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An evaluation of the impact of parent groups on the treatment of incest victims

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AN EVALUATION OF THE IMPACT OF PARENT GROUPS
ON THE TREATMENT OF INCEST VICTIMS

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A Project
Presented to the
Faculty of
California State University,
San Bernardino

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In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

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by
Janet Louise Black
June 1993
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June, 1993
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ABSTRACT

Child sexual abuse is on the rise. Per Finkelhor (1984), "child sexual abuse has increased significantly in the last 10-15 years." With the rising number of sexual abuse cases, a prominent concern for mental health professionals is the issue of treatment for these children. Numerous research studies are being conducted to determine what helps these children progress most effectively through therapy. The study discussed in this paper shows that by providing a group for the victims' parents/caretakers that parallels the victims' group, the progress of the victims is enhanced.
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INTRODUCTION/LITERATURE REVIEW

The sexual maltreatment of children has traditionally been surrounded by secrecy; until recently, therefore, this issue has received minimum recognition and response. In the 1970s, however, the subject of child sexual maltreatment became of increasing interest to a growing number of individuals, including members of the women's movement and the children's protection movement. One result of this interest was a higher level of public awareness about child sexual abuse. Finkelhor (1984) notes that "public awareness and reporting of child abuse has increased significantly in the last 10-15 years." According to Berry (1990), the nationally reported cases of child sexual abuse in 1987 increased by 18.6%, making a total of 8,392 reported cases. Even though the acknowledgement of child sexual maltreatment is important, the question of how to solve this problem remains even more significant.

Once the laws against child sexual abuse began to be enforced, the necessity for treating its victims, became especially clear. The issue of treatment was primarily addressed by social workers because of their previous involvement in increasing public awareness
about child sexual abuse. Furthermore, since social workers play such an active role in helping to change public policy, they continue to be a great asset in improving child abuse treatment policies. In developing such policies, the following factors must be considered: 1) age of the child, 2) type of abuse, 3) placement of the child, and 4) types of treatment for the child. While all of these issues are equally important, this study will focus primarily on treatment issues. One of the most important aspects of treatment is its effectiveness, which largely depends on selecting the treatment approach best suited to the client. Techniques used in treatment facilities, one being The Children's Center of the Antelope Valley, include the following: 1) individual therapy using play, art, and psychodrama, 2) some aspects of Gestalt therapy, and 3) group therapy (professional therapist at the Children's Center). Social workers are extensively involved in the treatment of sexually maltreated children. Therefore, they have a vested interest in participating in related research, including efforts to more thoroughly understand the characteristics of individuals who perpetrate sexual abuse.
Although all perpetrators are not alike, they do exhibit some common characteristics. Research has shown that perpetrators' childhoods include at least one of three very influential variables. The most common of these is that the perpetrators were themselves sexually abused as children. Another variable may be that the perpetrators were subjected to the belief that the sexual abuse of others is permissible. Finally, the third variable is the deprivation of appropriate nurturance that the perpetrators experienced during childhood. This deprivation resulted in emotional abuse (James, B. & Nasjleti, M., 1983; Meiselman, K.C., 1984; Faller, K., 1990). The presence of any or all of these variables within a person's childhood would definitely have a great influence on how that person would behave as an adult. However, it is important to understand that other factors are usually involved in influencing someone to become a perpetrator of child abuse.

One of these factors is the perpetrator's personality or psychic make-up. It has been found that the majority of perpetrators have been diagnosed as having personality disorders generally resulting from the previously mentioned childhood experiences. It is
very rare that a perpetrator is actually psychotic, rather the perpetrator is found to display a "psychopathic personality or, more commonly, a paranoid personality disorder" (Meiselman, K.C., 1984). Additionally, an individual's I.Q. generally does not influence whether he or she becomes a perpetrator.

In contrast, however, research has shown that alcohol is often a factor involved in child abuse situations. The consumption of alcohol deadens the perpetrator's moral constraints. This, coupled with an unusual amount of fantasizing about having sex with children, is an enormous catalyst to sexual abuse (James, B., & Nasjleti, M., 1983; Meiselman, K.C., 1984; Becker, cited by Sanford, 1988; Faller, K. 1990). Clearly, there are several characteristics that most perpetrators share.

One group of perpetrators, however, exhibits a somewhat different set of behaviors, behaviors that tend to make them less socially visible. Female perpetrators are the least reported child abuse offenders. One reason for this is that our society views the sexual involvement of older females with younger males as more acceptable than the reverse. However, the effects caused by female offenders can be
just as traumatic as those of their male counterparts. This is why it is vital to understand the characteristics generally shared by female perpetrators. For example, James & Nasjleti (1983) have observed that a majority of female perpetrators display "infantile and extreme dependency needs; a spousal relationship that is absent or emotionally empty; extremely possessive and overprotective attitudes toward child victims." Because these behaviors can correspond to traditional maternal roles, female perpetrators are often able to disguise their sexual advances onto the children as nurturance contacts.

In addition to exploiting socially accepted behaviors, female perpetrators also use alcohol as a disinhibitor; however, their primary defense is the use of "denial" (James & Nasjleti, 1983). Such a defense may prove especially convenient to many female perpetrators who find it necessary to raise their children alone. The extraordinary stress resulting from assuming both parental and professional roles increases the likelihood that these mothers will molest their children. Furthermore, if these women are step-parents, they will tend to be less inhibited about
becoming sexually active with their step-children (Faller, K.C., 1990). This is also true in the case of step-fathers: Russel (1986) & Finkelhor et al. (1986) found that step-fathers were much more likely to sexually abuse their step-children than were biological fathers.

