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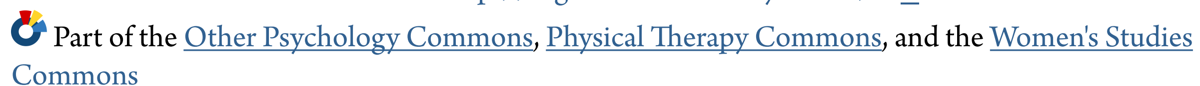
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THE EFFECTS OF GESTALT AND COGNITIVE-BEHAVIORAL THERAPY GROUP INTERVENTIONS ON THE ASSERTIVENESS AND SELF-ESTEEM OF WOMEN WITH PHYSICAL DISABILITIES FACING ABUSE

by

CILENE SUSAN ADAM RITA

DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of requirements

for the degree of

DOCTOR OF PHILOSOPHY

2010

MAJOR: COUNSELING

Approved by:

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Advisor Date

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2010

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DEDICATION

I would like to dedicate this dissertation to Pedro Rita, my devoted husband, whose unconditional love, support, respect and care helped me achieve and accomplish all I dare to dream. He is an inspiration in my life and to whom I am forever and ever thankful. Thank you for loving me for who I am.

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There are many people I would like to thank for their support and assistance in the completion of this dissertation project.

First of all, I thank God, for giving me the strength and health to pursue my dreams and finish this research project.

A special thank you goes to Dr. Arnold Coven, my major advisor, for his encouragement, inspiration, and shared knowledge in group work. Thank you to Dr. Shlomo Sawilowsky for his help in guiding me through the statistical analysis, Dr. Stuart Itzkowitz for his continuous support and encouragement, and Dr. Barbara LeRoy for her guidance, suggestions and superior knowledge in the field of disabilities.

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TABLE OF CONTENTS

Dedication ii

Acknowledgments ii

List of Figures vi

List of Tables vii

CHAPTER I: INTRODUCTION 1

Abuse in Women with Physical Disabilities 1

Assertiveness 2

Self-esteem 4

Group Therapy 5

Gestalt Therapy 6

Cognitive-Behavioral Therapy 8

Statement of the Problem 9

Research Questions 10

Definitions of Terms 11

Assumptions of the Study 13

Limitations of the Study 14

Summary 14

CHAPTER II: REVIEW OF THE LITERATURE 15

Introduction 15

Abuse in Women with Physical Disabilities 15

Self-esteem 23

Group Therapy 28

Gestalt Therapy 32

Cognitive-Behavioral Therapy 38

Summary 43

CHAPTER III: METHODOLOGY 44

Introduction 44

Research Design 45

Figure 1 Research Design 45

Variables 46

Setting 46

Participants 46

Preliminary Procedures 47

Treatment Procedures 49

Criterion Instruments 52

Research Questions and Hypotheses 54

Data Analysis 55

Summary 58

CHAPTER IV: RESULTS OF DATA ANALYSIS 59

Description of the Participants 59

Analysis of Pretests 67

Correlation 69

Research Questions and Hypotheses 70

Multivariate Tests 72

Treatment Group Summary 75

Summary 78

CHAPTER V: SUMMARY AND DISCUSSION 79

Introduction 79

Restatement of the Problem 79

Review of Literature Summary 80

Review of Methods and Procedures 83

Restatement of the Research Questions and Associated Hypotheses 84

Summary of Findings 85

Limitations of the Study 90

Recommendations for Future Research 91

Summary 92

APPENDIX A HIC APPROVAL FORM 94

APPENDIX B INFORMED CONSENT FORM 95

APPENDIX C CRITERION INSTRUMENTS 100

Demographic Questionnaire 100

Group Counseling Session Summary 102

APPENDIX D CORRESPONDENCE 103

Recruiting Flyer 103

Letter from Cooperating Agency 104

APPENDIX E HANDOUTS 105

Handout for Cognitive-Behavioral Group 105

Handout for All Groups 118

Local Resources for Assistance and Support – Ann Arbor 118

References 121

Abstract 141

Autobiographical Statement 143

LIST OF FIGURES

Figure 1: Research Design 45

Figure 2: Statistical Analyses 57

Figure 3: Group Counseling Session Summary *Format of Group Therapy Sessions-Gestalt Therapy (GT) Group Interventions* 75

Figure 4: Group Counseling Session Summary *Format of Group Therapy Sessions-Cognitive-Behavioral Therapy (CBT) Group Interventions* 77

LIST OF TABLES

Table 1: Age Distribution by Treatment Group …………………………………… 60

Table 2: Demographics by Treatment Group ……………………………………… 61

Table 3: Type of Disability by Treatment Group …………………………………. 63

Table 4: Type of Abuse Experience by Treatment Group ………………………… 65

Table 5: Past 12 months Abusive Experiences by Treatment Group ………………. 66

Table 6: Descriptive Statistics by Treatment Group ………………………………. 67

Table 7: Independent Samples *t*-Test ……………………………………………… 68

Table 8: Pearson Correlation Pre-and-Post Testing ……………………………….. 69

Table 9: Descriptive Statistics by Treatment Group - Assertiveness ……………… 71

Table 10: Descriptive Statistics by Treatment Group – Self-esteem ………………... 72

Table 11: Multivariate Analysis of Covariance (MANCOVA) Tests of Within Subjects Contrasts - Assertiveness ………………………………………. 73

Table 12: Multivariate Analysis of Covariance (MANCOVA) Tests of Within Subjects Contrasts – Self-esteem ………………………………………… 73

Table 13: Multivariate Analysis of Covariance (MANCOVA) Tests of Between Subjects Effects – Assertiveness and Self-esteem ………………………. 74

CHAPTER I

INTRODUCTION

Women with physical disabilities are experiencing increasing rates of violence, either within their families, by acquaintances, and/or in business and social organizations (Milberger, Israel, LeRoy, Martin, Potter & Patchak-Shuster, 2003). This includes verbal, economic, emotional, physical and sexual violence. In addition, they may experience other types of abuse such as intimidation, abandonment and neglect, forced isolation, withholding of equipment, medication, transportation, or personal service assistance (Masuda, 1996).

Abuse in Women with Physical Disabilities

Nosek, Young & Rintala (1995) found women with disabilities were more likely to experience abuse by their health providers, and personal assistants, and the duration of the abuse was significantly longer than for women without physical disabilities. Evidence has suggested the rate of experiencing violence is twice the rate as that of women without disabilities (Powers, 2002). Women with disabilities may lack a clear understanding of the different types of abuse, due to their inability to compare experiences with others and/or validate inappropriate practices.

One cause of disempowerment for women with physical disabilities may be the lack of access to information and services. Only a small amount of research exists examining the abusive experiences of women with disabilities. Thus, the need for more research is warranted. Based on a review of research, Chappell (2003) concluded, “women with disabilities face an abusive epidemic of monumental proportions” (p. 12). According to Powers, Curry, Oschwald, Maley, Saxton & Eckels (2002), “the inaccessibility, reliance on support services, poverty and isolation, is critical for understanding women’s increased risk for abuse” (p.4).

The discrimination and prejudice experienced by persons with disabilities, if internalized, sends the message that they are less worthy (Nosek & Hughes, 2001). While some research suggests disability is reported as the main reason why one has low self-esteem, others suggest that it is not the disability per se but the impact it has on the social, emotional, physical and environmental aspects of one's life that influences their self-esteem. Nosek, Hughes, Swedlund, Taylor & Swank (2003) conducted a study that indicated women with disabilities had significantly lower self-esteem, self-cognition, as well as greater social isolation than women without disabilities. According to Hughes, Robinson-Whelen, Taylor, Swedlund & Nosek (2004), the self-esteem of women with physical disabilities and chronic conditions can be affected by many reasons, including the exclusion they may feel, as well as the "devaluation that society often imposes on persons with physical impairment" (Goffman, 1963, as cited in Hughes, et. al., 2004). Counseling approaches that target increasing assertiveness and self-esteem of persons with disabilities may help them in preventing or reducing the abuse.

Young, Nosek, Howland, Chanpong & Rintala (1997) addressed the need for prevention services addressing the negative perception that women with disabilities have of their self-esteem, and body image. A study conducted by Saxton, Curry, Powers, Maley, Eckels & Gross (2001) revealed one of the barriers women with disabilities face regarding abuse is the difficulty in recognizing it and having their experiences validated. Research examining the effects of counseling interventions on the assertiveness and self-esteem of women with physical disabilities facing abuse is warranted.

Assertiveness

Assertiveness is believed to be an interpersonal behavior resulting from an intrapersonal cognitive state. In other words, assertiveness is seen as the ability one has to assert oneself as

well as the capability of saying no to requests that one does not want to fulfill. In recent decades however, the concept of assertiveness has broadened and includes interpersonal competence in conflicts, and capacity to maintain relationships (Bekker, Croon, van Belkom & Vermee, 2008) .

Assertiveness skills practiced in a safe environment, such as a group setting, may help women with physical disabilities to express themselves more effectively, and understand their capacity for self-growth and self-realization (Vail & Xenakis, 2007). Duckworth & Mercer (2006) suggested assertive behavior is in fact an acquired behavior that develops according to the individual's opportunity for practice and refinement. The goal of assertive communication and behavior is mutual respect. Duckworth & Mercer (2006) imply assertiveness increases the probability of having needs met and opinions appreciated. The maintenance of relationships is also a hypothesized positive outcome of assertive behavior and communication.

Women with physical disabilities exhibit high levels of stress, which may be accounted for by their perception of being unable to control events (Hughes, Taylor, Robinson-Whelen & Nosek, 2005). The choice of using more assertive behaviors to overcome many fears and lack of control is based on personal experiences and satisfaction. Enns (1992) suggested personal change involves the practice of new attitudes toward the self.

Many women with physical disabilities compare themselves to others in their ability to do something. "Social comparative standards also affect self esteem in how much satisfaction an individual derives from his/her accomplishments" (Bandura, 1993, p. 121). Self-esteem is defined by Rosenberg (1979) "as the sense of self-respect, worthiness, and adequacy and the self evaluation of one's self concept" (as cited in Hughes, Robinson, Whelen, Taylor, Swedlund & Nosek, 2004). Interventions that help women to be assertive, to stand up for their own rights while not stepping on the rights of others, is crucial for women if they are not to be powerless

victims (Worell & Remer, 2003). The impact of a short-term therapy intervention on the assertiveness and self-esteem of women with physical disabilities who have experienced abuse will be explored by this study.

Self-esteem

Self-esteem, according to Coopersmith (1968), is defined as the self-appraisal of one's significance, worth, competence, and success, when comparing one's self with others. A study conducted by Nosek, Howland, Rintala, Young & Chanpong (2001) revealed women with physical disabilities experience problems associated with low self-esteem, such as depression, unemployment, social isolation, limited opportunities to establish satisfying relationships, and emotional, physical, and sexual abuse.

Self-esteem plays a major role in the lives of women with physical disabilities (Nosek, Hughes, Swedlund, Taylor & Swank, 2003). The social stigma, and devaluation society often inflicts on women with physical disabilities affects their self-esteem. Due to the pressure and responses from society that women with physical disabilities may receive, their perceived self-beliefs of efficacy are affected and places diverse effects on their psychosocial functioning (Bandura, 1989). Neve (1996) points out women with physical disabilities that have experienced some kind of abuse often feel isolated, different and powerless, and often have low self-esteem. It is assumed people tend to avoid activities they believe surpass their capabilities, but do undertake activities and social events where they believe themselves capable of managing. Ozer & Bandura (1990) stated a person's "judgments of personal efficacy affect choice of activities and selection of environments" (p.472).

The self-esteem of women with physical disabilities may be compromised by a series of factors. Self-esteem is jeopardized by experiences of loss (Cornwell & Schmitt, 1990). In times

of health problems, symptom exacerbation, and/or an augment of functional limitations, self-esteem is affected placing doubt and resulting in signs (i.e., hopelessness, excessive worry and anxiety) of lower self-esteem. Self-beliefs about one's efficacy can be altered by a series of factors, such as mastery experiences, coping strategies modeling comparative self-appraisal, and positive social assessment by strengthening beliefs in graduated steps (Ozer & Bandura, 1990). The levels of self-esteem among women with physical disabilities were expected to increase after participating in the Gestalt and Cognitive-Behavioral therapy group interventions.

Group Therapy

Groups can range from couples to families to larger groups of anonymous members. Across a range of different groups compositions, group therapy common goals include self-understanding, personal growth, and building upon inner resources (Corey & Corey, 2001). According to Corey (2008), a group provides the empathy and support atmosphere necessary to create trust that leads to sharing and exploring concerns one may have.

The development of a group process is defined by literature differently, although all authors agree the character of a group evolves in a predictable process. The group process can constitute the treatment intervention (Huebner as cited in Chan, Berven & Thomas, 2004). The group process and interactions of members are the mechanisms that produce the therapeutic effects (Corey & Corey, 2001). Yalom (1995) defined eleven therapeutic factors as improvers of group members learning and growth. They are defined as: instillation of hope, universality, imparting of information, altruism, the corrective recapitulation of early family experiences, the development of socialization techniques, imitative learning, interpersonal learning, cohesion, catharsis and existential.

For women with physical disabilities participating in a group may be particularly important since they share common feelings, emotions and expectations. Participation in a group may intensify the instillation of hope and a sense of universality, where members may understand that their particular problems are not unique (Huebner as cited in Chan et al., 2004). Brabender and Fallon (1993) posited group gives the protected environment where members are encouraged to practice their newly acquired and modified behaviors spontaneously and without fear of negative consequences.

Group therapy provides an environment that encourages self-disclosure between group members (Riva, as cited in Seligman & Marshak, 1990). It is believed women with physical disabilities that are victims of abuse, experience low self-esteem and powerlessness. Shaller & Fieberg (1998) studied the problem of abuse of women with physical disabilities and concluded it may have a negative impact on woman's self-esteem and may also involve economic and social deprivation.

Gestalt and Cognitive-Behavioral group therapy interventions have been demonstrated as effective in the work with people with disabilities. Gestalt therapy group in rehabilitation settings may help individuals to experience and identify emotions in the here-and-now facilitating their fully experience, expression, exploration and acceptance of genuine aspects of self (Huebner as cited in Chan et al., 2004). Cognitive-Behavioral group therapy's main goals include providing symptom relief, assisting members in finding solutions and resolving their most pressing problems and consequently teaching relapse prevention strategies (Corey, 2008).

Gestalt Therapy

Gestalt therapy is an existential and experiential psychotherapy that focuses on the individual's experience in the present moment, therapeutic relationship, environment and social

contexts in which the individual resides, and self-regulating adjustment people make as a result of the overall situation (Yontef, 1993). The main premise of Gestalt therapy is the process, in the present moment, rather than the content.

Corey (1995) posited the goal of Gestalt therapy is the development of awareness with in the individual. Enns (1992) stated "awareness of current issues and social forces is still essential for helping women clearly identify the complexity of their experiences" (p.9). The Gestalt approach allows the individual to express his/her feelings being more "relational and expressive rather than introspective" (Bowman & Leakey, 2006, p.44).

Through the interventions used in Gestalt therapy, an array of opportunities can be offered inviting participants, in a safe environment, to express outwardly their internal experiences. Gestalt therapy benefits those individuals who like to explore rather than modify a behavior (Yontef, 1993). The goal in therapy is "growth and autonomy through an increase in consciousness" (Yontef, 1993, p. 16). Bowman & Leakey (2006) stated "acceptance of the moment in Gestalt becomes an opportunity to experience the totally unconditioned self in relation to others" (p. 44).

Women with physical disabilities facing abuse may benefit from Gestalt therapy because it does not rely exclusively on talk, but uses other channels of expression and awareness allowing the individual to fully experience the process. Bowman & Leakey (2006) posited Gestalt therapy can be "extremely helpful in working through issues of physical difference and disability" (p.45).

Nichols & Fine (1980) posited awareness in therapy facilitates change. The change occurs in terms of how individuals perceive themselves, and what they value as being important to them. The numerous techniques and experiments in therapy facilitate these changes. According to Corey (2004), techniques are exercises used to bring out action and interaction. On

the other hand, experiments are "phenomenologicaly based" (p. 312), in other words, individuals are invited to try some new behaviors and pay attention and become aware of what they experience (Corey, 2004). Examples of experiments might include dramatizing a painful memory, imagining a fearful encounter, creating a dialogue between two parts within oneself, and exaggerating certain postures (Polster, 1987).

Cognitive-Behavioral Therapy

The premise of Cognitive-Behavioral therapy is to assist individuals by restructuring negative thoughts, and re-establishing positive cognitions (Prochaska & Norcross, 2003). Cognitive-behavioral theory and strategies embrace a broad range of learning-based and cognitive approaches (Worell & Remer 2003). According to Phemister (2001), cognitive-behavioral therapy assists individuals in "setting and achieving short-term goals that work to build self-esteem and confidence and promote responsibility" (p. 9). Women with physical disabilities, who have been victims of abuse, generally need considerable help to cope with their feelings about the abuse and are in need of abuse intervention services to the same extent as women without disabilities (Swedlund & Nosek, 2000).

Cognitive-Behavioral interventions can be used with individuals of different ages, abilities, or gender, and from diverse ethnic and cultural backgrounds (Worell & Remer, 2003). Cognitive-Behavioral interventions include stress reduction, relaxation, cognitive restructuring, role-playing, skills development, problem solving, and use of imagery (Freeman, Simon, Beutler, & Arkowitz, 1989). These techniques may be applied toward developing assertiveness skills and addressing cognitions that have be developed as a function of the abuse, such as low self-esteem (Dutton, 1992).

When they become more able to make decisions and increase their sense of power, self-esteem and assertiveness are expected to increase. The empowerment of women can be encouraged by the use of Cognitive-Behavioral strategies. The main purpose of this study is to use a Cognitive-Behavioral group focused on building skills and improving the participants' current levels of functioning.

Statement of the Problem

The number of women with physical disabilities who have suffered some type of abuse in the United States is viewed as an epidemic. According to Young, Nosek, Howland & Chanpong (1997), an estimated "eight to twelve million women in the United States are at risk for abuse" (p. 34). In other words, they posit women with physical disabilities will be abused by someone at some point in their lives. The overall aim of this study was to compare the differential effects of a Gestalt and Cognitive-Behavioral group interventions increase assertiveness and self-esteem among women with physical disabilities who have experienced abuse.

The Gestalt therapy group intervention was designed to assist these women become more aware, and to use this awareness to increase their level of assertiveness and self-esteem. Improving the ability to experience and express emotions has long been a major curative factor in psychotherapy. Therefore, the experiment of having women with physical disabilities participate in the Gestalt therapy process was expected to increase assertiveness and self-esteem. Gestalt therapy is focused more on action; it is expected to facilitate awareness and effect changes on the "whole self", more efficiently (Farnsworth, Wood & Ayers, 1975 as cited in Coven, 1977). It is assumed by this researcher that assertiveness and self-esteem are part of the whole self. Using techniques such as role-playing, fantasy, empty chair as well as, Gestalt psychodrama experiments created in the here-and-now, were expected to facilitate awareness and

increase assertiveness and self-esteem. According to Harman (1996), Gestalt techniques are developed to help the client at an impasse, facilitate the client's awareness, and help the client make clearer contact with self.

The Cognitive-Behavioral therapy group intervention attempted to assist the women with physical disabilities to learn how to modify their thinking process so to influence their emotions and behaviors. Cognitive-behavioral therapy will allow one to investigate "the combination of psychological and situational problems which may be contributing to the patient's distress" (Blackburn & Davidson, 1995, p. 16).

Cognitive-Behavioral therapy addresses the irrational cognitions and negative assumptions that contribute to negative emotional states women with physical disabilities face (Hays & Iwamassa, 2006). The goal of Cognitive-Behavioral therapy in this study was to identify and target these cognitive distortions in treatment while balancing empathy and validation. The psychological effects of abuse can be evidence for distorted cognition, indicators of psychological distress, and relational disturbances (Dutton, 1992). Thus, cognitive-behavioral intervention may help women with physical disabilities facing abuse reconceptualize their problems in a way that will increase their chances of finding solutions.

Research Questions

This study examined the differential effects of two theoretical orientations, Gestalt and Cognitive-Behavioral group therapy interventions on the levels of assertiveness and self-esteem of women with physical disabilities facing abuse. To increase assertiveness and self-esteem, this study was conducted in two-hour segments over a period of six weeks. The research questions guiding this study were:

1. Will the level of assertiveness in women with physical disabilities facing abuse, who participate in Gestalt Therapy (GT) group interventions, be increased significantly more than those who are in the Cognitive-Behavioral Therapy (CBT) group interventions?
2. Will the level of self-esteem in women with physical disabilities facing abuse, who participate in Gestalt Therapy (GT) group interventions, be increased significantly more than those who are in the Cognitive-Behavioral Therapy (CBT) group interventions?

Definitions of Terms

The following definitions were relevant to this study:

Assertiveness

Assertiveness is an interpersonal expressive behavior which promotes equality in human relationships, enabling an individual to act in his or her own best interest, to stand up for himself or herself without anxiety, to express honest feelings comfortably, and to exercise his or her own rights without denying the rights of others (Alberti & Emmons, 1995).

Self-esteem

Self-esteem is defined as "the attitudinal component of the self; the affective judgments placed on the self-concept. Self-esteem consists of feelings of worth and acceptance and develops as a consequence of a sense of identity, awareness of competence, and feedback from the external world" (Gladding, 2006, p. 128).

