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# Group therapy for sexually abused adolescents : assessment of coping skills, negative beliefs, and self-esteem

Kimberly R. Akin

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GROUP THERAPY FOR SEXUALLY ABUSED ADOLESCENTS:  
ASSESSMENT OF COPING SKILLS, NEGATIVE BELIEFS,  
AND SELF-ESTEEM

By

KIMBERLY R. AKIN

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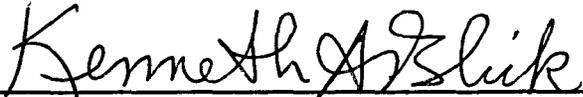
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I certify that I have read this thesis and find that, in scope and quality, it satisfies the requirements for the degree of Master of Arts.

  
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Dr. Kenneth A. Blick, Thesis Committee Chair

  
\_\_\_\_\_

Dr. Theresa A. Kruczek, Clinical Supervisor

  
\_\_\_\_\_

Dr. Andrew F. Newcomb, Committee Member

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## Group Therapy for Sexually Abused Adolescents:

### Assessment of Coping Skills, Negative Beliefs, and Self-Esteem

The sexual victimization of children is an increasing crime problem in this country and is now also recognized as a serious mental health issue. It has been estimated that the risk of victimization could be as high as one in ten for boys (Finkelhor, 1979) and one in three for girls (Anderson, Martin, Mullen, Romans, & Herbison, 1993). Girls are eight times as likely as boys to suffer rape (Finkelhor & Dziuba-Leatherman, 1994). Prevalence rates estimate between 15% and 38% of women (Finkelhor, 1984; Herman, 1981) and 6% of men (Finkelhor, 1984) have experienced childhood sexual abuse (CSA).

There is also increasing evidence of the lasting traumatic impact of CSA. For some children its effects may persist over many years, even into adult life. McConkey (1992) estimates that at least 40% of CSA victims suffer enough from these symptoms to require therapy before or during adulthood. CSA can leave a victim with feelings of fear, anxiety, depression, posttraumatic stress, negative beliefs about life, negative self-image, and diminished self-esteem (Briere, 1989; Briere & Runtz, 1993; Browne & Finkelhor, 1986; Courtois, 1979, 1988; Dolan, 1991; Grayston, De Luca, & Boyes, 1992; Greene, 1993; Herman, 1981; Herman, Russell, & Trocki, 1986; Jehu, Klassen, & Gazan, 1986; Kendall-Tackett, Williams, & Finkelhor, 1993; Mennen & Meadow, 1994; Vandermey & Neff, 1986).

The chronic and on-going nature of most CSA often leads to long-lasting feelings of helplessness, shame, guilt, diminished self-worth, and low self-esteem (Briere & Runtz, 1993; Burt & Katz, 1987; Jehu et al., 1986). Self-esteem is described as a person's evaluation of him/herself, and indicates the extent to which that person believes in his/her own self-worth (Coopersmith, 1981). People with high self-esteem feel that they are worthy and they like themselves, whereas people with low self-esteem do not. People with high self-esteem also tend to enjoy more productive social relationships (Coopersmith, 1975) compared to those with low self-esteem. Research indicates that sexual abuse is linked to feelings of diminished self-worth, negative self-image, impaired self-reference, and low self-esteem (Briere & Runtz, 1990, 1993; Courtois, 1979; Grayston et al., 1992; Kendall-Tackett et al., 1993; Mennen & Meadow, 1994; Steele & Alexander, 1981; Stern, Lynch, Oates, O'Toole, & Cooney, 1995).

Cognitive theory rests on the notion that thoughts and beliefs have a significant influence on mood, feelings, and actions. Cognitive and psychodynamic theorists tend to agree that childhood experience contributes to a person's assumptions and beliefs about life. Since childhood for sexual abuse survivors is plagued by negative experiences, the result is negative self-perceptions and negative beliefs about the world. Burns (1980) describes these negative beliefs as cognitive distortions, or cognitive errors, since they are

often incorrect and irrational. Common cognitive distortions are: all-or-nothing thinking, overgeneralization, mental filtering, disqualifying the positive, jumping to conclusions, magnification and minimization, emotional reasoning, should statements, labeling and mislabeling, and personalization (Burns, 1980; Jehu et al., 1986). These distorted thoughts can cause a person to dwell on perfection and overgeneralize their mistakes, expect too much out of themselves, or feel that one mistake guarantees future failure. They may minimize or deny positive experiences, magnify or dwell on negative experiences, and make negative interpretations of any experience even if there is no logically supportive evidence for it. Distorted thoughts can cause a person to overidentify with failure and blame themselves for events that are not under their control. A complete description of these cognitive distortions is provided by Burns (1980).