Just as there are clear similarities in perpetrator backgrounds, there are also similarities in the techniques used by these perpetrators on their victims. Studies show that the most common way for perpetrators to lure their victims into sexual acts is by earning the victims' trust through friendly, generous behavior. However, once the sexual activity has been initiated, threats are made in order to force the child to keep quiet. These threats can range from verbal confrontations to actual physical force and/or harming someone or something that is special to the victim (Sgroi, S.M., 1982; Meiselman, K.C., 1984). The perpetrator may be interested in a specific child, a certain type of child or children in general. However, Faller (1990) notes that the norm is the perpetrator with multiple victims ranging from children within to those outside his/her family unit. In support of her findings, Faller (1990) reports that "1/2 of incestuous
fathers were found to have engaged in prior child sexual maltreatment as adolescent offenders." If this is true, then it is imperative for parents and professionals alike to realize that the incest perpetrator does have the potential to abuse children outside of the family.

One of the most significant attributes to be considered in regard to perpetrators is their thought process. Incest perpetrators usually appear highly dominant, yet they are very dependent on their families for emotional support. The message that many perpetrators give to their families is that family members are responsible for the perpetrators' emotional stability: if the perpetrator falls apart, then the entire family will also fall apart. In preventing this, the family must also keep up the image that the perpetrator is strong and in control, or the entire family may get hurt (James, B. & Nasjleti, M. 1983). As a result, along with "rejection, ridicule, defiance" by the nonoffending parent, the child is left with no choice but to keep the secret of being sexually molested by his/her parent (Faller, K.C., 1990). Ironically enough, studies have shown that the majority of incest perpetrators are predominantly white male
power figures within the home—usually fathers, uncles, and step-fathers (Sgroi, S. M., 1982; Patton, M.Q., 1991). While a knowledge of the variables of incest perpetrators is important, the behaviors and circumstances surrounding the nonoffending family members are equally significant.

Numerous variables exist in the incestuous family. Particularly important to the members of such a family is how they are perceived by the outside world. It is imperative to them that they display normal behavior; therefore, they create dyads and alliances in order to keep the family functioning on the outside. This function allows them to keep their secret within the family (James, B., & Nasjleti, M., 1983).

Although just as damaging as other types of incest, mother-daughter incest is the least reported. One reason for this is that the mother traditionally plays the nurturing role. As a result, she is often able to molest her children under the pretense that she is just performing her normal motherly duties. Unfortunately, though, this type of incest has just as many, if not more, negative effects on the child as any other type of incest.

When mother-daughter incest occurs, the level of
the victim's confusion about the incident is unusually high. Also, the child's denial and the unusual dynamics within the mother-daughter relationship prevent the child from disclosing the incest (James & Nasjleti, 1983). One possible reason for this skewed relationship is the unfortunate increase in the number of single parents. A single-parent situation usually produces neglect and deprivation components for both the child & the mother; consequently, they go to each other for affection. Sometimes the level of affection given by the mother is far beyond the standards of parenting & more like those of a sexual companion. Although single-parent families are at high risk of incest, families with both parents are also at risk.

In the past two decades, extensive research has been conducted on incest in family units with both parents present. Meiselman (1984) insightfully observes that even though the collusive type of mother who "sets up" the incest situation through role reversal and denial of sex is the most studied type, she is not the only type. In contrast, the least-studied cases are those involving fathers who are psychopathic or psychotic. Furthermore, most information is gathered from the nonoffending parent.
When the nonoffending parent is the mother, she has sometimes acted in ways (unconsciously) that have encouraged the incestuous relationship between the father and daughter.

The mother often develops a very special, conflict-laden relationship with one of her daughters long before incest occurs. For example, the mother encourages her daughter to grow up prematurely. The two become allies & workmates in caring for younger siblings and performing other household duties. Eventually, the mother relinquishes her responsibility and allows her daughter to become a "little mother" (Meiselman, 1984). Finally, on an unconscious level, the mother backs out and puts her daughter in a wife-like role and is relieved when her husband directs sexual attention to the daughter. At the end of the pre-incest process, the daughter has been thrust into a premature adult role, rejected by her formerly loving mother, and somehow expected to be responsible for the needs of other family members, including providing sexual gratification for her father. This pseudomaturity & the daughter's need to protect the family from pain & disruption are two of the reasons why she continues the sexual acts with her father.
The belief that a child's promiscuity & delinquent behavior contribute to incest is a myth. No matter what the child's behavior is, he/she is not the instigator of sexual abuse, but is instead the victim of it.

As Rist (1979) has shown, children in these families are involved in a destructive triangulation. They meet the needs of their parents while their own needs go unheeded and their development unattended. Also, the children develop a high level of neediness, and they become self-sacrificing in order to get some level of attention from the parent which, in turn, keeps them in a victim role (James & Nasjleti).

This so-called triangulation can take place in many different ways and with each family member, yet Weinberg (1955) points out that the most common person used in the triangulation is the eldest daughter. Because females predominate as victims of incest, Patton (1991) correctly stresses the need for a more complete understanding of the characteristics of female victims.

