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SHORT-TERM GROUP THERAPY FOR SEXUALLY ABUSED GIRLS: A LEARNING THEORY BASED TREATMENT FOR NEGATIVE AFFECT

by

MARIE MURRAY BURKE

M.A., Wichita State University, 1981

A Dissertation Submitted to the Graduate Faculty of The University of Georgia in Partial Fulfillment of the Requirements for the Degree

DOCTOR OF PHILOSOPHY

ATHENS, GEORGIA

1988

SHORT-TERM GROUP THERAPY FOR SEXUALLY ABUSED GIRLS:

A LEARNING THEORY BASED TREATMENT

FOR NEGATIVE AFFECT

by

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MARIE MURRAY BURKE
Short-Term Group Therapy for Sexually Abused Girls: A Learning Theory Based Treatment for Negative Affect
(Under the direction of JOAN L. JACKSON)

The current study was designed to provide a method of systematically evaluating the efficacy of a short-term group intervention for sexually abused, young girls. To evaluate treatment effectiveness, objective assessment instruments were administered to both a treatment group and a matched waitlist control group prior to therapy, immediately after therapy, and at six week follow-up. A parent or guardian was also asked to complete a standardized questionnaire concerning the subject's behavior at the previously mentioned intervals. This study provides a detailed description of the procedures used in each treatment session. The procedure is a result of developing a treatment protocol which logically follows from an etiological perspective of anxiety and depression as viewed by social learning theory. Negative affect is a commonly reported symptom in sexually abused children.

It was predicted that on the objective measures which reflect negative affect, significant improvements would be found for subjects completing the treatment group when compared to the waitlist controls. Predictions were supported and indicate that a short-term, learning theory based treatment is effective in helping resolve anxiety and depression in child victims. Specifically, all dependent measures were analyzed using analysis of covariance

with pretreatment scores serving as the covariate. On the Children's Depression Inventory this analysis revealed that post-manipulation scores and follow-up scores of the two groups significantly differed with regard to total scores, $F(1,22) = 22.05$, $p < .001$. The same pattern was found with total Revised Children's Manifest Anxiety Scale scores. Treatment subjects' scores were found to be significantly different from waitlist controls' at post-manipulation and follow-up, $F(1,22) = 4.53$, $p < .05$. Total scores on a Fear Survey Schedule did not significantly differ between groups or show any trial effect, but a subscale designed to detect fears specific to sexually abused children did reflect a significant improvement in treated subjects. Also, parent ratings of internalizing symptoms endorsed on the Child Behavior Profile revealed a significant group effect, $F(1,20) = 4.63$, $p < .05$.

INDEX WORDS: Sexually Abused Children, Group Therapy

ACKNOWLEDGEMENTS

One piece of advice given to me early in my program of study was to choose my dissertation research committee carefully. This I took to heart and was reminded of as I stood before this small group of individuals feeling very humble. My respect and admiration for these people cannot be overstated. Thank you Joan Jackson for your tolerance, patience, and blessed thoroughness. Your support of me as a student and friend frequently ran into overtime. You are largely responsible for the respect I've developed for the field of clinical psychology; you have taught me the value of careful circumspection and inspired confidence in my clinical judgement.

I would also like to acknowledge Ruth Townsley and thank her for helping me survive. Thanks also to Amanda McCombs, Denise Henderson, and Ken Riddleburger for their contributions to this project. Only true friends give of themselves in the way you have. To Liam O'Hara, I give a future of thanks. And not forgetting my mother, who has seen me through this lengthy college career with incredible care, optimism, and love, I mention one of my goals. In my new life, many efforts will go towards letting her know what she means to me.

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INTRODUCTION

Based on data obtained from a records clearing house containing information provided by 32 states, the American Humane Association estimates that 60,000 to 100,000 reports of child sexual abuse are made each year (American Humane Association, 1984). Estimates of the frequency of child sexual abuse are even higher when cases that are not reported to appropriate agencies are included. Nevertheless, each year child protection agencies are presented with increasing numbers of such referred cases and are faced with the task of assessing and providing follow-up services for these victims of child sexual abuse. At the same time, a growing body of research is available which indicates that victims of child sexual abuse may suffer significant psychological problems following the abuse (Browne & Finkelhor, 1986). Therefore, the responsibility and the need for child protection agencies to locate and provide psychological services for these victims presents a difficult task. Agency workers frequently emphasize their lack of training and inexperience in dealing with the psychological sequelae of sexual abuse, and they cite lack of sufficient funding as a major obstacle in arranging for services to be provided by trained professionals.

Even if treatment providers are located, the efficacy of therapy for victims is difficult to establish since systematic evaluations of treatment outcome have rarely been conducted. Also, the majority of published material on treatment is in the form of case studies, thus limiting generalizability.

In response to the current state of affairs, it was the purpose of this study to present a detailed description of a structured, short-term group treatment program for sexually abused girls which is based on social learning theory and to examine treatment effectiveness by means of a pre-post control group experimental design.

Before describing the study, an overview of child sexual abuse, the impact of such abuse, and the possible etiology of psychological problems will be presented. Then the group treatment literature will be reviewed, and finally the treatment program will be introduced.

Child Sexual Abuse

A generally accepted definition of child sexual abuse has been offered by Finkelhor (1979). His definition emphasizes sexual experience occurring between a child under the age of 16 and a person more than 5 years older than the child. Further, the amended Child Abuse Prevention and Treatment Act of 1973 defines abuse as "the obscene or pornographic photographing, filming, or depiction of children for commercial purposes, or the rape, molestation, incest, prostitution, or other such forms of

exploitation of children under circumstances which indicate that the child's health and welfare is harmed or threatened..." (National Center on Child Abuse and Neglect, 1979).

Incidence rates vary since there is no single data source to consult for statistics on crimes committed against children. Differences in definitions of abuse and length of childhood, in reporting practices, and in methods of data collection confound efforts to gain a comprehensive understanding of how frequently sexual crimes are committed against children. As recently summarized by the U. S. Department of Justice (1985), incidence rates of child sexual abuse based on retrospective self-reports range from 38% of women in a sample of 933 (Russell, 1983), to 27% of women and 15% of men in a survey study of 2,000 respondents (Committee on Sexual Offenses Against Children and Youth, Canada, 1984), with the most conservative estimates coming from Kercher's (1980) study of 796 college students. In this study, 12% of women and 3% of men had been sexually abused as children. Estimates of national incidence rates based on reported cases of abuse in the United States range from 0.7 (Department of Health and Human Services, 1981) to 1.4 (American Humane Association, 1984) victims per 1,000 children. Clearly, these figures underestimate abuse in this population since non-reporting is quite common (Burke, 1986; Kidd & Chajet, 1984).

The national incidence data on abuse and neglect also provide a description of the average age, gender, and racial status of the victims (Russell & Trainor, 1984). According to these statistics, the majority of sexually victimized children are girls (84%) who have a mean age of 10.5 years. Seventy-five percent of the victims are white, with 15% black and 10% of other racial backgrounds. Retrospective studies tend to yield different descriptive statistics on victim characteristics since they do not depend on cases reported to appropriate authorities. Landis (1956) and Finkelhor (1981), for example, report that male victims are less likely to disclose sexual abuse than are females, thus the sex ratio reported in the national study is probably not representative of the victim population.

Without question, studies reveal that the perpetrators of child sexual abuse are usually male. The National Center on Child Abuse and Neglect (1979) indicates that 97 to 98 percent of the perpetrators are male, and that whether he is a family member or not, the man is most often a familiar person to the child. Mrazek, Lynch, and Bentovim (1981) present data obtained from a large survey of professionals who come into contact with sexually abused children. Based on 685 completed questionnaires, the perpetrator was the child's natural father or stepfather 12% of the time. Mothers were the known perpetrator in only 2% of the cases. Conte and Berliner's (1981)

study of 583 victimized children showed that 42% of the time the perpetrator was not related to the child but was known by the victim. Thus, in general, most studies support the notion that children are at greater risk of sexual abuse by people they know than by strangers. Also, many studies report that multiple sexual contacts are likely to occur (Sgroi, 1982). Courtois (1980) found that only 17% of cases she studied involved a single abuse incident.

Research also pinpoints a high risk age period which appears to be between four and nine years of age (Gelinas, 1983). The abuse is typically terminated at ages 14 or 15, when the victim is more likely to disclose the abuse, threaten to disclose the abuse, or to run away (Courtois, 1980; Finkelhor & Browne, 1985).

