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A critical overview of intrafamilial sexual abuse: Recognition of symptomology and the efficacy of group treatment

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Abstract

This paper provides the reader with knowledge of symptomology and a profile of the effects of intrafamilial sexual abuse on survivors of this devastating experience. This work provides a brief overview of group therapy as an effective remedial treatment for this population. This type of abuse, considered taboo in American society, is often kept secret. However, it is a highly prevalent social problem, affecting at least one third of the population (McFarlane, Waterman, Conerly, Damon, Durfee, & Long, 1986). Considering the prevalence and secrecy of this phenomenon, it is extremely important that mental health professionals are able to identify possible indicators of this abuse and to bring it to the surface in a caring, gentle, and therapeutic manner.

A CRITICAL OVERVIEW OF INTRAFAMILIAL SEXUAL ABUSE:
RECOGNITION OF SYMPTOMOLOGY AND THE EFFICACY OF GROUP
TREATMENT

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Laurie J. Belz

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Introduction

This paper provides the reader with knowledge of symptomology and a profile of the effects of intrafamilial sexual abuse on survivors of this devastating experience. This work provides a brief overview of group therapy as an effective remedial treatment for this population. This type of abuse, considered taboo in American society, is often kept secret. However, it is a highly prevalent social problem, affecting at least one third of the population (McFarlane, Waterman, Conerly, Damon, Durfee, & Long, 1986). Considering the prevalence and secrecy of this phenomenon, it is extremely important that mental health professionals are able to identify possible indicators of this abuse and to bring it to the surface in a caring, gentle, and therapeutic manner.

Definitions

In order to have the ability to recognize and treat child sexual abuse, one must first understand what exactly child sexual abuse consists of. Child sexual abuse has been loosely defined as the use of a child for the sexual gratification of an adult (Tower, 1993); or any sexual activity, overt or covert, between a child and an adult or another child who is significantly older, and the younger child's participation is gained through seduction or coercion (Ratikan, 1992). This sexual activity can take a variety of forms, including, but not limited to masturbation, fondling, oral copulation, sodomy, and intercourse (Knight, 1990; MacFarlane et al., 1986). Finkelhor (as cited in Tower, 1993) stated that American society is based on free will and consent. However, in order to consent, one must have knowledge and authority. Since children possess neither in regard to sexuality,

they cannot consent. Therefore, these acts against them are considered criminal.

Authors of the Federal Child Abuse Prevention and Treatment Act of 1974 provided the first legal definition of child sexual abuse (MacLennan, 1993). These officials defined child sexual abuse as the obscene or pornographic photographing, filming, or depicting of a child for commercial purposes. The Act also includes the rape, molestation, incest, prostitution, or other such forms of sexual exploitation of a child, where the child's health or welfare is harmed or threatened (Erickson, McEroy, & Colucci, 1984). MacLennan (1993) defined incest as the type of child sexual abuse which occurs when the perpetrator is a member of the family. This can include parents, step-parents, paramours, older siblings, older cousins, uncles, aunts, and grandparents. Barry (1984) stated that, although laws regarding incest vary from state to state, it is commonly defined as sexual exploitation between persons so closely related that marriage is prohibited by law. Tower (1993) defined a child rape as an intrusion of any part of the perpetrator's body into any orifice of the child's body. MacFarlane et al. (1986) divided sexual abuse into three categories: (a) non-touching acts, (b) non-violent touching acts, and (c) violent touching acts.

United States government officials have developed a very specific protocol concerning child sexual abuse. Knowledge of the abuse requires that mandatory reporters notify their local child abuse registries for investigative purposes. Officials at these registries then refer the cases to the appropriate social and legal systems (MacFarlane et

al., 1986). However, in a pluralistic culture such as this, it is important that these officials take socio-cultural considerations into account. Various socio-cultural groups interpret, express, and incorporate standards of appropriate sexuality in a wide variety of ways (MacFarlane, 1986). Sexual abuse tends to differ from physical abuse in several ways. First, sexual abuse perpetrators tend to premeditate acts, and second, there are no social norms that call for sexual relations between a parent and a child (Erickson et al., 1984).

Prevalence

The definitions utilized will affect researchers' statistics regarding child sexual abuse. However, regardless of the definitions used, prevalence is high. This section demonstrates just how commonly this type of abuse occurs. Tower (1993) cited the child protection movement and the feminist movement as crucial in bringing child sexual abuse to the public's awareness. Because Americans have traditionally perceived intrafamilial sexual relations to be unacceptable, the nation's people have felt uncomfortable with the issue and have kept it in the closet (Barry, 1984). With the women's movement and "the sexual liberation of our society, a rather horrifying skeleton has crept out of the closet" (Ratican, 1992, p. 33). It seems that sexual abuse is a common and widespread trauma (Knight, 1990; Tower, 1993), far more prevalent than previously thought (Ratican, 1992). In light of the social stigma attached to the concept of child sexual abuse and the coercion and secrecy attached to the crime, it is impossible for one to determine with any degree of certainty the prevalence of this abuse (Erickson et al., 1984). Experts have generally agreed that statistics are vastly underrepresented (Erickson et al.,

1984; Tschirhart-Sanford, 1980).