Female victims of incest generally display a common set of characteristics. One of the most
important of these is that the female is usually a
dominant figure within the family unit and is able to
meet the emotional needs of the adults (James, B., &
Nasjleti, M., 1983). Despite her dominant role,
however, such a female may still feel threatened by the
father. This is true even if he has not displayed any
physical violence or discussed possible consequences of
refusing to cooperate with him (Meiselman, K., 1984 &
Courtois, C., 1988). Finally, as mentioned previously,
the daughter has usually been put into her
pseudomaturity role with the expectation of pleasing
the father. With this in mind, it is important to
realize that the symptoms displayed by these particular
incest victims are similar to those of other victims of
incest and/or sexual abuse.

Such symptoms include feelings of guilt and shame,
which can play a major role in a victim’s life.
According to Patton (1991), parents caring for sexually
abused children find that emotional effects of abusive
events can be both “significant and long lasting.”
Among these emotional effects is confusion on the
victim’s part from being both a participant in the
incestuous acts and because she has sometimes
experienced “sexual pleasure” during the incidents. As
a result, she may think that she "must have wanted it to happen." Finally, additional guilt results from enjoying the rewards (gifts, etc.) that the father has used to manipulate her into cooperating and remaining silent (Meiselman, K., 1984, and Courtois, C., 1988).

Although the consequences of incest have been frequently studied, it is important to realize that its effects on each victim are unique and constantly changing. Sgroi (1982), James & Nasjleti (1983), and Meiselman (1984) have contributed numerous significant findings in support of this view. Meiselman (1984) suggests that "incest is usually a negative life event that is followed by adjustive difficulties that vary widely with social circumstances and preexisting personality characteristics." In addition, James & Nasjleti (1983) actually pinpoint certain factors that influence the level of trauma the victim experiences. These factors are as follows: 1) the frequency of the molest, 2) the duration of the molest, 3) the intensity and nature of the acts (either physical or passive threats), 4) the child's developmental stage, 5) the child's relationship to the victimizer, and 6) the family & community's support of the child when the sexual abuse is reported. In addition to
agreeing on the uniqueness of each case involving incest, these researchers also agree on the correlation between the types of sexual acts performed and the level of trauma that these acts produce.

James & Nasjleti (1983) and Meiselman (1984) agree that a positive correlation exists between the level of duress the victim experiences and the kind of sexual activity the perpetrator initiates. For example, a situation in which the perpetrator has forced oral-genital contact along with intercourse creates a much greater threat (both physical and emotional) than genitalia fondling. However, numerous studies show that despite differences such as these, incestual acts generally produce common symptoms and behaviors within the victims.

Sgroi (1982) reports that there is a common set of child-sexual-abuse impact issues. The most commonly reported of these is the "damaged goods syndrome," in which the victim feels as if he/she is no longer worthy of love and affection. In addition, he/she often experiences guilt, fear, and depression, along with a great deal of repressed anger and hostility toward the perpetrator and the nonoffending parent. The cumulative effects of these feelings often include poor
social skills (with both peers and adults), an impaired ability to trust others, blurred role boundaries, and role confusion both as a family member and as a child. Furthermore, the child experiences failure to accomplish appropriate developmental tasks, self-mastery, and control of his/her impulses. However, both the common and the idiosyncratic effects of incest must be identified and dealt with through appropriate treatment strategies.

Such treatment strategies and techniques are regularly addressed in the available literature. Before considering them, however, it is useful to understand which agencies are best suited to provide treatment for incest victims. Unfortunately, the literature contains relatively little information about such agencies. However, Gil (1991) and Patton (1991) point out the necessity for centralized services delivered from a nonprosecutorial or investigative source. Ideally, this would be a private, nonprofit agency providing both medical and counseling services. Such an agency would be capable of maintaining adequate communication with other resources. As a result, it would be better able to coordinate additional needed services for both the victim and his/her family.
Understanding the characteristics of this type of agency is highly important; however, an awareness of the difficulties faced by victims and their families as they seek services of such an agency is also necessary.

As with any other business, a counseling agency requires payment by the clientele. Given the present state of the economy, however, it is no surprise that individual families feel the pressure of lack of funds. Patton (1991) claims that the main reason why victims and their families are unable to receive adequate treatment is that they have insufficient funds and/or limited medical insurance. Furthermore, the combination of this inability to afford adequate service and the fact that some agencies provide less than adequate services results in a revictimization of the child. An additional impediment to successful therapy can be the resistance of the victim and his/her family. For example, the victim and other family members may refuse to begin therapy or may not stay in therapy long enough to deal with all of the issues at hand. Unfortunately, there appears to be no single, correct solution to this potential barrier to treatment.

The question of how long an incest victim needs
to be in therapy produces some controversy. Sgroi (1982) and Gil (1991) stress that therapy needs to be long-term; however, they do not specify how long. Whereas Damon & Waterman (1986) present findings that support a minimum of 1 year in therapy for intrafamilial sexual abuse. The general consensus among researchers seems to be that the duration of therapy for an incest victim is long-term, i.e., consisting of at least one year. However, the duration of therapy is important, only insofar as the therapy is provided to the appropriate individuals.

Numerous researchers continue to a variety of ways to provide therapy. These range from individual therapy exclusively for the victims, to a conjunction of individual therapy with group therapy for both the victims and their families, including the offender. However, the most effective and most frequently used treatment mode involves a setting that includes the entire family. Patton (1991), Everstine & Everstine (1983), Meiselman (1984), James & Nasjleti (1983), and Sgroi (1982) report that therapy which involves both the victim and his/her family members is the most beneficial. Although these researchers agree on this mode of therapy, their opinions still differ as to
when and how this type of therapy should be implemented.