Survivors of CSA who possess such cognitive distortions, are likely to interpret their feelings and emotional responses in an irrational and negative way, and the result can be low self-esteem. Previous research with survivors of CSA indicates that these cognitive distortions are often so automatic that the clients are totally unaware of their influence (Jehu et al., 1986). According to cognitive theory, the correction of such negative beliefs or cognitive errors will produce improvements in mood (Beck, 1976; Briere & Runtz, 1993; Burns, 1980; Kendall, 1993). Therefore, therapy for this population should

focus on eliminating or transforming the negative, distorted thinking into more positive, rational, and productive thinking.

There is an abundance of literature advocating treatment for survivors of CSA, but few studies are devoted to outcome research with survivors, so there is little information documenting the efficacy of therapy for this population (O'Donohue & Elliott, 1992). The following treatment approaches address negative beliefs and cognitions and have been shown to initiate lasting improvement in symptom recovery: solution-focused intervention (Dolan, 1991), systematic desensitization (Wolpe, 1958), stress inoculation and assertiveness training (Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988), and cognitive restructuring (Jehu et al., 1986). The treatment protocol under investigation was developed out of and incorporates all of these approaches, therefore they will be described in more detail.

Solution-focused intervention assumes that clients have the ability to develop their own effective solutions to their problems (Dolan, 1991). Therapy is therefore highly individualized and encourages clients to utilize their personal resources, as they work together with therapists to co-create solutions and goals. Negative beliefs about the self are gradually replaced with positive, goal-oriented beliefs.

Systematic desensitization is a counterconditioning technique whereby an anxiety or fear-invoking stimulus is paired with relaxation. The theory is

that fear and anxiety cannot physiologically coexist with relaxation, so a client is conditioned to relax when faced with an anxiety or fear-invoking stimulus, and the fear-invoking stimulus gradually becomes less threatening. Formally introduced by Wolpe (1958), systematic desensitization has been effective in reducing the fear and anxiety associated with rape (Frank et al., 1988).

Stress inoculation techniques can also be used to address the fear and anxiety associated with sexual abuse. Like systematic desensitization, stress inoculation utilizes relaxation training, but with emphasis on education about positive coping strategies and skill building. In fact, Resick et al. (1988) employed progressive muscle relaxation, cognitive techniques, and problem-solving, and found that it produced lasting improvement in fear and anxiety after only six group therapy sessions. Resick et al. (1988) concluded that these techniques also helped raise self-esteem.

Assertiveness is a positive approach to interpersonal communication whereby a person defends their own needs in a way that is respectful of others. An assertive interpersonal style can counter anxious feelings (Wolpe, 1969) and lead to effective communication and positive relationships. According to Resick et al. (1988), assertiveness training is an appropriate form of therapy with survivors because, by definition, the abuse experience is interpersonal, and survivors often have a particularly hard time asking for what they want and/or defending their right to say no. Survivors of CSA are

often left with negative feelings about themselves and their ability to foster supportive relationships. Assertiveness training has been effectively employed to help reduce fear, anxiety and avoidance in survivors (Resick et al., 1988).

Cognitive restructuring, a form of cognitive-behavioral therapy, has been employed with survivors of CSA to help them recognize their distorted beliefs and learn to replace them with more accurate beliefs (Jehu et al., 1986). Jehu et al. (1986) found statistically significant improvements in both beliefs and mood for 11 adult female survivors of CSA after cognitive restructuring therapy. Their therapeutic protocol included the provision of factual information about the prevalence and effects of CSA, in an attempt to combat common misconceptions held by the clients. They also employed logical reasoning, decatastrophizing, and distancing to help clients see the irrationality of their beliefs and self-blame (Jehu et al., 1986).

Treatment for survivors of CSA can be administered individually, but group therapy tends to be a popular approach (Haugaard & Reppucci, 1988). It has been suggested that group therapy is the most effective mode of therapy for adolescent survivors of CSA (Gagliano, 1987; Porter, Blick, & Sgroi, 1982), because group therapy can help clients validate their feelings and normalize their own reactions to the abuse (Vandermeij & Neff, 1986), as well as reduce feelings of guilt, shame, and stigmatization (Carver, Stalker, Stewart, &

Abraham, 1989), and foster feelings of belongingness (Hiebert-Murphy, De Luca, & Runtz, 1992). Belongingness is particularly important to adolescents who are typically turning toward their peers as their primary reference group. Corder et al. (1990) reported that group therapy enabled survivors to better understand their abusive experiences and themselves. Group therapy is also a recommended treatment modality because it responds effectively to the modern call for efficient service delivery.