MacFarlane et al. (1986) estimated that unreported incidents of child abuse may be as high as five to ten times that of the reported incidence. However, statistics regarding reported incidence vary as well. Barry (1984) and MacFarlane et al. (1986) reported that between 60,000 and 100,000 children are sexually abused annually. Although males and females are both victimized, Fowler and Wagner (1993) claimed that it appears as though females are at greater risk. Due to socialization, however, it is possible that males are even further underrepresented than females. Statistics regarding female victims vary. Researchers estimate that between 19 and 45 per cent of all females have been sexually abused before adulthood (Haskett, Nowlan, Hutchenson, & Whitworth, 1991; Mennen, 1992; Ratican, 1992). Forty-eight per cent of these females are currently in their teens (Sgroi, 1982), which makes the development of effective remedial treatment for adolescent girls urgent.

From a familial perspective, it is important to note that between 10 and 14 per cent of all American families are affected by some type of sexual abuse (Barry, 1984; MacFarlane et al., 1986). Barry (1984) also noted that sexual abuse is most prevalent in middle class families. Between 75 and 85 per cent of perpetrators are family, relatives, friends, or neighbors (Barry, 1984; Erickson et al., 1986; MacFarlane et al., 1986; MacLennan, 1993). Because sexual abuse often occurs within families, this is yet another reason that this crime often goes unreported (Barry, 1983).

Brother-sister incest is thought to be the most common form of incest, but is greatly

under-reported (MacFarlane, 1986). Erickson et al. (1984) and MacFarlane et al. (1986) cited father-daughter incest to be the most frequently reported, accounting for 70 to 80 per cent of all known cases. MacFarlane (1986) suggested that the rarest form of sexual abuse is mother-daughter incest. Perpetrators of sexual abuse are generally male, and their victims are most often female (Fowler & Wagner, 1993). Child sexual abuse is a highly prevalent social problem, and it appears to be one of the greatest traumas a child can experience.

Severity of Traumatic Effects

The severity of the trauma of child sexual abuse varies greatly and is dependent on a number of factors (Folette, Alexander, & Folette, 1991). The relationship of the perpetrator to the victim may be one of the most important factors in determining the severity of symptomology. The strength of the loving and trusting bond positively correlates with the severity of symptoms (MacLennan, 1993; Tschirhart-Sanford, 1980).

The type of sexual contact is a key factor. Characteristics of sexual abuse are more frequently associated with more severe forms of molestation, such as penetration, sodomy, and other physical injuries. If a child perceives lighter forms of abuse as "play," it seems to be less damaging (MacLennan, 1993; Tschirhart-Sanford, 1980). Folette et al. (1991) and Ratican (1992) both noted that the most severe forms of trauma are the presence of genital contact and the use of force by a father figure.

The duration of the abuse is a third factor. However, the literature is inconsistent

in this area. MacLennan (1993) and Tschirhart-Sanford (1980) both stated that children who deal with the abuse on an ongoing basis are more affected, while Folette et al. (1991) stated that shorter periods of abuse were associated with poorer adjustment.

Age and developmental level are other factors affecting adjustment (MacLennan, 1993). Tschirhart-Sanford (1980) claimed that if a naive child does not comprehend the abuse, he or she will not be as concerned as those children with clearer conceptions of right and wrong. Brown and Finkelhor (as cited in Folette et al., 1991) further stated that sexual abuse may have developmentally specific effects that emerge at different ages following the abuse, such as puberty.

Reactions of the parents or other significant adults at the time of the disclosure can have a profound effect on the child as well (Barry, 1984; MacLennan, 1993; Tschirhart-Sanford, 1980). Whether the child is believed, supported, reassured, and protected is crucial in how that child responds. Memmen (1992) stated that there is no research to show that severity of abuse in childhood is directly correlated to the severity of symptomology found in adulthood. This author claimed this to be more strongly influenced by support from significant adults, other types of trauma and abuse, and presence of adaptive capacities. More generally, Folette (1991) found that maladjustment and lower education levels were associated with. However, poor adjustment levels were not associated with higher levels of depression and symptomology. Overall, researchers supported the belief that sexual abuse can have a profound effect on children and that it is extremely important to understand the severity according to the survivor's perspective.

