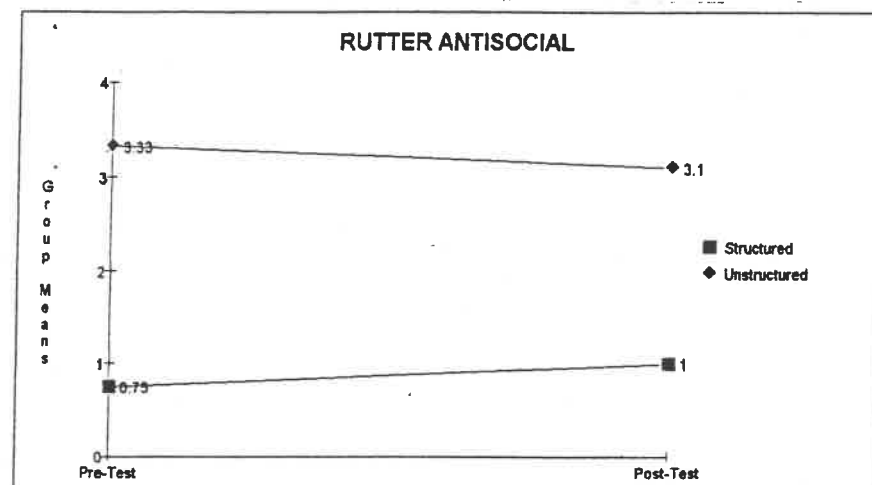
Levels of Significance: *p<0.05

The results indicate that on completion of the groups there was an increase in self-esteem in attitudes concerning physical characteristics, as well as attributes such as leadership and the ability to express ideas. The variable relating to a child's anxiety, worry, nervousness, sadness, fear and a general feeling of being left out of things, also approaches significance. This indicates a trend to increased self-esteem in this area. No significant difference is noted on any of the other variables measured in the pre- and post-test.

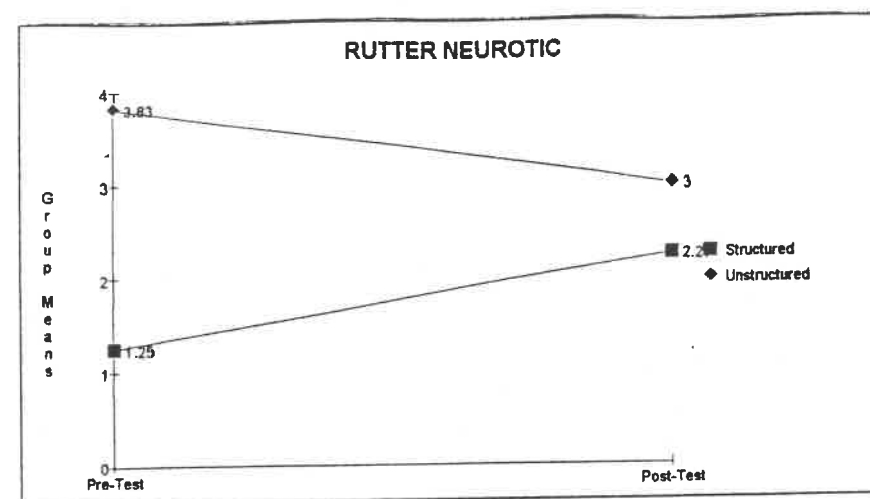
7.4 Results of Hypothesis 4

In order to ascertain if the degree of therapeutic change is significantly different for the structured than for the unstructured group, with no significant difference at pre-test level, the following results are presented.

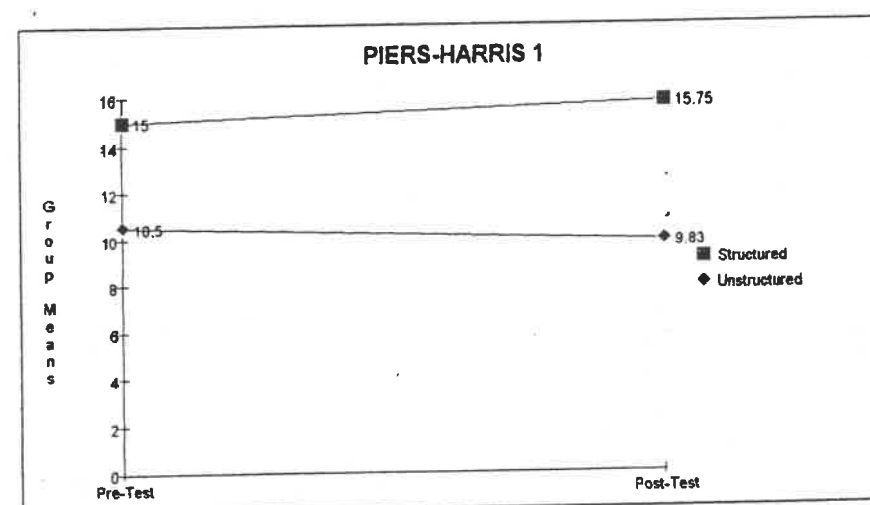
Figure 4a. Rutter Antisocial Subscale



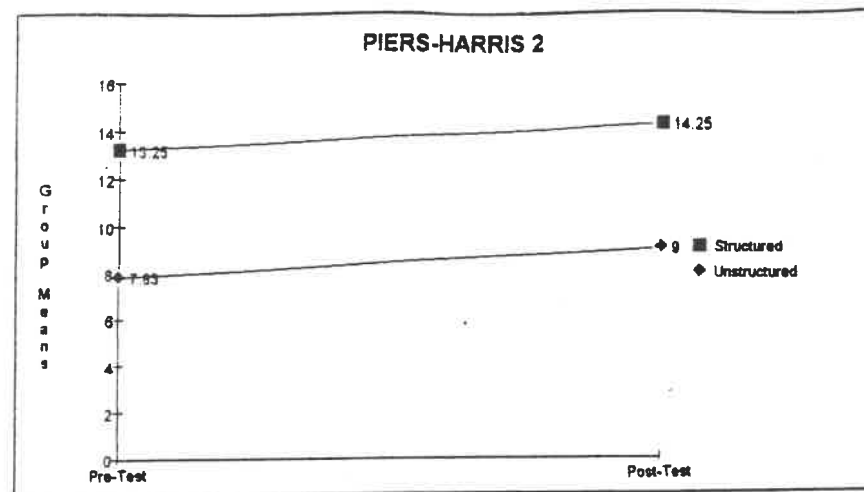
Although the two groups were nearing a significant difference in terms of the Rutter Antisocial Subscale at the pre-test ($t = -1.677$, $df = 5$, $p = 0.077$) neither intervention changed the scores much. Post-test scores were not significantly different either ($t = -1.387$, $df = 8$, $p = 0.101$). There is no evidence that one or other of the interventions was more effective (GRP x PREPOST : $F = 0.25$, $df = 1$, $p = 0.634$).

Figure 4b. Rutter Neurotic Subscale

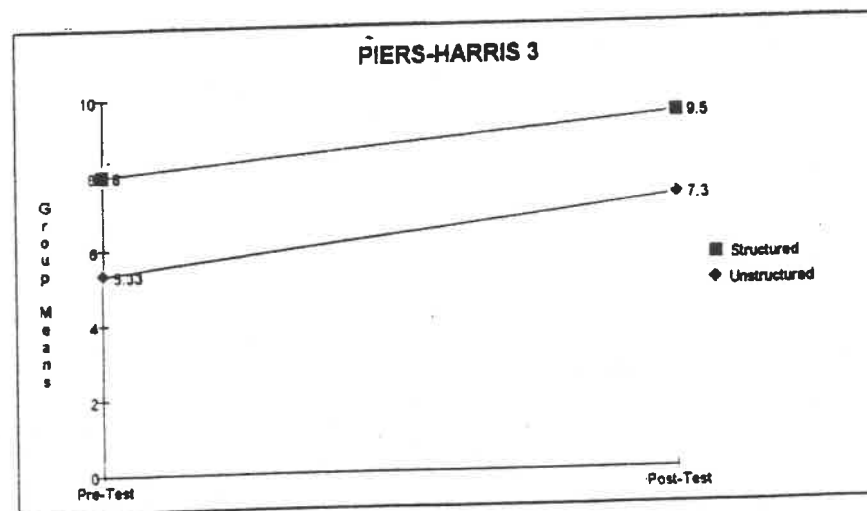
The two groups were significantly different in terms of the Rutter Neurotic Subscale at the pre-test ($t = -2.238$, $df = 8$, $p = 0.028$). However on the post-test score they were not significantly different ($t = -0.689$, $df = 8$, $p = 0.255$). The interaction did not reach significance (GRP x PREPOST : $F = 2.83$, $df = 1$, $p = 0.131$).