There is evidence that group therapy can contribute to increased self-esteem in survivors (De Luca, Hazen, & Cutler, 1993; Furniss, Bingley-Miller, & Van Elburg, 1988). De Luca et al. (1993) found an increase in self-esteem following a 10-week group counseling program for seven female victims of incest. Furniss et al. (1988) found improvements in self-esteem and assertiveness following participation in group therapy once a week for between seven months to two years. Hiebert-Murphy et al. (1992) also investigated self-esteem changes following group therapy for survivors, but found mixed results. After a nine-week group therapy intervention, three of five girls showed an increase in self-esteem, whereas the other two showed a decrease.

The group therapy protocol used in the present study was initially developed by Kruczek (1995) and recently revised by Kruczek and this author. Topics and activities were developed following a literature review of group

therapy recommendations, and are based on a combination of cognitive-behavioral therapy, solution-focused intervention, stress inoculation, and assertiveness training. Outcome literature supports small, local treatment models (Pilkonis, 1993) and therapeutic protocols which implement cognitive behavioral techniques and coping skill development (Finkelhor & Berliner, 1995; O'Donohue & Elliott, 1992; Downing, Jenkins, & Fisher, 1988). It has been suggested that the most effective intervention strategies for survivors are those which present specific skills, coping mechanisms, and alternative responses to the clients (Holmes & St. Lawrence, 1983).

The seven-session protocol in the present study responds to the call for cognitive and skill-building interventions. Each session addresses one of the following topics: safety-awareness and flashback management, external emotions (anger), internal emotions (depression, anxiety, guilt, shame, and self-worth), relaxation and self-nurturance, problem-solving and assertiveness, supportive relationships, and positive self-image. Each session is designed as an independent treatment episode, and all seven sessions are administered over about a two-week period.

Two previous outcome studies of the efficacy of the present group protocol have been conducted. Both Watson (1994) and Kruczek (1995) found significant improvement in levels of information mastery and positive skill development from pre- to posttreatment, followed by significant

improvement in symptom recovery at three month follow-up. However, neither Kruczek (1995) nor Watson (1994) included measures of distorted beliefs associated with the abuse.

The purpose of the present study was to continue the investigation of the group therapy protocol for survivors developed and revised by Kruczek (1996). The present study sought to replicate previous findings related to coping skill acquisition, and it sought to build on the work of Kruczek (1995) and Watson (1994) by assessing the negative beliefs and decreased self-esteem associated with CSA. It was hypothesized that following group therapy there would be (1) an increase in knowledge of alternative forms of effective coping strategies for survivors, (2) a decrease in dysfunctional/negative beliefs associated with CSA, and (3) an increase in self-esteem.

## Method

### Subjects

Seven adolescent females, age 13 to 17, with a history of sexual abuse participated in the study. Sexual abuse was defined as any sexual interaction between a child and an adult (someone five or more years older), that may or may not involve coercion or force (Browne & Finkelhor, 1986). Participants came from the inpatient and residential units of a child psychiatric treatment facility following discussion with and written referral by their individual therapist. They discussed the purpose and goals of the group with their

individual therapist and came to a mutual decision to join, with an initial commitment to participate in all seven group sessions, over the course of about two weeks.

The study lasted approximately five months, and during that time a total of 16 girls were referred to the study. One girl refused to participate after the first session, and eight girls were discharged from the treatment center before completing all group sessions/measures, leaving a total of seven girls who participated in the entire protocol. Only those participants who completed the protocol were included in the data analysis.

Information about demographics, abuse history, and symptoms were obtained from the individual therapists, and informed consent was obtained from the participants and their guardians, as part of the referral process. All seven participants had experienced some form of sexual abuse ranging from fondling to penetration. Four presented symptoms of depression and displayed suicidal or personally unsafe behaviors. Other symptoms common among the participants were anger management and impulse control problems, aggression, medication non-compliance, and dissociative symptoms.

All seven girls had been sexually abused by at least one male authority figure, including biological fathers, foster fathers, neighbors, family friends, and mother's boyfriends. Other perpetrators included foster brothers and

cousins. Abuse durations varied from isolated incidents to ongoing abuse over the course of months or several years. All seven girls had acknowledged the sexual abuse, five were willing to talk about it, and two felt that it somehow contributed to their current problems.

Due to the time-limited nature of the study, as well as ethical concerns about denial of therapy to those in need, a no-treatment or wait-list control group was not included.

