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# Client Survey of a Group Treatment Model for Adult Women Incest Survivors

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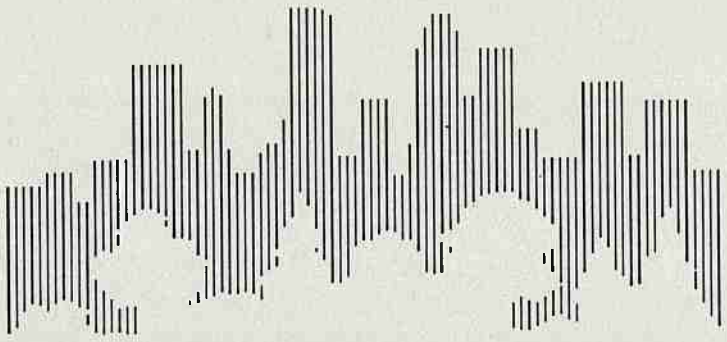

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# MASTERS IN SOCIAL WORK THESIS

Kristen A. Atmore

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MASTER OF SOCIAL WORK
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## *CERTIFICATE OF APPROVAL*

*This is to certify that the Master's thesis of:*

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*has been approved by the Examining Committee for the thesis requirements for the Master of Social Work Degree.*

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## Abstract

The problem of incest has been brought more and more out into the public eye in recent. As this recognition has increased, the growth in knowledge about how to treat incest has been enormous. Many clinicians and researchers agree the long term effects of incest can be very numerous and complex resulting in such symptoms as: chemical abuse, anorexia, self-mutilation, suicide attempts, depression, marital and parenting difficulties. Many therapists also believe that long-term therapy is necessary in the recovery process. However, there is little outcome evaluation for long-term, sexual abuse survivors groups in the literature.

This is an exploratory client survey to analyze the effectiveness of an adult women's incest survivors treatment group that uses a long-term, open-ended process oriented model, created by Noel Larson, Ph.D., LCP, called "Victim Treatment", which holds personality change as its treatment goal. The survey will offer information as to whether or not group goals are being attained and suggestions for modifications. In addition, this survey will act as an exploratory measure towards developing an evaluative tool for the Victim Treatment model by Noel Larson Ph.D., LCP.

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## Introduction

Since the 1970's the existence of incest has been recognized in the popular literature, academic journals and by practitioners, as not only a reality, but an overwhelming problem (Goodman & Nowak-Scibelli, 1985; Larson & Maddock, 1995; McPeek & Deighton, 1985; Sprei, 1987). Finkelhor (1984) indicated that as many as 15 percent of all women had been incestuously abused. In 1979, Diane Russel interviewed over 900 randomly chosen women from San Francisco and found that 38% had been sexually abused before the age of 18 (Engel, 1990). In 1985 a national survey of 2,626 adults showed 27% of the women and 16% of the men in the study had been survivors of childhood sexual abuse. Based on the research of Finkelhor 1984), Russel (1979), and Miller (1986), Courtois (1993) deduced that girls have a higher likelihood of being abused within the family, and boys are more susceptible to abuse outside the home. Bergart (1986) writes that it is likely that even these large statistics fall short of accuracy, given the high percentage of sexual abuse reported in the client population by social workers. She cites one example where a psychiatrist polled his female clients and discovered that fully one-third of them had been victims of incest.

Courtois (1993) defined sexual abuse as, "sexual touch of another through the use of force, whether it be: physical, the threat of physical harm, trickery or, blackmail. Incest is a particular form of sexual abuse which happens in a family context" (p.16). Abell & Sommers (1991) identify the abuser as: a mother, father, step-mother, step-father, uncle, aunt, sister, brother, grandparent, any other family member or, "familiar" considered by the family as a part of its system.

Over the years it has been discovered through work with incest survivors, that the effects of incest are highly complex. Courtois (1993) defined the typical life concerns of an incest survivors as,

> difficulty trusting others; with feelings or the expression of feelings, especially anger; with intimate and parenting relationships; with shame and low self-esteem; with depression and panic reactions; with feelings of numbness and emptiness inside; with psychosomatic illnesses, including headaches and gastrointestinal problems; with self-damaging behavior and thoughts; with chemical dependency and other addictive and compulsive behaviors, including eating disorders; with time loss, memory gaps, and sense of unreality; with flashbacks, intrusive thoughts, and images; with sleep disturbance. Tendencies toward co-dependence and workaholism are also evident in this population. (p.19)

Given the number of symptoms related to incest, many researchers and therapists advocate long-term therapy for incest survivors (Blake-White & Kline, 1985; Bonney, Randall & Cleveland, 1986; Coker, 1990; Follette, Niemeyer & Alexander, 1991; Ganzerian & Buchele, 1986 & 1987; Larson & Maddock, 1995).

Since the 1970's and primarily in the 1980's therapeutic groups have been discovered as a highly effective intervention when working with adult female incest survivors (Steinberg & Buttenheim, 1993). Repeatedly, the literature indicates that simply being in the same room with other women who have been through the same experience begins a healing process that individual therapy cannot achieve (Blake-White & Kline, 1985; Goodman & Nowak-Scibelli, 1985; Hays, 1987; Gold-Steinberg & Buttenheim, 1993). As one woman put it, both individual and family

therapy were productive, but not enough to normalize her feelings, or to help her to feel less like a "freak" (Bergart, 1985, p.267). Group therapy with incest survivors is almost always beneficial because it breaks the isolation, secrecy, and shame that is endemic to the experience. Where most clinicians do deviate from one another, however, comes with their opinions on group structure, including differences in short versus long-term time spans, open-ended versus closed-ended attendance commitments. In addition, clinicians use many different theoretical perspectives as a foundation for their group models such as, the Developmental model, Post Traumatic Stress Disorder, the Feminist Perspective, and Family Systems Theory. Often, clinicians integrate two or three approaches, and sometimes they do not adhere to any specific theoretical base. Zimpfer (1987) points this out in his review of group treatments: "many writers and clinicians approach incest as a distinctive group because of the specific difficulties incest survivors share (i.e., anxiety, difficulty achieving intimacy, low self-esteem etc.) and base their treatments on overcoming these problems." Thus, a clinician's treatment model does not necessarily reflect a "holistic, developmental, or societal view of the client" (p. 168).

In this thesis I will review literature on the various structures and theoretical approaches used in group treatment for adult female incest survivors that have been outlined above. In addition, I will be introducing a new practice model based on Family Systems Theory that could be viewed as a new stage in the way people view incest survivors. The model is simply titled "Victim Treatment" and the perspective is "Victim Typology". The author is Noel Larson Ph.D., LCP, a clinician and researcher in a metropolitan area. The research of my thesis will be an exploratory

evaluation of this model. The evaluative tool is a questionnaire or survey, which I designed. The subjects are members of an incest survivors group, also in a metropolitan area. The methodology of the evaluation will include a description and explanation of the questionnaire and the evaluative process. Limitations of the study will be discussed, and findings, interpretations and recommendations will be presented.

The research presented in this thesis comes out of a small targeted study which is not meant for the purpose of generalization. Rather it is intended to aid in the development of the group and as an exploratory step towards developing a tool to measure the effectiveness of this long term model. Study recommendations will present future changes one might make in designing another client survey of the Victim Treatment model. Suggestions for changes to the group will also be introduced, by focusing on creating a better fit between the application of the model and the reported client needs.

## Chapter I: Literature Review

This literature review was conducted using two computer abstracts, Academic Index 1991-94, and Psyche/Lit 1974-1994. The keywords used were: "women", "group-psychotherapy" and "sexual abuse", 74 articles were located, 39 were relevant. Interviews were also conducted with Noel Larson, the author of the Victim Treatment model, and Anne Cavin and Becky Tovar, clinical practitioners who utilize Larson's model. These interviews resulted in referrals to ten books and three papers on the topic of sexual abuse.

To begin I will present four theoretical orientations practitioners used in their treatment modalities: Developmental, Post Traumatic Stress Disorder (PTSD), the Feminist Perspective and Family Systems Theory.

### Theory

Developmental theory provides the basis for many group treatment models. One very common Developmental model used by practitioners was introduced by Erik Erikson in the 1950's (Nichols & Schwartz, 1991). Erickson created a map of personality development from infancy through old age and death (Greene & Ephross, 1984). In the map, Erikson, delineates the psycho-social goals humans struggle to achieve throughout the various stages of their lives. If the particular challenge of the first stage is met, the child will have a good chance at meeting the goal in the second stage, and so on. . . However, if the goal is not met, the child's

development will become delayed. This will interfere with their attempts to meet goals in the following stages.

Stages are separated by age. The first stage extends from infancy to 2 years. The psycho-social issue during this time is trust. If the child's needs are met with some consistency she will draw the hopeful expectation that the world will continue to meet her needs. If the goal was not met, she will have learned not to trust and may detach from social relationships in her future. The second stage is during ages 2 to 4. The psycho-social struggle at this time is between autonomy and shame. Autonomy is defined as, "a sense of self-control without a loss of self-esteem," (Greene & Ephross, 1984, p.89). Shame, on the other hand, is "the feeling of being exposed or estranged from parental figures", which involves feeling like a failure and lacking in self-confidence (p.90). The third stage lasts from ages 4 through 6 years, and the struggle is between initiative and guilt". According to Erikson, a child works through this issue by being "willing to go after things" and "to take on roles" through play (p.93). Play exercises a child's freedom of thought and expression. This, in turn brings a sense of purpose into her life. If play is restrained by the child's caretakers, however, the child will become inhibited.

The psycho-social crisis of industry versus inferiority is introduced in the 4th stage of a child's life, ages; 6-12 years. It involves the capacity to master tasks at school both individually, and as part of a team. Industry refers to task mastery and, again to inhibition (Greene & Ephross, 1984). Identity versus identity confusion is the psycho-social struggle of the 5th stage; 12-22 years (Kilgore, 1988). At this time, the peer group is the primary focus of interaction. A feeling of confidence is achieved in being able to integrate and share those aspects of self one has developed

through childhood in a way that is accepted by others. Greene and Ephross (1984) note that a critical feeling to carry away from this stage is a "feeling of sameness" (p.94) and an understanding of one's unique contributions to others. Identity confusion, then, is a sense of not belonging and a lack of knowledge about one's value to others. The last stage used here is Erikson's sixth stage; intimacy versus isolation. This stage involves the ability to form intimate relationships, occurring between the ages of 22 to 34 years (Axelroth, 1991; Bergart, 1986). The relationships include partnerships in friendship and love and that capacity includes, "being able to lose and find oneself in another" (Greene & Ephross, 1984, p.95).