Figure 4c. Piers-Harris Subscale 1 : Behaviour

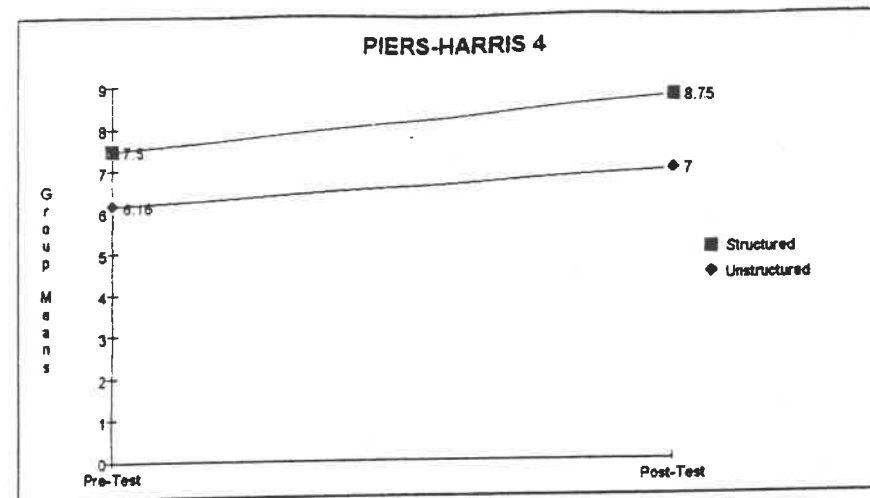
The two groups were significantly different in terms of the Piers-Harris Subscale 1 at the pre-test ($t = 2.509$, $df = 6$, $p = 0.0230$). At post-test they remain significantly different, demonstrating little change ($t = -3.749$, $df = 5$, $p = 0.007$). There is no evidence that one or other of the interventions was more effective (GRP x PREPOST : $F = 0.96$, $df = 1$, $p = 0.356$).

Figure 4d. Piers-Harris Subscale 2 : Intellectual and School Status

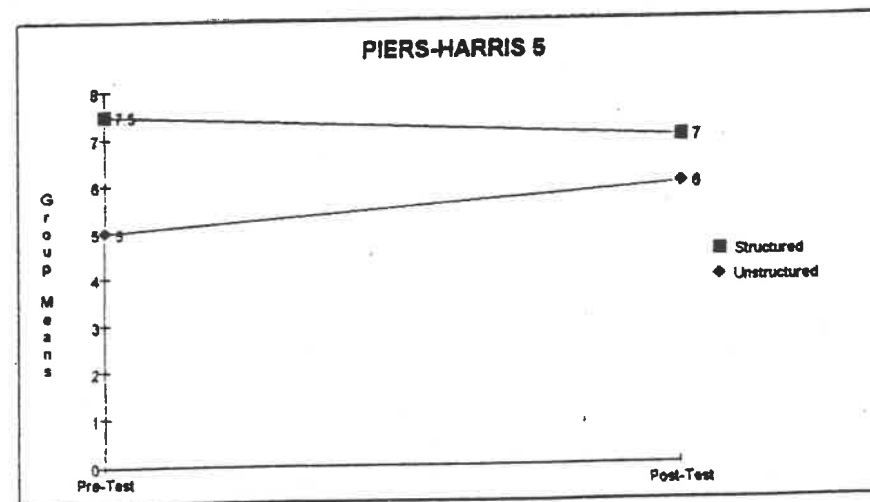
The two groups were significantly different in terms of the Piers-Harris Subscale 2 at the pre-test ($t = 3.913$, $df = 8$, $p = 0.010$). At the post-test they remain significantly different ($t = 2.174$, $df = 8$, $p = 0.031$). There is no evidence that one or other of the interventions was more effective (GRP x PREPOST : $F = .00$, $df = 1$, $p = 0.950$).

Figure 4e. Piers-Harris Subscale 3 : Physical Appearance and Attributes

The two groups were not significantly different in terms of the Piers-Harris Subscale 3 at the pre-test ($t = 1.437$, $df = 3$, $p = 0.123$). The post-test scores also reveal no significant difference ($t = 0.905$, $df = 7$, $p = 0.198$). There is no evidence that either of the interventions was more effective than the other (GRP x PREPOST : $F = 0.06$, $df = 1$, $p = 0.807$).

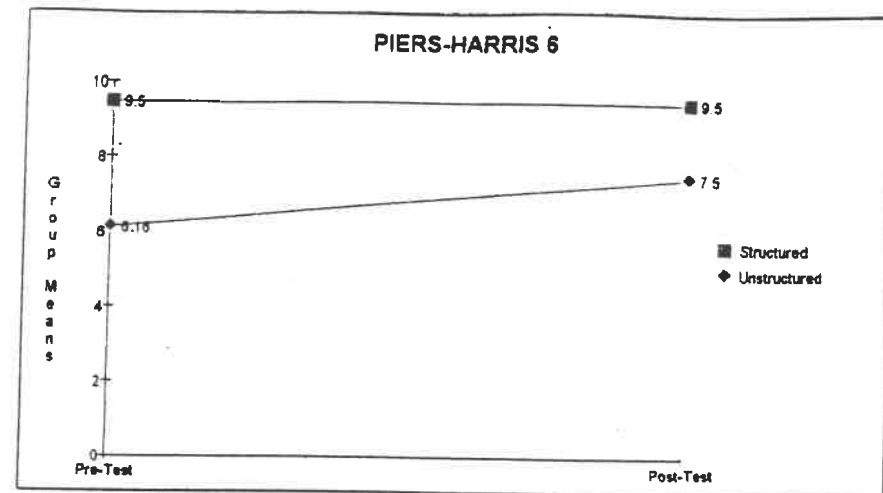
Figure 4f. Piers-Harris Subscale 4 : Anxiety

The two groups were not significantly different in terms of the Piers-Harris Subscale 4 at the pre-test ($t = 0.764$, $df = 4$, $p = 0.244$). The post-test scores also reveal no significant difference ($t = 1.271$, $df = 8$, $p = 0.120$). There is no evidence that either of the interventions was more effective than the other (GRP x PREPOST : $F = 0.10$, $df = 1$, $p = 0.761$).