Profile of a Sexual Abuse Survivor

Sexual abuse can and does happen regardless of age, sex, class, and race.

However, some authors have developed composites of a "typical" sexual abuse survivor. The "typical" survivor is generally a female, between the ages of eight and twelve, who is abused over a period of time by a relative or close acquaintance (Erickson et al., 1984; Tower, 1993). Incest survivors often express awe of adults. They have been taught to submit to authority. They generally love and trust their fathers, and they are often attention-seeking. Survivors often express curiosity about sexuality and sexual sensations. These children are often afraid to say "no" to the abuse, for fear of retaliation, and they may feel that if they submit, it will not happen to a younger sibling (Tower, 1993). Factors that put children at risk include the following: social isolation, a physically or emotionally absent mother, disabilities, or being the eldest daughter (Tower, 1993). Male sexual abuse survivors are generally victimized at younger ages and for shorter lengths of time than girls. Male survivors' perpetrators are more likely to be outside the family (Tower, 1993).

Behavioral changes typically follow sexual abuse. A child may lose his or her appetite, experience changes in sleeping patterns, or have nightmares. Unprovoked crying spells, bed wetting, and refusing to attend school are common behaviors. The child may exhibit unexplained fears of strange men or places, or he or she may exhibit fear of a particular person or situation. A survivor often fears playing alone, clings to a significant adult, and takes excessive baths (Tschirhart-Sanford, 1980).

Hazzard, King, and Webb (1986) cited commonly used coping mechanisms to include explanation, minimization, suppression, dramatization, and action. Russell (as cited in Ratican, 1992) found that female sexual abuse survivors had significantly greater numbers of negative experiences, such as repeated victimization, marital and familial instability, and lower socio-economic status. Sexual abuse generally has a significantly negative and pervasive psychological impact on its victims (Ratican, 1992). The literature outlines a wide array of affective, behavioral, cognitive, and physical symptoms suffered by sexually abused children (Deblinger, McLeer, & Henry, 1990).

Symptomology

Survivors of sexual abuse are often severely impacted by their childhood experiences (Roesler, Czech, Camp, & Jenny, 1992). They come to treatment presenting with a wide array of symptomology. Due to the variety of symptoms, a therapist must be aware of this diversity in order to diagnose and treat a client appropriately. This author has divided symptoms into the following five main categories: sexual, physical, affective, cognitive/relational, and clinical diagnoses.

Sexual Behavior

The first classification is the effects on sexual behavior. A sexual abuse survivor experiences traumatic sexualization. The individual's sexuality is shaped in a developmentally inappropriate and interpersonally dysfunctional manner. This can cause a number of results, including premature erotization and linking sexuality with guilt and shame (Patten, Gatz, Jones, & Thomas, 1989). Sexual abuse survivors may experience

characteristics that are related to sexual behavior, including inhibition (MacFarlane et al., 1986) and frigidity (Barry, 1984). The survivor may become confused about his or her sexuality and sexual orientation (Barry, 1984; MacFarlane et al., 1986). A preoccupation with sex and sexualized behavior beyond a child's developmental years is often seen (Kiser, Millsap, & Heston, 1992; Merrick, Allen, & Crase, 1994). Promiscuity and prostitution are common in older survivors (Fallon & Coffman, 1991). The most frequently experienced symptom related to sexual behavior is that of various sexual dysfunctions (Jackson, 1994; Jacobs, Harvill, & Masson, 1994). Jacobs et al. (1994) reported that between 56 and 87 per cent of sexual abuse victims have some type of sexual adjustment problems.

Physical Symptoms

A second area of concern is in the physical arena. Genital injuries, bleeding and bruising are among the most obvious. Pregnancy and sexually transmitted diseases are also of concern. MacFarlane et al. (1986) noted changes in sleeping patterns, especially increased nightmares. Fallon et al. (1991) cited changes in eating patterns to be common, often manifesting in eating disorders, especially bulimia. A final form of physical symptoms survivors experience include psychosomatic pain and illness. These psychosomatic symptoms most commonly take the form of headaches, backaches, pelvic pains, gastrointestinal problems, enuresis, tics, and other stress-related illnesses (MacFarlane et al., 1986; Ratican, 1992).