### Materials

The Skill Mastery Test (Kruczek, 1992) is a standard multiple-choice content analysis of positive coping strategies. The skills assessed by the 16 multiple choice questions on the Skill Mastery Test (SMT) are directly related to the skills taught in the group protocol under investigation. The respondent receives one point for each correctly answered question, and the total possible points are 16. A low score on the SMT indicates a low familiarity with the particular coping skills it addresses. The SMT has been used to demonstrate an increase in knowledge of coping strategies following group therapy for survivors (Kruczek, 1995; Watson, 1994). A reliability measure yielded a Cronbach's alpha of .796 for the SMT (Kruczek, 1992). The SMT was used in the current study to assess the extent to which knowledge of alternative coping strategies improved as a result of group participation.

The Belief Inventory (Jehu et al., 1986) is an inventory of 26 distorted

beliefs common to survivors of CSA. It has a high level of reliability ( $r = .93$ ,  $p < .001$ ), and reasonable concurrent validity with the Beck Depression Inventory ( $r = .55$ ,  $p < .01$ ). The Belief Inventory (BI) was chosen for the current study because the negative/distorted beliefs it measures relate directly to the issue of sexual abuse and to the content of the current therapeutic protocol. The BI presents the distorted beliefs to the reader, who then answers whether she believes the statement to be absolutely true for her, mostly true, partly true, mostly untrue, or absolutely untrue. The inventory is then scored such that higher agreement with each negative belief receives higher points, and the points are summed for a final score.

The highest possible score on the BI is 104, which indicates the highest possible agreement with all 26 dysfunctional beliefs. A lower score on the BI indicates a lower agreement with the negative beliefs. A score of 15 or higher is considered a clinically significant level of distorted beliefs (Jehu et al., 1986). The BI has been used to demonstrate a decrease in negative thinking following cognitive therapy with sexual abuse survivors (Jehu et al., 1986), and it was used in the current study to investigate changes in negative thinking as a result of group participation.

The Self-Esteem Scale (Rosenberg, 1965) is a 10-item questionnaire designed to measure adolescents' global feelings of self-worth or self acceptance. Reliability ( $r = .82-.85$ ) and validity ( $r = .55$  with the Coopersmith

Self Esteem Inventory) have been demonstrated (Blascovich & Tomaka, 1991). The Self-Esteem Scale (SES) presents the respondent with 10 statements about self worth, to which the respondent answers whether she strongly agrees, agrees, disagrees, or strongly disagrees with the statement. Half of the items are scored such that a high agreement with the statement indicates high self esteem, and half of the items are reverse-scored, such that high agreement indicates low self esteem. The highest possible score on the SES is 40, which indicates high self esteem. The lower the score, the lower the indication of self esteem. The SES was chosen for the current study because of its ease and timely administration. It was used to assess changes in survivors' feelings of self-worth following participation in the group therapy.

The Girls Group Workbook and Protocol Outlines (Kruczek, 1996) were recently revised with the help of this author. The workbook was designed specifically for the group protocol under investigation and consists of seven chapters which directly correspond to the seven group topics. Chapter one was designed as an orientation to familiarize the girls with the purpose and goals of the group. Chapter one also addresses the topics of personal safety, flashback management, and support systems. Chapter two focuses on externalized emotions, with particular emphasis on anger management techniques. Chapter three takes a look at internalized emotions such as fear, guilt, shame, embarrassment, and other painful feelings that often result

from negative beliefs and negative information from self and others. Chapter three emphasizes the importance of self-forgiveness and love as part of the healing process. Chapter four focuses on the importance of self-nurturance in the healing process and introduces several different relaxation techniques aimed at stress- and anxiety-reduction. The fifth chapter introduces potential warning signs of abusers and includes an activity that emphasizes the importance of recognizing and seeking support from positive relationships. Chapter six is about problem-solving and assertiveness and allows the girls to practice effective interpersonal communication skills. The seventh and final chapter in the group workbook is dedicated to the importance of a positive self-image. The need for a balanced self-perspective that focuses on the whole self, not just the abuse, is emphasized, and the girls are encouraged to focus on their positive attributes, their likes and hobbies, strengths and abilities, goals and future aspirations.

Each session in the protocol corresponds to a chapter in the workbook and includes a didactic activity, along with a creative arts activity, and the development of a positive associational cue to serve as a reminder of that day's topic. Each chapter in the workbook concludes with a homework assignment.

After completing the entire protocol, girls were also asked to fill out a client satisfaction questionnaire about their impression of and reaction to the

group. The 10-item questionnaire, developed by this author, assessed whether or not the girls enjoyed group, were glad to have participated, felt they benefitted from it, learned something new, would recommend it to other girls with similar experiences, and felt better about themselves as a result of group discussions and topics. The survey also provided the girls an opportunity to give feedback and suggestions for improving the group for future participants.