Gestalt Therapy

Gestalt Therapy is existential, given that it is grounded in the here-and-now; it focuses on personal choice, responsibility, and awareness (Corey, 2004). Gestalt therapy is best understood

by the experiential opportunity it gives individuals to experiment with new behaviors fostering the increase of self-awareness (Yontef, 1995). The effectiveness of Gestalt therapy is in focusing special attention on the surface of the behavior, the individual's gestures, voice, posture, movements, language and interaction with others.

In this study, the aim of the Gestalt therapy group interventions will be to provide women with physical disabilities the possibility of becoming more aware of their thinking, feeling, and doing. According to Coven (1977), people with disabilities often feel unsure about their feelings of acceptance and denial of the disability. These conflicted feelings may generate tension and stress. The limitation in movement, caused by the physical disability, may make it difficult for the individual to be aware that they can control their lives. The exercises and experiments of Gestalt Therapy will provide these individuals with the support and opportunity to observe other women and identify with other women's strengths and vulnerabilities, facilitating otheir awareness and growth.

Cognitive-Behavioral Therapy

Cognitive-Behavioral therapy is based on the theory of personality which maintains that people respond to life events through a combination of cognitive, affective, motivational, and behavioral responses (Beck & Weishaar, 2005). This approach focuses on developing a detailed case conceptualization as a way to understand how people view their world (Corey, 2001). The Cognitive-behavioral group therapy approach is very optimistic and positive about the prospects for developing effective interventions to address human distress (Worell & Remer, 2003).

The techniques used in cognitive-behavioral therapy are expected to help women with physical disabilities facing abuse to recognize irrational cognitions and negative assumptions that contribute to their negative emotional state (Hays & Iwamasa, 2006).

Physical Disability

Physical disability is defined as "having a significant limitation in mobility and /or self-care and constitutes a chronic life strain" (Hughes, Taylor, Robinson-Whelen & Nosek, 2005, p.14).

Abuse

Abuse of women with physical disabilities is here defined as "any intentional act that results in, or is likely to result in, harm or suffering, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or private life" (Hassouneh-Phillips, 2005, p. 70).

Assumptions of the Study

Assumptions of this research study included:

1. All women with a self-reported physical disability and abusive experience, participating in this research study, will be similar in characteristics pertaining to their economic resources, living conditions, and will be in the 18-70 years of age group.
2. That by being assured anonymity, participants will answer the questions honestly and without significant bias.
3. Individual differences in personality characteristics will be greatly reduced by the use of random assignment.
4. All individuals participating in this study will be able to read and understand at a minimum eighth-grade level.

Limitations of the Study

This study considered the following limitations:

1. This study was limited to women with a self-reported physical disability and abusive experience who volunteer to participate and may not be representative of all women or ethnicities. Generalizations to other populations of women with disabilities must be made with caution.
2. This study relied on paper and pencil instruments and self-reported which are subject to socially desirable responses.
3. Individuals were expected to self-report experienced abuse.
4. Additional unknown factors may have influenced the women's levels of assertiveness and self-esteem and not be accounted for in this study.

Summary

This chapter introduced the problem to be addressed in this study. Research variables, questions, and definition of terms were described. The basic assumptions and limitations of the study were presented. Chapter II presents the literature review and existing research on assertiveness and self-esteem, women with physical disabilities facing abuse, Gestalt Therapy (GT) and Cognitive-Behavioral Therapy (CBT) group interventions.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter focuses on the literature and existing research pertinent to this study. A review of the literature and existing research of the differential effects of Gestalt Therapy (GT) and Cognitive-Behavioral Therapy (CBT) group interventions on levels of assertiveness and self-esteem in women with physical disabilities facing abuse are presented. The dependent variables examined are assertiveness and self-esteem. The significant findings and relevance of those findings to the current study are discussed.

Introduction

Abuse among women with physical disabilities is an issue that is obtaining the attention of many researches in the area of disabilities. The prevalence of abuse among women in general has been fairly well documented, yet only a few studies have examined it among women with disabilities. A national study of women with physical disabilities conducted by Nosek, Howland, Rintala, Young & Chanpong (2001) suggests the same percentage of women with and without disabilities had experienced emotional, physical, or sexual abuse, but the women with disabilities experienced the abuse for longer periods of time. The study also implies women with disabilities have even fewer options of escaping or resolving the abuse than women without disabilities due to their difficulties in locomotion. This chapter focuses on the review of literature on the effects of assertiveness and self-esteem in women with physical disabilities facing abuse and coping strategies that allow them to continue living and cope with the abuse.

Abuse in Women with Physical Disabilities

Abuse has been identified as the most important health issue of women with physical disabilities (Hassouneh-Phillips, 2005). According to Tyiska (1998), women with physical

disabilities not only are at higher risk of abuse compared to women without disabilities, but the abuse may also have a greater negative impact on their well-being. It is thus understandable that the women who have suffered any kind of abuse may show signs of low self-esteem, powerlessness, as well as feelings of sadness, shame, guilt and depression (Dutton, 1992).

Women with physical disabilities have described numerous forms of abuse, including physical, sexual and financial abuse, medication manipulation, equipment disablement or destruction, neglecting to provide needed services, abuse of children and pets, and devastating verbal abuse (Saxton et al., 2001). A survey of 200 women conducted by Powers et al. (2002) substantiated the negative impact of abuse on women with disabilities' lives. Abuse prevented 29% of the participant's from being employed; 64% from taking care of their health; and 61% from living independently. According to Melcombe (2003), the unemployment rate among women with disabilities has been identified as being as high as 75%.

Women with disabilities face many barriers in their struggle for access and equality (Tilley, 1998). According to Saxton et al. (2001), "women with disabilities have lived their lives in a world that devalues and discriminates against both disabled people and women" (p. 407). The Center for Research on Women with Disabilities conducted an extensive national study of women with physical disabilities, which included a comprehensive assessment of emotional, physical, and sexual abuse. In this study they found 62% of women with physical disabilities as well as women without disabilities had experienced emotional, physical, or sexual abuse, but women with disabilities experienced abuse for longer periods of time. In addition, the abuse might have been withholding needed orthotic equipment (i.e, wheelchairs, braces), medications, transportation, or essential assistance with personal tasks, such as dressing or getting out of bed (Nosek, Howland, Rintala, Young & Chanpong, 2001).

In Young, Nosek, Howland, Chanpong, & Rintala (1997) study of violence against women with physical disabilities, intimate partners were most likely to be the perpetrators of physical and emotional abuse. Milberger et al. (2003) found 56% of a nonrandom sample of 177 women with disabilities reported abuse, and the abusers were typically their male partners. A survey of 511 women with disabilities developed by McFarlane, Hughes, Nosek, Groff, Swedlend, & Mullen (2001) on abuse found 10% of the women had experienced physical abuse, sexual abuse, or some other type of abuse within the past year, with intimate partners being the most common abusers, followed by family members and health and/or care providers. Nosek et al. (2001) national study of women with physical disabilities also found that women with disabilities were significantly more likely to experience emotional abuse by attendants, strangers, or health care providers than women without disabilities.

Women with physical disabilities or strength impairments may be more likely to be abused than other women if the abuser feels they will be relatively powerless to resist abuse (Martin, Ray, Sotres-Alvarez, Kupper, Moracco, Dickens, Scandlin & Gizlice, 2006). They also posit abusers may also feel women with disabilities may be less likely than other women to report any type of abuse. Nosek et al. (2001) posits the vulnerability of women with physical disabilities only tends to increase since their difficulty in escaping dangerous and abusive situations, as well as their need for assistance with personal tasks from the abuser, and the stereotype that they are dependent and passive are factors that contribute to it. A study of 91 women and men with severe disabilities, who used paid professional attendant services to help them carry out their daily life activities, found 10% of the respondents reported having been physically abused (Ulicny, White, Bradford & Mathews, 1990).

The dependence that women with disabilities have on others is a commonly cited risk for violence. According to Sobsey (1994), disabilities and abuse can be interrelated, and people may be trapped in a vicious cycle where "they experience permanent disability as a result of violence and become more vulnerable to violence because of their disability" (p. 47). Nosek et al. (2001) posited in order for one to understand the effects of disability one can not separate the effects of poverty, low self-esteem, and family background in identifying the precursors to violence against women with disabilities. Anderson (1997) suggested education is another factor that can potentially cause dependence and struggle for power stating "disabled women with fewer relative education resources may be more dependent, less powerful, and thus more prone to violent victimization" (p. 807).

Hassouneh-Phillips (2005) on a review of the abuse pathways model, a research study developed from a critical analysis of 72 life history interviews with women who had experienced abuse and physical disability, sought to describe the impact of abuse on women's psychological, physical, and social health. She posited the psychological effects of abuse most commonly reported included stress, depression, anxiety, and suicidal ideation. Physical effects included worsening bowel and bladder control, poor nutrition, skin breakdown, and impaired mobility. Social problems included distrust of others, social isolation, and homelessness. The barriers women with disabilities face in their struggles for access and equality is mentioned in the literature of the last decades as well as the need for disability-appropriate abuse interventions. On a previous pilot study conducted by the same author, Hassouneh-Phillips (2000), poverty, social isolation, violation of women's boundaries, and physical impairment were all aspects of compounded vulnerability. More women with disabilities live below the poverty line, are single-

parenting, and less likely to have social outlets than males with disabilities (Wagner, 1992, as cited in Ferri & Gregg, 1998).

According to Hassouneh-Phillips & Curry (2002), the inner processes and tensions women with physical disabilities experience over time, revolve around establishing an identity, redefining what it means to be a woman, and finding existential meaning in disability. The effects of abuse experiences on a woman's self-esteem and assertiveness are also aspects of extreme importance to be addressed in this study.

In the above studies, researchers have presented the difficulties and challenges women with physical disabilities facing abuse have to endure. The literature suggests it is not the disability per se but rather the impact it has on one's physical, emotional, social, and environmental aspects of life that influences self-esteem and self-concept (Nosek & Hughes, 2001). Livingston, Testa & VanZile-Tamsen (2007) posited psychological vulnerability (e.g. low self-esteem, low assertiveness) is considered a mechanism through which women risk their chances of being revictimized. According to Livingston et al. (2007), assertiveness "may be amenable to change through behavioral intervention" (p. 298). Evaluation studies contend assertiveness interventions may provide therapeutic benefits for abuse victims, including psychological distress, vulnerability, helplessness, and increases perceived control, self-esteem, and ability to set boundaries (Brecklin & Ullman, 2004; McCaughey, 1997; Ozer & Bandura, 1990).

Assertiveness

According to Duckworth & Mercer (2006), assertiveness is a function of instruction, modeling, and rehearsal. In a study conducted by Bekker, Croon, van Belkom & Vermee (2008) predicting individual differences in autonomy-connectedness, the authors found one is being and

feeling able to assert oneself in social interactions is one of the most powerful predictors in connecting to others. Elliott & Gramling (1990) suggested assertive individuals communicate their thoughts and feelings effectively and in a way that respects and considers the thoughts and feelings of others. On the other hand, individuals, low in assertiveness are more passive, preferring others to talk for them. Brecklin & Ullman (2004) posited assertiveness interventions aim to prevent violence against women by strengthening a woman's capacity to defend their selves.

Repeatedly in studies examining the dimensions of assertiveness (Arrindell, Akkerman, Van der Ende, Schreurs, Brugman & Stewart, 2005; Arrindell & Van der Ende, 1985; Arrindell, Sanderman, Van der Molen, Van der Ende & Mersch, 1988; Arrindell, Van der Ende, Sanderman, Oosterhof, Stewart & Lingsma, 1999), Arrindell and colleagues found a strong four-factor structure. The first factor is expressing negative feelings, for example, defending one's rights and interests in a public situation. The second factor is expressing feelings of insecurity and inadequacy, for example, asking for help and attention. The third factor is asserting oneself, such as introducing oneself and expressing one's opinion. The last factor is expressing positive feelings, such as receiving and giving compliments and praise (Arrindell et al., 1999).

Duckworth et. al. (2006) suggested assertive behavior is "acquired, practiced and refined as the individual develops" (p. 80). The author also posited assertive behavior is a result of early learning environments where behaviors that are reinforced are usually repeated. Rathus (1975) posited assertive individuals are more prone to make appropriate requests for social support and decline inappropriate support, and are subsequently better at defending themselves during interpersonal conflicts. Since assertiveness involves respecting the opinions of others, violence is the opposite side of assertiveness. According to Kubany & Ralston (2008), assertiveness is

advocating for oneself, which places a “strong emphasis on getting their own needs met as a high priority” (p. 221).

Helping women with physical disabilities learn assertive behaviors may help them develop positive attitudes and thus feel more powerful. Enns (1992) posited assertiveness interventions as an appropriate way for women to overcome difficulties “through the expression of feelings, reduction of anxiety and fear, alteration of beliefs and attitudes, and development of new behaviors” (p. 7). According to Worell & Remer (2003), it is crucial to train women to be assertive and stand up for their rights. The development of assertive skills is very important for women to have so they can “impact the environment effectively and bring about social change” (Worell & Remer, 2003, p. 79).

Massong, Dickson, Ritzler & Layne (1982) found assertive individuals used more mature and adaptive defensive mechanisms. Ames (2008) stated evidence showing what people care about affects their assertiveness. In other words, assertive behavior is affected by expectancies. People take into great consideration how others perceive them, emphasizing their need for belonging, which automatically influences the way they act. Vail & Xenakis (2007) recently developed a group model of experiential learning, using assertiveness and writing groups to empower women with chronic and physical disabilities, where humanistic and self-psychology concepts were used. A total of 19 women with a physical disability participated and each group had a total of 10, $1^{1/2}$-hour, weekly sessions. According to Vail & Xenakis (2007), the assertiveness and writing groups helped to provide the women an opportunity to learn, identify life issues, apply effective communication and problem-solving skills and understand their potential for self-growth and self-realization.

The techniques used by Vail & Xenakis (2007) were showed to have an effect on diminishing feelings of social discomfort and isolation, promoting self-exploration, and enhancing self-concept. The results of this study found "all participants noted positive changes in self-development, including acquiring new skills, ability for better self-expression, and feelings of self-worth, and self-growth" (Vail & Xenakis, 2007, p. 84).

Tomaka, Palacios, Schneider, Colotla, Concha & Herrald (1998) examined the relationship of assertiveness to threat and challenge appraisals to a potentially stressful event of 95 undergraduate women from the University of Texas at El Paso. The sample was divided into high and low assertiveness groups on the basis of a medium split of final distribution of assertiveness scores. Findings reveal high assertive women reported lower stress and greater perceived performance than did low assertive women. The study also revealed that in examining whether self-esteem and personal efficacy mediated the effects of assertiveness on stress-related outcomes, personal efficacy partially mediated the effects of assertiveness on coping ability, and self-esteem partially mediated the effects of assertiveness. The analysis revealed a significant multivariate effect for assertiveness group, $F(2, 92) = 5.63$, $p = .005$. In general, the results of this study showed that assertiveness can predict reactions to acute stress among women.

Enns (1992) emphasized the logical and intuitive appeal that assertiveness has as a protective factor, which continues to be highlighted in most intervention activities for women facing abuse. A model of communication presented by Ryan, Bajorek, Beaman & Anas (2005) presents assertiveness as the main strategy for interrupting the communication predicament of disability. Ryan, Anas & Mays (2008) posited assertiveness involves the "calm, confident presentation of clear messages which are neither passive nor aggressive" (p. 505). Livingston, Testa & VanZile-Tamsen (2007), in a longitudinal study of women's social experiences,

consisting of three waves of data collection, 12 months apart used a prospective path analysis that was used to examine the relationship between sexual refusal assertiveness and sexual victimization over time among a community sample of women. The sample accounted for women 18 to 30 years of age (n = 1,014). The findings of their study suggest that strengthening sexual assertiveness may help reduce vulnerability to future victimization. Livingston & colleagues (2007) attests "assertiveness may be amenable to change through behavioral intervention" (p. 298).

As posited by Neve (1996), women with disabilities who have been abused "often feel isolated, different and powerless, and often have low self-esteem" (p. 77). Therefore, as women have the opportunity to challenge their own stereotypes and are able to adopt assertive behaviors, they usually experience increased self-respect and consequently increased self-esteem (Enns, 1992). Lange & Jakubouski (1977) indicated assertiveness has been linked with low anxiety and increased personal effectiveness in a variety of settings. Enns (1992) emphasized a woman who considers her full range of behaviors and consequently the effects such behaviors have, can use assertiveness training to enhance her existing strengths.

Self-esteem

Self-esteem plays an important role in the well-being of women with physical disabilities (Nosek et al., 2003). Rosenberg (1979) defines self-esteem as having the sense of self-respect, worthiness, and adequacy. According to Coopersmith (1968), self-esteem can be defined as one's significance, worth, competence, and success, as compared to others. In other words, people develop their self-esteem based on their interpretations of how others appraise them. Self-esteem can in this way be equaled to one's assessment and evaluation at any particular time.

According to Campbell (1990), self-esteem is defined as “a global self reflexive attitude addressing how one feels about the self as it is viewed as an object of evaluation” (p. 539).

Enns (1992) posited self-esteem groups were initially designed to help women deal with the complexity of their social status and self-attitudes. Nosek et al. (2003) posited women with physical disabilities might have lower levels of self-esteem than women without disabilities. According to Herman (1992) and McCann, Sakheim, & Abrahamson (1988), self-representations are formed through interactions with others. Over time, if someone repeatedly verbally and/or physically abuses another, their self-schema becomes negative, resulting in helplessness and lacking of power to make appropriate decisions. Nosek & Hughes (2001) posited self-esteem for women with physical disabilities is shaped by responses they may get from the environment. In studies developed by Nosek and colleagues (2001 & 2003), findings show the damaging effects of negative messages that women with disabilities get from parents and siblings, school friends and teachers, and medical professionals. These messages of overprotection and exclusion from mainstream society activities may result in a devalued sense of self, producing negative feelings of being a burden, being ugly and/or unworthy of attention. Nosek & Hughes noted, “self-esteem for women with disabilities is whittled down by an unending barrage of assaults from the environment” (2001, p. 23).

According to Nosek et al. (2001), their study of women with physical disabilities revealed these women experience problems associated with low self-esteem, such as, depression, unemployment, social isolation, limited opportunities to establish satisfying relationships, and emotional, physical and sexual abuse. The National Center for Health Statistics (2002) reported women with disabilities tend to report lower levels of physical, mental, and social health status. Low self-esteem among women with physical disabilities is significantly related to higher

unemployment and reduced health promotion behaviors (Nosek et al., 2003). In Nosek and colleagues (2003) research on self-esteem and women with physical disabilities, they noted three developmental variables (i.e. less affection shown in the home, less involvement in school activities, and more overprotection) had the effect of lowering self-esteem and creating more social isolation.

Herman (1992) posited violence causes individuals to lose their ability to trust themselves and consequently the people around them. In a study conducted by Aguilar & Nightingale (1994), examining the association among physical violence, emotional abuse, sexual assault, and women's self-esteem, researchers compared 49 battered women to 49 nonbattered women randomly selected and found the emotional/controlling abuse factor was significantly predictive of lower self-esteem for the women who were battered. Physical and sexual abuses were not significantly related. A study conducted by Cascardi & O'Leary (1992), examining the relationship between self-esteem and the severity, frequency, and level of injury of physical abuse for 33 battered women, found self-esteem was significantly and negatively correlated with the frequency and severity of physical aggression.

For women with physical disabilities not only emotional or physical abuse may be a big factor that can affect one's self-esteem, but their internalization of social stigmas, exclusion, and devaluation that society often imposes may also have a profound impact. Disability per se may bring multiple losses, such as employment, visibility, and independence, which can all jeopardize one's self-esteem (Gill, 1996; Jans & Stoddard, 1999; Nosek, 1996). Women with physical disabilities not only experience greater levels of stress, but they may also be more vulnerable to its negative effects (Hughes, Robinson-Whelen, Taylor & Hall, 2006).

Hughes and colleagues (2005), in a study where 415 women with physical disabilities' perceived stress was observed, described greater perceived stress was linked with lower levels of social support, greater pain limitations, and recent experience with abuse. Lowered self-esteem is a feature of depression in women with physical disabilities (Bernet, Ingram & Johnson, 1993; Hughes et al., 2005). Vickery, Gontkovsky, Wallace & Caroselli (2006) suggested an unstable and rather poor view of self is associated with feelings of hopelessness, dissatisfaction and depression. Dutton (1992) posited women who suffer abuse demonstrate their lowered self-esteem "by believing that they do not deserve or are not worthy of better treatment by their intimate partner or by institutional systems designed to help them" (p. 63).

According to Penninx and colleagues (1998), high self-esteem may have positive effects on depressive symptoms in persons with disabilities. In a study on the enhancement of self-esteem with women with physical disabilities developed by Hughes and colleagues (2004), they concluded women with physical disabilities may benefit greatly from a self-esteem group intervention not only improving their self-esteem but also other indices of psychological health over a fairly brief period.

Two studies reported the importance that sexual satisfaction and body esteem have on the well being of people with physical disabilities. In a study conducted by Teleporos & McCabe (2002), investigating the association between sexuality and psychological well being in people with physical disabilities, found body esteem was more closely associated with self-esteem in women with physical disabilities whereas for men with physical disabilities it was sexual esteem that was more closely associated. In the same investigation they concluded people with physical disabilities' self-esteem have a strong association with concerns of feeling positive about their bodies.