Patton (1991) and Everstine & Everstine (1983) describe child sexual abuse as a crisis affecting the whole family, one that should be dealt with, therefore, using a strict family systems model. Meiselman (1984), James & Nasjleti (1983), and Sgroi (1982) agree, yet they continue to claim that the family systems model can be used with individuals, couples, groups or conjoint family therapy. The family systems model that is incorporated into therapy for incest victims, includes an individual therapy component. This component proves especially significant in this application.

Individual therapy with the victim is not just desirable—it is imperative. Gil (1991) and Meiselman (1984) stress the importance of individual therapy at the time of disclosure. This allows the therapist to work in a "crisis intervention" mode. Furthermore, individual therapy provides time for the child to begin to express his/her feelings. Similarly, it allows a safe place where the child can be encouraged and assisted in "putting the pieces together." Children in such an environment can begin to rebuild their
self-esteem and their world (Meiselman, 1984). However, considerable disagreement can be found regarding how long individual therapy meets all of the victim's needs.

While Gil (1991) and Meiselman (1984) stress the importance of individual therapy, other researchers tend to support a group therapy mode of treatment. James & Nasjleti (1983) declare that for all phases of treatment throughout the year, a peer group as the treatment mode is much more effective than any other. When using this type of treatment mode, however, many areas need to be considered. These include the age range of the children in the group, the actual group size, and the presence or absence of an enrollment protocol. For this mode to be most effective, all of the children in the group need to be at the same developmental stage. For example, a group of children ages of 7-9 or 10-12 would produce the best results. In addition, Furniss, Bengley-Miller & Bentovim (1984), and Furniss (in press) recommend that the size of the group should be between 3-10 members. As for the enrollment protocol, Sgroi (1982) adds that in order to be most effective, an open group membership should be utilized. She goes on to state that this type of
group provides a setting in which the children who have been in the group longer become informants and role models to the newer members. With these components identified, a verification of the group treatment mode may be considered.

Certain aspects of group therapy are particularly significant. One of these is the combination of education, psychotherapeutic techniques, and emotional support in separate group settings for victims of sexual abuse and their parents/caretakers. This has proven to be highly influential in the participants' recovery. An additional aspect is the combination of both the parents/caretakers and the children in group therapy together. However, this latter aspect appears less effective than the former promoting the participants' recovery. Nevertheless, both aspects have been considered by a number of theorists.

One example of the resulting literature involves a study conducted by Cohn, (1979). She found that "group approaches tend to be divided into those that are education, self-help oriented, and more traditionally psychotherapeutic." However, even though groups tend to be divided and employ only one level of operation, Cohn demonstrated that group approaches—even those
that do not deal with educational/therapeutic issues—can enhance parents' ability to relate to their children (Cohn, 1979).

Studies like the one conducted by Cohn have spawned additional investigations, including one performed by Tuszoniki (1985). This study focuses on group treatment of abusive parents. The findings revealed that group therapy, facilitated by a therapist who provided constructive role modeling along with education and emotional support, improved abusive parents' behavior. In another study, Rueveni (1982) researched the effects of implementing group therapy in which adults and children were involved as a therapeutic intervention. He found that "groups offer particularly suitable settings for helping sexually abused children [and] their parents ...." (1982). Such groups are known as "parallel groups."

Parallel groups have recently been introduced into some agencies treatment programs. In California, only two such facilities currently exist (Professional therapist at the Children's Center). To date, these agencies appear successful in providing treatment to their communities. Damon & Waterman (1986) and James & Nasjleti (1983) maintain that providing a structured
curriculum within a parallel group setting for both the child and his/her nonoffending parent is much more effective than providing groups solely for the victim. Furthermore, such a parallel group design facilitates the exploration of sexual abuse issues shared by both the victim and the parent. This group provides an opportunity for mothers to adjust and cope with their child's sexual trauma, as well as for the child to address and adjust to his/her own traumatic experiences. Finally, this type of setting helps instill within the mother the need to provide protection for her child (Damon & Waterman, 1986).

One reason for the importance of involving the mother in therapy is that, as previously mentioned, the majority of incest victims' mothers are victims themselves. The provision of a parallel group for mothers, allows them to address their own issues about incest, both as mothers and as child-victims. While in this group, the mothers are also kept informed as to what is being done in the child's group. This provides the mother with coping skills to help her deal with behaviors on the part of her child (such as acting out) which can result from activities (Damon & Waterman, 1986).
Regardless of whether the type of therapy received by victims & their families is individual or group, attendance is crucial. Indeed, the fact that the participants actually show up for the session implies some level of commitment to the therapeutic process. Furthermore, consistent attendance within a group setting allows the group members to learn mutual trust. As a result, they experience the therapeutic setting as a safe place to be, thus promoting healing. Sgroi (1982) reports that a child who becomes more confident, more self-assertive, and whose behavior becomes more appropriate for his or her age and developmental level, will almost certainly "make waves". Such fluctuations in the child's behavior will occur regardless of the type of sexual abuse (intra vs extrafamiliar) the child has suffered or the type of therapy he or she has received. Therefore, the overall treatment plan should address the family's response to these behavioral changes.
RESEARCH DESIGN

Previously cited research clearly demonstrates that group therapy for abusive parents is beneficial in changing their behavior. However, a significant question still remains: Does the inclusion of the parents as well as the children in group therapy benefit both simultaneously? In an attempt to answer this question, this study explored an even broader one:

Q: What helps sexually maltreated children progress through therapy?