The types of sexual abuse which may take place are varied. Russell (1983) presents an analysis of "types of abuse" by dividing the abusive activities into three categories. These are: (1) "very serious sexual contact," which includes forced or unforced vaginal penetration, fellatio, cunnilingus, or anal intercourse; (2) "serious sexual contact," involving forced digital vaginal penetration, non-forced vaginal or breast contact, and simulated intercourse; and (3) "least serious contact," defined as forced kissing, touching buttocks, thighs, legs, or clothed breast or genitals. Russell found that with intrafamilial abuse, 23% fell into the "very serious" category,

41% into the "serious" category and 36% in the "least serious" category.

Step-fathers reportedly committed the most serious acts of abuse (47%), as compared to biological fathers, who engaged in such activities 26% of the time. Least serious abuse, as reported by Russell, was associated with males closer in age to the victims (e.g., brother or cousin). Other studies (Farber, Showers, Johnson, Joseph, & Oshins, 1984; Finkelhor, 1980) reported that many cases of abuse involve bribery or intimidation and most involve some threat or implied threat for insuring secrecy.

Impact of Sexual Abuse

The impact of sexual abuse on children has been explored in numerous studies (Adams-Tucker, 1982; Browne & Finkelhor, 1986; Browning & Boatman, 1977; Burgess & Holmstrom, 1974; Friedrich, Urquiza, & Beilke, 1986; Gomes-Schwartz, Horowitz, & Sauzier, 1985; Goodwin, 1981; Jackson, Calhoun, Amick, Maddever, & Habif, 1986; Mrazek, 1981). Browne and Finkelhor (1986) present a review of these and other studies and briefly summarize in the following manner: "The empirical literature on child sexual abuse, then, does suggest the presence...of many of the initial effects reported in clinical literature, especially reactions of fear, anxiety, depression, anger, hostility, and inappropriate sexual behavior" (p. 69). They go on to say that because of methodological problems, it is uncertain if these reported findings reflect the

experience of all child victims of sexual abuse. At any rate a more detailed examination of studies reporting anxiety or fear symptoms as well as depression seems warranted since symptoms of these disorders are the focus of the current project.

Unfortunately, the majority of these studies fail to describe the use of any clear diagnostic criteria or standardized measurement of symptoms. For example, Anderson, Bach, and Griffith (1981) reviewed clinical data on 155 female adolescent sexual abuse victims. The authors reported psychological problems in over half of these females. Particularly they noted victims having "internalizing" symptoms. These included sleep and eating disturbances, fears and phobias, depression, guilt and anger. The symptoms were more frequently reported by the females involved in intrafamilial abuse, although 46% of those abused by someone outside of the family also reported these symptoms.

A Tufts' University study (Gomes-Schwartz, Horowitz, & Sauzier, 1985) of 156 abuse victims found that children in the 7-13 year old age group showed the highest incidence of psychopathology. This is an unusual study in that data were obtained via a standardized self-report measure. Of these 7-13 year olds, 45% manifested severe fears as measured by the Louisville Behavior Checklist.

Many studies report depression as being a major consequence of abuse, however, very few studies have used

standardized measures to assess depression. Instead, researchers typically note the prevalence of guilt and low self esteem (DeFrancis, 1969). Anderson et al. (1981), in a study of 227 sexually abused children found that 25% of these victims were seriously depressed after the abuse.

Browne and Finkelhor (1986) also summarize findings on the long-term effects of child sexual abuse and report that adults victimized as children are more likely to "manifest depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency towards revictimization, and substance abuse" (p. 72). Sexual impairment is also reported in many of the studies. Despite methodological problems, it appears safe to state that victims of child sexual abuse are at high risk for developing psychological problems.

Development of Psychological Problems

Since treatment procedures are, ideally, an extension of conceptual frameworks and theories about human behavior, a theoretical basis for examining the development of noted difficulties following sexual abuse is needed. Social learning theory provides such a framework by explaining the development of anxiety and depression in child victims via classical and operant conditioning. Other theories exist, such as psychoanalytic explanations of sexual assault related problems (Deutsch, 1945; Factor, 1954) and Burgess and Holmstrom's "crisis model" (1974), which focuses on disequilibrium following rape. However,

these theories fail to be predictive of precise problems which are likely to occur following the assault. They also rely on inferred "internal" mechanisms and circular reasoning in explaining the development of psychological problems following the abusive experience. Social learning theory, on the other hand, allows for prediction, has implications for assessment and treatment following child sexual abuse, and provides a framework for evaluating treatment outcome.

A few researchers have applied behavioral conceptualizations to adult sexual assault related problems, particularly in terms of anxiety, depression, and sexual dysfunction which frequently occur following assault (Feldman-Summers, Gordon, & Meagher, 1979; Kilpatrick, Best, & Veronen, 1978; Kilpatrick, Veronen, & Resick, 1977, 1979; Resick & Jackson, 1976; Tsai, Feldman-Summers, & Edgar, 1979; Veronen & Kilpatrick, 1980). Adult sexual assault is often described as a situation in which the victim is helpless, vulnerable, powerless, and in danger of physical harm. Empirical support has been obtained for the contention that victims respond to the event by experiencing high levels of fear and anxiety (Veronen, Kilpatrick, & Resick, 1979). A classical conditioning paradigm has been used in explaining the development of continued fear and anxiety following sexual assault (Kilpatrick, Veronen, & Resick, 1982). Here, characteristics of the assault (unconditioned stimuli, UCS) evoke

fear, anxiety, shaking and trembling, heart racing, difficulty breathing, and other autonomic nervous system (ANS) functions (unconditioned responses, UCR). Any stimuli associated with the assault may acquire the capacity to evoke the fear, anxiety, and ANS symptoms and thus become conditioned stimuli (CS), eliciting this anxiety response independently. At this point the victim's reaction is now a conditioned response (CR). Since some CS are commonly present in many daily settings--stimuli such as men, beds, dark places, a particular neighborhood--the conditioned response may occur frequently and may generalize to other stimuli similar to those CS present at the time of the assault.

A typical response to the experience of anxiety is avoidance of all stimuli which elicit this emotion. Thus, the avoidance response is negatively reinforced by anxiety reduction and becomes very resistant to extinction (O'Leary & Wilson, 1975).

Can such a conceptualization be applied to the child's victimization experience? Not all victims of child sexual abuse experience fear, pain, or anxiety during the experience, although many do report feeling this way (Finkelhor, 1979). If the child is threatened by the perpetrator that "he/she better not tell or else something bad will happen," this event may serve as the UCS and the abuse itself may come to elicit anxiety via second order conditioning (Kilpatrick et al., 1978). It is also

possible that the negative events frequently surrounding disclosure of abuse by a child (Giarretto, 1982; Lubell & Soong, 1982) begin a classical conditioning of anxiety, confusion, and painful feelings to a variety of similar stimuli, and second order conditioning to the disclosure and the abusive experience occurs. Thus, anxiety symptoms develop as a consequence of environmental conditions which allow conditioning to occur and be maintained as long as conditioned stimuli can be avoided. As previously noted, many child victims present with excessive fears and anxiety which differentiate them from nonvictimized children (Browne & Finkelhor, 1986; Fredrick et al., 1986; Gomes-Schwartz et al., 1985; Mrazek, 1981). Thus a logical component of treatment would be teaching children the skill of producing a response incompatible with anxiety while enduring exposure to various conditioned stimuli.

A second hallmark impact of child sexual abuse is withdrawal, sadness, suicidal thoughts, and a lack of enjoyment in life (Browning & Boatman, 1977; Defrancis, 1969). As described by Lewinsohn (1974), a reduction in rate of behavior prompted by fear-induced avoidance often results in a lower rate of response-contingent reinforcement. This relatively low rate of reinforcement is thought to precipitate depression. Particularly with children, withdrawal of support from significant others would also reduce the amount of reinforcement obtained by the victim. Not infrequently, victims of incest are

disbelieved, blamed, or even punished for disclosure of sexual abuse (Finkelhor & Browne, 1985). Often child victims are removed from their homes, schools, and friends in an effort to prevent further abuse. Here again, removal of positive reinforcement and the introduction of punishment may help explain the victim's tendency to withdraw from her environment and develop negative affect. Intervention for this depression would therefore need to include strategies aimed at increasing the child's rate of positively reinforced activity. Also, teaching the child methods of responding to anxiety-provoking events in her environment would help eliminate fear-induced avoidance behavior.

Group Treatment Studies

Over the last five years, a few published studies have appeared in the literature highlighting the advantages of group intervention with sexually abused girls and adolescents. These articles begin to delineate what is done procedurally during these therapy sessions and to present themes underlying the selection of particular procedures. Unfortunately, only one systematic evaluation of treatment effectiveness is presented in any of the articles. Therefore, a presentation of previous works will focus mainly on description of treatment methods.