Self-esteem has long been explored in individuals with a variety of medical conditions. For many researchers, self-esteem acts as a mediator of better psychosocial functioning and quality of life, supporting people in adjusting to illness and or disabilities (Anson & Ponsford, 2006; Schroevers, Ranchor & Sanderman, 2003). According to Essex & Klein (1989), enhanced self-esteem improves one's functional status by helping strengthen active coping. Nosek et al. (2001; 2003) qualitative studies of women with physical disabilities suggested negative messages regarding a woman's potential, such as being a burden or even expectations, profoundly influences women's self-esteem. Several researchers have noted many people with physical disabilities suffer from low self-esteem and feelings of inferiority because of their disability and body image (Tan & Bostick, 1995; Schlesinger, 1996; Anderson & Kitchin, 2000).

Sanford & Donovan (1984) suggested self-esteem enhancement is necessary for women to advance as a group to a level other than one perceived as less in society. Enns (1992) posited self-esteem enhancement in a group counseling setting, provides an ideal format for helping women deal with self-concept issues. The group setting reduces women's feelings of loneliness and isolation and provides the support and validation they need to be able to move on. Participation with others serves as a foundation for women's self-esteem or their "relational efficacy or relational confidence" (Jordan, 1994, p. 3). In a group setting, women have an opportunity to observe other women, and identify with other women's strengths and vulnerabilities (Joyce & Hazelton, 1982). Oliveira, Milliner & Page (2004) posited groups that facilitate self-disclosure and emotional interactions among its members accomplish more meaningful results.

Previous work (Dutton, 1992) with Gestalt and Cognitive-Behavioral group therapy interventions has shown to assist in increasing one's self-esteem and assertiveness behaviors.

Gestalt group therapy interventions will allow the women to "bring into focus their affective experiences, just as the Cognitive-Behavioral therapy allows them to focus on their thoughts and beliefs" (Dutton, 1992, p. 98). Gestalt group therapy interventions include mental experiments, guided fantasy, imagery, role-playing and body awareness (Corsini & Wedding, 2005). According to Enns (1987), Gestalt interventions encourage emotional expression as well as awareness of gender role restrictions. Cognitive-Behavioral group therapy interventions include stress reduction, relaxation, cognitive restructuring, role-playing, skills development, problem solving and the use of imagery (Freeman et al., 1989). According to Vail et al. (2007), reality does impose limits in all members of a society, but women with physical disabilities end up experiencing it in more literal ways. Therefore, group counseling utilizing Gestalt and Cognitive-Behavioral therapies may benefit this population. The group condition allows individuals to have their needs met and at the same time facilitates self-growth and self-understanding (Harwood, 1998).

Group Therapy

Groups can be found in many different circumstances, such as in families, work, educational settings, and social or community projects. Conyne, Wilson, Kline, Morran & Ward (1993), emphasized the notion that groups vary in purpose and structure when considering a broad view. Group therapy usually has a specific focus, which may be educational, vocational, social, or personal. According to Corey (2008), groups involve an interpersonal process that emphasizes thoughts, feelings and behaviors. Corey (2008) emphasizes the importance of group therapy in the process of self-discovering internal resources of strength. Yalom (1995) also contends the importance of interpersonal interaction and learning as crucial in group therapy. He stresses that it helps group members understand what is missing in their interactions with others,

which prevents them from changing. Through group therapy, group members are able to gain insight through the practice of new skills within the group and in everyday interactions (Yalom, 1995).

According to Gladding (2003), groups go through four developmental stages, which are, beginning, transitional, working, and termination stages. Group members experience all the stages differently. Corey (2008) defines the initial or beginning stage of a group as the occasion for orientation and exploration where group members learn how the group functions and where expectations are defined. The transitional stage is described by Yalom (2005), as being characterized by conflict, dominance, negative comments, and interpersonal criticism. Corey (2008) describes the working stage as the one where a more in-depth exploration of problems and changes of behaviors are attempted. Termination of a group is a time for “summarizing, pulling together loose ends, and integrating and interpreting the group experience” (Gladding, 2008, p. 107). The final stage is to assist group members in transferring what was learned in the group to their outside environments.

Yalom (1995) proposes the nature of relationships between interacting group members is what indicates the process. He identifies eleven factors that are therapeutic in group counseling that can enhance learning and growth of group members. They are defined as: instillation of hope, universality, imparting of information, altruism, the corrective recapitulation of early family experiences, the development of socialization techniques, imitative learning, interpersonal learning, cohesion, catharsis, and existential. Although research is sparse on how group participants experience such therapeutic factors and the processes by which they come forward, group-work literature does have suggestions for making these mechanisms active, based more on

practice wisdom than on empirical studies (Garvin, 1997; Northen & Kurland, 2001; Steinberg, 2004).

Kurtz (1997) suggested cohesion, universality, and hope as the most important therapeutic factors in mutual aid and support groups. For Yalom (1995), the key therapeutic factors in psychotherapy groups are catharsis, interpersonal learning, self-understanding, and cohesion. In a study conducted by Lindsay, Roy, Montminy, Turcotte & Genest-Dufault (2008), 72 men from domestic violence groups, were interviewed to explore the emergence of therapeutic factors as well as the therapeutic effects on participants and the group. A qualitative methodology based on semi-structured interviews was used and data were categorized according to the factors that emerged from the accounts. The overall results of this study encompassed all the therapeutic factors, but only three therapeutic factors were reported as the most important for those participants: imparting information, group cohesion, and instillation of hope. This study contributes to a better understanding of the role that therapeutic factors play in groups and the processes by which they are manifested.

Yalom (1995) asserts interpersonal interaction and learning is crucial in group therapy. Some experts argue groups are more effective than individual therapy in producing major changes in coping skills and interpersonal relationships. Huebner (as cited in Chan et al., 2004) indicates groups instill a sense of hope in members, which diminishes the myth that change is impossible and requires exceptional characteristics. The need for a sense of hope may be particularly significant for people with disabilities.

A study developed by Crawford & McIvor (1985) investigated the relationship between group psychotherapy and the psychological adjustment of patients with a primary diagnosis of multiple sclerosis in decreasing patient depression and anxiety at the same time increasing self-

concept and self-direction. Forty-one hospitalized patients with multiple sclerosis were screened and randomly assigned to one of three groups: insight oriented, current events, and control. After 50 group sessions, all patients were reassessed using a battery of four tests. Results were analyzed through analysis of covariance and the nonparametric Friedman test. Post-hoc procedures were also performed and obtained the following results: 1) the insight-oriented therapy group was significantly less depressed than both the events group and control group, and 2) the therapy and current events groups were significantly more internally oriented than the control group. This study shows that not only group therapy seems to benefit patients diagnosed with multiple sclerosis but also any supervised group involvement appears to improve significantly the patient's emotional state.

A study developed by Richter, Snider, & Gorey (1997) assigned 115 female survivors of sexual abuse directly to therapy groups, or wait-list control groups. Members who completed the therapy groups were significantly less depressed, and had significantly improved self-esteem than their wait-list counterparts and gains were maintained at follow up six months later.

Techniques used in group therapy can be verbal and nonverbal as well as structured exercises even though they are differentiated by therapeutic approach. Common techniques include reflection, clarification, role-playing, and interpretation (Corey, 2008). Corey (2008) suggests the main goal of experiential approaches such as Gestalt group therapy is to develop a realistic and present-centered understanding of self and empower group members to change and take responsibility for their lives. A group provides a safe environment where members can explore a full range of emotions while being accepted by the group. Focus is on present feelings, in the here and now, creating congruence between actions and feelings (Huebner as cited in Chan et al., 2004). Falvo (1999) suggested people with disabilities may be faced by many doubts and

therefore, the goal of group therapy is to help them face these problems in order to maintain their identity and stability.

In Cognitive-Behavioral therapy, the goal is to replace maladaptive behaviors and utilize adaptive behaviors and rational cognitions (Huebner as cited in Chan et al., 2004). Intervention strategies used in Cognitive-Behavioral group therapy tend to be more structured, with specific behavioral objectives (Burns & Beck, 1999). Seligman & Marshak (2004) indicated group issues and some procedures may be the same, but some themes are unique to people with disabilities, such as if the disability acquired is permanent, will improve or will become worse. Swett & Kaplan (2004) emphasized the use of a variety of techniques to assist group members in changing negative cognitions into realistic evaluations, such as, role-playing, systematic desensitization, relaxation, meditation, assertiveness, time management training, and many others.

Therefore, group counseling utilizing Gestalt and Cognitive-Behavioral therapies may benefit women with physical disabilities facing abuse. The group condition allows individuals to have their needs met and at the same time facilitates self-growth and self-understanding (Harwood, 1998).

Gestalt Therapy

Gestalt therapy is best understood in the context of our environment. The whole only exists by virtue of the interrelation of its parts (Corey, 2004). According to O'Leary (1992), forming a gestalt gives meaning to what is happening. Gestalt works with people's awareness and awareness skills, rather than classic analysis and interpretation (Yontef & Jacobs, as cited in Corsini & Wedding, 2005). Corey (2004) emphasized Gestalt therapy is existential in that it focuses in the here-and-now, personal choice and responsibility. Cottone (1992) suggested the

central beliefs in Gestalt involve: (a) a holistic view of self, (b) understanding of the person and environment (i.e., figure and ground), (c) emphasis on the here and now, (d) a straight and dynamic relationship between counselor and client, and (e) understanding that awareness in the here and now leads one to change. Attention in Gestalt therapy is paid to the immediate behavior (Perls, 1969).

Researchers suggest that participation in therapy, such as Gestalt group therapy, where the aim is to increase body awareness, has been shown to result, among other effects, in an enhanced capacity for emotional expression (Landsman-Dijkstra, Van Wijck, Groothoff & Rispens, 2004). Research showed self-awareness and body-awareness being related, as body-esteem has shown to be a high predictor for self-esteem (Mendelson, White & Mendelson, 1996). A body-awareness therapy for people with chronic and/or psychosomatic symptoms led to higher self-esteem, better active coping, and a higher quality of life in general (Landsman-Dijkstra et al., 2004). Therefore, a group setting utilizing Gestalt therapy is expected to greatly benefit women with physical disabilities facing abuse.

Researchers, (Hughes et al. 2003; Nosek, 1996; Stuifberger & Rogers, 1997) indicated women with physical disabilities and/or who have chronic health conditions, appear to benefit from relationships with one another, such as in a group setting, where self-management, increased awareness, empowerment and support are emphasized. In a Gestalt group, the goal is to give equal attention to the process and the content (Corey, 2004). Miriam Polster (1997) emphasized the importance that Gestalt groups have in allowing members to talk about parts of their lives that concern them as well as their way of relating to one another. Yontef (2007) posited Gestalt therapy helps a person to learn about his/her actual experience and to recognize when interrupting some important awareness, so he/she can learn to interrupt that interruption.

Many women enter counseling feeling powerless and are aware only of painful symptoms resulting from suppressed feelings and experiences, not that they are at increased risk for problems associated with low self-esteem, passivity, and depression (Fodor & Rothblum, 1984; Enns, 1987). The purpose of Gestalt counseling is to encourage personal growth. The focus of Gestalt interventions involves the assimilation of feelings, cognitions, beliefs, and perceptions of events in order to help one develop self-awareness (Degeneffe & Lynch, 2004). To reach present-centered awareness, Gestalt focuses on "concentrating on the client's movements, postures, language patterns, voice, gestures, and interactions with others" (Corey, 2004, p. 304). When people completely identify with what they think, feel, desire, choose, and how they behave, their feelings of self-rejection are replaced by a new felt sense of self (Gendlin, 1981).

Allen (1986) posited disability has not been addressed directly in Gestalt therapy. However, researchers have argued Gestalt therapy can indeed benefit persons with disabilities (Allen, 1986; Coven, 1979; Livneh & Sherwood, 1991). Phemister (2001) posited Gestalt therapy emphasizes responsibility and self-awareness, which can establish self-trust and secure understanding of how an experience may be influencing the person. More than that, he argues Gestalt therapy promotes self-understanding so people have a better understanding of what they can do to understand, accept, and, if desired, change a particular experience and the perceptions about it. Berger (1999) emphasizes Gestalt therapy's goal is to "aid the client to complete gestalts from the past, have richer experiences of self and others in the present, and to open a future full of new meanings that are always in formation" (p. 33). This statement can be interpreted to mean Gestalt therapy may have a great potential to enhance the work in women with physical disabilities facing abuse.

Many clinicians have recommended group therapy as an excellent treatment tool for women who have suffered abuse because the group format, itself decreases women's sense of isolation and stigmatization (Courtois, 1988; Gil, 1988). Women with disabilities experience a great deal, and different levels, of oppression that affects their self-esteem negatively. Berwald & Houtstra (2002) posited for "women with disabilities to recognize that their own problems are tied directly to a larger societal oppression which provides them with an opportunity to normalize their experience and not blame themselves for the problem" (p. 74). In a group setting utilizing Gestalt therapy, people are encouraged to get deeper, by focusing and experimenting, rather than explaining (Yontef, 2007). By experimenting with new behaviors in group, women are encouraged and empowered. Zimmermann (1995) believed if women were empowered, they would engage in activities that demonstrate motivation and control, decision-making and problem-solving skills. Gestalt therapy offers a great number of experimental techniques that can effectively help women with physical disabilities. "Small group work is presented as the ideal modality for empowering interventions……… raising consciousness, engaging in mutual aid, developing skills, problem solving and experiencing one's own effectiveness in influencing others" (Gutierrez, 1991, p. 206).

In a study of 46 clients, developed by Greenberg, Warwar & Malcolm (2008) comparing the effectiveness of emotion-focused group therapy using Gestalt empty-chair dialogue with a psychoeducational group in the treatment of individuals who were emotionally injured by a significant other, aspects of emotional process in resolving interpersonal issues were examined. Results of this study revealed clients using Gestalt empty-chair dialogue showed significant more improvement than the psychoeducational group. Greenberg and colleagues (2008) posited "….encouraging clients to speak from their inner experiences of violation, the therapist is

promoting ownership of the clients' emotional experience and is empowering clients to appropriately assign responsibility for harm done" (p. 185). The use of the Gestalt empty-chair dialogue has been shown as an excellent intervention in the treatment of depression, interpersonal problems, and trauma (Greenberg & Watson, 1998, 2006; Paivio & Greenberg, 1995; Paivio & Nieuwenhuis, 2001).

Clarke & Greenberg (1986) compared the effectiveness of Gestalt two-chair dialog (a humanistic-affective technique) with problem-solving (a cognitive-behavioral technique) in the resolution of intrapersonal conflicts related to a decision. Forty-eight people were randomly assigned to three groups: a problem- solving group (n = 16), a two-chair group (n = 16), and a waiting-list control group ($n=16$). Results of this study indicated that although both interventions were significantly more effective than no treatment, the Gestalt two- chair was significantly more effective than problem solving in reducing indecision. This study suggests that, in some cases, issues that carry a very strong or acutely intense emotional piece may be more responsive to affective rather than cognitive interventions.

Interventions in Gestalt therapy are used to incite the individual into contacting his/her feelings and expose conflicts, so they can be inspected and hopefully resolved. Coven (1977) posited Gestalt interventions for individuals with physical disabilities are also focused on present feelings, experiences and behaviors. It is their responsibility to choose: (a) how they want to live with a disability, (b) the new behaviors they would be willing to experiment with and, (c) how and when they want to become self-sufficient. Livneh & Sherwood (1991) posited specifically helpful utility with persons with disabilities is the focus on self-responsibility, as well as experimental games of unfinished business, exaggeration, and dialogue. Coven (1977)

emphasized in the here-and-now the counselor needs to increase the individual's awareness of needs in order to help he/she to fulfill them.

Passons (1975) suggested people who experience Gestalt therapy may be willing to change and take responsibility for their emotional, cognitive, and physical behavior. Gestalt therapy techniques may be best suited for encouraging free will in people with disabilities (Phemister, 2001). Enns, Campbell & Courtois (1997) suggested Gestalt techniques are useful for exploring intense feelings such as anger or sadness. These techniques provide opportunities for reflection, consideration of new ways of looking at things, and decisions. For women with physical disabilities facing abuse, the therapist should be aware of the emotions the experience of abuse may trigger, especially anger. Seagull & Seagull (1991) noted for people who suffered abuse, physical and emotional survival are frequently sustained by the suppression of anger, which may be a "life-saving adaptation to a rage-producing situation" (p. 18). Bowman & Leakey (2006) posited Gestalt techniques and experiments prompts people to "contact fully their inner state and then vividly enact this internal experience by bringing forth their voices and movements more authentically, clearly and openly" (p. 45).

Specific techniques are recommended for decreasing anxiety, fear, intense emotions, and dysfunctional cognitions that are related to people who suffered any type of abuse, such as coping imagery, and strategies that involve the challenging of dysfunctional cognitions (Rothbaum & Foa, 1996). Authors provided recommendations for conducting effective groups for abuse victims, although many are short-term focused (Cole & Barney, 1987; Goodman & Nowak-Scibelli, 1985). Yontef (2007) posited experiments in Gestalt therapy are attempts to explore and have several possibilities that "are only limited by imagination and creativity" (p. 19). The use of Gestalt techniques can be utilized in group therapy. Enns & colleagues (1997)

suggested group therapy that addresses abuse issues could be presented in a short-term format, which helps women in decreasing isolation, shame, and loneliness. The group format allows for information and support, as well as the development of trust and practice of new coping and interpersonal skills. In a Gestalt group setting, women may have the support needed to explore feelings that are kept in the background and bring these experiences into focal awareness.

There are techniques and/or experiments in Gestalt therapy that can benefit women with physical disabilities facing abuse to increase their level of assertiveness and self-esteem. Livneh & Sherwood (1991) posited people, who manifest feelings of depression and internalized anger, as may be the case for women who experienced abuse, can benefit from Gestalt therapy interventions such as the empty chair, role-playing, and games of dialogue and exaggeration to foster awareness of inner conflicts and unfinished business. As mentioned by Yontef (1995a), experiments are aimed more to discover something instead of focusing strictly on modifying a behavior. It is through the use of Gestalt group therapy the levels of assertiveness and self-esteem in women with physical disabilities facing abuse can be expected to increase and are warranted in this study.

To the knowledge of this researcher, the effectiveness of direct clinical assessment and interventions of Gestalt therapy with women with physical disabilities who have suffered abuse has not yet been investigated nor supported by research. Because of the scarcity of research attention on women with physical disabilities, some of the research support referenced in this dissertation is somewhat out of date, but may still be relevant to today's field of mental health.

Cognitive-Behavioral Therapy

Beck & Weishaar (2000) stated Cognitive-Behavioral therapy is a therapeutic approach that posits how one thinks largely determines how one feels and behaves. Sweet & Kaplan

(2004) posited Cognitive-Behavioral therapy as a collaborative exploration by client and therapist, where thinking patterns, and beliefs that an individual may have, leads to maladaptive behaviors, and /or erroneous beliefs about oneself or others, affecting their relationships. As stated by Phemister (2001), a person's belief system is what intensifies consequences. For instance, an individual's present cognitions that result in negative feelings about oneself, consequently lower self-esteem. Cognitive-Behavioral therapy may be quite beneficial to people with disabilities because of its emphasis on short-term goals (Phemister, 2001).

Dutton (1992) in her model of assessment and intervention for empowering women that experienced abuse, suggests Cognitive-Behavioral interventions may be applied in order to avoid further violence, develop assertiveness skills, and address cognitions that may have been developed as a consequence of abuse (e.g., low self-esteem, self-blame, tolerance of abuse). Cognitive-Behavioral interventions include stress reduction, relaxation, cognitive restructuring, role-playing, skills development, problem solving, and use of imagery (Freeman, Simon, Beutler & Arkowitz, 1989; McMullin, 1986).

Enns (1992) noted Cognitive-Behavioral interventions such as modeling, cognitive restructuring, and communication skills training can help individuals develop independence and increase self-nurturance. More importantly, Enns (1992) posited, " personal change involves the practice of new skills, but perhaps more importantly, focuses on the development of new attitudes toward the self" (p. 9). These new attitudes toward the self are very important since it means acceptance of one's own feelings. Young, Weinberger, & Beck (2001) posited cognitive-behavioral techniques such as enhancing interpersonal effectiveness (assertiveness) or improving physiological functioning (relaxation training) are important to help the individual regain control and effectiveness with daily activities.

According to Mona, Romesser-Scehnet, Cameron & Cardenas (2006), disability may not be the central point for every presenting problem an individual with a disability may present, but it is with no doubt part of the context in which the present problem occurs. Beck (1995) suggested an individual's emotions and behaviors are influenced by his or her perceptions of events. Tirch & Radnitz (2000) identified six categories of cognitive distortions relevant to people with disabilities. The first category relates to an overly negative view people with disabilities have of the world and others. The second category is based on the person's appraisal of his/her own self-worth. The third cluster of distortion is the expectation and perception of rejection. The forth type is hopelessness, the expectation of consistent failure, which can lead to depression, anxiety and despair. The fifth type of distortion is the sense of personal entitlement, a way to externalize painful emotions. The sixth and last cluster of distortion is related to feelings of vulnerability and victimization (Tirch & Radnitz, 2000).

The cognitive distortions above mentioned could all play a role in the maladaptive coping strategies people with disabilities may have. Mona et al. (2006) posited the goal of a cognitive-behavioral therapist is to "identify and target these cognitive distortions in treatment while balancing empathy and validation" (p. 210).