When used to understand incest, a Developmental perspective focuses on how incest disrupts the natural growth processes of human development. Incest creates such phenomenon in the child victim including, mistrust, guilt, shame, self-doubt, inferiority, isolation, despair, and role confusion (Zimpfer, 1987). Indeed, it interferes with each of Erikson's developmental stages (Follette, Follette & Alexander, 1991). As the child grows, these feelings act as blocks to mastering such tasks as identity formation, finding a sense of self-esteem, and learning how to achieve intimacy. Bass and Davis (1988) indicate that most female incest survivors who have repressed their memories begin recalling their abuse between the ages of 28-35 years. In addition, Bergart (1986) states incest survivors will often seek out therapy as a result of having difficulty in their relationships, which coincides with the life stage crisis Erikson identifies for that age-span. However, group therapy for incest survivors that uses a developmental perspective will involve re-working all previous life stage tasks (Axelroth, 1991; Barney, 1990; Blake-White & Kline, 1985; Hays, 1987; Kilgore, 1988; Mudry 1986). Larson and Maddock (1986)

suggest the presence of incest usually points to a family which was unable to support a child's developmental needs before the violation occurred.

The second perspective, Post Traumatic Stress Disorder (PTSD), is a very popular theoretical orientation for both individual and group treatment of incest survivors. It is backed by the American Psychological Association and used often in assessment by practitioners. A definition of PTSD is found in the Diagnostic and Statistical Manual of Mental Disorders, Edition IV (1994):

Diagnostic criteria for Post Traumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed , or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive, distressing thoughts, or perceptions.

(2) recurrent distressing dreams of the event.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated.)

(4) intense psychological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma.

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma.

(3) inability to recall an important aspect of the trauma.

(4) markedly diminished interest or participation in significant activities.

(5) feeling of detachment or estrangement from others.

(6) restricted range of affect (e.g., does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep.

(2) irritability or outbursts of anger.

(3) difficulty concentrating.

(4) hypervigilance.

(5) exaggerated startle response. (pp. 427-8)

PTSD was first named in the 1960's for Vietnam Veterans and Holocaust survivors who sought treatment for "flashbacks" of their trauma. Parallels were drawn for incest victims who showed the same symptoms. Blake-White and Kline (1985) wrote the following about the similar experiences:

> The soldier became a killer while the incest survivor became the complier, in order to survive. Both denied their reality and often identified with their aggressor. Both were told that what they were doing was acceptable, yet they suspected that it was wrong. Society delivered mixed messages to the veteran; the family delivered mixed messages to the child. In both cases, the psychosocial stressors were so severe that it was easiest to cope by either denying that incest had occurred or denying that it had been traumatic. (pp. 396-397)

PTSD is recognizable in clients who appear to be "spaced-out"; who complain of being unable to feel their feelings, even positive ones towards those people whom they love. Often the therapy revolves around helping them feel their feelings. Being in a safe environment with other incest survivors, who believe them when they speak about their abuse, can be a practice ground for being more psychologically present. In addition, being with other survivors can help clients feel less shameful about the abuse. Sometimes because the incest survivor feels ashamed, she unconsciously chooses not to feel. Being in an incest survivor group can raise a survivor's self-esteem, and thus release the shame. This allows her, then, to lessen her defense of disassociation.

The Feminist Perspective is used as a theoretical base for many incest groups. Anderson and Gold (1994) assert that the Feminist Perspective in therapy developed as a response to sexism inherent in traditional therapies. First, in psychoanalytic therapies, there is a lack of responsibility placed on socio-cultural factors as the source of women's emotional problems. Instead, women and men are abstracted from their

environment and labeled according to their inner drives. Therapy, then, focuses on changing the individual when perhaps better, more respectful, treatment from those in their environment is all they really need. Secondly, Vogel (1994) has pointed out that many developmental theories are gender biased. They reflect the stages of a male's growth experience which moves towards separation and individuation. Yet, the development of many women in comparison to this model appears stunted and incomplete. Feminist authors are now saying the growth of the female personality reflects a continually developing capacity for empathy and connectedness. Finally, feminists have challenged the hierarchical relationship between therapist and client. They point out how crucial it is for a woman to define her own experience, especially during her healing process, given that we live in a society which denies the mistreatment of women (Anderson & Gold, 1994; Bass & Davis, 1988; Larson & Maddock, 1995; Vogel, 1994).

When applied to incest, the Feminist Perspective recognizes it as a logical consequence of a patriarchal society. Zimpfer (1987) points out that in the Western world, the adult male wields the most power within the family due to: the family's financial dependence on him, property issues, his dominant physical stature over women, and a legal and medical system that often either blames victims of sexual abuse or does not believe them. Coker (1990) states that "In three fourths of the incest cases, the perpetrator is the father figure, natural, step, or surrogate" (p. 111). Brandt (1989) shows that "Twenty to thirty-three percent of all American women have experienced some type of childhood sexual encounter with an adult male" (p.75). Based on these reported figures it appears that father-

daughter dyads represent the highest population of incest violations though, it is possible there is a reporting bias in the literature of incest.

To counteract sexism in therapy with adult women incest survivors many feminists use a consciousness raising model in their group treatment. This implies a loose structure which allows the client to introduce her own topic for discussion, define her own problems, and pick her own pace for healing. The therapist and other women in the group relate the abuse to the sexism inherent to society. This makes the behavioral and emotional response of incest survivors normal instead of pathological.. Indeed, it is this validation that has made incest survivor groups so successful (Abell & Sommers, 1991; Bergart, 1986; Bonney, et. al., 1986; Buttenheim, 1993; Coker 1990; McPeek & Deighton, 1985; Ganzarain & Buchele, 1987; Gold-Steinberg & Buttenheim, 1993; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Kreidler & Hassan, 1992; Sprei, 1987).

Finally, the last theory provides the foundation for many group treatment models. It is called Family Systems Theory (FST). Family Systems Theory grew out of the 1950's with the first attempts by psychotherapists to include the family in an individual's therapy session (Nichols & Schwartz, 1991). Actually FST is part of a larger perspective entitled General Systems Theory (GST) which was adopted from the fields of Anthropology and Biology, as a way to understand how humans organize themselves in society. Bertalanffy a pioneer of GST said: "A system is any entity maintained by the mutual interaction of its parts. A system can be comprised of smaller systems and also be part of a larger system. Thus, the same organized entity can be regarded as either a system or a subsystem, depending on the observers focus of interest" (Nichols & Schwartz, 1991, p. 101). In line with GST, Family Systems Theory looks at

a family as an organic entity which maintains its structure through repeated interactions. Interactions are regulated by family rules and roles which uphold the structure, keeping the organism intact. As interactions become routine, they cement themselves as boundaries. Boundaries can be either healthy or unhealthy, yet either way, they form some sort of shape and identity for the family. Thus, families are protective of their boundaries. A Family Systems therapist, then, would look at incest as a product of the family system.

Zimpfer (1987) says there are predictable structural and functional stressors which precede incest. For example, there is usually role confusion within the family, involving the oldest daughter acting as the family caretaker or "mother" in the family. Many times the boundaries between the marital couple have become rigid, and a child may be brought into the dyad to provide for the emotional needs of one or both parents. A common precursor to incest is isolation of the family from any outside systems including no family friends, no help from social service agencies, and little to no interaction with the children's school system (Bonney, Randall & Cleveland, 1986). Again, a pervasive denial of anything unhealthy within the system is also a sign of incest. Finally, FST maintains that the pattern of incest is often duplicated by succeeding generations (Nichols & Schwartz, 1991).

In an incest group that uses Family Systems Theory as a base, facilitators might structure the group in a way that would promote clients to see it as a mock family. The facilitators count on the clients to transfer their emotions from their past experiences with the members of their family of origin and to project them onto other group members, or particularly onto themselves as “Mom” and “Dad” (Coker, 1990; McPeek &

Deighton, 1985). Therapists are then able to respond to the clients in a way that is different than what their family of origin would have done. For example, the therapists will not respond to a client's attempts to take care of the therapists' emotional needs, even though the client's parents may have asked them to take on that parental role in their family of origin. The therapists must maintain healthy boundaries between themselves and their clients in order for the group experience to be corrective (Kriedler & Hassan, 1992).

## Structure

A secondary area in the literature deals with different group treatment models for incest survivors used since the 1970's. I have grouped these into three categories: 1) Psycho-Educational 2) Interactional and 3) Process groups. These categories differentiate from one another by the way group interaction is structured, the way information gets disseminated, the length of time the groups run, and whether or not attendance is closed-ended or open-ended. Closed-ended refers to the rule that once the group starts no one else can join and clients are committed to attend according to the set schedule. Open-ended means that a client can join the group at any time, leave and return to the group as she decides, and determines when she is well enough to end her participation in the group (Bonney, et. al., 1986).

Almost all Psycho-Educational groups are short-term and closed-ended. The average length of a short-term group is under twelve weeks. A Psycho-Educational group is also highly structured. It is geared towards

dispensing information with the group leaders acting as presenters. The goals of a Psycho-Educational group are to provide factual information, social support, and emotional interaction with peers. Though there is not a lot of time for interaction structured into the Psycho-Educational format, Brandt (1989) and Roberts and Lie (1989) describe some groups as including a short amount time for discussing how the information directly relates to each member.

The primary goals of all short-term incest groups are about breaking isolation (Abell and Sommers, 1991; Gold-Steinberg & Buttenheim, 1993; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Sprei, 1987). Sprei (1987) for example, states the goals for one ten week group as, "acknowledging the abuse, recognizing, labeling and expressing such emotions as guilt, shame, anger, fear, and grief; gaining knowledge about incest and family dynamics; breaking feelings of isolation; gaining insight; making behavioral changes and deciding on a future course of action" (p. 203). With the exception of the last three, these goals refer to the beginning stage of dealing with incest in a group, when members validate their experience with others. Longer-term goals are reported as: increasing one's capacity for intimacy, identifying and choosing healthier coping mechanisms, changing familial relationships, dealing with parenting problems, psycho-sexual dysfunction and moving from a "Victim" stance in the world to one of "Survivor" (Bergart, 1986, Bonney, et. al., 1986; Coker 1990; Ganzarain & Buchele, 1987; Kreidler & Hassan, 1992; McPeek, & Deighton, 1985). Benefits to using the short-term approach according to Goodman and Nowak-Scibelli (1985) are: 1) A short-term approach keeps the focus on incest. This is important because victims have avoided the issue of incest all of their lives, and this gives them an opportunity to

confront the issue directly. 2) Clients tend not to become symptomatic in a short-term group because it does not provide an opportunity to discuss the abuse in depth. 3) It models clear boundaries for incest victims who grew up in families with ambiguous boundaries. 4) It highlights the ending of the group. Often incest victims have had many losses in childhood but have not learned to resolve them. A time limited group keeps the issue of loss alive and provides the opportunity to work through feelings associated with it.