Affective Symptoms

A third and more abstract classification of symptoms falls under affective characteristics. Common feelings that a survivor often experiences include the following: rejection, feeling unloved and inadequate (Barry, 1984), confusion (Ratican, 1992), irritation, sadness, isolation, mistrust, and abandonment (Kiser et al., 1992), and betrayal (MacFarlane, 1986). The survivor discovers that someone he or she was dependent on has harmed them or failed to protect them (Patten et al., 1989). Emptiness and powerlessness are also two commonly felt emotions (Fallon, 1991). Feeling powerless is especially difficult for an adolescent who is struggling developmentally with issues of independence, and for a male, whose victim status undermines his male identity as strong and aggressive (Patten et al., 1989). A survivor may become passive or emotionally constricted, and anxiety is a very common response (Hazzard et al., 1986). Anxiety can be so severe that panic attacks are experienced by a survivor. Extreme fears are also common and may develop into phobias (Mennen, 1992; Merrick et al., 1994). Depression is one of the most common affective results of sexual abuse (Wagner, Kilcrease-Fleming, Fowler, & Kazelskis, 1993).

Guilt and shame are also undeniable effects of child sexual abuse (Barry, 1984; Hazzard et al., 1986). Although most sexual abuse survivors experience these feelings, not all do. Some victims have been brought up with the belief that this is normal (Barry, 1984). For those survivors experiencing guilt and shame, this is often the result of the stigmatization or negative connotations that are communicated to the survivor and

incorporated into self image. The result of sexual abuse is often "damaged goods" syndrome (Patten et al., 1989). Characteristic of "damaged goods" syndrome, victims tend to blame themselves for the abuse, assuming that they were bad or wrong. This is often less painful, initially, for the child, than to acknowledge that a loved and trusted abuser is bad and hurtful. This self-blame is often reinforced by the abuser, the non-offending parent, relatives, and society. This self-blame can then lead to guilt. Survivors may become perfectionists by overcompensating for perceived defects, often taking responsibility for things that are not their fault (Ratican, 1992).

Guilt and shame often provide fuel for many characteristics of this next category symptomology related to behavior and acting out. Often survivors experiencing guilt and shame punish themselves by engaging in self-destructive behaviors (Ratican, 1992). Survivors often experience anger (Fish & Faynik, 1989) which, when turned inward, can contribute to various forms of self-punishing or self-destructive behaviors. Some self-destructive behaviors commonly observed in survivors of sexual trauma include the following: aggression, antisocial behavior, delinquency, stealing, tantrums, substance abuse, regressive behaviors, allowing themselves to be re-victimized, victims turning perpetrators, runaway or escape behaviors, masochistic orientation, self mutilation, withdrawal, poor social skills and suicidal behaviors (MacFarlane et al., 1986). Other common behavioral outcomes of child sexual abuse include truancy, a drop in grades (MacLennan, 1993), and pseudomaturity (Hazzard et al., 1986). Polarities in behavior patterns within a survivor's lifetime are not uncommon (Ratican, 1992).

Cognitive/Relational Symptoms

Survivors of child sexual abuse may suffer from a variety of symptoms relating to cognitive distortions or relational difficulties. Jackson (1994) claimed that symptomology affecting the mind may take the form of repressed memories, intrusive thoughts, dissociation, splitting or fragmenting of the personality, poor self image, and low self esteem. Flashbacks, hallucinations, and depersonalization are also common (Ratican, 1992), as are short attention span and problems concentrating (MacLennan, 1993), and obsessive-compulsive thoughts (Fallon & Coffinan, 1991). Often, survivors suffer from a "helpless victim" mentality, which increases a survivor's likelihood of being revictimized in other situations (Kiser et al., 1992). A survivor's relationships are often affected by marriage problems, and poor attachments are common (MacLennan, 1993), especially with the victim's mother (Barry, 1984).

Clinical Diagnoses

Research varies regarding the prevalence of clinical diagnoses, related to sexual abuse. While MacFarlane et al. (1986) stated that clinical severity is the exception, Jackson (1994) and Kiser et al. (1992) reported that about one third of sexual abuse victims develop clinically diagnostic symptoms. High percentages of persons with histories of sexual abuse have been linked to the following clinical diagnoses: psychotic, dissociative (formerly known as multiple personality disorder), agoraphobia, neurosis, and borderline personality disorder (MacFarlane, 1986); anxiety disorders,

obsessive-compulsive disorder, and passive-aggressive disorder (Ratican, 1992), eating disorders (Fallon, 1991), post-traumatic stress disorder (Deblinger, 1990), and depression (Roesler, 1992). Memmen (1992) reported that between 51 and 86 per cent of people with borderline personality disorder have histories of sexual abuse. It is evident from discussion of the previous categories, that sexual abuse may be linked to a number of other clinical disorders, in addition to these listed. The high prevalence of symptomology found in survivors stresses the need for mental health professionals to be aware of the variety of symptoms in which sexual abuse can manifest itself and to consider sexual abuse as a possibility when developing a treatment plan.