A study conducted by Hopps, Pepin, & Boisvert (2003) examining the effectiveness of cognitive-behavioral, goal-oriented teletherapy via inter-relay-chat to chronically lonely people with physical disabilities, had the main purpose of reducing feelings of loneliness. The study used a comparison design with pretest, posttest, follow-up, and a waiting-list control, with 19 participants forming seven groups of 2-3 people. The results of this study indicated participants felt less lonely after the intervention. The findings overall indicated group goal-oriented cognitive-behavioral therapy for chronic loneliness, resulted in statistically and clinically

significant improvement in reported feelings of loneliness, acceptance of disability, and social difficulties in challenging situations among people with physical disabilities.

Women with physical disabilities that faced abuse may develop Post Traumatic Stress Disorder (PTSD), a problem affecting an estimated 10.4% of U.S. women at some point of their lives (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). Cognitive Behavioral interventions have yielded promising results in the treatment of PTSD (Blake & Sonnenberg, 1998; Foa & Meadows, 1997) especially for female victims of abuse. There is evidence that cognitions or beliefs play an important role in the intractability and chronic nature of post-traumatic stress (Foa, Ehlers, Clark, Tolin & Orsillo, 1999; Kubany, 1997)

Studies that look at the impact of abuse in adult survivors of childhood abuse have revealed higher psychological distress and, in many individuals, present even post traumatic stress disorder symptoms. A pilot study developed by Chard, Weaver, & Resick (1997) on a Cognitive-Behavioral therapy protocol for treatment of adult survivors of childhood sexual abuse focused on beliefs related to safety, trust, power/control, self-esteem, and intimacy. The authors mentioned the increased need for short-term based treatments. In this pilot study, they combined a 26-session model of group and individual therapy over a 17-week period with a total number of 15 participants divided into three groups. Results showed great improvement and, at treatment completion, none of the clients met criteria for posttraumatic stress disorder. Clients who completed the protocol reported dramatic changes in their negative cognitions toward self, other, and the world, greater ease in managing stressful situations, less avoidance, no reexperiencing, and improvement in relationships with friends and significant others.

Bryant, Harvey, Dang, Sackville & Basten (1998) conducted a study that compared Cognitive-Behavioral Therapy (CBT) to Supportive Counseling (SC) on 24 participants with

acute stress disorder believed to be a precursor of chronic posttraumatic stress disorder (PTSD) following civilian trauma. Participants received five sessions of either Cognitive-Behavioral Therapy or Supportive Counseling. Findings suggest that fewer participants in CBT (8%) than in SC (83%) met criteria for PTSD at posttreatment. There were greater statistically and clinically significant reductions in intrusive, avoidance, and depressive symptomatology among the CBT participants than among the SC participants.

Cognitive-Behavioral therapy is very suitable for individuals with physical illnesses or physical symptoms (Sensky, 1989; Sensky & Wright, 1993). According to Sensky (2004) serious illnesses are commonly associated with maladaptive beliefs and attitudes, which can result in distress. Cognitive-Behavioral therapy interventions can also encourage skills individuals can use outside therapy sessions, enhancing one's sense of empowerment and control.

Smith, Peck, Milano & Ward (1988) tested the relevance of Beck's model to Rheumatoid Arthritis (RA) by examining the relation between cognitive distortion, as measured by the *Cognitive Error Questionnaire* (Lefebvre, 1980, 1981), and both self-reported and interview-rated depression and disability in 92 rheumatoid arthritis (RA) patients. Cognitive distortion was significantly associated with depression and also related to physical disability. Results of this study supported previous findings concerning the relevance of Beck's (1976) model to depression and disability that occurs in the context of other chronic painful conditions (Lefebvre, 1981; Smith, Follick, Ahern & Adams, 1986).

Many researchers (Allen, 1995; McDonald, 1984; Robinson & Worell, 2002; Toner, Segal, Emmot & Myron, 2002) agree that, extensions of Cognitive-Behavioral therapy interventions with women emphasize multiple assessment strategies that are very relevant to the lives of women. The broad range of Cognitive-Behavioral interventions and concepts helps to

"integrate ongoing thought processes with procedures for overt behavioral and situational change" (Worell & Remer 2003, p. 105).

Summary

This chapter focused on the literature and existing research pertinent to this study. A review of the literature and existing research of the differential effects of Gestalt Therapy (GT) and Cognitive-Behavioral Therapy (CBT) group interventions on levels of assertiveness and self-esteem in women with physical disabilities facing abuse were presented. The dependent variables reviewed were assertiveness and self-esteem. The significant findings and relevance of these findings to the current study were discussed. Chapter III describes the design of the study, research setting, preliminary procedures, assignment of treatment group, and group therapy interventions to be used in this study.

CHAPTER III

METHODOLOGY

Introduction

This chapter presents the research design, dependent and independent variables, setting, and procedure for evaluating the differential effects of Gestalt Therapy (GT) and Cognitive-Behavioral Therapy (CBT) group interventions on assertiveness and self-esteem of women with physical disabilities facing abuse. Participants were recruited from the Ann Arbor Center for Independent Living, and other agencies serving individuals with disabilities. Two groups consisting of four and seven women with physical disabilities that have experienced abuse were recruited. Experimental Group I participated in Gestalt Therapy (GT) group interventions and Experimental Group II in Cognitive-Behavioral Therapy (CBT) group interventions.

The research was conducted over a period of six weeks, totaling six weekly two-hour group sessions. There was an incentive of $ 50.00 offered to women for participating in the group therapy sessions. All participants met with the researcher prior to treatment. All participants were randomly assigned to one of the two treatment conditions. Both groups were conducted at the same location on separate days of the week. Participants completed the demographics and pre-test criterion instruments at the first group meeting. Both groups began in the same week. All participants completed the post-study instruments at the end of the six weeks following their final group session.

A pre-test was used to establish baseline information for the group participants' levels of assertiveness and self-esteem. A post-test was used to determine the effects of the interventions on the dependent variables. The post-test was conducted at the final group session.

Research Design

The study was a quasi-experimental pretest-posttest design (Hadley & Mitchell, 1995). Differential outcomes for two group therapy interventions, Gestalt Therapy (GT) and Cognitive-Behavioral Therapy (CBT), were compared in terms of the levels of assertiveness and self-esteem. All study participants were women with physical disabilities facing abuse who volunteered to take part in the research. All participants were randomly assigned to the experimental conditions in order to provide equality of the groups in terms of age, race/ethnicity, and physical disability. At the beginning of the first group therapy session, all participants completed the pre-study and demographic information instruments. All participants completed the post-study instruments following their respective group therapy sessions at the end of the six-week period. This study yielded pre-and-post experimental data to be compared between the two groups studied (Between Groups) as well as, between members within each group (Within Groups). Figure 1 details the research design.

Figure 1 Research Design

Research Group	Pretest	Experiment	Posttest
Experimental Group 1 Gestalt Therapy (GT) group interventions	O_1	X_1	O_2
Experimental Group 2 Cognitive-Behavioral Therapy (CBT) group interventions	O_3	X_2	O_4

Variables

Independent Variables

The independent variable for this study was random assignment to one of two experimental conditions. Experimental Group I Gestalt Therapy (GT) group interventions or Experimental Group II Cognitive-Behavioral Therapy (CBT) group interventions.

Dependent Variables

The dependent variables were assertiveness as measured by the *Rathus Assertiveness Scale* (*RAS*, Rathus, 1973) and self-esteem as measured by the *Culture-Free Self-Esteem Inventories* (*CFSEI-2*, Form AD, Battle, 1992).

Setting

Sessions were conducted at the Ann Arbor Center for Independent Living located in Ann Arbor, MI. The Ann Arbor Center for Independent Living (CIL) was established in 1976 as the first center for independent living in Michigan and fourth in the nation. The Ann Arbor CIL is a nonprofit organization dedicated to the success of children, youth, and adults with disabilities at home, school, work, and in the community.

Participants

The total number of women with physical disabilities facing abuse recruited for this research was 14 living in the Ann Arbor, Michigan suburban area. However, prior to the start of the study, three participants who were scheduled for the Experimental Group I experienced health issues and could not participate. Therefore, Experimental Group 1 Gestalt Therapy (GT) group interventions had four participants and seven participants were in Experimental Group 2 Cognitive-Behavioral Therapy (CBT) group interventions. Eligibility criteria were limited to: 1) women who had a primary diagnosis of a physical disability; 2) reside in the suburban Ann

Arbor area; 3) were between 21 and 70 years of age; 4) completed the eighth grade; 5) were not currently participating in group psychotherapy for abuse-related issues; 6) had not experienced a current psychotic episode; 7) did not have a cognitive impairment; 8) presented current or past experience with abuse; 9) did not have current drug or alcohol problems that would interfere with their participation in a group setting; and, 10) were physically and mentally able to participate in group therapy interventions.

Participants were recruited from the Ann Arbor Center for Independent Living (CIL), and other agencies serving individuals with disabilities. Flyers (see Appendix A) stating the purpose and benefits of the study were distributed to these agencies. All potential group participants received the flyer describing the group therapy intervention study from the researcher and/or staff in charge of the agencies where recruitment occurred. This flyer stated the purpose of the group therapy, day and time of the group therapy intervention sessions, location of the group therapy interventions, and amount of stipend to be received for participation.

The group therapy sessions were conducted by the researcher, a doctoral candidate experienced in group therapy interventions, currently completing the doctor of philosophy degree program in counseling at Wayne State University, and licensed as a limited licensed professional counselor. The researcher is experienced in working with persons with disabilities.

Preliminary Procedures

The following two sections provide an explanation of preliminary procedures used in this study.

Participants

Alternative formats for all study-related materials were provided as needed. Prior to the beginning of the group therapy intervention, group members who volunteered to participate were

required to read and sign an informed consent form. They were informed they could withdraw from the experiment at any time without penalty or prejudice. After completing the informed consent statement, the participants received an overview of the procedures to be implemented by the leader. They were informed of any risks or benefits of participation in the study.

After this discussion of procedures for the study, the participants were asked to complete the *Demographic Form* (Adam Rita, 2009) and pretest criterion instruments. The criterion instruments included the *Rathus Assertiveness Schedule* (*RAS*, Rathus, 1973) and *Culture-Free Self-Esteem Inventory* (*CFSEI-2*, Form AD, Battle, 1992) that provided baseline data for levels of assertiveness and self-esteem. All participants chose a personal four-digit identifying number, such as four digits of a phone number, family birth date, etc., to be used throughout the study for purposes of data identification. Participants were instructed to record this number on all of the pre-and-post instruments. This was done to provide anonymity and maintain confidentiality.

Many women with physical disabilities are dependent upon personal assistants for transportation to the site of intervention sessions, and for physical assistance. The presence of a personal assistant during interventions may inhibit a free exchange of information and freedom of expression and inhibit the participant's perception of confidentiality. Participants were informed of the researcher's commitment to confidentiality so they would feel free to speak in sessions. The Ann Arbor CIL has a waiting room across from where the group sessions were held where personal assistants can be available to provide assistance if needed by a group member. The participants in this research study did not have personal assistants accompanying them to the group sessions.

Treatment Procedures

The outcomes of the two group therapy interventions, Gestalt and Cognitive-Behavioral, were compared for the levels of assertiveness and self-esteem in women with physical disabilities facing abuse living in the suburban Ann Arbor area. Following completion of the criterion instruments the participants began their group sessions. The following sections describe the two treatment modalities.

Experimental Group 1 Gestalt Therapy (GT) Group Interventions

Participants in Experimental Group #1 received GT group therapy interventions. The GT group sessions were two-hours, once a week, for a period of six weeks. The Gestalt approach involved assimilation of feelings, cognitions, beliefs, and perceptions of past, present, and future events in order to help participants develop self-awareness and life needs (Degeneffe & Lynch, 2004). Gestalt group therapy involves three stages (Corey, 2004). The initial stage involves providing a climate of trust that supports risk-taking in the establishment of connections between members of the group (i.e., explore members' questions about their identity in the group, explore group members' commonalities). The second stage is helping members react to what is going on in the group (i.e., encourage members to challenge norms, express differences and dissatisfactions, differentiate roles from persons). The final stage provides opportunity for a more profound level of work (i.e., helping the group to arrive at a point of closure, recognizing and completing unfinished business).

The purpose of Gestalt group therapy is to give participants an opportunity to experiment with new behaviors allowing for an increase in self-awareness. In experimenting, participants can address unfinished business, learn how to meet their needs, and work towards becoming whole, and work towards closure, in other words "completing the unfinished Gestalt" (James &

Gilliland, 2003). Participants in the Gestalt group interventions were assisted and encouraged to make choices and therefore be responsible for their covert and overt behaviors. As mentioned by Coven (1979), people have the ability to define their own reality and make their own choices. As Perls (1969) stated, "what we are trying to do in therapy is step-by-step to re-own the disowned parts of the personality until the person becomes strong enough to facilitate his/her own growth" (p. 38).

Achieving the goals in Gestalt group therapy means the therapist attempted to engage participants in experiments, which in the safety of the therapeutic relationship enabled participants to work through issues of disability and abuse. These experiments were expected to help participants increase their levels of assertiveness and self-esteem, through role-playing, empty-chair dialogues, dream work, relaxation exercises, exaggeration games, and enactment, etc.

In this research study, Gestalt group therapy focused on self-awareness, self-integration, self-responsibility, and holism, which is particularly relevant in working with women with physical disabilities. The group leader facilitated participants' awareness by focusing on participants' experiences in the here-and-now rather than focusing exclusively on underlying problems or preset assumptions.

Experimental Group 2 Cognitive-Behavioral Therapy (CBT) Group Interventions

Participants in Experimental Group #2 received CBT group interventions. The CBT group sessions were two-hours, once a week, for a period of six weeks. The techniques were designed to help women with physical disabilities facing abuse to overcome the many obstacles they experience. The aim of the CBT interventions was to explore thinking patterns and beliefs that an individual holds and that may be leading to maladaptive behaviors and/or erroneous

beliefs about one's self. CBT group therapy involves three stages (Corey, 2008). During the initial stage, members get acquainted, oriented to the group process, and build cohesiveness. The working stage allows for assessment and evaluation (i.e., reinforcement, modeling) determining how well treatment goals are being attained (i.e., homework, coaching) and differentiating between effective and non effective strategies (i.e., cognitive restructuring, problem solving). The final stage provides opportunities for members to generalize new ways of thinking and reacting to their everyday living (i.e. encouragement of personal responsibility, provide time for practice situations of real world situations), and prepare members to face difficulties and deal with possible regressions (i.e., practice assertiveness techniques, develop alternative strategies).

The interventions in this study aimed to help participants handle difficult situations, such as living with a physical disability and facing abuse, in order to help them reduce stress and feelings of worthlessness. In the CBT interventions, all participants received cognitive-based stress management techniques (Kabat-Zinn, 2002), and behavioral-based relaxation training (Poppin, 1998). Participants were assisted in setting short-term and specific goals and assigned homework exercises, which were discussed during the group therapy sessions. Appendix D provides copies of homework assignments. The CBT group therapy sessions included relaxation training, cognitive restructuring, and assertive training. Participants were assisted in learning new cognitive, interpersonal, and behavioral skills.

Following each group therapy session, the leader completed a *Group Counseling Session Summary* (*GCSS*, Ellington, 1997) to document group members' participation. This form provided information concerning group themes, members' roles, significant patterns, interventions, session development, and goals and plans for ensuing sessions.

At the end of six weeks following the final group therapy session, all participants completed the post-test criterion instruments (*Rathus Assertiveness Scale, RAS*, Rathus, 1973; *Culture-Free Self-Esteem Inventories, CFSEI-2*, Form AD, Battle 1992) that provided post-treatment data. All participants received printed material concerning local resources for matters concerning persons with disabilities (See Appendix D) in order to provide references for future use.

Criterion Instruments

The following criterion instruments were used in this research:

Demographic Questionnaire (Adam Rita, 2009)

All study participants completed the self-report *Demographic Questionnaire* (Adam Rita, 2009) at the beginning of the initial group therapy session. Demographic characteristics included on the questionnaire were: age, racial/ethnic category, marital status, living arrangement, educational level, physical disability, employment, socioeconomic status, type of abuse and description of any current abusive experiences.

Rathus Assertiveness Schedule (RAS, Rathus, 1973*)*

The *RAS* (Rathus, 1973) is a 30-item survey for assessing assertive behavior in many contexts. It is a Likert scale -3 to +3 (very uncharacteristic of me to very characteristic of me), providing a possible score of -90 to +90. Negative scores indicate a lack of assertiveness, and positive scores indicate high assertiveness. This instrument has been widely used and has been reported to be reliable, presenting a Cronbach's alpha of .72 (Del Greco, Breitbach, Rumer, McCarthy & Suissa, 1986). The *RAS* has been shown to have moderate to high test-retest (Rathus, 1973) and split-half reliability (Rathus, 1973; Norton &Warnick, 1976; Pearson, 1979). Moreover, the validity of RAS has been established by correlating RAS scores with independent

raters' assessments of assertive others (Rathus, 1973); with other measures of assertiveness (Norton &Varnick, 1976); with nonverbal components of assertive behavior (McFall et al*.,* 1982) and trait and interpersonal anxiety (Orenstein, Orenstein & Carr, 1975). Galassi & Galassi (1978) concluded the items contained on the RAS include a wide range of situations involving assertiveness. A study investigating assertiveness training for disabled adults in wheelchairs using the RAS, showed significant increases in self-reported assertiveness, RAS $t(17) = 2.86$, $p = .005$. Finally, the RAS was chosen because the items clearly reflect both anxiety and behavioral components of assertiveness (Glueckauf & Quittner, 1992).

Culture-Free Self-Esteem Inventories (CFSEI-2, Form AD, Battle, 1992)

The *CFSEI-2* (Form AD, Battle, 1992) is a 40-item self-report measure of self-esteem widely used and reliable that requires yes/no responses. It has three subscales; general self-esteem (16 items), social self-esteem (eight items) and personal self-esteem (eight items). The scores for each subscale are combined to obtain a total score. On the basis of the standardized scores derived from the inventory, Battle (1992) developed five categories for respondents' self esteem consisting of: 1) very low (13), 2) low (14–19), 3) intermediate (20–26), 4) high (26–29) and 5) very high (30 +). The inventory has been standardized on largely Canadian and USA samples (Battle, 1977a, 1977b, 1978, 1990, 1992), but British adult norms (Bartram, Lindley & Fosteer, 1991) do not significantly differ from the American norms. Reliability over 0.80 and validity has been demonstrated across these studies.

Group Counseling Session Summary (GCSS, Ellington, 1997)

The *GCSS* (Ellington, 1997) was adapted from a counselor training and supervision instrument used at the Wayne State University, College of Education, Counseling and Testing Center. This instrument contains six questions to be used to document information concerning

group themes, members' roles, significant patterns, interventions, session development, and goals and plans for ensuing sessions. The group leader completed one of these forms following each group session. There are no reliability or validity figures published for this instrument.

Research Questions and Hypotheses

This quasi-experimental pre-test/post-test study examined differential changes in two dependent variables, assertiveness and self-esteem in women with physical disabilities facing abuse. Experimental Group I participated in Gestalt Therapy (GT) group interventions and Experimental Group II participated in Cognitive-Behavioral Therapy (CBT) group interventions. Both null hypotheses were tested at an alpha level of .05. Measures for each dependent variable, assertiveness and self-esteem, needed to be statistically significant for each null hypothesis to be rejected. The research questions and hypotheses guiding this study were:

1. Will the level of assertiveness in women with physical disabilities facing abuse, who participate in Gestalt Therapy (GT) group interventions, be increased significantly more than those who are in the Cognitive-Behavioral Therapy (CBT) group interventions?

H_1: Women with physical disabilities facing abuse participating in either Gestalt Therapy (GT) or Cognitive-Behavioral Therapy (CBT) group interventions will not differ in levels of assertiveness.

Null Hypothesis $\mu_1 = \mu_2$

Alternative Hypothesis $\mu_1 \neq \mu_2$

Instrument: *Rathus Assertiveness Schedule* (*RAS*, Rathus, 1973)

2. Will the level of self-esteem in women with physical disabilities facing abuse, who participate in Gestalt Therapy (GT) group interventions, be increased

significantly more than those who are in the Cognitive-Behavioral Therapy (CBT) group interventions?

H_2: Women with physical disabilities facing abuse participating in either Gestalt Therapy (GT) or Cognitive-Behavioral Therapy (CBT) group interventions will not differ in levels of self-esteem.

Null Hypothesis $\mu_1 = \mu_2$

Alternative Hypothesis $\mu_1 \neq \mu_2$

Instrument: *Cultural-Free Self-Esteem Inventories* (*CFSEI-2*, Form AD, Battle, 1992)

Data Analysis

Data were analyzed to determine the differential effects of participating in Gestalt Therapy (GT) or Cognitive-Behavioral Therapy (CBT) group interventions. The data analysis was separated into two sections. Statistical analysis was conducted utilizing SPSS for Windows, 17th (SPSS, Inc., 2008) computer program, and tested at an alpha level of .05. Descriptive statistics including frequency distributions for the nominally scaled demographic characteristics (age, racial/ethnic category, social economic status, marital status, education level, physical disability, and type of abuse) provided a profile of the sample. Cross-tabulations to determine the assumption of approximate normal distribution, measures of central tendency (mean, median, and mode), measures of variability (variance and standard deviation), and correlation of the dependent variables were performed.

