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An Empirical Investigation of Group Treatment for a Clinical Population of Adult Female Incest Survivors.

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This dissertation is dedicated to the memory of my father

Edward Nathan Torontow

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ABSTRACT

Because of the high prevalence of childhood incest in therapy-seeking populations of women, it is important to determine the treatment approaches that are most effective in resolving the negative consequences of this traumatic event. Although there is a general consensus in the clinical literature that a group treatment approach offers unique therapeutic benefits for this population that are not available in individual therapy, there is little empirical evidence to support this contention. The purpose of the present study was to empirically assess the effectiveness of a group treatment program on intrapersonal symptomatology and interpersonal difficulties in a clinical population of women with a history of incest. Subjects for the study were drawn from participants in a group treatment program conducted by a community-based, mental health agency and developed specifically for women with a history of incest. Thirty-two women who participated in the 20-week group treatment program were compared to thirty-one women who were wait-listed for the program for a similar period of time on measures of intrapersonal symptomatology and interpersonal difficulties. In addition, the effects of the group treatment program across time were examined by assessing intrapersonal symptomatology and interpersonal difficulties in group participants six months

following completion of the group treatment program. Results indicate that a time-limited group which focuses on the original trauma is effective in reducing intrapersonal symptomatology for women with a history of incest and that this improvement is stable over time. Although the women who received group treatment felt more support from friends following their experience in the group and appeared to see themselves in a more positive light in their relations with other women over time, interpersonal difficulties, in general, did not show as much improvement as intrapersonal symptomatology. Clinical implications of these findings as well as suggestions for future research are discussed.

An Empirical Investigation of Group Treatment for a Clinical Population of Adult Female Incest Survivors.

The sexual abuse of children by family members, commonly referred to as incest, has only recently been recognized as a serious mental health problem by professionals, both because it is so widespread and because of increasing evidence of its long-term traumatic effects (Herman, Russell, & Trocki, 1986). One large scale random survey indicates that as many as 16% of adult women have experienced some form of intrafamilial sexual abuse before the age of eighteen, with only 2% of cases ever reported to the authorities (Russell, 1983). The result of this situation is that clinicians are increasingly being faced with adult female clients who are disclosing incest for the first time and who are experiencing the devastating negative aftereffects of their childhood experience (Blake-White & Kline, 1985). As clients, these women present a variety of intrapersonal and interpersonal difficulties: depression, guilt, low self-esteem, loneliness and isolation, chronic revictimization, pervasive anger, alcohol and/or drug abuse, psychosomatic ailments, sexual dysfunction, and an inability to trust others and form intimate relationships (Bergart, 1986). Many of these difficulties have been confirmed by empirical studies (e.g., Harter, Alexander, & Neimeyer, 1988; Sedney & Brooks, 1984; Wheeler & Walton, 1987).

Recently, clinicians have been reporting a substantial increase in the number of women seeking help for the aftereffects of incestuous experiences in their childhood (Courtois & Sprei, 1988; Gordon & Alexander, 1993). Because the experience of incest appears to be so prevalent in clinical populations of women (e.g., Courtois, 1988; Gordon & Alexander, 1993; Herman, 1992), it is important for clinicians to be aware of the treatment modalities most effective in resolving the negative consequences of this traumatic event (Alexander, Neimeyer, Follette, Moore, & Harter, 1989). At this point, however, the literature on treatment for adult female survivors of incest represents a typical "first wave" of investigations in that it is descriptive and consists primarily of accounts based on clinical impressions and subjective, informal evaluation rather than on empirical evidence (Courtois, 1988; Zimpfer, 1987). While these accounts provide a wealth of valuable information for clinicians, conclusions regarding the relative effectiveness of different treatment modalities for this population remain tentative.

One popular and promising treatment modality that has emerged in the literature on treatment of adult female incest survivors has been the use of a group treatment approach (e.g., Deighton & McPeek, 1985; Goodman & Nowak-Scibelli, 1985; Gordy, 1983; Herman, 1992; Sprei, 1987). Indeed, there appears to be general agreement in the treatment literature that a group treatment modality has the potential to offer unique therapeutic benefits for adult female survivors that are not available in

individual therapy alone (e.g., Briere, 1989; Courtois, 1988; Herman, 1981, 1992; Herman & Schatzow, 1984). Again, however, these conclusions are based primarily on clinical impression rather than empirical evidence.

To date, only one controlled analogue study has been conducted which empirically examined the efficacy of group treatment for adult female survivors of incest (Alexander, et al., 1989). Although this study found that group treatment was more effective than no treatment in reducing depression and alleviating distress in adult female incest survivors, the study used a nonclinical, volunteer population recruited through media advertisement. Furthermore, one criterion for inclusion in the study was that subjects could not be involved in concurrent individual therapy. Since adult female incest survivors generally begin the process of recovery in individual therapy (Courtois, 1988; Herman, 1992; Lebowitz, Harvey, & Herman, 1993) and enter group treatment at some point during this process (e.g., Briere, 1989; Courtois, 1988; Herman, 1992; Herman & Schatzow, 1984; Meiselman, 1990), the results of the Alexander et al. study (1989) may only be generalizable to nonclinical populations of incest survivors and not to clinical populations.

The purpose of the present study was to empirically assess the efficacy of a group treatment program for a clinical population of adult female incest survivors. The subjects for this study were drawn from participants in a group treatment program conducted by the Family Service Centre of Ottawa-Carleton, a

community-based, mental health agency. The 20-week group treatment program was specifically designed and developed to focus on the original trauma and its effects on adult female incest survivors. The study examined specific changes in both interpersonal and intrapersonal difficulties for group participants and compared these changes to adult female incest survivors who did not participate in the group treatment program. In addition, the effects of group participation over time were examined by assessing intrapersonal and interpersonal difficulties in group participants six months following completion of the group treatment program.

A review of the literature will focus on the prevalence of incest for women in the general population, the long-term impact of incest on the lives of women including factors pertaining to severity of long-term effects, the theoretical formulations currently used to explain this impact, and a review of the literature on group treatment as it relates to this population.

REVIEW OF THE LITERATURE

Definitions of Incest

The terms "incest" and "intrafamilial child sexual abuse" have been used interchangeably in the literature (Seng, 1986). These terms differ from the more general term of "child sexual abuse" in that they refer specifically to an array of sexual activities between a child and an adult or older person (usually by at least 5 years) who is related to the child in some way or who is primarily responsible for the child's nurturance and/or protection. On the other hand, "extrafamilial child sexual abuse" refers to sexual abuse by a perpetrator who is not a member of the child's family or surrogate family who may be known or unknown to the child (Badgley, 1984).

The legal definition of incest in Canada has historically been limited to acts of sexual intercourse between close blood relations:

> "...a person knowing that another is by blood relationship his or her parent, child, brother, half-brother, sister, half-sister, grandparent, or grandchild, has sexual intercourse with that person" (Badgley, 1984, p.314).

However, in defining and treating child victims or adult survivors of incest in clinical settings, it is often necessary to go beyond any legal definition of what activities and/or

degrees of relatedness constitute the act of incest (Courtois, 1988). Indeed many behaviours that do not meet the legal definition of incest are psychologically damaging and thus of interest to both the researcher and the clinician (Shaefer & Evans, 1984). For purposes of the present study, a broad definition of incest adapted from Vander Mey and Neff (1982) was used which includes all forms of sexual contact, sexual exploitation (through pornography or prostitution), and sexual overtures initiated by an adult or older person who is in a position of trust and authority to a child through family ties or surrogate family ties.

Prevalence of Incest

As recently as 1955, the incidence of incest in the general population had been estimated to be as low as one case per million per year in the English speaking population (Weinberg, 1955). Certainly, the long history of secrecy and taboo surrounding the topic of incest (Courtois, 1980) as well as the Freudian/psychoanalytic tradition that attributed most reports of sexual involvement between parent and child to childhood fantasy (Masson, 1984; Rosenfeld, Nadelson, & Krieger, 1979) had helped to maintain the belief by both professionals and laypersons that the incidence of incest in the population was extremely rare. In the past decade, however, all forms of child sexual abuse, including sexual abuse by a family member, have received unprecedented societal acknowledgement and attention.

Championed by the powerful lobby of the Women's Movement

and the Child Welfare Movement, the topic of child sexual abuse has emerged as a public and policy issue (Finkelhor, 1982). Many highly personal accounts of childhood incest have been published (e.g., Allen, 1980; Armstrong, 1978; Brady, 1980; Peterson, 1991) encouraging women to break the silence around their own experiences of incestuous abuse. In addition, laws have recently been enacted that demand mandatory reporting in all cases where sexual abuse of children is suspected (Butler, 1985; Wolfe & Wolfe, 1988). However, although official incident reports of child sexual abuse have mushroomed since the late 1970's, (Finkelhor, 1987) the problem is almost universally conceded to be far greater than statistics on reported cases indicate (Finkelhor, 1982; Russell, 1986).

Since 1979, several major national and community surveys have been conducted to determine prevalence rates (the proportion of the population affected) of child sexual abuse in Canada and the United States; from these studies, estimates of the prevalence of child sexual abuse by family members in the population have been directly or indirectly obtained. Several of these studies are detailed below.

Finkelhor (1979) conducted one of the first prevalence studies of childhood sexual abuse using a retrospective survey of 796 New England-area college students. Detailed anonymous questionnaires were presented to the students in class with a return rate of 90%. Although the study did not focus on incest per se, results extracted from the data collected indicated that

approximately 10% of females in the study acknowledged that they had been sexually abused by an older relative (cf. Russell, 1986, p.65). When sibling and same age-peer relations and both wanted and unwanted acts were included, this figure increased to 28%. Furthermore, over 1% of the females in this study had experienced incestuous abuse by a father or stepfather. For this study, Finkelhor used a broad definition of incest which included contact as well as non-contact experiences, such as "an invitation to do something sexual" (p.178). Relatives included all step-relations as well as cousins and in-laws.

A seminal study which examined both intrafamilial and extrafamilial child sexual abuse was conducted by Russell in 1983. This study used a random probability sample of women over the age of eighteen drawn from all women living in the San Francisco Bay area. All women were personally interviewed about their childhood sexual experiences by an extensively trained staff of women with a response rate of 54%. Intrafamilial child sexual abuse was defined as "any kind of exploitive sexual contact that occurred between relatives no matter how distant the relationship, before the victim turned eighteen years old" (p.136). Experiences with a relative that were wanted and with a peer less than five years older that were viewed as nonexploitive were not included. Results from Russell's (1983) study indicated that 16% of the sample of 930 women reported at least one experience of incestuous abuse before the age of eighteen years; 12% had been sexually abused by a relative before the age of

fourteen. Furthermore, 4.5% of the total sample had been sexually abused by their biological father, stepfather, adoptive father or other father figure.

In 1983, a comprehensive survey was authorized by the Canadian Government to examine the prevalence of sexual assault among Canadian men and women (Badgley, 1984). A stratified probability sample of 2,135 men and women over eighteen was drawn from across the country and subjects were asked to complete a hand-delivered, anonymous questionnaire with a response rate of 94%. Although the survey was concerned with sexual assault against both children and adults, results were reported in such a way that it was possible to isolate sexual abuse incidents against children (under age 15) by those who were related or responsible for them although it was not possible to separate results for men and women. Results from this survey indicated that approximately 24% of the sample of both men and women had had an unwanted sexual experience of some kind with a blood relative (classified as incest); a foster-father, step-father, legal guardian, or employer if the child was under 21 (classified as guardianship position); or other family member not blood related (i.e., all adoptive, foster, or step-relations, excluding step- or foster father, P.217).

Finally, a national survey of 2,626 men and women 18 years of age or older was conducted by Finkelhor, Hotaling, Lewis, & Smith (1990). The sampling frame included all residential telephones in the United States, including the states of Alaska and Hawaii.

Phone numbers were randomly generated by computer and the refusal rate by those contacted for the interview was 24%. The definition of sexual abuse was broad-based and included any behaviour that the respondent would now consider as sexually abusive including touching, grabbing, kissing, being used for pornographic purposes, oral or anal sex, and intercourse or attempted intercourse by another person (unspecified age) while the respondent was 18 years of age or less. Results were reported so that information regarding incestuous experiences for women could be extracted. Finkelhor et al. (1990) found that 28% of the 1,481 women interviewed in this survey reported a history of sexual abuse. Of these women, 21% were sexually abused by a stranger while 79% were abused by a family member or someone known to them indicating a prevalence rate for incest of 22%. In addition, 98% of the perpetrators were male, and 6% were fathers or father-figures.

Although the above prevalence rates of child sexual abuse by a family member vary to some extent, these discrepancies can be attributed to differences in the definition of incest used, the composition of the sample, the response rate, and the technique of data collection (Painter, 1986; Peters, Wyatt, & Finkelhor, 1986). For example, it is possible that victims of sexual abuse may be underrepresented in college samples because the impact of the abuse often interferes with an individual's educational attainment (Peters, Wyatt, & Finkelhor, 1986). Or sexual abuse survivors may screen themselves out of personal interview surveys

because of the shame associated with the abuse resulting in a lowered prevalence rates when using this type of data collection methodology (Russell, 1983).

Despite the variations in prevalence figures found with different methodologies, overall results of the above surveys suggest that sexual abuse by someone known and trusted by a child is a significant problem in both Canada and the United States. In addition, similar prevalence rates have been found in samples drawn from other countries indicating that incest is not only a North American phenomenon (e.g., Anderson, Martin, Mullen, Romans, & Herbison, 1993). Although both male and female children are affected, it has been found that, in general, females are 2-3 times more likely to be victimized than males (Finkelhor, 1979, 1984). In a thorough review of the available retrospective surveys of childhood sexual abuse, Russell (1986) concluded that approximately one in six female children had experienced incestuous abuse before the age of eighteen and that approximately one in eight had been so abused before the age of fourteen (p. 74).

Impact of Incest

Long-Term Effects

At this time, no longitudinal prospective studies on the long-term effects of incest in identified child victims have been conducted (Herman, Russell, & Trocki, 1987). Information regarding the long-term effects of incest has been derived primarily from studies of adult women whose experiences of

childhood incest occurred anywhere from 5 to 25 years previously (Browne & Finkelhor, 1986). Although it is unknown what proportion of incest victims in the population recover well and what proportion go on to develop later difficulties, overall results from both clinical and nonclinical studies indicate that many incestuously abused children do have a broad range of effects over time (Herman, Russell, & Trocki, 1986). Indeed, studies of several adult female clinical populations have found that a high percentage of female psychiatric patients (Beck & Van der Kolk, 1987; Bryer, Nelson, Miller, & Krol, 1987), multiple (Kluft, 1987; Sachs, Goodwin, & Braun, 1986; Saltman & Solomon, 1982) and borderline (Gartner & Gartner, 1988; Herman, 1986; Lobel, 1992; Stone, 1981) personality disorders, prostitutes (James & Meyerding, 1977), and battered women (Walker, 1978) have a history of incestuous abuse.

The majority of studies that have looked at the impact of childhood sexual abuse on adult functioning have not differentiated between intrafamilial and extrafamilial childhood sexual abuse (e.g., Briere & Runtz, 1988; Elliott & Briere, 1992; Fromuth, 1986; Kilpatrick, 1986). This is unfortunate because many studies do report that the relationship of the perpetrator to the victim is a critical factor effecting the severity of the trauma (e.g., Feinhauer, 1989; Finkelhor, 1979; Russell, 1986; Wyatt & Newcomb, 1990) and several studies have found that intrafamilial child sexual abuse is related to more psychological difficulties in adulthood than extrafamilial abuse (Hartman,

Finn, & Leon, 1987; Sedney & Brooks, 1984).

The several studies that have looked specifically at the impact of childhood incest on later adult functioning are of three types: (1) descriptive case studies and clinical accounts of women in treatment for incest, (2) empirical studies of clinical populations that compare women with a history of incest to women without a history of incest, and (3) empirical studies of nonclinical populations that compare women with a history of incest to women without a history of incest. Clinical studies refer to studies in which subjects are drawn from some type of mental health setting while nonclinical studies refer to studies in which subjects are drawn from random representative surveys or from specific group (i.e., college students) or solicited through other means but who are not obtained from a mental health setting.

Case studies and clinical accounts that have attempted to delineate the range of possible outcomes of childhood incest from women in treatment for incest have relied on descriptions of the problems most commonly faced by these women either in individual or group treatment (e.g., Rivera, 1988; Tsai & Wagner, 1978). As is usual in case study reports which use no control group, a causal relation between incestuous abuse and adult difficulties cannot be made. However, although caution must be used in interpreting findings based solely on clinical description and/or untested clinical assumptions, these studies provide valuable insight into the clinical picture presented by many adult

survivors of incest.

Problems most commonly reported in these studies include low self-esteem and feelings of worthlessness (Deighton & McPeek, 1985); depression, guilt, and self-blame (Shapiro, 1987; Tsai & Wagner, 1979); problems of trust, intimacy, and inability to develop satisfying relationships with others (Courtois & Watts, 1982); difficulties in relating to the family-of-origin (Deighton & McPeek, 1985; Tsai & Wagner, 1978) sexual difficulties (Maltz, 1988; Maltz & Holman, 1987; Rowe & Savage, 1988; Tsai & Wagner, 1979); confusion, recurrent nightmares, flashbacks, and anxiety attacks (Ellenson, 1985; Gelinas, 1983; Lindberg & Distad, 1985); drug and/or alcohol abuse (Deighton & McPeek, 1985); and feelings of intense isolation and shame (Blake-White & Kline, 1985).

The few empirically-based clinical studies that have compared women with and without a history of incest have generally confirmed the descriptive literature above. For example, a study by Wheeler and Walton (1987) found that female psychotherapy patients with a history of incest had significantly higher ratings for anxiety, depression, somatic complaints, alcohol abuse, and psychotic thinking than a control group of psychotherapy patients with no history of incest. Meiselman (1981) reported that 87% of her sample of therapy patients with a history of incest were classified as having a serious problem with sexual adjustment compared to 20% of the comparison group (women in therapy at the same clinic with no history of sexual abuse), although her groups did not differ on depression. This

study also found that 64% of the incest group complained of conflict with or fear of their husbands or sex partners compared to 40% of the control group.

Langemade (1983) compared a group of women in therapy who had been incest victims with a matched control group of nonvictimized women and found that the incest victims were more sexually anxious, experienced more sexual guilt, and reported greater dissatisfaction with their sexual relationships than the controls. More recently, Hartman, Finn, and Leon (1987) compared women in therapy with a history of intrafamilial sexual abuse to those with a history of extrafamilial abuse and found that those with a history of incest reported higher current levels of anxiety and depression about the abuse. In addition, those in the incest group were more likely to report a greater history of inpatient psychiatric hospitalizations, suicide attempts, and subsequent revictimization than those in the extrafamilial sexual abuse group. Hartman et al. (1987) have suggested that findings from this study indicate that the sexual abuse in itself may be an insufficient explanation for the long-term negative sequelae of incest. They suggest that it is the unhealthy dynamics present in incest families which may prevent these children from recovering a sense of competence and worthiness disrupted by the abuse resulting in a much greater risk for subsequent exploitation by others as well as a greater risk for a multitude of psychological difficulties.

Empirically-based, nonclinical studies have also confirmed

many of the negative long-term effects of incest found in the clinical population. For example, when Russell (1986) examined the effects of incest on women in her community-based survey, she found that those experiencing incest scored significantly higher on a negative life experience scale (repeated sexual assault, marital abuse, separation or divorce, downward mobility, early motherhood, and motherhood without marriage) than nonvictim controls. In addition, incest victims who perceived their incest experience as more traumatic had significantly higher negative life experience scores than those that perceived their experience as less traumatic. Sedney and Brooks (1984) found that victims of incest from a college sample had significantly higher levels of nervousness and anxiety, depression, sleep disturbances, emotional problems, repeated victimization, and thoughts of hurting oneself than a control group from the same population. Interestingly, those that experienced extrafamilial abuse in this study differed from controls only in the area of reporting more nightmares and repeated victimization.

More recently, a study by Harter, Alexander, and Neimeyer (1988) compared a group of college women with a history of incest to a control group with no history on measures of social cognitions and social adjustment. These authors found that female incest survivors had a significantly higher perception of social isolation and poorer social adjustment than nonincest controls. Finally, in a well-controlled study using both clinical and nonclinical control groups, Lundberg-Love and her

colleagues (Lundberg-Love, Marmion, Ford, Geffner, & Peacock, 1992) found that women with a history of incest entering treatment had significantly higher levels of psychological distress and symptomatology than women in treatment who reported no history of sexual abuse or women not in psychological treatment. Women with a history of incest reported that they were significantly more depressed, felt more isolated, inhibited, socially introverted and more interpersonally sensitive than the other groups studied.

In summary, although a definitive causal relationship between childhood incest and later adult difficulties cannot be established using current cross-sectional research methodologies (Briere, 1992), there is an accumulation of positive findings in the literature to suggest that childhood incest may have a variety of negative long-term effects in adulthood. Moreover, although caution must be exercised in generalizing findings from clinical studies of long-term effects to the population of incest survivors at large, it appears that the use of clinical samples is well justified. For example, a study by Herman, Russell, and Trocki (1986) found that fewer than half of the adult women with a history of incest in a nonclinical survey (Russell, 1986) reported that they had recovered well from their experience. Furthermore, Herman et al. (1986) have suggested that results from Russell's (1986) study are overly optimistic in that the survey did not include women who were so severely traumatized that they were unable to function independently in the community,

or women with a history of incest who refused to participate in the original survey. Indeed, Herman et al. (1986) found that women in the original survey who had suffered forceful, prolonged, or highly intrusive sexual abuse, or who had been abused by their father or stepfather, reported long-lasting negative effects similar to a clinical sample of women with a history of incestuous abuse. Overall, the most consistent findings in the available literature appear to be that women with a history of incest frequently manifest depression, negative self-concept, guilt, shame, anxiety, somatic complaints, feelings of isolation, sexual difficulties, suicidal ideation, pervasive anger, problems with intimacy and trust, and self-destructive behaviours including drug and alcohol abuse (Browne & Finkelhor, 1986; Courtois, 1988; Green, 1993). Clearly, there is an indication that methods used to help these women recover from the prolonged effects of their childhood experiences of incest warrant further study.

Factors Affecting the Severity of Trauma

Given the potential that child sexual abuse, including incest, has for a variety of long-term negative effects in adulthood (Browne & Finkelhor, 1986; Green 1993), several researchers have begun to systematically examine variables which contribute to the severity of trauma experienced by this population. Areas most commonly examined relate to objective aspects of the sexual abuse situation and include age of the victim, frequency and duration of the abuse, the use of force,

type of sexual act, and degree of relatedness of the perpetrator. Groth (1978), on the basis of his clinical experience, hypothesized that the greatest trauma would occur in cases that continued for a longer period of time, occurred with a more closely related person, involved penetration, and was accompanied by aggression. Unfortunately, only a few studies have had enough cases or have been sophisticated enough statistically or methodologically to look at these hypotheses empirically (Browne & Finkelhor, 1986).

In one early study which attempted to address the nature of the variables contributing to the severity of trauma experienced, Tsai, Feldman-Summers, and Edgar (1979) compared three groups of women: sexual abuse victims seeking therapy (clinical group), sexual abuse victims who considered themselves well-adjusted and had never sought therapy (nonclinical group), and a nonvictimized control group. The results of this study found that the clinical group of women with a history of incest differed from the nonclinical group on several variables. Besides being significantly less well-adjusted than the nonclinical group on measures of the MMPI, the women in the clinical group reported that sexual molestation began at a later age (over 12 years) and occurred at both a higher frequency and for a longer duration than the nonclinical group. Browne and Finkelhor (1986) have pointed out that these results are questionable since the researchers had assumed that, because the women were in therapy, they were more severely affected by the sexual molestation than

the nonclinical group. However, in a volunteer sample of women with a history of incest, Courtois (1979) found that women seeking therapy do indeed report that they are more severely traumatized by the incest than women who do not seek therapy.

More recently, Finkelhor (1979), in a large retrospective survey of college students, asked those who reported any kind of childhood sexual abuse to rate how traumatic they thought the abuse was "in retrospect". When statistically correlated with historical information about the abuse situation, this study found no association between duration of the abuse, age of onset, or type of sexual activity, and degree of trauma. However, Finkelhor cautioned that the question regarding current trauma ("In retrospect, would you say this experience was positive? mostly positive? neutral? mostly negative? or negative?") may have been ambiguous in that "in retrospect" may have been interpreted to mean, "How did you feel about the experience <u>at the time it happened?</u>" [italics theirs] rather than "How do you feel about the experience looking back on things past from the perspective of the present" (p.98). Nonetheless, Finkelhor did find that abuse by a father or stepfather was significantly more traumatic for victims than all other abuse occurring either inside or outside the family. Furthermore, when all of the factors were put into a regression analysis, the use of force by the perpetrator explained more of the negative effects than any other factor.

Russell (1986) analyzed both the histories and self-report

measures of current trauma for 152 women with a history of incest drawn from a large nonclinical probability survey. The self-report measure of current trauma consisted of two multiple choice questions: (1) "Overall, how upset were you by this experience - extremely upset, very upset, somewhat upset, not very upset, not at all upset?", (2) Looking back on it now, how much effect would you say this experience has had on your life - a <u>great</u> effect, <u>some</u> effect, a <u>little</u> effect, or <u>no</u> effect?" [italics theirs].

In this study, Russell found that abuse by a father or stepfather was significantly more traumatic than from other family members supporting Finkelhor's (1979) finding. Unlike Finkelhor, however, Russell found that women who experienced incest of a longer duration were self-rated as suffering more severe trauma compared to those experiencing incest of a shorter duration or those experiencing a one-time occurrence of incest. In addition, this study found that the type of sexual activity and degree of force used was related to the degree of trauma experienced. Women reporting more severe types of sexual abuse (completed or attempted intercourse, fellatio, cunnilingus, anilingus, or anal intercourse) were significantly more traumatized compared to those reporting less serious types of sexual abuse (manual touching of unclothed breasts or genitals, unwanted kissing, or touching of clothed parts of the body). Furthermore, those who experienced physical force or violence rated themselves as significantly more traumatized compared to those who did not experience such force, in agreement with

Finkelhor's (1979) findings. Russell, in contrast to Tsai et al. (1979) but in agreement with Finkelhor (1979), found that age of onset of the abuse had little relationship to the severity of trauma experience although there was a nonsignificant trend towards a younger as opposed to older age. However, a study by Courtois (1979) found that younger victims may indeed have more severe reactions involving personal identity and relations to men in particular and to overall impact in general. Interestingly, Courtois' sample of adult incest survivors also reported less trauma with experiences of longer duration in contrast to the findings of Russell (1986), Finkelhor (1979), and Tsai et al. (1979).

A more recent study by Wyatt and Newcomb (1990) using a path-analysis approach found that long-term negative outcomes of abuse were directly affected by a close relationship to the perpetrator confirming Russell (1986) and Finkelhor's (1979) findings. These authors also found that a composite factor labelled "severity of the abuse" was directly related to negative outcome. This factor included number and type of abuse incidents as well as the use of physical coercion. Unfortunately, the use of a composite factor for "severity of abuse" limits the interpretation of these findings.

Finally, a study by Williams (1993) examined the self-reports of 531 self-identified survivors of child sexual abuse and related variables of the abuse situation to current impact. Subjects for this study were recruited through public

advertisements and from mental health settings. Five thousand questionnaires were distributed with a return rate of 10%. Interestingly, this study found that the cognitive appraisal of the traumatic event was the major determinant of subsequent adjustment or maladjustment accounting for more variance than such factors as type of abuse, use of force, or number of perpetrators although these factors were significant in the regression analysis. However, duration of abuse and age-of-onset did not appear related to severity of impact in this study. Williams (1993) cautioned that the results of this study may have been biased in that the majority of subjects that returned the questionnaires were well educated and were involved in therapy which may have made them more aware of the impact of abuse on their lives as well as willing to respond to the survey.

As can be seen from the above discussion, many difficulties exist in research that attempts to relate characteristics of the incest situation to severity of trauma experienced in adulthood. One problem is that the interrelatedness of the characteristics of the abuse may make an examination of any one particular characteristic nearly impossible (Haugaard & Reppucci, 1988). For instance, one might suspect that adult survivors who had experienced sexual abuse which involved intercourse to be more severely traumatized than those who had experienced only fondling. However, reports from the clinical literature indicate that, in incest, the sexual activities generally progress over time from fondling to mutual

masturbation to sexual intercourse and other more severe forms of sexual abuse (Russell, 1986). Consequently, one would probably find that, on the average, those who experienced intercourse had been abused over a longer period of time than those who did not experience intercourse, making the relative contribution of each of these factors difficult to determine. Furthermore, the method by which severity of trauma is measured has been highly subjective in nature, making comparisons between studies extremely difficult (Haugaard & Reppucci, 1988). Finally, the severity of trauma experienced by adult survivors is also a function of a multitude of mediating factors such as the amount of social support perceived and received from society, friends, or family members (Wyatt & Newcomb, 1990) as well as other individual, environmental, and demographic factors (Green, Wilson, & Lindy, 1985; Newberger & De Vos, 1988; Valentine & Feinauer, 1993).

In summary, although the data base for drawing conclusions regarding the variables that contribute differentially to the severity of trauma experienced in adult survivors is still relatively small and fraught with difficulties, some tentative remarks can be made. It appears that individuals who experience childhood sexual abuse show more symptoms in the long-term when the abuse involves fathers or stepfathers, involves more severe forms of sexual abuse, continues over a longer period of time, and/or involves physical force or violence (Finkelhor, 1987; Russell, 1986). How or

whether these variables interact in an additive fashion is as yet unknown. In addition, it is unknown to what degree variables such as the child's premorbid personality, family dysfunction, amount of social support, and other life stressors contribute to the degree of severity experienced in adulthood (Browne & Finkelhor, 1986) although some studies have begun to examine these factors. For example, Gold (1986) found that the adult victim's perceptions of the mother's response to the sexual abuse was significantly related to adult functioning and Harter et al. (1988), Fromuth (1986) and Nash, Hulsey, Sexton, Harralson, and Lambert (1993) found that family characteristics were more predictive of difficulties in adulthood than the abuse per se. However, one recent study (Edwards & Alexander, 1992) which used multiple regression analyses in which sexual abuse variables and family variables were entered simultaneously to predict current impact found that parental conflict, paternal dominance, and sexual abuse made independent contributions to subjects' psychosocial adjustment supporting the importance of both family factors and sexual abuse factors in the long-term adjustment of victims of sexual abuse. In conclusion, it is apparent from the tentative findings above that researchers and clinicians cannot automatically assume severity of impact based upon certain characteristics of the incest experience alone and that those involved in treating adult survivors of incest must respond and support the unique needs of each individual who seeks treatment regardless of the objective aspects of the abuse situation

(Courtois, 1988).

Theoretical Formulations of the Long-Term Effects of Incest

The majority of both clinical accounts and empirical research strongly suggests that incest that occurs in childhood can have far-reaching and sometimes devastating effects on adult functioning. However, theoretical models which attempt to conceptualize the mechanisms by which childhood incest impacts on adult functioning are few. Although the present research is not designed to test theoretical formulations of the long-term effects of incest, the following section will review two models that have been frequently proposed to explain these effects.

Several researchers have proposed that the sequelae of childhood incest can best be understood within the framework of a post-traumatic stress disorder (PTSD) model (e.g., Donaldson & Garner, 1985; Goodwin, 1985; Herman, 1992; Herman, Russell, & Trocki, 1986; Lindberg & Distad, 1985). These researchers have noted that many clinical descriptions of adult patients with a history of childhood sexual abuse are consistent with the diagnostic criteria for PTSD as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R: APA, 1987). Initially, PTSD was acknowledged as a clinical entity associated exclusively with adult responses to the stress of war or natural or accidental catastrophes (Trimble, 1985). Recently, however, the concept has been extended to include victims of childhood sexual abuse and has been applied to both children and adults (Eth & Pynoos, 1985; Finkelhor, 1987).

Generally, the PTSD diagnostic formulation is characterized by four main components (Figley, 1985). First, it identifies the existence of a recognizable stressor that would evoke significant symptoms of distress in almost anyone. Second, it recognizes that the trauma may be reexperienced either through recurrent intrusive recollections, dreams, or sudden feelings that the trauma were reoccurring because of an association with an environmental or ideational stimulus. Third, it recognizes the occurrence of a numbing of responsiveness to or reduced involvement with one's environment marked by diminished interest in one or more significant activities, feelings of detachment, and/or constricted affect. Finally, it postulates the occurrence of at least two of the following: hyperalertness, sleep disturbance, survival guilt, memory impairment or trouble concentrating, avoidance of activities because they trigger memories of the event, and intensification of symptoms when events similar to the stressful event occur.

More recently, Herman (1992) has suggested that the diagnostic indicators of PTSD as presently defined by the DSM-III-R (1987) are not comprehensive enough to include survivors of prolonged, repeated trauma, such as survivors of childhood incest, since the defining criteria were based on survivors of circumscribed traumatic events. She suggests the need for a new and expanded diagnostic formulation which goes beyond PTSD as it is currently presented in the DSM-III-R (APA, 1987). Herman (1992) has labelled this new formulation as "complex post-

traumatic stress disorder", in which the stressor would be "a history of subjection to totalitarian control over a prolonged period (months to years)" (Herman, 1992, p.121). Criteria would include alterations in affect regulation, alterations in consciousness, alterations in the perception of self and the perpetrator, alterations in relations with others, and alterations in one's systems of meaning. The symptoms of PTSD as currently defined by the DSM-III-R (APA, 1987) would be included within the above criteria.

Horowitz (1976, 1979) has attempted to explain the intrusive/avoidance symptoms commonly seen in PTSD by integrating psychoanalytic theories of repetition-compulsion with modern cognitive theories of information processing. Although this model has been applied to a variety of traumatic life events, it has also been used to explain PTSD symptoms in incest victims (e.g., Goodwin, 1985; Haugaard & Reppucci, 1988). Horowitz postulates that human cognition has an innate "completion tendency" wherein stressful traumatic experiences are repeatedly worked through until they can be fit into a person's model of self and the world. When a traumatic event such as incest occurs, painful memories of the event tend to remain active and may intrude in the form of flashbacks, recurrent nightmares, and/or intrusive repetitions of the event. The distressing nature of these memories often causes the individual to attempt to reduce their occurrence by withdrawing from the world, especially those parts of the world that might evoke the painful

memories. These attempts to shield oneself from the intrusive thoughts result in decreased involvement with the environment, dissociative episodes, and/or numbing of affect. Furthermore, until the traumatic event is fully mastered, the intrusive and avoidant symptoms continue to recur in a cyclic pattern which may be intense enough to disrupt normal functioning.