Figure 4g. Piers-Harris Subscale 5 : Popularity

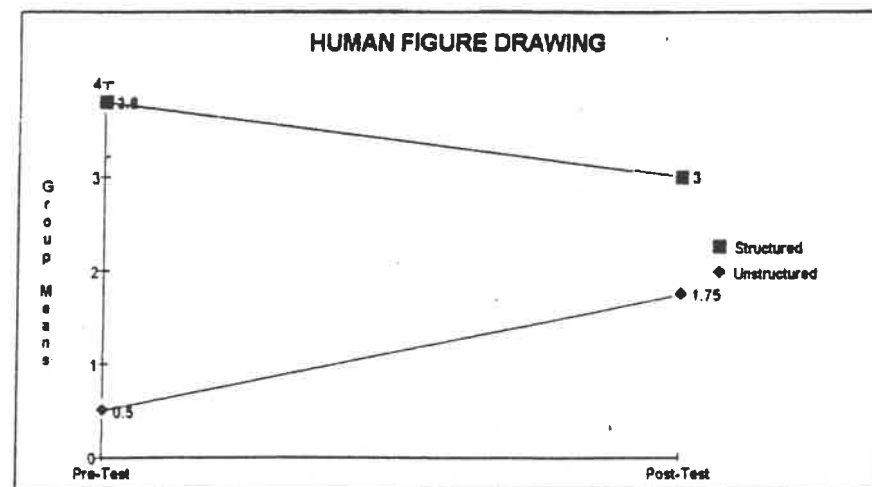
The pre-test scores reveal that the groups were almost significantly different in terms of the Piers-Harris Subscale 5 ($t = 1.597$, $df = 8$, $p = 0.074$). At post-test level there was no significant difference ($t = 0.512$, $df = 7$, $p = 0.311$). There is no evidence that either of the interventions was more effective than the other (GRP x PREPOST : $F = 0.73$, $df = 1$, $p = 0.417$).

Figure 4h. Piers-Harris Subscale 6 : Happiness and Satisfaction



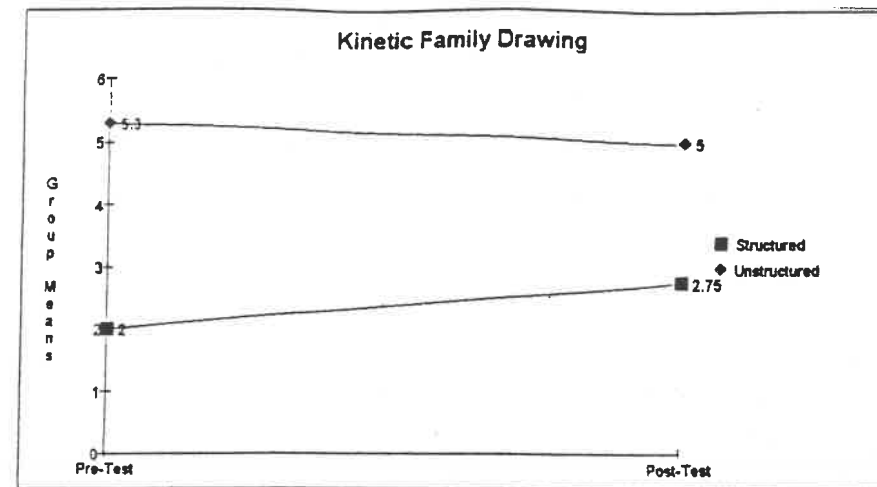
The two groups were significantly different in terms of the Piers-Harris Subscale 6 at the pre-test ($t = 3.261$, $df = 6$, $p = 0.009$). At the post-test they remain significantly different ($t = 3.162$, $df = 7$, $p = 0.008$). There is no evidence that one or other of the interventions was more effective (GRP x PREPOST : $F = .87$, $df = 1$, $p = 0.379$).

Figure 4i. Human Figure Drawing Test



The two groups were significantly different at pre-test in terms of the emotional indicators as measured on the Human Figure Drawings ($t = -5.423$, $df = 7$, $p = 0.0004$). However at the post-test there was no significant difference between the groups ($t = -1.321$, $df = 6$, $p = 0.117$). The interaction did not reach significance. (GRP x PREPOST : $F = 2.64$, $df = 1$, $p = 0.143$).

Figure 4j. Kinetic Family Drawing Test



The two groups were significantly different at pre-test in terms of the emotional indicators as measured on the Kinetic Family Drawings ($t = -3.314$, $df = 4$, $p = 0.015$). They remain significantly different at post-test ($t = -2.218$, $df = 6$, $p = 0.034$). There is no evidence that one or other of the interventions was more effective (GRP x PREPOST : $F = 0.74$, $df = 1$, $p = 0.419$).

7.5 Summary of the Results.

(i) The group therapy process allows for the verbalization of negative emotions relating to initial psychological effects of child sexual abuse. These findings appear to support Hypothesis 1.

(ii) The method of group intervention appears to have been a significant factor in the verbalization of negative emotions relating to initial psychological effects of child sexual abuse. The unstructured group format allowed for a greater verbalization of statements relating to anger and the expression of "feeling dirty". These findings appear to support Hypothesis 2.

(iii) There were no significant differences between the structured and unstructured groups in the verbalizations of statements in the following categories: Positive emotions generally reflective of therapeutic experiences; narrating the facts of child sexual abuse experiences; statements not directly related to child sexual abuse; and therapist input. In the category relating to defense mechanism the unstructured group allowed for a greater expression of boredom.

(iv) On completion of the groups there was an increase in self-esteem on Subscale 3 (Physical Appearance and Attributes) and Subscale 4 (Anxiety) of the Piers-Harris Children's Self-Concept Scale. This indicates a trend to increased self-esteem on completion of the groups. No significant difference was noted on any of the behavioural and emotional indicators measured on the Rutter Teacher's Questionnaire and the Projective Drawings. These findings appear to offer tentative support for hypothesis 3.

(v) The results pre-test on the Piers-Harris Children's Self-Concept Scale, the Rutter Teacher's Questionnaire and the Projective Drawings reveal that the groups were significantly different at pre-test level. These findings do not support Hypotheses 4. From an analysis of the results it would appear that overall the unstructured group showed significantly higher levels of behavioural and emotional factors as measured by the Rutter Teacher's Questionnaire and the Kinetic Family Drawing. The unstructured group also showed significantly lower levels of self-esteem as measured on some of the cluster scales of the Piers-Harris Children's Self-Concept Scale.

(vi) At post-test the groups remained significantly different. The unstructured groups displayed more emotional indicators as measured by the Kinetic Family Drawing, and lower levels of self-esteem as measured by the Piers-Harris Children's Self-Concept Scale.

(vii) The results reveal no evidence that the degree of therapeutic change was greater for one group than the other. These findings appear to refute hypothesis 4.

CHAPTER 8

DISCUSSION

Before considering any of the results in this research certain methodological problems relating to the subjects assignment to the structured or unstructured groups need to be considered:

(i) Because of the difficulties involved in the commencement of the groups, no attempt was made to match the subjects on variables such as education, nature of abuse, duration of abuse and identity of the perpetrator. The children were therefore arbitrarily assigned to the structured and unstructured groups.

(ii) The pre-test scores on the Piers-Harris Children's Self-Concept Scale (1984), the Rutter Teacher's Questionnaire (1976), Human Figure Drawing Test (1968) and the Kinetic Family Drawing (1970) were significantly different at pre-test level, with the unstructured group showing overall higher levels of behavioural and emotional indicators of disturbance and lower levels of self-esteem.

(iii) From the available histories of the subjects it would appear that three of the participants in the unstructured group were subject to more severe forms of abuse than those in the structured group. Research has shown that the more severe the abuse the more traumatized the child may be (Beitchman, Zucker, Hood, daCosta & Akman, 1991), and therefore more likely to express negative emotions relating to initial psychological effects of child sexual abuse.

All of the above factors will probably have had a bearing on the results obtained in this research and as such must be borne in mind when interpreting the results.

This discussion will be presented in two parts. The first part will discuss the contents of both a structured and an unstructured group treatment programme for sexually abused children and the second part will consider the effectiveness of these treatment groups.

8.1 Content of a Structured and Unstructured Group Treatment Programme for Sexually Abused Children.

Much of the work undertaken in the field of child sexual abuse has not been empirically validated. Most often there has been the assumption that children suffer both initial and long-term effects of child sexual abuse (Levett, 1994). Based on these assumptions and taking into account themes that appeared to emerge from previous groups for sexually abused children, Sturkie (1983) developed treatment themes which focus mainly around emotionally expressed psychological effects of child sexual abuse. These themes have become the focus of the sessions in the group treatment of sexually abused children (Berliner & Ernst, 1984; Hiebert-Murphy, De Luca, & Runtz, 1992). However, criticism has been levelled against the use of these themes. Haugaard and Reppucci (1988) claim that the introduction of specific themes may suggest symptoms and feelings to the participants that they did not previously experience. One of the aims of this study therefore was to empirically investigate if in fact children do express negative emotions relating to initial psychological effects of child sexual abuse. In addition, an attempt has been made to establish whether a structured or unstructured group format will allow for greater verbalization of these emotions, and whether or not the introduction of themes influences the content of the group therapy sessions.