Like the Psycho-Educational groups, the literature describes Process groups as short-term and closed-ended. Differences come in the way Process groups allow members to participate and how information gets disseminated. Process groups allow for more client participation than in Psycho-Educational groups and less so than in Interactional groups. In Process groups relating between the group leaders and the group members increases, but between the group members it remains moderate. Group leaders are also seen as facilitators rather than teachers. The facilitators aid members in making insights about their feelings and behavior instead of giving out information. They do share their theoretical orientation towards incest with the group but spend less time doing so, and bring it up spontaneously as it relates to what a group member is discussing. A facilitator, for example, may guide a client's thought process towards particular insights and validate those which align with her theory base. Therefor, the teaching is more indirect.

Process groups are also more oriented to the present than most Psycho-Educational or Interactional groups. For example, Barney (1990) and Roberts & Lie (1989) describe short-term incest groups that begin each session with a "check-in" time. Barney (1990) describes one group in

which members are encouraged to discuss what had happened to them over the week, even though it may not seem related to the topic of incest. The group leaders then help the members see how their "check-in" material relates to Post Traumatic Stress Syndrome (PTSD), which was the theoretical orientation the group leaders had chosen. In one session, for example, "a woman struggled to understand why she was unable to tolerate staying in her apartment or in her family's home in the late afternoon. In processing her thoughts, she made a connection between her present anxiety and her feeling as a little girl of desperation, and the desire to flee her house during that time of day when the abuse was occurring" (p. 281). The goals of this PTSD group are to help college women: 1) increase their awareness about how PTSD interacts in their everyday life in a way that makes developmental goals such as separating from their parents, becoming independent, and achieving intimacy more difficult than it is for students without PTSD, 2) to increase coping behavior, and 3) to develop a support system with other women experiencing similar difficulties.

While Psycho-Educational groups rely on lecture and a one way dynamic, and Process groups require insight using a two way communication, Interactional groups use a circular interaction to provide the learning experience. The therapist facilitates conversation by suggesting topics, offering feedback, and ensuring that the group sticks to agreed upon boundaries. Yet, it is the group dynamic which provides clients with the information they need to grow. Interactional groups are described in the literature as being long-term, which is anywhere from three-months to two years. The shorter-term groups may be closed-ended, but the longer tend to be open-ended.

Increasing a capacity for intimacy is described as the impetus for many Interactional groups. For example, Bergart (1986) describes a group which met for six months using group development theory to help incest victims process how their past sexual abuse affects their capacity for intimacy. The group leaders break group development into stages. The first stage focuses around diminishing isolation and self-hate. In this stage Bergart (1986) states that members achieve a sense of belonging they probably have never experienced before by talking about their abuse with others who have been through the same experience (p.270). The next stage is one in which members work out their power and control issues with each other. This may be played out by group members by not allowing therapists to get to know them. Members may say indirectly, " How do I know you won't take advantage of me or let me down? I'm better off handling my problems by myself" (Bergart, 1986, p. 271). For incest victims this is a particularly big issue because they were exploited as children. Following this stage is what is called the intimacy stage. This involves redefining boundaries. Clients begin to ask themselves, for example, "What am I responsible for and what is the other person's responsibility" (p. 273) ? Lastly, as members face termination they begin to put together supportive peer alliances outside of the group. In this way the group has helped clients move from isolation to intimacy.

Other Interactional groups are based on Family Systems Theory and intend for the group to become a kind of family. For example, Kreidler & Hassan (1992) describe an Interactional group treatment model which is used in a hospital setting by nurse specialists who act as facilitators and surrogate parents in the long-term (four month) closed-ended group. The group has three phases: 1) disclosure; in which members work with

establishing trust and sharing feelings 2) resolving feelings and the process of healing; in which members work on maintaining trust, recognizing the impact of their feelings on attitudes and set goals for change and 3) encourage healing in self and others; in which members work on trusting themselves and others and in supporting behavior changes in their self and in others.

The literature reveals that most long-term groups are also open-ended (Bonney et. al., 1986; Coker 1990; Kreidler & Hassan, 1992). Perhaps, it is necessary for the structure to become more flexible when the commitment may extend for over a year. In addition, it seems the in-depth exploration that comes out of long-term group therapy may also lead to a need for breaks. The benefit of open-ended groups is reported as offering a client more power over her healing process because she can choose if and when she needs a break from therapy (Bonney et al., 1986; Coker, 1990; Larson & Maddock, 1995). This is empowering as incest victims did not have power over their victimization. If they can choose the pace of their healing, survivors have more power over the effect therapy has on their lives. In addition, advocates of the open-ended format see the healing process as unique (Bass & Davis, 1988; Larson & Maddock, 1995). This structure also allows for enough flexibility to fit individual needs. Bonney (1986), however, made one criticism of the open-ended format, saying it disrupted the continuity of group development.

## Victim Treatment Model

The focus of this study is a model which utilizes concepts from many of the above perspectives. The author is Noel Larson Ph.D., LCP. Larson (1995) developed a group treatment model for adult female incest survivors called Victim Treatment. Larson's (1989) "Female Victim Typology" forms the basis of her treatment model. This Victim Typology is, in turn, based on Structural and Functional Family Systems Theory.

The term "victim type" that Larson uses refers to the personality an incest survivor develops in a family that teaches unhealthy boundaries. Larson asserts that boundaries shape an individual's personality. Thus, an incest victim who grows up in a family with disturbed boundaries cannot help but develop a personality with disturbed boundaries. It is crucial to note that Larson (1989) defines personality "not as attributes of individuals, but characteristics which develop through repeated interactions and experiences." In her Victim Treatment model, personality change is the goal for incest survivors.

Larson bases her Victim Typology on the Family Systems perspective which makes boundaries a priority when trying to understand families. Larson and Maddock (1986) point to four specific boundaries as forming the structure of all families. These are: the family/society-boundary, the intergenerational-boundary, the interpersonal-boundary and the intra-psychic-boundary. In an incest family the boundary between the family and society is overly rigid. The family is highly closed to interacting with any outside sources of social support. Members tend to look only to each other to meet their needs for affection and self-esteem. Children may not have many outside friends. The parents might not be

involved in the children's school system (Larson & Maddock, 1986). There may be no family friends. Furthermore, this boundary is usually so rigid in an incest family that members are not allowed to question the family behavior or explore the outside world. If, for example, a teenager decides to learn about the world and decides they do not agree with certain family values, she is seen as crazy and as outside of the system. That teenager cannot easily rejoin the family and receive the acceptance and belonging she needs. The boundaries between family and society are like barriers in incest families.

Secondly, the intergenerational-boundary refers to the hierarchy which separates the children from the adults. In incest families this tends to be overly diffuse. The children and the parents slide into each others' roles with ease. The oldest daughter, for example, may take on the cleaning and cooking responsibilities of the mother as well as the emotional nurturing role of her mother and may act emotionally like a spouse to her father (Larson & Maddock, 1986). However, intergenerational boundary disturbances can take on a myriad of configurations. Another example of this disturbance could result in a family where both parents neglect their responsibilities as caregivers and none of the children take on a parental role. Thus, the whole family is like a family of children. The roles can also be reversed between a son and his father or a son and his mother and so on.

Third, interpersonal-boundaries refer to the line which separates one individual from the another in a relationship. In an incest family this boundary becomes overly diffuse, as well. Murray Bowen, a Family Systems therapist talks about the undifferentiated ego-mass in an enmeshed family (Nichols and Schwartz, 1991). This means that family

members may not be able to differentiate between the thoughts and feelings of their family members and themselves. In an incest family, for example, the child/victim may believe that her father's/perpetrator's desires are her own. She may think: "I want the acceptance and affection I get when my dad is physical with me. Therefore, I must want sex." The father/perpetrator may feel that his needs are his child/victim's as well. He may think: "I feel attracted to her, so she must be a very sexual child."

Lastly, intra-psychic-boundaries are the boundaries in an individual's internal psyche. For example, denial is a loose boundary between one's perception of reality and the interpretation. Denial is pervasive in an incest family. The family members will skew their interpretation of what they see and hear to fit the belief system for the family: "I believe papa is a good man. Therefore, he did not hurt you, even though you told me so." Or, "I believe papa is a good man. Therefore, he did not hurt me, even though I saw him do it." These cognitions, then, are a result of what Larson identifies as pathological boundaries and what she re-works in her Victim Treatment model.

Along with boundary disturbances comes a struggle for power and control (Larson, 1989). Because the family is isolated, members compete for sparse resources to meet their needs for emotional nurturing and self-esteem. As they compete, members lose their sense of autonomy because they themselves are being asked to give too much to meet the needs of another, or they are exploiting the boundaries of someone else. In addition, they are continually struggling not to lose their sense of self to the undifferentiated ego-mass of the whole family system. Thus, members tend to divide into roles based on who relies on power to get what she needs, and who relies on control to protect herself. Larson defines power

and control as the following: power is the ability to get someone to do or be what you want, control is the ability to keep someone from doing something to you.

This differentiation between power and control distinguishes between those who are Perpetrators and those who are Victims in the incest family. Perpetrators burden themselves with too much power. Their needs, desires and beliefs dominate the family system. For example, a Perpetrator has a huge capacity for denial, and this denial becomes the accepted reality for the family. Her belief is that she is O.K. It is others and the world who are always at fault. Thus, the Perpetrator cuts off her capacity for empathy. She cannot relate to what another is feeling, especially if it is someone she has hurt. While this capacity protects the Perpetrator from feeling guilty, it also costs her the capacity to feel empathy for herself. The Perpetrator is not emotionally connected to herself. Larson argues this is to protect her from relating to the part of herself that feels just like the Victims in the family: powerless, desperate, abandoned and defective.

A Victim on the other hand, burdens herself with an excess amount of control. A Victim is continuously trying to interpret the needs of the Perpetrator. She does this to get the information she needs in order to please the Perpetrator. This protects her from being further victimized. Unlike the Perpetrator, the Victim has too much empathy. A Victim has denial but it is usually a denial of her own needs and limits, not the needs of the others. Furthermore, a Victim believes what the Perpetrator projects onto her: she is responsible for the abuse. This becomes a core belief in her identity. She believes she is defective and this is the filter she uses to interpret all the other messages she receives from society. It is

like a ring of shame she wears, which keeps her from being and knowing who she is in the world.

**Graph #1: Female Victim Typology**

Noel, R. Larson, Ph.D., LCP

| V | Vp | 25-50% Non Vp | V/P | Pv |
|---|---|---|---|---|
| Decompensated | Classic V | Overachiever | Dissociative | Perpetrator |
| 100% V | 80% V | 30-70% V | 50% V | 80% P |
| 0% P | 20% P | 30-70% P | 50% P | 20% V |

Larson (1989) brings an added complexity to Victims and Perpetrators which distinguishes her model from others (see above graph #1). According to Larson, a Victim is not simply a Victim and a Perpetrator is not just a Perpetrator. Rather, each member of the family internalizes a percentage of both Perpetrator and Victim characteristics into her personality. Actually, there are five types of victims which vary according how much Victim, "V", and how much Perpetrator, "P", one has internalized. (See appendix-b for a more detailed graph.) The only exception, in this typology is the Decompensated Victim who is 100% V. The rest have some combination of V and P in their personality. A Classic Victim is actually 80% V and 20% P. An Overachiever Victim varies between being 30-70% V and 30-70% P. A Dissociative Victim is 50% V, 50% P. A Perpetrator/Victim is 80% P and 20% V. It is important to note,

a Perpetrator/Victim is someone who has been an incest victim, but who has coped with this abuse by taking on the personality of a Perpetrator. It does not necessarily mean she sexually violates others.