Using the context of previous research, this study proposes the following hypotheses:

$H_1$: The incest victim's progression in therapy will improve when his/her parents/caretakers are included in their own group therapy.

$H_2$: The child's recovery will progress more quickly if it is his/her parent who is involved in therapy rather than his/her caretaker.
The study measured incest victims' progression while undergoing therapy for a period of one year. This therapy was received on an outpatient basis at The Children's Center of the Antelope Valley. The treatment program there offers parallel group therapy for sexual abuse victims and their parents/caretakers. The victim's age is used as a guideline to determine in which group he/she will be placed. The Center provides groups for victims whose ages are as follows: 1) preschool (3-5), 2) kindergarten (5-7), 3) younger latency (7-10), and 4) older latency (10-13). Simultaneously, his/her parents/caretakers (parent, other family member or foster parent) participate in a parallel group. The Center's staff considers this program to be very beneficial to both the incest victims and their families. Until this study had been conducted, however, the effectiveness of this treatment program had never been tested.

This study sought to clarify the level of effectiveness of this program, using a static-group comparison design. Three separate groups were considered throughout the study. One group consisted of victims who have parents in therapy, another of victims who have caretakers in therapy, and still
another of victims who have neither parents nor caretakers in therapy (see diagram below).

Sample Size

<table>
<thead>
<tr>
<th></th>
<th>Parents in grp. therapy</th>
<th>Caretakers in grp. therapy</th>
<th>Neither parents/ caretakers are in grp. therapy</th>
</tr>
</thead>
</table>

Sampling

Participants for this study were selected from case records of clients who had been in outpatient treatment at The Children's Center of the Antelope Valley. These records consisted of both open and closed cases. Furthermore, these cases reflected documentation of clients who had received treatment during the time period of December 1991 through December 1992. Other controlled variables pertaining to the clients who were victims of sexual maltreatment were as follows: 1) gender, 2) age, and 3) type of sexual maltreatment. The victim sample consisted of female children, aged seven to ten, who were incest victims. For the purposes of this study, incest was
defined as follows:

Inappropriate intrafamilial sexual activity among immediate, extended family members, and significant others, involving an adult (anyone at least 18 years of age) and a child, or a child and another child.

Demographic Description

Records on a total of 48 persons, divided into two separate groups, were included in the study. The two groups consisted of the following: 1) incest victims N=24, and 2) parents/caretakers N=24. All of the incest victims were females with a mean age of 8.2 years (standard deviation 1.062). The majority of the victims (96%) were molested more than once, with the mode being 6 times within a one-month period. Forty-two and one-half percent of the victim sample received group therapy, 35.5% of the victims received individual treatment and 22% of the victims received a combination of individual and group treatment. It was also found that 54% of the victims lived with their parents, while 46% lived either with another family member or a fosterparent.

The other group consisted of a combination of male and female parents/caretakers with a mean age of 36.
years (standard deviation 11.310). The only data used from the parents'/caretakers' cases was the variable pertaining to their lack of, or participation in, therapy. Fewer than one-half (46%) of the parents/caretakers attended the appointed adult parallel group. Moreover, only 6 out of these 11 adults attended therapy for a period of one year.

DATA COLLECTION/METHOD

The treatment program at the Children's Center of the Antelope Valley offers group therapy that is divided into three separate cycles over one year. These cycles are arranged as follows: January to April, May to August, and September to December. However, each cycle features an open enrollment protocol; thus, a child is able to enter the program at any time throughout the year. At the end of each cycle, therapists evaluate the child's progress by using a "Progress Evaluation" form. This form includes a Lickert Scale of A-E and 48 items to be assessed. It is from this form that the researcher and the Children's Center staff derived 20 items most indicative of the child's progress. The resulting data abstraction form with these 20 items, scored on a Lickert Scale of 1-5, was used as the data collection
instrument for this study (See Appendix A). The validity and reliability of this instrument are unknown.

Instrument's Validity and Reliability

Due to the level of subjectivity inherent in its use, the reliability of the Progress Evaluation form is projected to be low. Thus, the degree of random error in the form is probably comparatively high. However, the validity seems greater than the reliability; according to a professional therapist at the Children's Center, the face validity of the "Progress Evaluation" form is adequate. In other words, the form appears to measure what it was designed to measure. As with any such instrument, however, this one contains both strengths and weaknesses.

One advantage of this form is that it evaluates numerous variables pertaining to sexual abuse victims. These variables range from personal issues to family and social dynamics, all of which are directly affected by sexual abuse. Thus, this form provides the therapist with a thorough understanding of the child's emotional strengths and weaknesses. Such knowledge enables the therapist(s) to pinpoint areas of need for the child's subsequent therapy. Finally, the
provision of a Lickert Scale allows the therapist(s) to measure the child's progress. Despite its strengths, however, the "Progress Evaluation" form also contains certain limitations.

One limitation is the high level of subjectivity inherent in any evaluation tool of this type. Although each therapist may be thoroughly trained in the completion of both the form and of clientele evaluations, evaluation scores will still vary significantly among therapists. In other words, because of each therapist's individuality, a certain level of subjectivity in client evaluation remains unavoidable. Another limitation involves the issue of secondary analysis. The "Progress Evaluation" was initially developed for the Center's staff to use in measuring a child's rate of progress, not for the purposes of a research study such as this one. Significant as these limitations are, however, they can be overcome.

One way of accomplishing this is to verify that each form has been correctly completed. Such verification requires that the researcher be carefully trained in this procedure. Another way to decrease the subjectivity level is for the researcher to interpret
the issues and findings of the instrument as they were meant to be, not as the researcher wants them to be (Norusis, 1991).