Lubell and Soong (1982) presented a group treatment strategy for adolescent females who had been sexually abused. The goals of the group involved having the girls

feel better about themselves, having them improve their social skills, and letting members share their experiences and resolve feelings of loneliness. Six girls ages 13 or 14 were included in 19, seventy-five minute long sessions led by male and female co-therapists. During the sessions, themes of isolation, loss, anger, and hope were discussed. The members were encouraged to "share their experience(s), to mourn their losses while building new lives, to both feel and receive rage until resolution, and to talk positively about the future" (p. 314).

Lubell and Soong stated that this treatment was "viable and potentially quite helpful" (p. 315). However, their outcome measures consisted of unstructured feedback from each girl, her family therapist, and community workers. They reported that most of the informants noted improvement in the girls' self-esteem and functioning following group therapy.

Also in 1981, Delson and Clark presented their article on "Group Therapy With Sexually Molested Children." This "play therapy" group consisted of five girls in the age range of 6-11 years. Sixteen weekly sessions of approximately 75 minutes were held. Inclusion criteria were not delineated. The therapy was composed of "art therapy" and role-playing wherein each girl was given her own baby bottle to help her resolve her "infant regressed behavior" (p. 178). In other sessions, baby dolls, diapers, baby spoon, and baby food were provided for each girl in hopes

of continuing this resolution. The authors conceded that some children seemed to become "more regressed" during this play. Later sessions involved role-plays of upcoming courtroom experiences and periods of "horsing around." This rough play was described as wrestling, tackling, and fighting with soccer boppers as an outlet for aggression and angry feelings. Many sessions ended by providing nurturance via "round-robin" backrubs. These, the authors claim, teach the girls a non-threatening and non-sexual way of appropriate touching.

As in the previous study, the authors discussed improvements observed by the co-therapists in the area of self-respect. Unfortunately, no objective measures were administered to the groups, and treatment efficacy is difficult to determine. However, Delson and Clark should be commended for placing most of their therapeutic techniques in a theoretical framework--mainly a psychodynamic one. Many studies seem to neglect theory in their presentation of interventions for the problems that sexually abused children have. An evaluation of their treatment effectiveness may have provided support for their theoretical basis.

Sturkie (1983) presented a treatment that appears to have been more structured and guided by previously developed session plans based on significant themes. Also, group member characteristics were described, and it was indicated that any incest victim or any victim molested by

a known non-family member or a stranger was included in the group. Also the range of abuse, from rape to fondling, was presented with a note from the author that "no discernible negative impact on the group resulted from heterogeneity" of members (p. 301). Sturkie's groups were conducted in eight week cycles and included from four to eight members at any time depending on subject availability. The age of the girls ranged from seven to twelve years.

As part of treatment, Sturkie presented the group members with three rules: 1) group discussion would be kept confidential, 2) no one was required to talk unless she wanted to, and 3) only one person would be allowed to speak at a time. Eight "themes" for discussion coincided with the eight therapy sessions. The first of these was entitled "believability" and involved having group members and therapist provide acceptance and support regarding the girls' stories of victimization. Role-plays were also done at this point to allow the girls to confront a disbelieving parent. The second session dealt with "guilt and responsibility." During this session, the therapist provided reassurance and education about the child's role in the event. The group was also encouraged to discuss fears of abandonment which may have resulted from the "conflict of disrupting homelife" (p. 302). The final goal of the second meeting was to have the girls externalize internal feelings of guilt and replace these with anger.

Sturkie's third meeting involved having group members do body drawings and discussing how one's body is her own. The theme of this session was called "Body Integrity" and it underlay the use of role-plays to teach the girls to respond to invasion of personal space by yelling at the intruder. "Secrecy and Sharing" was the theme of session four, which involved a discussion of what is appropriate to talk about and share with others. The therapist encouraged the group not to keep "bad feelings" inside. The next session dealt with the theme of "anger." During this session, the girls were encouraged to scream what they would like to say to their abuser, to hit pillows, and to scream "no."

In session six, the therapist had each child complete an assertiveness scale for children, had the girls engage in role-plays demonstrating assertive social interactions with peers and adults, and encouraged the girls to confront "inappropriate social skill." Sturkie reports using "behavior modification procedures which lead to new prosocial behavior" (p. 305). These exercises were done in hopes of resolving the girls' sense of "powerlessness." No specific information is provided to aid the reader in understanding what behavior modification procedures were used or how they were applied. Also, no data are presented on the members' responses to the assertiveness schedule.

The seventh session dealt with "Other Life Crisis, Tasks, and Symptoms." It appears that this theme was meant to focus on group members' seductive and manipulative behaviors and to discuss difficult adjustment issues such as changing homes or schools.

The last session's theme of "Court Attendance" was explored by having group members share previous court experiences, and by conducting role-plays which would allow each girl the opportunity to gain a "symbolic control over the perpetrator" (p. 306).

In terms of outcome, Sturkie states that of 17 girls who completed therapy, there was no recidivism and none failed to make her court appearance. In addition, the author believes that treatment efficacy was demonstrated by the fact that the treatment subjects spent less than half the state's normal length of time in foster care. It was unclear to this reader how these findings demonstrated a significant change in group members behavior, although an examination of these behavioral indices is certainly a significant improvement over previous studies in which objective measures of treatment efficacy are totally neglected.

Mrazek (1981) administered a pre-treatment evaluation to the seven girls involved in her group therapy. The girls varied in age from four to seven years and were victims of intercourse, fondling, or manual stimulation. Perpetrators were not described. Along with a speech

evaluation by a trained speech therapist, the following assessment procedures were administered by a child psychologist prior to treatment: 1) observation of the child's free play, 2) observation of a structured family doll play, 3) a sentence completion task involving the wishes and dreams of each girl, and finally, 4) observation of the child in home and school settings. Therapy was then conducted by the author and one male "paraprofessional" therapist. Both therapists received training and supervision by a child psychologist.

Therapy was conducted once a week for 75 minutes per session over a period of six months. A list of therapy goals is presented by the author and is followed by a detailed case history of each group member. The specifics of each therapy session are not presented, nor is there any further mention of the assessment data collected prior to therapy. In terms of outcome, Mrazek states that all but two of the girls made improvements but that "post-test follow-up showed...that most of the girls continued to have emotional problems." In response, Mrazek suggests that ideally therapy should continue for approximately two to three years. It is important to note that this is one of the first published articles to focus on pre-treatment assessment--although post-treatment data are only vaguely discussed.

In 1982, Blick and Porter published an article entitled "Group Therapy with Female Adolescent Incest

Victims." As in the previously mentioned article by Mrazek, the importance of making group therapy just one of many components of treatment is brought to light. These authors also suggest family therapy, individual therapy for the child's sexual trauma, and stabilization of the family in conjunction with protecting the child from further abuse as an obligation of their treatment program.

These authors go on to describe the procedures of their group therapy. Length of therapy ranged from eight weeks to what was referred to as "open-ended" (p. 147). Issues such as transportation, time and place for the meetings, and use of a co-therapist are discussed in detail. Female victims of incest between the ages of eight and eleven years of age were included in the groups, and group size varied from three to thirteen members depending on the girls' needs and availability for therapy. Meetings typically lasted 75 minutes and included a period of "having snacks." This was done, the authors state, for the obvious reason of providing "symbolic nurturance" to group members. The therapist believed this to be a "powerful, subtle, therapeutic tool" (p. 156).

The two female co-therapists also focused on establishing rapport with each member and on developing group cohesion to help the girls reduce their sense of isolation. Treatment again appeared to follow themes which tend to overlap a great deal with previously published themes used in this specific type of group therapy. These

themes were: 1) ventilation of anger or negative feelings, 2) socialization skills aimed at teaching the girls healthy interactions, 3) preparation for court experiences, and 4) sex education. The authors also state that an occasional "fun" day was intermittently placed in the protocol.

In terms of outcome, the authors describe seeing improvements in the girls' self-esteem by observing the girls' ability to be assertive. They also state that most improvements were demonstrated after 1.5 to 2 years of therapy. No objective outcome data were provided.

Other articles have also touched upon the need for group therapy as one mode of intervention (Bander, Fein, & Bishop, 1982; Gabinet, 1983; Giarretto, 1982) for sexually abused children. These articles do not offer suggestions about how these groups should be conducted but they do point to the obvious need for providing special services to the children in conjunction with comprehensive involvement with the child's family.

A more recent study, conducted by Verleur, Hughes, and Dobkin de Rios (1986) appears to be the first of its kind in using a comparison control group and a systematic, pre-post data collection method. In this study, self-esteem and an increase in knowledge about human sexual behavior were targeted. Fifteen female adolescent incest victims ages 13-17 were provided group therapy on a weekly basis for six months. Fifteen other incest victims in the

same age range served as control subjects. Therapy was conducted at an inpatient treatment facility in California where all subjects were residents.