Though these personality types make sense within the incest family system, in society they provide limited effectiveness due to their rigidity. In the past, when family members divided themselves between acting more like a Perpetrator or a Victim, they set up a dichotomy. Family members learned they had two ways of responding to the world: being overpowering or being overpowered by others. Thus, even a Classic Victim is taught how to stand up for herself. She may get so tired of being "walked- on", she fights back. However, the fighting response may be too extreme for the context, and may ultimately be disempowering for the Victim. For example, if a Classic Victim is being treated poorly at work, it might be more appropriate to discuss the problem with someone with power who could help her confront her peers, rather than to report everyone's behavior to the agency Director. Thus, the sense of personal power and control that a Victim recieves from her family of origin is not always congruent with what the society at large expects from individuals (Larson, 1989). There are usually a larger variety of more tempered options to be considered than those an incest Victim feels she has available. Larson's group focuses on re-working a Victim's boundaries to a point of balance, where one can choose behavior that is neither overpowering nor overly controlled.

The goal of Larson's Victim Treatment model (1989) then is to re-work those areas of an incest Victim's personality which deviate from the norms of society in a ways that are ineffective for their lives. The goals of the group are as follows: 1) restructure pathological boundaries, 2) re-

establish internal locus of control, 3) re-work shame, self-destructive behaviors, and relationship capacity. The therapeutic process of the group comes through experiencing the group as if it were a family. Interpersonal learning is central to the group. Unlike the Victim's family, however, the group has overt rules which protect one from getting victimized, or from victimizing another group member. Larson (1989) states the rules as: "Time"; group members have an equal amount of time each session and group members time each other. "Content"; group members control the content by choosing what they want to talk about or even whether to talk. A group member may choose to have silence during her time. "Setting limits"; everyone has an absolute right to say no to anything they do not want to do. For example, there is a lot of homework but it is optional. "Asking for what one wants"; feedback comes only from the therapist unless a member asks for peer feedback. "Structured risk taking"; if a group member has a problem with another she brings it to the therapist who will bring the issue up with the other group member in a positive way. "Giving within limits"; group members can call the therapist during the week with a problem only after she has called two other group members. "Resolving manageable pieces"; specific issues are discussed as opposed to universal issues. "Safe social rehearsal"; group members are allowed to socialize with each other outside of the group. The structure of this group is also on-going and open-ended, meaning that it never ends, and group members can leave and return anytime they would like, though absences are not taken lightly and group members are asked to provide notice. In addition, reentry into a group after a long period of absence is usually affirmed by the client through renewing her verbal commitment to rejoin the group.

## Chapter II: Methodology

This chapter outlines the methods used to gather data for the evaluation of the Victim Treatment model by Noel Larson. Research questions are presented, a list of definitions for key terms is made available, and an explanation of how the questionnaire measures the variables is given. A description of the design is also included with design limitations and strengths, and a statement of purpose. Procedures for contacting subjects and for their protection from harm are also presented.

### Research Questions

The research questions are: Do group members perceive the Victim Treatment model by Noel Larson, Ph.D., LCP., as effective for themselves and others in the group? Are group members attaining the group goals set by the model's author? Are there any changes that can be made in the group's structure that would enhance the group members' satisfaction? A questionnaire with a Likert scale along with open-ended questions was used in order to measure attitudinal and behavioral changes as a result of participation in the group, and to determine the degree of client satisfaction.

### Operational Definitions

The following definitions derive from the literature of Courtois (1993), Larson (1995 & 1989) and Nichols & Schwartz (1991). Some are

according to the exact definitions given by the authors, others were created by integrating the information given by the authors.

*Incest*: any type of sexual behavior between a child and any family member (or "familiar" considered by the family as a part of its system) through the use of force, whether it be: physical, the threat of physical harm, trickery or, emotional blackmail.

*Survivor*: any person over the age of 18 who has been a childhood victim of incest and who is alive.

*Boundaries*: a pattern of interactions that through consistent repetition defines the rules and roles of a family or an individual.

*Pathological boundaries*: those boundaries an individual maintains even though they do not yield results desired by that individual.

*Family/Society-boundary*: the boundary which determines the level of interaction between a family and its community.

*Intergenerational-boundary*: the boundary which separates adults from children in a family by defining appropriate roles for each group.

*Interpersonal-boundary*: the boundary which separates each family member as an individual with unique thoughts and feelings from each other, and the family identity as a whole.

*Intra-psychic-boundary*: the boundary which separates internal psychological functions from one another, for example, the separation of the conscious from the unconscious.

*Rigid boundary*: the lack of interaction between different individuals, systems or subsystems.

*Diffuse boundary*: the overlap of boundaries between different individuals, systems or subsystems to the point of identity confusion.

*Present day family*: any friend, relative or person who provides either emotional and/or social support, and is identified by the subject as family.

*External locus of control* : depending on cues from the outside world to direct one's beliefs, feelings, thoughts and decisions.

*Internal locus of control* : the ability to decide how to feel, what to think, and what to do based on inward reflection which excludes external stimuli.

*Shame*: a primary belief that one's self is defective.

*Self- destructive behaviors*: behaviors which lead to sensations that temporarily distract one from feeling painful emotions such as shame.
*Control*: the ability to keep someone from doing something to you.

*Power*: the ability to get someone to do or be what you want.

*Relationship capacity*: the ability to interact with others in patterns which are not representative of Perpetrator or Victim attitudes and behaviors.

*Victim*: one whose dominant mode of interaction is controlling. In addition, Victims can be characterized with the following traits: 1) an underlying fear of abandonment, 2) a core belief they are defective, 3) anger at self for imperfections, 4) putting the needs of others before their own, 4) avoiding anger in others, 5) an external locus of control.

*Perpetrator*: one whose dominant mode of interaction is overpowering. In addition, Perpetrators can be characterized with the following traits: 1) a core belief that they are always right, while others and the world are always wrong, 2) active blame of others for their own problems, 3) a lack of empathy, 4) exploitive of the boundaries of others, 5) internal locus of control.

*Group structure*: the organization of group interaction including: 1) group rules, 2) the way information is disseminated, 3) time length, 4) open-ended or closed-ended format.

## Questionnaire Design

This description of the questionnaire is to be read with referral to the above operational definitions as needed. In addition, the reader may want to refer to the questionnaire in the back of the book under appendix-c. The first part of the questionnaire was designed with a Likert scale to

measure whether or not Larson's (1989) group treatment model goals were attained (see page 19 of thesis for further discussion). The questions were written twice, one retrospective measure before the subjects attended the group and one measure that came after the subjects had been in the group for a while. The "before" questions were in the first part of this section. The "after" questions were in the second part of this section. It is also important for the reader to know that the following boundary questions refer to the subjects' "present day" family (see above operational definition).

**Goal 1) Restructure-pathological boundaries**, was addressed in questions numbers 1-6, and 24-29, 8 and 31. This goal was broken up into sub-categories.

**a) Family/society-boundary**, was measured in questions, 1-3 and 24-26. These questions measured whether or not this boundary was too rigid.

**b) Intergenerational-boundary**, was measured in questions 4, 5, 27 and 28. These questions measured whether or not this boundary was overly diffuse.

**c) Interpersonal-boundary**, was measured in questions 6 and 29. These questions refer to the fluidity of this boundary.

**d) Intra-psychic-boundary**, was measured in Questions 8 and 31. These questions refer to the fluidity of this boundary.

**Goal 2) Re-establish internal locus of control**, was measured by numbers 9, 10, 32 and 33.

**Goal 3) Re-work shame, self-destructive behaviors and relationship capacity**, was also broken into categories.

**a) Shame**, was measured by questions 11 and 34.

**b) Self-destructive behaviors**, were measured by questions 12 and 34.

**c) Relationship capacity**, was measured by questions 13 and 36 by referring to the balance of Perpetrator and Victim like behavior within their interactions with significant people in their lives.

Since, relationship capacity is defined above as: "the ability to interact with others in patterns which are not representative of Perpetrators or Victims", questions, 7, 30, 14-23 and 37-45, also measure relationship capacity. The answers to these questions indicate which personality type the subject relies on the most. The reader may note that some of the subcategories overlap with the above boundary categories. This simply shows the relationship between pathological boundaries and Victim and Perpetrator personality traits as discussed by Larson (1989). However, the findings were kept separate.

**1) Victim attitudes and behavior**, were measured by questions: 14,16, 18, 20, 21, 37, 39, 41, 43, 44. Questions 7 and 30 are out of sequence but they also measure a common Victim attitude. Specifically, the questions measure the following traits which also correspond to the above operational definition of "Victim".

**a) Fear of abandonment:** 7 & 30.

**b) Self blame and internal anger:** 14, 16, 37 & 39.

**c) Other orientation:** 18 & 41.

**d) Anger avoidance:** 20 & 43.

**e) External locus of control:** 21 & 44.

**2) Perpetrator attitudes and behavior**, were measured by questions: 15, 17, 19, 22, 23, 38, 40, 42, 45 and 46. Specifically the

questions measure the following traits which also corresponds to the above operational definition of "Perpetrator".

a) **Belief of omnipotence:** 15 & 38.

b) **Active blaming behavior:** 17 & 40.

c) **Lack of empathy:** 19 & 42.

d) **Exploiting behavior:** 22 & 45.

e) **Internal locus of control:** 23 & 46.

Finally, the second part of the questionnaire is qualitative using open-ended questions to measure the clients' satisfaction with the current group structure, and to give them an opportunity to make suggestions for change. In addition, one qualitative question was offered to measure the groups' effectiveness in addition to the quantitative questions. This was asked to measure for changes not included in Larson's goals. It asked if there were any other ways they felt they had changed as a result of being involved in the group. The qualitative portion consists of 8 questions, numbered 47-53.

## Study Sample

The target population of my study consisted of 6 lower-middle class women, ages 28-36. Five of the subjects were identified as Caucasian and one identified as part Native American and part Caucasian. Four of these women have been in the group for over one year. One joined six months prior to the study. Three of these women were identified by the group leader as fitting the Classic Victim typology of Larson's Victim Typology. One of the women was identified as fitting the Perpetrator typology and

one other as fitting the Dissociative typology. These women were all incest survivors and had some therapy prior to attending the group. The screening process which preceded acceptance into the therapeutic group also excluded women who were: homophobic, overtly acting out, without another support, for example, friends or a therapist, and found unable to maintain confidentiality.