8.1.1 Categories of the Content Analysis

Each category of the content analysis will be discussed. The category relating to negative emotions relating to initial psychological effects of child sexual abuse will be

dealt with in detail, and the remaining five categories will only be dealt with briefly. For an operational definition of each category and the related examples of verbalizations see Section 7.1 (pp 79ff).

8.1.1.1 Therapist Input

In the structured group 43.37% of the total communication was devoted to input by the therapist and in the unstructured group the amount was 40.34%. Though not significantly different the structured group required greater therapist input which may have been related to the introduction by the therapist of a different theme in each group session. However, the structured group only had 4 participants and the unstructured group had 6 participants. This difference in numbers may also have had a bearing on the participation of the therapists. This proportion of therapist input is however not unexpected in group therapy with children (Ginnot, 1968).

8.1.1.2 Narrating the Facts of Child Sexual Abuse Experiences

19.76% and 16.41% of the communication in the structured and unstructured groups respectively was related to the participants talking about their experiences of having been sexually abused. From an analysis of the transcripts it appears that the participants in the unstructured group experienced greater difficulty in talking about the abuse and demonstrated greater resistance when the topic of sexual abuse was discussed. This is despite the children having been initially self-identified as having been sexually abused. These findings are supported by Hazzard, King and Webb (1986) who found that when group participants were first encouraged to discuss the sexually abusive incident(s), many initially refused, stating that they found it very difficult to do so. The transcripts revealed that even on completion of the groups, the participants still appeared to find it difficult to discuss their abuse and appeared at times reluctant to remember the events. A contributing factor may have been that this programme was initiated almost 6 months after the children had self-disclosed, thereby making them reluctant to re-live their experiences.

Another factor which needs to be considered is that only one cycle of treatment consisting of 9 sessions was held, with one additional session for the unstructured group. It therefore may be possible that the children needed a longer period of time before feeling safe to disclose the details of their abuse.

8.1.1.3 Defense Mechanisms

In keeping with their difficulty in talking about the abuse, the unstructured group participants showed higher levels of defenses as measured by the loosely defined defense mechanism category (3.03% for the structured and 7.73% for the unstructured group). This indicates that the participants in the unstructured group had greater difficulty in expressing their emotions, showed greater levels of denial and a significantly greater level of boredom. However, the total expression of boredom in the unstructured group can be related to one child, Sandy. It appeared that Sandy utilized this defense when she was unable to cope with her feelings and memories relating to child sexual abuse. She resisted any attempts at exploration, choosing rather to utilize the primitive defense of denial. Shapiro & Dominiak (1990) propose sexually abused children use denial as a defensive measure against painful affects and ideation related to sexual abuse. Denial becomes the mechanism by which survivors protect themselves from experiencing personal reactions, anxieties and memories arising from the denied trauma. One of the participants in this study, when asked to draw the perpetrator of her abuse, drew herself with "beautiful make-up and lovely earrings". When asked about her drawing she claimed "I do not know where he is...I made him disappear".

8.1.1.4 Positive Emotions Generally Reflective of Positive Therapeutic Experiences

Positive emotions generally reflective of therapeutic experiences formed a minor part of the verbalizations in both groups (2.83% for the structured group and 3.86% for the unstructured group respectively). Statements such as "When I told my parents what

had happened, they went to speak to the man straight away and this made me feel good inside," gives support to the importance of parental reaction to disclosure of abuse, as would be expected on the basis of the study by Silver & Wortman (1980; cited in Wyatt & Powell, 1988). The participants also expressed therapeutic benefits related to being able to share their experiences in a group (Knittle & Tuana, 1980). One of the participants, on completion of a group session stated that she had learnt that "if you have got bad things on your chest it is good to talk about them".

8.1.1.5 Statements Not Directly Related to Sexual Abuse

The verbal content of the groups not directly related to sexual abuse made up 13.74% of the content of the structured group and 10.94% of the content of the unstructured group. The transcripts reveal no obvious reason for the differences in these results.

8.1.1.6 Negative Emotions Relating to Initial Psychological Effects of Child Sexual Abuse

With regard to the expression of negative emotions relating to initial psychological effects of child sexual abuse, the unstructured group showed greater levels of verbalization of these emotions. In part explanation of this difference the methodological problems mentioned above need to be taken into account (see introduction to this chapter). An additional factor that may have contributed to a greater verbalization of negative emotions was the unstructured format. No theme was introduced in the group sessions, thereby allowing the participants greater freedom to discuss any of their problems.

The most commonly cited negative emotions relating to initial psychological effects of abuse in this research were anger, fear, sadness and peer problems. This would appear to substantiate existing research on the initial effects of child sexual abuse (Alter-Reid,

Gibbs, Lachenmeyer, Sigal & Massoth, 1986; Beitchman, Zucker, Hood, daCosta & Akman, 1991; Browne & Finkelhor, 1986 & 1990; Lusk & Waterman, 1986). All of these studies have found support for the existence of these initial psychological effects in varying degrees. These findings would also appear to refute the criticisms of Haugaard and Reppuccini (1988) who claimed that the introduction of themes would suggest to the participants feelings that they were in fact not experiencing.

8.1.2. The Four Most Frequently Expressed Negative Emotions

8.1.2.1 Anger

The expression of anger was significantly different for the structured and the unstructured groups. However, in both groups it was the most frequently expressed emotion. This finding is supported by previous research by Dwivedi, Brayne and Lovett (1992) who found that anger was the emotion shown most vividly and frequently in their work with sexually abused adolescent girls. Lubell and Soong (1982) and Sturkie (1983) also found that the expression of anger was present throughout all the sessions. For the structured group it would appear that the children were able to express their anger in the initial stages of the group treatment programme, whereas the expression of anger appears to have escalated in the unstructured group (see Figure 3b, p.72). This increase in the expression of anger was related to the participants speaking about the perpetrators of their abuse. Research suggesting that children may feel anger towards their mothers or towards society (Meiselman, 1978; Sturkie, 1983;) was not substantiated in this study. An informal study of the transcripts of the sessions revealed that most of the anger expressed was directed towards the perpetrators of sexual abuse, and the children appeared to have a great need to verbalize this anger.

The Draw-the-Perpetrator task developed by Goodwin (1982) further enabled the children to get in touch with their anger, despite the initial reluctance to engage in this exercise. Goodwin (ibid) found that children refused to draw about their sexual abuse as

frequently as they refused to talk about the event. She also found images of male phalluses were often incorporated into the drawings of sexually abused children. However, this is not substantiated by this research as all the children refused to draw the bodies of their perpetrators, claiming that they found it too "scary" and threatening. When asked to complete this task all the children were only able to draw the faces of their perpetrators. Even so, this exercise proved very therapeutic for the participants. One of the children, on completion of her drawing, stated:

Stupid, idiotic animal, idiot, pig brain. I hate you because you molest children..stupid, moron, ugly fool.

Another child, when talking about her drawing, stated that she wanted to be able to hit and punch the perpetrators in his brains because by doing that she may be able to "get him out of my brains".

The session of psychodrama in the unstructured group proved to be the most beneficial of all the sessions in both groups for the expression of anger. Blatner (1973; cited in Bannister, 1992) claims that:

psychodrama makes explicit the unconscious acting out that we use as a psychological defense mechanism to discharge internal impulses through symbolic or actual enactment (p.80).

It appears that the psychodrama technique provided an emotional catharsis for some of the children as well as a means to attain a sense of cognitive mastery over the abusive events.