The treatment group subjects are described as homogeneous and all sexually victimized by fathers or adult male caretakers. Abusive activity ranged from fondling to vaginal or anal intercourse, and time since abuse is not specified. It is unclear whether control and treatment groups were matched on any variables prior to group assignment, and the method of assignment is not stated. Pre- and post-treatment total scores on the Coopersmith Self-Esteem Inventory and the Anatomy/Physiology Sexual Awareness Scale were used as dependent measures of change.

As hypothesized, the incest victims participating in the therapy program showed significantly higher scores on the Coopersmith Self-Esteem Inventory than victims not receiving the group therapy. This finding reflects more positive self-esteem in the treated subjects. Also, treated subjects showed a significant increase in sexual knowledge in the areas of anatomy, venereal disease, and birth control as compared to control subjects.

These authors conclude that "effective treatment techniques and procedures for sexually abused adolescent victims are sorely lacking in the psychological literature" (p. 853) and that specific techniques may be particularly useful for this population. They also feel that their intervention brought about improvements in the areas

targeted for change. The study is, indeed, a notable piece of research because of the empirical approach used to evaluate treatment effectiveness, specifically in the administration of measures sensitive to the desired therapeutic changes. It is unfortunate, however, that these researchers did not specify the techniques used to improve self-esteem or materials used for the teaching of "sexual awareness." It would not be possible to replicate their research without more detailed information about procedures.

The articles mentioned in this review do have several points in common, particularly in the choice of "themes" presented to victims during various sessions. Each of these studies focused on the need to establish good rapport with the children and to provide an environment conducive to ventilation of emotion followed by acceptance and reassurance. The therapists described in the studies encouraged discussion of fears and guilt feelings. In many ways some of these approaches appear to function as a method of desensitization. First the child is asked to re-experience the abuse by talking about the event. Then the therapist consoles, supports, and reinforces this behavior allowing the child to more comfortably face further exposure to the painful memories. Also, most of the studies presented in this review used some form of modeling and role-playing techniques to either teach assertive behavior or social skills, or to help the child learn

appropriate courtroom behaviors and responses. In some ways, it appears that many of the procedures used in the previously described studies can be described by social learning theory terms or mechanisms. Unfortunately, only one of the studies provided any standardized or systematically obtained data to determine treatment efficacy or to support chosen methods of intervention.

Purpose of the Study

The current study provided a method of systematically evaluating the efficacy of group intervention for sexually abused girls. The purpose of this study, therefore, was to evaluate treatment effectiveness by administering standardized self-report assessment instruments to both the treatment and waitlist control groups prior to therapy, immediately after therapy, and at a six week follow-up. Parents or guardians of the victims in both groups were also asked to complete a standardized questionnaire concerning the subjects' behavior at the previously mentioned intervals. As yet, only one study found by this researcher has presented data in the published literature on group therapy with sexually victimized children, and therefore statements about treatment effectiveness have thus far been limited almost entirely to clinical observations.

As with several of the previously reviewed group treatment articles, this study also provided a detailed description of procedure in each session. The procedure is a result of developing a treatment protocol which

logically follows from an etiological perspective of anxiety and depression as viewed by social learning theory. If the underlying theory is sound, the appropriate mode of intervention can be determined directly from the theory. Assuming that the proposed treatment protocol does indeed extend from social learning theory and that the procedure is applied systematically for each group, then ultimately effectiveness of treatment supports the underlying social learning theory.

It was predicted that on the objective measures which reflect negative affect (anxiety, fears, and depression) in children, significant improvements would be indicated for subjects completing the treatment group when compared to the waitlist control group. It was also predicted that the child's parent or guardian would note such improvements in treatment subjects, which would be reflected in their post-treatment and follow-up evaluations. This treatment was not designed to totally ameliorate the difficulties that child victims and their families have. It was also not intended to replace pre-existing treatment programs that deal with child sexual abuse in a comprehensive manner including child protection, individual therapy for the child and family members, family intervention, and court preparation training.

If, however, the predictions of this study were supported and a short-term, learning theory based treatment was effective in helping resolve anxiety and depression in

child victims, then certain implications would be clear. Short-term therapy would have merit in allowing agencies to obtain professional intervention for child sexual abuse victims at a minimum cost. Psychologists would have an efficient and effective treatment for victim's anxiety and depression at their disposal. Also, if the study's predictions were supported, some support for the utility of a learning-based conceptualization of abuse effects would be demonstrated.

METHOD

Subjects

Twenty-five female victims from confirmed cases of child sexual abuse served as subjects in this treatment study. Subjects ranged in age from 8 years to 13 years. As cited early in this paper, this age group is at the highest risk of being sexually abused and accounts for a large percentage of abuse cases reported to child protection agencies. To be accepted in this study, a subject must have acknowledged that abuse had occurred and enough evidence must have been presented to the referring agency (Department of Family and Children Services, Department of Social Services, the Navy Family Service Center, and private practitioners) for the abuse to be considered "confirmed" by this agency. One county agency in Georgia and two agencies in South Carolina provided referrals.

Additional criteria for inclusion included (1) reports of behavioral difficulties in subjects indicated in records of assigned child protection case workers, (2) a pretreatment score on the Children's Depression Inventory of at least one standard deviation above the mean score obtained from a normative sample of girls aged 8 to 13, and (3) abuse must have occurred within the last two years. Subjects were excluded if they were not within one

year of their age appropriate grade level in school or if they participated in special education classes. No child missed more than one consecutive session of treatment.

Instruments

Children's Depression Inventory (CDI; Kovacs, 1981, 1983). The CDI consists of 27 items. On each item, the child is asked to select among alternatives on a 3-point scale indicating intensity of particular symptoms. This measure is widely used. Reports of adequate reliability and validity have been cited. For example, Kovacs (1981) states that this inventory has "solid psychometric properties" (p. 309). Based on data from 875 fourth through eighth graders in Canada, internal consistency was found to be .86 (coefficient alpha), and the item-total score correlations were statistically significant (.31 to .54). Kazdin (1981), reviewed the reliability information available on the CDI and also cited evidence of adequate reliability. For example, test-retest reliability of .72 was cited, and interitem correlations were determined to be statistically significant.

The validity of this inventory is supported by correlations with other ratings and self-report measures of depression as well as DSM-III diagnoses. Also the CDI has been found to reliably discriminate between psychiatric samples and nonclinic groups and child guidance clients versus pediatric outpatient groups (Kovacs, 1981). High CDI scorers also tend to have low self-esteem ratings

(Piers-Harris correlations = -.66), which is supportive of the construct of childhood depression.

Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978). This scale consists of 37 items to which the child responds by circling "true" or "not true" as the item pertains to him/her. There are three a priori or logically derived subscales of anxiety (Physiological Anxiety, Worry and Oversensitivity, and Concentration Anxiety), which are combined to provide a total index of anxiety. Since items from all subscales were pertinent to the current study, the total anxiety score was analyzed for each subject. The inventory's "lie" scale, which measures the child's willingness to endorse socially desirable behaviors, was not examined, as this was not targeted in the treatment protocol.

Normative data, reliability, and validity have been examined by Reynolds and Richmond (1978). These researchers found a KR20 reliability estimate of .83 with their initial sample of 329 subjects in grades one through twelve and .85 in their cross-validation group of 167 children. Allison (1970), reported comparable reliability for both male and female samples. Reynolds and Piget (1981) discuss findings supporting the validity of the RCMAS as a measure of children's anxiety. As with the CDI, significant correlations with other measures of anxiety and with DSM-III diagnoses support the claim that the RCMAS is a valid indicator of this construct.

Revised Fear Survey Schedule for Children (FSSC-R; Scherer & Nakamura, 1986). This questionnaire contains 80 items which the child rates on a 3-point scale (1 = none, 2 = a little, 3 = a lot) of fear. Reliability and validity findings are discussed by Ollendick (1978), who reports coefficient alphas of .95 and .93 in two different samples utilizing a total of 199 children ages 8-11 years. A test-retest coefficient of .82 was found in one sample after a one week interval. Ollendick also discusses evidence that the FSSC-R is a valid measure of children's fears across five areas (fear of failure or criticism; fear of the unknown; fear of injury and small animals; fear of danger and death; and medical fears).