The PTSD conceptualization of the effects of childhood incest has definite advantages in that it provides a clear label and description of some of the acute and delayed reactions to childhood incest (intrusive imagery, nightmares, flashbacks, and the numbing of affect etc.). However, this model has been criticized by Finkelhor (1987) on several points. First, he argues that the PTSD model does not account for symptoms which are commonly observed in many incest victims but which fall outside the parameters of a PTSD diagnosis such as substance abuse, suicidality, or chronic revictimization, although other authors have suggested that these may indeed be secondary elaborations of the core symptoms of the PTSD syndrome (e.g., Courtois, 1988; Gelinas, 1983). Second, he suggests that the PTSD model locates almost all of the symptoms in the affective realm and does not take into account cognitive disturbances such as distorted beliefs about the self and others, self-blame, guilt, low self-esteem, pervasive anger, or feelings of worthlessness. Finally, Finkelhor criticizes the model in that it does not sufficiently reveal the process by which the dynamics of the sexual abuse lead to the various symptoms noted.

Recently, Finkelhor and Browne (1985) have proposed a process model of the dynamics involved in childhood sexual abuse that may account for its impact on the individual. This model is an eclectic but comprehensive model that suggests a variety of dynamics which give rise to a variety of different symptoms and can be applied to either the child victim or adult survivor of incest. Although the model incorporates some elements of the PTSD model, it is also broad enough to account for symptoms which do not fall within the parameter of PTSD model as defined by the DSM-III-R (APA, 1987).

In their model, Finkelhor and Browne have analyzed the experience of intrafamilial sexual abuse in terms of four traumagenic dynamics: traumatic sexualization, betrayal, powerlessness, and stigmatization. According to these authors, the conjunction of these four dynamics in one set of circumstances - incest - distorts the child's cognitive and emotional orientation to the world and may result in some of the behavioural, emotional, and interpersonal sequelae that are commonly noted in victims of incest. For example, the traumatic sexualization dynamic refers to the fact that the child's sexuality is shaped in an inappropriate and dysfunctional fashion. The child is often rewarded by attention or affection for sexual behaviour inappropriate to his/her level of development and understanding and thus may learn to use his/her own sexuality to manipulate others to satisfy developmentally appropriate needs. This may result in sexualized behaviour in

the child as well as sexual problems in adulthood including promiscuity or phobic avoidance of sex, difficulties with physiological sexual functioning, and the inability to differentiate sex from affection.

Similarly, the dynamic of betrayal by someone whom the child is virtually dependent upon, trusts, and loves, may manifest itself in grief reactions and depression over the loss of that trusted figure as well as a distrust of others and an aversion to intimate relationships. The sense of betrayal may also extend to nonoffending family members who were unknowing or unable to protect the child from harm. This same dynamic may show up throughout life in the form of a desperate search for a redeeming relationship or in impaired judgment about the trustworthiness of other people leading to increased vulnerability to further physical, psychological, and/or sexual abuse. On the other hand, continued anger and hostility at the betrayer may lead to pervasive anger in all relationships or may be turned inward resulting in chronic depression and/or self-destructive behaviours.

The powerlessness dynamic refers to the process whereby the child's will, desires, and sense of efficacy are continually contravened. The child feels fearful and trapped in a situation that he/she does not understand and cannot escape from. One consequence of this is an excessively fearful and anxious child who may manifest many of the PTSD symptoms experienced by victims such as nightmares, phobias, hypervigilance, dissociation, sleep

problems, and somatic complaints that can become chronic or reappear in later life in a delayed fashion. Secondly, having been continually frustrated in any attempts to protect themselves, victims often have a low sense of efficacy which may later translate into low self-esteem, feelings of worthlessness, chronic revictimization, and more generalized despair and depression. Finally, the dynamic of powerlessness may produce a compensatory reaction which is an unusual need by the victim to control or dominate other people or situations in order to regain a sense of power. The effect of this dynamic is most damaging in that it may account for those victims who later become abusers as a compensation for past powerlessness.

The final dynamic of stigmatization refers to the sense of badness, shame, and guilt that is communicated to the child around the experience of incest and becomes incorporated into the child's self-image and identity. This may come from the abuser who blames the child for initiating the activity in some way (which the child may have done in order to receive affection or attention) or the pressure of secrecy which also conveys a message to the child that somehow he/she is involved in something shameful. These feelings are exacerbated in the event of disclosure since the child envisions that it is his/her fault for disrupting the family. Furthermore, the incest experience may lead the child to believe that he/she is different based on the belief that no one else has had such an experience and that others would reject a person who had. This may lead to isolation

and alienation and the victim may gravitate to stigmatized levels of society such as prostitution or substance abuse, or engage in self-destructive behaviours including suicide.

Although Finkelhor and Browne's (1985) model is at a very high level of generality regarding the behavioural, emotional, and interpersonal sequelae of incest, clinicians have found that many of the above issues do present consistently when treating adult female survivors of childhood incest (e.g., Courtois, 1988; Meiselman, 1990; Tsai & Wagner, 1979). A pilot study of Finkelhor and Browne's model (Hazzard, 1993) was recently conducted which attempted to test its validity. For this study, a 56-item measure of trauma-related beliefs was developed to assess the four traumagenic dynamics outlined by Finkelhor and Browne (1985); traumatic sexualization, betrayal, powerlessness, and stigmatization. The measure was then used to predict outcomes on psychological/behavioural measures in 59 women who had experienced incest in childhood. Multiple regression analyses found that stigmatization beliefs predicted low self-esteem, interpersonal problems, depression, anxiety, and overall psychological distress; betrayal beliefs predicted interpersonal problems, lack of control, and sexual problems although it did not predict depression as hypothesized by Finkelhor and Browne (1985); powerlessness beliefs predicted low self-esteem and depression; and traumatic sexualization beliefs predicted anxiety and sexual avoidance. The findings suggested that the four traumagenic dynamics do give rise to a multiplicity of negative

consequences but that these consequences are also multiply determined.

Although the above two models appear to be useful for understanding the symptoms and difficulties experienced by adults with a history of incest, other models have been suggested (e.g., Hartman & Burgess, 1993; Janoff-Bulman & Frieze, 1983; Murdy, 1986; Newberger & De Vos, 1988; Putnam & Trickett, 1992; Summit, 1983; Young, 1992) indicating that child sexual abuse is a complex phenomenon that may elude one definitive explanation of its long-term consequences. While each theory contributes further to an understanding of the multiple and varied effects of child sexual abuse, it is doubtful that any one theory will adequately explain the consequences to all victims (Haugaard & Reppucci, 1988). Although theoretical formulations of long-term effects of incest are necessary for understanding and predicting possible outcomes of childhood sexual abuse, it is perhaps most useful at this point for mental health professionals to accept the variety of ways that individuals can be affected so that treatment programs can be designed which are comprehensive enough to meet the varied needs of this population (Courtois, 1988; Haugaard & Reppucci, 1988; Lebowitz, Harvey, & Herman, 1993).

Adult Female Incest Survivors and Treatment

Clearly there is evidence that many incest victims exhibit emotional and behavioural symptoms as adults that may be serious enough to bring them into treatment. The proportion of the adult incest population seeking treatment is, at present, unknown

(Herman, Russell, & Trocki, 1986). However, Briere and Runtz (1988) and others (e.g., Courtois, 1988; Gordon & Alexander, 1993) have noted that there is an over-representation of sexual abuse victims in therapy-seeking groups of women.

Several researchers have noted that the majority of women who have experienced childhood incest present for treatment for problems other than the incest per se (e.g., Faria & Belohlavek, 1984; Gelinas, 1983). In one study, Briere & Runtz (1988) found that only 39% of women who ultimately revealed that they had been sexually abused in childhood referred to the sexual abuse when describing their presenting problems. Cole (1985) has suggested that many a "difficult client" has kept her incest experience a major secret from everyone in her life including her therapist. Furthermore, those who seek help for other problems are often unaware that they have been victims of incest because of amnesia for abuse-related memories (Briere & Conte, 1993; Faria & Belohlavek, 1984; Herman & Schatzow, 1987). In most instances, the problem of incest may be completely overlooked unless the therapist is alert to signs which suggest a previous incest experience and is willing to raise the issue with the client (Faria & Belohlavek, 1984). Indeed, Courtois (1988) and others (e.g., Mennen, 1992) have suggested that all therapy clients should be asked about childhood sexual experiences as part of routine intake procedures.

Both Gelinas (1983) and Ellenson (1986) have outlined certain "indicators" that may help therapists detect a masked

history of incest in female patients. Gelinas (1983) has suggested that incest clients often enter treatment with a "disguised presentation" consisting of a characterological depression with compulsive and dissociative elements. She notes that if this presentation is made the focus of treatment, therapy tends to be relatively unsuccessful and the client is at risk for becoming a repetitive treatment seeker with a life course increasingly impaired by the incest. Ellenson (1986), after interviewing over sixty female patients with a history of incest, found that all, with one exception, had certain perceptual (illusions: visual, auditory, and tactile hallucinations) and thought content (persistent phobias, recurring nightmares, frequent dissociations, and large gaps in childhood memory) disturbances which could be used to predict a history of incest. Other researchers have suggested that incest victims are likely to have symptoms similar to those that are diagnosed with PTSD (e.g., Blake-White & Kline, 1985; Lindberg & Distad, 1985) which include such symptoms as numbing of affect, hypervigilance, flashbacks, nightmares, and dissociative episodes.

It is not surprising that many of the above symptoms in clients with a history of incest can often lead to multiple and erroneous diagnoses and it is expected that, in the past, this was largely the case (Ellenson, 1986). The most common of these misdiagnoses have been borderline personality disorder, latent schizophrenia, paranoid schizophrenia, and bipolar affective disorder (Haskell, 1988). Often the misdiagnosed client with a

masked history of incest will receive treatment that is inappropriate to the actual psychological difficulties as well as prognoses that are not as hopeful as a more informed and accurate evaluation would have indicated. Recently, however, it has been found that clients with a history of incest have a greater readiness to disclose as a result of more public and media information about incest (Josephson & Fong-Beyette, 1987). In addition, mental health professionals are gradually becoming more aware of the prevalence of incest in the population and are using this knowledge to inquire about childhood sexual abuse in their patients. Consequently, many clinicians have reported a substantial increase in the number of women who require treatment for the aftereffects of their incest experiences (Courtois & Sprei, 1988).[1]

Courtois (1988) has discussed the philosophy of treatment for this population that incorporates and integrates ideas from feminist theory, traumatic stress theory, self-developmental theory and loss theory. She suggests that the above four theoretical frameworks can help the clinician to understand the aftereffects of incest as well as direct treatment. In

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[1] A recent backlash by the False Memory Syndrome Foundation (c.f., Golman, New York Times, 1992), a group of parents who claim that they have been falsely accused of sexual abuse by their adult children and who are using the legal system to justify their innocence, claims that therapists are using unethical procedures to induce clients to remember fabricated instances of childhood incest. The growing strength of this organization may prevent some therapists from pursuing this line of questioning in their assessment of clients helping to return the topic of incest to its previous state as a taboo subject for investigation.

treatment, incest is viewed as a gender issue, related to women's conditioning and socialization in the family and in the larger culture. Women's role as "victim" is challenged; they are encouraged to see themselves as empowered and to make behavioural changes consistent with this determination including placing the responsibility for the abuse with the perpetrator. In order to heal, the survivor must grieve the losses that accompanied the abuse and separate from the destructive messages given to her by her family of origin. Finally, the symptoms of PTSD are seen as a normal response to the stress of incest. PTSD symptoms and secondary elaborations (e.g., drug use, suicidal tendencies, dissociation, flashbacks) are treated by providing a safe, supportive and nonblaming environment from which the client can explore the trauma and its impact on her life.

Most frequently, treatment for adult female survivors has been conducted on an individual or group basis (Courtois, 1988) but other modalities such as couples/marital (e.g., Ingram, 1985; Johnson, 1989) and family (e.g., Giaretto, 1976, 1982) therapy have been described. Courtois (1988) has conceptualized incest treatment as a recovery or healing process that may require different treatment approaches at different stages of recovery. For example, treatment most frequently begins with individual work. Here, the incest client can develop a sense of trust with one other individual in a caring, attentive, and supportive environment. Because much of the damage of incest is in the realm of interpersonal functioning, the establishment of a strong

therapeutic relationship in individual therapy appears central to the healing process (e.g., Briere, 1989; Courtois, 1988; Meiselman, 1990; Mennen, 1992). Once this relationship is established, recovery can begin through techniques aimed at catharsis, reality testing, memory retrieval, symptom amelioration, cognitive restructuring of faulty beliefs, etc. (Meiselman, 1990). At some point during individual treatment, the adult survivor is frequently referred to a group treatment program with other incest survivors. Although the issues worked on in group treatment are similar to those explored in individual work, the group also provides additional support by reducing the sense of isolation, shame, and stigma that incest survivors frequently experience and find so distressing (e.g., Briere, 1989; Cole & Barney, 1987; Herman, 1992). Indeed, many authors have reported that the sharing and empathy derived from common experiences and reactions of other incest survivors in group work seem to be an invaluable and essential part of the healing process and can provide enormous therapeutic relief (e.g., Briere, 1989; Courtois, 1988; Cole & Barney, 1987; Forward & Buck, 1963; Herman, 1981; Herman, 1992; Herman & Shatzow, 1984). Later, assertiveness training courses, marital therapy, parenting skills courses, or career oriented programs may be introduced as needed. Typically, contact with an individual therapist is maintained throughout the recovery process (Courtois, 1988).

In summary, it appears that incest survivors enter treatment for many reasons ranging from depression to

difficulties in interpersonal relationships (Courtois, 1988). However, once incest is identified, many authors believe that it is essential to make incest the focus of therapy regardless of the theoretical orientation of the therapist or the techniques he/she uses to promote healing (e.g., Briere, 1989; Ellenson, 1989; Gelinas,1983). Failure to do so may doom the clinician's best efforts to relative failure since the etiologic roots of the problem will not have been adequately addressed (Briere, 1989). The most frequently proposed course of treatment once incest has been disclosed generally includes individual work to allow basic healing to take place, followed by group work after some integration is achieved (Briere, 1989; Courtois, 1988; Herman, 1981; Meiselman, 1990). Indeed, there is general agreement that the group treatment modality offers the incest survivor unique therapeutic benefits that are not available in individual therapy alone (e.g., Briere, 1989; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984). The following sections will review the available literature on the group treatment modality for this population.

Group Treatment for Adult Female Survivors of Incest

Rationale for Group Treatment

Most commonly, clients with a history of incest present for treatment in individual therapy and are subsequently referred to an incest survivor's group either simultaneously to or following individual therapy (Courtois, 1988). As previously noted, van der Kolk (1987) has suggested that most clients who have been

victimized initially benefit from individual therapy in that it allows disclosure within a safe environment, the reestablishment of a trusting relationship with at least one other person, and a place wherein the client can explore and validate perceptions and emotions with the undivided attention from the therapist. However, in individual therapy, there is often an inherent inequality in the therapist/client relationship which may reinforce feelings of helplessness and dependency, especially on the part of a client with a history of incest (e.g., Courtois, 1988; Courtois & Sprei, 1988; Meiselman, 1990). Furthermore, there is little doubt that one of the major problems faced by adult incest survivors is the sense of isolation that results from having been involved in a secretive, taboo practice (Courtois, 1988; Finkelhor & Browne, 1986). Even when incest is disclosed in individual therapy, it is still done in a private and confidential context and may inadvertently serve to maintain the coercive secrecy and isolation that the incest client has had to live with for most of her life (Courtois, 1988; Drews & Bradley, 1989). Thus, although individual therapy is initially beneficial for the incest client, many authors suggest that it does not go far enough in the recovery process (e.g., Courtois, 1988; Herman & Schatzow, 1984). For example, Herman and Shatzow (1984) have stated that "Individual psychotherapy may often be helpful for incest victims; however, within this treatment modality, it is difficult to come to a full resolution of the issues of secrecy, shame, and stigma" (p. 606).

In contrast to individual therapy, the act of attending a group is, in and of itself, a public acknowledgment of the incest and may release the incest client from her burden of secrecy which is so much a part of the incest dynamic (Blake-White & Kline, 1985; Drews & Bradley, 1989). In addition, group members often come to recognize that they are not alone and that they share commonalities of the experience including immediate and long-term aftereffects and inappropriate coping mechanisms. The commonalities among group members frequently serve to normalize their experience and problems such as low self-esteem, guilt, and problems with intimacy and sexuality may come to be viewed less as character defects and more as common reactions to the incestuous abuse.

Involvement in a group with other survivors is believed to have additional benefits for the incest client besides reducing the intense isolation. Whereas the very nature of individual therapy precludes a sense of mutual support and tends to reinforce dependency in individuals who have been victimized (van der Kolk, 1987), group therapy provides an environment that encourages interactions and supportive relationships between group members (Yalom, 1985). In a group, individuals who have been victimized can begin to reexperience themselves as helpful to other people, which may increase feelings of mastery and control (van der Kolk, 1987). Sprei (1987) has also suggested that many women find it easier to talk to close friends, spouses, or other family members about the abuse once their secret is

shared and discussed within a group context. Members often develop friendships with each other, learning perhaps for the first time how to create intimate, trusting, and mutually satisfying relationships. The group often serves as a "new family" for members and may make it easier to deal with family-of-origin problems since they can be rehearsed and worked through without fear of rejection or reabuse.

Sprei (1987) has also noted that the group is a powerful catalyst for identifying and exploring feelings about the incest, as well as long-held beliefs regarding childhood rules and messages fostered within the abusive environment. For example, although a member may believe that she is responsible for her sexual abuse, she rarely will believe that the other group members caused or deserved their own abuse. In addition, as the incest client reconnects with and works through painful memories, the group provides a uniquely supportive atmosphere in which members can identify with each others' emotions based on their own personal experience and understanding. Finally, the group presents an opportunity, largely unavailable in individual therapy, for the practice of new social skills since group members can try on new behaviours and learn to give and receive feedback in a supportive environment (Courtois, 1988).

At least a dozen clinical accounts describing group treatment programs for adult female incest survivors have been published. In general, the available literature on group treatment programs for adult female incest survivors has focused

on describing the group structure, organization, and/or the theme around which the group treatment was focused. Variously included in this literature are rationales pertaining to such issues as the screening of group members, the use of concurrent individual therapy, and leadership composition. Although the present study is not designed to evaluate differences in particular elements of group structure and organization, leadership composition, or group treatment themes, the following section will attempt to briefly review the available literature.

Group Structure and Organization

Time-Limited vs Time Unlimited. Reports outlining short-term, time-limited groups (between 4 and 30 sessions) have predominated the literature on group treatment for incest survivors (Alexander & Follette, 1987; Bergart, 1986; Cole, 1985; Deighton & McPeek, 1985; Fowler, Burns, & Roehl, 1983; Gordy, 1983; Herman & Schatzow, 1984; Sprei, 1987; Tsai & Wagner, 1978) and appear to have a number of advantages especially germane to this population. By its very nature, a time limit minimizes the possibility of regression and highlights the strengths of the participants, both important considerations for women who tend to see themselves as helpless and powerless (Goodman & Nowak-Scibelli, 1985). Furthermore, the imposition of a time limit establishes firm and clear boundaries from the outset, of special importance in working with individuals who grew up in families where boundaries were diffuse and ambiguous. Sprei (1987) has suggested that the use of a time limit promotes goal-oriented

work, focuses attention on common themes relating to incest, and minimizes the development of interpersonal conflicts within the group. Herman & Schatzow (1984) have suggested that the pressure of a time limit facilitates bonding, diminishes the members' resistance to sharing emotionally charged material, and encourages members to put the past behind them and learn to get on with their lives. Finally, Gordy (1983) provides two additional reasons for using a time-limited approach. The first is aimed at protecting group leaders in their own ability to cope due to the impact of the subject matter. The second deals with the ongoing fear of closeness expressed by group members. By limiting the number of sessions, these authors aimed to overcome the fears of ambivalent members who were struggling with how much closeness they were risking in joining the group.

Although the time-limited approach appears to be the most popular format, a few authors have employed a long-term format wherein no termination date is imposed on the group (Blake-White & Kline, 1985; Courtois, 1988; Ganzarain & Buchele, 1986; Mennen & Meadow, 1992). Courtois (1988) and others (e.g., Ganzarin & Buchele, 1986) have suggested that the use of a limited number of sessions does not allow for a complete working through of the trauma and its secondary elaboration nor does it allow enough time to work toward a deeper level of trust. Recently, however, van der Kolk (1993) and Herman (1992) have suggested that time-limited and time-unlimited formats serve different purposes in the recovery process. Herman (1992) has noted that time-limited

groups are more appropriate for focusing on the original trauma while time-unlimited formats are more appropriate for addressing interpersonal issues that prevent the survivor from establishing intimate and trusting relationships with others. van der Kolk (1993) has strongly emphasized that a time-unlimited group which focuses on the original trauma invariably ends in participants getting "hooked on the trauma" and being unable to move forward to address any other issues. He suggests that the original trauma be addressed using a time-limited format and that time-unlimited groups be used later in the recovery process when the client wishes to work on interpersonal problems.

Closed vs Open Groups. Although most groups described in the literature have either used or recommended a closed format (Alexander & Follette, 1987; Cole & Barney, 1987; Fowler, Burns, & Roehl, 1983; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; McBride & Emerson, 1989), compelling reasons for open groups have been put forward by Blake-White and Kline (1985). These authors believe that when a woman discloses, it should be acknowledged immediately rather than having her wait for services and support until the start of a new group. In addition, because women vary greatly in the amount of time needed to come to resolution of their issues, open-ended, long-term groups permit participants to stay on or exit as needed. However, Bergart (1986) and others (e.g., McBride & Emerson, 1989) have found that open-ended groups can be overly disruptive for this population. Because of the difficulty that incest survivors have with issues

of trust, the addition of new members to the group may be experienced as threatening and block the momentum of the group process. Other authors have also recommended using a closed format because it enhances the development of group cohesiveness, particularly important for incest clients who tend to experience anxiety in group situations (e.g., Sprei, 1987). Finally, Mayer (1983) has indicated that a closed group is more appropriate because of the intensity of emotions experienced when dealing with incest and the safety that a closed group provides when dealing with these emotions.

Screening of Group Members. Several authors have commented on the issue of screening members for group participation (Bergart, 1986; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Mennen & Meadow, 1992; McBride & Emerson, 1989; Sprei, 1987; Tsai & Wagner, 1978). Although Tsai and Wagner (1978) accept all women who wish to participate in group treatment, the general consensus appears to be that some screening is necessary since a group modality may not be appropriate or beneficial for all incest survivors (Sprei, 1987). However, Briere (1989) has noted that caution is needed in determining exclusion criteria for group participation. He notes that some criteria used to exclude participants may be similar to the major long-term effects of sexual abuse. Taken to an extreme, if the criteria for group participation are too stringent, victims who are more severely affected by their incest experience would effectively be screened out leaving only those

with less need for treatment.

Herman and Schatzow (1984) have outlined three conditions required for inclusion in their group: (1) that prospective members express generally positive feelings about participating in a group with other incest victims, (2) that prospective members be functioning reasonably well in day-to-day life, and (3) that group members have an appropriate ongoing relationship with an individual therapist. Sprei (1987) has found that both a sufficient level of tolerance for group intimacy, as well as sufficient level of energy to deal constructively with painful feelings arising from the incest are necessary if incest clients are to benefit from a group setting. Goodman and Nowak-Scibelli (1985) suggest that psychotic or suicidal clients be eliminated from group participation along with those whose life situations are markedly unstable. Herman and Schatzow (1984), Cole and Barney (1987), and Sprei (1987) have excluded individuals who are actively alcohol or drug dependent or who are going through a severe life crisis. Sprei (1987) has also indicated that intense paranoia, life-threatening eating disorders, severe self-mutilation, multiple personality, and inability to control dissociative states, aggression, or impulsive tendencies may be contraindications for group treatment.

Mennen and Meadow (1992) have suggested that a candidate with many unsuccessful experiences in therapy may not be appropriate for group work until ambivalence about treatment in general is approached in individual therapy. As well, Bergart

(1986) maintains that clients who are severely narcissistic or ambivalent will not benefit from group treatment and that this modality should be deferred until sufficient individual work has been done. McBride and Emerson (1989) have suggested that psychotics, individuals who show a tendency to violence or who are overtly suicidal, or those in a state of extreme denial, may not benefit from group treatment and should be maintained in individual therapy. Given the intensity of the group experience, many authors have also recommended excluding those incest clients who are so overwhelmed by their incest experience that group work would only be experienced as an additional burden (e.g., Goodman & Nowak-Scibelli, 1985).

Concurrent Individual Therapy It is interesting to note that many of the clinical accounts that describe group treatment have utilized participants that have been referred for group treatment following some history of individual therapy or counselling (e.g., Bergart, 1986; Cole & Barney, 1987; Ganzarain & Buchele, 1986; Gordy, 1983; Herman & Schatzow, 1984; Kreidler & Hassan, 1992; McBride & Emerson, 1989). Furthermore, the authors of these reports have generally insisted that group members continue individual therapy while undergoing the group treatment program. For example, Ganzarain and Buchele (1986) invited individual psychotherapists to refer adult female incest survivors (18 years of age or older) who were in individual psychotherapy to serve as members of their long-term, group treatment program. Members in this group were required to remain

in individual therapy while in the process of group work. Herman and Schatzow (1984) used private practitioners and local agencies as referral sources for their group treatment program. In addition, a criterion for group inclusion was that group members have an ongoing relationship with their individual therapist. This criterion has also been included in group treatment programs described by Goodman and Nowak-Scibelli (1985), Roberts and Lie (1989), Gordy (1983), Bergart (1986), Cole and Barney (1987), and Kreidler and Hassan, (1992).

Several advantages of concurrent individual and group treatment have been noted in the literature on group treatment for adult female incest survivors. For example, Briere (1989) has noted that the process of group treatment is an inherently stressful one for survivors. He suggests that the combination of individual and group treatment allows for a division of labour; the survivor gains from the social interaction, feedback, and support of group treatment, yet has an individual therapist who can devote his/her full attention to the client and her more pressing needs and issues that may arise from the group work. Courtois (1988) has noted that concurrent individual treatment provides the survivor with a supportive relationship within which to process and reintegrate the memories and emotions generated in the group. Hall, Kasses, and Hoffman (1986) have noted that individual and group treatment support and strengthen each other and that this combination may speed the individual's therapeutic progress. Sprei (1987) has noted that concurrent individual and

group treatment allows different issues to be addressed, different transferences to arise, and different types and levels of interventions to be made. Finally, Sprei (1987), Courtois (1988), and Herman and Schatzow (1984) have indicated that concurrent individual and group treatment appears to provide the most effective treatment for incest trauma. However, in order for a survivor to fully benefit from concurrent treatments, Courtois (1988) recommends that written permission be obtained to contact the primary therapist during the course of the group as the need arises. Such contacts impede secrecy and splitting between therapists and treatments while allowing for coordinated treatment planning and the enlistment of the primary therapist's support if the survivor becomes distressed and disorganized.

Group Leadership

Use of Co-therapists The idea of co-leadership has been universally endorsed in the literature on group treatment for incest survivors (Alexander & Follette, 1987; Blake-White & Kline, 1985; Cole, 1985; Cole & Barney, 1987; Deighton & McPeek, 1985; Fowler, Burns, & Roehl, 1983; Ganzarain & Buchele, 1986; Goodman & Nowak-Scibelli, 1985; Gordy, 1983; Herman & Schatzow, 1984; Mennen & Meadow, 1992; Sprei, 1987; Tsai & Wagner, 1978). Co-therapists for adult incest survivor groups have been strongly recommended for several reasons. Typically, the intensity of the group process and the emotional content places great demands on the therapist (Courtois, 1988). A co-therapy model allows for mutual therapist support in that co-therapists can "rescue" each

other when one of them becomes blocked or has difficulty working because his/her own personal issues have been triggered by issues raised in the group (McBride & Emerson, 1989). Furthermore, the use of two therapists facilitates observation and processing of the group's interaction patterns and dynamics (Blake-White & Kline, 1985). Finally, the group itself benefits from the combined input of two therapists and can continue to meet even if one of the therapists is absent (Blick & Porter, 1987).

Sex of Therapists Although the co-therapy model itself is highly endorsed, there has been a diversity of opinion as to the gender composition of the co-therapy team. Some authors (e.g., Blake-White & Kline, 1985; Courtois, 1988) advocate two female therapists while others (e.g., Deighton & McPeek, 1985; Ganzarain & Buchele, 1986) suggest a male/female composition. For example, Blake-White and Kline (1985) suggest that women with a history of incest typically tend to distrust men and may hesitate to open up if a male therapist is present. Furthermore, they suggest that the presence of a male therapist may affect the honesty and integrity of the group in that incest survivors may tend to sexualize their relationship with, perform for, or give away their power to a male therapist. Courtois (1988) has noted that many survivors will not join a group which includes either male members or leaders since they perceive females as being safer and more trustworthy than males as well as more understanding of victimization issues.

On the other hand, Deighton and McPeek (1985) and Goodman and

Nowak-Scibelli (1985) feel that it is essential that female incest clients explore their feelings toward men with a supportive and competent male therapist. In having a male/female team, group members fearful and/or distrustful of men can explore these issues with the male therapist while the presence of the female therapist can act as a safety net if needed. Furthermore, Ganzarain and Buchele (1986) believe that a male/female team can serve as a surrogate parental couple, offering group members additional transference targets and serving as models for appropriate child rearing. Finally, Blake-White and Kline (1985), although advocates of a female/female team, concede that a male co-therapist could prove useful later in a long-term therapy group but would not be beneficial at the start of group treatment when the pivotal task centres around the creation of trust.

In summary, although the majority of group descriptions presented in the literature use female co-therapists, the issue of which gender composition is most beneficial has not been empirically established. Clearly, there is a necessity for different models to be evaluated but, as Courtois (1988) has noted, the more important issue is the matching of the leadership composition to the unique needs and preferences of each group.

Theoretical Perspectives in Group Treatment

Several authors who have used time-limited models of group treatment have also used specific theoretical perspectives or

themes in formulating the context for these groups (e.g., Alexander & Follette, 1987; Cole & Barney, 1987; Deighton & McPeek, 1985; Goodman & Nowak-Scibelli, 1985). For example, Alexander and Follette (1987) have used personal construct theory in providing a framework for conceptualizing and treating the problems associated with incest in a 10-week group treatment program. Personal construct theory states that an individual seeks to make sense of the world by developing certain psychological constructs or dimensions that provide a basis for organizing perceptions and predicting future behaviour and events. In an incestuous family, the child learns to construe the world and the self in inappropriate ways resulting in distorted perceptions which may lead to both intra and interpersonal difficulties. The goal of group therapy is to explore the relationship between these constructs and current symptomatology within a safe environment leading to a more appropriate construing of the self and others.

Cole and Barney (1987) present a short-term group treatment approach based on Horowitz's (1976) stress response model. They note that survivors of incest frequently experience symptoms of post-traumatic stress which cluster into a stress response syndrome involving alternating periods of intrusive (under-controlled) and avoidance (over-controlled) symptoms. Symptoms in the avoidance phase include amnesia, forgetfulness, dissociation, and selective inattention. The intrusive phase results in hypervigilance, unbidden repetitive thoughts and

imagery, hallucinations, confusion, waves of intense affect, tremors, sweating, and nightmares. The incest survivor oscillates between these two phases and symptom intensity and change are observed or reported during the moves from one phase to the other. However, between the extremes of the avoidance and the intrusive phases, Cole and Barney postulate a "therapeutic window" wherein the symptoms are sufficiently manageable to permit reworking of traumatic material. The goal of therapy is to monitor and utilize the therapeutic window in individual group members for reprocessing and integrating this material and to offer group members strategies to ease distress when the therapeutic range (window) is exceeded.

Deighton and McPeek (1985) describe a short-term group treatment approach based on the family theories of Bowen and Framo. These authors believe that the incest survivor needs to learn both how to differentiate from her family-of-origin and to deal with the emotional reactivity engendered by family contacts. The goal of therapy is for the client to work toward becoming increasingly differentiated to the extent that thinking and feeling functions become separate so that emotional reactivity to family members can be controlled. Consequently, Deighton and McPeek's group treatment makes extensive use of family-of-origin contacts as a resource for change. The basic operational premise is that dealing with family-of-origin issues is the key to resolving guilt and anger left over from incestuous childhood experiences. The emotional cut-off from the family is viewed as

the major obstacle to the resolution of the effects of incest, one which prevents the client from becoming a survivor.

Finally, Goodman and Nowak-Scibelli (1985) base their 12-week group treatment program on the loyalty theory of Boszormenyi-Nagy and Sparks (1973). Group therapy provided by these authors rests on three assumptions following from this theory: (1) that in any situation involving sexual contact between an adult and a child, the adult is responsible, (2) that there is a need to hold the offender accountable without scapegoating him/her, and (3) that the incest victim maintains a loyalty to the perpetrator and other family members in spite of the sexual abuse. Within this framework, Goodman and Nowak-Scibelli suggest that, regardless of the extent or duration of the abuse, most victims continue to express both positive and negative feelings toward the perpetrator and other family members and, therefore, loyalty issues need to be addressed and explored in order for treatment to be effective. Toward this end, Goodman and Nowak-Scibelli are careful not to blame or scapegoat any member of the victim's family allowing the woman to feel freer in expressing all of her feelings (good and bad) toward the perpetrator and family members. By not addressing the loyalty dynamics, Goodman and Nowak-Scibelli believe that clinicians run the risk of clients leaving treatment prematurely in their continued efforts to protect their families.

It appears that the above authors have used different theoretical perspectives in order to provide a particular focus

or theme for time-limited group treatment with adult female survivors of incest. It is appropriate that time-limited group models that focus on the original trauma are structured around a particular theme in order to help regulate group process (van der Kolk, 1993). However, Courtois (1988) has suggested that group leaders must be cautious when utilizing a particular theoretical perspective or theme for group work with incest survivors. The use of too narrow a theoretical perspective or theme may prevent group members from working with issues that they feel do not fit into the group's mandate. This may serve to further disempower the group member and to leave her feeling more isolated. Furthermore, because the aftereffects of incest can be so diverse, a group that becomes too focused in one area may inadvertently ignore difficulties in other areas. For example, adult female survivors of incest may present not only with the immediate symptoms of PTSD but also with family issues, loss issues, and/or problems around sexuality. It appears important that if a time-limited group is theme-oriented or has a particular focus, the theme must be comprehensive enough to allow group members to feel that their unique issues are worthy of discussion or else the composition of the group must be changed to include only those with a particular characteristic or symptom (Courtois, 1988).