Prior to testing the research hypotheses, a *t*-test for independent samples using the pre-test scores for the dependent variables, assertiveness and self-esteem, was conducted to determine if the groups were statistically equivalent prior to treatment. At the pre-test stage, the

test for homoscedasticity (homogeneous variances) was not significant for the *RAS* (Rathus, 1973). This means the underlying assumption of equal variances remains tenable. The independent samples *t*-test, however, was significant. This means the two groups did not share baseline equality at the beginning of the study, and in further analyses, the pretest scores should be used as covariates. The underlying test of homoscedasticity for the *CFSEI-2 (*Form AD, Battle, 1992) was not significant. The independent samples *t*-test was not significant indicating there was baseline equality on this measure. A multivariate analysis of variance (MANCOVA) was conducted to examine group differences in assertiveness and self-esteem at posttest. It compared women with physical disabilities facing abuse outcome changes in assertiveness and self-esteem from pre-treatment to post-treatment. Pre-test scores on these variables were used as covariates. The mean scores were compared to determine which group had the highest, most increased levels of assertiveness and self-esteem. Differential effects for each dependent variable (assertiveness and self-esteem) needed to be statistically significant for each null hypothesis to be rejected. The statistical analysis for each hypothesis is presented in Figure 2.

Figure 2 Statistical Analyses

Research Question	Variables	Statistical Analysis
1. Will the level of assertiveness in women with physical disabilities facing abuse, who participate in Gestalt Therapy (GT) group interventions, be increased significantly more than those who are in the Cognitive-Behavioral Therapy (CBT) group interventions? H_1: Women with physical disabilities facing abuse participating in either Gestalt therapy (GT) or Cognitive-Behavioral Therapy (CBT) group interventions will not differ in levels of assertiveness.	Independent Variable: Group Assignment: Experimental Group 1: Gestalt Therapy (GT) group interventions Experimental Group 2: Cognitive-Behavioral Therapy (CBT) group interventions Dependent Variables: Posttest scores on the *Rathus Assertiveness Schedule* (*RAS*, Rathus, 1973) Covariates: Pretest scores on the *Rathus Assertiveness Schedule* (*RAS*, Rathus, 1973)	A multivariate analysis of covariance (MANCOVA) with group membership as the fixed independent variable was used to compare level of assertiveness in women with physical disabilities facing abuse from pre-experiment to post-experiment at the completion of six weeks. Pretest scores on this measure were used as covariates. Mean scores were compared to determine which group had the most increased level of assertiveness following the experiment at the completion of the six week period.
2. Will the level of self-esteem in women with physical disabilities facing abuse, who participate in Gestalt Therapy (GT) group interventions, be increased significantly more than those who are in the Cognitive-Behavioral Therapy (CBT) group interventions? H_2: Women with physical disabilities facing abuse participating in either Gestalt Therapy (GT) or Cognitive-Behavioral Therapy (CBT) group interventions will not differ in levels of self-esteem.	Independent Variable: Group Assignment: Experimental Group 1: Gestalt Therapy (GT) group interventions Experimental Group 2: Cognitive-Behavioral Therapy (CBT) group interventions Dependent Variables: Posttest scores on the *Cultural-Free Self-Esteem Inventories* (*CFSEI-2*, Form AD, Battle, 1992) Covariates: Pretest scores on the *Cultural-Free Self-Esteem Inventories* (*CFSEI-2*, Form AD, Battle, 1992)	A multivariate analysis of covariance (MANCOVA) with group membership as the fixed independent variable will be used to compare level of self-esteem in women with physical disabilities facing abuse from pre-experiment to post-experiment at the completion of six weeks. Pretest scores on this measure were used as covariates. Mean scores were compared to determine which group had the most increased level of self-esteem following the experiment at the completion of the six week period.

Summary

Chapter III described the method of assigning the treatment conditions to one of the two experimental groups, research setting, and description of participants, treatment procedures, and criterion instruments used in this study. Chapter III also presented in detail the research design, research questions and hypotheses, and statistical analyses utilized. Chapter IV presents the results of the statistical analyses and description of the findings from the data collected for this study.

CHAPTER IV

RESULTS OF DATA ANALYSIS

This chapter reports the results of the data analysis used to describe the participants and test hypotheses established for this study. This chapter is divided into two sections. The first section uses descriptive statistics to provide a profile of the women with physical disabilities facing abuse who participated in the study. The second section uses inferential statistical analysis to test each of the two hypotheses for the study.

The purpose of the study was to investigate the effects of Gestalt Therapy (GT) group interventions and Cognitive-Behavioral Therapy (CBT) group interventions on the assertiveness and self-esteem of women with physical disabilities facing abuse. It was hypothesized these interventions would help women with physical disabilities facing abuse increase their levels of assertiveness and self-esteem. The study posited there would be statistically significant differences for these variables between women with physical disabilities who received Gestalt Therapy (GT) group interventions and women with physical disabilities who received Cognitive-Behavioral Therapy (CBT) group interventions.

A description of the participants was gathered using the *Demographic Questionnaire* (Adam Rita, 2009). The data reported in this chapter includes pre-testing and post-testing of assertiveness levels using the *RAS* (Rathus, 1973) and self-esteem using the *CFSEI-2 (*Form AD, Battle, 1992) in women with physical disabilities facing abuse.

Description of the Participants

Eleven women with physical disabilities facing abuse chose to participate in the study. Initially, fourteen women signed up to participate in the study. However, prior to the start of the study, three participants who were scheduled for the Experimental Group I experienced health

issues and could not participate. Therefore, Experimental Group 1 Gestalt Therapy (GT) group interventions had four participants and seven participants were in Experimental Group 2 Cognitive-Behavioral Therapy (CBT) group interventions. Hadley and Mitchell (1995) stated "there is no standard minimum sample size necessary for research to be regarded as sound" (p. 274). The actual age distribution of the women with physical disabilities facing abuse is presented in Table 1 by treatment group.

Table 1
Age Distribution by Treatment Group
N=11

Treatment Group	Mean	N	Std. Deviation	Minimum	Median	Maximum
Gestalt	44.50	4	14.84	32	41.50	63
Cognitive Behavioral	41.57	7	14.34	24	41.00	65
Total	42.64	11	13.84	24	41.00	65

The maximum age in both experimental groups was 65 years of age. The minimum age for Experimental Group 1 was 32 and 24 years of age in Experimental Group II. The mean age in both groups was 42.64 years (*SD* = 13.84). Additional demographics describing the participants in the study are presented in Table 2 by treatment group.

Table 2
Demographics by Treatment Group
N=11

Demographic	Description	Gestalt Group	Cognitive Behavioral Group	Total
Marital Status	Single	1	5	6
	Married/Living Together	1	2	3
	Divorced/Separated	2	0	2
	Total	4	7	11
Ethnicity	Caucasian	2	2	4
	African American	1	5	6
	Hispanic/Latino	1	0	1
	Total	4	7	11
Current Living Arrangement	Independent	4	4	8
	With Family	0	1	1
	Semi-Independent	0	2	2
	Total	4	7	11
Highest Educational Degree Completed	Less than High School Diploma	0	1	1
	High School/GED Diploma	2	4	6
	Bachelor Degree	1	2	3
	Master Degree	1	0	1
	Total	4	7	11
Employment Status	Full-time	1	1	2
	Part-time	1	0	1
	Volunteer	0	2	2
	Unemployed	0	2	2
	Retired	1	1	2
	Other	1	1	2
	Total	4	7	11
Household Income	Less than $10,000	2	0	2
	$10,000-$20,000	1	6	7
	$21,000-$30,000	0	1	1
	$51,000-$60,000	1	0	1
	Total	4	7	11

The marital status distribution included one single, one married and two divorced women in the Gestalt Therapy (GT) group interventions. Participants in the Cognitive-Behavioral Therapy (CBT) group interventions were five single and two married women. The racial/ethnic distribution included two Caucasians, one African American and Hispanic/Latino participants in

the Gestalt Therapy (GT) group interventions. Participants in the Cognitive-Behavioral Therapy (CBT) group interventions included two Caucasians and five African Americans. All participants in the Gestalt Therapy (GT) group interventions live independently. Four participants live independently, one with her family, and two semi-independently in the Cognitive-Behavioral Therapy (CBT) group interventions.

The levels of education for participants in this study were two with a High School/GED Diploma, one with a Bachelor's Degree, and one with a Master's Degree in the Gestalt Therapy (GT) group interventions. The levels of education in the Cognitive-Behavioral Therapy (CBT) group interventions were comprised of one woman with less than a High School Diploma, four with a High School/GED Diploma, and two with a Bachelor's Degree.

The Gestalt Therapy (GT) group interventions participants' employment status were reported as one woman with Full-time status, one Part-time, one Retired, and one Other. Other was stated as receiving disability payment assistance. The Cognitive-Behavioral Therapy (CBT) group interventions participants' employment status was one woman with Full-time status, two Volunteers, two Unemployed, one Retired and one Other. Other was stated as being paid as a Student Assistant.

Two women with physical disabilities in the Gestalt Therapy (GT) group interventions and none in the Cognitive-Behavioral Therapy (CBT) group interventions earned less than $10,000. One participant in the Gestalt Therapy (GT) group interventions and six in the Cognitive-Behavioral Therapy (CBT) group interventions earned $10,000- $20,000. None of the women in the Gestalt Therapy (GT) group interventions household income was $21,000-$30,000, and one woman in the Cognitive-Behavioral Therapy (CBT) group interventions earned

$21,000-$30,000. Gestalt Therapy (GT) group interventions had one woman who earned $51,000-$60,000 and none in the Cognitive-Behavioral Therapy (CBT) group interventions.

Table 3 describes the participants' types of disabilities by treatment group for this study.

Table 3
Type of Disability by Treatment Group
N=11

Type of Disability	Yes/No	Gestalt Group	Cognitive Behavioral Group	Total
Cerebral Palsy	No	4	7	11
	Total	4	7	11
Traumatic Brain Injury	No	4	4	8
	Yes	0	3	3
	Total	4	7	11
Multiple Sclerosis	No	2	6	8
	Yes	2	1	3
	Total	4	7	11
Muscular Dystrophy	No	4	7	11
	Total	4	7	11
Spina Bifida	No	4	7	11
	Total	4	7	11
Spinal Cord Injury	No	4	7	11
	Total	4	7	11
Arthritis	No	3	5	8
	Yes	1	2	3
	Total	4	7	11
Joint & Connective Tissue Disorder	No	3	3	6
	Yes	1	4	5
	Total	4	7	11
Other Types of Disability	No	1	4	5
	Yes	3	3	6
	Total	4	7	11

Three women in the Cognitive-Behavioral Therapy (CBT) group interventions reported having Traumatic-Brain Injury and none in the Gestalt Therapy (GT) group interventions. Two

women in the Gestalt Therapy (GT) group interventions and one woman in the Cognitive-Behavioral Therapy (CBT) group interventions reported having Multiple Sclerosis. One woman in the Gestalt Therapy (GT) group interventions and two in the Cognitive-Behavioral Therapy (CBT) group interventions reported having Arthritis. One woman in the Gestalt Therapy (GT) group interventions and four in the Cognitive-Behavioral Therapy (CBT) group interventions reported having a Joint and Connective Tissue Disorder. Three woman in each treatment group reported having Other types of Disability. Other types of Disabilities were described in the Gestalt Therapy (GT) group interventions as Lupus, Narcolepsy, Hard of Hearing, and Legally Blind. Other types of Disabilities in the Cognitive-Behavioral Therapy (CBT) group interventions were described as Lupus, High Blood Pressure, and COPD – Chronic Obstructive Pulmonary Disease. None of the participants in either treatment group reported having Cerebral Palsy, Muscular Dystrophy, Spina Bifida, and/or Spinal Cord Injury.

Table 4 presents the types of abuse experienced by the women in each treatment group participating in this study.

Table 4
Type of Abuse Experience by Treatment Group
N=11

Type of Abuse Experience	Yes/No	Gestalt Group	Cognitive Behavioral Group	Total
Have you ever experienced Emotional and/or Verbal Abuse?	Yes	4	7	11
	Total	4	7	11
Have you ever experienced Physical Abuse?	No	3	5	8
	Yes	1	2	3
	Total	4	7	11
Have you ever experienced Sexual Abuse?	No	4	2	6
	Yes	0	5	5
	Total	4	7	11
Have you ever experienced Financial Abuse?	No	1	5	6
	Yes	3	2	5
	Total	4	7	11
Have you ever experienced Neglect?	No	1	5	6
	Yes	3	2	5
	Total	4	7	11
Have you ever experienced Other Abuse?	No	4	7	11
	Total	4	7	11

Four women in the Gestalt Therapy (GT) group interventions and seven women in the Cognitive-Behavioral Therapy (CBT) group interventions have experienced Emotional and/or Verbal Abuse. One woman in the Gestalt Therapy (GT) group interventions and two women in the Cognitive-Behavioral Therapy (CBT) group interventions reported experiencing Physical Abuse. No women in the Gestalt Therapy (GT) group interventions and five women in the Cognitive-Behavioral Therapy (CBT) group interventions reported experiencing Sexual Abuse. Three women in the Gestalt Therapy (GT) group interventions and two women in the Cognitive-Behavioral Therapy (CBT) group interventions reported experiencing Financial Abuse and Neglect. None of the participants reported experiencing any Other Abuse.

Table 5 presents Abusive Experiences the participants reported in the past 12 months by treatment group.

Table 5
Past 12 months Abusive Experiences by Treatment Group
N=11

Past 12 months Abusive Experiences	Yes/No	Gestalt Group	Cognitive Behavioral Group	Total
In the past 12 months, has anyone ever threatened to hurt you physically?	No	4	6	10
	Yes	0	1	1
	Total	4	7	11
In the past 12 months, has anyone ever pushed or shoved you?	No	4	5	9
	Yes	0	2	2
	Total	4	7	11
In the past 12 months, has anyone ever made you fear for your safety during arguments?	No	4	3	7
	Yes	0	4	4
	Total	4	7	11
In the past 12 months, has anyone ever done anything else that hurt you physically or emotionally?	No	1	3	4
	Yes	3	4	7
	Total	4	7	11
In the past 12 months, has anyone ever made you feel as if he owns or controls you?	No	4	4	8
	Yes	0	3	3
	Total	4	7	11

During the past 12 months, none of the women in the Gestalt Therapy (GT) group interventions stated anyone ever threatened to hurt them physically. In the Cognitive-Behavioral Therapy (CBT) group interventions, one woman stated someone had threatened to hurt her physically. None of the women in the Gestalt Therapy (GT) group interventions stated anyone had ever pushed or shoved them in the past 12 months and two women in the Cognitive-Behavioral Therapy (CBT) group interventions responded positively to this question. None of the women in the Gestalt Therapy (GT) group interventions and four women in the Cognitive-Behavioral Therapy (CBT) group interventions reported anyone had made them fear for their

safety during arguments in the past 12 months. Three women in the Gestalt Therapy (GT) group interventions and four women in the Cognitive-Behavioral Therapy (CBT) group interventions stated anyone did something to hurt them physically or emotionally in the past 12 months. Three of the women in the Cognitive-Behavioral Therapy (CBT) group interventions and none of the women in the Gestalt Therapy (GT) group interventions reported yes to the question, had anyone made them feel as if someone owned or controlled them in the past 12 months.

Analysis of Pretests

Descriptive statistics by treatment group for the dependent variables (assertiveness and self-esteem) as measured by the *RAS* (Rathus, 1973) and *CFSEI-2 (*Form AD, Battle, 1992), respectively are shown in Table 6.

Table 6
Descriptive Statistics by Treatment Group
N=11

	Treatment Group	N	Mean	Std. Deviation	Std. Error Mean
RAS Pretest	Gestalt	4	30.75	19.65	9.83
	Cognitive Behavioral	7	-.57	21.34	8.07
CFSEI-2 Pretest	Gestalt	4	14.75	6.55	3.28
	Cognitive Behavioral	7	15.57	5.26	1.99

For the Gestalt Therapy (GT) group interventions, the pre-test mean scores for the dependent variable, assertiveness, as measured by the *RAS* (Rathus, 1973) were (M = 30.75, SD = 19.65) and pre-test mean scores for the Cognitive-Behavioral Therapy (CBT) group interventions were (M = -.57, SD = 21.34). For the Gestalt Therapy (GT) group interventions, the pre-test mean scores for the dependent variable, self-esteem as measured by the *CFSEI-2 (*Form AD, Battle, 1992) were (M = 14.75, SD = 6.55) and pre-test mean scores for the Cognitive-Behavioral Therapy (CBT) group interventions were: (M = 15.57, SD = 5.26).

Prior to testing the research hypotheses, a *t*-test for independent samples using the pre-test scores for the dependent variables, assertiveness and self-esteem, was conducted to determine if the groups were statistically equivalent prior to treatment. The dependent variables were the participants' pre-test scores for assertiveness as measured by the *RAS* (Rathus, 1973) and self-esteem as measured by the *CFSEI-2 (*Form AD, Battle, 1992). Results of the *t*-test for independent samples are shown in Table 7.

Table 7
Independent Samples t-Test
N=11

		Levene's Test for Equality of Variances		*t*-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
RAS Pretest Assertiveness	Equal variances assumed	.04	.85	2.40	9	.04	31.32	13.03	1.84	60.80
CFSEI-2 Pretest Self-esteem	Equal variances assumed	.14	.72	-.23	9	.82	-.82	3.59	-8.93	7.29

At the pre-test stage, the test for homoscedasticity (homogeneous variances) was not significant for the *RAS* (Rathus, 1973) (F = .04, p = .85). This means the underlying assumption of equal variances remains tenable. The independent samples *t*-test, however, was significant (t = 2.40, df = 9, p = .04). This means the two groups did not share baseline equality at the beginning of the study, and in further analyses, the pretest scores should be used as covariates. The underlying test of homoscedasticity for the *CFSEI-2 (*Form AD, Battle, 1992) was not significant (F = .14, p = .72). The independent samples *t*-test for self-esteem was not significant (t = -.23, df = 9, p = .82), indicating there was baseline equality on this measure.

Correlation

A Pearson correlation analysis was performed at pre-and-post testing to determine the relationship between the two dependent variables, assertiveness and self-esteem. Table 8 presents the results of this correlation analysis.

Table 8
Pearson Correlation
Pre-and-Post testing
N=11

Measure		*RAS* Pretest	*RAS* Posttest	*CFSEI-2* Pretest	*CFSEI-2* Posttest
RAS Pretest	Pearson Correlation	1.000	.776**	.528	.718*
	Sig. (2-tailed)		.005	.095	.013
	N	11	11	11	11
RAS Posttest	Pearson Correlation	.776**	1.000	.686*	.695*
	Sig. (2-tailed)	.005		.020	.018
	N	11	11	11	11
CFSEI-2 Pretest	Pearson Correlation	.528	.686*	1.000	.918**
	Sig. (2-tailed)	.095	.020		.000
	N	11	11	11	11
CFSEI-2 Posttest	Pearson Correlation	.718*	.695*	.918**	1.000
	Sig. (2-tailed)	.013	.018	.000	
	N	11	11	11	11

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Results of the Pearson correlation analysis revealed no significance at the 0.05 level for the pre-test *RAS* (p = .095) or the *CFSEI-2* (p = .095). Significance results were found at the 0.05 level for the post-test *RAS* (p = .018) and the *CFSEI-2* (p = .018). This finding shows there was a significant correlation between the two variables, assertiveness and self-esteem, at the conclusion of the study. Therefore, these two dependent variables are positively correlated.

Research Questions and Hypotheses

This study examined the differential effects of two group theoretical orientations, Gestalt (GT) and Cognitive-Behavioral Therapy (CBT) group interventions on the levels of assertiveness and self-esteem of women with physical disabilities facing abuse. This study attempted to answer the following two research questions: (1) Will the level of assertiveness in women with physical disabilities facing abuse, who participate in Gestalt Therapy (GT) group interventions, be increased significantly more than those who are in the Cognitive-Behavioral Therapy (CBT) group interventions?, and (2) Will the level of self-esteem in women with physical disabilities facing abuse, who participate in Gestalt Therapy (GT) group interventions, be increased significantly more than those who are in the Cognitive-Behavioral Therapy (CBT) group interventions? In this study, two research hypotheses were developed that corresponded with the two research questions. They were tested using inferential statistical analyses, and an alpha level of .05 was adopted to determine statistical significance.

Statistical Hypothesis 1:

The first statistical hypothesis stated women with physical disabilities facing abuse participating in the Gestalt Therapy (GT) group interventions and women with physical disabilities facing abuse in the Cognitive-Behavioral Therapy (CBT) group interventions would not differ in levels of assertiveness. The assumption of this hypothesis was both experimental situations would be equally as effective in increasing levels of assertiveness in women with physical disabilities. Descriptive statistics were obtained for the posttest measures of change in level of assertiveness. Table 9 presents the post means by treatment group for assertiveness.

Table 9
Descriptive Statistics by Treatment Group Assertiveness
N=11

	RAS Posttest	
	Gestalt	Cognitive Behavioral
N	4	7
Mean	27.25	-3.57
Median	26.50	8.00
SD	16.64	30.99

The posttest mean scores for the dependent measure of assertiveness for women with disabilities participating in the Gestalt Therapy (GT) group interventions were M = 27.25 (SD =16.64) and Cognitive-Behavioral Therapy (CBT) group interventions were M = -3.57 (SD = 30.99).

Statistical Hypothesis 2:

The second statistical hypothesis stated women with physical disabilities facing abuse participating in the Gestalt Therapy (GT) group interventions and women with physical disabilities facing abuse in the Cognitive-Behavioral Therapy (CBT) group interventions would not differ in levels of self-esteem. The assumption of this hypothesis was both experimental situations would be equally as effective in increasing levels of self-esteem in women with physical disabilities facing abuse. Descriptive statistics were obtained for the posttest measures of change in levels of self-esteem. Table 10 presents the post means by treatment group for self-esteem.