Scores on the FSSC-R have been correlated with scores on the State-trait Anxiety Inventory (Spielberger, 1970) and the Piers-Harris Children's Self-Concept Scale (Piers & Harris, 1969). Correlations were large and statistically significant for girls and moderate and significant for boys. Ollendick concludes that low fear as measured by the FSSC-R is associated with a high self-concept and low "trait" anxiety. The FSSC-R measure also significantly differentiated school-phobic children from a matched control group. Total fear scores were examined for each subject in the current study.

In addition to the FSSC-R's original items, Wolfe and Wolfe (D. Wolfe & V. Wolfe, personal communication, December 18, 1986) have developed an additional scale of 27

items which is specifically designed to be sensitive to the types of fears sexually abused children may have. The psychometric properties of this scale are yet to be determined; therefore, responses to items on this scale were examined separately and used in an exploratory manner.

Achenbach Child Behavior Checklist and Profile (CBP; Achenbach & Edelbrock, 1983) is a measure which can be completed by parents or guardians and teachers. Three areas of social competence (school performance, social involvement, and hobbies and activities) as well as specific problem behaviors can be examined using this instrument. Achenbach and Edelbrock (1979), in studying parents' responses to 450 children ages six to sixteen, reports test-retest correlations averaging .87 and an interparent correlation of .67. In terms of validity, Achenbach has demonstrated the Child Behavior Profile's ability to differentiate between reports on a clinical sample of twenty-two children and those obtained on a normative sample. Within the clinical sample, parents reported a significant decrease in total behavior problems following six months of treatment at a child guidance clinic. It appears that the CBP is a reliable and valid indicator of behavior problems in children. Factor analysis of the Child Behavior Checklist yields two broad groupings of behavior problems, internalizing and externalizing behaviors. Since the internalizing group reflects depression, withdrawal, anxiety, and avoidant

behavior, scores based on these items were analyzed for the current study.

Procedure

Subjects were assigned to the treatment group or the waiting list control group, which was provided treatment following completion of the study. Assignment to groups was random, with the constraints that treatment subjects were matched with waiting list subjects on (1) age (Table 1 presents results of an analysis of variance confirming the absence of significant age differences between groups, $F(1,23) = .04$, n.s.); (2) type of abuse experienced (intrafamilial vs. extrafamilial abuse) (A chi-square test was conducted on the frequency of intrafamial vs extrafamial abuse in both groups. No significant difference was found, $X^2(1) = .0076$, n.s. Table 2 presents these data.); (3) reported amount of force used during the abuse as provided by each subject's assigned case worker (Amount of force used was coded as 0 = no force, 1 = verbal threats, 2 = physical force. A chi-square conducted on these frequency data revealed no significant difference between groups on this variable, $X^2(2) = .479$, n.s. Table 3 contains chi-square frequencies and results). The assignment procedure resulted in 12 girls in the treatment group and 13 in the waitlist control group.

Treatment and control groups were formed following contact with various referring agencies in a northeast Georgia county and two counties in South Carolina. In

Table 1

Results of Analysis of Variance of Age

Source	SS	df	F	p
Group	0.124	1	0.04	.852

Mean age for Treatment group = 9.5

Mean age for Waitlist Control group = 10.3

Table 2

Chi-Square Analysis for Intrafamial vs Extrafamial Abuse

Group	Intra-famial	Extra-famial	X^2	Critical value at p<.05
Treatment	10	2		
Waitlist Control	11	2		
Total	21	4	.0076	2.706

Table 3

Chi-Square Analysis for Amount of Force Used During Abuse

Group	No Force	Verbal Threats	Physical Force	X^2	Critical value at $p<.05$
Treatment	4	7	1		
Waitlist Control	5	6	2		
Total	9	13	3		
				.479	4.605

exchange for treatment, these agencies located the victimized girls in need of therapy and provided a brief summary of descriptive data on each subject prior to her inclusion in the study so that matching and group assignment could be made. Only girls involved in confirmed cases of disclosed abuse were eligible for the study. The referring agency was also requested to help obtain signed consent forms (Appendix A) from the girls' parents or guardians and to coordinate transportation to the treatment site. No fewer than three and no more than eight girls were to be accepted per treatment group.

The therapist who conducted the group therapy was a fifth year psychology student at the University of Georgia. This student, later referred to as the "therapist" had completed her APA approved clinical internship where she was involved in treatment and assessment of sexually abused women and children. She had also had a variety of experiences conducting behaviorally oriented group and individual therapy with children with a particular emphasis on treatment of anxiety symptoms often accompanied by depression.

Treatment Protocol

Following the administration of self-report measures, the formalized treatment protocol was introduced to the treatment groups. All sessions began by having the therapist sit with the girls in chairs positioned in a small circle in a private conference room at the participating

agency's building. For a detailed description of the treatment procedure, refer to Appendix B.

During session one, introductions were made and a rationale for the development of the group was presented. "Good touching vs. bad touching" was discussed as the establishment of rapport was begun. The girls were educated about normative reactions to "bad touching" and confidentiality was explained and emphasized. In Session two, a Progressive muscle relaxation exercise was taught, symptoms of anxiety clarified, and a rehearsal of the muscle groups conducted. The group was expected to practice the relaxation technique at home. The effectiveness of this technique as a method of anxiety reduction with children has been demonstrated in various studies (Ince, 1976; Knapp & Wells, 1978; Miller, Barret, Hampe, & Noble, 1972; Reynolds & Coats, 1986; Ross, 1981; Tasto, 1969). The third session included an assessment of the girls' individual use of the relaxation exercise, a review of the procedure, and a discussion of problems or success in using the procedure. In addition, a detailed list of anxiety-provoking situations was developed for use in the next session.

By the fourth session, the girls were expected to use the relaxation technique independently and were asked to do so following an imagery task which is designed to induce anxiety symptoms. The second part of the fourth session focused on identifying situations or time periods

when group members feel depressed. Following this discussion a sample list of pleasurable events was developed and a rationale for "making oneself" engage in these activities was presented. A series of studies, described by Lewinsohn and his colleagues (Lewinsohn, 1974; Lewinsohn & Graf, 1973; Lewinsohn & Libet, 1972; Lewinsohn & MacPhillamy, 1974) shows that participation in pleasurable activities is significantly correlated with the absence of depression. The effectiveness of this procedure with children has not been well established thus far in the literature. However, the successful treatment of selected depressive symptoms in children using behavioral techniques has been demonstrated (e.g., Frame, Matson, Sonis, Fialkov, & Kazdin, 1982; Matson, 1982; Ross, 1981). Homework for this session required that each girl develop her own list of pleasurable events and engage in at least three of these activities before the next session.

Sessions five and six were focused on teaching group members a method of actively dealing with anxiety-producing interactions with strangers or anyone who might attempt "bad touching." The mnemonic "LID" was used to help the group learn the three steps, "Look" for a safe place, "Ignore" the stranger, "Do" yell rejection and run to the safe place. Role-play involving the therapist was used to teach the procedure. The effectiveness of this procedure was demonstrated by Wurtele, Saslawsky, Miller, Marrs, and Britcher (1986) in a study comparing this role-play method

to an instructional film. The role-play method was found to be significantly more effective in increasing a child's knowledge of how to handle inappropriate advances made by adults. A subsequent study by Wurtele, Marrs, and Miller-Perrin (1987) has supported the importance of participant modeling as an effective treatment component. The initials, "LID" were developed for this study as a neumonic device to aid subjects in learning the behaviors outlined in this article. Although this procedure may provide protection from further abuse, this has not been empirically demonstrated. This procedure was expected to provide subjects with a feeling that they themselves can do something should a future victimization situation arise. Thus, the aim at this stage of the intervention was to instill a sense of "self efficacy" (Bandura, 1977). Also, during the sixth session, termination issues were discussed and post-treatment data collected. Six weeks after the post-testing data collection, both groups were administered the measures to obtain follow-up data.

RESULTS

The five dependent measures chosen to address the effectiveness of treatment were analyzed by means of repeated measures analyses of covariance (ANCOVA) with time of testing (posttreatment vs. follow-up) as the within subjects factor and treatment versus waitlist control group as the between subjects factor. In each analysis, the initial testing score (pre-treatment) served as the covariate.