## Procedure for Contacting Subjects

As was the wish of the subjects, this study was anonymous. The researcher had no direct contact with the subjects. The questionnaire was presented to the group by the group leader and was presented as optional. Subjects were handed the questionnaire in a stamped envelope containing the researchers address. In addition, the subjects were told the group leader would not see the results of the questionnaire until the answers were consolidated and in published form. The subjects were also told the results of their answers would be presented in aggregate form to solidify their anonymous status in the study.

## Study Design

An AB: Basic Single Subject design with a retroactive baseline was used in this research. This means there was one intervention phase and one retroactive baseline phase. There have been some limitations to this design. Lumping the intervention into a single phase was not

representative of the actual length of intervention which occurred weekly and varied for subjects, with participation ranging from 6 to 18 months. In addition, one intervention phase did not control well for the possibility of an extraneous event causing the shift in the base line. Thus, the validity of the answers are put into question. Reliability was also limited since there was no repetition to determine whether or not the questionnaire would yield the same results each time it was taken. However, due to the time constraints of the experiment it was not possible to do multiple measurements. Another limitation comes in that the baseline was derived from the memory of the incest survivor group members. This also weakened the reliability of the responses. Triangulation of methods would have strengthened this research. However, in order to maintain the subjects' anonymity, it was not possible to go back historically to obtain a baseline through agency records, or to do any interviews. Strengths of the research design, though, included the anonymity provided for the subjects. The subjects were also assured the leaders would not see the raw data due to the method of collection. These precautions helped to control for social desirability in the responses. In addition, the questionnaire was based on an extensive literature search which brought face validity to the questions. First, the literature search aided the researcher in choosing which attitudes and behaviors to measure in the questionnaire. Those symptoms that were most often mentioned and those which reflected a Systems perspective as used by Larson were included in the survey. Secondly, the search helped the researcher to frame the questions in ways that would not trigger judgment and thus cause the subjects to seek the most socially desirable answer. The literature informed the researcher, for example, that the goals were not made overt in Larson's model. Thus, instead of

asking the subjects about a goal directly like boundaries, questions were asked about the subjects' real life interactions and the word boundary was avoided. This made it more difficult for the subjects to decipher which answer would be the most socially approved of answer. In addition, by asking how often behavior occurred as opposed to whether or not the subjects felt good or bad about their behavior, the researcher took measures to avert the notion of "good" or "bad".

## Statement of Purpose.

This was meant to be a small targeted study and not for the purpose of generalizations but rather to aid in the development of the group and as an exploratory step towards developing a tool to measure the effectiveness of this long term model.

## Protection from Harm

The research questions did not refer to the direct experience of sexual abuse. Instead they referred to symptoms of sexual abuse. Thus, there was a minimal risk the questionnaire would stimulate memories about the client's past sexual abuse. There was more of a risk, however, that subjects would become self-critical by trying to judge how much "progress" they had made in the group through the questionnaire. To counteract this, the subjects were told the questionnaire was not an evaluation of their individual performance, rather it was a measure of the

effectiveness of the group model. They were also told that individual progress was not obviously evident by their answers on the questionnaire. In fact, sometimes a person may appear to be regressing when in reality they are moving forward. However, if the questions did bring up painful self-realizations or incest memories, the subjects were told to either discuss this in the following group session or, to call a group leader. Two weeks after the questionnaire was returned, none of the subjects had mentioned feeling harmed in any way by taking part in the study.

## Data Analysis

Due to the small sample size and low rate of response, the data was analyzed by hand. To do this, the responses to the Likert scale were categorized according to the goals Larson (1989) put forth: 1) restructure pathological boundaries, 2) re-establish internal locus of control, 3) re-work shame, self-destructive behaviors and relationship capacity. The average rate of change was then calculated for each goal. Group structure and client satisfaction were derived from the responses on the qualitative part of the questionnaire. Qualitative data was presented according to the operational definition of group structure which is: the organization of group interaction including: 1) group rules, 2) the way information is disseminated, 3) time length, 4) open-ended or closed-ended format. Data on client satisfaction was obtained from all of the qualitative questions especially number 55 which asked, "What did you initially come to this group for and are you getting it?"

## Chapter III : Findings

This chapter divides the finding into quantitative and qualitative results. The quantitative results are divided into the categories according to the questionnaire as was presented in the design section. The qualitative data is divided according to themes found in the responses.

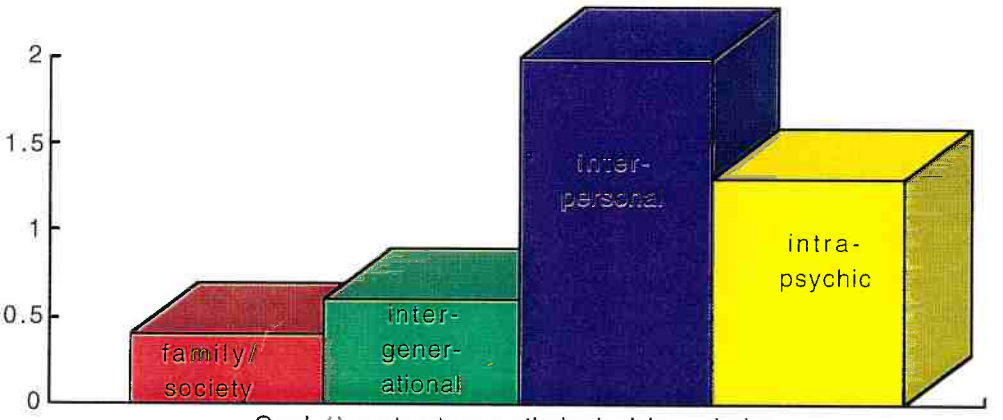
### Quantitative Results.

Four of the five group members mailed their questionnaire back to the researcher. Three (n=3) were filled out. One questionnaire was returned empty. The overall rate of change for all three of the subjects was **.6014492**. The overall rate of change for the person with the least amount of time in the group, out of the three respondents, was **.5652**. The person with middle range of time had a rate of change of **.5**. The person who had the longest amount of time, out of the three, had an average rate of change at **.7391304**. Thus, it appeared that length of time in the group did have an impact on the level of change based on comparing the numbers of the persons with the least and most amount of time in the group. However, there may have been more significant variables affecting the rate of change like personality type or the subject's attitude towards taking the questionnaire.

The quantitative data was categorized as discussed in the Questionnaire Design section (pp. 31-33). The quantitative data revealed that on the average the subjects made progress towards achieving all of Larson's stated goals. Each question showed positive growth for the

subjects as a whole. None of the answers indicated regression. Individually, however, there were some responses which indicated a lack of growth or no change.

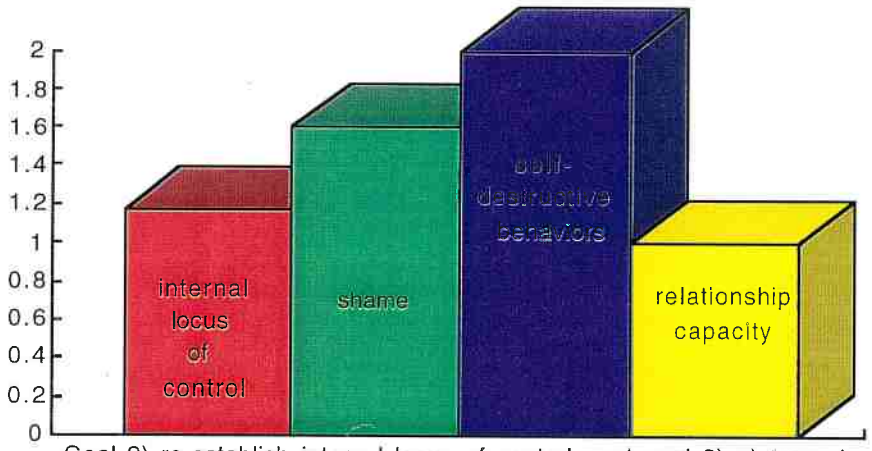
**Graph #2: Degree of Change in Goal 1) Boundaries.**




Goal 1) restructure pathological boundaries

The boundary section of the survey revealed growth overall (see graph #2 above). The average rate of change between the three subjects measured in the family/society-boundary category was **.4**, showing that this boundary was becoming less rigid. The intergenerational-boundary was becoming less diffuse for subjects with average rate of change at **.6**. The interpersonal-boundary responses resulted with an average change of **2.**, again indicating less boundary diffusion. The intra-psychic-boundary responses also revealed movement away from boundary diffusion at an average rate of **1.3**.

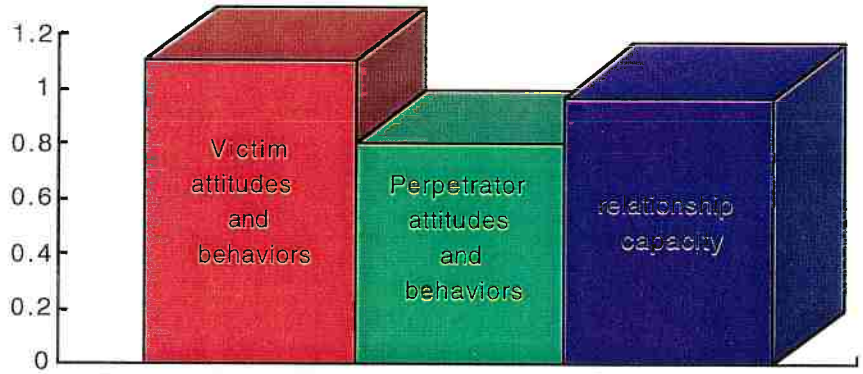
**Graph #3: Degree of change in goals 2) Re-establish Internal Locus of Control and 3) a) Re-work Shame and b) Self-destructive Behaviors.**




Goal 2) re-establish internal locus of control, and goal 3) a) re-work shame, and b) reduce self-destructive behaviors, and c) improve relationship capacity.

The subjects also showed growth in attaining Larson's second and third goals (see graph #3 above). The average rates of change away from an external locus of control and from shame represented the most positive growth towards Larson's goals in this group. The average rate of movement from an external locus of control towards an internal locus was **1.16**., and the average rate of change away from feeling shame was **1.6**. The question on self-defeating behaviors revealed that subjects had lessened the amount of time they participated in these behaviors. The average for the three subjects was **2**. The question which measured only relationship capacity showed an average rate of movement towards balance between giving and receiving was a **1**.

**Graph #4: Degree of change in Goal 3) c) Re-work Relationship Capacity.**




Reduce Victim attitudes and behaviors. Reduce Perpetrator attitudes and behaviors. Improve relationship capacity.