### Procedure

The treatment group met three times a week for one hour, and was a regularly scheduled therapeutic activity. Prior to joining group, participants were administered the assessment battery, including the SMT, SES, and BI. They were given a copy of the Girls Group Workbook and were oriented to the group, which is the purpose of the first chapter. Administration of each session was standardized according to the protocol outlines. An earlier study by Kruczek (1995) utilized videotaping to demonstrate the capacity for standardized application of the protocol using the treatment manual. This author as well as two other therapists from the treatment center served as group leaders in the present study. Participants remained in the group until completion of the six remaining sessions, at which time they were again administered the three measures of skill mastery, beliefs, and self-esteem. Individual scores from pretreatment were compared to scores posttreatment

on all three measures.

Since participation in the group was voluntary, participants were rewarded with bonus points, in keeping with the existing general treatment program. Participants received bonus points for attending group, participating, bringing their workbook, and completing homework assignments.

### Results

Ratings of skill mastery, negative beliefs, and self-esteem, as measured by the SMT, SES, and BI, were analyzed for significant differences from pre- to posttreatment using within subjects analyses of variance. The actual scores and group means for each of the three measures at pre- and posttreatment can be seen in Table 1 (subjects are numbered for confidentiality.)

The mean pretreatment score on the SMT was 8.27 (SD= 2.63) and increased to 11.86 (SD= 2.34) posttreatment. Six of the seven participants' scores on the SMT improved, and one participant's score remained the same from pre- to posttreatment. Overall, the mean scores on the SMT improved significantly, as predicted, from pre- to posttreatment,  $F(1,6) = 17.51, p = .006$ .

The mean pretreatment score on the SES was 27.50 (SD= 5.89) and increased only slightly to 27.86 (SD= 3.13) posttreatment. Three of the seven participants' SES scores increased, three participants' scores decreased, and one participant's self esteem score remained the same from pre- to posttreatment.

As predicted, the overall group mean improved, but the change was nonsignificant,  $F(1,6) = .08, p > .05$ .

The mean pretreatment score on the BI was 23.43 ( $SD = 18.68$ ) and decreased to 20.57 ( $SD = 22.88$ ) posttreatment. Pretreatment scores for four of the seven participants reflected clinically significant levels of distorted beliefs, compared to only two with such levels posttreatment. Although the group mean decreased overall from pre- to posttreatment, only two of the seven participants' scores actually decreased, and the other five increased. The overall decrease in mean negative thinking scores was nonsignificant,  $F(1,6) = .13, p > .05$ .

According to their responses on the group survey, all seven participants felt that they learned something from group, six said they would try to incorporate some of the new skills into their own healing process and would recommend the group to other girls with similar experiences. Five of the seven responded positively to the rest of the questions, indicating that they liked the group overall, were glad to have participated, felt they benefitted from group in some way, felt better about themselves as a result of group discussions, and would participate in the group again if they could. Of the three girls who added their own comments to the end of the survey, one requested more arts and crafts, one wished group had lasted longer than two weeks and suggested we lengthen the workbooks and group sessions. The

third commented that she would not change anything about group because it made her feel important and helped her cope with her rape issues. The group environment provided survivors the opportunity to connect with other girls with similar experiences and facilitate the social support they may not have been getting from their family and friends.

### Discussion

The results of this study support previous findings that short-term group therapy can have a positive effect on adolescent survivors of sexual abuse (Corder, Haizlip, & DeBoer, 1990; DeLuca et al., 1993; Furniss et al., 1988; Hiebert-Murphy et al., 1992; Kruczek, 1995; Resick et al., 1988; Watson, 1994). Survivors showed significant improvements in knowledge of alternative coping strategies after only two or three weeks of therapy, which supports previous findings that coping skill acquisition can be effectively produced after only brief interventions (Corder et al., 1990; Kruczek, 1995; Watson, 1994). Group therapy affords survivors the opportunity to learn about and develop new positive coping skills that they can eventually incorporate into their own personal healing process in a way that works for them (Corder et al., 1990; Kruczek, 1995; Watson, 1994). Positive and effective coping skills can enable survivors to face and cope with their symptoms in a way that positively affects their recovery for months and years following therapy (DeLuca et al., 1993; Furniss et al., 1988; Kruczek, 1995; Resick et al., 1988;

Watson, 1994).