Depression

The analysis of total scores on the Children's Depression Inventory (CDI) revealed a significant main effect for group, indicating that combined across both posttreatment and follow-up intervals treatment subjects' scores significantly differed from those of the waitlist control group, $F(1,22) = 22.05$, $p < .0001$. Inspection of adjusted means at posttreatment and follow-up shows less endorsement of depressive symptoms for treatment subjects on the CDI. Adjusted means were 10.64 and 18.33 for treatment and waitlist control groups, respectively at the posttreatment assessment. Follow-up adjusted means were 10.64 and 16.74 for treatment and control groups, respectively. Results of this ANCOVA are presented in Table 4

Table 4

ANCOVA Results and Mean CDI Scores for Posttreatment and Follow-up Testing

Source	SS	df	F	p
Group	546.82	1	22.05	.001
Trial	6.85	1	0.49	.493
Group x Trial	6.85	1	0.49	.493

Group	Pre M	Post M	Adjusted Post M	Follow-up M	Adjusted Follow-up M
1	17.42	10.50	10.64	10.50	10.64
2	17.85	18.46	18.33	16.91	16.74

Note: Group 1 = treatment subjects, N=12
Group 2 = waitlist control subjects, N=13

The higher the score, the more depressive symptoms are endorsed.

accompanied by adjusted and non-adjusted CDI means at each testing period.

Anxiety

Total anxiety scores (excluding the lie scale) were computed for the Revised Children's Manifest Anxiety Scale (RCMAS). Analysis revealed a significant main effect for group, $F(1,22) = 4.53$, $p < .05$. Adjusted means indicate that the treatment group endorsed fewer anxiety items on the RCMAS at posttreatment and follow-up combined than did waitlist control subjects. Adjusted means at posttreatment were 14.96 for the treatment group and 18.13 for controls. At follow-up, the treatment group adjusted mean was 13.96, while the control group mean was 16.83. Results of this ANCOVA are presented in Table 5 along with group mean scores.

Specific Fears

Total scores on the Revised Fear Survey Schedule for Children were also subjected to a repeated measures ANCOVA. No significant differences were revealed by this analysis. The sexual abuse fears subscale scores were also subjected to an ANCOVA. This analysis revealed a significant main effect for group, $F(1,22) = 6.37$, $p < .05$. Adjusted means for treatment subjects at posttreatment and follow-up were 24.09 and 21.92, respectively. For controls, the posttreatment mean score was 27.97, and a mean of 28.29 was obtained at follow-up testing. Table 6 contains ANCOVA results for the total FSSC-R and for the

Table 5

ANCOVA Results and Mean RCMAS Scores for Posttreatment and Follow-up Testing

Source	SS	df	F	p
Group	103.93	1	4.53	.044
Trial	13.66	1	1.05	.316
Group x Trial	0.09	1	0.01	.932

Group	Pre M	Post M	Adjusted Post M	Follow-up M	Adjusted Follow-up M
1	17.25	14.25	14.96	13.25	13.96
2	19.92	19.00	18.13	17.36	16.83

Note: Group 1 = treatment subjects, N=12
Group 2 = waitlist control subjects, N=13

The higher the score, the more anxiety symptoms are endorsed.

Table 6

ANCOVA Results and Mean FSSC-R Scores for Posttreatment and Follow-Up Testing

DV	Source	SS	df	F	p
Total Scores	Group	97.76	1	0.19	.669
	Trial	362.20	1	2.49	.129
	Group x Trial	165.68	1	1.14	.297
Sexual Abuse Subscale	Group	283.56	1	6.37	.019
	Trial	13.47	1	1.15	.296
	Group x Trial	13.47	1	1.15	.296

DV	Group	Pre M	Post M	Adjusted Post M	Follow-up M	Adjusted Follow-up M
Total Scores	1	108.91	100.08	101.22	90.66	91.80
	2	110.30	100.23	100.34	100.09	97.46
Sexual Abuse Subscale	1	29.83	23.83	24.09	21.66	21.92
	2	30.46	28.23	27.97	28.54	28.29

Note: Group 1 = treatment subjects, N=12
Group 2 = waitlist control subjects, N=13

The higher the score, the more fear acknowledged.

sexual abuse fears subscale. Adjusted and non-adjusted means are also presented.

Parent Rating of Internalizing Symptoms

Internalizing T-scores obtained from the Behavior Problem Checklist of the Child Behavior Profile were analyzed using an ANCOVA with initial testing scores as the covariate. A significant main effect for group was also found in this analysis, indicating an observed reduction in internalizing symptoms for the treatment subjects at posttreatment and follow-up combined, $F(1,20) = 4.63$, $p < .05$. Adjusted means for the treatment group at posttreatment and follow-up were 60.11 and 59.40, respectively, while control group means were 67.67 and 64.99 at the two points. Table 7 presents these ANCOVA results and both adjusted and non-adjusted means.

Table 7

ANCOVA Results and Mean CBP Scores for Posttreatment and Follow-up Testing

Source	SS	df	F	p
Group	431.79	1	4.63	.049
Trial	17.46	1	0.26	.616
Group x Trial	12.89	1	0.19	.666

Group	Pre M	Post M	Adjusted Post M	Follow-up M	Adjusted Follow-up M
1	64.75	59.75	60.11	58.73	59.40
2	66.23	67.82	67.67	66.00	64.99

Note: Group 1 = treatment subjects; N=12 at posttreatment, N=11 at follow-up
Group 2 = waitlist control subjects; N=11 at posttreatment, N=10 at follow-up

The higher the score, the more internalizing symptoms are noted.

DISCUSSION

As the results indicate, girls who were involved in the short-term, learning theory based treatment showed a significant decrease in symptoms of negative affect as measured by the standardized self-report instruments designed to reveal anxiety, depression, and fears common to sexual abuse victims. On both the Children's Depression Inventory and the Revised Children's Manifest Anxiety Scale, sexual abuse victims receiving this therapy reported less subjective distress immediately following treatment and at the six week follow-up period than did those matched victims serving as controls.

Although the design of the study does not permit conclusions about the mechanism of therapeutic change, several factors may be responsible for the observed reduction in negative affect. After learning the progressive muscle relaxation exercise and reportedly using it daily or more frequently as necessary; the girls not only acquired a useful skill, but also they expressed a sense of having something they themselves could do to help control and/or alleviate anxiety. The same can be said for increasing pleasant events. In addition to having an available method for coping with sadness and increasing the amount of time spent in enjoyable activities, the girls

expressed an understanding of using this strategy as a tool when they feel upset.

Another factor which seemed to play an important part in reducing self-reported negative affect was having the girls learn to identify signs of depression and anxiety. This was done so that the girls could implement a "skill" as soon as symptoms began to appear. During one session when the girls were asked to first imagine an anxiety producing situation and then use progressive muscle relaxation to reduce the anxiety, it was clear that treatment subjects were able to detect and verbalize symptoms that let them know they were becoming anxious and upset. Interestingly, each subject had her own special pattern of symptoms that served as her indicator or "warning signal". Following in-session relaxation exercise, the girls reported feeling a notable decrease in arousal level and distress.

By far one of the girls' favorite activities during the course of treatment was learning and role-playing the "LID" procedures for dealing with potentially dangerous or frightening situations involving strangers. At the follow-up meeting, several of the girls reported having had an opportunity to use the procedure, and they appeared to be quite pleased with their ability to respond to threatening situations. It was hypothesized that these role-play situations would serve to increase the subjects' sense of self-efficacy, thus impacting on depressive

feelings associated with learned helplessness and situation specific anxiety symptoms produced when the girl felt she had no way out of a frightening encounter.

It was also predicted that sexual abuse victims receiving treatment would show a decrease in the self-reported number of fear evoking stimuli listed on the Revised Fear Survey Schedule. That the treatment subjects' total scores on this instrument did not significantly differ from those of control subjects at either post-treatment or follow-up intervals is thought to be due to the fact that total scores reflect a wide range of possible fears that any child may have (e.g. fear of animals, medical fears, fear of injury, etc.). This wide range of fearful stimuli may not be specifically relevant for sexually abused children.

The Wolfe and Wolfe subscale, designed to reflect abuse related fears proved to be a more sensitive measure of treatment related changes in fearfulness. At post-treatment and follow-up, treatment subjects showed a significant decrease in the number of abuse related fears they reported as causing distress. Control subjects showed no change in their levels of these specific fears. Thus, support was found for the hypothesis that this subscale is sensitive to the types of fears sexually abused girls have and that the short-term intervention provided in this study begins to ameliorate the subjective experiences of fear for those specific items. The

mechanisms underlying this change may involve extinction made possible by an increased sense of self efficacy leading to exposure to more stimuli.

Results also indicated that parent or guardian ratings of internalizing symptoms, as reflected in CBP scores, for treatment subjects were significantly different than those for waitlist control subjects. This finding reflects a perceived decrease in anxiety and depressive symptoms for the treatment subjects by someone else living with the child and supports the idea that changes in affect for treated victims were not only noticed by the victims (thus limited to self-report), but also were apparent in the victims' behaviors at home.

It is notable that treatment gains observed immediately after treatment were maintained at the follow-up session. An inspection of means provides no evidence that treatment subjects' mean scores were beginning to regress to pre-treatment values. Overall, the predictions made prior to data collection were supported. There appears to be evidence that a short-term learning theory based therapy conducted in a group setting is an effective intervention for ameliorating negative affect in sexually abused young girls.