The second part of the quantitative section measured the rate of movement away from Victim and Perpetrator personality traits which also indicated improvement or decline of the subject's relationship capacity (See above graph # 4.). The first two bars on the graph refer to those questions which specifically measured Victim and Perpetrator attitudes and behaviors. The last bar on the graph refers to questions 13 and 36 which asks specifically about the balance between Victim and Perpetrator behaviors in their relationships. The average rate of change away from Victim attitudes and behaviors was **1.1**. The average rate of change away from Perpetrator traits was **.8**. By combining the Victim and Perpetrator numbers and including the data from the question in the above paragraph which strictly measures relationship capacity, the average rate for improving one's capacity for relationship was found to be **.972**.

## Qualitative Results

The responses to the qualitative questions provided a rich supplement to the quantitative data. Question 48, for example, was intended to measure whether there had been any other changes not accounted for in the model's goals. In addition, this question gave the subjects the chance to express changes that were measured in the Likert scale but in a more personal way. Themes in these responses were found around boundaries. One subject indicated her interpersonal boundary had been in her opinion too "open". Another subject said that the biggest difference the group has made for her was awareness. She talked about working consciously to change her behavioral and emotional patterns. Since boundaries have been described as patterns of interaction, one can infer that her statements were regarding boundary changes, and thus affecting a change in her personality. Another subject indicated the group was helping her to break the rigidity of her family of origin's family/society boundary, specifically the rule, "Don't talk about the abuse." Another theme was moving from an external to a more internal locus of control. Certainly, the example of "awareness" and working consciously to change patterns indicated that the subject was taking control of her life. This in turn indicated that some of her Victim attitudes and behaviors were changing. This was also a theme in the other responses. Some of the responses which indicated changes in Victim traits also indicated change in Perpetrator traits. One response, for example, showed a subject realizing she could not change others. She said she could only change herself. This indicated a shift to a more internal locus of control. Yet, the shift away from trying to change others was also a shift away from trying to

overpower others, if power was defined as the ability to get someone to do or be what you want.

To measure group structure, the rest of the questions asked about group rules (refer to thesis, p.24), group interaction with members and leaders, and leadership style. Each question asked which of the above were helpful and if anything could be changed to make the group more affective. When asked which group rules were helpful (question 49) the response indicated the feedback rule was the most helpful. "Feedback comes only from the therapist unless a member asks for peer feedback" (Larson, 1989). A secondary theme was found around timing, "group members talk for an equal amount each session and group members time each other" (Larson, 1989). Responses showed some subjects liked this rule. Third, there was positive feedback about the non-confrontational rule entitled, "Structured risk taking"; if a group member has a problem with another they bring it to the therapist who will present the issue to the other group member in a positive way. However, data in the following section under group interaction indicated that sometimes this rule is problematic, because when misunderstandings do occur, tensions can run high for the rest of the group time. This lack of being able to resolve problems as they occur was reported as uncomfortable. Yet, the response to the question asking for suggestions to improve the rules suggested that no improvements needed to be made. This was indicated both through a lack of responses and by direct statements saying the rules did not need improving.

When asked about the group interactions, the subjects suggested there were strong feeling of safety, trust, and closeness between group members including the group leaders. This section did offer suggestions

for change which occurred around the need just mentioned above to correct miscommunications as they occur. A secondary theme for change was found around the desire to know how much progress others had made in working through their issues. However, there was some reluctance to stating this as a suggestion because of the emphases group leaders placed on not taking care of others.

In terms of leadership style (questions 53 and 54), the respondents had high praise. Responses indicated the subjects were given a lot of control over their own healing and that this was appreciated. For example, the subjects liked being able to choose their own topics and their own pace in therapy. One response described the leaders acting as guides rather than authority figures. "They don't tell us how to change." The feedback the subjects received from the leaders was also appreciated. Subjects stated that the feedback was challenging, creative, encouraging and respectful. None of the subjects offered any criticism for the group leaders.

The last qualitative question was more open-ended, designed to measure overall client satisfaction. It asked: "What did you initially come to this group for and are you getting it?" The most prominent reason given for joining the group was 1) to break isolation. Though the subjects may have had support in other areas of their lives, it appeared there had not been enough support around the topic of incest. 2) To gain more power over their own lives. 3) To change behaviors, and 4) as on subject put it to stop "blaming and suffering". All three subjects stated "Yes", they were getting what they came to get out of the group. The gratitude these subjects felt about their experience in the group was powerful. Responses indicated the subjects felt lucky to be in this incest survivors group. Other

responses expressed the desire to break the isolation of the many incest survivors that might not have support. "We're not alone!", one subject stated.

# Chapter IV: Discussion, Limitations, and Summary.

## Discussion

**Is the Victim Treatment model by Noel Larson, Ph.D., LCP. effective for members of the adult, women's incest survivor group in the study?** This general research question could not be answered due to the limited scope of the study. The sample size n=3 out of N=5 was not suitable for generalizations.

**Are group members attaining the group goals set by the model's author?** There was movement towards meeting the goals Larson put forth for this group. All of the changes in the study reported movement towards attaining group goals, none of the changes showed regression. The subjects as a whole scored the highest with a (**2.**) in the categories of interpersonal-boundaries and self-destructive tendencies. The second highest categories were shame (**1.6**) and intra-psychic-boundaries (**1.3**). The lowest rates of change were found in the categories of family/society-boundary (**.4**), intergenerational-boundary(**.6**), and Perpetrator traits (**.8**). The Victim category received a higher score (**1.1**) than the Perpetrator category (**.8**). This was a positive finding since the group facilitators had indicated that most of the group members contained more Victim than Perpetrator traits in their personality.

Overall, the subjects tended to move up or down the Likert scale by just one point. Since one of Larson's goals in personality change is to create more balanced responses, this indicated that the subjects' Victim and Perpetrator attitudes and behaviors were becoming less extreme. In

addition, most of the responses were in the middle range of the Likert scale which might also be indicative of balance.

However, there were some extremely low and high responses on the questionnaires and these sometimes pointed out trouble. For example, question number 5 (I am able to say "no" to friends if I am too tired to help them) received some "never" responses before the intervention. These then moved only one notch to "hardly ever" responses after the intervention. Another question received high scores both before and after the intervention (18 and 41), "I am the kind of person who would carry your pain if that would make you feel better." These responses suggested the subjects were still struggling with their intergenerational-boundaries, showing that their families of origin had placed them in the role of caretaker. Evidently, the subjects were carrying this role with them into their present day families.

The study also suggests that subjects were struggling with intra-psychic boundaries and through rigid self-judgments or perfectionism. This is also Victim behavior. For example, the subjects all tested high for getting angry at themselves if they were feeling depressed or upset (16 and 40). This question might have indicated the subjects were also still struggling with feelings of shame. If they believed they were defective, they might have had little patience for feeling depressed.

The area of self-destructive behaviors was a concern (12 and 35). The answers ranged between several "always" responses before the intervention to some "usually" and "sometimes" responses. Finally, the study also revealed that abandonment fears were high, also moving from "always" responses before the intervention to "usually" and "sometimes" responses after the intervention.

Some high responses, though, revealed strengths. For example the questions which measured internal locus-of-control and self-esteem, or lack of shame, showed the subjects had grown quite a bit in perceiving themselves as powerful and able to manage their life. Their confidence in their capabilities had grown as well as their ability to define themselves despite the feelings and beliefs of others. The question measuring shame: "I believe I am an adequate, capable, good and successful person.", ended (35) with "sometimes" and "always" answers.

**Are there any changes that can be made in the group's structure that would enhance the group members' satisfaction?**

The subjects did not have a lot of suggestions for change. Many of the qualitative responses, especially to the last question, indicated they were satisfied with the group structure. However, there may have been some resistance to answering the questions which asked for criticism or suggestions. This could have been due to the personality traits of the population. Victims characteristically tend not to want to run the risk of causing anger or of hurting anyone. Anger in the past might have been aimed at the subjects in the form of verbal, physical or sexual abuse. Victims also tend to be very empathetic. They know how criticism can feel because of their own shame and may have wanted to avoid the risk of hurting a group leader's feelings. In addition, deep seated fears of abandonment might cause the subjects' to not risk "making waves" in the group. However, there was one clear suggestion for change from subjects which indicated that tensions had been allowed to build-up in the group. Perhaps some of the restraints on confrontation and feedback have hindered the ability to resolve issues regarding group dynamics.

## Limitations

Though the return rate of n=3 was adequate representing 60% of the sample N=5, larger numbers in the overall study would have greatly increased the validity of this study. The reason the sample size was originally kept to five was to control for external variables that might have made the data less comparable. There were many groups which used The Victim Treatment model by Larson. However, most did not adhere purely to her guidelines. Some groups separated the Victim types: Classic Victim, Dissociative, Overachiever, etc., and some mixed types. For example the study group mixed three Overachiever Victims with one Dissociative Victim and one Perpetrator/Victim. In addition, some groups used different leadership styles. There may have been other differences as well. In retrospect, I think the need for more data overrode the need for purity.

The difficulty of getting responses from this population pointed to several research problems. First, the group leader stated that the consent form and the scripted speech she had to deliver to the subjects brought a drama and formality to the study which caused the subjects to hesitate (Tovar, personal communication, June, 1995). When the idea of the study had been introduced informally by the leader all the group members had been enthusiastic about participating. Yet, when they heard twice about the risk of inducing incest memories, once in the consent form and once in the group leaders speech, they were concerned. This was unfortunate because the risk of stimulating memories as a result of answering the questions was low. The questions addressed the symptoms of incest and not the trauma itself. Secondly, the questionnaire was challenging for the

subjects because it did require contemplation of the growth around their issues related to incest. The group leader stated that some of the resistance was probably due to group members "not wanting to look at their stuff." (Tovar, personal communication, June, 1995) Finally, one group member stated she might have returned the questionnaire earlier if it had been less quantitative. This pointed to the difficulty of objectifying one's psychological experience. The subject alluded to feeling that a number could simply not express her answers to the questions. On the other hand, one subject did not write very much on the qualitative part of the questionnaire. Without the quantitative data the researcher would have had little information for that subject. Perhaps she liked the quantitative part better. The Likert scale also allowed the researcher to make clear comparable observations.

Another limitation was the lack of data which allowed the researcher to assess whether or not the questions measured what they were intended to measure. For example, did the Likert scale measure the goals? How does the reader know if the subjects interpreted the questions the way the researcher intended. There were two comments made by one subject indicating more clarity was needed. Next to one question, for example, the subject asked whether it referred to her interactions with group members or with people outside of the group. Another example, came with question 46, which was intended to measure an exploitive attitude characteristic of Perpetrators, "I have a hard time guessing what people want from me so, I just act on what I know I want out of the relationship." However, one subject added a comment next to it, saying: "Learning to ask". This pointed out that this question could have also measured movement from an external locus of control, "guessing", to an internal one, "asking". Thus,

it could have been interpreted as a question designed to measure Victim behavior. Whether or not the qualitative section measured client satisfaction and was a stated in a way that could have yielded suggestion for change may have also been a limitation in this study. Question 54, for example did not receive any responses: "What do the group leaders do that is not helpful?" The wording on this question differed from the questions on group interaction and group rules which asked, "if anything could be improved upon". Perhaps the more critical framing of the above group leader question inhibited responses. More testing of this questionnaire would have helped to tailor it more towards the subjects' perceptions.