Table 10
Descriptive Statistics by Treatment Group
Self-esteem
N=11

	CFSEI-2 Posttest	CFSEI-2 Posttest
	Gestalt	Cognitive Behavioral
N	4	7
Mean	18.50	16.71
Median	23.00	15.00
SD	10.38	6.85

The posttest mean scores for the dependent measure of self-esteem for women with disabilities participating in the Gestalt Therapy (GT) group interventions were M = 18.50 (SD = 10.38) and Cognitive-Behavioral Therapy (CBT) group interventions were M = 16.71 (SD = 6.85).

Multivariate Tests

A multivariate analysis of covariance (MANCOVA) with group membership as the fixed independent variable was used to compare levels of assertiveness and self-esteem in women with physical disabilities facing abuse from pre-experiment to post-experiment at the completion of six weeks. Pretest scores on this measure were used as covariates. Mean scores were compared to determine which group had the most increased level of assertiveness and self-esteem following the experiment at the completion of six weeks. Main effects for each dependent variable (assertiveness and self-esteem) needed to be statistically significant for each null hypothesis to be rejected.

The within subjects analysis contrasted the pretest and posttest scores of assertiveness and self-esteem to determine if a statistically significant difference could be noted. Table 11

presents the results of the within subjects contrasts (MANCOVA) for the dependent variable, assertiveness.

Table 11
Multivariate Analysis of Covariance (MANCOVA)
Tests of Within-Subjects Contrasts
Assertiveness
N=11

Source	RAS	Type III Sum of Squares	df	Mean Square	F	Sig.
RAS	Posttest (2) vs Pretest (1)	86.793	1	86.793	.328	.581
RAS * Grp	Posttest (2) vs Pretest (1)	2381.793	1	2381.793	8.997	.015
Error(*RAS*)	Posttest (2) vs Pretest (1)	2382.616	9	264.735		

a. computed using alpha = <.05

The results indicated there was a significant level of difference, F (1, 9) = 8.997, p =.015, within subjects contrasts for the dependent variable assertiveness.

Table 12 presents the results of the within subjects analysis (MANCOVA) for the dependent variable, self-esteem.

Table 12
Multivariate Analysis of Covariance (MANCOVA)
Tests of Within-Subjects Contrasts
Self-Esteem
N=11

Source	CFSEI-2	Type III Sum of Squares	df	Mean Square	F	Sig.
CFSEI-2	Posttest (2) vs. Pretest (1)	1.644	1	1.644	.018	.898
CFSEI-2 * Grp.	Posttest (2) vs Pretest (1)	2.825	1	2.825	.030	.866
Error(*CFSEI-2*)	Posttest (2) vs Pretest (1)	844.402	9	93.822		

a. computed using alpha = <.05

The results indicated there was no statistically significant difference, F (1, 9) = .030, p =.866, within subjects contrast for the dependent variable self-esteem.

Table 13 presents the results of the MANCOVA between subjects effects by experimental group analysis for assertiveness and self-esteem.

Table 13
Multivariate Analysis of Covariance (MANCOVA)
Tests of Between Subjects Effects
Assertiveness & Self-Esteem
N=11

Source	Dependent Variable	SS	df	MS	F	Sig.	Partial Eta^2
Corrected Model	*RAS* Posttest	7223.64[a]	3	2407.88	9.43	.01	.80
	CFSEI-2 Posttest	563.74[b]	3	187.91	26.95	.00	.92
Intercept	*RAS* Posttest	1666.43	1	1666.43	6.53	.04	.48
	CFSEI-2 Posttest	.16	1	.16	.02	.88	.00
*RAS*Pre	*RAS* Posttest	32.50	1	32.50	.13	.73	.02
	CFSEI-2 Posttest	26.72	1	26.72	3.83	.09	.35
*CFSEI-2*Pre	*RAS* Posttest	1785.11	1	1785.11	6.99	.03	.50
	CFSEI-2 Posttest	135.57	1	135.57	19.45	.00	.74
Grp	*RAS* Posttest	845.82	1	845.82	3.31	.11	.32
	CFSEI-2 Posttest	1.50	1	1.50	.22	.66	.03
Error	*RAS* Posttest	1786.91	7	255.27			
	CFSEI-2 Posttest	48.81	7	6.97			
Total	*RAS* Posttest	9652.00	11				
	CFSEI-2 Posttest	3929.00	11				
Corrected Total	*RAS* Posttest	9010.55	10				
	CFSEI-2 Posttest	612.55	10				

Multivariate tests of between subjects effects indicated there was no statistically significant difference between the groups in terms of *RAS* (F = 3.31, df = 1, 7, p = .11) posttest and *CFSEI-2* (F = .22, df = 1,7, p = .66) posttest, using respective pretests as covariates. A preliminary test of equality of covariance matrices was conducted. Box's M = 7.20, F = 1.72, df = 3, 912.84, was not significant (p = .16), meaning this underlying assumption was not violated. Regarding the multivariate analysis, Pillai's trace was .329, F = 1.47, df = 2, 6, p = .302. The associated tests, Wilk's Lambda, etc., had the same resulting p values. Thus, the result was not statistically significant between groups. Based on the non-significant findings on the dependent variables, assertiveness and self-esteem, both null hypotheses were retained.

Treatment Group Summary

The group therapy intervention sessions were conducted by the researcher, a doctoral candidate, experienced in group therapy interventions, currently completing the doctor of philosophy degree program in counseling at Wayne State University, and licensed as a limited licensed professional counselor. Following each session, the researcher completed a *Group Counseling Session Summary (GCSS*, Ellington, 1997) to record the group process that occurred during each session. To supplement the statistical analysis of the research study, the group sessions were semi structured and followed the qualitative format presented in Figure 3 for the Gestalt Therapy (GT) group interventions and Figure 4 for the Cognitive-Behavioral Therapy (CBT) group interventions. These descriptions were taken from the *Group Counseling Session Summary* (*GCSS*, Ellington, 1997).

Figure 3 Group Counseling Session Summary
Format of Group Therapy Sessions-Gestalt Therapy (GT) Group Interventions

Session 1

- Fill out pre group therapy instruments at beginning of session
- Introduction of leader
- Introduction of members
- Discussion and overview of group expectations, rules, norms
- Emphasis on the processes occurring on the intrapersonal and interpersonal level of awareness
- Encouragement of interpersonal contact

Session 2

- Welcome members to group
- Visualization (name experience) - awareness of inner feelings
- Share of group experience
- Exercise/Experiment: change *have to* into *choose to* messages, developing ownership of feelings and acts
- Share of group experience

Figure 3 Group Counseling Session Summary (continued)
Format of Group Therapy Sessions-Gestalt Therapy (GT) Group Interventions

Session 3

- Welcome members to group
- Visualization – inner child, encountering the child in you
- Share of group experience
- Members offer feedback to each other – words as gifts to each other
- Sum group work experience

Session 4

- Welcome members to group
- Experience with stone – creative process, work with interjected voices
- Share of group experience
- Use of empty chair technique -
- Personalize concepts of inner experience and feelings – self-esteem, assertiveness
- Sum group work experience

Session 5

- Welcome members to group
- Body-mind warm-up – use relaxing music to stimulate breathing, awareness of feelings, elicit fantasy material
- Use of fantasy work – promote personal awareness and assertiveness
- Identify personal care importance
- Sum group work experience

Session 6

- Welcome members to group
- Discuss members feelings with termination of group
- Intensify importance of here-and-now
- Encourage positive self-view aspect of oneself followed by members pointing out positive aspects seen by each other
- Draw picture of positive self-view aspect and have all members write a word of positive feedback
- Share experience in group
- Final discussion focusing on group highlights and growth
- Review members request for group continuation
- Fill out post group therapy instruments at end of session
- Pay members stipend for participation in group therapy session

Figure 4 Group Counseling Session Summary
Format of Group Therapy Sessions-Cognitive-Behavioral Therapy (CBT) Group Interventions

Session 1
- Welcome members to group
- Fill out pre group therapy instruments at beginning of session
- Introduction of leader
- Introduction of members
- Discussion and overview of group expectations
- Introduce the concept of self-esteem and its effect on the lives of women with physical disabilities
- Present homework and its objectives

Session 2
- Welcome members to group
- Overview/monitoring homework from previous week and shared of experiences while doing it
- Introduction to cognitive restructuring. Help members identify and evaluate their cognitions, understand the negative behavioral impact of certain thoughts and the replacement with more realistic and appropriate thoughts.
- Discuss A-B-C (Activating event, Belief, emotional Consequence) model of emotion
- Exercise and practice in group – positive thoughts
- Present homework for following week and its objectives

Session 3
- Welcome members to group
- Overview/monitoring homework from previous week and shared of experiences while doing it
- Discussion about critic within oneself
- Group exercise: combating distortions – critic within oneself and self-esteem development
- Present homework for following week and its objectives

Session 4
- Welcome members to group
- Overview/monitoring homework from previous week and shared of experiences while doing it
- Review experience of previous week – members share experiences
- Introduce concept of healthy boundaries and definition of assertiveness
- Exercise in group – visualization technique
- Group exercise identifying and changing self *should* messages
- Present homework for following week and its objectives – practice wants into words

Figure 4 Group Counseling Session Summary (continued)
Format of Group Therapy Sessions-Cognitive-Behavioral Therapy (CBT) Group Interventions

Session 5

- Welcome members to group
- Overview/monitoring homework from previous week and shared of experiences while doing it
- Communication styles and effective communication
- Exercise and role play practicing assertive behavior and assertive communication
- Discuss outcomes of effective communication
- Present homework for following week and its objectives – effective requests

Session 6

- Welcome members to group
- Overview/monitoring homework from previous week and shared of experiences while doing it
- Demonstrate and practice assertive behavior
- Reflect on personal meaning of self-esteem and assertiveness practices
- Summarize group therapy sessions process and members experiences
- Final discussion focusing on group highlights and growth
- Review members request for group continuation
- Fill out post group therapy instruments at end of session
- Pay members stipend for participation in group therapy session

Summary

This chapter presented the results of the data analysis used to describe the participants and test the hypotheses established for this study. Descriptive statistics to provide a profile of the women with physical disabilities facing abuse who participated in the study were detailed. Inferential statistical analyses were used to test each of the two hypotheses for the study. Chapter V provides a summary of the study, assumptions and limitations, discussion of the results, conclusions regarding the research questions and hypotheses, relevance for women with physical disabilities facing abuse, and recommendations for future research.

CHAPTER V

SUMMARY AND DISCUSSION

Introduction

The purpose of this study was to examine the differential effects of Gestalt and Cognitive-Behavioral group therapy interventions on assertiveness and self-esteem among women with physical disabilities facing abuse. Women with physical disabilities experience abuse in many forms, and are at risk because they are perceived to be less able to defend or care for themselves than women without disabilities (Groce, 1988). This chapter presents a brief overview of the problem addressed, relevant literature pertaining to this research, and methodologies and procedures implemented in this study. This chapter also provides a discussion and implications applicable to each research hypothesis and recommendations for future research on women with physical disabilities facing abuse.

Restatement of the Problem

Emotional, physical and sexual abuse in women with physical disabilities is a problem largely unrecognized by services providers. The abuse women with physical disabilities experience, particularly those who are dependent on others for care, can take many forms. According to the Bureau of Justice Statistics (2009), in 2007 about 19% of violent crime victims with a disability believed they were victimized because of their disability.

Researchers have paid attention to the fact that abuse towards people with disabilities has been an undeniable fact for years. According to Nosek et al. (2001), "advocates and researchers in the field of disability … are bringing to light case studies and statistics that point to disability as a risk factor for abuse" (p. 178). A national study of 439 women with physical disabilities and 421 women without disabilities found 62% of both groups of women had experienced emotional,

physical, or sexual abuse at some point in their lives (Young et al., 1997). The same study posited, women with disabilities experienced the abuse for a longer duration, were more likely to be abused by a higher number of perpetrators, reported a higher number of health care workers and/or assistants as their perpetrators, and had fewer options for escaping or resolving the abuse (Young et al., 1997).

Counselor educators must be aware of the fact that abuse can lead to a great lack of self-esteem and assertiveness. Damaging effects of negative messages can result in devaluing oneself. According to Enns et al. (1997), the feelings of helplessness and loss of personal control can be shown as consequences of being a victim of abuse, making it absolutely essential for the psychotherapy relationship to model a cooperative and collaborative partnership. Counselors can provide the collaborative partnership during group therapy in order to help women with physical disabilities facing abuse benefit from it, decreasing isolation, shame, and loneliness.

This study specifically investigated the differential effects of Gestalt and Cognitive-Behavioral group therapy interventions on assertiveness and self-esteem among women with physical disabilities who have experienced abuse. It was expected the levels of assertiveness and self-esteem in women with physical disabilities facing abuse, who participated in Gestalt (GT) or Cognitive-Behavioral (CBT) group therapy interventions, would show an increase in self-esteem and assertiveness.

Review of Literature Summary

This research study was based on a growing awareness regarding the impact of abuse in the lives of women with physical disabilities. Women with physical disabilities' self-esteem and assertiveness are directly affected by the experiences with abuse and despite an apparent consensus of its importance and need for more research, the issue remains an understudied social

problem. According to Rosenberg (1979), self-esteem is equated with an individual's sense of worthiness, adequacy, and self-respect. Women with physical disabilities are experiencing increasing rates of violence, either within their families, by acquaintances, and/or in business and social organizations (Milberger et al., 2003). This includes verbal, economic, emotional, physical and sexual violence. In addition, they may experience other types of abuse such as intimidation, abandonment and neglect, forced isolation, withholding of equipment, medication, transportation, or personal service assistance (Masuda, 1996). Dutton and Painter (1981, 1993) posited a woman's sense of self is further diminished by the abuser's negative, critical comments that continue as she makes an effort to meet his demands.

According to Powers et al. (2002), being aware of "the inaccessibility, reliance on support services, poverty and isolation, is critical for understanding women's increased risk for abuse" (p. 4). Women with physical disabilities have described numerous forms of abuse, including physical, sexual and financial abuse, medication manipulation, equipment disablement or destruction, neglecting to provide needed services, abuse of children and pets, and devastating verbal abuse (Saxton et al., 2001). A survey of 200 women conducted by Powers et al. (2002) substantiated the negative impact of abuse on women with disabilities lives. Abuse prevented 29% of the participants from being employed; 64% from taking care of their health; and 61% from living independently. According to Melcombe (2003), the unemployment rate among women with disabilities has been identified as being as high as 75%.

In a study conducted by Nosek et al. (2003) examining 475 women with a variety of mild to severe physical disabilities and 406 women without disabilities, they found sense of self in women with disabilities, in terms of self-esteem, self-cognition and social isolation, had

significantly lower self-esteem, self-cognition, and greater social isolation than women without disabilities.

Corey (2008) emphasizes the importance of group therapy in the process of self-discovering internal resources of strength. Yalom (1995) also contends the importance of interpersonal interaction and learning as crucial in group therapy. He stresses that it helps group members understand what is missing in their interactions with others, which prevents them from changing. Through group therapy, group members are able to gain insight through the practice of new skills within the group and in everyday interactions (Yalom, 1995). Group psychotherapy that facilitates self-disclosure and emotional interactions among the members accomplishes meaningful results (Oliveira, Milliner & Page, 2004).

Techniques used in group therapy can be verbal and nonverbal as well as structured exercises even though they are differentiated by therapeutic approach (Corey, 2008). Falvo (1999) suggested people with disabilities may be faced by many doubts and therefore, the goal of group therapy is to help them face these problems in order to maintain their identity and stability.

The main goal of experiential approaches such as Gestalt group therapy is to develop a realistic and present-centered understanding of self and empower group members to change and take responsibility for their lives (Huebner, 2004, as cited in Chan et al., 2004). Researchers (Hughes et al. 2003; Nosek, 1996; Stuifberger & Rogers, 1997) found women with physical disabilities and/or who have chronic health conditions, appear to benefit from relationships with one another, such as in a group setting, where self-management, increased awareness, empowerment and support are emphasized. Allen (1986) posited disability has not been addressed directly in Gestalt therapy. However, researchers have argued Gestalt therapy can indeed benefit persons with disabilities (Allen, 1986; Coven, 1979; Livneh & Sherwood, 1991).

Phemister (2001) posited Gestalt therapy emphasizes responsibility and self-awareness, which can establish self-trust and secure understanding of how an experience may be influencing the person. In a group setting utilizing Gestalt therapy, people are encouraged to get deeper, by focusing and experimenting, rather than explaining (Yontef, 2007).

In Cognitive-Behavioral therapy, the goal is to replace maladaptive behaviors and utilize adaptive behaviors and rational cognitions (Huebner, 2004, as cited in Chan et al., 2004). Intervention strategies used in Cognitive-Behavioral group therapy tend to be more structured, with specific behavioral objectives (Burns & Beck, 1999). Dutton (1992) in her model of assessment and intervention for empowering women that experienced abuse, suggests Cognitive-Behavioral interventions may be applied in order to avoid further violence, develop assertiveness skills, and address cognitions that may have been developed as a consequence of abuse (e.g., low self-esteem, self-blame, tolerance of abuse). Many researchers (Allen, 1995; McDonald, 1984; Robinson & Worell, 2002; Toner, Segal, Emmot & Myron, 2002) agree that, extensions of Cognitive-Behavioral therapy interventions with women emphasize multiple assessment strategies that are very relevant to the lives of women.

Review of Methods and Procedures

The research was conducted over a period of six weeks, consisting of six weekly two-hour group sessions. The group therapy sessions were conducted by the researcher, a doctoral candidate, experienced in group therapy interventions, currently completing the doctor of philosophy degree program in counseling at Wayne State University, and licensed as a limited licensed professional counselor. The sample for this study included 11 women with physical disabilities facing abuse who agreed to voluntarily participate in the study. Sessions were conducted at the Ann Arbor Center for Independent Living located in Ann Arbor, MI. There was

an incentive of $50.00 offered to women participating in the group therapy sessions. All participants met with the researcher prior to treatment. Both groups were conducted at the same location on separate days of the week.

The study was a quasi-experimental pretest-posttest design (Hadley & Mitchell, 1995). Differential outcomes for two group therapy interventions, Gestalt (GT) and Cognitive-Behavioral (CBT), were compared in terms of the levels of assertiveness and self-esteem. All participants were randomly assigned to the experimental conditions in order to ascertain equality of the groups in terms of age, race/ethnicity, and physical disability. Before the beginning of the first group therapy session, all participants completed the two criterion instruments; *Rathus Assertiveness Schedule* (*RAS*, Rathus, 1973) and *Culture-Free Self-Esteem Inventory* (*CFSEI-2*, Form AD, Battle, 1992) that provided baseline data for levels of assertiveness and self-esteem and the *Demographic Form* (Adam Rita, 2009) described the personal characteristics of the participants. Following the conclusion of each group session, the leader completed the *Group Counseling Session Summary* (*GCSS*, Ellington, 1997) to detail information concerning group themes, members' roles, significant patterns, interventions, session development, and goals and plans for ensuing sessions. At the end of the six-week period, the criterion instruments were re-administered as posttest measures to determine the treatment effects on the dependent variables, assertiveness and self-esteem.

Restatement of the Research Questions and Associated Hypotheses

This study addressed the following two research questions: 1) Will the level of assertiveness in women with physical disabilities facing abuse, who participate in Gestalt Therapy (GT) group interventions, be increased significantly more than those who are in the Cognitive-Behavioral Therapy (CBT) group interventions? 2) Will the level of self-esteem in

women with physical disabilities facing abuse, who participate in Gestalt Therapy (GT) group interventions, be increased significantly more than those who are in the Cognitive-Behavioral Therapy (CBT) group interventions? The criterion instruments were: a) *Rathus Assertiveness Scale* (*RAS*, Rathus, 1973), and b) *Culture-Free Self-Esteem Inventories* (*CFSEI-2*, Form AD, Battle 1992).

The two statistical hypotheses for this research, tested at an alpha level of .05, were:

> H_1: Women with physical disabilities facing abuse participating in either Gestalt Therapy (GT) or Cognitive-Behavioral Therapy (CBT) group interventions will not differ in levels of assertiveness.
>
> H_2: Women with physical disabilities facing abuse participating in either Gestalt Therapy (GT) or Cognitive-Behavioral Therapy (CBT) group interventions will not differ in levels of self-esteem.

Summary of Findings

Cross-tabulation procedures were used to describe the demographic data reported by the participants at the beginning of the experiments. This study included 11 women with physical disabilities that have experienced abuse. Four women participated in the Gestalt Therapy (GT) group interventions and seven in the Cognitive-Behavioral Therapy (CBT) group interventions. Statistical significance was determined using an alpha level of .05.

Prior to testing the research hypothesis, a *t*-test for two independent samples was used to determine if the groups were statistically equivalent for the dependent variables (assertiveness and self-esteem) prior to treatment. The mean pretest scores measuring assertiveness and self-esteem were used as the dependent variables. Group assignment was the independent variable.

The results of the *t*-test for two independent samples provided no evidence of statistically significant differences between the two groups for the dependent variables, assertiveness and self-esteem prior to the beginning of the Gestalt Therapy (GT) and Cognitive-Behavioral Therapy (CBT) group interventions. Based on these findings, the underlying assumption of equal variances remains tenable. The independent samples *t*-test, however, was significant for assertiveness which means the two groups did not share baseline equality at the beginning of the study, and in further analyses, the pretest scores were used as covariates.