At this point, further research appears warranted since the effective components of the treatment protocol are yet to be determined. The design chosen for this initial investigation of a short-term learning theory

based treatment did not involve any placebo treatment comparison group or any comparison group which received different component parts of the treatment package. This type of research dismantling process would begin to address the question of effective treatment components.

Implications of these results seem to be very important for professionals dealing with treatment of sexual abuse in children and for agencies in need of an efficient, low-cost intervention for a growing number of abuse cases. Whereas long-term, intensive individual and family therapy may be ideal for many of these victims, it is often impossible to locate funds and resources for supplying services of this kind. An effective, short-term group therapy, on the other hand, is more easily arranged and could be conducted at minimal cost to participants and referring agencies.

Another implication of the current study's findings is support for the utility of a learning-based conceptualization of abuse effects. Further, it would seem advantageous to rely on social learning theory for development, revisions, and refinements of this and other therapeutic interventions aimed at ameliorating symptoms of negative affect. The current study's treatment protocol could be easily adapted to treating the anxiety and depression of children which results from various other traumatic experiences (e.g., medical procedures, physical abuse, other types of victimization, loss of a family member, etc.).

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APPENDIX A

Consent Form

H.R. # 3,430

INFORMED CONSENT AGREEMENT
MEDICAL UNIVERSITY OF SOUTH CAROLINA

("Short-term Group Therapy for Sexually-Abused Girls: A Learning Theory Based Treatment for Anxiety and Depression")

I, _____, do agree for my child, _____
(name of parent/legal guardian) (name of child)
and I to participate in this research project involving sexually-abused girls. The purpose of the project is to examine the effectiveness of a learning theory based treatment for emotional problems resulting from sexual abuse.

A/B. PROCEDURES/DURATION OF PARTICIPATION: I understand that the therapy will consist of six weekly meetings approximately one hour in length. I also understand that my child will complete questionnaires regarding her perceptions of her fears, anxiety, depression and the abusive experience at three different intervals of time spaced six weeks apart. Also, I know that my child may not qualify for the study if she is not currently experiencing distress; and that if she qualifies, her treatment may be postponed for up to twelve weeks. I also understand that I will complete one questionnaire myself concerning my child's behaviors at these same three intervals. I understand that I will be told the results of the overall research project when it is completed, if I so desire. Total anticipated duration of participation is three months.

C. POSSIBLE DISCOMFORTS AND/OR RISKS: There are few risks involved in my or my child's participation in this research project. Some distress may occur when completing the questionnaires which discuss the abusive event, or when my child is asked to discuss feeling sad or anxious in the therapy setting. If such distress occurs, it will be directly dealt with during the group therapy by teaching each participant effective methods of reducing anxiety, muscle tension, and depressed mood. If at the conclusion of treatment my child is experiencing and difficulties for which psychological intervention is appropriate, I understand that I will be referred to the appropriate department at the Medical University of South Carolina (803/792-2945). In addition, my child's teacher will complete one (1) questionnaire on my child's behavior at three (3) different time periods, if the teacher is willing; however, the teacher will not be informed that my child has been sexually abused.

D. POSSIBLE BENEFITS: There are several potential benefits from participation in this study. Foremost is the potential for reducing my child's symptoms of depression and/or anxiety which may have resulted from the sexual abuse experience. In addition, the project provides increased awareness for the Medical University of South Carolina as an agency providing services for affect problems.

E. ALTERNATE METHODS OF TREATMENT: If for any reason, the investigators and/or myself feel that my child is not benefiting from the proposed treatment or wishes to discontinue participation, I understand that I would be referred for alternative treatment methods (i.e., individual and/or family therapy).

(See Page 2)

H.R. # 3,430

Marie M. Burke, Principal Investigator, or Dr. Dean Kilpatrick, Professor of Psychiatry at MUSC, has agreed to answer any inquiries that I may have concerning the procedures and has informed me that I may also contact the Medical University of South Carolina Institutional Review Board for Human Research (803/792-4148) directly concerning patient rights. This Board administers the agreement with the United States Department of Health and Human Services covering the protection of human subjects.

I understand that in the event of any injury resulting from the research procedures to the participant, reasonable medical treatment not otherwise covered by third party payments will be available free through the Medical University; financial compensation is not available for medical treatment elsewhere, loss of work, or other expenses. I may contact the Medical University of S.C. Hospital Medical Director (803/792-3932) concerning medical treatment.

I understand that the participant's records of participation in this study are not accessible to the general public and confidentiality will be maintained. Information that may be gained from this study will be used only for research and educational purposes. Information may be published with permission of the principal investigator in medical journals, but the participant's identity will not be revealed. However, identifying information will be available to monitors from the MUSC I.R.B. for Human Research and the U.S. Food and Drug Administration.

This information will be held in strictest confidence by the principal investigator and participating research members. It is also understood that the questionnaires and involvement in group therapy will remain confidential unless it is required by law or professional ethics that the information be released, or if evidence of unreported abuse is offered by the participant during treatment. It is also understood that specific information pertaining to the participant's abusive experience will be obtained from NFSC(Navy Family Service Center, U.S. Naval Base, Charleston, S.C. 29408) case records.

It is also understood that participation is totally voluntary, and I may choose not to participate. I also understand that I am free to withdraw my consent and discontinue participation at any time. Discontinuation will in no way jeopardize the participant's ability to receive treatment now or in the future at this Institution. I will receive a copy of this informed consent after it has been read, understood, and signed.

PERSON OBTAINING CONSENT	NAME OF PARTICIPANT
WITNESS	SIGNATURE OF PARENT(s)/LEGAL GUARDIAN
DATE OF CONSENT	WITNESS

(Consent form reviewed and approved by MUSC I.R.B. for Human Research: JUL 2 1 1987 .)

Parent or Guardian's Consent Form for Participation

in "Short-term group therapy for sexually abused girls: A learning theory based treatment for anxiety and depression."

I, the undersigned, agree to participate with my child in the research project "Short term therapy for sexually abused girls" being conducted by Marie M. Burke (542-1173) of the University of Georgia's psychology department. The purpose of the project is to examine the effectiveness of a learning theory based treatment for emotional problems resulting from sexual abuse. I understand that this information will be held in strictest confidence by the Principal investigator and participating research team members. I also understand that my questionnaires and involvement in group therapy will remain confidential unless it is required by law or professional ethics that the information be released or if evidence of unreported abuse is offered by my child during treatment. I am aware that specific information pertaining to my child's abusive experience will be obtained from DFCS case records.

I understand that the therapy will consist of six weekly meetings approximately one hour in length at the DFCS office in my child's home county. I also understand that my child will complete questionnaires regarding her perceptions of her fears, anxiety, depression and the abusive experience at three different intervals of time spaced six weeks apart. Also, I know that my child may not qualify for the study if she is not currently experiencing distress and that if she qualifies, her treatment may be postponed for up to twelve weeks. I understand that I will complete one questionnaire concerning my child's behaviors at these same three intervals.

I understand that I will be told the results of the overall research project when it is completed if I so desire. I also understand that I may withdraw my agreement to participate and my agreement for my child to participate at any time without effecting my relationship or services with the Department of Family and Children Services.

There are few risks involved in my participation and my child's participation. Some distress may occur when completing the questionnaires which discuss the abusive event or when my child is asked to discuss feeling sad or anxious in the therapy setting. If such distress occurs, it will be directly dealt with during the group therapy by teaching each participant effective methods of reducing anxiety, muscle tension, and depressed mood. If at the conclusion of treatment, my child is experiencing any difficulties for which psychological intervention is appropriate, I understand that I may be referred to the Psychology Clinic of the University of Georgia. I also understand that if my child's teacher is willing, he or she will complete one questionnaire on my child's behavior at three different time periods but that he or she will not be informed that my child has been sexually abused.

There are several potential benefits from participation in this study. Foremost is the potential for reducing your child's symptoms of depression and/or anxiety which may have resulted from the sexual abuse experience. In addition, the project provides increased awareness of the University of Georgia Psychology Clinic as an agency providing services for affect problems.

All research programs at the University of Georgia which involve human subjects are carried out under the oversight of the Institutional Review Board. Questions or problems regarding these activities should be addressed to Dr. Jean-Pierre Piriou, Associate Vice President for Research, 604-A Graduate Studies Center, University of Georgia (542-5941).

I have been given the right to ask and have had answered any inquiry concerning the foregoing and may do so in the future. Questions, if any, have been answered to my satisfaction. I have read and understand the foregoing.