Treatment of Sexual Abuse

When victims of sexual abuse do not receive treatment, it affects not only the victim, but others as well. First, the perpetrator may abuse another child. Second, the non-offending parent is likely to have a great deal of guilt. Finally, and most importantly, if the victim goes untreated, a variety of symptoms aforementioned could occur (Tower, 1993). However, it is possible for a victim of child sexual abuse to grow up to be well adjusted, if it is understood that he or she has not changed into a bad person because of the abuse (Tschirhart-Sanford, 1980).

Most victims can be helped to live well-adjusted lives, despite the emotional scars, with some level of therapeutic intervention (Sgroi, 1982). Prendergast (1994) stated that trained, professional intervention for a minimum of short-term therapy is a requirement. Treatment is provided to sexually traumatized children on the assumption that

this trauma has detrimental effects on the development of these children. Merrick et al. (1994) suggested that trauma and difficulties later in life are connected to child sexual abuse. Immediate treatment can prevent the emergence of some of the predictable destructive and dysfunctional behaviors later in life (Sgroi, 1982). MacFarlane et al. (1986) claimed that it is extremely important to minimize the trauma and disruption in the child's life. Key factors in this process are to keep the child in the family home whenever possible (MacFarlane et al., 1986), and to encourage parental support in helping the child to feel protected and supported (Merrick et al., 1994). In order to provide effective treatment, mental health professionals need to consider the child's perception of the abuse, reactions and resources of the parties involved, and the dynamics of the abuse (Merrick et al., 1994).

In order to deal with the abuse, children develop strategies to survive the assault. These strategies, which help them to survive the situation, become ineffective in other areas of their lives. These survival skills need to be reframed in order to empower the client, focusing treatment on strength and resilience, rather than on pathology (Mennen, 1992). Also, helping survivors of sexual trauma to remember events, process feelings, and to shift responsibility for the abuse from themselves to their perpetrators will often bring some relief to their symptoms (Hopkins, 1995). Doing this will also enable survivors to integrate this into a new sense of self (Mennen, 1992).

It is important to note that survivors of sexual abuse most often seek treatment for symptoms caused by the abuse, rather than the abuse itself. However, if the underlying

sexual abuse is not disclosed and worked through, treatment of the presenting symptoms is generally unsuccessful (Ratican, 1992). When disclosure does occur, the counselor should identify current problems as learned responses that were developed in order to cope with the abuse. Redefining a victim as a survivor and reassuring that he or she is not to blame can be empowering to the client (Ratican, 1992). Roesler et al. (1992) pointed out that therapy never progresses faster than the client determines.

Choosing the appropriate treatment modality is complicated by post-abuse behavioral variations that have been observed among survivors, resulting in the need to determine treatments on an individual basis (Wagner, 1993). Roesler et al. (1992) and Sgroi (1982) reported that the treatment modality of choice is some combination of individual, group, and family treatment. The remainder of this paper focuses specifically on remedial group treatment for sexual abuse survivors. Although both males and females suffer from sexual abuse, females are the predominate victims seeking treatment (Mennen, 1992). Therefore, much of the remainder of this section will be based on literature concerning the treatment of females.

Group Therapy

The group approach or a combination of group and individual therapy is generally considered to be the treatment of choice as remedial treatment for sexual abuse survivors (Corey & Corey, 1992). Group modalities have been one of the most systematically described and researched of any treatment modalities. Group treatment focuses on the individual survivor of the abuse, not on the family (Silovsky et al., 1994). Groups have

been successfully utilized with survivors of various ages, in a variety of settings (Jacobs et al., 1994; Roesler et al., 1992). Tower (1993) found group therapy to be especially helpful with adolescents. Sgroi (1982) also cited group therapy to be the preferred treatment for teen sexual abuse survivors. Lynch, Condon, Newell, and Regan (1990) agreed that groups are appropriate for adolescents, due to developmental level. Groups also effectively decrease feelings of alienation and isolation through sharing with peers in the group setting (Lynch et al., 1990). Group therapy provides opportunities that are not available within the context of individual or family therapy (Hazzard et al., 1986). The aim in group therapy with sexual abuse survivors is to provide a safe and therapeutic environment for victims. Positive role modeling is an important component of group therapy, as well. Other objectives include sharing, recognizing that they are not alone, understanding the impact of their experiences, working through unresolved feelings, and making desired changes (Corey & Corey, 1992). Merrick et al. (1994) stated that group therapy is often the treatment of choice, because it counters the effects of isolation and promotes social interaction, especially in processing issues surrounding the abuse.

Sexual abuse survivors are likely to benefit from either support or therapy groups. Groups give survivors an opportunity to disclose their experiences and discuss their pain with others who have also been victimized. This can be empowering because the feelings regarding the abusive experience are validated and the secrecy surrounding the abuse is put to an end. The chance to speak openly in a supportive and confidential environment helps survivors to gain the courage to work productively in other types of

therapy (Jacobs et al., 1994).