Mean negative thinking and self-esteem scores did not change significantly immediately following the present short-term protocol. In fact negative thinking scores for 5 of the 7 subjects actually increased, contrary to what was hypothesized. This could be because the girls were not in touch with their own negative beliefs going into group, but as a result of group discussions, they realized and admitted their own adherence to many of the dysfunctional beliefs of their peers. When tested posttreatment, they may have been reporting a truer indication of the extent of their personal negative and distorted beliefs about themselves and life. Part of the purpose of the group is to help girls validate and normalize their own beliefs and experiences, so it is beneficial for them to realize that they are not alone in their thinking. Once the girls realize that their dysfunctional thinking and behavior is a normal response to abusive and traumatic experiences, they can begin to forgive themselves and turn to more functional thinking and coping strategies.

The hypothesis that self-esteem would improve was also not supported, but previous studies of symptom recovery have also failed to find immediate improvements following short-term therapy lasting only two or three weeks (Kruczek, 1995; Watson, 1994). Longer term therapy, however, has been shown to produce significant improvements in self-esteem, beliefs,

and mood (DeLuca et al., 1993; Furniss et al., 1988; Jehu et al., 1986; Resick et al., 1988). DeLuca et al. (1993) found significant improvements in self esteem and anxiety after a ten-week treatment period and a nine month follow-up period. Furniss et al. (1988) reported significant improvements in anxiety, assertiveness, self esteem, and trust after group therapy that lasted anywhere from seven months to two years. Jehu et al. (1986) reported clinically and statistically significant improvements in beliefs and mood following about six months of individual therapy with survivors. Resick et al. (1988) found lasting improvements in self esteem and mood after six, two-hour group sessions and at three- and six-month follow-up. Most importantly, the previous studies of the current protocol by Kruczek (1995) and Watson (1994) demonstrated significant improvements in symptom recovery at a three month follow-up, indicating that the short-term intervention did somehow contribute to longer-term emotional and behavioral improvements.

Thus, previous findings, along with the findings of the present study, indicate that it may take longer than two or three weeks for a survivor's global set of beliefs, self esteem, mood, or other symptoms to improve dramatically. The emotional and behavioral benefits of short-term interventions may not always be apparent immediately after the cessation of therapy, but tend to show up later after the survivor has had a chance to fully incorporate her newly-acquired skills into her personal healing process.

Future research could benefit from the development and implementation of assessment measures that can capture subtle changes in thinking and feeling over shorter treatment intervention periods.

It has been suggested that the most effective approach to the treatment of childhood sexual abuse is a multicomponent package which includes family counseling as well as individual and group therapies (Giarreto, 1982; Sgroi, 1982). Therefore, one limitation to the present study could be that only one mode of intervention was measured and accounted for. All of the participants were concurrently involved in other types of therapy at the treatment center, including art, music, recreation, individual and family therapy. The improvements in coping skill acquisition and mastery can reasonably be attributed to participation in the present group protocol. But changes in global self-esteem or beliefs should reasonably be attributed to all of the environmental, interpersonal, and therapeutic influences on the girls during their residence at the treatment center. Future outcome studies of group therapy for survivors may want to consider the efficacy and interactions of multifaceted treatment protocols.

Another limitation to the present study was its small sample size, however it is not unusual for clinical outcome studies of treatment efficacy to have small sample sizes (DeLuca et al., 1993; Furniss et al., 1988; Hiebert-Murphy et al., 1992; Jehu et al., 1985-86). For example, DeLuca et al. (1993)

used related measures t-tests to report changes in self-esteem scores from pre- to posttesting of only seven subjects. Furniss et al. (1988) also examined self-esteem changes, among other things, and reported detailed data on only ten subjects, using visual inspection to analyze the results. Hiebert-Murphy et al. (1992) examined changes in self-esteem, anxiety, and loneliness on only five subjects from pre-, mid- and posttreatment and also used visual inspection of the results. Jehu et al. (1985-86) analyzed distorted beliefs and self-esteem data from pre- and posttreatment of eleven subjects and used a one-way repeated measures analysis of variance.

Outcome studies of clinical treatments depend on the availability of and consent from human subjects. Due to health insurance limitations and short hospital stays, the number of potential participants is unpredictable. It seems that when conducting clinical outcome studies under time-limited circumstances, researchers tend to have less control over sample size, and often are unable to perform the more complicated statistical analyses which require large samples.

Although this portion of the study has come to a close, the efficacy of the present group protocol, as developed by Kruczek (1996), continues to be under investigation. The girls group described in the present study is an on-going treatment group, and another study of its treatment efficacy is currently underway by Drs. Kruczek and Vitanza of the treatment center. The present

study has supported the findings of Kruczek (1995) and Watson (1994) and has contributed to the on-going effort to improve on the girls group protocol for adolescent survivors of sexual abuse. These and future efforts to develop an effective short-term group intervention for survivors occur in response to the current trend toward brief therapy with demonstrated efficacy.