Outcome Research on Group Treatment

Although the descriptive literature suggests that group treatment for adult female incest survivors has positive outcomes

for participants, little empirical evidence is available to confirm this contention. A few empirical studies do exist which have examined the effects of group treatment with children and adolescents who have been sexually abused. For example, James (1977) reported a significant increase in the level of comfort in discussing the sexual abuse following eight sessions of group therapy with seven female adolescent incest victims in a juvenile detention centre, although levels of self-esteem did not increase. In addition, Verleur, Hughes, and Dobkin de Rios (1986) found that the level of self-esteem in a group of 15 adolescent female incest victims involved in a residential treatment program increased significantly compared to matched controls following six months of group treatment.

More recently, MacKay, Gold, and Gold (1987) gave pre- and posttreatment measures to five girls, aged 12 to 18, who had been abused by a family member. Treatment consisted of eight sessions of structured drama therapy involving role-playing and improvised playlets of themes and issues relevant for this group regarding their abuse situations. Results from this study indicated that there was a significant reduction in reported levels of hostility. However, no statistical differences were found in levels of depression, self-esteem, overall intensity of psychological symptoms, attributional style, or social support following treatment, although trends toward significance were evident. Unfortunately, the small sample size in this study, as well as the study by James (1977) may have attenuated any visible

effects. MacKay et al. (1987) suggested that the trend toward significant effects in their study, particularly in the areas of depression, self-esteem, and attributional style indicates that significant effects on these variables may have emerged had the treatment continued beyond eight sessions. However, any positive results from the studies by James (1977) and MacKay et al. (1987) must be interpreted with caution since no control groups were employed in the design of these studies. Finally, because the above are treatment outcome studies of clinical populations, it is important to comment on and/or systematically control for any other treatment that is being utilized in conjunction with the treatment being examined. Unfortunately, it is unknown whether subjects in the studies by Veleur et al. (1986), James (1977), and MacKay et al. (1987) were receiving other forms of treatment that may have contributed to the observable improvement.

At the present time, only one controlled study has been published which empirically assesses the effects of group treatment for adult incest survivors. In this study, Alexander, Neimeyer, Follette, Moore, and Harter (1989) compared two models of group treatment and a wait-list control group using women with a history of incest. Sixty-five subjects were recruited via the media to participate in one of eight 10-week groups for women who had been abused by fathers, stepfathers, or other close relatives. Subjects were required to be over the age of 18 and not in concurrent individual therapy during the course of treatment or the wait-list period. Following completion of the

Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the Social Adjustment Scale (SAS; Weissman & Paykel, 1974), the Symptoms Checklist-Revised (SCL-90-R; Derogatis, 1983), and the Modified Fear Survey (MFS; Vernon & Kilpatrick, 1980), subjects were randomly assigned to one of two group treatment conditions or to the wait-list condition.

One group treatment condition involved an interpersonal transaction (IT) group format. This format is based on the work of Landfield (1977) and Neimeyer, (1988) and consists of a series of very brief interactions among all possible combinations of dyads of group members during which partners disclose their feelings about an assigned topic (e.g., problems of trust). Special "bridging questions" are then used to prompt whole-group processing of the experience in a subsequent plenary phase of the group session. The second group treatment condition followed guidelines provided by Courtois (1988) for treatment of incest survivors (Process group). Typically, the beginning sessions involved group members sharing their goals, expectations, and incest histories. Subsequent sessions focused on each member's actual interactions within the group as a means of developing a new perspective on incest, of understanding the problematic interpersonal behaviours that helped perpetuate the member's general "victimization", and of experimenting with new ways of relating to the group and others. Topics for discussion during group sessions were left to the discretion of the members themselves.

Subjects randomly assigned to the IT and Process groups were retested following termination of the group treatment program and again at a six months. Subjects randomly assigned to the wait-list control group were retested following a waiting period of 12 weeks and were offered membership in the next available group. Two subjects who were randomly assigned to the wait-list condition decided that their distress was too great for them to withstand a 12-week delay in treatment and were referred to other therapists because lack of treatment would constitute an ethical violation.

Four groups were conducted in each of the two group formats (IT and Process) for a total of eight treatment groups. These groups were led by four advanced female doctoral students who formed co-therapy teams and who were supervised on a weekly basis through the use of videotapes by two licensed clinical psychologists. Each pair of group leaders conducted groups in each condition to control for differential competence and match between the two leaders.

Results from this study found that both group formats were significantly effective relative to the wait-list condition in reducing depression as measured by the BDI and in alleviating distress as measured by the SCL-90-R. The process group condition proved to be particularly therapeutic in enhancing the social adjustment of group participants as compared to the IT group condition and the wait-list condition in which social adjustment actually deteriorated. Interestingly, no significant

differences were found between types of group treatment (IT and Process) or treatment outcomes for individual groups indicating that group therapy, in itself, is indeed effective in ameliorating some of the long-term negative effects associated with the experience of incest.

Although the above study provides the first empirical data supporting the efficacy of time-limited group therapies as treatments for adult survivors of childhood incest, the results of this study must be interpreted with caution. A major concern is the generalizability of the result of this study to clinical populations of incest survivors who are already in treatment. For example, subjects for the above study consisted of a volunteer, nonclinical sample which may not be representative of the population of incest clients most severely affected by their incest experiences. It is possible that the ability to disclose incest in response to a newspaper or television advertisement may indicate that the majority of these women were already functioning at a fairly high level. It is well known that most women with a history of incest will not volunteer their incest experience, even within individual therapy, unless specifically asked (Briere & Runtz, 1988; Courtois, 1988). Furthermore, it has been found that women who have experienced incest and who seek treatment, are generally more severely distressed and report more negative aftereffects from their incest experience than those who do not seek treatment (Herman, Russell, & Trocki, 1986; Tsai, Feldman-Summers, & Edgar, 1979; Courtois, 1979). Indeed,

pretreatment measures of depression on the BDI ($\underline{M}$ = 17.6) indicate that the subjects in this study were only mildly depressed (c.f., Beck, Steer, & Garbin, 1988).

Second, a main criterion for inclusion in the study was that the subjects were not involved in concurrent individual therapy. Again this suggests that the women in this study may not be representative of the population of incest victims who are typically involved in group treatment for incest. For example, several authors have suggested that group treatment is only one part of the recovery or healing process (e.g., Courtois, 1988; Courtois & Sprei, 1988, Briere, 1989, Meiselman, 1990). In general, women with a history of incest are referred for group treatment some time after individual work is begun and when both therapist and client feel that it is appropriate. This suggests that the sample used in the above study (ie. women who were not involved in individual therapy) may not be representative of those who are typically involved in group treatment programs for incest.

A third caution in interpreting the results of the above study is the demand characteristics of the study's setting. The study took place in a university research environment and the groups were led by doctoral students in clinical psychology. It is possible that the subjects in such a setting were more aware of the research aspects of the group treatment and were consequently more pressured to report themselves as "improved" on the second and follow-up evaluations. Such experimenter-

expectancy bias is often prevalent in university research settings (Jung, 1971). It would be expected that research within a community-based group treatment program with a clinical population of incest survivors may suffer less from such demand characteristics and thus have greater external validity.

Rationale and Research Strategy

The foregoing literature review has established that many adult female survivors of incest experience a broad range of negative aftereffects over time. Although the proportion of women with this history who seek treatment is at present unknown, there is some evidence to suggest that those who do seek treatment may be more severely traumatized than those who do not. Most commonly, these women begin their recovery process in individual therapy, often seeking it out for problems other than incest. However, because of increased clinical sensitivity, women are now being asked directly about past experiences of sexual abuse, and if incest is disclosed, it is being made the focus of treatment. However, although individual therapy is an integral part of the healing process for incest survivors wherein they can experience, perhaps for the first time, validation and acceptance from a caring other, most clinicians suggest that it does not go far enough in breaking the isolation and stigmatization that a woman with an incest history feels. Indeed, there is a general consensus by authors in this area that group treatment seems uniquely suited to address some of the major issues with which incest survivors struggle.

At this time, only one analogue study (Alexander et al., 1989) has empirically examined group treatment for this population. However, although this study found that group treatment was significantly more effective than a wait-list condition for a volunteer, nonclinical sample of adult female incest survivors, there are currently no controlled studies which have examined the efficacy of group treatment for a clinical population of adult female incest survivors. The present study was conducted in order to extend Alexander et. al's (1989) findings by using a clinical population drawn from a community-based, social-service agency. Certainly it is important to evaluate treatment modalities for this population in the clinical settings in which they occur in order to increase ecological validity (Kazdin, 1986). As such, a controlled study which empirically examines the efficacy of a group treatment program in a clinical setting and with a clinical population of adult female incest survivors is both timely and necessary.

The present study involved the comparison of two groups of adult female incest survivors: those who participated in a group treatment program for incest and those who were in a wait-list condition for the group treatment program. Subjects for the study were drawn from participants in the "Victim to Survivor" program conducted by the Family Service Centre of Ottawa-Carleton for adult female survivors of incest. The majority of consumers of this program are referred by individual therapists within the community and generally remain in individual therapy during the

group treatment program. The study was designed to assess specific changes in subjects who participated in the 20-week group treatment program and to compare these changes to subjects who were required to wait for treatment for a comparable length of time. Due to practical and ethical constraints on the part of the Family Service Centre, subjects who participated in the present study were not randomized into those receiving the group treatment program and those on the wait-list condition, but were assigned to the treatment group or the wait-list group based on time of request for treatment (see Method). Finally, subjects who completed the group treatment program were assessed at six-month follow-up in order to determine the effects of the group treatment program over time.

Both the clinical and empirical literature indicate that adult female incest survivors in treatment report a wide variety of problems ranging from depression and anxiety to difficulties in forming satisfying relationships with others. The variables that were examined in this study stem from this literature and have been organized into two categories: intrapersonal symptomatology and interpersonal difficulties (c.f. Ingram, 1985).

In the area of intrapersonal symptomatology, the research and clinical literature most consistently reports the manifestation of chronic depression and negative self-concept in adult female incest survivors. In addition, it is well known that this population commonly experiences a high level of

psychological distress (anxiety, excessive fears, somatic complaints, anger and hostility). Finally, many authors have reported the occurrence of symptoms consistent with post-traumatic stress disorder (hypervigilence, sleep disturbances, nightmares, dissociation, numbing of affect, flashbacks, memory problems, and difficulties in concentration).

The second category of difficulties most frequently described by adult survivors of childhood incest involves difficulties with interpersonal relationships. Because the trauma of incest is profoundly social and involves the distortion of emotional bonds to those that the child loves and trusts, adult survivors of incest often report an inability to form a secure, intimate relationship with a significant other. In addition, interpersonal difficulties frequently extend beyond intimate and/or committed relationships to general difficulties with the survivor's family members, as well as men and women in the survivor's social milieu. The present study attempted to determine the effects of a group treatment program on difficulties in the interpersonal domain since it is this particular domain that seems much more resistant to change and may be more amenable to a group treatment approach (Alexander, Neimeyer, & Follette, 1991).

Finally, although not a main hypothesis, the present study attempted to explore subjects' perception of parenting styles in their families-of-origin. As noted in the literature, many authors suggest that the degree of difficulty experienced by

adult survivors of childhood incest may be related to the general degree of family dysfunction rather than the sexual abuse per se. Several authors have attempted to characterize incestuous families (e.g., Lustig, Dresser, Spellman, & Murray, 1966; Mrazek & Bentovim, 1987; Trepper & Barrett, 1986). For example, there are suggestions that incest families are highly patriarchal in structure (e.g., Herman, 1981; Meiselman, 1978); fathers in these families are often described as dominant and controlling, while mothers are described as passive and unavailable to their children. Although this description makes intuitive sense, other descriptions are also available, such as a domineering and controlling woman married to a dependent and inadequate man (Stern & Meyer, 1980, cited in Pelletier & Handy, 1986). Because a more complete understanding of this issue is required, subjects in the study were asked to report on their mothers' and fathers' parenting styles in order to increase the base of information regarding characteristics of incestuous families.

Hypotheses

The following main hypotheses were tested:

1. a) It was hypothesized that subjects in the treatment group as compared to subjects in the wait-list group would have significantly less intrapersonal symptomatology following the group treatment program, that is:

i) depressive symptomatology would be significantly lower.

ii) symptoms of psychological distress would be

significantly lower.

iii) symptoms of post-traumatic stress would be significantly lower.

iv) emotional and general self-concept would be significantly higher.

b) It was hypothesized that subjects in the treatment group as compared to subjects in the wait-list group would have significantly less interpersonal difficulties following the group treatment program, that is:

i) measures of perceived social support from family and from friends would be significantly higher.

ii) self-concept in relation to same sex and opposite sex peers would be significantly higher.

iii) secure attachment behaviours to a significant other would increase significantly.

2. a) It was hypothesized that subjects in the treatment group would continue to improve or at least maintain improvement in intrapersonal symptomatology at six-month follow-up, that is:

i) depressive symptomatology would remain significantly lower at six-month follow-up as compared to pretreatment.

ii) symptoms of psychological distress would remain significantly lower at six-month follow-up as compared to pretreatment.

iii) symptoms of post-traumatic stress would remain significantly lower at six-month follow-up as compared to pretreatment.

iv) emotional and general self-concept would remain significantly higher at six-month follow-up as compared to pretreatment.

b) It was hypothesized that subjects in the treatment group would continue to improve or at least maintain posttreatment changes in interpersonal difficulties at six-month follow-up based on the comparison of the treatment and follow-up phases of the study, that is:

i) measures of social support from family and from friends would remain significantly higher at six-month follow-up as compared to pretreatment.

ii) self-concept in relation to same sex and opposite sex peers would remain significantly higher at six-month follow-up as compared to pretreatment.

iii) secure attachment behaviours toward a significant other would remain significantly higher at six-month follow-up as compared to pretreatment.

METHOD

Formation of Treatment and Wait-List Groups

It is the present policy of the Family Service Centre to admit individuals into the "Victim to Survivor Group" on a first come, first served basis. As part of the administrative procedures of the Family Service Centre, individuals who request treatment are placed on a waiting list at the time of initial contact. Approximately one month before the start of each new group treatment program, (August and January of each year) these individuals are contacted in order of request and evaluated by the group leaders by means of a personal interview to determine whether or not they meet the Family Service Centre's inclusion criteria for group admission (see below). The evaluation interviews end when a maximum of ten group participants is reached. Individuals who are not evaluated due to group completion are maintained on the waiting list until the start of the next available group.

Subjects for the present study were not randomized to the treatment and wait-list groups but were assigned to respective groups based solely on time that services were requested. Although some selection bias may have been introduced by this procedure, it was expected to be minimal in that selection was based only on the time of the request for services and not on any inherent characteristic of the subject.

Subjects for the treatment group were recruited from individuals who were accepted by the Family Service Centre into the group treatment programs beginning February, 1989; September, 1989; February, 1990; September, 1990, and February, 1991. Evaluative interviews for participants in the above group treatment programs were held in January, 1989; August, 1989; January, 1990; August, 1990, and January, 1991, respectively. The above evaluative interviews for the treatment group took place approximately one week to one month prior to the start of each group treatment program.

In order to be accepted into the "Victim to Survivor Group", the Family Service Centre has the following inclusion/exclusion criteria:

1. Prospective members must be 18 years of age or over.
2. Prospective members must not be living in the home of the perpetrator.
3. Prospective members must preferably be in concurrent individual therapy; if not in concurrent individual therapy, the prospective group member must be able to contact their individual therapist or have at least one close relationship with whom they are able to process feelings engendered by the group treatment process.
4. Prospective members must make a commitment to attend all 20 sessions.
5. Prospective members must be able to make some connection in their own mind between the past incest experience and present difficulties.
6. Prospective members must not be actively abusing drugs or alcohol and must not be actively suicidal.
7. Prospective members must indicate a willingness to be part of a group with other incest victims and to see incest as the central issue of the group.

As can be seen from the above inclusion/exclusion criteria of the Family Service Centre, participation in individual therapy is a desirable but not a necessary requirement for participation in the "Victim to Survivor Group". However, a criterion for inclusion in the present study was that subjects be involved in individual therapy. To be included in the study, subjects in the treatment group must have attended a minimum of 16 sessions of individual therapy during the 20-week group treatment program. Subjects were thus considered eligible for inclusion in the treatment group if they were (1) deemed eligible for inclusion in the "Victim to Survivor Group" according to the Family Service Centre's inclusion/exclusion criteria, and (2) met the inclusion criterion of a minimum of 16 sessions of individual therapy during the 20-week group treatment program. Participation in the treatment group was strictly voluntary.

Following the recruitment of subjects for the treatment group, the administrative procedures of the Family Service Centre were modified in order to accommodate the creation of the wait-list group for the study. This modification involved evaluative interviews for the group treatment program being held approximately 18 to 22 weeks before the start of each group treatment program instead of one week to one month before the start of each group treatment program. Thus, in order to form the wait-list group, group leaders at the Family Service Centre conducted evaluative interviews with prospective group members in March, 1991; August, 1991; March, 1992; and August, 1992 for

group treatment programs that began September, 1991; February, 1992; September, 1992; and February 1993, respectively. Evaluative interviews ended when a maximum of ten group participants was reached.

As with the treatment group, a criterion for individual therapy while on the wait-list was established. Subjects on the wait-list must have attended individual therapy sessions for a minimum of 80% of the number of weeks on the wait-list. (Example: if subject was on the wait-list for 20 weeks, she must have attended 16 sessions of individual therapy during that time period). Thus, subjects were considered eligible for the wait-list group if they were (1) deemed eligible for inclusion in the "Victim to Survivor" according to the Family Service Centre's inclusion/exclusion criteria, and (2) met the inclusion criterion of attending individual therapy sessions for a minimum of 80% of the number of weeks on the wait-list. Subjects were excluded from the study if they participated in any other therapy group during the waiting period. Participation in the wait-list group was strictly voluntary.

Subjects

Treatment Group

Fifty subjects accepted by the Family Service Centre into five consecutive groups conducted between February, 1989 and February, 1991 were recruited to form the treatment group. Six subjects did not meet the inclusion criterion for the study (in individual therapy for a minimum of 16 weeks during the 20-week

group treatment program), six subjects failed to complete the group treatment program, and one subject did not complete the research leaving 37 subjects to form the treatment group.

Wait-list Group

Thirty-six subjects accepted by the Family Service Centre into four consecutive groups conducted between September, 1991 and February, 1993 were recruited for the wait-list group. Three subjects were excluded because they did not meet the inclusion criterion for the study (in individual therapy for a minimum of 80% of the number of weeks on the wait-list) and two subjects did not complete the study leaving 31 subjects to form the wait-list group. The mean number of weeks on the wait-list of the 31 subjects was 19.8 $\pm$ 1.8. No subject participated in any other therapy group during the waiting period.

Procedure

All potential treatment and wait-list subjects were informed of the present study during the evaluative interview by the group leaders at the Family Service Centre. Subjects for both the treatment group and the wait-list group who were accepted into the group treatment program, stated that they were in individual therapy, and agreed to participate in the study were contacted by phone by the researcher immediately following the evaluative interview and an appointment was arranged for administering the assessment measures at a time and location convenient to the subject. Due to the sensitive nature of the study, some time was taken during the initial appointment to

explain the nature and purpose of the study and to insure confidentiality. Subjects were also informed of their right to withdraw from the study at any time and that withdrawal from the study would not effect their participation in the group treatment program. All subjects were asked to sign a consent form outlining the purpose of the study, their right to confidentiality, and their right to withdraw from the study at any time (See Appendix A and Appendix B for consent forms for the treatment group and the wait-list group, respectively).

Subjects in the treatment group and the wait-list group were given a demographic questionnaire (see Appendix C and Appendix D for demographic questionnaires for the treatment group and the wait-list group, respectively) and the assessment measures. The assessment measures included the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961); the Centre for Epidemiologic Studies of Depression Scale (CES-D; Radloff, 1977); the Brief Symptom Inventory (BSI; Derogatis, 1977); the Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979); four scales of the Self-Description Questionnaire (SDQ III; Marsh & O'Neill, 1984); the Perceived Social Support from Friends and from Family Scales (PSS-Fr; PSS-FA; Procidano & Heller, 1983); the Attachment Questionnaire (AQ; West, Sheldon, & Reiffer. 1987); and the Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979).

Following completion of the 20-week group treatment program or the wait-list period (approximately 20 weeks), subjects were

contacted and an appointment was made for follow-up assessment. Subjects in the treatment group and the wait-list group were given a posttreatment questionnaire (See Appendix E and Appendix F for the posttreatment questionnaire for the treatment group and the wait-list group, respectively) and the same assessment measures that were administered at the initial assessment. An additional six-month follow-up assessment was conducted for subjects in the treatment group only. Subjects in the treatment group were given a six-month follow-up questionnaire (See Appendix G) and the same assessment measures as given at the initial and follow-up assessments. No further measures were given to subjects in the wait-list group.

The Group Treatment Program

The Family Services Centre of Ottawa-Carleton is a well established and respected mental health agency that has been operating in the community of Ottawa-Carleton for approximately 75 years. The "Victim to Survivor Group" is a treatment protocol for adult female survivors of incest that has been developed specifically for women with a history of incest. The organization and format of the group treatment program follows the majority of recommendations in the literature for time-limited groups of this nature. Each group treatment program consists of 20, 2 1/2 hour sessions which are held on a weekly basis. Groups are closed and consist of a maximum of ten participants and two female co-therapist. The group leaders (see below) are highly experienced in working with adult female

survivors of incest in groups and are considered experts in their field in the Ottawa community. The screening criteria for group inclusion/exclusion at the Family Service Centre are consistent with the majority of clinical recommendations in the literature.

The focus of the "Victim to Survivor Group" is on the original trauma and the theme is changing one's perspective from that of a victim to that of a survivor. This theme is intentionally loose so as to be comprehensive enough to allow each group member to work on issues that are important for her, whether they be loyalty issues, family issues, or symptoms of traumatic stress. The goals of the "Victim to Survivor Group" are to provide a safe place wherein group members can begin to share their individual histories of incest while receiving support from others who have experienced similar histories of sexual abuse in their families. In the process of sharing, the group members are invited to explore attitudes and feelings about the abuse and its effects on their present lives and to begin to make more independent choices based on emerging personal power.

The sessions in the group treatment model used by the Family Service Centre are structured across the 20-week period to follow the phases of recovery that are outlined by Courtois (1988) and others (e.g., Meiselman, 1990). The phases include 1) establishing a safe place, 2) breaking the silence, 3) working through, and 4) reintegration. The group process itself generally resembles the process described by Mann (1973) for time-limited individual therapy (cf. Courtois, 1988). The

process involves 1) rapid symptomatic improvement, 2) the return and worsening of symptoms, 3) the development of resistance to change and negative transference, and 4) progress on presenting concerns and termination. This process can be seen to merge closely with the four phases of recovery described below.

The first phase of treatment is the establishment of a safe place wherein members can begin to express their feelings about their incest experience. During this phase, symptoms rapidly improve as bonding takes place between the group members and leaders. Structured exercises allow the incest and its past and current effects to be explored in a safe and nonthreatening atmosphere. Each member is invited to set goals that she wishes to achieve through the group. As in Mann's process model, there is often a "flight into health" during this initial phase that results from the letting go of the secret and the meeting of others who have shared similar experiences. Three sessions are devoted to this phase.

This is followed by the second phase (five sessions) devoted to the recounting of each member's own history of incest within the safe and supportive group environment. Each week, two group members are invited to tell their story and to "break the silence". During this phase, there may be continued good feelings between the group members as they continue to bond and break their isolation, but there is usually a returning and worsening of symptoms and often a "closing down" on the part of some group members (cf. Courtois, 1988, p. 251) as the stories

are being told. Some members need to test their defences in order to determine if the defences are still working after the intimacy and intensity of the first phase; others begin to experience either intrusive or avoidant symptoms of PTSD and there may be flashbacks and/or dissociation during the group sessions.

The next phase (eight sessions) is devoted to "working through" the original trauma. Each member is invited to state what her personal goals are in coming to the group and to use the group in order to obtain these goals. Various experiential exercises using the metaphor of the "child within" are used in this phase. These exercises help group members to say "No" to the powerlessness of the "child within". Who or what each member needs to say "No" to will depend on her individual goals and her sense of what she needs in order to move ahead from victim to survivor.

The metaphor of the "child within" helps the group member to recollect, explore, and abreact the traumatic material of her incest experience from an adult context. The abused child is experientially brought into treatment. In the context of the supportive environment, the survivor reconnects with the abused child and reexperiences the trauma and the feelings of childhood, in particular issues around responsibility, guilt, confusion, ambivalence, shame, anger, sadness, and/or loss. The goal of each experiential exercise is to reconnect the abused child with the nurturing adult in order to set the stage for personal

development and empowerment. Work on an individual basis has a rippling effect to other members of the group so that each member can deal with the elements from the individual sessions that have the most meaning for her.

During this phase, group members also begin to focus on the differences between them as opposed to the commonalities of the group that were pronounced during the first phase. As a result, transference issues are more noticeable and conflict may begin to arise both between group members and with the group leaders. During this phase, group process issues are addressed as they arise but the primary focus remains on achieving each individual's personal goals by working through the traumatic material. In this way, the "Victim to Survivor" theme regulates the group process so that the group can continue to be productive and move forward because of time limitations.

The last phase of group treatment (four sessions) focuses on the progress that each group member has made, what she has left to do, as well as termination issues. Group activities include such exercises as guided imagery involving scenes of personal empowerment, discussions on how the time usually spent in the group will be spent after the group ends, reevaluation of goals and setting new goals, affirmation exercises in which group members are invited to say what each other member has given to them, and ceremonies and rituals that celebrate new beginnings. Regression during this final phase is carefully limited as the ending of the group is imminent. Members are gently reminded of

the impending termination of the group and issues of sadness and anxiety at separation are addressed. The group ends with a graduation exercise that signifies a new beginning even though there may be more individual work to be done.

Each session of group treatment follows a specific format that includes Housekeeping, Personal Time, Journal Time, Main Work, Homework, and Go-Around. Housekeeping consists of general announcements that affect the group, passing out articles of interest, etc. Personal time is used to allow each member to express where she is "right now" as the group meeting is beginning. The group members are invited to discuss significant events that occurred since the last group meeting, both good and bad; reactions from unfinished business from previous sessions; and/or anything that they need to tell or ask from the group.

Journal time offers time for each group member to share thoughts from her Journal, if she wishes. This Journal is given to each member at the start of the group treatment program. Members are then invited to use this Journal during the program to keep a record of their inner life - dreams, reflections, memories, stories, poetry, etc. that are meaningful for them.

The Main Work is the primary focus of each session. The Main Work of the first phase (sessions 1-3) consists of various exercises that deal with incest in a general way until some safety can develop between group members. For example, the Main Work of the first session is called "Brainstorming" in which members are invited to brainstorm around the words "incest",

"victim", and "survivor". Members are invited to call out words that they associate with the above. All of the words that are put forward are written on a flip chart, compiled, and returned to the group members in the following session. This is a very nonthreatening exercise as group members do not have to immediately divulge their history but need only participate as much as feels comfortable for them.

The Main Work of the second phase (sessions 4-8) involves each group member telling the others her story and receiving feedback and validation from the group. The Main Work of phase three (sessions 9-16) consists of discussions and exercises around change. For example, in session 11, each group member is invited to make a "No" list of things or people that she needs to say "No" to in order to take back the power that was taken away from her as a child and to reclaim that power as an adult. Finally, the Main Work of the last phase (sessions 17-20) centres on moving forward and termination. For example, one exercise invites the group members to participate in a special ritual where the group leaders present them with symbols of growth and renewal. Another exercise and discussion deals with new goals that have developed over the course of the group and how these goals are going to be accomplished after the end of the group.

Homework is given to group members between sessions. Homework allows group members time to think about certain issues in advance which decreases anxiety and leads to increased group interaction. For example, Homework for the 17th week of the

program is "What am I going to do on Wednesday nights after the group ends?".

Finally, a Go-Around exercise is used at the end of each session. The Go-Around gives each member a chance to briefly state where she is now that the session is over. Setting aside this time assists members to work within time boundaries, to ground themselves in the present, and to focus on leaving the group setting and returning to the real world.

In summary, the issues dealt with in the "Victim to Survivor Group" include many of the same foci as recommended by authors that have used more specific theoretical perspectives (cf. Theoretical Perspectives in Group Treatment, this paper). Self-construals, loyalty issues, traumatic symptoms, and family relations are variously dealt with in the group process but are focused around the metaphor of the "child within" instead of standing as separate themes. Because the aftereffects of incest are so diverse and may affect each group member differently, it is felt that the group treatment program described above may be more comprehensive than those which concentrate on one particular consequence of incest. The common theme is that each group member needs to be in touch with the "child within" in order to facilitate her transformation from victim to survivor.

A manual outlining the above program in greater detail is available through the National Clearinghouse on Family Violence, Health Canada (Saxe, Johnson, Barrett, Erickson-Fraser, Kalil, & Collins, 1993).

Group Leaders

A female co-therapy team has conducted all incest groups at the Family Services Centre of Ottawa-Carleton since the establishment of the program in 1984. Each group treatment program utilizes two members of a three member team (Pauline Barrett, Lorna Erickson-Fraser, and Kathy Kalil). The co-therapy team rotates between groups with each group conducted by two of the three team members. Each member of the co-therapy team has a Master's Degree in Social Work and deals extensively with incest clients in her individual practice. The team members have a range of 15 to 31 years experience in both individual and group work and all have been involved in conducting various workshops and training programs for other mental health professionals who treat incest survivors. As such, it would be expected that the competency level of each leader is of the highest degree. Therefore, the present study assumed equivalence of group leader competency and group differences due to group leader composition were not examined.

Individual Treatment

The majority of women entering the group treatment program at the Family Services Centre are involved in a variety of individual therapies conducted by different therapists in the community who have different orientations and techniques. Current estimates suggest that there are well over 400 psychotherapy techniques in use for adults (Karasu, 1985, cited in Kazdin & Bass, 1989). However, it is also well known that

different therapies share many commonalities which may account for therapeutic change such as the special relationship between client and therapist and the provision of support, empathy, and concern received during therapy (e.g., Frank, 1982; Waterhouse & Strupp, 1984).

Kazdin (1986) has noted that in treatment outcome research, it may be important to allow some features of the treatments to vary in order to represent the treatments more faithfully, even though the variations may also be looked upon as confounds. For purposes of the present study, certain features of individual therapy such as orientation of the therapist and specific techniques used were allowed to vary randomly across all subjects. However, factors such as the total amount of time in individual therapy before the group, amount of time in individual therapy dealing directly with incest issues before the group, and degree of resolution of incest issues at the time of the initial assessment were included in the demographic questionnaire for subjects in the treatment and wait-list groups in order to control for group differences on these factors. In addition, in order to insure that subjects in the treatment group and the wait-list group were indeed considered in individual therapy during the group treatment program and the wait-list condition, an inclusion criterion for number of sessions of individual therapy during the group treatment program and the wait-list period was established. For the treatment group, the inclusion criterion consisted of remaining in individual therapy for a

minimum of 16 weeks during the 20-week group; for the wait-list group, the inclusion criterion consisted of remaining in individual therapy for a minimum of 80% of the number of weeks on the wait-list.

Measures

The self-report measures used in the present study assessed both intrapersonal symptomatology and interpersonal difficulties. As well, a self-report measure which assessed parenting styles of subjects' mothers and fathers was included. Copies of all measures are presented in Appendix H.

The Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961). The BDI is a 21-item, self-report measure of affective, cognitive, motivational, and physiological symptoms of depression. Each item describes a specific behavioural manifestation of depression and consists of a graded series of four self-evaluative statements which are rank ordered and weighted to reflect the range of severity of the symptom from neutral (0) to maximum (3) severity. The BDI has been found to possess high internal consistency (alpha coefficient of .85) and discriminant validity (e.g., Bech, Gram, Dein, Jacobsen, Vitger, & Bolwig, 1975; Clark, Cavanaugh, & Gibbons, 1983; Davies, Burrows, & Pynton, 1975). It has been used extensively as a pre- and posttest measure for assessing change during psychotherapy. Time for completion is about 10 minutes.

The Centre for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). The CES-D is a 20-item, self-report inventory

designed to measure depressive symptomatology in the general population. It provides a "state" measure of depressive symptomatology insofar as it indicates present levels of functioning in the "past week". The items assess depressed mood, feelings of guilt, worthlessness, loneliness, hopelessness, psychomotor retardation, concentration problems, appetite loss, and sleep disturbances. Subjects are asked to rate each item (e.g., "I felt that I could not shake off the blues even with help from my family or friends") as it occurred during the past week on a 4-point scale ranging from rarely or none of the time (0) to most or all of the time (3). The CES-D has been found to have high levels of internal consistency (alpha coefficient of .80 to .90). Test-retest reliability measured over intervals ranging from two weeks to one year has varied between .40 and .70. The validity of the scale has been supported in a number of studies (e.g., Devins & Orme, 1985; Radloff, 1977). Time for completion is about 10 minutes.

The Brief Symptom Inventory (BSI; Derogatis, 1977). The BSI, an abbreviated form of the SCL-90-R, is a 53-item, norm referenced, self-report inventory designed to reflect the psychological symptom patterns of both clinical and non-clinical populations on nine dimensions: somatization; obsessive-compulsive; interpersonal sensitivity; depression; anxiety; hostility; phobic anxiety; paranoid ideation; and psychoticism. In addition, scores can be summed to yield three indices of symptom severity. The general severity index (BSI-G) is the most

sensitive single indicator of the respondent's distress level, combining information on numbers of symptoms and intensity of distress. Each item (e.g., "feeling fearful") is rated on a 5-point scale ranging from not at all (0) to extremely (4). The BSI shows high internal consistency (.77 to .90) and test-retest reliability (.78 to .90) as well as high correlations with the longer SCL-90-R (.92 to .98 for the symptom subscales) (Derogatis, Rickels, & Rock, 1976). Time for completion is about 10 minutes.

Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979). The IES is a 15-item, self-report measure designed to assess two common responses to stressful life events: intrusion and avoidance. Seven items assess intrusive imagery (intrusion subscale, IES-I) and eight items assess avoidance tendencies (avoidance subscale, IES-A) that have occurred during the past seven days. Each item (e.g., "I thought about it when I didn't mean to") is rated on a 4-point scale ranging from not at all (0) to often (3). The intrusion and avoidance subscales have been found to have high levels of internal consistency (.78 and .82, respectively) and test-retest reliability (.89 and .79, respectively). Test-retest reliability for the total scale has been reported as .87. The IES has been found to be sensitive to therapeutically induced change (Horowitz et al., 1979) and has been used with both clinical and nonclinical populations. Time for completion is about 10 minutes.

The Self-Description Questionnaire III (SDQ III; Marsh &

O'Neill, 1984). The SDQ III is a 136-item, self-report instrument designed to measure multidimensional academic and nonacademic self-concepts for late adolescents and adults. For the present study, four nonacademic subscales were selected to measure self-concept in the areas of general self-concept (SDQ-G), social self concept (with same sex (SDQ-SS) and opposite sex (SDQ-OS) peers), and emotional self-concept (SDQ-E). These four subscales yield 42 items. The general self-concept subscale scale consists of 12 items (e.g, "Overall, I have a lot of respect for myself"). The social self-concept subscales (with same sex and opposite sex peers) consist of 10 items each (e.g., "I find it difficult to meet members of the opposite sex (same sex) whom I like") and the emotional self-concept subscale consists of 10 items (e.g., "I am anxious much of the time"). Each item is rated on an 8-point scale with responses ranging from definitely false (1) to definitely true (8). Internal consistency coefficients range from .79 to .95 (Byrne & Shavelson, 1986) and test-retest reliabilities range from .66 to .94 (Marsh, Richards, & Barnes, 1986). The SDQ III has also demonstrated high construct validity (e.g., Byrne, 1988). The time for completion is about 10 minutes.

Perceived Social Support From Friends and From Family Scales (PSS-FR; PSS-FA; Procidano & Heller, 1983). This measure consists of two self-report scales designed to measure the extent to which an individual perceives that his/her needs for emotional support are fulfilled by friends (PSS-FR) and by family (PSS-FA).

Each scale consists of 20 statements which require the respondent to circle either "yes", "no", or "don't know" (e.g., "My friends give me the moral support I need" (PSS-FR), or "My family gives me the moral support I need" (PSS-FA). For each item, the response indicative of perceived social support is scored as +1 so that scores range from 0, indicating no perceived support, to 20, indicating maximum perceived support for each scale. The "don't know" category is not scored. Both scales have been found to have high levels of internal consistency (.88 and .90 for the PSS-FR and PSS-FA, respectively) and test-retest reliability for both scales is reported as .80 (Tardy, 1985). Time for completion of both scales is about 10 minutes.

Attachment Questionnaire (AQ; West, Sheldon, & Reiffer; 1987). The AQ is a 35-item, self-report measure designed to assess adult attachment in terms of seven criteria and provisions definitive of the unique function of reciprocal attachment in meeting security needs: separation protest, use of attachment figure, availability, reciprocity, secure base, feared loss, and proximity seeking. Each item (e.g., " I worry about losing my attachment figure") is rated on a 5-point scale ranging from strongly disagree (1) to strongly agree (5). Scores will be reflected so that higher scores will indicate more secure attachment behaviours. Internal consistencies of individual scales range from .73 to .94 and test-retest reliabilities range from .67 to .81 (West, Sheldon, & Reiffer, 1987, unpublished manuscript). In addition, the AQ and has been found to

successfully discriminate between patients and nonpatients (West, et al., 1987). Time for completion is about 10 minutes.

Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979). The PBI is a 25-item, self-report measure which assesses two principal dimensions of parental behaviour: care and protection. The PBI is designed to be used for either parent and assesses respondents' perceptions of that parent with respect to the amount of demonstrated care and protection experienced within the first 16 years. Both the PBI for mother and for father were used in this study. High scores (over 27 for mothers and over 24 for fathers) on the 12-item care scale indicate that parental behaviours were characterized by a high degree of warmth and affection (eg., "enjoyed talking things over with me"). High scores (over 13.5 for mothers and over 12.5 for fathers) on the 13-item overprotection scale indicate that parental behaviours were characterized by control, intrusion, and infantilization (eg., "invaded my privacy"). Each item (e.g., "Did not help me as much as I needed") is rated on a 4-point scale from very like (1) to very unlike (4). Test-retest coefficients have been found to range from .87 to .92 (Parker, 1984). In addition, the PBI has been found to be a valid measure of actual, and not merely perceived, parental characteristics (Parker & Lipscombe, 1981). Time for completion of both forms of the PBI is about 15 minutes.

Data Analysis

All data analyses were performed separately for intrapersonal and interpersonal dependent measures. Intrapersonal dependent measures consisted of the BDI; the CES-D; the general severity index of the BSI (BSI-G); two scales of the IES, the avoidance scale (IES-A) and the intrusion scale (IES-I); and two scales of the SDQ-III, the emotional self-concept scale (SDQ-E) and the general self-concept scale (SDQ-G). Interpersonal dependent measures consisted of a summary score of items on the AQ (AQ-T); a further two scales of the SDQ-III, the same-sex self-concept scale (SDQ-SS) and the opposite-sex self-concept scale (SDQ-OS); and the PSS-FR and PSS-FA scales. Any of the above measures with missing data on more than 5% of cases (Tabachnick & Fidell, 1989) were deleted from multivariate procedures and examined separately since their presence would greatly reduce the power of the study. SPSS Frequencies (SPSS Inc., 1990) was used for data reduction and screening of the treatment group and the wait-list group for subsequent analyses. All multivariate analyses used Pillai's criterion at an alpha level of .05 unless otherwise noted.

Because subjects in both the treatment group (TG) and the wait-list group (WLG) entered the study at different points in time, a nuisance variable i.e., "subgroup" was created in order to determine if there were any significant differences between subgroups for demographic and pretreatment dependent measures. On theoretical grounds, "subgroup" was not expected to be an

influential factor, but it was necessary to adopt a strategy which would empirically determine its actual influence (Kirk, 1982), if any. Otherwise, data from the treatment group and wait-list group would have mistakenly appeared as though they had been obtained from two intact groups. SPSS Crosstabs and SPSS Manova (SPSS Inc., 1990), as appropriate to the data, were used to examine differences between subgroups within the treatment group and the wait-list group.

Because there is often a high drop-out rate in group treatment programs for women with a history of incest (L. Erickson-Fraser, March, 1993, personal communication), it was decided to compare the drop-out group (DG; subjects in the treatment group who did not complete the group treatment program) with those who completed the group treatment program to determine if drop-outs were from the same population as treatment completers. Between-group analysis was conducted using Fisher's exact tests and multivariate analyses of variance (MANOVA) to compare demographic and pretreatment dependent measures for the drop-out group and the treatment group. Discriminant analyses were conducted to determine whether subjects in the drop-out group and the treatment group could be discriminated based on scores on the pretreatment measures.

Since subjects in the present study were not randomized to the treatment group and the wait-list group, a series of Chi-Square, Fisher's exact tests, and MANOVAs, as appropriate to the data, were used to determine group equivalence on both

demographic and pretreatment dependent measures. Any demographic or dependent variable found to be significantly different between groups could then be used as a covariate in further analyses. In particular, four demographic variables found to be theoretically related to severity of long-term effects of abuse (Courtois, 1988) were to be examined: use of force, duration of the abuse, age-of-onset of the abuse, and single vs. multiple abusers. As well, because all subjects in the study were required to be in individual therapy, differences between the treatment group and the wait-list group on variables related to subjects' experience of individual therapy were considered to be of particular importance such as amount of time spent in individual therapy before the group, amount of incest therapy, and degree of resolution of incest issues before the group. The number of covariates used, if any, could then be tailored to the final sample size (Stevens, 1986). If significant differences were not found on demographic or pretreatment dependent variables, multivariate analysis of covariance (MANCOVA) would not be used on subsequent analyses, as a covariate model would greatly reduce the power of the test for group differences (Tabachnick & Fidell, 1989).

To test Hypothesis #1 (effectiveness of the group treatment program), a repeated-measures MANOVA on both intrapersonal and interpersonal dependent measures was conducted with Time (Pretreatment, Posttreatment) as the repeated measure and Group (TG, WLG) as the between-subjects factor. Significant

multivariate F's were examined using two procedures: (1) univariate analysis of variance (ANOVA) using the Bonferroni adjustment to control for Type 1 error rate and (2) stepdown analysis for correlated dependent measures (Tabachnick & Fidell, 1989). The latter procedure was used as it was expected that dependent measures for both intrapersonal and interpersonal data would be moderately correlated. Although the stepdown procedure is more appropriate than the Bonferroni adjustment for dependent measures correlated in excess of $\pm.30$, it is necessary to interpret significant stepdown Fs using both univariate and stepdown significant results since nonsignificance in a stepdown analysis does not mean that a particular variable is unaffected by treatment but rather that no unique variability is portioned to that particular dependent variable after adjustment for higher priority variables. However, although both of these procedures are required to correctly interpret the pattern of stepdown Fs, more emphasis is given to the dependent measures that are significant in the stepdown analysis (Tabachnick & Fidell, 1988).

The stepdown procedure first assesses the highest priority dependent measure in a series of univariate ANOVAs. The second-highest priority dependent measure is then assessed in an analysis of covariance (ANCOVA) with the highest-priority dependent measure as the covariate. This process is continued until all dependent measures are analyzed. For the present study, the following prioritized order of intrapersonal dependent measures was developed: BDI, CES-D, BSI-G, IES-A, IES-I, SDQ-E,

SDQ-G. The BDI and CES-D were entered first because change in depressive symptomatology has been found to be a powerful indicator of improvement in therapy (Beck, Steer, & Garbin, 1988). Measures of general psychological distress and specific post-traumatic symptomatology were entered next, followed by scores measuring emotional and general self-concept.

Interpersonal dependent measures were placed into the stepdown analysis in the following order: PSS-FR, SDQ-SS, SDQ-OS, PSS-FA. Perceived social support from friends (PSS-FR) was entered first because the literature suggests that one of the main functions of group treatment for incest survivors is that it reduces isolation (Courtois, 1988) which may have an effect on measures of perceived social-support from friends. Self-concept in regards to same sex peers (SDQ-SS) was entered next because the group treatment program was exclusively for women with a history of incest and was conducted by female co-therapists. Self-concept in regards to members of the opposite sex (SDQ-OS) follows. The measure of perceived social-support from family members (PSS-FA) was entered last because this variable may be more resistant to change for this particular population (Courtois, 1988). The measure of secure attachment (AQ-T) was examined separately because there were missing data on more than 5% of cases.

Finally, analysis of simple effects using univariate ANOVAs was conducted on intrapersonal and interpersonal dependent measures found significant in the univariate and stepdown

procedures with greater emphasis being given to measures found significant in the stepdown procedure. These analyses looked at group differences as a function of time.

To test hypothesis #2 (effects of the group treatment program across time), data from the intrapersonal and interpersonal dependent measures for the treatment group only were subjected to a repeated-measures MANOVA with Time (Pretreatment, Posttreatment, Follow-up) as the within-group, repeated measure. Significant multivariate effects were analyzed using a series of univariate ANOVAs with Greenhouse-Geisser corrected degrees-of-freedom to control for violations of the sphericity assumption in repeated-measures analysis (Jennings, 1987). A series of trend analyses was then conducted on dependent measures that were found to be significant in the univariate repeated-measures ANOVAs in order to determine the best-fitting function that would describe the relationship between mean scores on the dependent measures at the three time points: pretreatment, posttreatment, and follow-up. Because subjects were assessed at three points in time, only a linear function and/or a quadratic function could be fit to the data.

In accordance with the move toward the specification of clinically significant change in treatment studies (c.f., Jacobson, Follette, Revenstorf, Baucom, Hahlweg & Margolin, 1984), a strategy for determining clinical significance was utilized to provide further information about the effectiveness of the group treatment program for individual subjects. Two

criteria for determining clinical significance were used: (1) a posttreatment score which would indicate that a subject was more likely to belong to a functional rather than a dysfunctional population on the variable of interest, and (2) a reliable change index (RC) greater than ± 1.96 which would indicate that the magnitude of change of the subject during the course of therapy was unlikely to be due to an artifact of measurement error. If a subject's posttreatment score met both of the above criteria, the subject was considered "recovered". The BDI was chosen as the variable to test for clinical significance since it is a well recognized indicator of change during treatment (Beck, Steer, & Garbin, 1988).

It was necessary to decide between three cut-off scores for determining whether a subject was considered a member of a functional population. First, Beck, Steer, and Garbin (1988) have reported that the Centre for Cognitive Therapy has established that a score of 10 or less on the BDI is indicative of minimal depression in the general population. Second, using Jacobson and Truax's (1991) criteria when normative data on the instrument of interest are available, the cut-off score would lie half-way between the mean of a functional population (4.5; Beck & Steer, 1987) and the mean of the dysfunctional population examined in the study. This methodology produced a cut-off score of 14. Finally, it was also felt that an appropriate cut-off score would be one which fell completely outside the range of the dysfunctional population in the study (Jacobson & Truax, 1991),

where range is defined as extending two standard deviations beyond the mean of the dysfunctional population in the direction of functionality. In this case, the cut-off score was 8. It was decided to calculate clinical significance using the three cut-off scores because the present study was exploratory in nature.

The reliable change index was calculated for each subject's posttreatment score following the method suggested by Jacobson and Revenstorf (1988). The reliable change index is equivalent to the difference score (pretreatment - posttreatment) divided by the standard error of measurement calculated by multiplying the averaged standard deviation of the experimental group (TG) and the control group (WLG) at pretreatment by the square root of one minus the test-retest reliability of the measure (.76; Beck, Steer & Garbin, 1988). Subjects whose posttreatment scores showed a statistically reliable change (i.e., a reliable change index greater than $\pm$ 1.96) from pretreatment levels were considered to have made a clinically significant change (improvement or deterioration).

In addition, as suggested by Jacobson and Truax (1988), it was decided to report how many subjects made a clinically reliable improvement (RC greater than $\pm$ 1.96) but did not recover, that is, (1) that change was in the direction of functionality, (2) that the RC was greater than $\pm$ 1.96, but (3) that the subject's score did not reach the cut-off point that would indicate recovery.

Deterioration was operationalized as a change in the

direction of dysfunctionality that was clinically reliable (i.e., RC greater than ± 1.96).

In order to describe subject's current perception of mother and father's early parenting styles, PBI scores for mothers and for fathers were plotted separately in quadrants defined by "Care" and "Protection" dimensions. The "Protection" dimension is a continuum wherein high scores indicate overcontrolling, intrusive behaviours on the part of the parent while low scores indicate lack of protective/neglectful behaviours on the part of the parent. The axes for the quadrants were constructed to intersect at means obtained from Care and Protection scores of a nonclinical group studied previously (Parker, 1983). For mothers, the dichotomized Care score was 27.0 and the Protection score was 13.5. For fathers, the dichotomized Care score was 24.0 and the Protection score was 12.5. SPSS Crosstabs (SPSS, 1990) was used to determine the percentage of subjects in each of four quadrants which represent four different parenting styles based on the degree of care and protection towards the child (under 16 years of age; Parker, Tupling, & Brown, 1979; Parker, 1984). These quadrants have been labelled as "affectionless control" (high control - low care), "absent or weak bonding" (low protection - low care), "affectionate constraint" (high control - high care), and "optimal bonding" (low protection - high care).

RESULTS

The results of the study have been organized into seven sections: (1) data reduction and screening of the treatment and wait-list groups for subsequent data analysis; (2) a comparison of the subjects who completed the group treatment program with those who did not; (3) a comparison of treatment and wait-list groups to determine group equivalence on demographic and pretreatment dependent measures; (4) the results of hypothesis #1 (the effectiveness of the group treatment program for the treatment group as compared to the wait-list group on both intrapersonal and interpersonal dependent measures); (5) the results of hypothesis #2 (the effectiveness of the group treatment program at six-month follow-up for the treatment group only on both intrapersonal and interpersonal dependent measures), (6) an analysis of the clinical significance of the group treatment program for the treatment and wait-list groups; and (7) an analysis of the PBI, a questionnaire which seeks to describe subjects' perception of early parenting styles of their mothers and fathers.

Data Reduction and Screening of the Treatment and Wait-list Groups

Subjects for the TG were recruited from groups beginning February, 1989; September, 1989; February, 1990; September, 1990; and February, 1991. Fifty subjects agreed to participate in the

study and completed the pretreatment assessment. However, six subjects (12%) did not meet inclusion criteria for the TG (a minimum of 16 sessions of individual therapy during the 20-week group treatment program), six subjects (12%) dropped out before completion of the group treatment program (drop-out group; DG), and one subject (2%) failed to complete the research leaving 37 subjects in the TG.

Demographic and dependent measures for the remaining 37 treatment group subjects were examined through SPSS Frequencies (SPSS Inc., 1990) to determine whether the data met assumptions for multivariate analysis of variance (MANOVA). All variables were within the normal range for skewness and kurtosis using a criterion of three standard deviations around the mean. Further inspection of the data indicated that five subjects were identified as having a raw score more than three standard deviations from the sample mean on at least one continuous variable. The five subjects found to have univariate outliers were deleted from the data base. No subjects were designated as being multivariate outliers using a criterion of $p < .001$ for the Mahalanobis distance. A total sample of 32 subjects remained to form the TG.

Because subjects in the TG entered the study at five different points in time, a nuisance variable i.e., "subgroup" was created in order to determine if there were any significant differences between the five subgroups (February, 1989; September, 1989; February, 1990; September, 1990; and February,

1991) on demographic and pretreatment dependent measures. Continuous demographic measures of age, age-of-onset of the abuse, total amount of time in individual therapy, and amount of incest therapy were examined using multivariate analysis of variance (MANOVA) for the five subgroups. No significant differences between subgroups were found on the above variables (F (16,108) = 1.25, p >.05). Because there were too few subjects in each subgroup to meet minimum expected frequencies required for Chi-square analysis and/or Fisher's exact tests, analysis of categorical demographics could not be carried out. Separate MANOVAs found no significant differences on either the intrapersonal (F (28,96) = 1.22, p >.05) or interpersonal (F (16, 104) = 1.15, p >.05) dependent measures. It would appear from these findings that subjects from the five treatment subgroups could be combined without influencing interpretation of the overall analysis between the TG and the WLG.

WLG subjects were assessed in March, 1991; August, 1991; March, 1992; and August, 1992, approximately 20 weeks before the start of their respective group treatment programs. Thirty-six subjects were recruited for the WLG. Three (8%) were excluded because they did not meet the inclusion criteria (in individual therapy a minimum of 80% of the number of weeks on the wait-list) and two (5%) did not complete the study (one subject moved out of the city and one decided to enter the group treatment program at a later date) leaving 31 subjects in the WLG.

Demographic and dependent measures from these 31 subjects

were examined using SPSS Frequencies (SPSS, Inc., 1990) to determine if the data met assumptions for multivariate analysis of variance. All variables were within the normal range for skewness and kurtosis using a criterion of three standard deviations around the mean. Further inspection of the data indicated that no subjects were identified as having a raw score more than three standard deviations above or below the sample mean on any continuous variable. In addition, no subjects were found to be multivariate outliers using a criterion of $p < .001$ for Mahalanobis distance. Since no subjects had to be deleted, a total sample of 31 subjects formed the WLG.

As with the TG, subjects in the WLG entered the study at four different points in time necessitating a comparison between the four subgroups (March, 1991; August, 1991; March, 1992; and August, 1992) that comprised the WLG. A MANOVA between the four subgroups found no significant differences for age, age-of-onset of the abuse, total amount of time in individual therapy, and amount of incest therapy (F (12,78) = .80, $p > .05$). Chi-square and Fisher's exact tests could not be conducted on the categorical demographics because of the small sample size in each of the subgroups. MANOVAs between the four subgroups found no significant differences for either the intrapersonal (F (21,69) = 1.48, $p > .05$) or interpersonal (F (12,78) = 1.77, $p > .05$) dependent measures. Again, it would appear from these findings that subjects in the four wait-list subgroups could be combined without influencing interpretation of the overall analysis

between the TG and the WLG.

Comparison Between the Treatment Completers and the Drop-Out Group

Six subjects in the treatment group (12%) did not complete the group treatment program for the following reasons: four gave no reason but did not return after attending several sessions (3, 3, 5, and 11 sessions), one was psychiatrically hospitalized after the fifth session, and one began to reabuse alcohol and decided to return to AA after the eighth session. The drop-outs were spread evenly across the subgroups of the treatment group: one from the group beginning in February, 1989; one from September, 1989; one from February, 1990; two from September, 1990; and one from February, 1991.

In order to determine if the subjects who completed the group treatment program (n = 32) differed from subjects that dropped out of the group treatment program (n = 6), intrapersonal and interpersonal dependent measures from the DG and the TG were analyzed. Preceding this analysis, data from the DG were screened demonstrating that all variables were within the normal range for skewness and kurtosis and that there were no univariate or multivariate outliers. However, because only three out of six subjects in the DG filled out the AQ-T, this variable was not included in subsequent analyses for interpersonal dependent measures.

Separate MANOVAs indicated that the DG differed significantly from the TG on both intrapersonal (exact F (7,29) =

3.36, $p < .05$) and interpersonal (exact F (4,32) = 5.88, $p < .05$) dependent measures. Because several of the intrapersonal and interpersonal dependent measures exhibited correlations in excess of $\pm .30$, examination of both intrapersonal and interpersonal dependent measure was conducted using a series of univariate ANOVAs with Bonferroni adjustments and stepdown analysis of the prioritized dependent measures as outlined in the Data Analysis section.

Results of the pooled, within-cell correlations, univariate ANOVAs with Bonferroni adjustment, and stepdown analysis for both the intrapersonal and interpersonal dependent measures are presented in Tables 1 and 2.

Insert Table 1 and 2 about here

Examination of the univariate Fs for intrapersonal dependent measures (see Table 2) indicated that the CES-D (exact F (1,35) = 13.29, $p < .007$) and the BSI-G (exact F (1,35) = 12.71, $p < .007$) accounted for the overall significant difference between the DG and the TG. The stepdown analysis demonstrated that a unique contribution to the significant differences between the DG and the TG was made by the BDI (stepdown F (1,35) = 6.43, $p < .05$) and the CES-D (stepdown F (1,34) = 5.65, $p < .05$). The unique contribution of the IES-A approached significance (stepdown F (1,31) = 3.57, $p = .06$). Overall, it appears that women in the DG had significantly higher levels of depressive

symptomatology than the treatment completers as well as higher levels of psychological distress. They also appear to have more avoidance behaviours regarding their incest issues although the differences between the DG and TG on this variable only approached significance.

Examination of univariate and stepdown Fs for interpersonal dependent measures (See Table 2) indicated that the same variables that were responsible for the overall significant difference between the DG and the TG also made unique contributions to the significant difference between the two groups. Results from the stepdown analysis indicated that a unique contribution to the significant difference between the TG and the DG was due to group differences on the PSS-FR (Stepdown F (1,35) = 6.83, p <.05, SDQ-SS (Stepdown F (1,34) = 7.76, p <.05) and the PSS-FA (stepdown F (1,32) = 5.28, p <.05). Overall, women in the DG had lower perceived support from their friends, lower self-concept regarding their social interactions with other women, and lower perceived support from their families than treatment completers.

With respect to the demographic variables, a MANOVA was conducted between the DG and the TG for age, age-of-onset of the abuse, total amount of time in individual therapy and amount of incest therapy. No significant differences were found between the DG and the TG (F (4,32) = 1.05, p >.05) on these variables. A series of Fisher's exact tests found no significant differences in birthorder (p >.05), marital status (p >.05), duration of the

abuse ($p > .05$), use of force ($p > .05$), or reason for entering therapy ($p > .05$). Because answers to questions about education, substance abuse, and physical and sexual abuse as an adult were not asked until the posttreatment assessment, these variables could not be examined. However, an interesting finding did emerge: all of DG had been abused by multiple abusers while only 43% of the treatment completers had been abused by multiple abusers ($p < .05$, Fisher's exact test).

In order to determine if this was an artifact of the DG in this study or whether all women in the present study who had experienced multiple abusers may have differed from women who had experienced a single abuser, the TG and the WLG were each divided into two groups: those who had been abused by multiple abusers and those who had been abused by a single abuser.

As can be seen in Table 3, means for intrapersonal and interpersonal pretreatment dependent measures for the TG and WLG divided according to single vs. multiple abusers appeared comparable. However, there appeared to be large differences between the means of the pretreatment dependent measures of the DG (all abused by multiple abusers) and the means of the TG and WLG divided according to single vs. multiple abusers.

Insert Table 3 about here

MANOVAs conducted separately on the TG and WLG utilizing single vs. multiple abusers as an independent factor found no

significant differences for either intrapersonal (TG: exact F (7,24) = .34; WLG: exact F (7,23) = 1.69) or interpersonal (TG: exact F (4,26) = .393; WLG: exact F (4,26) = .098) dependent measures. This finding suggests that subjects in the TG and subjects in the WLG could not be differentiated based on whether they had been abused by a single abuser or by multiple abusers, and that the significant differences found between the TG and the DG could not be explained by the fact that subjects in the DG had all been abused by multiple abusers.

Finally, subjects who had experienced multiple abusers but who had completed the group treatment program (TG-MA, n=14) were compared to the DG using multivariate discriminant analysis in order to identify variables that might significantly discriminate between these two groups.

Two separate direct discriminant function analyses were conducted using intrapersonal and interpersonal dependent measures as predictors of membership in the DG and the TG-MA. The discriminant analysis for intrapersonal dependent measures revealed distinctively different groups as suggested by the group centroids on the discriminant function (DG = +2.3; TG-MA = -.082) and a canonical correlation of .82 for the discriminant function (Wilks's lambda = .32, df = 7, p <.05). Using a loading factor greater than ±.50 as a criterion for meaningful prediction (Tabachnick & Fidell, 1989), it was found that the BSI-G (loading factor = .76) and CES-D (loading factor = .63) were the best predictors of group membership. Using all of the intrapersonal

dependent measures (BDI, CES-D, BSI-G, IES-I, IES-A, SDQ-E, SDQ-G), the discriminant function classification equation was able to correctly classify 95% of the subjects into their actual group (DG or TG-MA).

The discriminant analysis for interpersonal dependent measures also revealed distinctively different groups as indicated by the group centroids on the discriminant function (DG = -1.6; TG-MA = +.70) and a canonical correlation of .75 for the discriminant function (Wilks's lambda = .43, df = 4, p < .05). Using a loading factor greater than $\pm$ .50 as a criterion for meaningful prediction, it was found that the SDQ-SS (loading factor = .75) and the PSS-FA (loading factor = .58) were the best predictors of group membership. Using the four interpersonal dependent measures as predictors (PSS-FR, SDQ-SS, SDQ-OS, PSS-FA), the discriminant function classification was able to correctly classify 95% of the subjects into their actual groups (DG or TG-MA).

The above results must be viewed with caution because of the small size of the DG in all of the comparisons. However, it appears that the subjects who did not complete treatment were from a distinctively different population than those who completed treatment. In general, although subjects in the DG did not differ from treatment completers on demographic variables such as age, age-of-onset of the abuse, total amount of time in individual therapy, amount of incest therapy, birthorder, marital status, duration of the abuse, use of force, or reason for

entering therapy, they appeared to have more depressive and psychological symptoms, to perceive their families as less supportive, and to see their social interactions with other women in a more negative light than women who completed the group treatment program. In addition, they may have also had more avoidance behaviours which would prevent them from dealing with the abuse. The fact that the DG had been abused by multiple abusers did not appear to be a significant factor in their dropping out of the group treatment program. On the basis of the above findings, it seems appropriate that these subjects were not included in any subsequent analyses as they may have severely limited the generalizability of any results found in the present study.

Comparison of Characteristics of the Treatment and Wait-List Groups

Because the present study was a quasi-experimental design, the TG and WLG were compared on all demographic variables to determine group equivalence. Chi-square, Fisher's exact test, and MANOVAs were used to examine group differences, depending on the nature of the demographic variable (i.e, continuous or categorical). If a categorical variable did not have enough subjects in each cell, the categories were combined in order to meet minimum expected frequency requirements. Table 4 displays the demographic characteristics of the TG and the WLG.

Insert Table 4 about here

As can be seen in Table 4, there were no significant differences between the TG and WLG on age, race, birthorder, relationship status, education, employment, or children. Since no significant differences were found between the TG and the WLG, the following summary will apply to the total sample.

Overall, the women who participated in the study were white (95%), in their mid-thirties, and were, for the most part, either never married (41%) or separated/divorced (38%). The majority had more than high school education (66%) and were employed (65%). About half (46%) of the women had children.

Characteristics related to the abuse for the TG and WLG are presented in Table 5. No significant differences between the TG and WLG for age-of-onset of the abuse, duration of the abuse, single vs. multiple abusers, use of force, or degree of upset at the time of the abuse.

Insert Table 5 about here

Since there were no significant differences between the TG and the WLG, the following summary will apply to the total sample. The average age-of-onset of the abuse was five years of age with 60% of the women reporting that the abuse began at the age of five or under. The primary abuser was generally the father, although 54% of the women had multiple abusers. For 65% of the women, the abuse lasted longer than three years.

Approximately half (52%) experienced force during the abuse and 85% said that they were very or extremely upset at the time of the abuse while only 15% said that they were not very or somewhat upset. Eleven women (17%) could not answer this question because they did not remember how they felt at the time of the abuse. Only two women in the study (3%) reported that the abuser had acknowledged that the abuse occurred.

A comparison of negative adult experiences for the TG and WLG is presented in Table 6. As can be seen in Table 6, there were no significant differences in the adult experiences of the TG and WLG.

Insert Table 6 about here

Since there were no significant differences between the TG and the WLG, the following summary will refer to the total sample. Most of the women in the study (73%) had experienced some kind of sexual abuse as adults. Of these, more than half (57%) reported being raped either by a stranger or by someone known to them. In addition, almost half of the total sample had experienced physical abuse as adults (41%). All but one woman had thought of committing suicide (98%) with 36% actually attempting suicide. About 40% of the women reported that they had abused drugs or alcohol at some time. Finally, all but one woman in the total sample (98%) reported that the incest had had a great effect on their lives.

Table 7 is a presentation of the characteristics of individual therapy for the TG and WLG. No significant differences were found in the experience of individual therapy for the TG and the WLG.

Insert Table 7 about here

Since there were no significant differences between the TG and WLG, the following summary will refer to the total sample. On average, the women who participated in the study had been in individual therapy for about four and a half years. Most (70%) had sought therapy for reasons other than incest. Of these, 43% (30% of the total sample) reported that they knew about the incest when they entered therapy but only disclosed to their therapist some time after therapy had begun while 57% (40% of the total sample) reported that they began to retrieve memories of the incest once individual therapy was in progress. On average, the women had spent a little over two years dealing directly with their incest issues, most in weekly therapy sessions (84%). About half (49%) of the total sample reported that their incest issues, at the time of the pretreatment assessment, were "a little resolved" compared to "not at all resolved" (22%), "somewhat resolved" (28%) or "mostly resolved" (0%).

Finally, in order to determine equivalence between the TG and the WLG at pretreatment on the dependent measures, separate MANOVAs were conducted on intrapersonal and interpersonal

pretreatment dependent measures. The AQ-T was not included in the MANOVA for interpersonal measures since 17 (27%) of the women reported that they did not have an attachment figure (8 in the TG; 9 in the WLG). Results indicated that there were no significant differences at pretreatment for either the intrapersonal (exact F (7,55) = 1.42, p >.05) or interpersonal (exact F (4,57) = .26, p >.05) dependent measures. A separate MANOVA for the AQ-T found no significant differences between the TG and the WLG (F (1,43) = 1.08, p>.05) at pretreatment.

In summary, the above comparisons between the TG and the WLG found no significant differences on any demographic or pretreatment dependent measure. As such, no covariates were used in the subsequent analyses.

Hypothesis #1: The Effectiveness of the Group Treatment Program

Treatment implementation To verify that the group treatment protocol for all subjects followed a similar format, subjects in the TG (N = 32) were given a treatment implementation checklist following the group treatment program (See Appendix I). This checklist consisted of seventeen questions regarding different group activities and exercises as outlined in the treatment manual (Saxe, et al., 1993). Each question was scored as "yes", "no", or "unsure". Thirty-one subjects (97%) indicated that all of the activities and exercises included in the checklist took place. One subject (3%) was unsure about one item.

Reliability of Intrapersonal and Interpersonal Dependent Measures

Cronbach's alpha coefficient, an estimate of internal consistency, was calculated for all intrapersonal and interpersonal dependent measures at first administration in order to insure acceptable reliability. Results are presented in Appendix J. As can be seen from Appendix J, estimates of internal consistency for all measures are within acceptable limits and are similar to those reported in the literature (see Measures, p.89, this paper).

Intrapersonal dependent measures A 2 X 2 (Group: TG and WLG X Time: Pretreatment and Posttreatment) between-subjects MANOVA was conducted on data from the BDI, CES-D, BSI-G, IES-A, IES-I, SDQ-E, and SDQ-G in order to test the effectiveness of the group treatment program on intrapersonal symptomatology. Means and standard deviations for the TG and WLG at pretreatment and posttreatment are presented in Table 8.

Insert Table 8 about here

Results of the overall MANOVA indicated a significant main effect for Group (exact F (7,55) = 2.87, p <.05), for Time (exact F (7,55) = 4.43, p <.05), and for the Group X Time interaction (exact F (7,55) = 13.63, p < .05). Because the Group X Time interaction was significant indicating differential effects for the TG and WLG over time, interpretation of main effects was not conducted.

In order to determine which intrapersonal dependent measures

contributed to the significant Group X Time interaction, two procedures were conducted: the first consisted of a series of univariate ANOVAs with Bonferroni adjustments (p = .007) for each dependent measure and, because many of the dependent measures exhibited correlations greater than ± .30, the second consisted of a stepdown analysis on the prioritized dependent measures as outlined in the Data Analysis section.

Results of the pooled, within-cell correlations, univariate ANOVAs and the stepdown analysis are summarized in Tables 9 and 10.

Insert Tables 9 and 10 about here

Examination of the univariate F's indicated that all of the intrapersonal dependent measures except the IES-I contributed to the significant Group X Time interaction using alpha = .007. Further examination of stepdown F's indicate that the BDI and the IES-I were the two dependent measures primarily responsible for the significant Group X Time interaction. That is, the variance in the CES-D, BSI-G, IES-A, SDQ-E, and SDQ-G could be accounted for through overlap with the variance of the BDI and the IES-I, both of which made a unique contribution to the significant Group X Time interaction.