Data were examined to determine the outcome effects of participation in either the Gestalt Therapy (GT) or Cognitive-Behavioral Therapy (CBT) group interventions on women with physical disabilities facing abuse. Analysis of the data were separated into two sections. All statistical analyses were conducted utilizing SPSS for Windows, 17th (SPSS, Inc., 2008) computer program, and tested at alpha level .05. Descriptive statistics including frequency distributions for the nominally scaled demographic variables (i.e., age group, marital status, race/ethnicity, current living arrangement, level of education, employment status, household income, type of disability, type of abuse experience and abusive experiences in the past 12 months) to provide a profile of the sample were employed. Cross-tabulations to determine the assumption of approximate normal distribution, measures of central tendency (mean, median, and mode), and measures of variability (variance and standard deviation) were performed. A Pearson correlation analysis was performed at pre-and-post testing to determine the relationship between the two dependent variables, assertiveness and self-esteem; and calculated for comparison purposes. Results at posttest for both variables demonstrated they were positively related.

Multivariate analysis of covariance (MANCOVA) with group membership as the fixed independent variable to determine the outcome effects on the dependent variables, assertiveness and self-esteem, from pre-experiment to post-experiment was used. There were no significant findings in assertiveness and self-esteem in women with physical disabilities facing abuse in post testing, following participation in the Gestalt Therapy (GT) and Cognitive-Behavioral Therapy (CBT) group interventions. To determine if the differences between groups were statistically significant for the two dependent variables, assertiveness and self-esteem, within subjects contrasts and between subjects effects were examined. Overall, it does not appear participation in either Gestalt Therapy (GT) or Cognitive-Behavioral Therapy (CBT) group interventions had a statistically significant effect on the dependent variables, assertiveness and self-esteem. Therefore, null hypotheses 1 and 2 were retained.

Discussion of Findings

In the present study, the differential outcome effects of Gestalt and Cognitive-Behavioral group therapy interventions on the assertiveness and self-esteem of women with physical disabilities facing abuse were explored. Because no statistically significant results were found in assertiveness and self-esteem between groups, one might disregard the efficacy of this research project.

As counselors we expect some positive outcomes from group therapy interventions that may not be measurable. The correlation between the two dependent variables showed assertiveness and self-esteem were positively correlated at posttest, indicating there was a relationship between the two variables. Although no statistically significant changes were found from pre-to-post test experiment, participants reported the activities and interactions within the group helped them reconcile some past painful experiences and expressed the willingness and

interest in continuing with the groups even after finishing the research study. One hundred percent attendance by group members may have allowed for the enhancement of the group process.

Research has found group work to be an appropriate form for women “that need to increase their knowledge in an accepting, supportive, respectful, and non-pathological atmosphere” (Sands & Solomon, 2003, p. 19) especially focused on enhancing their levels of assertiveness and self-esteem. The women with physical disabilities that participated in either therapeutic group demonstrated being very involved and eager to get involved in the group interventions.

In a study on the enhancement of self-esteem with women with physical disabilities developed by Hughes and colleagues (2004), they concluded women with physical disabilities may benefit greatly from a self-esteem group intervention not only improving their self-esteem but also other indices of psychological health over a fairly brief period. According to the researcher’s observations, it appeared sharing experiences, frustrations, uncertainties and difficulties helped the women to feel better, allowing for feelings of universality, cohesion and hope to take place and consequently fostering increased self-esteem and assertiveness. Kurtz (1997) suggested cohesion, universality, and hope as the most important therapeutic factors in mutual aid and support groups.

Herman (1992) posited violence causes individuals to lose their ability to trust themselves and consequently the people around them. Focusing on interventions that had the premise ideas of increasing assertiveness and self-esteem of women with physical disabilities facing abuse was therefore, essential. According to Worell & Remer (2003), it is crucial to train women to be assertive and stand up for their rights. The development of assertive skills is very important for

women to have so they can "impact the environment effectively and bring about social change" (Worell & Remer, 2003, p. 79). The study offered six two-hour sessions for each group and focused on helping the women to develop assertive skills and subsequently enhance their self-esteem thus allowing for a positive outcome.

Observations of both group treatments were recorded by the researcher to document the group process throughout the six weeks intervention. It was observed participants in the Gestalt Therapy (GT) group interventions got easily involved in the group approach and showed cohesiveness throughout the sessions. An example of the impact of group process that was observed during one of the sessions was the result of the application of one visualization technique. Participants were asked to visualize their name being called and how they saw it happen, what feelings emerged and how they could sense themselves. Group members shared their feelings of lost connection with who they are, and were, and how that influences perceptions they have of themselves. Another exercise/experiment, group members were asked to write down five phrases starting with *I have to*. After completion, they were asked to change the phrases written down by substituting *I have to* for I *choose to* messages, developing ownership of feelings and acts. Group members reported this exercise became a trigger for thoughtful insight on how to approach life and look at daily interactions differently. Weeks later this exercise and its effect on the members remained important as multiple discussions of this exercise ensued. Yalom (1995) asserts interpersonal interaction and learning are crucial in group therapy.

In the Cognitive-Behavioral Therapy (CBT) group interventions, although following a more direct psychoeducational approach, group members stated they had benefited from the opportunity to self-disclose and share their emotional interactions with each other. Intervention

strategies used in Cognitive-Behavioral group therapy tend to be more structured, with specific behavioral objectives (Burns & Beck, 1999). Members were very engaged and open to exercises and role playing practices of assertive behavior and communication as well as reflecting on personal meaning of self-esteem and assertiveness. The exercises as well as the interaction with other members of the group facilitated and encouraged members to try new behaviors and try new approaches in place of old ones. Homework assignments also appeared to help members develop new perspectives in terms of self-esteem and assertiveness issues. Falvo (1999) suggested people with disabilities may be faced by many doubts and therefore, the goal of group therapy is to help them face these problems in order to maintain their identity and stability. In both groups, it was observed members appeared to enjoy participating and were eager for more knowledge and self-discoveries. All participants requested continuation of the group sessions.

Limitations of the Study

There are several limitations to be considered when interpreting the results of this research study. First, the small sample size of this study limits generalizing the outcome to other populations or locations. Both groups consisted of a small number of participants, which is considered ideal and more effective in group therapy, but does not provide statistical significance. “Small group work is presented as the ideal modality for empowering interventions……… raising consciousness, engaging in mutual aid, developing skills, problem solving and experiencing one’s own effectiveness in influencing others” (Gutierrez, 1991, p. 206).

Second, only women with physical disabilities facing any type of abuse were recruited, and an exclusionary criterion was created in order to provide a homogeneous sample. Most women who participated in the group therapy interventions had more than one disability and

came from socially and economically disadvantaged backgrounds which may have made them more likely to be in abusive situations. According to Powers, et al. (2002), “the inaccessibility, reliance on support services, poverty and isolation, is critical for understanding women’s increased risk for abuse” (p. 4). Although not a limitation to the research study, economic costs and lack of accessible transportation sometimes are barriers to participation and should be considered when working with women with disabilities facing abuse. For most of the participants, this study provided the only opportunity for them to receive group therapy at no cost. This researcher had to ensure transportation was provided for most of the members as inaccessibility and means to come to the sessions were issues. Most women lived independently and depended on others or on public transportation to come to the sessions, therefore, providing transportation and/or the monetary help for these women was absolutely essential.

Another limitation may have been the short time frame (i.e., six weekly two-hour interventions). A better chance of maximizing the possibility of making a change in assertiveness and self-esteem may exist if a larger sample size was utilized. Additional unknown factors may have influenced the women’s levels of assertiveness and self-esteem and not be accounted for in this study.

Recommendations for Future Research

Future research could use a larger sample by conducting several small therapy groups over a longer period of time, which may produce statistically significant results. In this study, women requested continuation of group therapy sessions, making one assume benefits may be enhanced as well.

Future studies should provide all necessary means for the women to attend therapeutic sessions, as these stressors may limit their total benefits. Basic needs should be offered, such as

transportation, safe and accessible location and consideration of the participants' individual needs regarding time/day frames. Therapeutic sessions offered early in the day or too late may be a burden in the lives of women with physical disabilities. Breaks throughout sessions also have to be considered as many persons with disabilities may need to use the restroom longer and more frequently, and take medications.

It is suggested future research take into consideration the importance of meeting with prospective group members prior to the start of the interventions so as to ensure appropriate member placement, matching as much as possible members' needs with therapy and interventions being offered.

The results of the *Rathus Assertiveness Scale* (*RAS*, Rathus, 1973), and *Culture-Free Self-Esteem Inventories* (*CFSEI-2*, Form AD, Battle 1992) although lacking statistical significance, did show a positive correlation between the dependent variables, assertiveness and self-esteem. Future researchers could utilize this knowledge to develop studies examining other dependent variables such as anxiety, hope expectations, quality of life, and/or anger, which may result in greater impact on the lives of women with physical disabilities facing abuse.

Summary

Herman (1992) posited violence causes individuals to lose their ability to trust themselves and consequently the people around them. Focusing on interventions that provide for the enhancement of assertiveness and self-esteem in women with physical disabilities facing abuse is essential. Interventions that help women to be assertive, to stand up for their own rights while not stepping on the rights of others, is crucial for women if they are not to be powerless victims (Worell & Remer, 2003).

One has to be careful in generalizing the findings of this study, considering the lack of statistically significant differences between the experimental groups, and also the abovementioned limitations of the research design. As recommended, group therapy interventions for longer periods of time and with multiple small groups and examining other dependent variables should be addressed in future research to determine if support could be found for the use of Gestalt and Cognitive-Behavioral therapy group interventions to enhance levels of assertiveness and self-esteem.

. Despite the fact there was no statistically significant differences between treatments, there remains a necessity for future group therapy research focused on developing effective treatments for women with physical disabilities facing abuse.

APPENDIX A

HIC APPROVAL FORM

WAYNE STATE UNIVERSITY

HUMAN INVESTIGATION COMMITTEE
101 East Alexandrine Building
Detroit, Michigan 48201
Phone: (313) 577-1628
FAX: (313) 993-7122
http://hic.wayne.edu

NOTICE OF EXPEDITED APPROVAL

To: Cilene Adam Rita
Theoretical & Behavior Foundations
268 Simons

From: Ellen Barton, Ph.D. ________________
Chairperson, Behavioral Institutional Review Board (B3)

Date: September 05, 2009

RE: HIC #: 088309B3E

Protocol Title: The Effects of Gestalt and Cognitive-Behavioral Group Therapy Interventions on the Assertiveness and Self-Esteem of Women with Physical Disabilities Facing Abuse

Sponsor:

Protocol #: 0908007456

Expiration Date: September 04, 2010

Risk Level / Category: Research not involving greater than minimal risk

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The above-referenced protocol and items listed below (if applicable) were **APPROVED** following *Expedited Review* (Category 7*) by the Chairperson/designee *for* the Wayne State University Behavioral Institutional Review Board (B3) for the period of 09/05/2009 through 09/04/2010. This approval does not replace any departmental or other approvals that may be required.

- Flyer
- Consent Form (dated 8/14/09)

- Federal regulations require that all research be reviewed at least annually. You *may* receive a *"Continuation Renewal Reminder"* approximately two months prior to the expiration date; however, it is the Principal Investigator's responsibility to obtain review and continued approval ***before*** the expiration date. Data collected during a period of lapsed approval is unapproved research and can ***never*** be reported or published as research data.
- All changes or amendments to the above-referenced protocol require review and approval by the HIC **BEFORE** implementation.
- Adverse Reactions/Unexpected Events (AR/UE) must be submitted on the appropriate form within the timeframe specified in the HIC Policy (http://www.hic.wayne.edu/hicpol.html).

NOTE:

1. Upon notification of an impending regulatory site visit, hold notification, and/or external audit the HIC office must be contacted immediately.
2. Forms should be downloaded from the HIC website at ***each*** use.

*Based on the Expedited Review List, revised November 1998

APPENDIX B

INFORMED CONSENT FORM

Research Informed Consent

Title of Study: THE EFFECTS OF GESTALT AND COGNITIVE-BEHAVIORAL THERAPY GROUP INTERVENTIONS ON THE ASSERTIVENESS AND SELF-ESTEEM OF WOMEN WITH PHYSICAL DISABILITIES FACING ABUSE

Principal Investigator (PI): Cilene Susan Adam Rita, Doctoral Candidate
College of Education
Department of Theoretical and Behavioral Foundations
Counselor Education Program
(734) 975 6616

Purpose

You are being asked to be in a research study using two different group therapy interventions with women with physical disabilities facing abuse. This study is being conducted at the Ann Arbor Center for Independent Living, a nonprofit organization dedicated to the success of children, youth, and adults with disabilities at home, school, work, and in the community. The estimated number of study participants will be 16-20. **Please read this form and ask any questions you may have before agreeing to be in the study.**

In this research study, I am interested in determining if either of the two types of group therapy interventions sessions will increase assertiveness and self-esteem in women with physical disabilities facing abuse.

Study Procedures

If you agree to take part in this research study, you will be asked to complete the demographic form, which will be used to describe the participants in the study. You will also complete questionnaires to rate your levels of assertiveness and self-esteem at the beginning of the study and at the end of the six weeks when completing your respective group therapy sessions.

You will be asked to choose a personal four-digit number to be used to identify the demographic form and questionnaires. This will be done to ensure anonymity and maintain confidentiality. You will be asked to participate in one of two types of group therapy intervention sessions.

The study will require your participation for a total of twelve hours (two hours per week for a period of six weeks). At the beginning of initial intervention session, you will be asked to complete the informed consent form, demographic questionnaire and two instruments used to measure assertiveness and self-esteem. Following the completion of these documents, you will be randomly assigned to one of two treatment conditions. At the end of the final intervention session, you will be asked to complete the post-test instruments.

Research Informed Consent (cont.)

Title of Study: THE EFFECTS OF GESTALT AND COGNITIVE-BEHAVIORAL THERAPY GROUP INTERVENTIONS ON THE ASSERTIVENESS AND SELF-ESTEEM OF WOMEN WITH PHYSICAL DISABILITIES FACING ABUSE

Principal Investigator (PI): Cilene Susan Adam Rita, Doctoral Candidate
College of Education
Department of Theoretical and Behavioral Foundations
Counselor Education Program
(734) 975 6616

Participation is voluntary. If you choose not to participate, you will not be penalized.

Benefits

As a participant in this research study, there may be no direct benefits for you; however, information from this study may benefit other people now or in the future.

Risks

There are no known risks at this time to participation in this study.

The following information must be released/reported to the appropriate authorities if at any time during the study there is concern that:

- child abuse or elder abuse has possibly occurred,
- you have a reportable communicable disease (i.e., certain sexually transmitted diseases or HIV)
- you disclose illegal criminal activities, illegal substance abuse or violence.

There may also be risks involved from taking part in this study that are not known to researcher at this time. There are no known reported incidents of harm to women with physical disabilities facing abuse who have participated in similar studies.

Alternatives

The only alternative is to not participate in this study.

Study Costs

Participation in this study will be of no cost to you.

Research Informed Consent (cont.)

Title of Study: THE EFFECTS OF GESTALT AND COGNITIVE-BEHAVIORAL THERAPY GROUP INTERVENTIONS ON THE ASSERTIVENESS AND SELF-ESTEEM OF WOMEN WITH PHYSICAL DISABILITIES FACING ABUSE

Principal Investigator (PI): Cilene Susan Adam Rita, Doctoral Candidate
College of Education
Department of Theoretical and Behavioral Foundations
Counselor Education Program
(734) 975 6616

Compensation

For taking part in this research study, you will be compensated for your time and inconvenience. I understand by voluntarily participating in the twelve-hour, six week group therapy sessions, I will receive the amount of fifty dollars ($50.00) at the conclusion of the six week group therapy session.

Research Related Injuries

In the event this research related activity results in an injury, treatment will be made available including first, emergency treatment, and follow-up care as needed. Care for such will be billed in the ordinary manner to you or your insurance company. No reimbursement, compensation, or free medical care is offered by Wayne State University. If you think that you have suffered a research related injury, contact the PI right away at (734) 975 6616.

The agency that referred you to this study is not obligated nor can be held responsible in any way for the treatment, follow-up, and/or any research-related injury.

Confidentiality

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. You will be identified in the research records by a code number of your choosing.

Information that identifies you personally will not be released without your written permission. However, the study sponsor, the Human Investigation Committee (HIC) at Wayne State University, or federal agencies with appropriate regulatory oversight (e.g., Food and Drug Administration (FDA), Office for Human Research Protections (OHRP), Office of Civil Rights (OCR), etc.) may review your records.

Research Informed Consent (cont.)

Title of Study: THE EFFECTS OF GESTALT AND COGNITIVE-BEHAVIORAL THERAPY GROUP INTERVENTIONS ON THE ASSERTIVENESS AND SELF-ESTEEM OF WOMEN WITH PHYSICAL DISABILITIES FACING ABUSE

Principal Investigator (PI): Cilene Susan Adam Rita, Doctoral Candidate
College of Education
Department of Theoretical and Behavioral Foundations
Counselor Education Program
(734) 975 6616

Group members may choose to use a pseudo name to protect their personal identity during the group therapy sessions. When the results of this research are published or discussed in conferences, no information will be included that would reveal your identity.

Voluntary Participation/Withdrawal

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you decide to take part in the study, you can later change your mind and withdraw from the study. You are free to only answer questions that you want to answer. You are free to withdraw from participation in this study at any time. Your decisions will not change any present or future relationship with Wayne State University or its affiliates, or other services you are entitled to receive.

The PI may stop your participation in this study without your consent. The PI will make the decision and let you know if it is not possible for you to continue. The decision that is made is to protect your health and safety, or because you did not follow the instructions to take part in the study.

Questions

If you have any questions about this study now or in the future, you may contact Cilene Susan Adam Rita, (734) 975-6616 or one of the research team members at the following phone number (313) 577-1613.

If you have questions or concerns about your rights as a research participant, the Chair of Human Investigation Committee can be contacted at (313) 577-1628. If you are unable to contact the research staff, or if you want to talk to someone other than the research staff, you may also call (313) 577-1628 to ask questions or voice concerns or complaints.

Research Informed Consent (cont.)

Title of Study: THE EFFECTS OF GESTALT AND COGNITIVE-BEHAVIORAL THERAPY GROUP INTERVENTIONS ON THE ASSERTIVENESS AND SELF-ESTEEM OF WOMEN WITH PHYSICAL DISABILITIES FACING ABUSE

Principal Investigator (PI): Cilene Susan Adam Rita, Doctoral Candidate
College of Education
Department of Theoretical and Behavioral Foundations
Counselor Education Program
(734) 975 6616

Consent to Participate in a Research Study

To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study you may withdraw at any time. You are not giving up any of your legal rights by signing this form. Your signature below indicates that you have read, or had read to you, this entire consent form, including the risks and benefits, and have had all of your questions answered. You will be given a copy of this consent form.

___________________________________ ________________
Signature of participant Date

___________________________________ ________________
Printed name of participant Time

___________________________________ ________________
Signature of witness* Date

___________________________________ ________________
Printed name of witness* Time

___________________________________ ________________
Signature of person obtaining consent Date

___________________________________ ________________
Printed name of person obtaining consent Time

*Use when participant has heard this consent form read to them (i.e., illiterate, legally blind).

APPENDIX C

CRITERION INSTRUMENTS

Demographic Questionnaire

Participant Identification Number ________________

Please provide the following demographic information by completing checking the appropriate box of each category. This information remains confidential and will be used confidentially in a written report. Thank you for your cooperation with this project.

1. Date of birth: ___/___/___ 2. Age: ___________ Years

3. Marital Status: ☐ Single ☐ Married/Living together ☐ Divorced/Separated
   ☐ Widowed ☐ Other, please specify:_______________________

4. Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic/Latino
   ☐ Native American ☐ Asian American ☐ Arabic or Chaldean American
   ☐ Other, please specify:_________________

5. Current living arrangement: ☐ Independent ☐ With Family ☐ Semi-independent
   ☐ Group Home ☐ Other, please specify: _________________

6. Type of disability: ☐ Cerebral Palsy ☐ Traumatic Brain Injury
   ☐ Multiple Sclerosis ☐ Muscular dystrophy ☐ Lupus
   ☐ Spinal cord injury ☐ Arthritis ☐ Joint & connective tissue disorder
   ☐ Other, please specify: _____________________

7. What is the highest educational degree you have completed?
   ☐ Less than high school diploma ☐ High School/GED ☐ Associate Degree
   ☐ Bachelor Degree ☐ Master Degree ☐ Doctorate Degree

8. Employment Status: ☐ Full-time ☐ Part-time ☐ Volunteer
   ☐ Unemployed ☐ Retired ☐ Other, please specify: ____________________

9. Household Income: ☐ $10,000–20,000 ☐ $21,000-30,000 ☐ $31,000-40,000
   ☐ $41,000-50,000 ☐ $51,000-60,000 ☐ Over $60,000

Demographic Questionnaire (cont.)

10. Have you ever experienced: ☐ Emotional and/or verbal abuse ☐ Physical abuse

 ☐ Sexual abuse ☐ Financial abuse ☐ Neglect

 ☐ Other, please specify: ________________________________

11. In the past 12 months, has anyone ever:

 a) Threatened to hurt you physically? ☐ Yes ☐ No

 b) Pushed or shoved you? ☐ Yes ☐ No

 c) Made you fear for your safety during arguments? ☐ Yes ☐ No

 d) Done anything else that hurt you physically or emotionally? ☐ Yes ☐ No

 e) Made you feel as if he owns you or controls you? ☐ Yes ☐ No

GROUP COUNSELING SESSION SUMMARY

Counselor(s): ____

Date: ___________ Session #: ________ Time: _________

Members attending:

____

____

____

Note in your own words, your reactions and interpretations relating to:

I. Group themes that developed:

II. Group member roles (initiators, stoppers, silent members, scapegoats, etc) and what group members were doing:

III. Significant patterns (i.e. seating arrangements, nonverbal data, etc):

IV. Interventions (i.e., who; thrust; what occurred before, during and after; effective ones and/or ineffective ones; identify as appropriate or inappropriate; and why):

V. How group session began and ended:

VI. What will be your goals and plans for ensuing sessions (short and long term goals, homework, etc.)?

Adapted from: Ellington (1997).