8.1.2.2. Fear

Much of the fear expressed appeared to be related to fear of subsequent episodes of abuse as well as reprisals from the perpetrators. This is supported by research done by Blick and Porter (1982). The expression of fear became very evident in the structured group when the identity of one of the perpetrators, who was a teacher at the school, was revealed. The survivor concerned in this abusive incident immediately feared that the perpetrator would harm her again, and experienced a sense of powerlessness and fear. Other participants in the groups found it difficult to believe that they would be able to keep themselves safe if placed in an abusive situation again. This fear appeared to be closely linked to a sense of powerlessness.

8.1.2.3 Sadness

Whilst sadness was the third most common emotion expressed, from an analysis of the transcripts it appears that the children found it very difficult to express their feelings in relation to sadness. The therapists attempted to facilitate the expression of this emotion, which was evidently present at a non-verbal level, by utilizing art as a form of expression. One of the children, when asked to draw her feelings of sadness, drew a black circle, stating that she felt "like a black hole inside".

8.1.2.4 Peer Problems

Almost all the children expressed numerous problems relating to their peers and it was evident that some of the children were experiencing problems maintaining friendships. This is supported by research done by Mrazek & Kempe (1981). Many of the difficulties in relationships appeared to be related to low self-esteem. Most often the children denied "feeling different" as a result of the abuse. However, despite this denial, support was shown for the "damaged goods syndrome" (Finkelhor & Brown, 1985). The

unstructured group showed a significantly higher level of "feeling dirty" and soiled as a result of the abuse. These factors have obvious consequences for interpersonal relationships and the child's level of self-esteem.

8.1.2.5 Other Negative Emotions

All the other negative emotions expressed appeared to offer support for the existing research on initial psychological effects of child sexual abuse (Finkelhor, 1990). The participants expressed feelings of guilt, anxiety, isolation, powerlessness and low self esteem. They also spoke about the negative experiences related to not being believed when disclosing the events of their abuse.

8.1.3 Overall Trend in the Expression of All Negative Emotions Relating to Initial Psychological Effects of Child Sexual Abuse

The two groups appear to have expressed the same degree of negative emotions at the commencement of the group programme, but as the groups progressed the unstructured group clearly shows a greater verbalization of negative emotions relating to initial effects of child sexual abuse. (see Figure 3a, p.72). The pattern is variable for the structured group. These differences may once again be explained by the fact that the unstructured group displayed more behavioural and emotional disturbances and lower levels of self-esteem prior to the commencement of the programme. The session of psychodrama, sessions related to the discussion of trust, sexual abuse and perpetrators, allowed for the greatest overall verbalization of negative emotions in the unstructured group.

For the structured groups the sessions relating to themes of secrecy and sharing, powerlessness and assertiveness, and other life crises (Sturkie, 1983) allowed for the greatest overall expression of negative emotions. However, the transcripts of the group process reveals that many different themes were consistently raised and explored by the

participants in each session of the structured groups, thereby suggesting that the introduction of a specific theme at the start of a group may not be necessary.

8.2. The Relative Effectiveness of a Structured and Unstructured Group Treatment Programme for Sexually Abused Children

The results reveal that on completion of the groups there was a significant increase in self-esteem on Subscales 3 (Physical Appearance and Attributes) of the Piers-Harris Children's Self-Concept Scale. Subscale 4 (Anxiety) was approaching significance. This indicates a trend to increased self-esteem on completion of the groups. No significant difference was noted on any of the behavioural and emotional indicators measured on the Rutter Teacher's Questionnaire and the Projective Drawings. These results appear to offer tentative support for the use of group therapy treatment programmes for child sexual abuse survivors.

The results also reveal that there is no evidence to suggest that the degree of therapeutic change was greater for the structured or unstructured group. It can therefore be concluded that the type of group format was not a significant factor in the treatment outcome.

However, many factors need to be considered in relation to these results. The principal therapist was not able to attend a number of groups and the co-therapist was relatively inexperienced in working with sexually abused children. While it could not be avoided, it became apparent that this lack of continuity in relation to the attendance of the principal therapist may have had an adverse effect on the group process in both groups. The participants initially appeared reluctant to discuss certain issues when both therapists were once again conducting the groups. However, this reluctance was soon overcome and the participants themselves denied experiencing any problems in relation to the attendance or non-attendance of the principal therapist. An attempt was made to deal with this problem by having regular meetings and supervision for the co-therapist and the

children were encouraged to express their feelings in relation to this matter. In the face of these difficulties, the structured format provided valuable guidelines for the novice therapist.

The introduction of a specific theme at the commencement of each session in the structured group did not appear to meet with resistance from the children. This is in contrast to previous research done with adults. McDonogh (1993) found that adult survivors of sexual abuse were resistant to the presentation of themes at the commencement of each session and this resistance was more marked in the members who had been in psychotherapy prior to the implementation of the group programme. However, the experience of conducting a structured and unstructured group programme concurrently provided the therapists with an unique opportunity to experience the benefits of each type of programme. It became apparent, as stated above, that there was no need to introduce a specific theme at the beginning of each session as the children themselves chose to talk about problems they were concerned about. These opportunities could then be used to encourage the participants to talk about any underlying problems in relation to the sexual abuse events, which they found difficult to discuss. The group process also revealed that the introduction of a theme at the beginning of a session did not necessarily result in the expression of corresponding emotions relating to the theme. All the negative emotions relating to initial effects of child sexual abuse appear to be interrelated and therefore do not need to be dealt with in isolation. However, the negative emotions that the children expressed all appeared to support the existing research on initial effects of child sexual abuse and many of them were directly related to the themes which are utilized in a structured group format.

The use of different types of techniques such as drawing, story-telling and psychodrama proved very successful in eliciting feelings in both groups. Despite the unstructured nature of the group format proposed by Yalom (1985), he nevertheless recommends the use of these structured activities, if necessary, in brief specialized therapy groups. The participants in the unstructured group experienced greater difficulty in talking about their abuse and demonstrated greater resistance when the topic of sexual abuse was discussed.

The unstructured format appeared to allow for a greater use of these different techniques and this appears to have been advantageous to the group participants. Their use in structured and unstructured groups for sexually abused survivors is therefore recommended.

In relation to the efficacy of the groups, the short duration of the group treatment programme has to be considered. Taking into account the limited degree of change and the content of the group process transcripts, it is likely that the participants could have benefited from extended group work, which is advocated by Sturkie (1983). This was not possible in this study, but on completion of the groups two of the children were referred for individual follow-up. Whilst it cannot be proved that the participants would have experienced further growth with added sessions, an analysis of the group process revealed enthusiasm for such sessions, which clearly suggests that the group experience was positive and supportive. At the time of this research, none of the participants or other family members were involved in any other type of therapy. However, Courtois (1988) advocates that if necessary, groups be used in conjunction with other modalities such as family or individual therapy.

This lack of involvement with the families may also have been a factor which contributed to the limited effectiveness of the group programme. Wolfe and Gentile (1992) claim that the emotional support that each child receives from their family is one of the most fundamental variables affecting the sequelae of sexual abuse. Of note is that during the group treatment programme only two of the parents contacted the therapists to enquire about their children's progress. While no firm conclusions can be drawn from this factor, the use of assessment instruments which can be used to assess the quality of parent-child relationships are recommended (Wolfe & Gentile, 1992). It is contended that these measures assist in "organizing the therapeutic process, with regard to decisions about group, individual, and/or family modes of treatment" (ibid p.180).

The post-test measurements utilized in analysis of this study were completed one week after the last group sessions. It was not possible to re-test the participants again at a later

stage and it is therefore recognized that no information is available on the lasting therapeutic benefits of the treatment programmes. This underscores the need for longitudinal research which is supported by Finkelhor (1990) and Briere (1992).

8.3 Critique of the Research Methodology

This study has various methodological problems, some of which were considered previously (see Chapter 8, p.83). However, other factors need to be taken into account when considering the results of this research.