In line with the statistical model described in the Data Analysis section, each intrapersonal dependent measure was tested using univariate ANOVAs to determine simple effects, but more

emphasis was given to the BDI and the IES-I, measures that were significant in the stepdown analysis (Tabachnick & Fidell, 1989).

Results of the simple main effects for the BDI indicated that scores on the BDI were significantly lower for the TG at posttreatment compared to pretreatment (F (1, 61) = 86.15, p <.05) and significantly higher for the WLG at posttreatment than at pretreatment (F (1, 61) = 12.00, p, <.05) (See Figure 1). Results of simple main effects for the IES-I indicated that scores on the IES-I were significantly lower for the TG at posttreatment compared to pretreatment (F (1, 61) = 3.86, p <.05) but not significantly different for the WLG at posttreatment compared to pretreatment (F (1, 61) = .27, ns) (See Figure 2).

Results of the simple main effects of the CES-D, BSI-G, IES-A, SDQ-E, and SDQ-G were as follows: Scores on the CES-D and the BSI-G were significantly lower for the TG at posttreatment compared to pretreatment (CES-D: F(1,61) = 16.62, p <.05; BSI-G: F (1,61)= 32.27,p <.05) and significantly higher for the WLG at posttreatment than at pretreatment (CES-D: F (1,61) = 5.61, p <.05; BSI-G: F (1,61) = 5.65, p <.05), analogous to the effects of the BDI.

Scores on the IES-A, the SDQ-E, and the SDQ-G were analogous to the effects of the IES-I. For the IES-A, scores for the TG were significantly lower at posttreatment compared to pretreatment (F (1,61) = 25.17, p <.05) but not significantly different for the WLG at posttreatment compared to pretreatment (F (1,61) = .00, ns). Scores on the SDQ-E and the SDQ-G were

significantly higher for the TG at posttreatment than at pretreatment (SDQ-E: F (1,61) = 19.27, p <.05; SDQ-G: F (1,61) = 22.42, p <.05) but not significantly different for the WLG at posttreatment compared to pretreatment (SDQ-E: F (1,61) = .54, p >.05; SDQ-G: F(1,61) = 3.22, p >.05).

Overall, it appears that women who participated in the group treatment program became significantly less depressed and had significantly less intrusive symptoms than women who did not participate in the group treatment program. The decrease in depressive symptomatology and intrusive symptoms appeared to be concomitant with the lessening of psychological distress and avoidant behaviours as well as an improvement in general and emotional self concept. Women who did not participate in the group treatment program became significantly more depressed which also appeared to give rise to more psychological distress. However, intrusive and avoidant symptoms for women in the wait-list condition remained the same over the waiting period as did general and emotional self-concept.

Interpersonal dependent measures Because scores on the AQ-T were missing for 17 (27%) subjects (8 in the TG and 9 in the WLG), the AQ-T was deleted from the following analyses and examined separately. A 2 X 2 (Group: TG and WLG X Time: Pretreatment and Posttreatment) MANOVA was conducted on data from the PSS-FR, SDQ-SS, SDQ-OS, and the PSS-FA in order to test the effectiveness of the group treatment program on interpersonal difficulties. Means and standard deviations for the TG and the

WLG at pretreatment and posttreatment are presented in Table 11.

Insert Table 11 about here

Results of the overall MANOVA indicated no significant main effects for Group (exact F (4, 57) = .53, p >.05) or for Time (exact F (4, 57) = 1.54, p >.05) but a significant Group X Time interaction (exact F (4, 57) = 3.06, p <.05) indicating differential effect for the TG and the WLG on interpersonal dependent measures.

In order to determine which intrapersonal dependent measures contributed to the significant Group X Time interaction, the dependent measures were tested using both univariate ANOVAs with a Bonferonni adjustment (p = .0125) as well as a stepdown analysis since several dependent measures exhibited correlations in excess of ±.30 In the stepdown analysis, dependent measures were entered in the prioritized manner as outlined in the Data Analysis section. Results of the pooled, within-cell correlation, univariate analysis and stepdown analysis are presented in Tables 12 and 13.

Insert Tables 12 and 13 about here

Examination of the results obtained from the univariate ANOVAs and the stepdown analysis were identical indicating that the PSS-FR was responsible for and made a unique contribution to

the significant Group X Time interaction. The simple main effect for PSS-FR revealed a significant increase in perceived social-support from friends for the TG at posttreatment compared to pretreatment (F (1,61) = 9.24, p <.05) but no significant difference for the WLG at posttreatment compared to pretreatment (F (1,61) = 2.64, ns) (See Figure 3).

Means and standard deviations for the AQ-T for the TG and the WLG are presented in Table 14. A separate MANOVA with Group (TG, WLG) as the between-subjects factor and Time (Pretreatment, Posttreatment) as the within-subjects factor was conducted on data from the AQ-T. Results indicated a main effect for Time (F (1,44) = 9.32, p <.05). The main effect for Group was not significant (F (1,44) = .703) nor was the Group X Time interaction (F (1,44) = 3.13). Examination of the means of the AQ-T (See Table 14) indicated a significant increase in secure attachment behaviours for both the TG and WLG between pretreatment and posttreatment.

Insert Table 14 about here

Posttreatment Questionnaire Following the group treatment program, subjects in the TG were asked to rate (1) their experience of the group treatment program and (2) their degree of resolution of incest issues following the group treatment program.

Sixteen subjects (50%) in the TG rated the group experience

as "extremely helpful", 12 subjects (38%) rated the group experience as "very helpful", and four subjects (12%) rated the group as "moderately helpful". No subjects rated the group as "only slightly helpful" or "not helpful at all".

Nineteen subjects (60%) in the TG rated their degree of resolution of incest issues as either "somewhat resolved" or "mostly resolved" and 13 subjects (40%) rated their degree of resolution of incest issues as either "not at all resolved" or "a little resolved". The degree of resolution of incest issues differed significantly from pretreatment (χ^2 (1) =6.34, $p<.05$) indicating that a significantly greater number of subjects rated their resolution of incest issues as "somewhat resolved" and "mostly resolved" after the group treatment program.

Subjects in the TG were also asked whether they felt that individual therapy was necessary while going through the group treatment program. Thirty-one subjects (97%) answered "yes" while one subject (3%) answered "no".

Subjects in the WLG were asked to rate their degree of resolution of incest issues following the waiting period. Twelve subjects (39%) rated the degree of resolution of their incest issues as "somewhat resolved" or "mostly resolved" while 19 subjects (61%) reported that their degree of resolution of incest issues was "not at all resolved" or "a little resolved". The degree of resolution of incest issues for the WLG did not differ significantly from pretreatment ($\chi^2(1)= .54$, $p >.05$) indicating that subjects did not change the rating of the degree of

resolution of their incest issues during the waiting period.

Hypothesis #2: The Effectiveness of the Group Treatment Program Over Time

Intrapersonal dependent measures A within-subjects (TG) repeated-measures MANOVA with Time (Pretreatment, Posttreatment, Follow-up) as the repeated measure was conducted on data from the BDI, CES-D, BSI-G, IES-A, IES-I, SDQ-E, and SDQ-G in order to test the effects of the group treatment program over time on intrapersonal difficulties. Means and standard deviations for the TG at pretreatment, posttreatment, and six-month follow-up are presented in Table 15.

Insert Table 15 about here

The overall multivariate test of significance indicated a significant effect for Time (exact $F(14,17) = 5.34$, $p < .05$). Because the data violated sphericity assumptions, a series of univariate ANOVAs using the Greenhouse-Geisser correction were conducted. In addition, trend analyses were performed to determine the effects of Time on each of the intrapersonal dependent measures that were significant in the univariate ANOVA using the corrected degrees-of-freedom. Results of these analyses are presented in Table 16.

Insert Table 16 about here

As can be seen in Table 16, Time had a significant effect on all of the intrapersonal dependent measures. Results of the trend analysis indicated that each of the intrapersonal dependent measures exhibited both a significant linear as well as a significant quadratic trend across time except for the IES-I which showed a significant linear trend only.

Examination of the means at pretreatment, posttreatment, and follow-up for the intrapersonal dependent measures (See Table 15) indicated both a significant negative linear trend and a significant quadratic trend for the BDI, CES-D, BSI-G, and IES-A. For the SDQ-E and the SDQ-G, a significant positive linear trend and a significant quadratic trend were found. The IES-I showed a significant negative linear trend only.

Overall, it appears that subjects in the TG improved significantly between pretreatment and follow-up on all intrapersonal dependent measures. The trend analysis indicated that for the BDI, CES-D, IES-A, SDQ-E, and SDQ-G, improvement occurred between pretreatment and posttreatment and was maintained between posttreatment and follow-up. At posttreatment and follow-up, subjects in the TG had significantly less depressive symptomatology, less psychological distress, fewer avoidance symptoms of post-traumatic stress, and greater general and emotional self-concept. Moreover, subjects had significantly less intrusive symptoms of post-traumatic stress following the group treatment program and these symptoms continued to decrease significantly over time in a linear fashion between posttreatment

and follow-up. These results are displayed graphically in Figures 4 to 10.

Interpersonal dependent measures Because 11 out of 32 subjects (44%) in the TG did not complete the AQ-T at one of the assessment times (either pretreatment, posttreatment, or six-month follow-up), the AQ-T was deleted from the following analyses and examined separately. A within-subjects (TG), repeated-measures MANOVA with Time (Pretreatment, Posttreatment, Follow-up) as the repeated measure was conducted on data from the PSS-FR, SDQ-SS, SDQ-OS, and PSS-FA in order to determine the effectiveness of the group treatment program over time on interpersonal difficulties. Means and standard deviations for interpersonal dependent measures of the TG at pretreatment, posttreatment, and follow-up are presented in Table 17.

Insert Table 17 about here

The overall multivariate test of significance indicated a marginally significant effect for Time (exact F (8,22) = 2.33, p = .055). Since the results approached significance, it was decided to continue with the analysis as it is generally believed that interpersonal difficulties are much more resistant to change (Herman, 1992). Because the data violated assumptions of sphericity, univariate ANOVAs were conducted using the Greenhouse-Geisser correction. In addition, trend analyses were performed to determine the effects of Time on any interpersonal

dependent measures found significant in the univariate ANOVAs. Results of these analyses are presented in Table 18.

Insert Table 18 about here

As can be seen in Table 18, there was a significant effect for Time for the SDQ-SS only. Trend analysis of the SDQ-SS across pretreatment, posttreatment, and follow-up indicated a significant linear trend and examination of the means of the SDQ-SS (See Table 17) indicated that this trend was positive. These results suggest that self-concept in relation to other women showed improvement between pretreatment and follow-up with improvement following a linear pattern across pretreatment, posttreatment, and follow-up. These results are displayed graphically in Figure 11.

Means and standard deviations of the AQ-T for the TG at pretreatment, posttreatment, and follow-up are presented in Table 19. Data from the AQ-T were subjected to a separate repeated-measures MANOVA with Time (Pretreatment, Posttreatment, Follow-up) as the repeated measure. The multivariate F indicated a significant effect for Time (exact F (2, 19) = 10.18, p, <.05) which remained significant when the Greenhouse-Geisser correction was applied (F (1.37, 27.42) = 8.72, p <.05) since the data violated sphericity assumptions. Trend analysis indicated a significant linear trend only (F (1,20) = 9.86, p <.05) and examination of the means (See Table 19) indicated that this trend

was positive. Results suggest that behaviours indicative of secure attachment increased significantly from pretreatment to follow-up and that this increase followed a linear pattern across pretreatment, posttreatment and follow-up indicating continued improvement following the group treatment program.

Insert Table 19 about here

Six-month follow-up questionnaire Subjects in the TG were asked to rate their degree of resolution of their incest issues at the six-month follow-up.

Twenty-two subjects (71%) reported that their incest issues were "somewhat resolved" or "mostly resolved" while nine subjects (29%) felt that their incest issues were " a little resolved" or "not at all resolved". Chi-square analysis of the degree of resolution of incest issues across pretreatment, posttreatment, and six-month follow-up indicated that a significantly greater number of subjects believed that their incest issues were resolved at six-month follow-up than at pretreatment or posttreatment (χ 2(2) = 12.47, $p<.05$).

In addition to the above question, subjects were asked (1) whether they had remained in individual therapy over the six month follow-up period, (2) whether they had kept in contact with other group members, and (3) whether they had joined any other group. Twenty-six subjects (84%) had remained in individual therapy during the previous six months while five subjects (16%)

had not. Twenty-three subjects (74%) remained in contact with other group members while eight (26%) did not maintain any contact. Finally, sixteen subjects (52%) joined another group during the six-month period while fifteen (48%) did not. Of the sixteen subjects that joined other groups, thirteen (81%) joined the "Grads Group" at the Family Service Centre which is a group for women who have completed the group treatment program. One subject (6%) joined Al-Anon and two subjects (12%) joined other unspecified self-help groups.

Summary of Treatment Results

Overall, results of the study indicated that there was a differential effect for subjects who participated in the group treatment program compared to those who did not on measures of both intrapersonal symptomatology and interpersonal difficulties.

In regards to intrapersonal symptomatology, participants in the group treatment program had less depressive symptomatology and less intrusive thoughts about the incest following the group treatment program whereas subjects in the wait-list group exhibited more depressive symptomatology although intrusive thoughts about the incest remained unchanged.

For the group treatment participants, the lessening of depressive symptomatology and intrusive thoughts about the incest appeared to be accompanied by a concomitant decrease in general psychological distress and avoidant behaviours in relation to the incest experience as well as an increase in both emotional and general self-concept. For the wait-list group, depressive

symptomatology increased during the waiting period accompanied by a concomitant increase in overall psychological distress. However, symptoms of post-traumatic stress (intrusive thoughts and avoidant behaviours) as well as general and emotional self-concept remained unchanged. In general, improvements in intrapersonal symptomatology were maintained for the group treatment participants at six-month follow-up.

Participation in the group treatment program had a more limited effect on measures of interpersonal difficulties. Perceived social-support from friends increased significantly for those who participated in the group treatment program but remained unchanged for those who did not. However, although perceived social support from family members and self-concept regarding one's relationships with other men and women did not change significantly during the group treatment program for either the group participants or the subjects on the wait-list, the group participants began to see themselves in a more positive light in relation to other women at six-month follow-up. Interestingly, attachment behaviours indicating greater security to one's attachment figure increased for both the group participants and those waiting for treatment. Attachment behaviours indicating greater security to one's attachment figure continued to increase between posttreatment and six-month follow-up for those that participated in the group treatment program.

Clinically Significant Change

Table 20 presents a summary of the percentage of subjects

who met criteria for clinically significant change at posttreatment and at six-month follow-up on the BDI.

Insert Table 20 about here

As can be seen from Table 20, the percentage of subjects in the TG who were considered recovered at posttreatment ranged from 34% (using a cut-off score of 8) to 44% (using a cut-off score of 14). The percentage of those that had recovered at the six-month follow-up increased to 45% (using the cut-off score of 8), and to 48% (using the cut-off score of 14). At posttreatment and six-month follow up, no subjects in the TG showed clinically significant deterioration.

The percentage of subjects in the TG considered improved but not recovered at posttreatment ranged from 22% (cut-off score of 8) to 13% (cut-off score of 14). The percentage of those considered improved but not recovered at six-month follow-up ranged from 16% (cut-off score of 8) to 13% (cut-off score of 14).

Finally, 19% of subjects in the WLG exhibited clinically significant deterioration at posttreatment while 81% remained unchanged. No subjects in the WLG showed either improvement or recovery at posttreatment using the criteria established in the Data Analysis section.

The Parental Bonding Index

Cronbach's alpha, an estimate of internal consistency, was

calculated for mother's care and protection scales and for father's care and protection scales. Results indicated that Cronbach's alpha for mother's care scale was .93; for mother's protection scale, .87; for father's care scale, .88; and for father's protection scale, .90.

Data from the total sample were analyzed separately for the mother's care and protection scales (N=63) and for the father's care and protection scales (N=61). For mothers, the mean care score was 9.87 (SD = 9.1) and the mean protection score was 20.90 (SD = 9.6). For fathers, the mean care score was 9.72 (SD = 7.9) and the mean protection score was 21.31 (SD = 9.6). Means for mother's care score, mother's protection score, father's care score, and father's protection score were compared to hypothesized population means from a nonclinical group studied previously (Parker, 1983; mother's care score, M = 27.0; mother's protection score, M = 13.5; father's care score, M = 24.0; father's protection score, M = 12.5) using a series of t-tests. Results indicated that all means from the sample in the present study were significantly different from hypothesized population means of the nonclinical group (mother's care: $t(63) = 15.08$, $p < .05$; mother's protection: $t(63) = 6.13$, $p < .05$; father's care: $t = 14.01$, $p < .05$; and father's protection: $t = 7.14$, $p < .05$). It would appear that subjects in the present study perceived both their mothers and fathers as significantly less caring and more controlling than subjects from the nonclinical group.

Mean scores from a nonclinical sample (Parker, 1983) were

used as axes to form the quadrants describing parental styles (as outlined in the Data Analysis section). Results indicated that 70% of subjects perceived their mothers as exhibiting high control - low care (affectionless control), while 23% perceived their mothers as exhibiting low protection - low care (weak or absent bonding). Two percent viewed their mothers as showing high control - high care (affectionate constraint) while 5% indicated that they experienced low protection - high care (optimal bonding) with their mothers. These results are presented graphically in Figure 12.

Results for fathers were similar. Seventy-three percent of subjects perceived their fathers as exhibiting high control - low care (affectionless control), while 22% perceived them as exhibiting low protection - low care (weak or absent bonding). Three percent viewed their fathers as showing high control - high care (affectionate constraint) while 2% stated that they experienced low protection - high care (optimal bonding). These results are presented graphically in Figure 13.

Overall, it appears that the majority of subjects in this study (72%) perceived both parents as exerting affectionless control, that is, a style of parenting that limits a child's independence through intrusion, infantalization, and/or overprotection while showing little care in the form of emotional warmth, empathy, or affection. In addition, approximately 22% perceived their parents as seriously negligent in either caring for or protecting them. Overall, only about 6% of subjects felt

that there were indications that they were cared for by their parents, whether or not this also involved controlling behaviours.

DISCUSSION

The purpose of this study was to determine the efficacy of a group treatment program for a clinical population of adult female incest survivors on measures of intrapersonal symptomatology and interpersonal difficulties. In discussing the results obtained in this study, the limitations of the study will be addressed first. The discussion will then focus on the characteristics of the sample of women who participated in the study. This will be followed by a comparison between the women who dropped out of the group treatment program with those who completed the program. The research findings regarding the main hypotheses of the study will then be reviewed. Finally, the discussion will focus on the results pertaining to subjects' perception of style of parenting in their family-of-origin. Clinical implications of the findings and avenues for future investigations will then be addressed.

Limitations of the Study

Kazdin (1983) has noted that the study of clinical trials represents somewhat of a final achievement in treatment outcome research. However, this kind of research has certain limitations due to practical, administrative, and ethical demands of clinical work (c.f., Kramer, 1981). Therefore, although the design of the study served to maximize ecological validity, several limitations of the design need to be acknowledged.

The main limitation of the present study was the

nonrandomization of subjects to the treatment and wait-list groups. Although subjects were assigned to the treatment group or wait-list group based only on time of referral and not on any inherent characteristic of the individual, some selection bias may have been present. Thus, although a sample size was chosen that was sufficient to produce equivalence on nuisance variables (Strube, 1991), the findings of the present study must be interpreted with caution.

A second limitation of the present study was that subjects were involved in a variety of individual therapies conducted by different therapists from different orientations and for various durations. Although every attempt was made to equate groups on variables pertaining to individual therapy, it is possible that some factors of individual therapy that could not be assessed had an influence on group differences. Future research would greatly benefit from a standardized individual treatment for those who are participating in studies of this kind.

Finally, due to practical concerns of the Family Service Centre, the data for both the treatment and wait-list group were collected by a single researcher who was not blind to the research hypotheses of the study. Ideally, data collection by several researchers blind to the hypotheses of a study insures that outcome is not affected in a direction in favour of the hypotheses being tested (Jung, 1971). Therefore, the factor of experimenter bias needs to be acknowledged as a limitation of the present study.

Characteristics of the Sample

Of the 86 subjects (50 in the treatment group and 36 in the wait-list group) who originally agreed to be part of the present study, all were previously involved in individual therapy and only nine were eventually excluded from the study because they did not remain in individual therapy during the course of the study for the number of sessions established by the inclusion criteria. This suggests that the subjects who participated in the present study can be considered as being drawn from a clinical as opposed to a nonclinical population. The average BDI score of subjects in both the treatment and the wait-list group at the initial assessment was 25.3 compared to 17.7 for subjects in the Alexander et al. (1989) study suggesting that this sample was more depressed than a nonclinical, volunteer sample and may indeed represent a different population than the one recruited by Alexander et al. (1989) through media advertisement. A score of 25.3 is indicative of moderate to severe depression whereas a score of 17.7 is indicative of mild depression (Beck, Steer, & Gabin, 1988).

Overall, women who participated in the group treatment programs at the Family Service Centre were white (95%) and in their mid-thirties. The majority had more than high school education (66%) and about two-thirds were employed (65%) suggesting that, as a group, these women were relatively well-functioning in that they were able to complete their education beyond high school and were employed. However, the type or level

of employment was not ascertained so it is unknown whether the level of education was reflected in the type of job held.

Several studies have also reported that participants in group treatment programs have had a level of education beyond high school and were employed (e.g., Brandt, 1989; Herman & Schatzow, 1987). This suggests that women who participate in incest groups in general may be a fairly self-selected sample in that they are able to attain some level of achievement in regards to work and education as well as able to avail themselves of therapeutic help for their incest issues. However, an alternate explanation may be that the selection criteria used by group treatment programs (e.g., Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Sprei, 1987) may be successful at eliminating those survivors who are functioning less well.

Although many women in the study were educated beyond high school and employed, the majority were either never married (41%) or separated/divorced (38%). These results are similar to statistics reported by Alexander et. al (1989), Herman and Schatzow (1987), and Brandt (1989) and suggest that many incest survivors do indeed have difficulties establishing or maintaining intimate relationships although they may succeed in other life areas. The fact that these women did appear to have had some success in the areas of work and education does not alter the fact that they had experienced many negative life events and were experiencing high levels of psychological distress, as will be discussed below.

With respect to characteristics of the incestuous abuse for this sample, the average age-of-onset of the abuse was 5.1 years. Russell (1986) has reported that the mean age-of-onset in her nonclinical sample was 11.2 years of age and that only 11% were victims of incest before the age of five years. However, 60% of subjects in the present study reported that their abuse began before the age of five supporting Russell's (1986) contention that earlier age-of-onset is often related to more serious aftereffects in adulthood and is thus more prevalent in clinical populations of incest survivors. Another possible explanation for the finding of earlier age-of-onset in this and other clinical samples may be that, in general, subjects drawn from clinical populations may be able to access earlier instances of trauma than nonclinical populations specifically because they are in treatment (Herman & Shatzow, 1987).

For 65% of the women in the present study the abuse lasted longer than three years. For 75% the primary abuser was a father or father-figure and over half of the women (54%) reported multiple abusers. Furthermore, 52% experienced force during the abuse. These results are consistent with reports of other clinical populations of female incest survivors (e.g., Herman, Russell, & Trocki, 1986) but differ considerably from results from nonclinical populations (e.g., Russell, 1986) who, on average, experience less force, less abuse by multiple perpetrators, shorter duration of abuse, and a wider range of relationships to the abuser. When asked "How upset were you at

the time of the abuse?", 85% of subjects in this study reported that they were "very or extremely upset" compared to 15% who reported that they were "not very or somewhat upset". Not surprisingly, many of the above factors (i.e., duration of abuse, abuse by a father or father-figure, multiple abusers, and use of force) have been consistently related to severity of aftereffects in adulthood (e.g., Courtois, 1988; Briere & Runtz, 1988; Russell, 1986; Wyatt & Newcomb, 1990) and indicate that, as a whole, this sample appears to have been severely affected by their incest experience.

The majority of women in the study also reported experiences of repeated victimization. Most of the women (73%) reported some kind of sexual abuse as an adult. Of those who had experienced sexual abuse as an adult, 57% reported rape by either a stranger or someone known to them while 43% reported other kinds of unwanted sexual acts. These results are higher than those found by Wyatt, Guthrie, and Notgrass (1992) who reported that 44% of a nonclinical sample of women sexually abused as children experienced either contact or noncontact sexual abuse in adulthood but are similar to the findings by Herman (1981) who found that 68% of her clinical sample of women with a history of incest had reported being victims of rape or attempted rape in adulthood.

In addition to adult sexual abuse, 41% of the total sample had experienced physical abuse as an adult. Unfortunately, revictimization, both sexual and physical, is a consistent

finding in the literature on female sexual abuse survivors (van der Kolk, 1989) and indicates that this is a serious problem for women with a history of incest. One theory suggests that a combination of low self-esteem and learned helplessness which often results from childhood victimization may lead to a belief that one has little control over others in the environment which can, in turn, increase passivity with respect to the ability to protect one's self from harm (Peterson & Seligman, 1983). This may be especially true for those that have suffered from prolonged abuse, the use of force, and abuse by many family members as is the case with the present sample (Russell, 1986).

As well as a high rate of revictimization, 98% of the sample had thoughts of committing suicide and 36% had actually attempted suicide in the past. This history of suicide attempts of incest survivors is also well documented in the literature for both clinical and nonclinical populations (Bagley & Ramsey, 1985; Briere & Runtz, 1986; Sedney & Brooks, 1984). Briere and Runtz (1989) have suggested that many abuse survivors believe that extraordinary measures are required to gain the caring attention of others, given their perceived lack of power and undeservedness. Interestingly, no subject attempted suicide during the group treatment program and 47% indicated that their suicidal thoughts had decreased.

Finally, in respect to other negative experiences, 40% of the women in the study reported that they had abused drugs or alcohol at some time in their lives. Again this is consistent with

reports in the anecdotal (e.g., Armstrong, 1978) and empirical literature (e.g., Benward & Densen-Gerber, 1975) which suggests that drug and alcohol abuse is frequent among survivors of childhood incest. The strong connection between drug and alcohol abuse and incest has frequently been attributed to the fact that it provides an avenue of escape from the intense psychological pain felt by most incest survivors although some authors (e.g., Briere, 1989) have also suggested that there may be a self-destructive quality in the use of drugs and/or alcohol. This study did not ask subjects to give their reason for "using" which would be an interesting question for future research.

Overall, it appears that the women who participated in this study had had to deal with a multitude of negative life experiences. There was a striking contrast between their ability to achieve academically and retain employment and their difficulty in protecting themselves from reabuse or maintaining an intimate relationship. In addition, it appears that, in general, these woman were suffering a great deal of distress as evidenced by the high level of suicidal ideation, suicide attempts, and drug and alcohol abuse. When asked "Looking back on it now, how much effect would you say that your incest experience has had on you life?", the women overwhelmingly (98%) reported that it had a "great effect" as opposed to "some effect", "a little effect", or "no effect". The fact that these women were functioning well enough to pass the selection criteria for group inclusion attests to their strength and ability in

overcoming the many aversive events in their lives.

Individual Therapy

Overall, women in the study had been in individual therapy for about four-and-a-half years and had spent about two-and-a-half years dealing specifically with their incest issues, generally on a once-a-week basis. Although 30% of the women began therapy because they wanted to work specifically on their incest issues, the majority (70%) originally entered individual therapy for problems other than incest. (Some of the problems listed were depression, suicide attempts, relationship problems, anxiety, alcohol and/or drug abuse, and emotional distress.) Of these, 43% (30% of the total sample) reported that they knew about the incest but did not tell their therapist until sometime after individual therapy had begun while 57% (40% of the total sample) reported that they had no memories of the incest until after they had been in individual therapy for some time.

Herman and Shatzow (1987), in a study of memories of abuse in incest survivors reported that 28% of subjects in their study had severe memory deficits around the abuse and that 64% did not have full recall of the abuse suggesting that repression of memories of the abuse is a common phenomenon in adult survivors. These authors also found that repression of the abuse was significantly related to the age-of-onset of the abuse and to the use of force, with younger age-of-onset and greater force being related to more repression. As previously noted, 60% of the present sample reported that the abuse had begun before age

five and more than half (52%) had reported the use of force which may explain the high degree of repression (40%) in this sample.

Because subjects were in individual therapy before the group treatment program, subjects in both the treatment and wait-list groups were asked how resolved their incest issues were at the initial assessment in order to insure that the groups were equated on this variable. No statistically significant differences were found between the treatment and wait-list groups. Overall, approximately half of the subjects in the study (50% for the treatment group vs 48% for the wait-list group) reported that their incest issues were "a little resolved" compared to "not at all resolved" (22% vs 23%), "somewhat resolved" (28% vs 29%), or "mostly resolved" (0% vs 0%). This suggests that the majority of women who participated in the present study were at similar places in their healing process before entering group treatment and that they had made some progress in resolving their incest issues. Courtois (1988) recommends that it is preferable that members be at similar points in the resolution of their incest issues, or, at the very least, that they not be widely divergent. As well, Herman (1992) suggests that it is essential that members have enough resolution to be able to cope with the intense emotions that the group can generate.

Characteristics of the Drop-Out Group

Although there was no hypothesis concerning who would complete the group treatment program and who would not, the fact

that there were six woman who dropped out of the group treatment program over the course of the study provided an opportunity to determine if these subjects were from a different population than those who completed the program. Alexander et al. (1989) found that the seven women in their analogue study who failed to complete treatment did not differ from treatment completers on the basis of any demographic variable or pretreatment dependent measure. However, the findings of the present study indicated that women who dropped out of treatment were functioning significantly less well at pretreatment than those that completed the group treatment program. The discrepant findings between the present study and the Alexander et al., (1989) study may simply be a function of the difference between a clinical and nonclinical sampling population.

Although the drop-out group in the present study did not differ from the treatment completers on the basis of demographic variables such as age, age-of-onset of the abuse, total amount of time in individual therapy, amount of time in incest therapy, birthorder, marital status, duration of the abuse, or use of force, there were significant differences on both intrapersonal and interpersonal dependent measures. In addition, all six women had been abused by multiple abusers although this did not appear to be a significant factor in determining their ability to complete the group treatment program (See Table 3). Unfortunately, because questions concerning education, substance abuse, and physical and sexual abuse as an adult were not asked

until posttreatment assessment, it is unknown whether the drop-out group differed from treatment completers on these variables.

With respect to intrapersonal symptomatology, the drop-out group were more highly distressed and had more depressive symptomatology than the treatment completers. In addition, they appeared to have more avoidant behaviours in relation to their incest experience at the pretreatment assessment although this variable closely approached but did not reach significance.

Post-traumatic stress theory suggests that avoidance behaviours (denial, withdrawal, dissociation, psychic numbing) "kick in" when intrusive symptoms become overwhelming and unmanageable (Courtois, 1988). When this happens, the survivor retreats in a self-protective fashion in order to regulate the affect engendered by intrusive memories and flashbacks related to the original trauma. Although no measures of PTSD or other intrapersonal symptomatology were taken for the six women when they dropped out of the group treatment program, the fact that they were more highly distressed and were using more avoidance behaviours than treatment completers at the initial assessment suggests that they may have been using these behaviours to ameliorate the high degree of psychological distress they were feeling (Cole & Barney, 1987). As the group progressed, the witnessing of the others' anxiety and emotions as well as the reexperiencing of their own feelings about the abuse may have been so distressing that in order to maintain an avoidant state, the group member had to leave the group completely. To help

clarify the issue of why some women are unable to complete group treatment, it is important for future research to make every effort to assess these individuals when they leave a group treatment program.

It is also interesting to note that the drop-out group had significantly greater interpersonal difficulties than treatment completers at the pretreatment assessment. They perceived both their friends and their families as less supportive of them and they had a significantly lower self-concept regarding social interactions with other women although their self-concept in relation to other men was the same as treatment completers. Certainly, it makes intuitive sense that women with these attributes may not be able to make good use of a group treatment approach. The composition of a group dedicated to resolving incest issues for women almost always consists of only female members and is predicated on the giving and receiving of support from other women who have had similar experiences (Briere, 1988; Courtois, 1988; Sprei, 1987). If one believes that they will not be able to secure support from the other group members and/or that other women, in particular, do not see them as important, significant, or worthy of attention, there would be a strong tendency to see the group as an aversive experience, which may be related to premature termination.

Although the above discussion must be viewed with caution because of the small size of the drop-out group, the findings regarding characteristics of the women who did not complete the

group treatment program indicate the importance of the screening interview for potential group treatment participants. Although only six women out of thirty-eight (16%) in the present study were unable to complete the group treatment program, Blake-White and Kline (1985), who did not screen potential group members, found that nearly 40% of female incest survivors withdrew after one to five sessions of group therapy. Results from the present study indicate that the selection criteria may not only need to include but focus on questions assessing how the woman feels about herself in relation to other women, whether she feels supported in her current life, and whether or not she is still trying to avoid dealing with her incest issues. Certainly, it is much easier to recognize potential group participants who may be in the intrusive phase of PTSD since they generally appear highly anxious and distressed (Briere, 1989) than ones who may be in the phase of avoiding or denying the abuse. Furthermore, many survivors of incest are very compliant (Russell, 1986; Hays, 1987) and may enter a group due to the therapist's suggestion rather than due to their own motivation and/or readiness (Herman, 1992). If such is the case, the group member may not only leave the group because she is not ready to deal with her issues but would feel disempowered and reabused by those who are attempting to provide a beneficial therapeutic experience for her. Future research will hopefully direct hypotheses towards clarifying characteristics of treatment drop-outs although it is not reasonable to expect that this will eliminate all drop-outs from

occurring.

Group Treatment Effects

Hypothesis #1: The Effectiveness of the Group Treatment Program

Hypothesis #1 states that subjects in the treatment group as compared to subjects in the wait-list group would have significantly less intrapersonal symptomatology and interpersonal difficulties following the group treatment program. In discussing Hypothesis #1, intrapersonal symptomatology and interpersonal difficulties will be considered in turn.

The data from the present study indicate that group treatment was highly effective in reducing overall intrapersonal symptomatology in a clinical sample of adult female incest survivors. Furthermore, results regarding intrapersonal symptomatology both support and extend the findings of Alexander et al's (1989) study which found a significant decrease in depression, psychological distress, and fear following group treatment in a volunteer, nonclinical sample of women with a history of incest.