PROCEDURE

Data were collected on the 48 participants (24 victims and 24 parents/caretakers). Utilization of the data abstraction form allowed the researcher to obtain data from the Center's case records without face to face interviews with the clients. As a result, the data collection procedure was performed unintrusively. The researcher acquired data from the "Progress Evaluation" forms within the case records for two separate time frames during a one-year period, from the end of December, 1991, to the end of December, 1992. If the child was not in therapy for the full year, the period consisted of the time between the child's entrance and her termination date. If the child's case record did not contain a "Progress Evaluation" form, the researcher retrieved the information verbally from the child's therapist(s).

The data regarding the parents/caretakers revealed their level of participation in therapy. Even though group therapy was mandatory for them, they sometimes ended their group work prematurely. Thus, their
children became the sole recipients of treatment. The Director of the Center maintains that the parents'/caretakers' participation in therapy strongly enhances the victims' progress; therefore, the parents'/caretakers' group records were carefully assessed for attendance.

**PROTECTION OF HUMAN SUBJECTS**

Because the Children's Center is a training facility, its "Consent for Treatment" form contains a clause that introduces the "possibility of research." Therefore, once the client or parent/caretaker signs this form, he/she also consents to be involved in research. Again, data were collected via case records rather than through interviews. Each case was assigned a number in order to ensure confidentiality and objectivity.
RESULTS

T-tests were performed on the 20 data items that pertained to the victims' progress in therapy. The T-test was utilized to determine if there was a difference in the mean scores for the period between the victims' onset of treatment and the termination of their treatment (or after one year, whichever came first). For all items except number 32 (Child is beginning to trust and respect other group members) and number 28 (Child understands issues surrounding sexual identity), there was significant improvement during the time period studied (see Table One).

A relatively large number of parents/caretakers attended group inconsistently. Therefore, a reliable indicator of the program's effectiveness would be a comparison of outcomes for children whose parents/caretakers were in therapy for the full year and those whose parents/caretakers never attended a group. Because of the small number of such cases, Mann-Whitney U-tests were performed to determine the level of the victims' progression with and without parents'/caretakers' participation in therapy. These tests were performed on the 20 data items for 11 out of the 24 victims. Six of these 11 parents/caretakers
were consistently involved in group therapy, whereas 5 of the 11 never attended a group. This analysis was selected to determine the extent to which the parents'/caretakers' participation in group affected the victims' progress. Results show that for only 5 of the 20 items was the child's progression significantly enhanced by the parents'/caretakers' participation in the parallel group. For items 14 (identify methods of coercion), 15 (knows how molestation situation was maintained), 16 (developed plans for future protection from abuse), 20 (can identify personal strengths), and 22 (accepts that she is not all good or all bad), there was significantly (p < .05) greater improvement in the progress of those victims whose caregivers were in group than those whose caregivers were not (see Table Two).

The results appear to confirm the first hypothesis, that the incest victims' progression in therapy does improve when his/her parents/caretakers are included in their own group therapy. The results also appear to confirm the second hypothesis, that the child's recovery does progress more quickly when his/her parent is involved in therapy.
DISCUSSION

In the past 20 years, researchers have focused on what types of therapy are most beneficial for sexually maltreated children. Generally, studies show that no matter what type of therapy is used, it should include a Family Systems Theory component (Patton, 1991; Everstine & Everstine, 1983). Meiselman (1984), James & Nasjleti (1983), and Sgroi (1982) claim that the Family Systems model can be used in either group or individual therapeutic settings. However, Gil (1991) and Meiselman (1984) stress that individual intervention should be employed as a general introduction to therapy. Although the study presented in the preceding pages tends to agree with these other studies, significant discrepancies exist.

For the most part, this study did support previous research as to the value of family treatment when dealing with sexual abuse victims. Indeed, the victims made significant progress over the one year period, especially in the following areas: identify feelings in others, express herself without fear of losing control, identify thoughts before behaviors, recognize problem areas, and identify problem solving choices. High scores in these areas suggest that these children
have acquired a significant level of empowerment. These scores also suggest that the children have learned how to make constructive decisions pertaining to themselves and their environment.

Perhaps these high scores can be attributed to the fact that the group consisted of members within the same age range and developmental stage; therefore, they were able to interact with one another appropriately. For example, the group members felt safe enough to risk sharing their personal experiences within the group. As a result of this sharing, the members learned more about themselves as they identified with the experiences of fellow members. In doing so, they learned how to improve their social skills. Thus, this level of interaction among group members appeared to be highly beneficial. However, when the victims' parents/caretakers participated in the parallel group, the victims' progress became further enhanced.

The study shows that the victims' progress was significantly accelerated by the parents'/caretakers' participation in the parallel group. This progress was particularly notable in the following areas: identify methods of coercion, how the molestation situation was maintained, has plans for future protection from abuse,
and accepts that she is not all good or all bad. Perhaps the most significant factor involved in these children's rate of progress is the parents'/caretakers' learned awareness of allowing and encouraging their children to discuss what they have learned in group. While discussing these issues, both the parent/caretaker and the child are able to vent their emotions and concerns. Thus, the child feels supported. In addition, the parent/caretaker projects an attitude of belief and acceptance toward what the child is disclosing. Equally valuable is what the parents/caretakers learn in their group therapy. For example, they receive education on how to cope with their children's behaviors at home. Moreover, they experience an atmosphere of mutual support that enables them to more effectively use this new education. The combined knowledge that both the parents/caretakers and the children acquire results in a faster, more productive recovery process.