The sample of sexual abuse survivors that took part in this study are not representative of the population at large. Apart from the two children from the children's home, the remaining subjects were all drawn from one school which services a low socio-economic area. This therefore limits the ability to generalize the findings of this research. Beutler and Hill (1992) claim that sample representativeness is especially important in the field of survivors of childhood sexual abuse as little is known about the incidence of specific symptoms and syndromes in this population.

No attempt was made to discriminate abuse-specific from abuse-concurrent or abuse-antecedent events (Briere, 1992). From the histories obtained from the participants it is possible that some of them may have been experiencing abuse "effects" which might be due to pre-existing risk factors or psychological disturbance. This is substantiated by the fact that one of the participants in this study was hearing voices and was referred for a psychiatric consultation on completion of the groups (see Appendix A). In addition the role of coexisting familial dysfunction, other forms of maltreatment, and the impact of social or demographic factors as they moderate or exacerbate what are thought to be simple abuse effects, have not been considered (Briere, 1992).

Additional problems encountered include the low number of subjects included in the study and the lack of a control or comparison group. Briere (1992) proposes that variables which are relevant to child abuse comparison groups are: Demographic characteristics such as age, race, sex, education, and socio-economic status, clinical status, various measures of family functioning, and history of childhood traumas and stressors other than sexual abuse. Because no control group was utilized in this study, the results cannot be generalized to the total population of child abuse survivors.

As mentioned previously, the principal therapists inability to attend every session and the inexperience of the co-therapist both constitute serious confounding factors. Replication studies using various different samples and therapists would have to be undertaken to substantiate the results of this study.

The measuring instruments used in this research also present various methodological problems. Briere (1992) claims that instruments not developed specifically for abuse or trauma survivors may not be sensitive to abuse-specific symptoms. He also proposes that the use of the same instruments pre- and post-test may result in a repeated measurement effect. This may then affect the reliability of the outcome results.

In conclusion, it is recognized that much of this study has been guided by clinical and ethical considerations and not primarily to gain a methodologically pure study. However, this represents the reality of clinical research in terms of dealing with tensions and dilemmas created by the different principles of methodology and clinical ethics.

8.4 Summary of the Discussion

The first aim of this study was to investigate, by empirical means, the verbalization of negative emotions relating to initial psychological effects of child sexual abuse in a structured and an unstructured treatment group. Transcripts of all the sessions were content analyzed and a need for the following categories became evident: Negative

emotions relating to initial psychological effects of child sexual abuse; positive emotions generally reflective of therapeutic experiences; defense mechanism; narrating the facts of child sexual abuse experiences; statements not directly related to child sexual abuse; and therapist input. In the structured group 17.27% of the content was related to the expression of negative emotions relating to initial effects of child sexual abuse and in the unstructured group this amount was 20.72%. These findings appear to offer support for the fact that children who have been sexually abused do verbalize negative emotions relating to initial psychological effects of child sexual abuse.

The four most frequently expressed negative emotions were anger, fear, sadness and peer problems. The greatest anger expressed appeared to be directed against the perpetrators of the abuse and the participants had a great need to express this anger. These findings may appear to offer limited support for the use of themes in a treatment programme for sexually abused children (Sturkie, 1983). However, from the results of the content analysis and an examination of the transcripts of the group process, it is apparent that all the themes which centre around negative emotions relating to initial psychological effects of child sexual abuse are interrelated and are often dealt with continuously throughout the ongoing group process. There is therefore no evidence of a need to deal with any of these themes in isolation. The need to utilize a structured group format therefore requires further research, although there does appear to be support for the type of themes which are introduced in these groups.

The use of an unstructured group format appears to have allowed for a greater diversity of topics to be discussed and allowed the group process to unfold naturally. The use of this format was also a significant factor in the verbalization of negative emotions relating to initial psychological effects of child sexual abuse. However, these findings are inconclusive because the structured and unstructured groups were significantly different at pre-test, and this may account for the differences noted.

The second aim of this study was to evaluate the effectiveness of a structured group treatment programme (Sturkie, 1983) and that of an unstructured group treatment

programme, in an attempt to ascertain whether the unstructured programme allows for a greater improvement in the children in relation to the variables measured. The variables investigated were levels of self-concept and behavioural and emotional indicators of disturbance.

The results suggest that the participants displayed an increase in self-esteem on completion of the groups. This offers tentative support for the use of group therapy for child abuse survivors. However, it appears that the children may have been adversely affected by the problems relating to the attendance or nonattendance of the principal therapist and this may have affected the results obtained. In addition, the various other methodological problems relating to this study need to be taken into account when considering these results. An examination of the transcripts reveal that the participants would have benefited from an extended group programme. The use of a structured and unstructured group format was not a significant factor in the treatment outcome of these children.

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APPENDIX A**Brief History of each Child Included in the Groups****Structured Group****Karin**

Karin had requested help following the child abuse prevention programme at the school. She claimed that she had been receiving abusive phone-calls. However when her mother was interviewed it was revealed that Karin had been involved in an incident of abuse (inappropriate touching) by her schoolteacher. At this time her mother had reported the incident to the school principal, but no further action had been taken. Karin comes from an "intact" supportive family and it is reported that her school record is satisfactory. She is in Std. 3 and is 11 years 5 months old.

Jane

Jane had received previous psychological help in 1990 following sexual abuse (inappropriate touching) by her grandfather. At this time she was referred for psychological help because of attention seeking behaviour, and self-stimulating behaviour (masturbation). Jane comes from a supportive "intact" family and is progressing well as school. She is in Std. 1 and is 9 years 1 month old.

Tara

Tara had received previous counselling as a result of a history of sexual abuse by her father. Tara lives with her grandmother and both parents. Her father is apparently of borderline intelligence and her mother is mentally retarded. Both are unemployed. Her school performance is adequate and she is in Std. 1 and is 9 years 5 months old.

Sharon

Sharon was included in the program after having disclosed that she had had some frightening experiences (inappropriate touching) by a stranger. When interviewed her mother denied any knowledge of this incident or any other, but reluctantly allowed for her daughter to be involved in the programme. During the course of the group Sharon disclosed incidents of inappropriate touching and appeared very frightened by these incidents. Towards the end of the groups she became reluctant to attend the sessions. Sharon comes from an "intact" family, but they appear to be unsupportive. Her school performance is reported to be satisfactory. She is in Std 1 and is 9 years 5 months old.

Unstructured Group**Cindy**

When Cindy was in Class One she was sexually abused (alleged oral sex and masturbation) by a neighbour. At this time she was examined by a District Surgeon, but no legal proceedings were initiated. Cindy received no further counselling or help of any type after this incident. When the abuse took place Cindy's parents were divorced although they were still living together. Her mother, who is herself a survivor of child abuse, has subsequently remarried and Cindy now has limited contact with her father which is very distressing for her. At school Cindy has been found to be stealing and her school performance is below standard. During the course of the group she ran away from home with three friends and was found by the Child Protection Unit. She claimed that she had been sexually abused but this was found to be untrue. Cindy is in Std. 4 and is 12 years 2 months old.

Laura

Laura has a history of sexual abuse and the family has previously had contact with social work agencies. Her mother claims that her father is the perpetrator, but this has never been substantiated. The type of abuse is unknown. Laura is an epileptic and is being treated with medication. She is not performing well at school and is awaiting placement in a special school because of learning difficulties. During the course of the group Laura complained of hearing voices and was referred for a psychiatric consultation. She is in Std. 1 and is 8 years 6 months old.

Leonie

Leonie has a long history of sexual abuse which has previously been investigated by the Child Protection Unit. At the time of disclosure both Leonie and her mother received psychological assistance. The perpetrator was a family friend. Leonies' parents are divorced and her mother is remarried. Her school work is reported to be adequate and she is in Std 4. Her age is 12 years 6 months.