Since the study included a variety of measures of intrapersonal symptomatology which were moderately correlated, a statistical model was employed which attempted to extract the variables which accounted for most of the variance within the composite of dependent intrapersonal measures. Using this statistical model, it was determined that measures of depressive symptomatology and intrusive symptoms of PTSD were unique in

contributing to the overall significant findings for intrapersonal symptomatology and that measures of general and emotional self-concept, general psychological distress, and avoidance symptoms of PTSD could be accounted for through overlapping variance with depressive symptomatology and intrusive symptoms of PTSD. That is, although emotional and general self-concept increased significantly and general psychological distress and avoidance symptoms of PTSD decreased significantly, it appears that these other symptoms were secondary to the significant decrease in depressive symptomatology and intrusive symptoms of PTSD.

It is not surprising that the lifting of depression and relief from intrusive thoughts and imagery is concomitant with improvement in other areas of intrapersonal functioning. Several authors (e.g., Howard, Lueger, Maling, & Martinovich, 1993) have suggested that improvement in therapy is sequential, with improvement in subjective well-being preceding a significant reduction in symptomatology. Chronic depression and intrusive symptoms of PTSD have often been considered the most distressing sequelae of incest and the most common presenting complaint when treatment is sought (Gelinas, 1983; Ellenson, 1986). A lifting of the depression and a lessening of intrusive thoughts about the incest may lead to feeling better in general and may help a survivor to focus on more positive aspects of self, reduce the need to use avoidance behaviours, and lessen general psychological distress. This is consistent with the contention

that "enhancement of subjective well-being, with its mobilization of hope....may be enough to mobilize the patient's coping resources to such an extent that the patient can handle his or her symptoms (e.g., sleep better, have less difficulty concentrating, ruminate less) and cope more effectively" (Howard, Lueger, Maling, & Martinovich, 1993, p. 683-684). Certainly, being together with others who have had similar experiences and working through the feeling around the incest in a supportive and caring environment can lead to a sense of hope about the future.

Although intrapersonal symptomatology improved significantly for the treatment group, this was not the case for subjects who were wait-listed for the group treatment program. Subjects in the wait-list condition became significantly more depressed and exhibited significantly higher psychological distress following the waiting period. However, intrusive and avoidant symptoms of PTSD as well as general and emotional self-concept remained at the same level across the 20-week waiting period.

Several reasons can be considered in explaining why subjects in the wait-list condition became more depressed and distressed while waiting for the start of the group treatment program. Ordinarily, women who participate in the group treatment program at the Family Service Centre are assessed approximately one to four weeks before the beginning of the program (c.f., Saxe et al., 1993); that is, they begin treatment relatively soon after the initial contact with the group leaders. In the present study, the women who served as subjects for the wait-list group

were assessed for group participation approximately 20 weeks before the group was to begin. Ordinarily, there is often a marked ambivalence about joining an incest survivor's group and this ambivalence as well as the anticipation of the beginning of the group often increase the survivor's level of overall distress (Hays, 1987). Certainly the long wait-list period imposed on women in this study may have exacerbated any depression or psychological distress that they were experiencing to begin with. The fact that all wait-list subjects were in individual therapy during the wait-list period may have been a factor in preventing levels of PTSD symptomatology from increasing further.

An alternate explantation for the deterioration of the wait-list group is that subjects in the wait-list group had a poorer quality of individual therapy relative to the treatment group who benefited from a higher quality individual therapy while in the group treatment program. Since the treatment and wait-list groups were not randomized, this is certainly a possibility but unlikely. Although the quality of individual therapy was not controlled for in the present study, it was expected to vary randomly across both groups. Indeed, the fact that all subjects in the study were directed towards group treatment while in individual therapy indicates that their individual therapists must have had some knowledge of the needs of this population. In addition, the sample size of each group was sufficient to produce equivalence on nuisance variables across groups that were not controlled for through experimental means (Strube, 1991).

Because there were no six-month follow-up measures taken for the wait-list group as these subjects entered treatment following the second assessment, it is unknown whether or not this group would have continued to deteriorate, remained the same, or improved through spontaneous remission of symptoms. However, measures of clinical significance for the BDI did indicate that 19% (6 subjects) of the wait-list group manifested clinically significant deterioration between the two assessment points. Furthermore, subjects in the wait-list group reported that their degree of resolution of incest issues did not change between the first and second assessments. Finally, since 34 out of 36 wait-list subjects did enter the group following the waiting period, it is safe to assume that they had not improved to the point of feeling that the group would be unnecessary.

Although the group treatment approach used in the present study appeared to have a powerful effect on intrapersonal symptomatology, the effects on interpersonal difficulties were more limited. The only interpersonal measure which showed an immediate effect following the group treatment program was perceived social support from friends which increased significantly for the treatment group but remained unchanged for the wait-list group.[2] This is not surprising since a main rationale for using a group treatment modality for this

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[2]. Although attachment to a significant other increased significantly for both the treatment and wait-list groups, this variable was found to be compromised and will be discussed separately below.

population is that it reduces the intense isolation that is a major source of distress for the woman with a history of incest. Survivors frequently report that they have no close friends (Faria & Belohavek, 1984; Goodman & Nowak-Scibelli, 1985) and no sense of belonging (Bergart, 1986; Brown & Beletsis, 1986); that they are different from others (Lubell & Soong, 1982) and uncomfortable with peers (Bergart, 1986). A group provides the advantage of bringing together individuals with similar traumatic experiences to help validate what was previously considered a unique personal reality (Fischman & Ross, 1990). The sense of belonging that is promoted in a group setting where all share a common experience is essential to breaking the intense isolation and feelings of differentness that survivors experience. In addition, a group often provides a new "family" for the survivor as well as an establishment of friendships with others with the same concerns and difficulties which may lead to greater feelings of being supported by the one's community of peers.

The fact that self-concept in relation to other men and women did not improve following the group treatment program indicates that a 20-week time-limited group, such as the one examined in this study, may not be of long enough duration to have an affect on how the survivor perceives herself in relation to other people in general. Herman (1992) has suggested that a time-limited, structured group is more appropriate for focusing on and working through feelings around the original trauma and that a long-term group is more appropriate for processing and

working through interpersonal difficulties which effect the survivor in her day-to-day interactions with others. Yalom (1985) has suggested that the most powerful advantage of the long-term group is its ability to serve as a microcosm of the member's interpersonal struggles outside the group. It is only with long-term group work that beliefs relating to interpersonal relating can emerge and be opened up for examination and correction by other group members (Mennen & Meadow, 1992). This type of change may be difficult or impossible in a short-term group that focuses primarily on the original trauma (van der Kolk, 1993).

It is also not surprising that perceived social-support from family-of-origin members did not improve following the group treatment program. Courtois (1988) notes that the goal of incest therapy with adult survivors is not to reconcile the survivor with her family of origin but to help her to realistically perceive her family and its functioning and then decide how much contact, if any, is desired. As the results of this study indicate, 75% of subjects were abused by a father or father-figure and only two subjects (3%) reported that their abuser ever acknowledged that the abuse had taken place. In addition, much of the abuse reported for this sample began at an early age (before age five), continued for more than three years, and involved the use of force indicating that, as a whole, these families could be described as nonnurturing and nonprotective (Courtois, 1988). As the survivor achieves more support from

persons outside the family, she may be able, for the first time, to distance herself and/or feel less need for her family's support. Thus, as the survivor's perceived social-support from friends increases, as the results of this study indicate, the survivor may focus less on her need for support from her family-of-origin.

Finally, although measures of secure attachment behaviours increased significantly for the treatment group, they also increased significantly for the wait-list group, the only variable to show a positive effect for this group. When the original data for both groups were reexamined to find reasons for these results, it was discovered that many of the "attachment figures" chosen by subjects in both groups were understandable but unlikely choices. For example, 12% of subjects in the treatment group and 10% of subjects in the wait-list group had chosen their individual therapist as their attachment figure which may explain the increase in secure attachment behaviours for this particular subsample. It would be expected that as the therapist becomes more trustworthy for the survivor over time and provides a more secure base from which the survivor can explore various aspects of her life, the survivor may report an increase in secure attachment behaviours with regards to this person (Bowlby, 1988; McMillen, 1992; Sable, 1992).

In addition to the above, 12% of subjects in the study had chosen such individuals as their priest, acupuncturist, sister, A.A. sponsor, O.A. sponsor, roommate, boyfriend's mother, or ex-

husband as their attachment figure and 21% of subjects changed their attachment figure between the pretreatment and posttreatment questionnaires, a period of about 20 weeks. Moreover, of the 21% of subjects who were married or in common-law relationships in the present study, 25% did not choose their husband or partner as their attachment figure.

The above findings are understandable in light of the fact that incest survivors have been found to have a significantly higher rate of a disorganized attachment style than the normal population (Alexander, 1993). This style has been described as resulting from abuse and neglect by the primary caregiver and is characterized by approach-avoidance behaviours consistent with the desire for proximity to and, at the same time, fearfulness of the person or persons who are primarily responsible for nurturing the child. The fact that subjects chose unlikely attachment figures, did not consider their marital partners to be their attachment figures, and changed their attachment figures across a relatively short period of time may indicate their disorganization in developing secure adult attachments. At this point, it is difficult to interpret the results of this particular measure and it is suggested that future research use multiple measures of attachment behaviour including a measure of attachment style which includes a category analogous to disorganized attachment (c.f., Bartholomew & Horowitz, 1991).

Hypothesis #2: The Effectiveness of the Group Treatment Program Over Time

Hypothesis #2 states that subjects in the treatment group would continue to improve or at least maintain improvement in intrapersonal symptomatology and interpersonal difficulties at six-month follow-up. In discussing the results of Hypothesis #2, intrapersonal symptomatology and interpersonal difficulties will again be considered in turn.

Not only do the data support the effectiveness of group treatment on intrapersonal symptomatology for the treatment group, they also indicate that the improvements in intrapersonal symptomatology made during the group treatment program were maintained at six-month follow-up. Using a conservative statistical model, the results indicated that women who participated in the group treatment program had significantly less depressive symptomatology, less intrusive and avoidance symptoms of PTSD, less psychological distress, and greater general and emotional self-concept at six-month follow-up than preceding the group treatment program. A trend analysis of the data indicated that, for the majority of intrapersonal symptomatology, improvements that took place over the period of the group treatment program were maintained across the follow-up period although they did not improve further. Only intrusive symptoms of PTSD continued to improve at the same rate during the six-month follow-up as during the group treatment program.

It may appear from the above results that the power of the group treatment program is limited and that once the group has ended, symptoms do not appear to improve any further. Certainly,

when examining the majority of the trend analyses, the presence of a significant quadratic trend might indicate the gradual return to pretreatment status. However, examination of the means across the three assessment points (see Table 15) indicates that this is not the case and that the trend was toward continued improvement albeit not at the same rate as during the group treatment program. Considering the fact that the follow-up assessment was conducted six months after the group treatment program ended, it is a good indication that the gains made during the group treatment program were genuine and not just a "flight into health" (Mann, 1973).

An additional factor in assessing the effectiveness of the group treatment program across time is an examination of the clinically significant change in depressive symptomatology as measured by the BDI. Using the most stringent criterion (a cut-off score of 8), it was found that 45% of the women were no longer depressed at six-month follow-up as compared to 34% who were considered recovered immediately following the group treatment program. This is an increase of 11% of women who were no longer considered as part of a dysfunctional population in regards to depressive symptomatology at the six-month follow-up. Although only one measure was examined with regards to clinically significant improvement, the measure chosen was also one that was found to uniquely contribute to the statistically significant improvement following the group treatment program, suggesting that it is a robust indicator of clinical improvement.

Furthermore, although the statistical analysis of group effectiveness across time indicated only that the improvement in depression following the group treatment program was maintained at six-month follow-up, the analysis of clinically significant improvement provided additional information in that 11% of subjects continued to improve to the point of no longer being depressed. This information is certainly lost when examining only statistically significant results and needs to be routinely included in treatment outcome studies (Jacobson & Truax 1991).

It is interesting to note that intrusive symptoms of PTSD, the second measure to uniquely contribute to significant improvement immediately following the group treatment program, showed a pattern of improvement over the six-month follow-up period that differed from other symptoms of intrapersonal symptomatology. Although improvement was maintained for all other measures of intrapersonal symptomatology at six-month follow-up, intrusive symptoms continued to improve at the same rate as during the group treatment program. This suggests that intrusive thoughts and imagery regarding the incest experience continued to be worked through and integrated remarkably quickly over the six-month period following the group treatment program.

A possible explantation for the fact that intrusive symptoms of PTSD continued to improve in a linear fashion both during and following the group treatment program may be that 84% of the women in the treatment group continued in individual therapy following the group treatment program. It is possible that a

group treatment program specifically focused on the original trauma can open up these issues to a point were they are more easily addressed in individual therapy as well, and that this process continues after the group has ended. This would allow the survivor to more rapidly integrate the traumatic events into her self-structure which would lead to more resolution and less need to keep the information about the incest in "active memory" (Green, Wilson, & Lindy, 1985, p.56).

The fact that the majority of women decided to continue in individual treatment after the end of the group indicates that their issues around the incest were not completely resolved. As Alexander et al. (1989) have also noted, it is understandable that a short-term group, although contributing to clinically statistical improvement on several measures, is not sufficient to preclude the need for subsequent therapy for many women. The fact that the women in this study chose, for the most part, to continue with individual therapy, attests to their determination to heal the negative aftereffects of their childhood incest experiences. Certainly, motivation for change on the part of the individual has as much to do with recovery as the availability of clinically effective programs (Keithly, Samples, & Strupp, 1980).

Compared to intrapersonal symptomatology, the group treatment program appeared to have a much more limited effect on interpersonal difficulties over time. The effectiveness of the group treatment program on the composite of interpersonal difficulties over time was only marginally significant (p =

.055). Looking at each of the variables independently, only the measure of self-concept in relation to other women showed significant improvement between pretreatment and follow-up.

It is encouraging to find that there was a trend toward continued improvement over time for self-concept in relation to other women. Seventy-four percent of women in the treatment group remained in contact with other group members following the group and 50% joined some other type of group. Of these, the majority (81%) continued with a bi-weekly "Grads" group at the Family Service Centre. This group is an unstructured, casual get-together for women who wish to maintain contact with other women who have gone through group treatment programs. The group is not therapeutic in nature but is social and there is no requirement to attend meetings or to participate in activities. However, it would be expected that this type of activity may have had some effect on the women's ideas about themselves in relation to other women.

Although there was a significant increase in perceived social support from friends immediately following the group treatment program, this improvement was not statistically significant at the six-month follow-up. However, an examination of the means does indicate that the level of perceived social support from friends remained relatively similar to that achieved immediately following the group treatment program. Certainly the group provides a degree of intimacy between the women that is difficult to maintain following the group's termination

(Courtois, 1988). Other friendships or other groups may not be able to replace the sense of belonging or support that the group provided. Most of the women who participated in the group treatment program commented that the group was not long enough and that they would miss the support that the group gave to them. Certainly the loss of the group may recapitulate the many other losses that the survivor has had to endure and may affect the perception of others as being as supportive and as caring.

It is also not surprising that perceived social support from the family did not change between pretreatment and six-month follow-up. This suggests that women who go through the group treatment program seem to do so not for the intention of reconciling with their families-of-origin but primarily for their own healing. Since all of the women in the present study had been sexually abused by a close family member, it is not unexpected to find that most did not change their perception of support from their families-of-origin over time.

Self-concept in relation to members of the opposite sex showed no change across the period of the group treatment program or at six-month follow-up. This finding was not unexpected as the majority of women in this study had been abused by a male figure and may have had particular difficulty in relating to men in general. Courtois (1988) has noted that difficulties relating to the opposite sex are often the most resistant to change because of the eroticization of love and affection and subsequent betrayal on the part of the perpetrator who is usually

male. The norm for the opposite sex self-concept scale in a normal population of women over 21 years is 59.7 (Marsh, 1990). The mean for treatment subjects in the present study across pretreatment, posttreatment, and six-month follow-up was 26.3. It is clear that these women have an extremely low self-concept in relation to members of the opposite sex. Whether this area of self-concept can be improved through a group treatment program with other women only is difficult to speculate. A long-term group consisting of both men and women that focuses on interpersonal process may be more helpful in resolving this particular interpersonal difficulty.

Finally, although there was a significant increase in secure attachment behaviours over time for the treatment group, the same cautions as previously mentioned are pertinent with regards to this particular measure. Forty-four percent of women in the treatment group did not have an attachment figure at one of the assessment points and had to be excluded from the analyses. Twenty-seven percent of those who did have an attachment figure at all assessment points changed their choice of attachment figure between assessments and used individuals who may not have been appropriately labelled an attachment figure. Again, this may indicate the disorganization of attachment on the part of women with a history of incest and the need for caution in interpreting this result.

The Parental Bonding Index

Because there is little empirical data regarding incest

survivors' perception of their families-of-origin, subjects in the present study were asked to report on their mothers' and fathers' parenting styles using the Parental Bonding Index. Results of this exploratory investigation indicated that the majority of women in the present study (72%) perceived both their mothers and fathers as exhibiting "affectionless - control". Affectionless - control has been defined as a style of parenting that limits a child's independence through intrusion, infantalization, and/or overprotection while showing little care in the form of emotional warmth, empathy, or affection from other family members (Parker & Lipscombe, 1981). Thus, affectionless - control on the part of the parents appears to be a significant risk factor for later intrapersonal and interpersonal difficulties (Parker, 1984). Indeed, many authors believe that the degree of early family dysfunction is as important a factor in determining long-term adjustment as the sexual abuse per se (e.g., Alexander & Lupfer, 1987; Edwards & Alexander, 1992; Fromuth, 1986).

Although the Parental Bonding Index has not been used previously with women with a history of incest, other researchers have found that family-of-origin characteristics consistent with affectionless - control are typical of many incest families. For example, one study found that women with a history of incest reported less intimacy and more intimidation in their families-of-origin than a normed group (Carson, Gertz, Donaldson, & Wonderlich, 1990). Others studies have found that women with a

history of incest perceive their families-of-origin as exhibiting less involvement with each other in terms of emotional support, closeness, and activities (Ray, Jackson, & Townsley, 1991) and as exerting greater control (Jackson, Calhoun, Amick, Maddever, & Habif, 1990). In addition, Cole and Woolger (1989) found that women from incestuous backgrounds had more negative perceptions of their fathers and mothers in terms of acceptance and control than women abused by men who were not related to them. Although it can be argued that these studies were based on retrospective data which may be biased, a recent study by Madonna, Van Scoyk, and Jones (1991) using videotaped interviews with incest and nonincest families (parents and children) reported that incest families' dysfunctional patterns included a rigid family belief system, emotional unavailability and the inability to nurture autonomy in family members.

An interesting finding in the present research is that the women in this study perceived both their fathers and their mothers as exhibiting affectionless-control. As previously noted, the dimension of "Protection" is a continuum with overcontrolling and intrusive behaviours at the high end and lack of protection/neglect at the low end. Although there has been much speculation about the dynamics of incestuous families, one common hypothesis is that the incestuous family is patriarchal in nature; fathers are often characterized as domineering and authoritarian, while mothers are characterized as passive/dependent and unable to move to protect their children

(Finkelhor, 1979; Herman & Hirschman, 1981; Lustig, Dresser, Spellman, & Murray, 1966). If this were indeed the case, results would have shown the majority of fathers as exhibiting high control and the majority of mothers as exhibiting low protection. However, this finding was not evident.

Although results of this study suggest that subjects perceived their fathers as emotionally unavailable and overcontrolling in line with the patriarchal hypothesis, mothers were perceived similarly. The fact that most mothers were perceived as having a parenting style consistent with affectionless - control confirms Finkelhor's (1986) contention that certain preconditions must exist for incest to occur. The lack of emotional support on the part of the mother, and attempts to restrict the autonomy of the child, may leave the child even more vulnerable to incest, because the child is unable to develop assertive skills for resisting the abuse and is also unable to turn to a parent who is supportive and emotionally available (Finkelhor, 1986). As Herman has also stated "It appears that only a strong alliance with a healthy mother offers a girl a modicum of protection from sexual abuse" (1981, p.48). On the other hand, there is the possibility that behaviours perceived as overcontrolling may have been active attempts on the part of the mother to protect the child, even if these attempts were more restrictive to the child's autonomy than protective. Certainly, it is possible that women with a history of incest, in general, see their mothers in a very negative light regarding both care

and protection since their mothers were ultimately unable to protect them from the abuse (Courtois, 1988).

Twenty-two percent of the sample in the present study described their parents as seriously negligent in both caring and protection. The finding that women with a history of incest in this particular sample saw their parents in terms of either affectionless - control or weak/absent bonding (low care - low protection) indicates that not all incest families have the same dynamic. This is consistent with the idea that there is not just one dynamic in incest families (Trepper & Barrett, 1986). A parenting style characterized by lack of care and protection seems to represent the disengaged/chaotic family style described by Barrett and her associates (1986) in which the parents and children function on the same level with no one enforcing rules or boundaries and where parents are emotionally immature.

Several cautions are necessary when interpreting the above findings regarding perception of parenting styles. First, there is total reliance on retrospective data from the women themselves with no corroborating evidence from others present at the time of the abuse, thus, the impact of bias cannot be ascertained. Women with a history of incest may be more biased towards seeing their parents in a negative light than women from dysfunctional family systems where no incest has taken place (Carson, Gertz, Donaldson, & Wonderlich, 1991). Although the measure used in the present study is purported to assess actual as opposed to perceived parental characteristics in depressed populations, it

has not been validated with populations of women with a history of incest. In addition, the women in the present study were drawn from a clinical population which limits the generalizability of these findings. Finally, the study compared subjects' perception of parenting style with a normed population instead of a comparison group of nonabused women. Since the prevalence of childhood incest is generally high in populations of women (Green, 1993), group differences may have been attenuated to some extent. Future research which examines early family characteristics would benefit from using carefully matched comparison groups as well as corroborating evidence from other family members. Notwithstanding the above cautions, the findings suggest that it may be more important for the woman with a history of incest to disengage rather than to reengage to her family-of-origin in order to fully heal from the trauma of incest.

Conclusions, Clinical, and Research Implications

The number of women who enter treatment seeking help in dealing with the negative aftereffects of incest is rapidly growing (Courtois, 1988; Courtois & Sprei, 1988; Meiselman, 1990). Shrinking resources and the enormous cost of treatment have made the question of what constitutes effective treatment for this population of immediate concern. Overall results of this study indicate that a time-limited, structured group which focuses on the original trauma is effective in reducing intrapersonal symptomatology for women with a history of incest

and that this improvement is stable over time. In addition, the women who received group treatment felt more support from their peers following their experience in the group; many continued to maintain contact with other group members after the ending of the group, and, over time, appeared to see themselves in a more positive light in their relations with other women. However, interpersonal difficulties, in general, did not show as much improvement as intrapersonal symptomatology.

What do these results mean for clinicians who treat women with a history of incest? As one of the first studies of group treatment for a clinical population of incest survivors that is both ecologically valid and empirically-based, these results confirm the general consensus in the anecdotal literature that group treatment is an effective intervention for women with a history of incest. More specifically, the findings of the study suggest that a time-limited group that focuses on the original trauma can ease much of the distress experienced by survivors as a results of their early life experiences. However, the fact that there was a significant improvement in intrapersonal symptomatology and a more limited improvement in interpersonal difficulties suggests that short-term, time-limited groups may not be appropriate for resolving interpersonal trust issues or for changing long-entrenched patterns of relationships.
The results of this study confirm the contention by many writers in this area that time-limited and long-term groups for incest survivors serve different purposes and are necessary at different

points in time in the recovery process (e.g., Herman, 1992; Mennen & Meadow, 1992; van der Kolk, 1993). According to Herman (1992) time-limited, structured groups for incest survivors should be designed to focus on the original trauma and to deal with remembrance and mourning of past events. Because they are closed and goal-directed, these types of groups have a very high degree of cohesion and serve as a sustaining source of emotional support during the process of remembrance and mourning (Herman, 1992). On the other hand, once the survivor has had some success putting the trauma in the past, her options expand. Herman (1992) sees the next task as reconnection with others which can be facilitated by a long-term group that focuses on day-to-day interpersonal difficulties. The task of learning to reconnect and trust others is a long one (van der Kolk, 1993) and is difficult to resolve in a time-limited, structured group (Courtois, 1988; Mennen & Meadow, 1992). The results of the present study do indicate that interpersonal difficulties are more resistant to change and may need a different kind of intervention once the trauma has been sufficiently dealt with.

Future research in this area needs to be directed toward determining who will benefit most from group treatment as well as which types of groups are most effective for which types of difficulties. A recent study by Follette, Alexander, and Follette (1991) found that group members who were more educated, unmarried, and initially less depressed benefited more from group therapy. However, these results have not been replicated

(Hazzard, Rogers, & Angert, 1993) indicating that more research is needed in this area. In addition, only a single study has been conducted which attempted to compare different group treatment programs for this population (Alexander et al., 1989) and no studies have empirically examined the effects of a long-term group on interpersonal difficulties. As well, it is important to determine whether combined individual therapy and group treatment is more effective than group treatment alone for this population. Although 97% of women in the treatment group believed that individual therapy was necessary while going through the group, no subjects were included in this study who were not in individual therapy. A clinical trial which compares women survivors in combined individual and group treatment to women survivors in group treatment alone would extend the findings of the present study.

Another question that needs to be addressed is when in the recovery process is a group treatment program most effective. For example, Courtois (1988) and others (Herman, 1992; van der Kolk, 1987) believe that some time in individual therapy is necessary before a group can be considered. This study found that for the majority of women there was only "a little or some" resolution of their incest issues following an average of 2 1/2 years in individual therapy specifically for incest issues. Considering the level of depression that was evident in the pretreatment assessment of the women in this study, would it have been more beneficial to suggest group treatment earlier in their

treatment? Perhaps as clinicians we are somewhat reluctant to subject our incest clients to what can be perceived as a difficult transition to group work. However, as the literature suggests and as the results of this study indicate, group treatment can be a powerful vehicle wherein each woman can be helped along her own individual path towards healing.

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Table 1

Pooled Within-Cell Correlations for Intrapersonal and Interpersonal Dependent Measures For the Treatment and Drop-Out Groups

Intrapersonal

Variable	1	2	3	4	5	6	7
1. BDI	-						
2. CES-D	.66	-					
3. BSI-G	.62	.60	-				
4. IES-A	-.11	-.04	.26	-			
5. IES-I	.51	.40	.63	.15	-		
6. SDQ-E	-.56	-.42	-.40	.00	-.40	-	
7. SDQ-G	-.50	-.43	-.48	-.14	-.41	.56	-

Interpersonal

Variable	1	2	3	4
1. PSS-FR	-			
2. SDQ-SS	.35	-		
3. SDQ-OS	.16	.23	-	
4. PSS-FA	.02	.19	.51	-

Note: N=37. BDI = Beck Depression Inventory; CES-D = Center for Epidemiological Studies of Depression Scale; BSI-G = Brief Symptom Inventory - General Severity Index; IES-A = Impact of Events - Avoidance Scale; IES-I = Impact of Events - Intrusion Scale; SDQ-E = Self-Description Questionnaire - Emotional Scale; SDQ-G = Self-Description Questionnaire - General Scale; PSS-FR = Perceived Social Support from Friends; SDQ-SS = Self-Description Questionnaire - Same-Sex Scale; SDQ-OS = Self-Description Questionnaire - Other-Sex Scale; PSS-FA = Perceived Social Support from Family.

Table 2

Univariate and Stepdown Tests of Significance for Intrapersonal and Interpersonal Dependent Measures for the Treatment and Drop-Out Groups

Measure	Univariate df	Univariate F	Stepdown df	Stepdown F
		Intrapersonal		
BDI	1/35	6.43	1/35	6.43**
CES-D	1/35	13.29*	1/34	5.65**
BSI-G	1/35	12.71*	1/33	2.11
IES-A	1/35	6.51	1/32	2.96[1]
IES-I	1/35	.17	1/31	3.57
SDQ-E	1/35	4.43	1/30	.31
SDQ-G	1/35	6.58	1/29	.06
		Interpersonal		
PSS-FR	1/35	6.82*	1/35	6.82**
SDQ-SS	1/35	14.61*	1/34	7.76**
SDQ-OS	1/35	.03	1/33	.47
PSS-FA	1/35	5.28*	1/32	5.28**

Note: Intrapersonal: $N=37$; * $p \leq .007$ (Bonferroni adjustment); ** $p \leq .05$;
Interpersonal: $N=37$; * $p \leq .0125$ (Bonferroni adjustment); ** $p \leq .05$;
[1] $p = .06$.

Table 3

Means and Standard Deviations of Pretreatment Measures for the Treatment, Wait-List, and Drop-Out Groups Analyzed by Single vs. Multiple Abusers

Measure	Treatment Group		Wait-List Group		Drop-Out Group
	Single	Multiple	Single	Multiple	Multiple
			Intrapersonal		
BDI					
M	26.44	26.71	23.36	24.50	36.20
SD	7.86	7.67	10.42	12.54	9.57
CES-D					
M	30.11	30.85	30.45	32.15	46.00
SD	10.20	6.46	10.60	12.59	10.46
BSI-G					
M	1.67	1.57	1.41	1.88	2.60
SD	.68	.42	.71	.79	.46
IES-A					
M	23.55	22.50	21.45	24.35	32.80
SD	8.21	8.45	8.60	7.56	5.07
IES-I					
M	21.61	22.92	20.18	21.40	24.00
SD	9.61	8.16	9.45	9.06	10.05
SDQ-E					
M	35.72	32.14	33.54	36.55	22.00
SD	14.10	10.39	16.80	15.30	6.28
SDQ-G					
M	50.38	52.78	42.90	48.10	30.00
SD	18.13	18.44	24.28	19.58	11.22

.....

Table 3 (Cont.)

Means and Standard Deviations of Pretreatment Measures for the Treatment, Wait-List, and Drop-Out Groups Analyzed by Single vs. Multiple Abusers

	Treatment Group		Wait-List Group		Drop-Out Group
Measure	Single	Multiple	Single	Multiple	Multiple
			Interpersonal		
PSS-FR					
M	14.47	12.42	13.54	14.10	8.33
SD	4.20	4.94	4.59	4.89	3.72
SDQ-SS					
M	51.47	49.85	51.27	54.00	32.50
SD	11.93	9.84	11.95	13.09	9.46
SDQ-OS					
M	35.47	36.14	39.72	38.50	34.50
SD	12.72	14.66	16.72	15.49	21.78
PSS-FA					
M	5.00	4.86	4.90	5.40	1.16
SD	3.55	3.06	4.32	5.16	1.16

Note. Treatment Group: *N*=32; Wait-List Group: *N*=31; Drop-Out Group: *N*=6.

Table 4

Demographic Characteristics for the Treatment and Wait-List Groups

Variable	Group: Treatment Group	Group: Wait-list Group	*F*	χ^2	Fisher's
Age (years)					
M	35.0	36.7	1.25		
SD	5.9	6.2			
Race					
Caucasian	30(94)	30(97)			*p*>.05
Other	2(6)	1(3)			
Birthorder					
Only or oldest female	22(69)	15(52)		1.84	
Other	10(31)	14(48)			
Relationship status					
Married, common-law	7(25)	6(22)		1.39	
Separated, divorced	10(25)	14(42)			
Never married	15(50)	11(35)			
Education					
Up to high school	12(37)	8(28)		.83	
More than high school	20(63)	22(78)			
Employed					
Yes	24(90)	17(55)		3.10	
No	8(10)	14(45)			
Children					
Yes	12(38)	17(54)		1.53	
No	20(62)	14(45)			

Note. N=63; *$p<.05$; percentages in parentheses.

Table 5

Characteristics Related to the Abuse for the Treatment and Wait-List Groups

Variable	Group: Treatment Group	Group: Wait-list Group	F	χ^2	Fisher's
Age-of-onset of abuse					
M	5.67	4.72	1.10		
SD	2.54	4.17			
Age-of-onset according to age[1]					
5 or under	17(53)	21(68)			
6 - 9	11(34)	5(16)			
10-13	4(13)	4(13)			
over 13	0(0)	1(3)			
Duration					
Less than 3 years	6(19)	4(13)		.41	
More than 3 years	20(63)	21(68)			
Unsure	6(18)	6(19)			
Abusers					
Single abuser	18(56)	11(35)		2.7	
Multiple abusers	14(44)	20(65)			
Relationship of primary abuser[2]					
Father	25(79)	19(61)			
Step- or adoptive father	1(3)	2(7)			
Brother	2(6)	5(16)			
Uncle	0(0)	1(3)			
Grandfather	3(9)	2(7)			
Mother	0(0)	0(0)			
Other	1(3)	2(6)			
Use of force					
Yes	17(55)	16(59)		.22	
No	14(45)	11(40)			

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Table 5 (Cont.)

Characteristics Related to the Abuse for the Treatment and Wait-List Groups

Variable	Group: Treatment Group	Group: Wait-list Group	F	χ^2	Fisher's
How upset were you at the time of the abuse?[3]					
Not very or somewhat upset	2(7)	6(26)			p>.05
Very or extremely upset	27(93)	17(74)			
Acknowledgement of abuse by abuser					p>.05
No	31(97)	30(97)			
Yes	1(3)	1(3)			

Note. N=63; *p<.05; percentages in parentheses.

[1] p>.05 for Fisher's exact test when categories are combined into "0-9" and "10 and over". Results are presented in uncombine categories in order to give the reader a more complete description

[2] p>.05 for Fisher's exact test when categories are combined into "father" and "other". Results are presented in uncombined categories in order to give the reader a more complete description

[3] 11 subjects were unable to answer this question.

Table 6

Negative Adult Experiences for the Treatment and Wait-List Groups

Variable	Group: Treatment Group	Group: Wait-list Group	F	χ^2	Fisher's
Sexual abuse as an adult					
Yes	24(75)	22(71)		.18	
No	8(25)	9(29)			
Kinds of sexual abuse[1]					
Rape	13(54)	13(59)		.24	
Other[2]	11(46)	9(41)			
Physical abuse as an adult					
Yes	14(44)	12(39)		.09	
No	18(56)	19(61)			
Suicidal ideation					
Yes	31(97)	31(100)			$p>.05$
No	1 (3)	0(0)			
Suicide attempts					
Yes	12(38)	11(35)		.005	
No	20(62)	20(65)			
Substance abuse					
Yes	11(34)	14(45)		.76	
No or unsure	21(66)	17(55)			

Table 6 (Cont.)

Negative Adult Experiences for the Treatment and Wait-List Groups

Variable	Group: Treatment Group	Group: Wait-list Group	F	χ^2	Fisher's
Looking back on it now, how much effect would you say that your incest experience has had on your life?[3]					
No effect	0(0)	0(0)			
A little effect	0(0)	0(0)			
Some effect	0(0)	1(3)			
A great effect	32(100)	30(97)			

Note. N=63; percentage in parentheses.