While the program produced positive results for most of the items measured, two data items showed particular deterioration. One such item (child understands issues surrounding sexual identity) deteriorated considerably (67%) over the one-year
period. The most likely reason for this relates to the age of the participants themselves. Because of their age, their sexual identity possibly seemed unimportant to them. Furthermore, because these participants had already experienced premature exposure to sexual activity, they generally chose to avoid discussing sexuality.

This avoidance seemed to manifest itself in a declining level of trust among group members. This study also showed no statistically significant change in two measures "exhibited distrust for other members." One possible explanation for this relates to the child's level of recovery at the time the evaluation was completed. For example, if the child had just entered into therapy near the end of the one-year period, he/she would possibly score lower on this item, thus demonstrating a low level of trust. There were more victims in group treatment at the end of the year than at the beginning.

CONCLUSION

Although there were some deteriorations among the children studied, the study did support both hypotheses. Nevertheless, certain factors involved in this study, along with questions for future studies,
needs to be addressed.

The subjectivity inherent in the scoring process as well as insufficient documentation were the most probable reasons for the fluctuation in the study's scores. In addition, therapy generally causes sexual abuse victims to act out and appear more symptomatic during therapy than before its onset. Thus, although a victim is actually progressing through therapy, he/she may appear to be regressing which, in turn, skews evaluation scores.

With these factors in mind, researchers conducting future studies would be well-advised to consider two components: 1) subjectivity levels and 2) the fluctuating emotions an abuse victim experiences during different stages of therapy. Another area requiring particular attention is the need for clear, consistent documentation. Finally, the necessity for getting the parents/caretakers more involved in group therapy must be addressed. In this way, the victims' recovery process can be both further enhanced and more accurately measured.
**Appendix A**

**DATA ABSTRACTION FORM:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ID #</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>7, 8, 9, 10, _</td>
</tr>
<tr>
<td><strong>Lives with Caretaker</strong></td>
<td>0, Other family member=1, Parent=2</td>
</tr>
<tr>
<td><strong>Multiple molests?</strong></td>
<td>(MM) no=0 yes=1</td>
</tr>
<tr>
<td><strong>Multiple offenders?</strong></td>
<td>(MO) no=0 yes=1</td>
</tr>
<tr>
<td><strong>Physical threat in order to keep silent?</strong></td>
<td>(PhTH) no=0 yes=1</td>
</tr>
<tr>
<td><strong>Passive threat in order to keep silent?</strong></td>
<td>(PaTH) no=0 yes=1</td>
</tr>
<tr>
<td><strong>Duration of abuse?</strong></td>
<td>_ mos.</td>
</tr>
<tr>
<td><strong>Frequency of abuse per month?</strong></td>
<td>_1 x mo. _1-2 x mo _2-3 x mo _5-6 x mo. _7-8 x mos. more than 8 x per mo.</td>
</tr>
</tbody>
</table>

**VARIABLE**

<table>
<thead>
<tr>
<th></th>
<th>Cycle 1</th>
<th>Cycle 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date began cycle</strong></td>
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<td></td>
</tr>
</tbody>
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10. **Child receives which type(s) of treatment? (CHTX)**

<table>
<thead>
<tr>
<th>Mos. in Tx.</th>
<th>Ind=0 grp=1</th>
<th>Ind=0 grp=1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>both=2</td>
<td>both=2</td>
</tr>
</tbody>
</table>

40
11 Caretaker attends parallel grp
(CAP) no=0 yes=1 no=0 yes=1
mos. in Tx. ___

12 Other family member attends parallel group. (OFAP)
no=0 yes=1 no=0 yes=1
mos. in Tx. ___

13 Parent attends parallel grp.
(PAP) no=0 yes=1 no=0 yes=1
mos. in Tx. ___

14 Child can identify the methods of coercion whether
physical and/or psychological.

1 2 3 4 5 1 2 3 4 5
EDCBA EDCBA

15 Child can recognize how the molestation situation
was maintained.

1 2 3 4 5 1 2 3 4 5
EDCBA EDCBA

16 Child has developed a plan/plans for future
protection from abuse.

1 2 3 4 5 1 2 3 4 5
EDCBA EDCBA
17 Child can identify feelings in others.

18 Child accepts/respects other people's feelings when different from her own.

19 Child can express feelings without fear of loss of control.

20 Child can identify personal strengths.

21 Child can identify personal weakness.
22 Child can accept she is not all good or all bad (ambivalence).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>E</td>
<td>D</td>
<td>C</td>
<td>B</td>
<td>A</td>
<td>E</td>
<td>D</td>
<td>C</td>
<td>B</td>
<td>A</td>
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23 Child can control impulses

<table>
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<th>2</th>
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<th>4</th>
<th>5</th>
<th>1</th>
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<th>3</th>
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<th>5</th>
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<td>D</td>
<td>C</td>
<td>B</td>
<td>A</td>
<td>E</td>
<td>D</td>
<td>C</td>
<td>B</td>
<td>A</td>
</tr>
</tbody>
</table>

24 Child can identify thoughts that occur prior to behavior.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>1</th>
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<td>C</td>
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<td>E</td>
<td>D</td>
<td>C</td>
<td>B</td>
<td>A</td>
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</tbody>
</table>