Jody

Jody was included in the programme at the request of her parents who claimed that she had not been sexually abused, but felt that she would benefit from the programme. During the programme Jody disclosed two incidents of abuse. Both of her parents had been aware of these incidents. Her school performance is reported to be satisfactory and she is in Std. 4. She is 12 years 6 months old.

Sandy

Sandy was referred to the programme from the local Children's Home. She had been involved in an incident with several young boys from the home where she had been

touched inappropriately and it was felt that she needed to learn how to protect herself. Sandy was initially happy to be involved in the program, but soon became very defensive and disruptive in the groups. Towards the end she refused to attend certain sessions. Sandy has had very limited contact with her parents and has been in the home for 6 years. She is in a special school and is on medication for behavioral problems. She is in Std. 3 and is 10 years 9 months old.

Cathy

Cathy was referred to the programme by the local Children's Home because of inappropriate sexual behaviour. During the course of the program she disclosed that she had been sexually abused (inappropriate touching) by a family friend prior to admission to the home. Cathy has very limited contact with her mother and her father is dead. She is in Std. 2 and is 10 years 9 months old.

Lindy

Lindy was included in the programme at the request of the Children's Home. Because of poor family circumstances Lindy had been placed in the home for a few months, but at the commencement of the group therapy programme she was once again living at home. Prior to her placement in the home an incident of sexual abuse had been reported by Lindy, but she subsequently denied having been abused. However because of illness she only attended one session and was then excluded from the programme. She is 8 years 9 months old.

APPENDIX B**Group Process Notes for the Sturkie Model of Structured Group Intervention for Sexually Abused Children****Session One****Present:** 2 Therapists

4 Children

Theme: Introduction to the Groups, Rule Setting and Believability

All participants were welcomed to the group and a discussion then followed on the necessity for rules during the groups. The children, together with help from the therapists decided on rules which they thought would be applicable for the groups. Each child was given a chance to write a rule on a small blackboard which had been obtained for this purpose.

The following rules were included:

- (i) Only one person was allowed to speak at a time
- (ii) Confidentiality was essential and nobody was allowed to speak about what had happened outside of the group situation. However, if asked, the children could tell their parents about themselves and what they had shared, but they were not allowed to talk about anyone else in the group
- (iii) Honesty was necessary
- (iv) Each person must try and attend all the groups
- (v) Each participant has to listen and not interrupt others, or change the subject

The theme of believability was then introduced and each child was invited to explore their feelings with regard to how it feels to be believed or not believed in any situation. Reasons for parents and other people's refusal to believe their stories were also explored.

All children chose to share some of their experiences in which they had not been believed.

They all chose situations relating to home or school and not situations relating to sexual abuse.

To conclude the group each child was asked to draw a picture of themselves and how they felt when someone believes them and how they felt when someone does not believe them.

Session 2

Present: 2 Therapists

5 Children

Theme: Guilt and Responsibility

Because of the additional group members the rules governing the group's functioning were once more discussed.

The children were then asked to divide into pairs and to tell each other something that they had felt guilty about. Following this they were encouraged to share their experiences with the group. Three of the children chose to tell the group members about an incident relating to guilt feelings. All of these situations related to incidents which happened at home or at school. The issue of responsibility was then introduced and the children were encouraged by the therapists to see that at times they could not be held responsible for events that happen to them. In addition, they could not be held responsible for their behaviour when it included undue influence and pressure from adults. The children were encouraged to express their feelings about whom they felt was to "blame" in these situations.

Session 3**Present:** 2 Therapists

4 Children.

Theme: Body Integrity and Protection

The reason for the children attending the group was introduced and the primary focus was that of sexual abuse. One of the children chose to share what had happened when she had been abused. The need for confidentiality was then stressed as the perpetrator in this instance was a school teacher at the school and he was well known to all the children.

The children were then asked to draw their bodies and label them. The aim of this session was to assist the children in re-establishing their body integrity and to allow the children to experience a sense of physical safety by helping them to identify specific inappropriate kinds of physical contact. A lively discussion then followed when the children were asked to label and share their names for the various parts of the female and male anatomy. Emphasis was placed on the notion of keeping one's body safe and that "one's body is one's own and that no one, not even an adult has the right to touch particular areas of it without permission" (Sturkie, 1983).

Session 4**Present:** 2 Therapists

4 Children

Theme: Secrecy and Sharing

The issue of secrecy and sharing was particularly relevant in this group because there had been a breach of confidentiality. One of the children had told her friends about the incident of abuse which had been revealed the previous week. An additional problem

arose because the perpetrator was a teacher in the school that all the children attended. The group time was therefore used to support the child who had initially disclosed her abuse. An attempt was made to try and understand why one of the members had found it necessary to break the confidentiality of the group situation. Feelings of anger and sadness, but also those of anxiety and fear regarding the disclosure were dealt with. All members were asked to reconfirm their commitment to the group and the necessity for confidentiality was stressed.

Session 5

Present: 1 Therapist

2 Children:- Due to school sport commitments two of the children could not attend the group.

Theme: Anger

The aim of this session was to deal with anger that the children felt towards the perpetrators and anyone else connected with the abusive events in their lives. However because of the decreased numbers (only 2 children) and the previous weeks breach of confidentiality it was decided to deal with each child's personal issues first and then in conclusion to deal with the issue of anger. Support and reassurance was given to Karin who was still concerned about the breach of confidentiality in relation to the teacher who had abused her. Tara expressed a need to know more about the body and "where babies come from". A mini sex education lesson was given and this was then linked to keeping ourselves safe. Issues relating to assertiveness were dealt with and the children were helped to see how they could express their anger constructively.

Session 6**Present:** 1 therapist

3 children:- One child was not able to attend because of prior family arrangements.

Theme: Powerlessness/Assertiveness

Two children shared their experiences of having been sexually abused and their resultant feelings of powerlessness. The children were encouraged to find ways in which they could assert themselves when faced with an incident of sexual abuse. Practical scenarios were discussed and the children were encouraged to identify ways of keeping themselves safe. The major goal of this session was to empower the children should they again be exposed to abusive situations.

Session 7**Present:** 2 Therapists

4 Children

Theme: Other Life Crises

The group discussed at length the influence of peers as one of the children did not want to come to the group because of peer pressure. They then all discussed various problems they had encountered in relation to their friends. Issues of "feeling different" and the "stigma" following sexual abuse were explored. The children were encouraged to develop authentic relationships with each other and an emphasis was placed on mutual acknowledgement of thoughts and feelings. One of the children then spoke of her abuse and the issue of keeping oneself safe was again dealt with.

Session 8**Present:** 2 Therapists

4 Children

Theme: Court Appearance

The group commenced with a discussion of peer problems as one of the children was still subject to peer pressure in relation to her coming to the group.

The focus of the session then moved to what would happen if a child was required to appear in court following an incident of sexual abuse. Despite the fact that none of these children were likely to appear in court, it nevertheless remains an area of concern for sexually abused children. Psycho-drama was used to enact the court experience. The children and the therapists role-played the entire court proceedings. Through the use of role-play the children were encouraged to experience and gain a sense of symbolic control over the experience.

The group concluded with a discussion about termination and also a discussion about arrangements for the party the following week.

Session 9**Present:** 1 Therapist

4 Children.

Party

Refreshments were provided by the therapists. The emphasis of the group was to have fun and to socialize with the children.

One of the children had brought tiny gifts for the therapists and the other children. All of the participants expressed their disappointment that the group was ending and asked whether they could come back the following year.

APPENDIX C**Group Process Notes for the Unstructured Model of Group Intervention for Sexually Abused Survivors****Session One****Present:** 2 Therapists

3 Children

As in the structured group, rules were set at the beginning of the group. The same set of rules was decided on with the addition of the rule that the children were not allowed to play games during the group time. The group process was explained and the children were encouraged to bring any themes or concerns of their own to the group as no structure or predetermined theme would be imposed on the groups. General concerns about being part of a group were discussed and then issues relating to trust, sharing and believability were discussed.