[1] Percentages refer only to those that have experienced sexual abuse as an adult.

[2] Other = unwanted sexual acts and/or sexual harassment.

[3] $p>.05$ for Fisher's exact test when categories are combined into "no or a little effect" and "some or a great effect". Results are presented in uncombined categories in order to give the reader a more complete description.

Table 7

Characteristics of Individual Therapy for the Treatment and Wait-List Groups

Variable	Group: Treatment Group	Group: Wait-list Group	F	χ^2	Fisher's
Total time in IT (years)					
M	4.3	4.9	.39		
SD	4.7	3.6			
Time in IT dealing with incest issues (years)					
M	2.1	2.7	1.75		
SD	1.8	1.8			
Reasons for seeking IT					
Incest	9(28)	10(32)			.12
Other issues	23(72)	21(68)			
Disclosure of incest in IT					
Incest reason for IT	9(28)	10(32)			3.75
Knew about incest but disclosed sometime after IT had begun	7(22)	12(38)			
No memories of incest until after IT had begun	16(50)	9(29)			

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Table 7 (Cont.)

Characteristics of Individual Therapy for the Treatment and Wait-List Groups

Variable	Group: Treatment Group	Group: Wait-list Group	F	χ^2	Fisher's
Frequency of IT sessions					
Once per week	26(81)	27(87)			p>.05
Less than once per week	6(19)	4(13)			
Resolution of incest issues					
Not at all resolved	7(22)	7(23)		.04	
A little resolved	16(50)	15(48)			
Somewhat resolved	9(28)	9(29)			
Mostly resolved	0(0)	0(0)			

Note. N=63; *p<.05; percentages in parentheses; IT = individual therapy.

Table 8

Means and Standard Deviations For Intrapersonal Dependent Measures at Pretreatment and Posttreatment for the Treatment and Wait-List Groups

	Group			
	Treatment Group		Wait-List Group	
Measure	Pre	Post	Pre	Post
BDI				
M	26.56	13.72	24.09	28.96
SD	7.65	10.17	11.66	9.76
CES-D				
M	30.43	22.18	31.54	36.41
SD	8.65	13.85	11.77	9.59
BSI-G				
M	1.62	1.03	1.71	1.96
SD	.58	.65	.79	.68
IES-A				
M	23.09	15.53	23.32	23.32
SD	8.20	8.04	7.93	7.43
IES-I				
M	22.18	19.40	20.96	20.26
SD	8.89	10.55	9.06	8.74
SDQ-E				
M	34.15	44.18	35.48	33.74
SD	12.55	15.16	15.63	10.44
SDQ-G				
M	51.43	63.75	46.28	41.45
SD	18.01	19.19	21.11	16.32

Note: *N*=63.

Table 9

Pooled Within-Cell Correlations for Intrapersonal Dependent Measures for the Treatment and Wait-List Groups

Variable	1	2	3	4	5	6	7
1. BDI	-						
2. CES-D	.77	-					
3. BSI-G	.75	.80	-				
4. IES-A	.37	.39	.34	-			
5. IES-I	.44	.34	.41	.17	-		
6. SDQ-E	-.58	-.65	-.60	-.30	-.23	-	
7. SDQ-G	-.64	-.53	-.52	-.17	-.24	.57	-

Note: N=63.

Table 10

Univariate and Stepdown Tests of Significance for Group X Time Interaction for Intrapersonal Dependent Measures for the Treatment and Wait-List Groups

Measure	Univariate df	Univariate F	Stepdown df	Stepdown F
BDI	1/61	80.64*	1/61	80.64**
CES-D	1/61	20.69*	1/60	1.14
BSI-G	1/61	32.25*	1/59	.12
IES-A	1/61	12.38*	1/58	1.44
IES-I	1/61	1.02	1/57	6.01**
SDQ-E	1/61	12.98*	1/56	.09
SDQ-G	1/61	108.20*	1/55	.88

Note: N=63; *$p \leq .007$ (Bonferonni adjustment); **$p \leq .05$.

Table 11

Means and Standard Deviations for Interpersonal Dependent Measures at Pretreatment and Posttreatment for the Treatment and Wait-List Groups

	Group			
	Treatment Group		Wait-List Group	
Measure	Pre	Post	Pre	Post
PSS-FR				
M	13.54	15.54	13.90	12.61
SD	4.58	4.60	4.72	6.00
SDQ-SS				
M	50.74	55.64	53.02	52.80
SD	10.89	12.37	12.56	12.52
SDQ-OS				
M	35.77	38.74	38.93	37.25
SD	13.40	12.69	15.67	15.50
PSS-FA				
M	4.93	4.48	5.22	4.87
SD	3.28	3.99	4.81	5.18

Note: *N*=62.

Table 12

Pooled Within-Cell Correlations for Interpersonal Dependent Measures for the Treatment and Wait-List Groups

Variable	1	2	3	4
1. PSS-FR	-			
2. SDQ-SS	.60	-		
3. SDQ-OS	.22	.18	-	
4. PSS-FA	.23	.21	.10	-

Note: N=62.

Table 13

Univariate and Stepdown Tests of Significance for Group X Time Interaction for Interpersonal Dependent Measures for the Treatment and Wait-List Groups

Measure	Univariate		Stepdown	
	df	F	df	F
PSS-FR	1/60	9.56*	1/60	9.56**
SDQ-SS	1/60	4.45	1/59	1.15
SDQ-OS	1/60	4.52	1/58	.88
PSS-FA	1/60	.01	1/57	.70

Note: N=62; *p ≤.0125 (Bonferroni adjustment); **p ≤.05.

Table 14

Mean and Standard Deviation of the AQ-T at Pretreatment and Posttreatment for the Treatment and Wait-List Groups

	Group			
	Treatment Group		Wait-List Group	
Measure	Pre	Post	Pre	Post
AQ-T				
M	122.62	130.83	127.50	129.68
SD	18.47	13.63	17.94	19.28

Note: *N*=45.

Table 15

Means and Standard Deviations for Pretreatment, Posttreatment, and Follow-up Intrapersonal Dependent Measures for the Treatment Group

	Treatment Group		
Measure	Pretreatment	Posttreatment	Follow-up
BDI			
M	26.67	13.83	12.48
SD	7.75	10.30	9.21
CED-D			
M	30.32	21.61	22.22
SD	8.76	13.63	13.54
BSI-G			
M	1.60	1.03	1.04
SD	.57	.66	.64
IES-A			
M	22.90	15.74	15.67
SD	8.26	8.09	8.50
IES-I			
M	22.42	19.87	15.97
SD	8.94	10.39	9.20
SDQ-E			
M	34.80	44.67	45.06
SD	12.20	15.16	13.47
SDQ-G			
M	51.80	63.61	64.22
SD	18.18	19.49	17.57

Note: *N*=31.

Table 16

Results of Univariate ANOVAs with Greenhouse-Geisser Correction and Trend Analysis for Pretreatment, Posttreatment, and Follow-Up Intrapersonal Dependent Measures for the Treatment Group

Measure	Univariate		Trend Analysis		
	df	F		df	F
BDI	1.97/59.09	42.67*	Linear	1/30	63.19**
			Quadratic	1/30	17.14**
CES-D	1.98/59.45	8.05*	Linear	1/30	10.58**
			Quadratic	1/30	5.22**
BSI-G	1.85/55.60	15.02*	Linear	1/30	19.74**
			Qadratic	1/30	8.84**
IES-A	1.85/55.43	11.85*	Linear	1/30	14.21**
			Quadratic	1/30	7.80**
IES-I	1.64/49.13	9.79*	Linear	1/30	14.06**
			Quadratic	1/30	.45
SDQ-E	1.95/58.42	10.99*	Linear	1/30	15.58**
			Quadratic	1/30	5.39**
SDQ-G	1.96/58.77	11.16*	Linear	1/30	15.58**
			Quadratic	1/30	5.44**

Note: $N = 31$; *$p \leq .05$ with Greenhouse-Geisser adjusted degrees-of-freedom; **$p \leq .05$.

Table 17

Means and Standard Deviations for Pretreatment, Posttreatment, and Follow-up Interpersonal Dependent Measures for the Treatment Group

	Treatment Group		
Measure	Pretreatment	Posttreatment	Follow-up
PSS-FR			
M	13.63	15.63	15.37
SD	4.64	4.65	4.57
SDQ-SS			
M	51.30	56.16	56.03
SD	10.61	12.23	13.19
SDQ-OS			
M	35.70	39.00	40.20
SD	13.62	12.82	14.32
PSS-FA			
M	4.93	4.50	4.66
SD	3.34	4.06	3.72

Note: *N*=30

Table 18

Results of Univariate ANOVAs with Greenhouse-Geisser Correction and Trend Analysis for Pretreatment, Posttreatment, and Follow-Up Interpersonal Dependent Measures for the Treatment Group

Measure	Univariate		Trend Analysis		
	df	F		df	F
PSS-FR	1.78/51.60	3.21			
SDQ-SS	1.81/52.62	5.42*	Linear	1/30	6.70**
			Quadratic	1/30	3.57
SDQ-OS	1.79/51.96	3.24			
PSS-FA	1.93/55.93	.23			

Note: N = 30; *p ≤ .05 with Greenhouse-Geisser adjusted degrees-of-freedom; **p ≤.05.

Table 19

Mean and Standard Deviation for the AQ-T at Pretreatment, Posttreatment, and Follow-up for the Treatment Group

	Treatment Group		
Measure	Pretreatment	Posttreatment	Follow-up
AQ-T			
M	121.81	132.04	135.09
SD	18.53	13.05	16.49

Note: *N*=21

Table 20

Percentages of Improved, Recovered, and Deteriorated Subjects at Posttreatment and Follow-Up for the Treatment and Wait-List Groups Using Three Cut-Off Scores on the BDI

Cut-Off Score	% improved	% recovered	% unchanged	% deteriorated
Treatment Group				
N=32		Posttreatment		
14	13	44	43	0
10	16	41	43	0
8	23	34	43	0
N=31		Six-Month Follow-Up		
14	13	48	39	0
10	13	48	39	0
8	16	45	39	0
Wait-List Group				
N=31		Posttreatment		
14	0	0	81	19
10	0	0	81	19
8	0	0	81	19

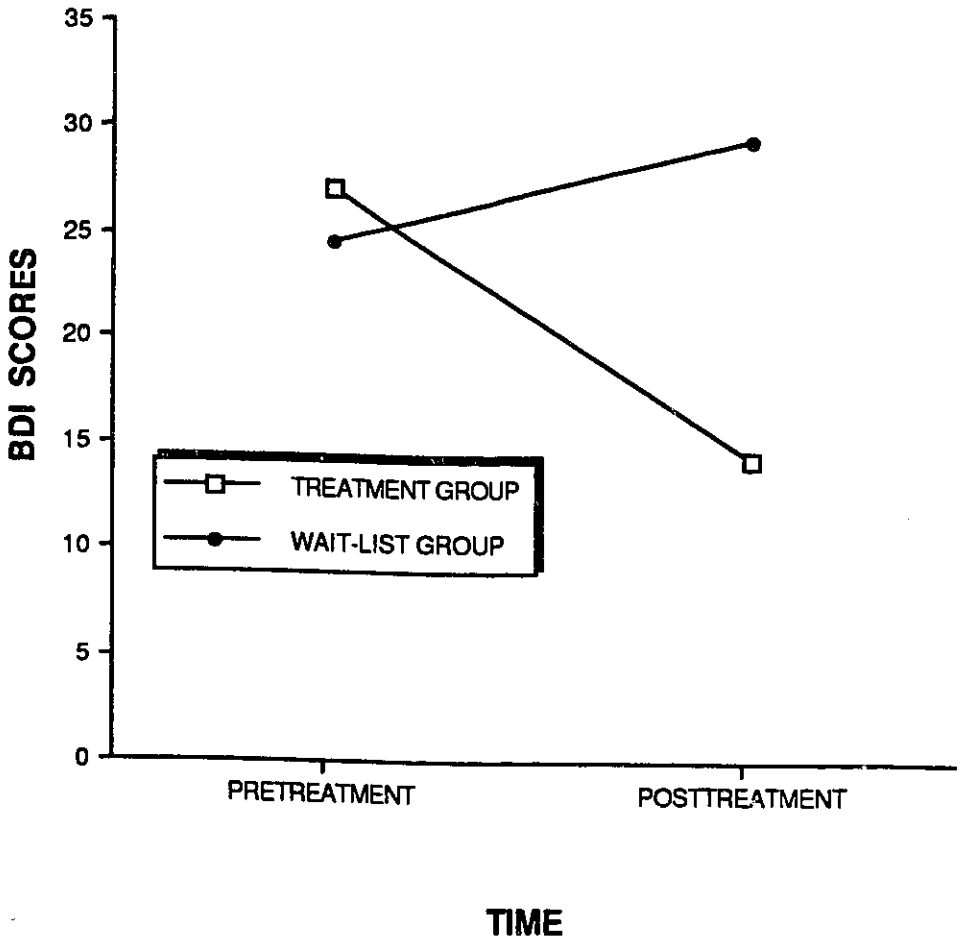

Figure 1. Mean BDI scores for the Treatment and Wait-list Groups at Pretreatment and Posttreatment.

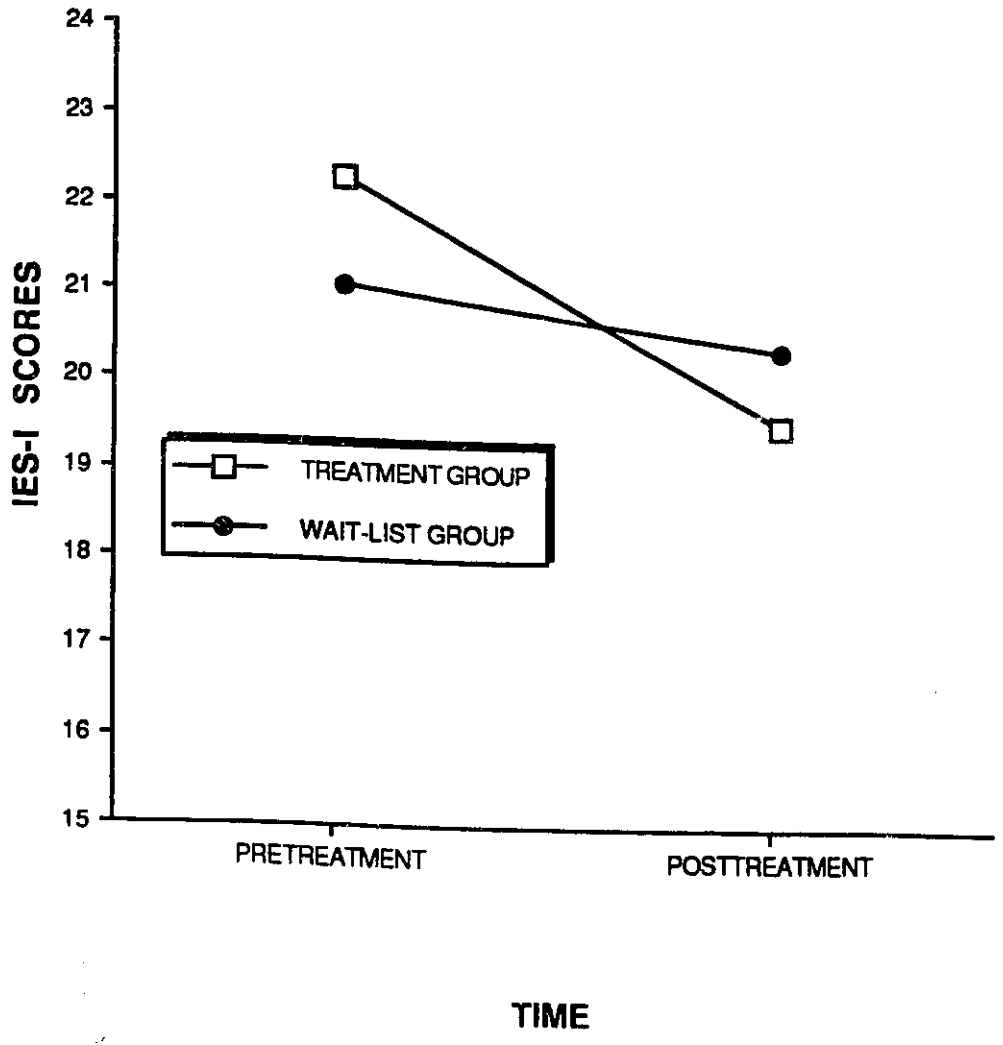

Figure 2. Mean IES-I scores for the Treatment and Wait-list Groups at Pretreatment and Posttreatment.

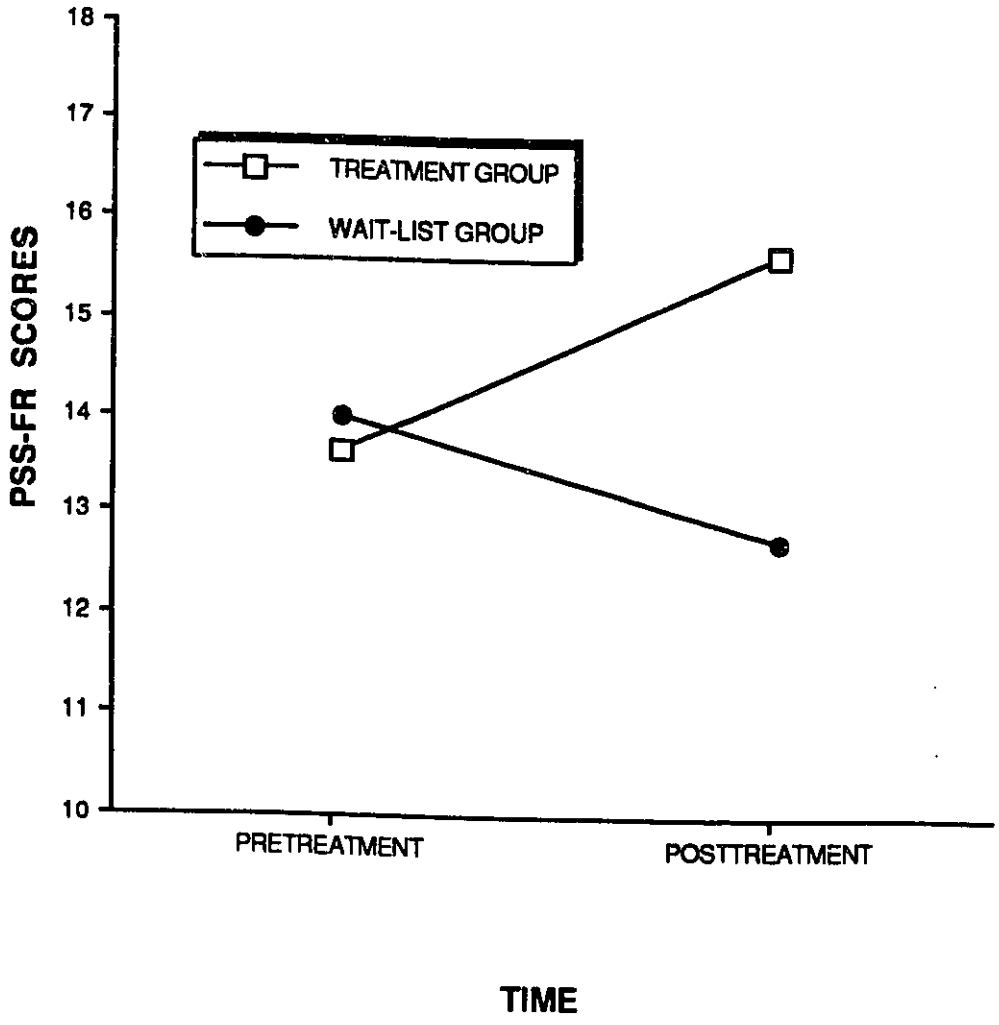

Figure 3. Mean PSS-FR scores for the Treatment and Wait-list Groups at Pretreatment and Posttreatment.

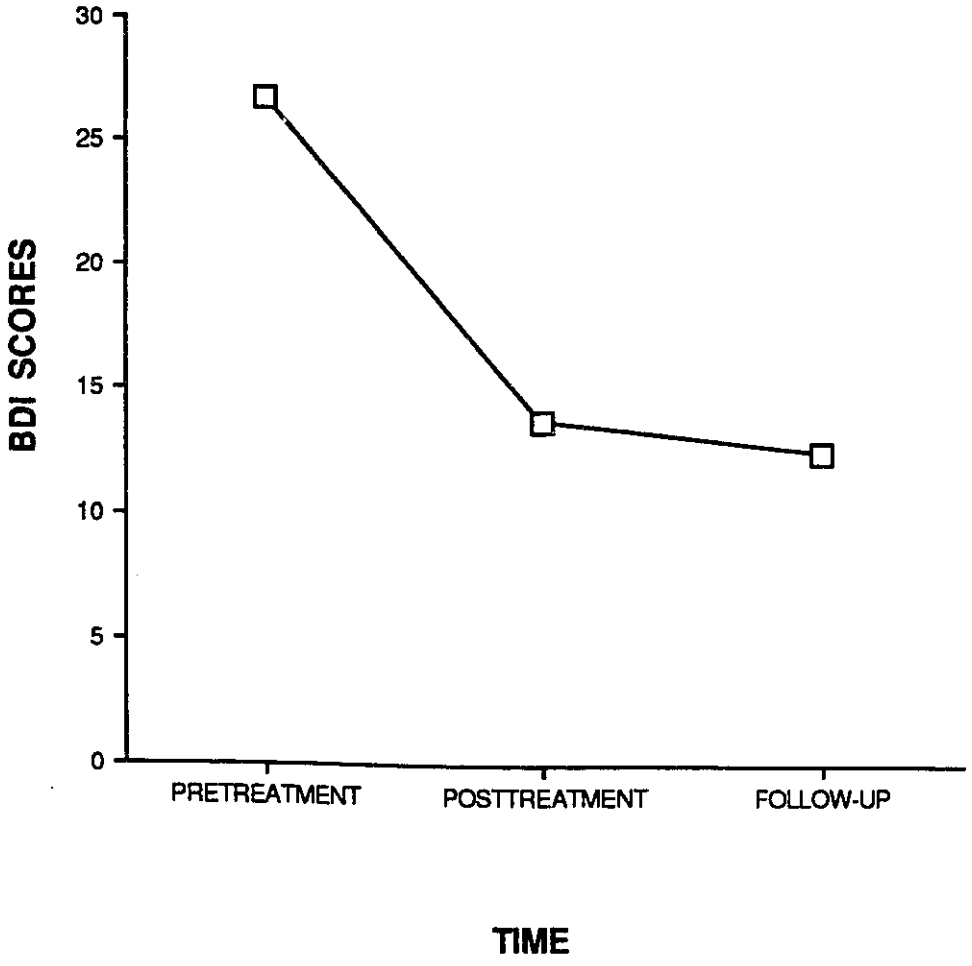

Figure 4. Mean BDI scores across Pretreatment, Posttreatment, and Follow-up for the Treatment Group.

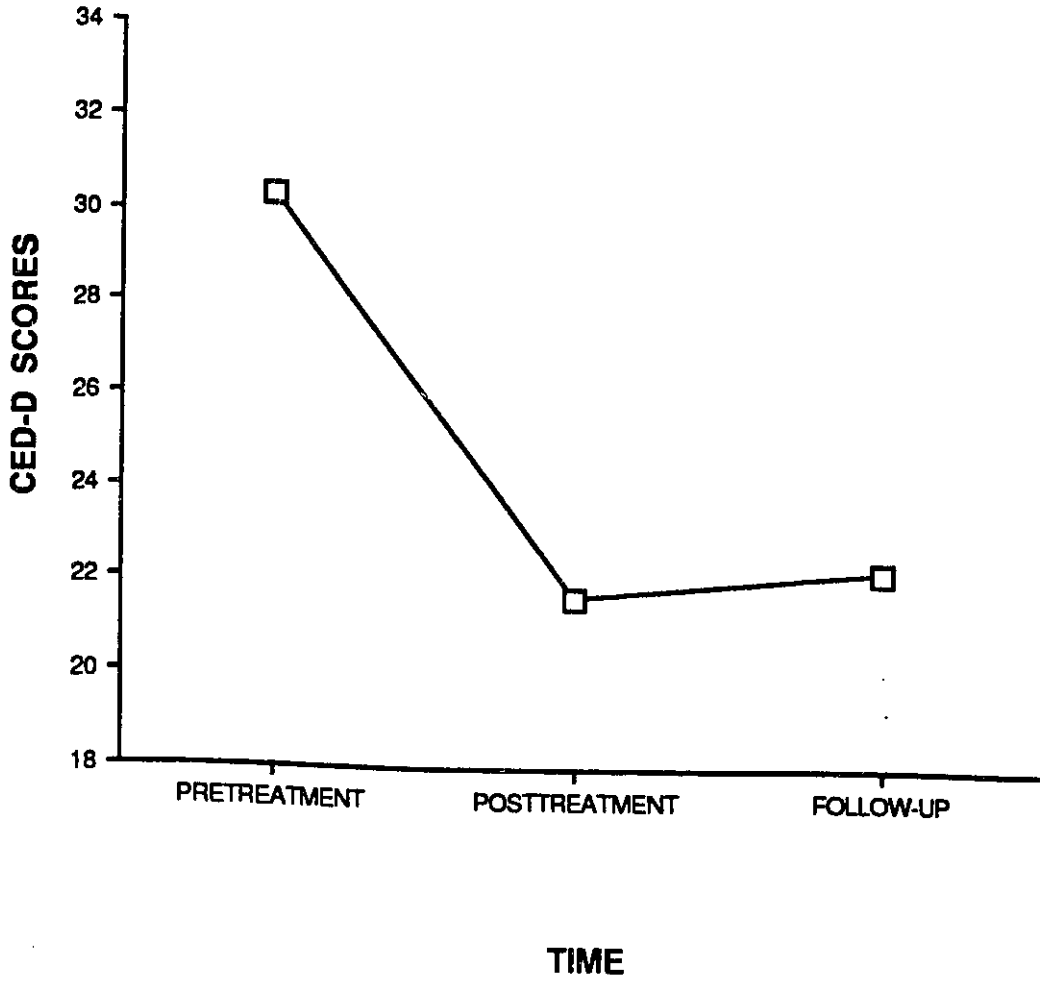

Figure 5. Mean CES-D scores across Pretreatment, Posttreatment, and Follow-up for the Treatment Group.

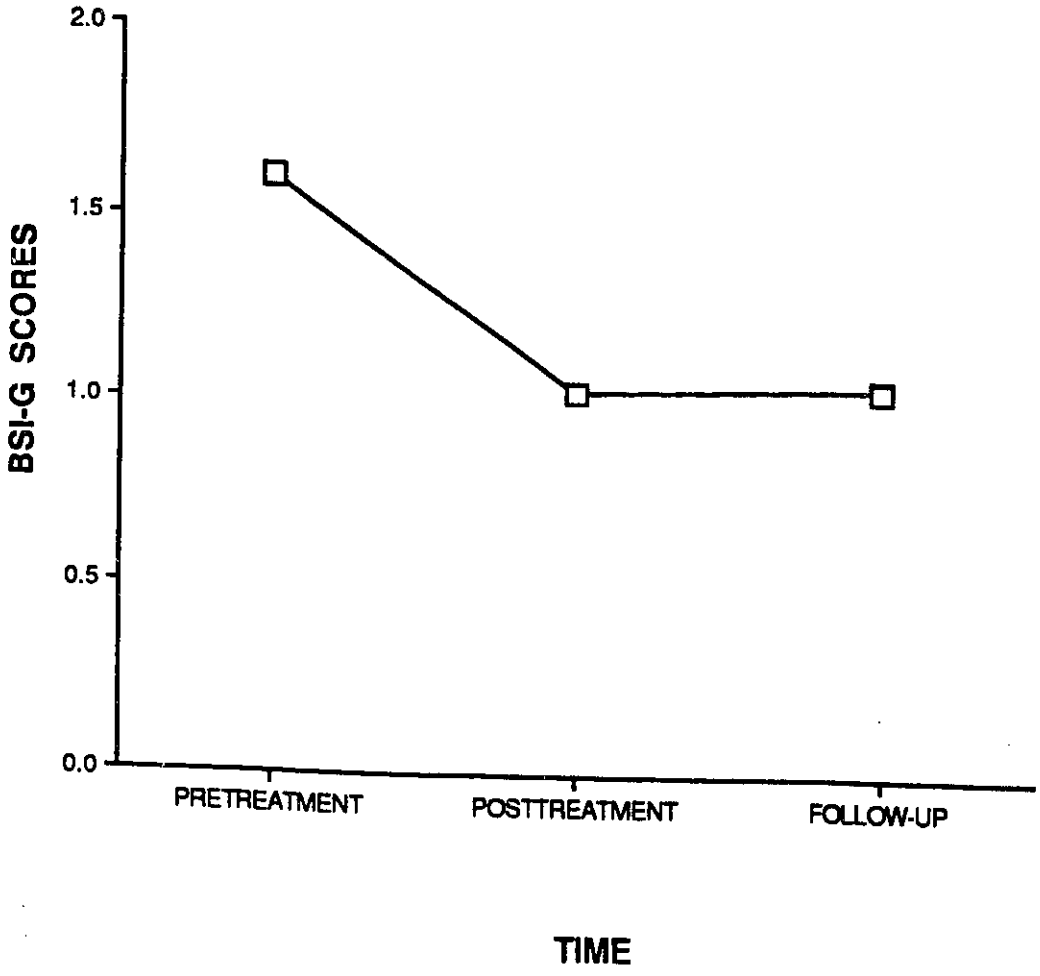

Figure 6. Mean BSI-G scores at Pretreatment, Posttreatment, and Follow-up for the Treatment Group.

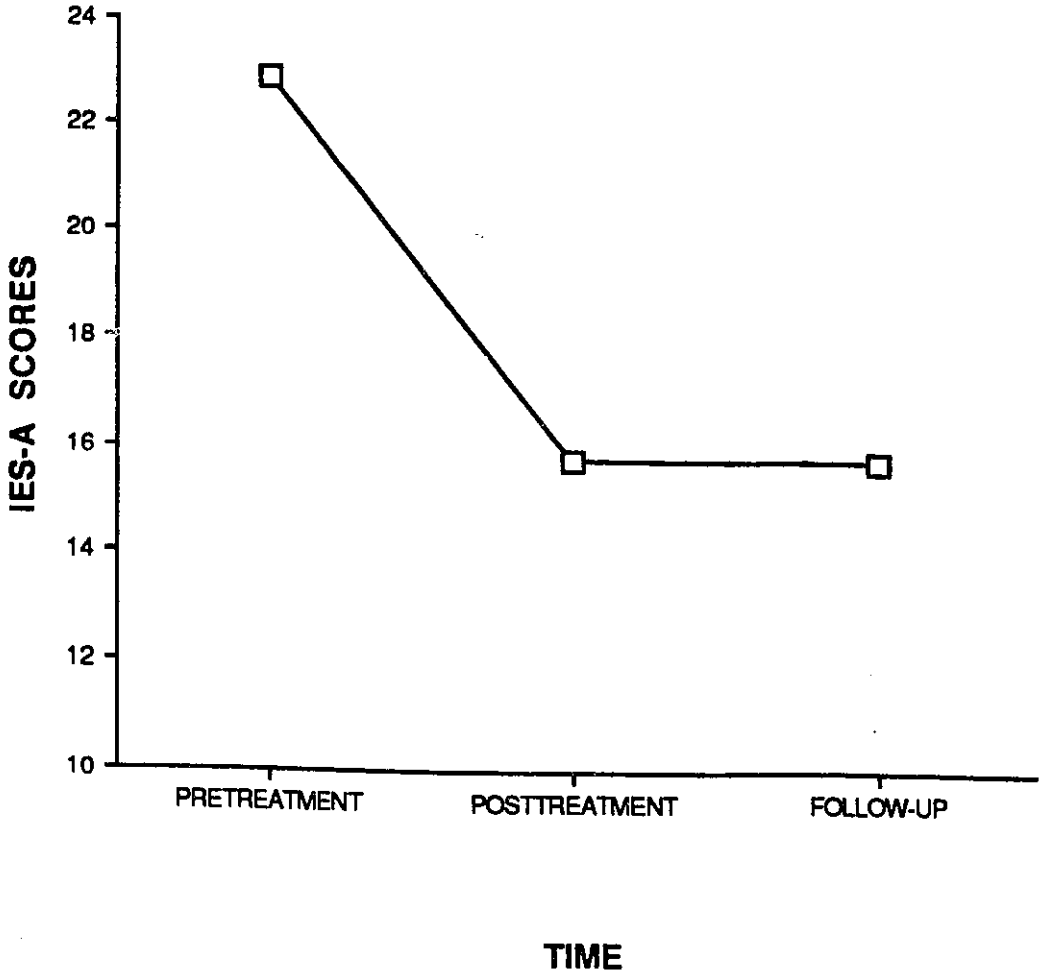

Figure 7. Mean IES-A scores across Pretreatment, Posttreatment, and Follow-up for the Treatment Group.