Another research question to consider in this part of the survey is: did the qualitative questions match the definition used to measure group structure? The operational definition for group structure was: the organization of group interaction including: 1) group rules, 2) the way information is disseminated, 3) time length, 4) open-ended or closed-ended format. The subjects responded to the first three of these criteria but they did not illicit a response regarding the last two criteria of the definition. Perhaps additional questions which directly address numbers 3) and 4) could be added in the future to make sure all the points get addressed. Anytime a researcher uses open-ended questions there is no guarantee the answers will reflect the focus for which the researcher was looking. However, I believe the open-ended questions, particularly the first and the last, brought the richest responses and were needed to supplement the quantitative section.

## Summary

The findings of this study reveal that overall the subjects' attitudes and behavior have changed since they became members of the group using Larson's Victim Treatment model. The subjects have made progress towards attaining Larson's goals. In addition, the answers to the qualitative section described a sense of client satisfaction with the structure of the group. Thus, based on the data found, the Victim treatment model appears to be working well for the specific group in the study.

Though the tool, the questionnaire, is certainly in its most primary form in terms of being a viable resource for researchers or clinicians who want to test the effectiveness of their work, the findings did point to the potential of an instrument like this. Using a Likert scale along with open-ended questions provided specific measurable answers and gave the subjects room to add what they felt was left out of the first section. While the ethical challenges of research with this population are great, and the technical challenge of working with psychological content are great, the results of this study testify to the plausibility of its usefulness. More studies with larger samples will be needed to determine how to upgrade the validity and reliability of evaluations for long-term incest survivor groups, such as the one presented here.

# Chapter V: Conclusion Recommendations and Concluding Remarks.

## Conclusion

The literature indicates that treatment for incest survivors will continue to be an area for growth within the fields of Psychology and Social Work. Already, knowledge about the extent of incest, the causes and its effects have increased dramatically since it first became public knowledge in the early 1970's (Larson & Maddock, 1995). Today there are several theoretical perspectives: Developmental, Post Traumatic Stress, the Feminist Perspective and Family Systems Theory, that both practitioners and the public use to understand incest. These theories have also contributed greatly to the way practitioners are structuring treatment for survivors. There is contention over which approach is better, particularly amongst those who advocate for short-term incest groups and those who believe in long-term groups (Blake-White & Kline, 1985; Bonney, Randall & Cleveland, 1986; Coker, 1990; Follette, Niemeyer & Alexander, 1991; Ganzerian & Buchele, 1986 & 1987; Larson & Maddock, 1995). In any case, we as professionals are beginning to become more aware of the complexities of incest, its insidious affect, and the great need for incest treatment. Groups have consistently been found to be helpful for incest survivors (Steinberg & Buttenheim, 1993).

The Victim treatment model offered by Noel Larson is an exciting departure from many of the groups that are available today. Incest

survivors have long-term effects (Courtois, 1993). Larson's (1985) Functional and Structural Systems perspective points out that being a victim of incest is much more than a traumatic event. It is a way of being taught how to interact with the world. Victims' of incest will continue to be victimized and/ or to victimize others unless they challenge old interactional patterns and learn new ones. Survivors of incest have to be very conscious of where they came from, who they want to be, and where they are heading. This is a large task and both Larson's Typology (1989) and her Victim Treatment model provide some structure for the kind of deep work she believes incest survivors need to do.

The need for formal evaluations of long-term treatment in today's politically conservative environment is great. Many third party payers are not in favor of long-term treatment strategies, particularly those that are more focused on the client's growth process rather than specific measurable outcomes. Thus, the attempt of this study to define precise long-term symptoms of incest survivors in the form of attitudes and behaviors was timely and ambitious.

## Recommendations.

I recommend a few topical changes for the sake of validity before this instrument is re-used. To begin, each of the questions used to measure the goals of the model need to be equal in number to each other. The Victim and Perpetrator questions, however, only need to be equal in number to each other as they are not comparable with the other goals. The qualitative questions should also be comparable in format and formed

in the positive, "What could be improved upon?", rather than the negative, "What is not helpful?" Question number 54 needs to be re-worded.

In terms of feedback that would aid in the fit between the group members in study and the structure of their group, I would largely suggest that the leaders continue to work with the model as they have been. They should also congratulate themselves. The findings suggest their leadership style has been helpful to clients and integral to their satisfaction. One concern was presented about the group dynamics. Some of the data implied that tension built up in the group and expressed frustration with having to wait to discuss the misunderstandings. Perhaps group members should be allowed to process issues about group dynamics as they are experienced in the group If guidelines are provided for this kind of confrontation, it may be possible for it to be done in a respectful and affective manner. In addition, this change may increase the sense of internal locus-of-control group members feel they have in the group.

I also recommend the leaders facilitate some discussion in the group on the topic areas of: 1) intergenerational-boundaries, particularly, care-taking, 2) Intra-psychic-boundaries, like, rigid self-perfectionism, 3) shame, 4) self-destructive behaviors, and 5) fears of abandonment. These areas were presented in the Discussion section as possible problem areas for the subjects.

In addition, this study showed the difficulty of presenting the subjects with the possible risks associated with research related to incest in a way that is not unrealistically alarming. I recommend that more research be undertaken, perhaps through secondary sources, that brings a greater understanding to researchers and ethical committees about what triggers incest flashbacks. More information of the risks research on incest

presents would provide more guidelines for research, and prevent the avoidance of doing research on incest treatment models due to fear.

To improve the reliability and validity of the instrument I have several recomendations. First, providing a pre and a post test should be used instead of a retrospective baseline. Time constraints provided the need to rely on the memory of the subjects. Thus, I also recommend the next researcher allow for nine or more months between the pre and post test. In addition, controlling for the lengths of time subjects were members of the group would make the subjects' experiences more comparable and would lead to more discoveries about how impactful the group is. For example, is length of time a predicting factor for the degree of change in subjects or, is degree of change based more heavily on other variables like a subject's personality type? Finally, to repeat myself, more pilot-testing of the instrument presented here is also recommended. More testing could result in refining the questions to better match the perceptions of the population, and to more objectively define the concepts being measured. This would greatly strengthen the validity and reliability of this survey.

## Concluding Remarks

Overall, I feel this was a study well worth the effort. I believe this evaluation tool could prove to be quite useful for practitioners as a client survey. I also believe, one day this questionnaire or one like it could be part of a wider program evaluation. However, that reality will depend on the willingness of administrators, practitioners and social work researchers

to tend to the conscientious and patient work of social science research. I would like to extend my gratitude to those women who took the risk of acting as subjects in this study. Without their willingness to share their experience and to trust their anonymity would not be violated, this study could not have occurred. In light of the past violation of trust incest survivors have experienced, this was a courageous act, an act that was also altruistic because their data could one day lead to a tool which could validate the effectiveness of long-term process oriented, incest survivor groups. I also would like to thank Becky Tovar, the group leader, for her commitment and flexibility while helping to administer and create this study. In addition, I would like to thank Noel Larson for allowing me to evaluate her Victim Treatment model and for her help in this study.

# Evaluation of a Group Treatment Model for Adult, Female Incest Survivors.

## Consent Form

You are invited to be in a research study on the effectiveness of the group treatment model by Noel Larson for adult, female, incest survivors. You were selected as a possible participant because you are a member of a group that is using this model. In addition, this study will measure the effectiveness of the group process in you group. We are asking each member of this group to participate in this study. Please read this form and ask any questions you may have before agreeing to be in the study.

Background information:
This study is being conducted by Kristen Atmore as part of her Master's Thesis. Kristen Attends the Master of Social Work program at Augsburg College.

Procedures:

If you agree to be in this study, we would ask you to fill out the questionnaire that will be handed to you on Thursday, May 25th after our group. The questionnaire is to be filled out, put into the envelope which will be provided and put into the mailbox out side of the building. It will be mailed directly to the researcher, Kristen Atmore. It should take you no more than 45 minutes to fill the questionnaire out. If you do not have time to fill out the questionnaire after the group but would like to, you can take it home with you and mail it from a different mailbox. However, the researcher asks that they be mailed in by Thursday, June 1st. Do not put your name anywhere on the questionnaire.

Risks and Benefits of Being in the Study:

The study has several risks. First, though this questionnaire does not contain any questions that refer directly to your past sexual abuse, it is possible it could cause you to think about your past abuse. The questionnaire focuses on the symptoms caused by sexual abuse such as, compulsive shopping or low self-esteem. Thus, if asking about

your symptoms triggers abuse memories this questionnaire could trigger abuse memories.

Secondly, if discussing the symptoms caused by past sexual abuse is painful for you, this questionnaire could be painful for you.

Lastly, this questionnaire measures the amount of change in your attitudes and behavior since you joined this treatment group. Thus, there is a danger that you would judge yourself negatively by thinking that you have not made enough progress in reducing symptoms since you joined the group. However, it is crucial that you know, neither the researcher nor the group leaders have a preconceived notion about what is a "good" amount of change or what is a "bad" amount of change. In fact, sometimes an increase in symptomatic behavior is seen as progressive. This can be a sign that one is working hard to change a pattern. Thus, there is no "good" or "bad". This questionnaire is designed to see if the group model is effective, not the group members.

The benefit to participating in this study is the chance to offer feedback about the group. Your feedback could result in improvements in the group's structure or process in order to better fit the needs of group members.

Confidentiality:

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be kept in a locked file; only the researcher will have access to the records. In addition, the group leaders will not be able to look at the questionnaires. After you fill out the questionnaire, you will mail it directly to the researcher, Kristen Atmore. A stamped and addressed envelop will be provided with the questionnaires. There will be no names on any of the questionnaires. The direct researcher will not see or talk to any of the group members without their prior permission. The questionnaires will be shredded and destroyed on June 30th.

Voluntary Nature:

Your decision whether or not to participate will not affect your current or future relationship with: Augsburg College, their department of Social Work, Family and Children's Services or your group leaders. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contacts and Questions:

The name of the researcher conducting this study is Kristen Atmore. If you have any questions regarding the study, you may contact her at 1856 Selby Avenue, St. Paul, MN. 55401. Phone: (612) 644-3772. You may also contact her research advisor Maria Brown: (612) 330-1771.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and received answers. I consent to participate in the study.