Groups provide a number of primary therapeutic factors. Yalom (as cited in Silovsky & Hembree-Kigin, 1994) stated that instillation of hope, universality, and social learning occur. Groups address issues of isolation and social stigma (Sgroi, 1982; Silovsky, et al., 1994). Members are able to share the fact that they are victims of a universal taboo, which in other settings often contribute to feelings of alienation and guilt (Sgroi, 1982). Therapy and support groups lend themselves to a commonality and a basis for identification (Corey & Corey, 1992). The use of groups can decrease resistance to treatment through mutual self disclosure and positive peer interaction (Silovsky et al., 1994). Groups also give members a place to discuss with others feelings about the abuse without facing immediate self-disclosure (Hazzard et al., 1986; Sgroi, 1982). It allows members to depend on peers for support, encouraging opportunities to relate to others in socially appropriate ways, hence increasing social skills and self worth (Sgroi, 1982). Dependency needs can be met without the intimacy or intensity of individual therapy (Hazzard et al., 1986). Overall, groups tend to encourage and empower their members (Corey & Corey, 1992).

Jacobs et al. (1994) recommended that clients participate in individual counseling prior to the group setting, in order to gain an initial understanding of what has happened. Survivors often deny or rationalize their abuse and feel shameful. Clients are generally better able to benefit from group counseling after they deal with their denial (Jacobs et al., 1994). Jacobs et al. (1994) also recommended continued individual counseling while

attending a group, in order to have a safe person outside the group with whom to process.

Corey and Corey (1992) found that group therapy seems to be the treatment of choice among victims. Support groups offer a number of advantages. Feelings can be vented in a safe environment (Tower, 1993). A safe environment is also conducive to increased optimism, recall of memories, increased feelings of intimacy between group members, and a sense of belonging or mutuality (Knight, 1990). Groups present opportunities for giving and receiving feedback that challenges distorted beliefs (Corey & Corey, 1992); enhancing self esteem; and giving and receiving help, advice, suggestions, comfort, and support (Knight, 1990). Learning about social skills and sexual education are added benefits to groups (Tower, 1993). It is important to note that groups can be used to provide accurate information and an alternative viewpoint regarding sexual relationships as potentially pleasurable, mutual experiences, rather than exploitive (Hazzard et al., 1986). The study of group treatment done by Sgroi (1982) found that it had the following effects on group members: decreases in pseudomaturity and increases in age appropriate activity, increases in self esteem, increases in assertiveness, increases in willingness to seek help from repeated abuse, and increases in ability to express feelings toward perpetrators. Decreases were noted in sexual and intimacy problems.

Pragmatics of Group Treatment

There are a number of logistics to consider when planning a therapy or support group. Hazzard et al. (1986) stated that a therapy group must be held in a safe, neutral and comfortable location. Sessions should be held in the late afternoon or early evening, in

order to minimize work and school disruptions. Sgroi (1982) cited the optimal number of members to be between eight and ten, with two therapists. When forming groups, several decisions need to be made. These include age range, open versus closed format, time frames, assessment, and structure of the sessions.

The first consideration relates to age. Most group leaders take a developmental approach, and age range is limited to between two and four years apart (MacLennan, 1993). Individual maturity should be a primary consideration, in addition to chronological age (Hazzard et al., 1986). MacLennan (1993) recommended that, while younger groups are often of mixed sex, adolescent groups should be made up of only one sex.

Group facilitators must also determine whether the group will be an open or closed group. There are advantages to both. Corey and Corey (1992) and Silovsky et al. (1994) pointed out that closed groups enhance the development of trust. However, Hazzard et al. (1986) and Sgroi (1982) advocated for open groups because of the opportunity for members who are at various points in their recovery to role model for those just beginning the process. In addition, Hazzard et al. (1986) stated that there are advantages to "re-working" issues, which tends to occur more often in open groups.

Time frames are another consideration in the implementation of group therapy. Time is extremely important in the development of trust and the working through of issues and trauma (Corey & Corey, 1992). Groups are commonly time limited, with preselected topics (Silovsky et al., 1994). Knight (1990) agreed that groups should be time limited, because research showed that short-term group treatment is at least as effective as long

term group treatment. Knight (1990) concluded from her review of the research that the most effective treatment would be fifteen weekly sessions at one and one half hours each. However, Corey and Corey (1992) stated that this short term therapy is only the initial therapeutic component. MacLennan (1993) noted a controversy in the literature regarding this issue. Hazzard et al. (1986) supported this by stating that time frames vary from two to six months for brief group therapy to one and one half to two years for long term group therapy. Corey and Corey (1992) stated that groups should run for at least six months, but generally would optimally run from twelve to eighteen months. Maximum therapeutic benefits come between one and one half to two years, according to Sgroi (1982). Most sources agreed that session length should be limited to one and one half hours (Sgroi, 1982).