25 Child recognizes and identifies problems.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
<th>1</th>
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<td>D</td>
<td>C</td>
<td>B</td>
<td>A</td>
</tr>
</tbody>
</table>

26 Child can identify problem-solving choices.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>E</td>
<td>D</td>
<td>C</td>
<td>B</td>
<td>A</td>
<td>E</td>
<td>D</td>
<td>C</td>
<td>B</td>
<td>A</td>
</tr>
</tbody>
</table>
27 Child knows and uses correct names for body parts.
1 2 3 4 5 1 2 3 4 5
E D C B A E D C B A

28 Child understands issues surrounding sexual identity.
1 2 3 4 5 1 2 3 4 5
E D C B A E D C B A

29 Child exhibits tolerance/empathy for others.
1 2 3 4 5 1 2 3 4 5
E D C B A E D C B A

30 Child can set personal boundaries.
1 2 3 4 5 1 2 3 4 5
E D C B A E D C B A

31 Child can respect others' boundaries.
1 2 3 4 5 1 2 3 4 5
E D C B A E D C B A
32  Child is beginning to trust and respect other group members.

33  Child is beginning to ask other members for what she wants.

34  Appears open to positive influence by group members and leaders.
<table>
<thead>
<tr>
<th>MEASURE</th>
<th>t-VALUE</th>
<th>Deterioration</th>
<th>No Chg.</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>C14 Identifies methods of coercion</td>
<td>t(11) = 3.00</td>
<td>--</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>C15 Recognizes how molestation was maintained</td>
<td>t(11) = 2.69</td>
<td>--</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>C16 Has plans for future protection</td>
<td>t(11) = 3.03</td>
<td>--</td>
<td>42%</td>
<td>58%</td>
</tr>
<tr>
<td>C17 Identifies feelings in others</td>
<td>t(11) = 4.06</td>
<td>--</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>C18 Accepts others' feelings being different from their own</td>
<td>t(11) = 2.55</td>
<td>8%</td>
<td>33%</td>
<td>59%</td>
</tr>
<tr>
<td>C19 Can express self w/o fear of losing control</td>
<td>t(11) = 3.63</td>
<td>--</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>C20 Can identify personal strengths</td>
<td>t(11) = 2.60</td>
<td>8%</td>
<td>33%</td>
<td>59%</td>
</tr>
<tr>
<td>C21 Can identify personal weaknesses</td>
<td>t(11) = 2.69</td>
<td>--</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>C22 Can accept she is not all good or all bad</td>
<td>t(11) = 4.02</td>
<td>--</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>C23 Can control own impulses</td>
<td>t(11) = 2.69</td>
<td>8%</td>
<td>33%</td>
<td>59%</td>
</tr>
<tr>
<td>C24 Can identify thoughts before behavior</td>
<td>t(11) = 3.63</td>
<td>--</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>T-value</td>
<td>p-value</td>
<td>Percentage of Agree</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------------------</td>
</tr>
<tr>
<td>C25</td>
<td>Recognizes &amp; identifies problems</td>
<td>t(11) = 4.02</td>
<td>p &lt; .05</td>
<td>33%</td>
</tr>
<tr>
<td>C26</td>
<td>Can identify problem solving choices</td>
<td>t(11) = 5.00</td>
<td>p &lt; .05</td>
<td>17%</td>
</tr>
<tr>
<td>C27</td>
<td>Knows &amp; uses correct body part names</td>
<td>t(11) = 3.46</td>
<td>p &lt; .05</td>
<td>42%</td>
</tr>
<tr>
<td>C28</td>
<td>Understands issues surrounding sexual identity</td>
<td>t(11) = 4.18</td>
<td>p &lt; .05</td>
<td>67%</td>
</tr>
<tr>
<td>C29</td>
<td>Exhibits tolerance &amp; empathy</td>
<td>t(11) = 2.17</td>
<td>p &lt; .05</td>
<td>67%</td>
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<tr>
<td>C30</td>
<td>Can set personal boundaries</td>
<td>t(11) = 2.87</td>
<td>p &lt; .05</td>
<td>50%</td>
</tr>
<tr>
<td>C31</td>
<td>Child respects others' boundaries</td>
<td>t(11) = 2.28</td>
<td>p &lt; .05</td>
<td>8%</td>
</tr>
<tr>
<td>C32</td>
<td>Begins to trust &amp; respect other group members</td>
<td>t(7) = .89</td>
<td>p &lt; .10</td>
<td>12%</td>
</tr>
<tr>
<td>C33</td>
<td>Ask other members for what she wants</td>
<td>t(7) = 3.06</td>
<td>p &lt; .05</td>
<td>37%</td>
</tr>
<tr>
<td>C34</td>
<td>Accepts positive influence by other group members</td>
<td>t(7) = 2.65</td>
<td>p &lt; .05</td>
<td>37%</td>
</tr>
</tbody>
</table>
Table 2

<table>
<thead>
<tr>
<th>Measure</th>
<th>U-Score</th>
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</thead>
<tbody>
<tr>
<td>14) Identifies methods of coercion</td>
<td>0*</td>
</tr>
<tr>
<td>15) Recognizes how molestation was maintained</td>
<td>3*</td>
</tr>
<tr>
<td>16) Has plans for future protection</td>
<td>2*</td>
</tr>
<tr>
<td>20) Can identify personal strengths</td>
<td>2*</td>
</tr>
<tr>
<td>22) Can accept she is not all good or all bad</td>
<td>2*</td>
</tr>
</tbody>
</table>

* significance, p < .05
References