Signature Date

Signature of investigator Date

appendix-b

# Female Victim Typology

Noel R. Larson, Ph. D., Lcp

| | *V* | *Vp* | *25-50% Non V/P* | *V/p* | *Pv* |
|---|---|---|---|---|---|
| | Decompensated | Classic | Overachelver | Dissociative | Perpetrator |
| Victim | 100% V | V 80% | V 30-70% | V 50% | V 20% |
| Perpetrator | 0% P | P 20% | P 30-70% | P 50% | P 80% |
| DX | Schizophrenic, Schizo-affective Obsessive-Compulsive. | Hystroid, Bi-polar, PTSD Depressed, Dependent Personality. | Adjustment Reactions, Depressive Episodes. | Borderline, Mulliple, Narcissistic. | Conduct Disorder Anti-social, Aggressive. |
| Defenses | Collapsed, Suicidal, hopeless High death risk. | Highly Symtomatic, can Perp. as needed Medium death risk. | Encapsulate V & P, Externally functional, High risk for decomp. if non P/V part too small. | Many appear functional. on exterior, hollow center, manipulation/splitting. | Rigid defense structure, Denial central. Heavy defenses protect little girl. |
| Level of Regression | Sever/sometimes infancy. | Periods of regression, "open-sore" primary. | None externally, except in episodes. | Old/young Flips. | No neediness or pain. |
| Denial | Unable to deny. | Some Denial. | Heavy denial/ no denial. | Heavy denial/ no denial. | Power primary. Denial primary. |
| Rigididty of Pattern | Usually transitional. | Very stable. | Mostly stable. | Flips but stable. | Very Stable. |
| Emotional Connections | Disconnected. | Overinvolved. | Sociall connected, emotionally disconnected | Overinvolved. Instant intimacy. | Disconnected. |
| Family Role | Varies. | Crazy one. | Star | Special one. | Most Loyal to family of origin. |
| Life Postion | All versions. | Marginally employed. | Success often married with little intimacy. | Mixed success. Sequential marriages. | Marginally employed. Sequential marriages. |
| Credibility | Little or none. | Sometimes Credible. | Credible. | Mostly credible. | Very credible. |

Questionnaire

1. Before you joined this group, how often was the following statement true: "I shared my personal pain with people whom I was well acquainted." ?

--1----------2----------3----------4----------5---
never hardly ever sometimes usually always

2. Before you began this group, how often was the following statement true: " I had people in my life, outside of my family, that helped me to feel good about myself." ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

3. Before you began this group how often was the following statement true: " If someone I needed to talk to was busy, I had at least two other people with whom I could talk." ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

4. Before you joined this group, how often was the following statement true: "I would get angry if a friend told me she was too tired to help me with my problems." ?

--1----------2----------3----------4----------5---
never hardly ever sometimes usually always

5. Before you joined this group, how often was the following statement true: " If I was feeling exhausted, I would tell my friends I could not help them with their problems at that time." ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

6. Before you began this group, how often was the following statement true: " When I was with my friends, I usually felt the same way they did." ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

7. Before you began this group, how often was the following statement true: " I worried about losing my partner and/or close friends. " ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

8. Before you began this group, how often was the following statement true: " I found myself thinking differently than others."?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

9. Before you joined this group, how often was the following statement true: " I consciously made choices about how I wanted to respond to people who had hurt my feelings." ?

----1----------2----------3----------4----------5----
never hardly ever sometimes usually always

10. Before I joined this group, how often was the following statement true: "If I expressed my feelings and beliefs and got nothing but strange looks in response, I often thought to myself, 'I must be a really weird person.' " ?

----1----------2----------3----------4----------5----

never hardly ever sometimes usually always

11. Before I joined this group, how often was the following statement true: " I believed I was an adequate, capable, good and successful person." ?

---1----------2----------3----------4----------5---

never hardly ever sometimes usually always

12. Before I joined this group, how often was the following statement true: " I would engage in one or more of the following behaviors, at least, once every two weeks; overeating to the point of feeling sick, throwing up after a meal, skipping two meals in a row, spending money I did not have in my budget, having sex with casual acquaintances, cutting my skin, getting drunk or high, and/or shoplifting." ?

----1----------2----------3----------4----------5---

never hardly ever sometimes usually always

13. Before I joined this group, how often was the following statement true: "I feel like my relationships consist of equal amounts of listening and talking and of giving and receiving." ?

----1----------2----------3----------4----------5----

never hardly ever sometimes usually always

14. Before you joined this group, how often was the following statement true: " I often feel guilty for the littlest mistakes." ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

15. Before you joined this group, how often was the following statement true: "If I do not agree with someone, I usually think their ideas are pretty stupid and definitely wrong." ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

16. Before I began this group, how often was the following statement true: " When I am having a bad day, I will get upset at myself if, I cannot snap out of it. " ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

17. Before you began this group, how often was the following statement true: " If I am having a bad day, I usually snap at someone else before the day is done." ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

18. Before you began this group, how often was the following statement true: " I am the kind of friend who would carry your pain for you, if that would make you feel better. " ?

-1----------2----------3----------4----------5----

never hardly ever sometimes usually always

19. Before you began this group, how often was the following statement true: "A lot of people whom I am close to have accused me of not being a good listener or said that I do not try to understand them."

--1----------2----------3----------4----------5----

never hardly ever sometimes usually always

20. Before you began this group, how often was the following statement true: " It is rare for me to act in a way that I know makes others angry." ?

-------1----------2----------3----------4----------5-----

never hardly ever sometimes usually always

21. Before you joined this group, how often was the following statement true: " I plan and make decisions about my future." ?

----1----------2----------3----------4----------5----

never hardly ever sometimes usually always

22. Before you joined this group, how often was the following statement true: " I pressure people to tell me personal information even when I know that is not what they want to do." ?

----1----------2----------3----------4----------5----
never hardly ever sometimes usually always

23. Before you began this group, how often was the following statement true: " I have a hard time guessing what people want from me so, I just act on what I know I want out of the relationship.

-------1----------2----------3----------4----------5-----
never hardly ever sometimes usually always

24. Now that you have been in this group for a while, how often is the following statement true: "I share my personal pain with people whom I am well acquainted." ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

25. Now that you have been in this group a while, how often is the following statement true: " I have people in my life, outside of my family, that help me to feel good about myself."?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

26. Now that you have been in this group for a while, how often is the following statement true: " If someone I need to talk to is busy, I have at least two other people with whom I can talk." ? 7

--1----------2----------3----------4----------5----

never hardly ever sometimes usually always

27. Now that you have been in this group for a while, how often is the following statement true: "I get angry when a friend tells me she is too tired to help me with my problems. " ?

--1----------2----------3----------4----------5----

never hardly ever sometimes usually always

28. Now that you have been in this group a while, how often is the following statement true: "If I am exhausted, I tell my friends I cannot help them with their problems at this time." ?

--1----------2----------3----------4----------5----

never hardly ever sometimes usually always

29. Now that you have been in this group for a while, how often is the following statement true: " When I am with my friends, I usually feel the same way they do." ?

--1----------2----------3----------4----------5----

never hardly ever sometimes usually always

30. Now that you have been in this group for a while, how often is the following statement true: " I worry about losing my partner and/or close friends. " ? 8

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

31. Now that you have been in this group for a while, how often is the following statement true: " I find myself thinking differently than others" ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

32. Now that you have been in this group a while, how often is the following statement true: " I consciously make choices about how I want to respond to someone who hurts my feelings." ?

----1----------2----------3----------4----------5----
never hardly ever sometimes usually always

33. Now that I have been in this group for a while, how often was the following statement true: " If I express my feelings and beliefs and get nothing but strange looks in response, I often think to myself, 'I must be a really weird person.' " ?

----1----------2----------3----------4----------5----
never hardly ever sometimes usually always

34. Now that I have been in this group for a while, how often is the following statement true: I believe I am an adequate, capable, good and successful person." ?

----1----------2----------3----------4----------5---
never hardly ever sometimes usually always

35. Now that I have been in this group for a while, how often is the following statement true: " I engage in one or more of the following behaviors at least once every two weeks; overeating to the point of feeling sick, throwing up after a meal, spending money I do not have in my budget, having sex with casual acquaintances, cutting my skin, getting drunk or high, and/or shoplifting. " ? 9

----1----------2----------3----------4----------5---
never hardly ever sometimes usually always

36. Now that I have been in this group for a while, how often is the following statement true: " I feel like my relationships consist of equal amounts of listening and talking and of giving and receiving." ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

37. Now that you have been in this group for a while, how often is the following statement true: " I often feel guilty for the littlest mistakes." ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

38. Now that you have been in this group for a while, how often is the following statement true: "If I do not agree with someone, I usually think their ideas are pretty stupid and definitely wrong." ?

--1----------2----------3----------4----------5----
never hardly ever sometimes usually always

39. Now that you have been in this group for a while, how often is the following statement true: " When I am having a bad day, I will get upset at myself if, I cannot snap out of it. " ? 10

--1----------2----------3----------4----------5----

never hardly ever sometimes usually always

40. Now that you have been in this group for a while, how often is the following statement true: " If I am having a bad day, I usually snap at someone else before the day is done." ?

--1----------2----------3----------4----------5----

never hardly ever sometimes usually always

41. Now that I have been in this group for a while, how often is the following statement true: " I am the kind of friend who would carry your pain for you, if that would make you feel better. " ?

--1----------2----------3----------4----------5----

never hardly ever sometimes usually always

42. Now that you have en in this group for a while, how often was the following statement true: "A lot of people whom I am close to have accused me of not being a good listener or said that I do not try to understand them."

--1----------2----------3----------4----------5----

never hardly ever sometimes usually always

43. Now that you have been in this group for a while, how often is following statement true: " It is rare for me to act in a way that I know makes others angry." ?

-------1----------2----------3----------4----------5-----
never hardly ever sometimes usually always

44. Now that you have been in this group for a while, how often is the following statement true: "I plan and make decisions about the future."

----1----------2----------3----------4----------5----
never hardly ever sometimes usually always

45. Now that you have been in this group for a while, how often is the following statement true: " I pressure people to tell me personal information even when I know that is not what they want to do." ?

-------1----------2----------3----------4----------5-----
never hardly ever sometimes usually always

46. Now that you have been in this group for a while, how often is the following statement true: " I have a hard time guessing what people want from me so, I just act on what I know I want out of the relationship.

-------1----------2----------3----------4----------5-----
never hardly ever sometimes usually always

**Please continue on to the next page.**

**This portion of the questionnaire may be typed or written at home in way that disguises your own handwriting.**

47. How long have you been in this group?

48. Please write down any other ways you feel you have changed as a result of being involved in this group.

49. Were there any group rules that you felt were helpful? How were they helpful?

50. How could the group rules be improved upon? Please describe.

51. At this point in time, what do you like about the way group members interact with each other? (This includes both group therapy clients and group leaders.)



52. In what ways do you think the group interactions could be improved upon?

53. What do the group leaders do that is helpful?



54. What do the group leaders do that is not helpful?

55 What did you initially come to this group for and are you getting it?

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