Another step in the formation of a group is to assess the potential group members for appropriateness. A group facilitator should strive to ensure the best possible combination of members, a combination that will compliment each others strengths and weaknesses. Young, attractive, verbal, intelligent, and successful ("YAVIS") clients have the best prognosis (Fisher, Winne, & Ley, 1993).

The structure of the group sessions themselves are very important. Sessions must include a number of items. A review of the highlights of the members' weeks provides an appropriate place to begin. This easily leads into teaching coping strategies and problem-solving skills on an as needed basis. This ensures that topics discussed will be pertinent to the group members. Refreshments are recommended next. Offering a snack

demonstrates nurturance and encourages socialization among group members. Following refreshments, abuse and relationship issues can be explored through discussion or structured activities (Silovsky et al., 1994).

Treatment Issues in Group Treatment

With logistics in place, clinicians then need to evaluate abuse issues in order to fit the topics to the group members (Silovsky et al., 1994). Issues to be discussed within the group can be predetermined, based on the needs of the individual members of the group. Several sources have cited specific issues to be covered. MacFarlane et al. (1986), Sgroi (1982), and Tower (1993) agreed that there are ten main issues that sexual abuse survivors must deal with during the healing process. These issues include the following: (a) "damaged goods" syndrome, (b) guilt, (c) fear, (d) depression, (e) low self esteem and poor social skills, (f) repressed anger and hostility, (g) impaired ability to trust, (h) role and boundary confusion, (i) pseudomaturity and failure to accomplish developmental tasks, and (j) self mastery and control. MacFarlane, et al. (1986) and Sgroi (1982) both noted that the first five issues listed affect nearly all sexual abuse victims, regardless of the identity of the perpetrator, while the final five issues are more likely to affect intrafamilial sexual abuse victims. Hazzard et al. (1986) divided treatment themes into short and long term tasks. Short term issues to be dealt with included emotional reactions of others, court testimony, and personal emotional reactions. Long term issues included family relations, interpersonal relations, sexuality, self-esteem, and self assertion.

Goals in Group Treatment

Once the group facilitator determines appropriate issues to be covered, he or she develops treatment goals. Groups commonly focus on problem-solving, coping skills, and dealing with issues such as secrecy, trickery, and betrayal (MacLennan, 1993). Knight (1990) described group goals as the following: (a) acknowledging the abuse and associated feelings, (b) decreasing feelings of isolation, and (c) assisting members in deciding on further therapeutic choices. Sgroi (1982) cited ventilation of anger, increasing socialization, preparing for court, and sexual education to be important goals that are amenable to a group setting. MacFarlane et al. (1986) agreed with these and added assertiveness training and natural consequences. As stated before, specific treatment topics should be the result of a pre-treatment evaluation. However, flexibility is required in order to cover these and any other unexpected issues or crisis (Silovsky et al., 1994).

Techniques in Group Treatment

Techniques utilized in the group process will vary, depending on the phase the group is in. General phases of the group process include the following: (a) Weeks 1-4: reaching out, building trust, developing mutuality; (b) Weeks 5-12: the working phase, shifting from the past to the current issues and concerns; and (c) Weeks 13-15: closing and termination (Knight, 1990). Hazzard et al. (1986) suggested that a lot of structure be utilized in the initial phase of group process, in order to decrease anxiety and increase

communication. Trust building activities early in the process encourages this to occur (Silovsky et al.,1994). Icebreakers and group-go-round techniques positively affect the group process in this phase. Individual contracts identify members' strengths and needs, and they may also be helpful in goal definition (Sgroi, 1982). This creates more flexibility in appropriateness of the technique.

Often less structure will be required further into the group process. Younger groups emphasize play therapy, exercises, role playing, games, art, and storytelling (MacLennan, 1993). These techniques, utilized in older groups, encourage fun, provide a distraction from premature intimacy that sometimes threatens the group's development, and aid in diagnostic assessment. Sgroi (1982) found that art therapy can be utilized in different phases of the process, in order to work on specific problem areas, such as body image. Another useful technique is role playing. Many facilitators utilize this technique to help members to prepare for court, practice the expression of feelings, and enact ways of handling abusive situations (Hazzard et al., 1986). Educational techniques, such as sex education, can also be beneficial (Sgroi, 1982). Silovsky et al. (1994) stated the importance of utilizing empirically validated therapeutic procedures whenever possible. Examples of these include the following: relaxation training, cognitive-behavioral therapy for depression and guilt, social skills training for increasing assertiveness and poor peer relations, and sex education to clear misconceptions regarding sexuality.