## References

- Anderson, J., Martin, J., Mullen, P., Romans, S., & Herbison, P. (1993). Prevalence of childhood sexual abuse experiences in a community sample of women. Journal of the American Academy of Child and Adolescent Psychiatry, *32* (5), 911-919.
- Beck, A. T. (1976). Cognitive therapy and the emotional disorders. Madison, CT: International Universities Press.
- Beutler, L. E. (1993). Designing outcome studies: Treatment of adult victims of childhood sexual abuse. Journal of Interpersonal Violence, *8* (3), 402-414.
- Blascovich, J., & Tomaka, J. (1991). Measures of self-esteem. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), Measures of personality and social psychological attitudes (pp. 115-159). New York: Academic Press, Inc.
- Briere, J. (1989). Therapy for adults molested as children: Beyond survival. New York: Springer.
- Briere, J., & Runtz, M. (1990). Differential adult symptomology associated with three types of child abuse histories. Child Abuse and Neglect, *14*, 357-363.
- Briere, J., & Runtz, M. (1993). Childhood sexual abuse: Long-term sequelae and implications for psychological assessment. Journal of

Interpersonal Violence, 8 (3), 312-330.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. Psychological Bulletin, 99 (1), 66-77.

Burns, D. D. (1980). Feeling good: The new mood therapy. New York: Signet.

Burt, M. R., & Katz, B. L. (1987). Dimensions of recovery from rape: Focus on growth outcomes. Journal of Interpersonal Violence, 2 (1), 57-81.

Carver, C. M., Stalker, C., Stewart, E., & Abraham, B. (1989). The impact of group therapy for adult survivors of childhood sexual abuse. Canadian Journal of Psychiatry, 34, 753-758.

Coopersmith, S. (1975). Building self-esteem in the classroom. In S. Coopersmith (Ed.). Developing motivation in young children. San Francisco: Alton Publishing.

Coopersmith, S. (1981). The Antecedents of Self-Esteem. Palo Alto, CA: Consulting Psychologists Press, Inc.

Corder, B. F., Haizlip, T., & DeBoer, P. (1990). A pilot study for structured, time-limited, therapy group for sexually abused pre-adolescent children. Child Abuse and Neglect, 14, 243-251.

Courtois, C. (1979). The incest experience and its aftermath. Victimology: An International Journal, 4, 337-347.

Courtois, C. (1988). Healing the incest wound: Adult survivors in

therapy. New York: Norton.

De Luca, R. V., Hazen, A., & Cutler, J. (1993). Evaluation of a group counseling program for preadolescent female victims of incest. Elementary School Guidance and Counseling, 28, 104-114.

Dolan, Y. M. (1991). Resolving sexual abuse: Solution-focused therapy and Ericksonian hypnosis for adult survivors. New York: W. W. Norton and Company.

Finkelhor, D. (1979). Sexually victimized children. New York: Free Press.

Finkelhor, D. (1984). Child sexual abuse: New theory and research. Beverly Hills: Sage Publications.

Finkelhor, D., & Dzuiba-Leatherman, J. (1994). Victimization of children. American Psychologist, 49 (3), 173-183.

Frank, E., Anderson, B., Stewart, B. D., Dancu, C., Hughes, C., & West, D. (1988). Efficacy of cognitive behavior therapy and systemic desensitization in the treatment of rape trauma. Behavior Therapy, 19, 403-420.

Furniss, T., Bingley-Miller, L., & Van Elburg, A. (1988). Goal-oriented group treatment for sexually abused adolescent girls. British Journal of Psychiatry, 152, 97-106.

Gagliano, C. K. (1987). Group treatment for sexually abused girls. Social Casework: The Journal of Contemporary Social Work, 68, 102-108.

Giarreto, H. (1982). A comprehensive child sexual abuse treatment program. Child Abuse and Neglect, 6, 263-278.

Grayston, A. D., De Luca, R. V., & Boyes, D. A. (1992). Self-esteem, anxiety, and loneliness in preadolescent girls who have experienced sexual abuse. Child Psychiatry and Human Development, 22 (4), 277-286.

Green, A. H. (1993). Child sexual abuse: Immediate and long-term effects and intervention. Journal of the American Academy of Child and Adolescent Psychiatry, 32 (5), 890-902.

Haugaard, J. J., & Reppucci, N. D. (1988). The sexual abuse of children: A comprehensive guide to current knowledge and intervention strategies. San Francisco, CA: Jossey-Bass.