APPENDIX D

CORRESPONDENCE

Recruiting Flyer

JOIN A RESEARCH STUDY EXAMINING WOMEN'S INTERPERSONAL RELATIONSHIP DIFFICULTIES

Scheduled to begin: *November*, 2009

Location: Ann Arbor Center for Independent Living
3941 Research Park Drive
Ann Arbor, MI 48108

Incentive: Participants will receive a stipend of fifty dollars ($50.00) for completing all group sessions. Stipend will be paid at the close of the final session.

Who can participate: All women with physical disabilities who have some difficulties in life and are looking to have some personal time to work on personal issues using group therapy.

Further information, please contact:

Cilene Susan Adam Rita, MS, LLPC
av2438@wayne.edu or (734) 546 1733

Doctoral Candidate in Counseling
Wayne State University
Counselor Education Program

Data gathered from participants will be anonymously used in the following dissertation:

The Effects of Gestalt and Cognitive Behavior Group Therapy Interventions on the Assertiveness and Self-Esteem of Women with Physical Disabilities Facing Abuse

Letter from Cooperating Agency

Providing support, offering hope, transforming lives.

August 4, 2009

Cilene Susan Adam Rita
Wayne State University
Detroit, MI

Dear Mrs. Adam-Rita:

The Center for Independent Living (AACIL) in Ann Arbor, MI agrees to assist you with the identification and recruitment of women with physical disabilities facing abuse for participation in your study on the effects of Gestalt and Cognitive-Behavioral group therapy interventions on the assertiveness and self-esteem.

Our participation will consist of providing information about your study to consumers of our services, providing them with contact information or written materials that you have developed which describe the study and providing space for the group sessions. Participation of any and all consumers is voluntary and will have no bearing on the services rendered by the AACIL. Furthermore, AACIL will not individually recruit or identify women for the study and will assure consumers that their decision not to participate will in no way affect the services received or offered by our organization. AACIL agrees to allow you, as appropriate, to present information about the study to women currently participating in groups facilitated by AACIL staff.

As an organization dedicated to the success of adults with disabilities and a provider of mental health services, AACIL is interested in the provision of quality care services and with the results of research that assist in the establishment of best practices. We are pleased to assist you in having a successful research experience.

Sincerely,

Dana Emerson
Director of Operations

A nonprofit organization dedicated to the success of children, youth and adults with disabilities at home, at school, at work and in the community.

3941 Research Park Drive | Ann Arbor, Michigan 48108 | (734) 971-0277 | www.aacil.org

APPENDIX E

HANDOUTS

Handout for Cognitive-Behavioral Group

Meeting Group 1: Homework

Self-Esteem

To do this exercise you'll need a blank piece of paper. Set a timer for ten minutes or note the time on a clock. Write your name across the top of the paper, and then write everything positive and good you can think of about yourself. Include special attributes, talents, and achievements. You can use single words or sentences, whichever you prefer. You can write the same things over and over if you want to emphasize them. Don't worry about spelling, grammar, or organization. Write down whatever comes to mind but avoid making any negative statements or using any negative words.

When the ten minutes are up, read the paper to yourself. You may feel sad when you do so because it is a new, different, and positive way of thinking about yourself and it can contradict some of the negative thoughts you may have had about yourself. Read the paper several times, then put it in a convenient place – your pocket, purse, wallet, or the table beside your bed. Read it over to yourself several times a day to keep reminding yourself of how great you are!

____

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Handout for Cognitive-Behavioral Group

Meeting Group 2: Homework

More Practice with Positive Thoughts

Last week you learned to change negative thoughts to positive ones. This exercise is similar to the one you did then. This time, you will make a list of negative thoughts you have about yourself and develop positive responses to each one. Again, use the following guidelines in developing your positive statements.

- Avoid using negative terms such as “bad”, “blame”, “shame”, or “guilty”. Instead, use only positive words such as “friendly”, “warm”, “compassionate”, “competent”, or “responsible”.
- Substitute “it would be nice if” for “should”.
- Use “I”, “me”, or your name in the positive rebuttal.

Negative thought	Positive response
I never do anything right.	I do lots of things well.
I will never be worth anything.	I am a valuable person.
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
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Handout for Cognitive-Behavioral Group

Meeting Group 3: Homework

Raise your Self-Esteem

1. Make a list of your ten greatest achievements. For example:

I learned to read.

I raised a wonderful child.

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Read this list often.

Meeting Group 3: Homework (cont.)

2. Make a list of ten ways you can treat yourself that don't include food and that don't cost anything. For example:

   Watch children playing on a playground.
   Study a beautiful flower.
   Chat with a friend.
   Window shop.

   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____

   Give yourself one or several of these treats every day.

3. Laughing makes you feel good about yourself. Make a list of five things that make you laugh.

   ____
   ____
   ____
   ____
   ____

Handout for Cognitive-Behavioral Group

Meeting Group 3: Handout

Things to Remember Every Day

- **I deserve to feel good about myself.**
- **I deserve to take good care of myself. That includes eating right, getting plenty of exercise, doing things I enjoy, getting good health care, and attending to my personal hygiene needs.**
- **I choose to spend my time with people who are nice to me and make me feel good about myself.**
- **I am a good person and I deserve to be alive.**

Source: Copeland & Harris (2000)

Handout for Cognitive-Behavioral Group

Meeting Group 4: Homework

Wants into Words - Assertiveness

1. Spend at least one hour each day of this week doing something you really enjoy. Note how you feel before and after this activity.

The most important skill in asking for what you want is formulating an assertive request. If asking for things is hard for you, it's wiser to prepare your request in advance, rather than to say what comes to mind spontaneously. Preparing an assertive request first involves getting the facts and then distilling them into a clear statement of your wants. Here are the facts you need:

From ____

Write down the name of the person who can give you what you want. If there are several people from whom you want the same thing, write out separate requests for each of them.

I want ____

Spell out what you want the other person to do. Stay away from abstractions like "show respect" or "be honest". Don't ask for a change of attitude or level of interest. Instead, specify exact behavior: "I want to have an equal vote in choosing a daycare provider" or "I want Joe to tell me the real reason he keeps postponing our wedding and where he gets all the money he throws around."

When ____

Indicate the deadline for getting what you want, the exact time of day you want someone to do something, or the frequency with which you want something – any aspect of time that will help narrow down and refine your request. For example, you might want to help

Meeting Group 4: Homework (cont.)

cleaning the house every week. Be specific and write, “Every Saturday morning right after breakfast.”

Where ____

Write down the places where you want something – any aspect of location that will serve to precisely define what you want. If you want to be left alone when you are in your den, specify that place as your special place to be alone.

With ____

Specify any other people who have to do with your request. For example, if you want your husband to stop teasing you about your forgetfulness in front of his relatives, spell out all the relatives’ names.

This outline is designed to help you specify *exactly* what it is you are requesting – the desired behavior, the time, the place, and the situation. When you clarify these facts in advance, your request will be so specific that negotiation will be easier and arguments less likely.

Now make your own request outline. From your wants inventory, choose three things that you want from three different people. Be sure to choose items that you rated only mildly or moderately uncomfortable. For each want, fill in the facts for your request outline:

From:

I want:

When:

Where:

With:

Handout for Cognitive-Behavioral Group

Meeting Group 5: Homework

Your Feelings

Feelings help the listener have empathy for your experience in a situation. The best way to express your feelings is in the form of “I messages.” In “I messages” you take responsibility for your emotions. You say:

I felt hurt.

I was a little angry.

I felt left out.

I was saddened.

I was disappointed.

I felt mainly confused.

This is in contrast to “you messages”, which are accusatory and pejorative and dump all responsibility for your feelings on the other person:

You hurt me.

You made me angry.

You left me out.

What you did depressed me.

You disappointed me.

You confused me.

Handout for Cognitive-Behavioral Group

Meeting Group 5: Homework (cont.)

Notice that “you messages” tend to make people defensive and hostile, while “I messages” seem less confrontational and tend to elicit concern.

Putting it together

Whole messages are very compelling. It’s time to generate whole messages of your own to complete your assertive request. The format is simple:

I think (my understanding, perceptions, interpretations).

I feel (“I messages” only).

I want (your requests).

Here are some short examples of wants expressed in the form of whole messages:

I think I do more than my share of the work around here. I feel resentful when I’m working and you’re reading the paper or watching TV. I want you to help me with setting the table and doing the dishes after meals.

I think George and I have a lot in common. I enjoy being out with him, and I’m getting to like him a lot. I want to invite him to dinner next week and have you help me make some lasagna.

I don’t think your cousin is a very good mechanic. I feel obligated to take my car to him because he’s family, but I get really mad when he can’t fix things right the first time. The clutch is slipping again, and this time I want to take it to the show downtown.

Handout for Cognitive-Behavioral Group

Meeting Group 5: Handout

Rules for Requests

Work on your requests until they are as clear, direct, and uncritical as possible. Then try them out on the people who can give you what you want. To help you in perfecting your requests, here are some rules for asking.

1. If possible, get the other person to agree on a convenient time and place for your conversation.
2. Keep your request small enough to avoid massive resistance.
3. Keep your request simple – just one or two specific actions for the other person to understand and remember.
4. Don't blame or attack the other person. Use "I messages" so that you will stick to your own thoughts and feelings. Try to be objective – stick to facts. Keep your tone of voice moderate.
5. Be specific. Give exact figures and times for what you want. Don't hedge. Don't make a lot of conditions. Describe what you want in terms of behavior, not a change in attitude.
6. Use assertive, high self-esteem body language: maintain eye contact, sit or stand erect, uncross your arms and legs, make sure that you're close enough. Speak clearly, audibly, and firmly, without a whining or apologetic tone to your voice. Practice your requests in front of a mirror to correct problems in your body language. You can also listen to your request on tape to evaluate your voice tone and inflection.
7. Sometimes it's helpful to mention the positive consequences of giving you what you want. You could also mention the negative consequences of denying your request, but the positive approach works better. As the old adage has it, you're likely to catch more flies with honey than with vinegar.

When you have perfected your requests and practice them in the mirror, go ahead and make them in real life. Taking that step will not be easy, but it will be very rewarding. Start with the least threatening person first. After you have made your prepared requests, go back to your list and prepare some others, still saving the most discomforting confrontations for last.

This is one area in which practice does make perfect and success builds upon success. As you work through your list of wants, you will soon find that you don't have to argue with yourself so much about whether a particular desire is reasonable or legitimate. You will need to spend less time rehearsing your requests. You will begin to see what you want more clearly and to ask for it spontaneously and directly.

You'll be surprised at how often people will simply say yes to a clear, nonjudgmental request. You will benefit in double by getting what you want and gaining more self-confidence as well.

Source: McKay & Fanning (2000).

Handout for Cognitive-Behavioral Group

Meeting Group 6: Handout

Communication Skills Log Worksheet

Date: _____________ Time: ____________________

1. Identify a situation or a person that you would like to be more assertive with this week:

2. What are your thoughts and feelings about the person or the situation?

3. How would you like to communicate in this situation: (write about your plan, for example, what would you like to say or how would you like to behave in the situation?)

Answer the following after you have completed your communication goal this week:

1. What were the nonverbal messages (given and received)?

2. What were the verbal messages (given and received)?

3. What feelings and thoughts did you experience after you communicated in the manner you wanted?

Handout for Cognitive-Behavioral Group

Meeting Group 6: Handout

When you want to be assertive, say…

- I agree
- I disagree
- I’d like that
- I don’t want to
- I feel uncomfortable about…
- I’d like to think about it
- Could you do that?
- I have an issue I want to talk to you about
- I don’t appreciate that
- I have an issue I want to talk to you about
- I don’t appreciate that
- I have a problem with that
- I see it differently
- No
- Yes
- I feel…
- That’s unacceptable
- What alternative could you suggest?
- It is important to me
- I am not interested
- I am not able to fit that into my schedule
- I’d like to make a suggestion
- No thank you
- Yes, I do mind
- I don’t like that
- Let me explain
- You’re entitled to your opinion
- In my opinion
- I think
- I believe
- Something is bothering me
- Let’s take turns
- How can we find a solution?
- I don’t think that’s fair
- That does not seem reasonable to me
- This is what I need
- I would appreciate
- I really like it when…

Handout for Cognitive-Behavioral Group

Meeting Group 6: Handout

- Could you repeat that please?
- I don't want to have an argument
- Not right now, thank you
- I'd rather not
- I'd prefer not to
- I think we should discuss this
- Wait a minute. Let me see if I understand this correctly…
- Hold on a minute
- I've got a problem with that
- I see it from a different angle
- I don't think so at all
- I understand your point of view, but…
- I don't have time
- I need your help here
- There's something important that I'd like to talk about
- My feelings are real
- I see what the problem is
- I don't know
- I guess you misunderstood me
- I misunderstood you
- May I make a suggestion?
- I'd like to ask you something
- Would you like to hear my opinion?
- When can we talk about this?
- This is hard for me to say
- Would you be willing to try…?

Handout for All Groups

Local Resources for Assistance and Support – Ann Arbor

If you are ever in immediate danger call 911
A TDD system has been built into 9-1-1 since 2000. If a TDD caller calls 9-1-1 on any line, the phone recognizes the tones and brings up the system, which operators begin typing on.

If you need HELP or INFORMATION, call:

National Domestic Violence Hotline ………………………………………..….. 1-800-799-7233
……………………………………………………………………….... 1-800-787-3224 (TTY)
National Suicide Prevention Lifeline ……………………………….……… 1-800-273-TALK
…………………………………… 1-800-799-4889 (TTY)
National Youth Crisis Hotline ………………………………………………. 1-800-HIT-HOME
Children's Protective Services Abuse Hotline ……………………..……… 1-800-252-5400
Poison Control ……………………………………………………………….. 1-800-222-1222
……………………………………………………………… 1-800-356-3232 (TDD)
Relief After Violent Encounters (RAVE) ………………………….. 1-877-952-RAVE(7283)
SafeHouse Center ……………………………………………………………… (734) 973-0242
P.O. Box 7052
Ann Arbor, MI 48107
24-hour Hotline ……………………………..(734) 995-5444 (confidential interpreters available)
24-hour ……………………………………………………………...…. (734) 973-2227 (TTY)
Website: www.safehousecenter.org
Domestic Violence Project, Inc. ……………………………… 313-995-5444 (Hotline/Crises)
…………………………………….... 313-973-0242 (Business)
P.O. Box 7052
Ann Arbor MI 48107
Michigan Coalition Against Domestic & Sexual Violence …………………... (517) 347-7000
……………. (517) 381-8470 (TTY)

If you need **HEALTH SERVICES**, call:

Your Family Doctor ……………………………………………………… ________________
University of Michigan Health System ………………………….……………… (734) 936-4000
Saint Joseph Mercy Health System ……………………………….…………… (734) 712-3456

If you need **Other Services,** call:

Public meetings that address issues concerning people with disabilities? ..(734)794-150, ext 41206
Please contact the Commission on Disability Issues
PO Box 8647
Ann Arbor MI 48107-8647

Handout for All Groups
Local Resources for Assistance and Support – Ann Arbor (cont.)

Ann Arbor Center for Independent Living ….. (734) 971-0277……. (734) 971-0310 (TTY)
Information and referrals, peer consultation, independent living skills training, systems advocacy, benefits counseling, all-abilities recreation list, rehabilitation engineering and technology, job placement, small business development, youth services. Mon.-Fri. 9 a.m.-5 p.m. To volunteer, call Melissa Sartori, ext. 27. msartori@aacil.org, www.aacil.org
3941 Research Park - Ann Arbor, MI

Telephone number for TDD relay service?.. 1-800-649-3777 or 711
TDD relay service is available toll free from the Michigan Relay Center by calling. For more information visit the Michigan Relay Center website.

Adapted Recreation (Ann Arbor Public Schools Department of Community Education & Recreation) ……………………………………………………....(734) 994-2300, ext. 53203
Classes in cooking, dance, art, exercise, living skills, and other areas; bowling league for teens and adults with mental or physical challenges. www.aareced.com
1530 Eisenhower Place – Ann Arbor, MI

Adult Learning Systems—Lower Michigan Inc. ……………………………... (734) 668-7447
Support to help mentally ill and developmentally disabled clients live the range from independence to total dependency (24-hour residential services). Must be referred through a county agency. als-lm@prodigy.net, www.als-lm.org
1954 South Industrial, suite A – Ann Arbor, MI

Assistive Media ………………………………………………………………. (734) 834-3034
Produces audio-based periodicals, short stories, and books to serve the blind and physically disabled. Recordings available online and through specialized podcasts. www.assistivemedia.org
400 Maynard, suite 11B – Ann Arbor, MI

Association for Community Advocacy ……………………………………… (734) 662-1256
Advocacy for people with disabilities, to provide them with choices, opportunities, and support for full inclusion in community life. info@washtenawaca.org, www.washtenawaca.org
1100 N. Main, suite 205 – Ann Arbor, MI

Handout for All Groups
Local Resources for Assistance and Support – Ann Arbor (cont.)

Michigan Ability Partners …………………………………………………….. (734) 975-6880
Housing and vocational services for veterans and others with disabilities; resume preparation, job placement and coaching, transitional work training, career planning. Also substance abuse treatment; housing placement, development, and support; and personal financial management help. info@mapagency.org, www.mapagency.org
3810 Packard, suite 200 – Ann Arbor, MI

Michigan Rehabilitation Services (Michigan Department of Energy, Labor, and Economic Growth) ……………………………………………………………………….. (734) 677-1125
Vocational rehabilitation, training, counseling, and job placement assistance for disabled county residents. Participants must attend orientation. Call for appointment. www.michigan.gov/mrs
3810 Packard, suite 170 – Ann Arbor, MI

Partners in Personal Assistance ………………………………………….… (734) 214-3890
Offers ways for people with disabilities to make decisions about their care. Clients choose and supervise their own personal assistants. info@annarborppa.org, www.annarborppa.org
1100 N. Main, suite 117 – Ann Arbor, MI

Real Life Living Services ……………………………………………………… (734) 222-6076
Provides in-home and community support, care, assistance, and companionship—around the clock if needed—for people with disabilities. Accepts referrals from state agencies and others.
www.rlls.org 1100 N. Main, suite 217 – Ann Arbor, MI

Therapeutic Riding Inc. ……………………………………………...………(734) 741-9402
Horseback riding for area youth and adults with physical and mental disabilities. No riding experience required for participants or volunteers. Volunteers must be at least age 14 and attend orientation. info@therapeuticridinginc.org, therapeuticridinginc.org
4715 E. Joy - Ann Arbor, MI

Washtenaw County Library for the Blind and Physically Disabled ………. (734) 327-4224
…………….. (888) 460-0680
Free library service for those unable to read standard-print materials because of a visual or physical disability. Books, magazines, and videos in alternative formats such as recorded cassette, Braille, and descriptive video are mailed to registered patrons at no charge. Assistive technology and borrowing privileges available. Mon. 10 a.m.-9 p.m., Tues.-Fri. 9 a.m.-9 p.m., Sat. 9 a.m.-6 p.m., Sun. noon-6 p.m. wlbpd@aadl.org, wlbpd.aadl.org
Ann Arbor Public Library, 343 S. Fifth, Ann Arbor, MI

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ABSTRACT

THE EFFECTS OF GESTALT AND COGNITIVE-BEHAVIORAL THERAPY GROUP INTERVENTIONS ON THE ASSERTIVENESS AND SELF-ESTEEM OF WOMEN WITH PHYSICAL DISABILITIES FACING ABUSE

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The purpose of this study was to examine the differential effects of Gestalt and Cognitive-Behavioral group therapy interventions on assertiveness and self-esteem among women with physical disabilities facing abuse. The eleven women, who met the study criteria, were randomly assigned to one of two experimental conditions, Gestalt Therapy (GT) and Cognitive-Behavioral Therapy (CBT) group interventions. The *Demographic Questionnaire* (Adam Rita, 2009) documented personal characteristics of the participants. The criterion instruments were: a) *RAS* (Rathus, 1973), and b) *CFSEI-2 (*Form AD, Battle, 1992) measuring assertiveness and self-esteem respectively and were administered pre-and-post treatment. The research was conducted over a period of six weeks, totaling six weekly two-hour group sessions.

It was hypothesized these interventions would help women with physical disabilities facing abuse increase their levels of assertiveness and self-esteem. To determine if the differences between groups were statistically significant for the two dependent variables, assertiveness and self-esteem, MANCOVAs within subjects contrasts and between subjects effects were examined. Based on these findings, neither Gestalt Therapy (GT) nor Cognitive-

Behavioral Therapy (CBT) group interventions produced statistically significant outcome effects on the dependent variables, assertiveness and self-esteem. The findings did not support the research hypotheses; therefore both null hypotheses were retained.

AUTOBIOGRAPHICAL STATEMENT

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EDUCATION:

2004-2010 WAYNE STATE UNIVERSITY, Detroit, Michigan
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1991-1996 VALE DO ITAJAI UNIVERSITY, Itajai, SC, Brazil
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