Date: _____

Child's Name: _____

Relationship to Child: _____

Signed: _____

Please sign both copies. Keep one and return the other to the investigator.

APPENDIX B

Treatment Manual

Session #1

An introduction and "rationale" period is immediately necessary since subjects may be somewhat distressed by not knowing what is meant to occur in the group. The therapist begins by introducing herself to the girls and by explaining that she is a person who has gone to school to study different ways to help people with many types of problems. In particular, she has learned ways to help kids with their problems -- even the kinds of problems which are the most difficult to talk about. At this point, the girls are asked to introduce themselves and to guess at what types of problems the girls in the group might have in common. Having been placed in the treatment groups typically by a CPW who investigated the report of sexual abuse seems to serve as a good indicator (to the subjects) of what the agenda topic will be. Since isolation, loss, detachment, and a sense of being ostracized are frequently noted in the treatment and theory literature (Finkelhor & Browne, 1985), letting each group member acknowledge victimization and hear the commonality of the experience from other members helps with establishment of rapport and empathy.

The therapist also encourages a discussion of "good touching/bad touching" while probing for subjective consequences of bad touching. (In other words, how their experience made them feel.) Since the focus of the groups is on treatment of specific symptoms, it is not deemed

necessary for each girl to "retell" the specifics of her abuse. In fact, some speculation suggests that recalling the event in detail may arouse considerable anxiety and ANS arousal and may thus lead to second-order conditioning, making the group treatment characteristics conditioned stimuli for the unpleasant conditioned response (Kilpatrick et al., 1982, p. 487). Instead, acknowledgment of a common experience and similar reactions are emphasized. The girls are told about "symptoms" frequently reported in studies on abused children with the intention of conveying that such "symptoms" are quite normal and predictable.

This first session ends by having the girls make a verbal group contract to keep all group information confidential. The therapist also explains the limits of confidentiality, particularly in terms of suicidal intentions and court demands.

Session #2

Subjects are taught a progressive muscle relaxation procedure developed for pre-adolescent children. As an introduction to the technique, the girls are asked to identify feelings, thoughts, and reactions associated with being "scared" or "nervous." Examples of situations which produce these reactions are provided and elicited by the subjects to help clarify the concept of "nervous." Reactions provided by subjects are listed on a chalkboard and

the therapist uses this list to verify with each individual that she has experienced some of these symptoms.

The group then is told that they will be taught an "exercise" that will help them deal with being scared or nervous and asked to place their chairs in a position which allows for viewing the therapist while avoiding face-to-face contact with the other subjects. Following instruction of the exercise, which is modeled by the therapist, the subjects are asked to describe personal reactions to the exercise. They are then asked to rehearse the sequence of muscle groups used in the exercise until each girl demonstrates knowing the procedure well enough to do it on her own at home. As a group, the subjects are asked to give the relaxation exercise a title. This is done to provide an easy communication word for future discussion of progressive muscle relaxation. Prior to leaving, the girls are asked to practice the exercise at least once a day for the upcoming week and to select a comfortable location for doing the practice.

Session 3

The purpose of this session is to allow the therapist an opportunity to assess the group's use and practice of the relaxation technique and to encourage discussion of problems encountered, as well as particularly successful experiences with the exercise. The therapist then asks the group to name the muscle groups in order prior to guiding the girls through the exercise for a second time.

In an effort to encourage each girl to use her own knowledge of the skill, this second guided relaxation exercise contains fewer verbal instructions than when initially taught.

Following an assessment of this guided rehearsal, the group discusses situations which make them nervous and methods of "finding a good time" to reduce their anxiety by using the relaxation exercise. This list of situations is to be written on the chalkboard for the educational purpose of exposing the group to a wide array of situations which may be appropriately suited to later using the relaxation technique. At the end of this session, the girls again are asked to practice the exercise at least once a day and more frequently as needed.

Session 4

Assessment and "trouble-shooting" of the girls' use of the relaxation technique is made prior to asking the group to engage in an imagery task requiring that each girl think of a recent situation that made her nervous or scared. The subjects are told to pretend they are experiencing the situation again, and to indicate feeling uncomfortable by raising their hands when the nervous feeling occurs. After all hands have been raised, the group is instructed to do their relaxation exercise. A discussion of thoughts and feelings during both stages of this procedure follows.

Also in this session, the group is asked to think about times when they feel particularly "sad" or "down on themselves and the world." It is then explained to the girls that a good way of dealing with sad feelings is to find an enjoyable activity that they engage in not only when they're feeling sad, but also as a normal part of their weekly routine to help keep them from feeling bad. A list of pleasant activities is developed by letting each group member write a favorite activity on the board. The therapist also participates in this activity in an effort to provide some pleasant activities which can be done in a variety of settings. As homework, the girls are asked to develop their own comprehensive list of pleasant activities as well as continuing practice of their relaxation skills. They are also asked to select three things from their lists to engage in prior to the next session.

Sessions 5

The purpose of this session is to introduce the group to a general strategy of dealing with a variety of settings in which they may find themselves feeling uncomfortable and to present a method of responding if approached by someone who makes them feel nervous. Following a discussion of these potential situations, the steps to "LID" are introduced.

Step one, "Look," emphasizes developing the skill of identifying a safe place to go if a potentially dangerous or abusive situation arises. The skill involves

developing the habit of finding a location to run to if help is needed or if the child feels particularly anxious or unsafe. Once a plan for retreat is established, the child can relax and put the safe place "in the back of her mind." If someone makes the child feel uncomfortable or if a stranger comes within the child's general area, the child is taught to "Ignore" (step two) the individual unless that person comes within close proximity of the child. Important behaviors within this close proximity area include direct advances by the individual, particularly any efforts to corner the child or make suggestions about "bad" touching or leaving the premises together. At this point the child is instructed to follow step three, which is cued by the word "Do." Here the child gets out of arm's reach, looks the individual in the eye, and yells an appropriate message such as "Don't touch me," "Get away from me," "No,", or "Dad, help." Immediately upon saying the message the child should run to her previously selected "safe place."

Each group member during this session is asked to practice doing each step of "LID" following a modeled performance by the therapist. Following each girl's practice, the group provides feedback, and role-plays are repeated as necessary until appropriate acquisition of the skill is demonstrated.

To help reduce any anxiety which this exercise may have aroused in the girls, the group is encouraged to

discuss any feelings or thoughts associated with the role-play experience. They are then instructed to do the muscle relaxation exercise and to note the change from any prior anxiety level to a more relaxed and comfortable state. Pleasant events lists are read by each group member at the close of this session. Homework includes continued relaxation practice and identification of the "safe place" component of the "LID" role-play in a variety of locations throughout the week.

Session 6

The purpose of this final treatment session is to evaluate the group's understanding of the "LID" procedure, to discuss termination issues, and to obtain posttreatment data. Initially, the girls are asked to discuss their homework assignment from the previous session from which a list of settings and their safe places are made. Also, a list of potentially "nervous" interactions where the "LID" procedures might be used is developed.

The therapist then reviews the number and types of skills that the girls have acquired over the last six weeks and provides each member with feedback regarding her participation and contribution to the group. The group is then reminded that the skills they have learned should be used on a continuing basis. A pleasant events list developed by combining members' individual lists of pleasurable activities is distributed. Finally, the posttreatment data are collected on each participant.

APPENDIX C

IRB Letter of Approval

OFFICE OF THE VICE PRESIDENT
FOR RESEARCH

BOYD GRADUATE STUDIES RESEARCH CENTER THE UNIVERSITY OF GEORGIA ATHENS, GEORGIA 30602 (404) 542-3360

April 15, 1987

Ms. Marie M. Burke
Department of Psychology
Psychology Building

Dear Ms. Burke:

Thank you for attending the IRB meeting on March 12 and for providing us with the revised consent form and other additional information for your study, "Short-Term Group Therapy for Sexually Abused Girls: A Learning Theory Based Treatment for Anxiety and Depression." It has now been approved for the use of human subjects for the period April 24, 1987 through April 23, 1988, as requested.

You will need to inform us of any significant changes or additions to your study and obtain approval of them before they are put into effect. If you need additional time to complete the study, you will need to obtain an extension of the approval period before continuing beyond April 23, 1988. It is important to allow at least three weeks for approval of requests for additional time or changes.

Please use the enclosed Status Report Form for requesting approval of changes or an extension of the approval period, or if neither is required, for reporting completion of your study.

Please let us know if we can be of further assistance.

Sincerely,

Jean-Pierre Piriou
Chairman
Institutional Review Board

d
Enclosure: Status Report Form

cc: Dr. Deborah R. Richardson
✓ Dr. Joan L. Jackson