In conclusion the children were asked to select and draw an animal they would like to be and to explain the reasons for their choice. In keeping with the findings of Gagliano (1987) it was possible to attempt to interpret covert needs to be loved and valued or needs to control the environment in terms of safety and protection from the drawings. The children's drawings also appeared to express a need to be free of restrictions and control.

Session 2**Present:** 2 Therapists

5 Children

Because of the change in group members the rules were once more explained in detail. One of the children felt she could not promise not to tell her friends about the group and she was asked to leave the group and return when she had reconsidered her decision.

The conversation then centred around the development of trust and the children's need for secrecy. They then chose to speak about problems they were having in various peer relationships at school. The development of age appropriate peer-interaction skills was encouraged and attempts were made to support the development of self-worth.

Session 3

Present: 1 Therapist

6 Children

Due to the problems associated with confidentiality in the previous group, this session commenced with a lengthy discussion about the necessity for confidentiality. The children expressed the need for safety and secrecy if they were to share any important issues. They then discussed situations that had taken place in which they had felt powerless and scared. Peer problems were once again discussed. However throughout the session the group members were very restless and irritable with each other and appeared to be experiencing difficulty in sharing and trusting each other. The session ended with a "draw-a-feeling" exercise which is useful in promoting emotional expression without emphasis on intellectualization (Hazzard et al., 1986). Each child was asked to draw a picture to demonstrate their current emotions. These were then shared with the group.

Session 4

Present: 2 Therapists

4 Children:- 2 of the children were ill with German Measles.

The group commenced with one of the children expressing her concern and anxiety with regard to her home situation and in particular with regard to her father. She then went on to talk at length about "voices inside her head" which tell her to do good and bad things. The other children's feelings in relation to these issues were elicited.

Story telling was then introduced into the group. The subject of sexual abuse was raised by means of each person telling part of a story. The children became very restless and distracted at this point, but with encouragement were able to begin to discuss sexual abuse. The therapists attempted to assist the children in understanding that the sexual abuse was not their fault and that they could not be held responsible for anything that had happened. Because of the general level of anxiety in the group the children were then asked to draw a picture of their choice and to share it with the group.

Session 5

Present: 2 Therapists

6 Children

At the start of the group one of the children expressed her desire to leave the group, saying that it was boring. Her feelings were dealt with and a discussion followed on the difficulties of speaking about sexual abuse. To facilitate the expression of these feelings an imaginary girl called Julie-Sophie was created and each child was invited to say how she thought Julie-Sophie might be feeling if she had been sexually abused. They were then asked to draw a picture of Julie-Sophie and to share with the group how Julie-Sophie was feeling after she had been sexually abused. This created much discussion and the children then decided to draw themselves and shared how they had felt after having been sexually abused.

Session 6

Present: 1 Therapist

6 Children

Two children shared their experiences of being sexually abused and this led to a conversation concerning perpetrators. The children spoke about the type of person who sexually abuses little girls. They were able to see how very often they had been tricked and bribed into a compromising situation. This brought with it the realization that the

sexual abuse was not their fault. This then helped the children to verbalize their feelings in relation to their sexual abuse. In contrast to some of the previous groups, there appeared to be a high degree of trust and support among the group members.

Session 7

Present: 1 Therapist

5 Children:- One child had a dentist appointment.

Initially one of the children refused to join the group and the other members expressed their anger towards this child. Angry feelings were then also expressed towards the perpetrators. Details of a sexual abuse incident were shared by one of the children. The children were then asked to draw a picture of the perpetrator and to write down their feelings towards this person. This caused a certain amount of anxiety in the group and all the children were only able to draw the face of the perpetrator as drawing the body felt too threatening. They then chose to share with the group their feelings in relation to the person who had abused them and this led to one other child sharing about her abuse. This exercise enabled the children to get in touch with a lot of negative feelings towards the perpetrators.

Session 8

Present: 2 Therapists

6 Children

At the beginning of the session the children were very distracted and resistant. It was thought initially that this may be due to the fact that the second therapist had returned to the group after a 2 week absence. However, the children denied this. They then shared with the therapist some of their experiences of the last two groups and the difficulties involved in talking about sexual abuse. One of the girls shared how she had felt when she saw the perpetrator again and this elicited feelings of sadness in the children which they could not easily express. They were then asked to draw a picture which could

adequately express their feeling of sadness. Two of the children expressed the feeling of being in a big black hole.

It became evident to both therapists that these children would benefit from further sessions, so the necessity for further groups was discussed with the children. They all readily agreed that they would like to return for 2 to 3 more groups and it was decided to investigate this option.

Session 9

Present: 2 Therapists

6 Children

Despite the children expressing a desire for extra groups they were very reluctant to deal with any issues. The psycho-drama concept was therefore used to enact a court case. This proved to be very successful in enabling the children to get in touch with their anger towards the perpetrators. None of the children in this group have appeared in court and it is not expected that any of them will have to in the foreseeable future.

Because of upcoming exams it proved difficult to extend the groups further and it was therefore decided to terminate the group after the party the following week.

Session 10

Present: 1 Therapist

6 Children

Once again the therapist provided the refreshments and the emphasis was on fun and socialization. The children all made themselves party hats and sang a party song. Some of the children expressed relief that the groups were ending, whereas others wanted to continue the programme.

APPENDIX D**Projective Drawing Instructions****Instruction for the Human Figure Drawing Test**

"On this paper I would like you to draw a whole person. It can be any kind of person you want to draw, just make sure it is a whole person, and not only a stick figure or a cartoon figure."

Instructions for the Kinetic Family Drawing Test

"Draw a picture of everyone in your family, including you, doing something. Try to draw whole people, not cartoons or stick figures. Remember, make everyone doing something, some kind of action."

APPENDIX E

Descriptive Statistics

ID	AGE	GROUP	PREAS	PREH	POSTAS	POST	PPH1	PPH2	PPH3
1	9.1	1	0	2	0	3	16	16	10
2	9.5	1	1	0	1	0	14	11	4
3	9.5	1	1	0	1	3	15	12	6
4	11.5	1	1	3	2	3	15	14	12
5	12.2	2	10	3	7	3	6	6	5
6	8.67	2	4	6	4	6	11	7	6
7	12.25	2	0	1	0	1	15	2	4
8	8.9	2	4	6	6	2	5	9	6
10	12.67	2	0	4	0	2	15	11	6
9	10.9	2	2	3	2	4	11	12	5
MEAN	10.519	1.6	2.3	2.8	2.3	2.7	12.3	10	6.4
STD	1.47264	0.489898	2.93428	2.039608	2.410394	1.552417	3.769615	3.898718	2.457641
MIN	8.67	1	0	0	0	0	5	2	4
MAX	12.67	2	10	6	7	6	16	16	12

PPH4	PPH5	PPH6	POPH1	POPH2	POPH3	POPH4	POPH5	POPH6	HFDP
10	7	10	16	17	12	10	9	10	1
10	9	10	15	13	7	10	5	9	0
7	5	9	16	11	6	10	4	9	1
3	9	9	16	16	13	7	10	10	0
7	8	5	9	15	12	6	10	9	3
4	1	5	7	7	5	4	3	7	4
6	3	9	11	2	2	3	3	6	4
8	3	6	5	14	12	10	7	9	6
6	8	9	16	7	6	8	4	8	2
6	7	3	11	9	7	9	9	6	4
6.7	6	7.5	12.2	11.1	8.2	7.7	6.4	8.3	2.5
2.147091	2.683282	2.376973	3.969887	4.548626	3.572114	2.325941	2.764055	1.417745	1.910497
3	1	3	5	2	2	3	3	6	0
10	9	10	16	17	13	10	10	10	6

HFDP	KFDP	KFDP
0	1	4
3	4	2
3	3	3
1	0	2
5	5	7
2	5	6
4	6	4
3	7	6
3	4	2
1	5	0
2.5	4	4
1.431782	2.04939	1.825742
0	0	2
5	7	7