Group Facilitator

The group facilitator plays a crucial role in the success of a group. First, the group

requires commitment from its therapist(s). Second, the therapist(s) need to be actively involved, and third, the therapist(s) must have the ability to create a high level of energy and flexibility (Sgroi, 1982). A sexual abuse therapy or support group requires therapists who are experienced and comfortable with this issue (Silovsky et al., 1994). It is imperative that leaders have knowledge of issues surrounding incest and sexual abuse. Personal issues must be worked through (Jacobs et al., 1994). A group facilitator's role is to function as facilitator, educator, observer, parental role model, alter ego, and limit setter. There is a need to be firm, warm gentle, understanding, reliable, and able to create a safe environment. A leader must possess knowledge of group process and dynamics, as well as knowledge of incest, child sexual abuse, and incestuous family dynamics (Corey & Corey, 1992). He or she needs to be able to provide a healing and accepting atmosphere.

Jacobs et al. (1994) recommended that the leader work with one member at a time, due to the sensitive nature of the issue. The authors stated that others will learn by watching. Co-therapy is recommended for groups of four or more members. Co-therapy can be extremely advantageous (Silovsky et al., 1994). It allows for shared responsibility for diffusion of anger and hostility that is transferred. Also, when one therapist is working with a member on a one to one basis, the other therapist is free to observe the remainder of the group. The therapist dyad can also provide role modeling (Sgroi, 1982).

Female co-therapists appear to promote trust and openness most, at least in the beginning stages (Hazzard et al., 1986). Silovsky et al. (1994) cited a disagreement within the literature as to whether a co-therapist team, consisting of one member of each gender

may be more appropriate. According to Silovsky et al. (1994), some researchers agreed that same sex counselors increase disclosure and trust levels, especially at the beginning. However, they advocated that male-female co-therapists are able to expose the group to a healthy, adaptive relationship between a man and a woman through role modeling (Silovsky et al., 1994).

Disadvantages to Group Therapy

It would be unrealistic to say that group therapy is the perfect answer in the treatment of child sexual abuse. Although there are many advantages to using this modality, there are also drawbacks. First, in assessing appropriateness of members, it is crucial to realize that groups are not appropriate for those with poor self control or those with severe developmental delays (Silovsky et al., 1994). Hazzard et al. (1986) agreed that clients with severe intellectual limits are inappropriate for groups. In addition, they also stated that those with severe pathology are unsuitable for group treatment. More specifically, those who are actively psychotic, have borderline personality disorder, severe depression, are severely withdrawn, are acutely suicidal, aggressive, or are active substance abusers should not be involved in group treatment (Knight, 1990). It is imperative that members are assessed closely, so that they receive the mental health care they require.

Another disadvantage is that of defensiveness and lack of follow-through. This can take several forms. Leaders may see uncooperative parents or relatives, resistance in the form of poor attendance, clients may leave sessions before they are over, or they may scapegoat the leader or one particular member (Lynch et al., 1990). The drop-out rate in

group therapy is a crucial issue, especially in long term groups. Fisher et al. (1993) completed a study which examined the characteristics affecting follow-through with group treatment. They determined that predictors of poor group treatment outcomes included the following: lower education levels, greater severity of abuse, and higher levels of initial distress and depression.

Even accounting for the disadvantages of group treatment, it seems apparent that these are heavily outweighed by the advantages of this treatment modality. Although group treatment is not for everyone, it is apparent that it is helpful for a large portion of sexual abuse survivors. There are few well-defined empirical outcome evaluations that have been conducted on group treatment modalities (Silovsky et al., 1994). Evidence supporting group treatment tends to be anecdotal. There is also no research that can show that one group treatment modality is more effective than another (Silovsky et al., 1994).

Conclusion

Important advancements have been made recently in regard to identification, evaluation, and treatment of sexually abused children. Child sexual abuse is a prevalent problem; one of the most devastating traumas that a child can experience. Attention needs to continue to be given to this issue in order to enable and encourage mental health professionals to recognize the symptoms and develop effective treatment approaches. This paper has provided the reader with much-needed information pertaining to how sexual abuse can manifest itself in various symptomology, as well as to explore one treatment modality that appears to be effective with a large portion of the survivor population. It is

recommended that much more be done in the way of research in this area, an area that affects approximately one third of the population. "However good the news about how far we have come in our awareness in this area, it is still overshadowed by the bad news concerning how far we have to go" (MacFarlane et al., 1986, p. 330).

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