Herman, J. L. (1981). Father-daughter incest. Cambridge, MA: Harvard University Press.

Herman, J. L., Russell, D. E. H., & Trocki, K. (1986). Long-term effects of incestuous abuse in childhood. American Journal of Psychiatry, 143, 1293-1296.

Hiebert-Murphy, D., De Luca, R. V., & Runtz, M. (1992, April). Group treatment for sexually abused girls: Evaluating outcome. Families in Society: The Journal of Contemporary Human Services, 205-213.

Holmes, M. R., & St. Lawrence, J. (1983). Treatment of rape-induced trauma: Proposed behavioral conceptualization and review of the literature.

Clinical Psychology Review, 3, 417-433.

Jehu, D., Klassen, C., & Gazan, M. (1986). Cognitive restructuring of distorted beliefs associated with childhood sexual abuse. Journal of Social Work and Human Sexuality, 4, 1-35.

Kendall, P. C. (1993). Cognitive-behavioral therapies with youth: Guiding theory, current status, and emerging developments. Journal of Consulting and Clinical Psychology, 61 (2), 235-247.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. Psychological Bulletin, 113 (1), 164-180.

Kruczek, T. A. (1992). The skill mastery test. Unpublished measurement, Medical College of Virginia, Richmond, VA.

Kruczek, T. A. (1995). Efficacy of group therapy with sexually abused teens. Unpublished manuscript, Medical College of Virginia, Richmond, VA.

Kruczek, T. A. (1996). Girls group treatment manual. Unpublished manual, Virginia Treatment Center for Children, Medical College of Virginia, Richmond, VA.

McConkey, N. (1992). Working with adults to overcome the effects of sexual abuse: Integrating solution-focused therapy, systems thinking, and gender issues. Journal of Strategic and Systematic Therapies, 11, 4-19.

Mennen, F. E., & Meadow, D. (1994). Depression, anxiety, and self-

esteem in sexually abused children. Families in Society: The Journal of Contemporary Human Services, 75 (2), 74-81.

O'Donohue, W. T., & Elliott, A. N. (1992). Treatment of the sexually abused child: A review. Journal of Clinical Child Psychology, 21 (3), 218-228.

Pilkonis, P. A. (1993). Studying the effects of treatment in victims of childhood sexual abuse. Journal of Interpersonal Violence, 8 (3), 392-401.

Porter, F. S., Blick, L. C., & Sgroi, S. M. (1982). Treatment of the sexually abused child. In S. M. Sgroi (Ed.), Handbook of clinical intervention in child sexual abuse (pp. 109-146). Lexington, MA: Lexington Books.

Resick, P. A., Jordan, C. G., Girelli, S. A., Hutter, C. K., & Marhoefer-Dvorak, S. (1988). A comparative outcome study of behavioral group therapy for sexual assault victims. Behavior Therapy, 19 (3), 385-401.

Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University Press.

Steele, B. J., & Alexander, H. (1981). Long term effects of sexual abuse in childhood. In P. B. Mrazek & C. H. Kempe (Eds.). Sexually abused children and their families. New York: Pergamon.

Stern, A. E., Lynch, D. L., Oates, R. K., O'Toole, B. I., & Cooney, G. (1995). Self esteem, depression, behavior and family functioning in sexually abused children. Journal of Child Psychology and Psychiatry and Allied Disciplines, 36 (6), 1077-1089.

Vandermeij, B. J., & Neff, R. L. (1986). Incest as child abuse: Research and implications. New York: Praeger Publishers.

Watson, W. (1994). The efficacy of group therapy with sexually abused adolescent females. Unpublished paper, Department of Psychology, University of Richmond, VA.

Wolpe, J. (1958). Psychotherapy by reciprocal inhibition. Stanford, CA: Stanford University.

Wolpe, J. (1969). The practice of behavior therapy (1st ed.). New York: Pergamon Press.

Table 1

Skill Mastery, Self-Esteem, and Beliefs Scores for Each Subject at Pre- and Post-Treatment.

Subject	Pretreatment	Posttreatment
----- Skill Mastery Test -----		
1	5	9
2	12	15
3	9	9
4	9	12
5	5.3	13
6	10.6	14
7	7	11
Group means	8.27	11.86
----- Self-Esteem Scale -----		
1	25	24
2	37	33
3	22.5	25
4	20	26
5	33	30
6	28	28
7	27	29
Group means	27.50	27.86
----- Belief Inventory -----		
1	47	66
2	5	11
3	46	0
4	34	36
5	18	9
6	9	13
7	5	9
Group means	23.43	20.57