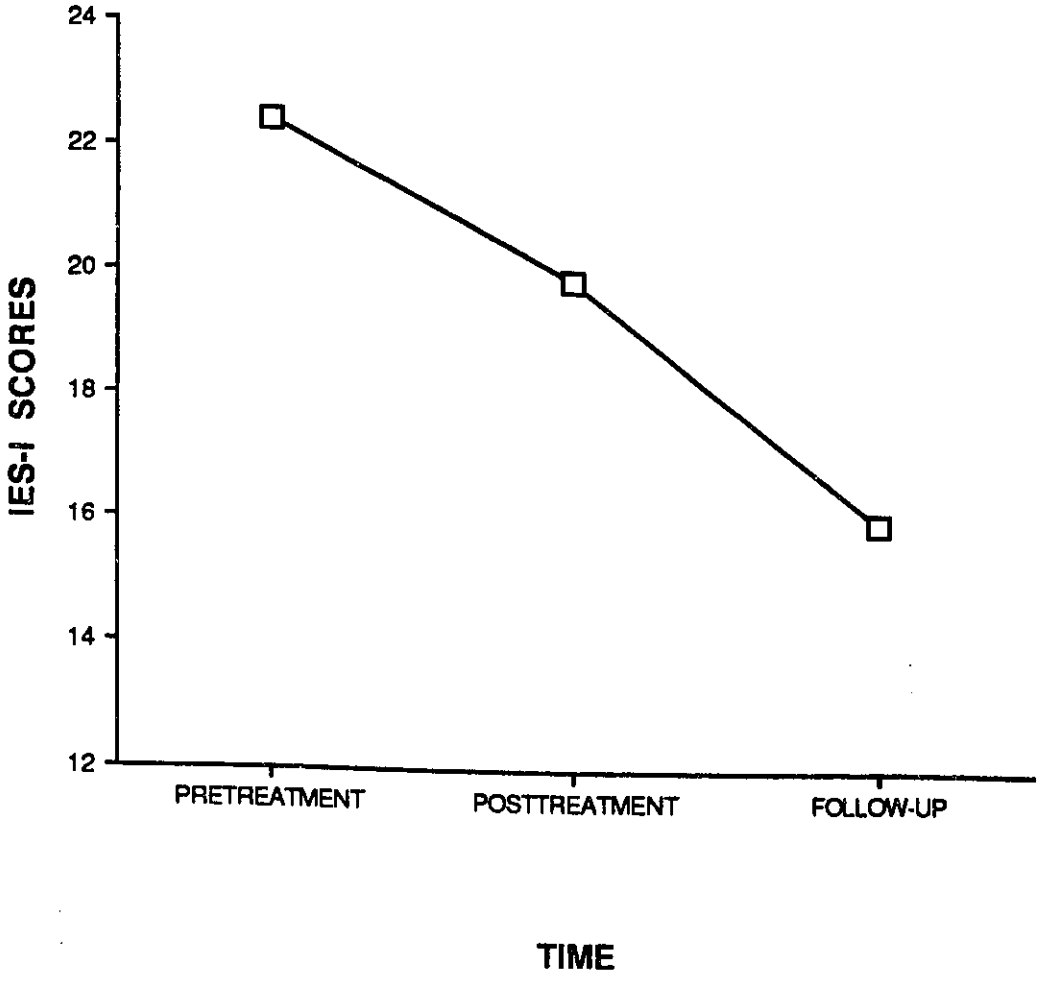

Figure 8. Mean IES-I scores across Pretreatment, Posttreatment, and Follow-up for the Treatment Group.

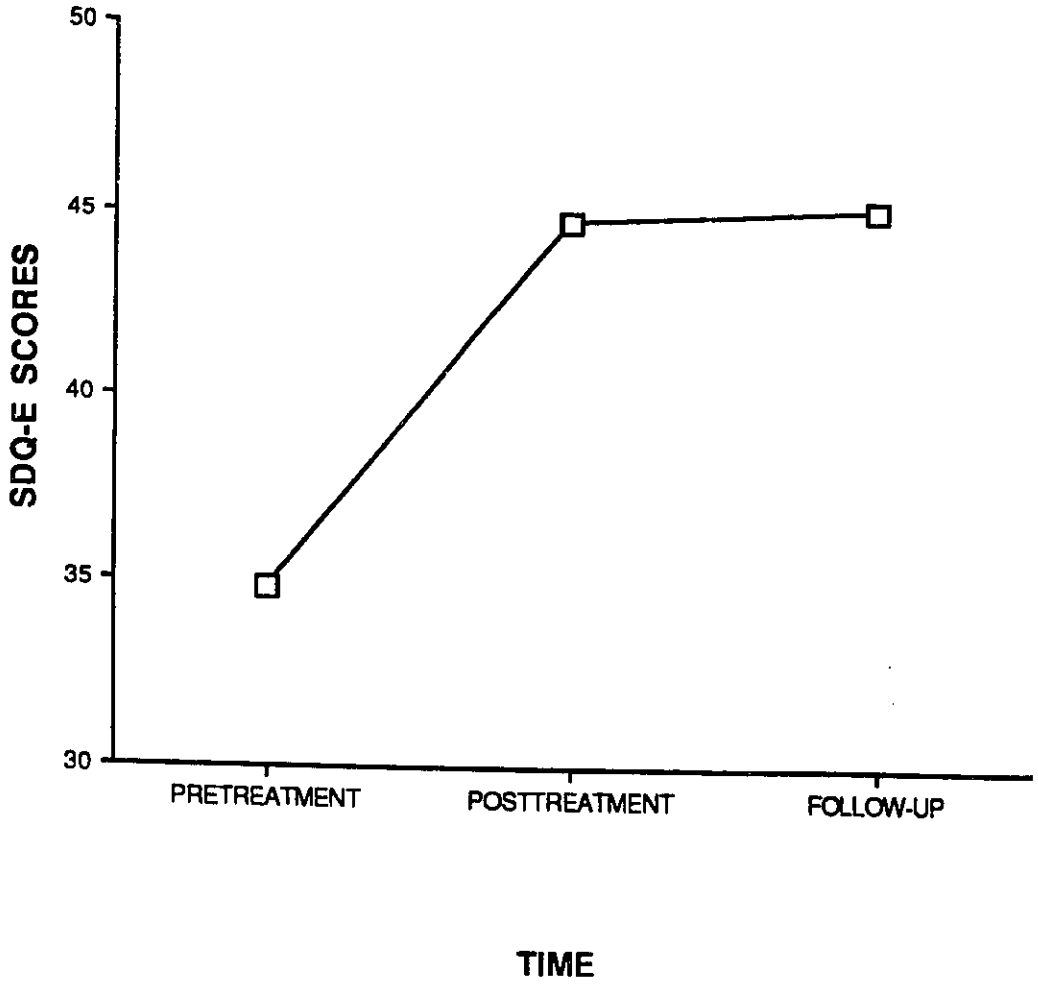

Figure 9. Mean SDQ-E scores across Pretreatment, Posttreatment and Follow-up for the Treatment Group.

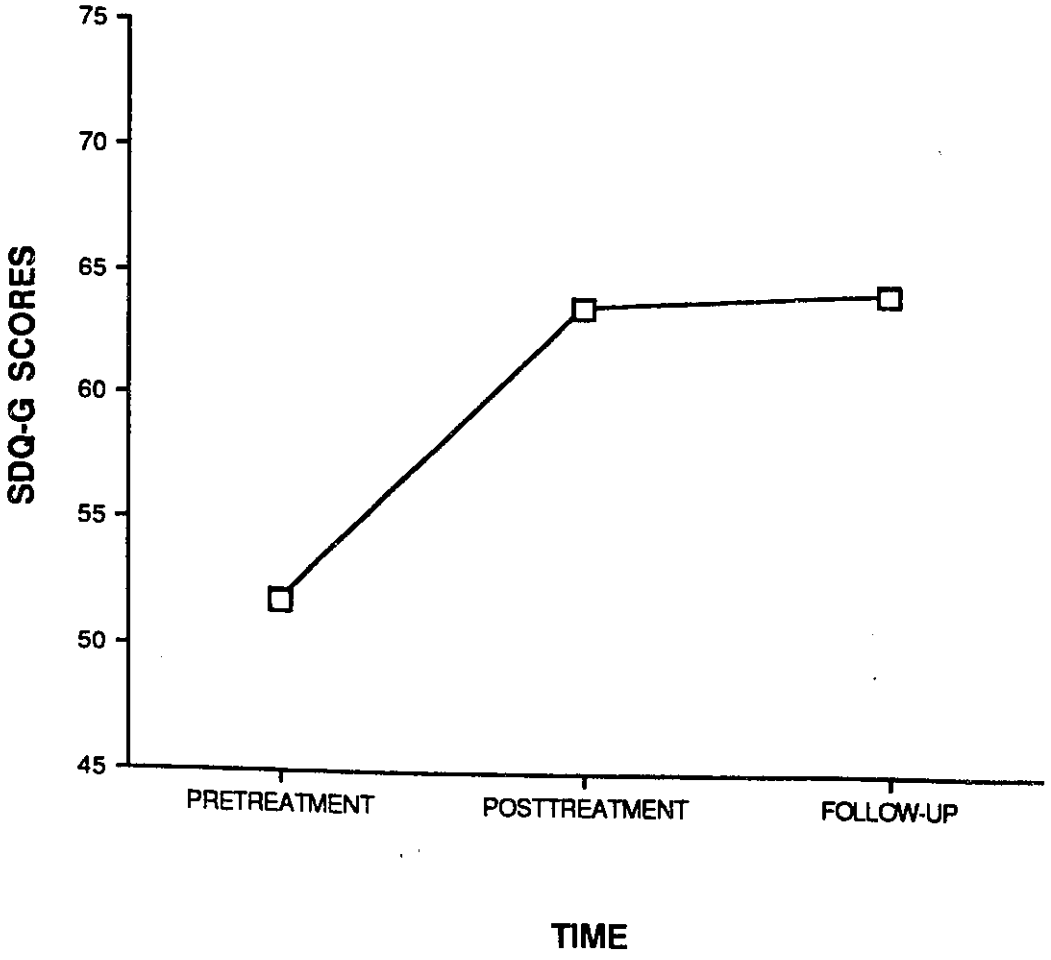

Figure 10. Mean SDQ-G scores at Pretreatment, Posttreatment, and Follow-up for the Treatment Group.

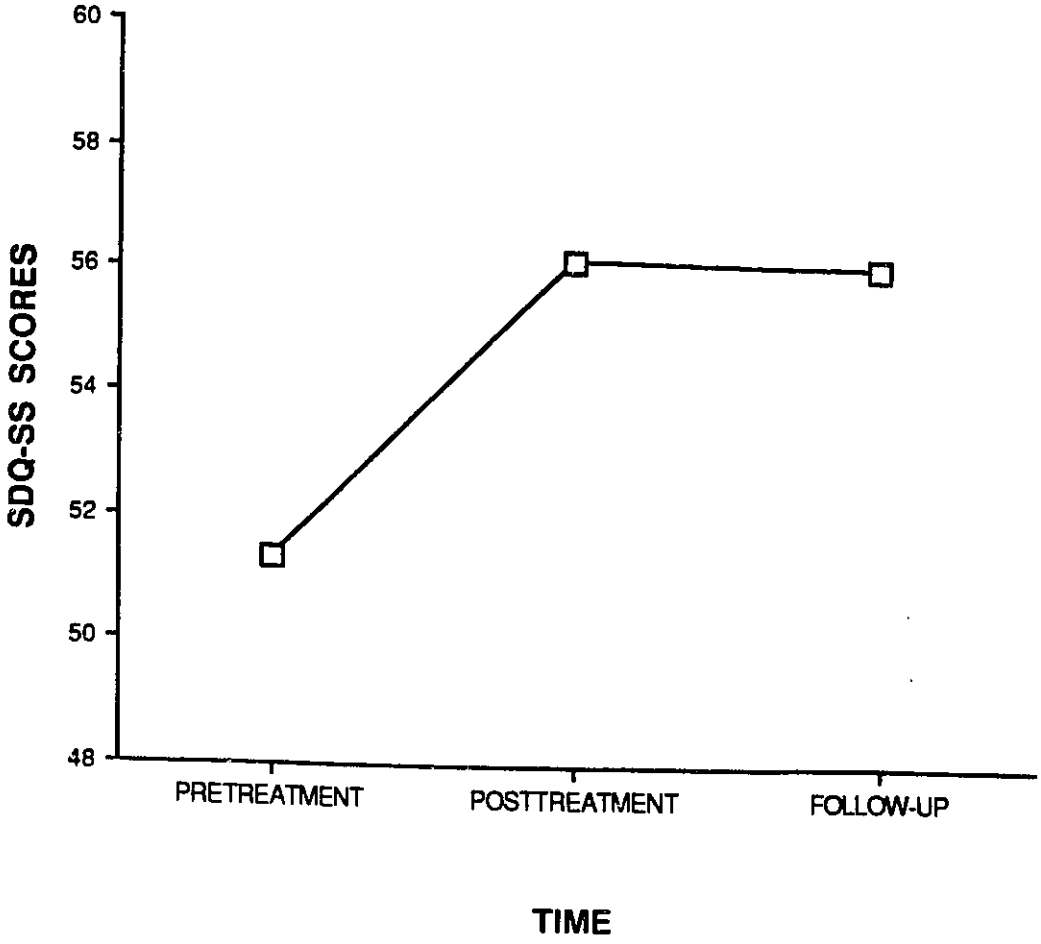

Figure 11. Mean SDQ-SS scores across Pretreatment, Posttreatment, and Follow-up for the Treatment Group.

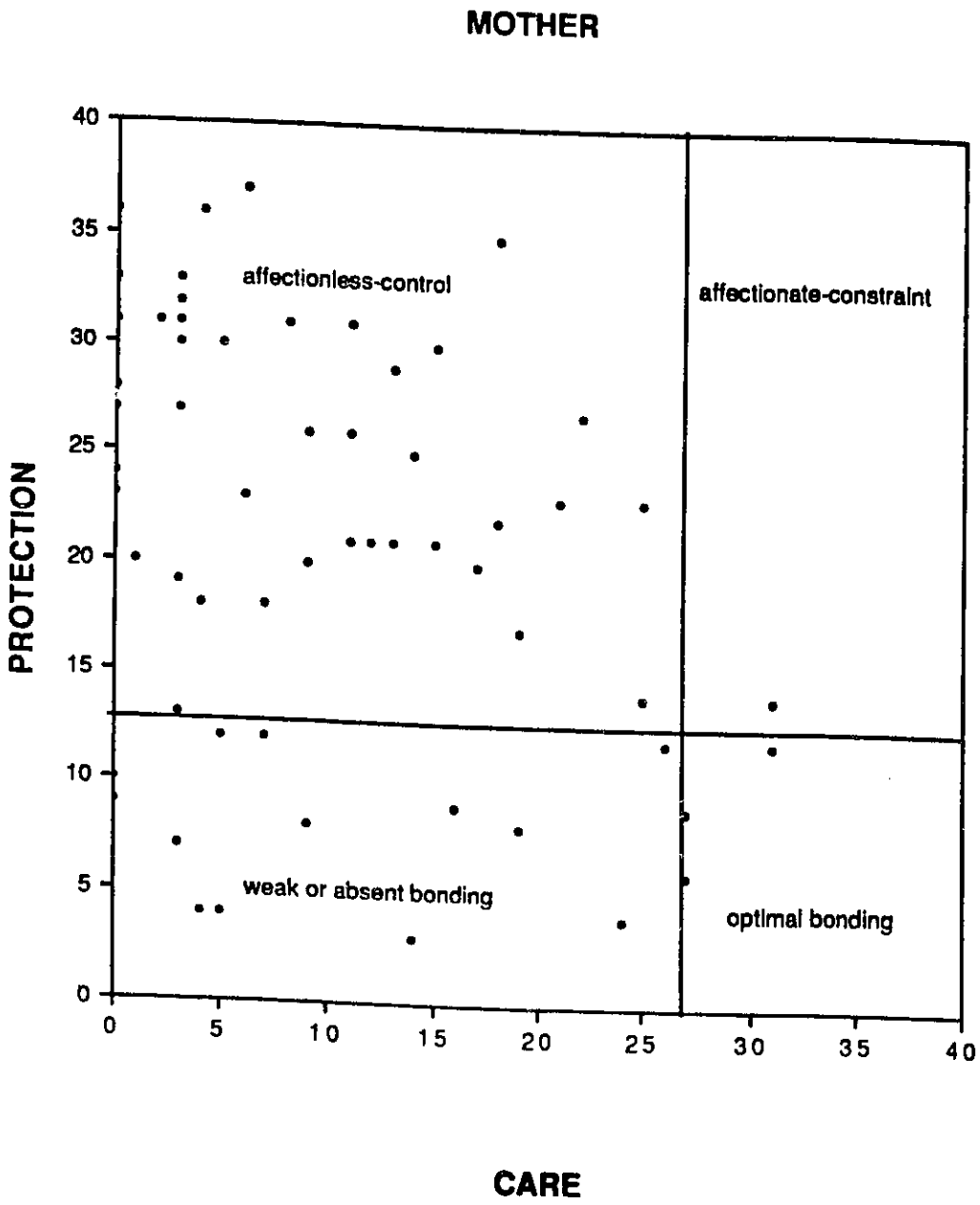

Figure 12. Care as a function of Protection for Mothers as measured by the PBI. Quadrants have been formed using Means from a nonclinical population (Parker, 1984; M Care = 27.0; M Protection = 13.5).

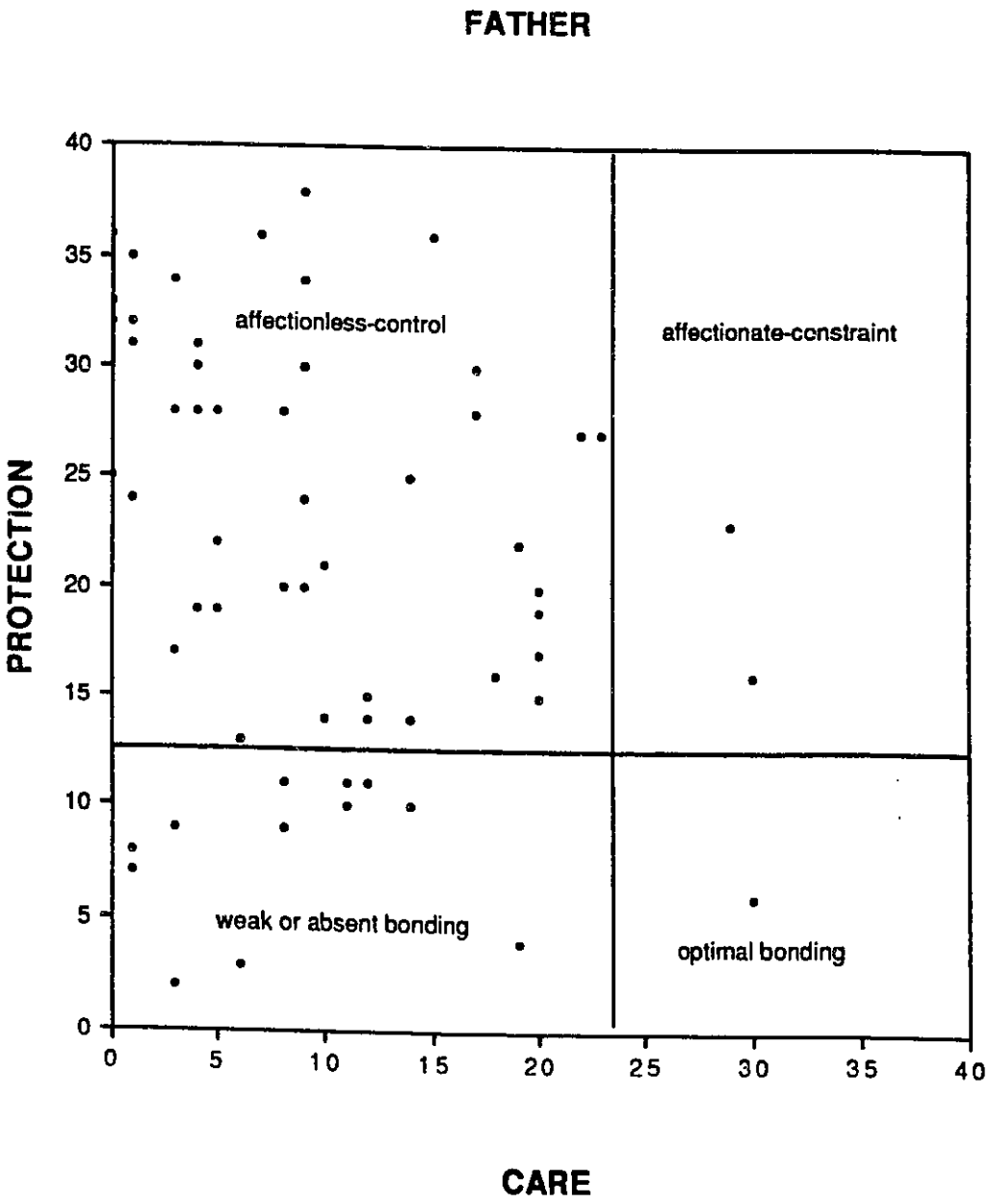

Figure 13. Care as a function of Protection for Fathers as measured by the PBI. Quadrants have been formed using Means of a nonclinical population (Parker, 1984; M Care = 24.0; M Protection = 12.5).

APPENDICES

Appendix A

INFORMED CONSENT FORM

Purpose of the Study

The purpose of this study is to determine what effect group treatment has on some of the problems experienced by women who have experienced childhood incest. If you agree to participate in this study, you will be given several questionnaires to complete before the beginning of the group, upon completion of the group, and again in about six months time. These questionnaires are not a test; there are no right or wrong answers. The questions will ask you how you feel about yourself and/or your incest experience. In this way, we will be able to see how the group has helped you deal with your feelings about your incest experience. It is important for us to understand the ways in which groups such as the one you will be attending operate so that we can improve them in order to meet your needs. As such, feedback from this study will be given to your Group Leaders in order to help them to better understand how the group has effected you.

Confidentiality

All information contained in these questionnaires will be kept in strictest confidence in accordance with the guidelines of the Ontario Board of Examiners in Psychology. If you agree to participate in this study, an identification code will be assigned to you and will be used on all of the questionnaires. No names will be used. At the end of the study, any identification information will be destroyed.

Participation

Participation in this study is strictly voluntary and you may withdraw at any time. If you decide to withdraw form this study, it will in no way affect your participation in the group.

I, _____ have read and understood the nature of the study and willingly agree to participate on the understanding that I can withdraw from the study at any time. It is understood that all information will remain strictly confidential and that I will not be identifiable in any presentation of the results of the study. If I decide to withdraw from the study, it will in no way affect my participation in the group.

Signature:_____ **Date:**_____

Appendix B

INFORMED CONSENT FORM

Purpose of the Study

The purpose of this study is to determine what effect group treatment has on some of the problems experienced by adult female incest survivors. In order to examine this question, it is necessary to compare women who have already completed the group treatment program with those who have not yet gone through the program. It is hoped that you will agree to be part of the group that has not yet gone through the group treatment program but has been accepted as a prospective group member.

If you agree to participate in this study, you will be given several questionnaires to complete at this time and again in about 20 weeks, just before the beginning of the group. These questionnaires take about 1 to 1 1/2 hours to complete. These questions are not a test; there are no right or wrong answers. The questions will ask you how you feel about yourself and/or your incest experience. By examining these questionnaires, we will be able to better understand the ways in which groups, such as the one you will be involved with, effect the problems experienced by many adult female survivors of incest.

Confidentiality

All information contained in these questionnaires will be kept in strictest confidence in accordance with the guidelines of the Ontario Board of Examiners in Psychology. If you agree to participate in this study, an identification code will be assigned to you and will be used on all of the questionnaires. No names will ever be used. At the end of the study, any identification information will be destroyed.

Participation

Participation in this study is strictly voluntary and you may withdraw at any time. If you decide to withdraw from this study, it will in no way affect your participation in the Group.

I,_____ have read and understood the nature of the study and willingly agree to participate on the understanding that I can withdraw at any time. It is understood that all information will remain strictly confidential and that I will not be identifiable in any presentation of the results of the study. If I decide to withdraw from the study, it will in no way affect my participation in the Group.

Signature: _____ **Date:**_____

Appendix C

DESCRIPTIVE DATA SHEET

CODE NUMBER_____

AGE_____

COUNTRY OF BIRTH_____

NUMBER OF SIBLINGS_____

AGE AND SEX OF SIBLINGS_____

_____

_____

_____

_____

RELATIONSHIP STATUS

MARRIED_____

SEPARATED_____

DIVORCED_____

WIDOWED_____

SINGLE_____

IF SEPARATED, DIVORCED, WIDOWED, OR SINGLE, ARE YOU PRESENTLY IN A RELATIONSHIP?

YES_____

NO_____

IS YOUR PRESENT RELATIONSHIP WITH A MAN_____?

WOMAN_____?

DO YOU HAVE ANY CHILDREN? YES_____

NO_____

IF YES, ARE ANY OF YOUR CHILDREN PRESENTLY LIVING WITH YOU?

YES_____

NO_____

ARE YOU PRESENTLY EMPLOYED? YES_____

NO_____

ARE YOUR PARENTS STILL LIVING? MOTHER_____

FATHER_____

IF YES, DO YOU REMAIN IN CONTACT WITH YOUR MOTHER_____ ?

FATHER_____?

ANY SIBLINGS_____?

AS FAR AS YOU CAN REMEMBER, AT WHAT AGE WERE YOU WHEN THE FIRST INCIDENCE OF SEXUAL ABUSE OCCURRED? _____

RELATIONSHIP OF ABUSER OR ABUSERS TO YOU:

FATHER_____

STEP-FATHER_____

BROTHER_____

UNCLE_____

GRANDFATHER_____

MOTHER_____

OTHER_____(SPECIFY)

WAS PHYSICAL FORCE EVER USED IN THE ABUSE? YES_____

NO_____

LENGTH OF TIME THAT ABUSE CONTINUED (CHECK ONE ONLY)

ONE INCIDENT ONLY _____

THREE MONTHS OR LESS _____

LONGER THAN THREE MONTHS, UP TO ONE YEAR _____

LONGER THAN ONE YEAR, UP TO THREE YEARS _____

LONGER THAN THREE YEARS _____

UNSURE, DON'T KNOW _____

HAVE YOU EVER DISCLOSED THE SEXUAL ABUSE PREVIOUSLY? YES____

NO_____

IF YES, TO WHOM HAVE YOU DISCLOSED?_____

IF YES, HOW LONG AGO (APPROXIMATELY) WAS THE ABUSE DISCLOSED?_____

HAVE YOU EVER BEEN IN THERAPY BEFORE? YES_____

NO_____

IF YES, HAVE YOU DISCLOSED THE SEXUAL ABUSE IN THERAPY?

YES_____

NO_____

WAS DEALING WITH THE SEXUAL ABUSE YOUR PRIMARY REASON FOR SEEKING INDIVIDUAL THERAPY?

YES_____

NO_____

IF NO, WHAT WAS YOUR PRIMARY REASON FOR SEEKING INDIVIDUAL THERAPY?_____

IF SEXUAL ABUSE WAS NOT YOUR PRIMARY REASON FOR SEEKING INDIVIDUAL THERAPY, DID YOUR MEMORIES OF INCEST RETURN WHILE YOU WERE IN THERAPY_____?

OR

DID YOU KNOW ABOUT THE INCEST AND DISCLOSE IT TO YOUR THERAPIST SOME TIME AFTER INDIVIDUAL THERAPY HAD BEGUN_____?

IF INCEST WAS NOT YOUR PRIMARY REASON FOR SEEKING INDIVIDUAL THERAPY, COULD YOU ESTIMATE HOW LONG AFTER YOU BEGAN INDIVIDUAL THERAPY THAT YOU AND YOUR THERAPIST STARTED TO DEAL WITH YOUR INCEST ISSUES_____?

COULD YOU PLEASE ESTIMATE THE TOTAL AMOUNT OF TIME THAT YOU SPENT IN INDIVIDUAL THERAPY BEFORE THE BEGINNING OF THE GROUP_____.

WERE YOUR SESSIONS OF INDIVIDUAL THERAPY HELD:

DAILY_____

TWICE A WEEK_____

ONCE A WEEK_____

ONCE EVERY TWO WEEKS_____

MONTHLY_____

OTHER (PLEASE SPECIFY_____?

IF POSSIBLE, COULD YOU ESTIMATE THE NUMBER OF SESSIONS OF INDIVIDUAL THERAPY THAT YOU HAD BEFORE THE BEGINNING OF THE GROUP.

LESS THAN 10_____

BETWEEN 10 AND 20_____

BETWEEN 20 AND 50_____

BETWEEN 50 AND 100_____

OVER 100_____

IN YOUR ESTIMATION, WHAT PROPORTION OF TIME IN INDIVIDUAL THERAPY WAS SPENT DEALING EXPLICITLY WITH YOUR INCEST ISSUES. THIS COULD INVOLVE DEALING WITH THE ACTUAL INCIDENT(S) OF INCEST, FEELINGS AND THOUGHTS ABOUT THE INCEST, DIFFICULTIES IN YOUR PRESENT LIFE WHICH YOU ATTRIBUTE TO THE INCEST, OR OTHER ISSUES THAT ARE INCEST RELATED SUCH AS DEALING WITH FAMILY MEMBERS, ETC.

75 - 100%_____

50 - 75%_____

25 - 50%_____

0 - 25%_____

AS BEST AS YOU CAN, COULD YOU BRIEFLY DESCRIBE SOME OF THE THINGS THAT YOU AND YOUR THERAPIST DO IN INDIVIDUAL THERAPY.

_____

_____

_____

_____

_____

HOW RESOLVED DO YOU THINK YOUR INCEST ISSUES ARE NOW BEFORE ENTERING THE GROUP?

MOSTLY RESOLVED_____

SOMEWHAT RESOLVED_____

A LITTLE RESOLVED_____

NOT AT ALL RESOLVED_____

ARE YOU CURRENTLY IN INDIVIDUAL THERAPY?

YES_____

NO_____

IF YES, ARE YOU PLANNING TO CONTINUE IN INDIVIDUAL THERAPY DURING THE COURSE OF THE GROUP?

YES_____

NO_____

HAS YOUR ABUSER EVER ACKNOWLEDGED HIS/HER RESPONSIBILITY IN THE ABUSE? YES_____

NO_____

OVERALL, HOW UPSET WERE YOU BY YOUR INCEST EXPERIENCE AT THE TIME?

EXTREMELY UPSET_____

VERY UPSET_____

SOMEWHAT UPSET_____

NOT VERY UPSET_____

LOOKING BACK ON IT NOW, HOW MUCH EFFECT WOULD YOU SAY THAT YOUR INCEST EXPERIENCE HAS HAD ON YOUR LIFE?

A GREAT EFFECT _____

SOME EFFECT _____

A LITTLE EFFECT _____

NO EFFECT _____

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE.

Appendix D

DESCRIPTIVE DATA SHEET

CODE NUMBER_____

AGE_____

COUNTRY OF BIRTH_____

NUMBER OF SIBLINGS_____

AGE AND SEX OF SIBLINGS_____

_____

_____

_____

RELATIONSHIP STATUS

MARRIED_____

SEPARATED_____

DIVORCED_____

WIDOWED_____

SINGLE_____

IF SEPARATED, DIVORCED, WIDOWED, OR SINGLE, ARE YOU PRESENTLY IN A RELATIONSHIP?

YES_____

NO_____

IS YOUR PRESENT RELATIONSHIP WITH A MAN_____?

WOMAN_____?

DO YOU HAVE ANY CHILDREN? YES_____

NO_____

IF YES, ARE ANY OF YOUR CHILDREN PRESENTLY LIVING WITH YOU?

YES_____

NO_____

ARE YOU PRESENTLY EMPLOYED? YES_____

NO_____

ARE YOUR PARENTS STILL LIVING? MOTHER_____

FATHER_____

IF YOUR PARENTS ARE STILL LIVING, DO YOU REMAIN IN CONTACT WITH

YOUR MOTHER_____

YOUR FATHER_____

ANY SIBLINGS_____ ?

AS FAR AS YOU CAN REMEMBER, AT WHAT AGE WERE YOU WHEN THE FIRST INCIDENCE OF SEXUAL ABUSE OCCURRED? _____

RELATIONSHIP OF ABUSER OR ABUSERS TO YOU:

FATHER_____

STEP-FATHER_____

BROTHER_____

UNCLE_____

GRANDFATHER_____

MOTHER_____

OTHER _____
(PLEASE SPECIFY)

WAS PHYSICAL FORCE EVER USED IN THE ABUSE? YES_____

NO_____

LENGTH OF TIME THAT ABUSE CONTINUED (CHECK ONE ONLY)

ONE INCIDENT ONLY _____

THREE MONTHS OR LESS_____

LONGER THAN THREE MONTHS,
UP TO ONE YEAR _____

LONGER THAN ONE YEAR,
UP TO THREE YEARS _____

LONGER THAN THREE YEARS_____

UNSURE, DON'T KNOW_____

HAVE YOU EVER DISCLOSED THE SEXUAL ABUSE PREVIOUSLY?

YES_____

NO_____

IF YES, TO WHOM HAVE YOU DISCLOSED?_____

IF YES, HOW LONG AGO (APPROXIMATELY) WAS THE ABUSE DISCLOSED?_____

HAVE YOU EVER BEEN IN INDIVIDUAL THERAPY?

YES_____

NO_____

IF YES, HAVE YOU DISCLOSED THE SEXUAL ABUSE IN INDIVIDUAL THERAPY?

YES_____

NO_____ _____

WAS DEALING WITH THE SEXUAL ABUSE THE PRIMARY REASON FOR SEEKING INDIVIDUAL THERAPY?

YES_____

NO_____

IF NO, WHAT WAS YOUR PRIMARY REASON FOR SEEKING INDIVIDUAL THERAPY_____

IF SEXUAL ABUSE WAS NOT YOUR PRIMARY REASON FOR SEEKING INDIVIDUAL THERAPY, DID YOUR MEMORIES OF INCEST RETURN WHILE YOU WERE IN THERAPY_____?

OR

DID YOU KNOW ABOUT THE INCEST AND DISCLOSE IT TO YOUR THERAPIST SOME TIME AFTER INDIVIDUAL THERAPY HAD BEGUN _____?

IF INCEST WAS NOT YOUR PRIMARY REASON FOR SEEKING INDIVIDUAL THERAPY, COULD YOU ESTIMATE HOW LONG AFTER YOU BEGAN INDIVIDUAL THERAPY THAT YOU AND YOUR THERAPIST STARTED TO DEAL WITH YOUR INCEST ISSUES_____?

COULD YOU PLEASE ESTIMATE THE TOTAL AMOUNT OF TIME THAT YOU HAVE SPENT IN INDIVIDUAL THERAPY_____.

WERE YOUR INDIVIDUAL THERAPY SESSIONS HELD

DAILY_____

TWICE A WEEK_____

ONCE A WEEK_____

ONCE EVERY TWO WEEKS____

MONTHLY_____

OTHER (PLEASE SPECIFY_____

IF POSSIBLE, COULD YOU ESTIMATE THE NUMBER OF SESSIONS OF INDIVIDUAL THERAPY THAT YOU HAVE HAD

LESS THAN 10_____

BETWEEN 10 AND 20_____

BETWEEN 20 AND 50_____

BETWEEN 50 AND 100_____

OVER 100_____

ARE YOU CURRENTLY IN INDIVIDUAL THERAPY?

YES_____

NO_____

IF YES, ARE YOU PL NG TO CONTINUE IN INDIVIDUAL THERAPY UNTIL THE BEGINNINC THE GROUP?

YES_____

NO_____

AT THIS TIME, HOW RI VED DO YOU THINK YOUR INCEST ISSUES ARE?

MOSTLY RESOLVED_____

SOMEWHAT RESOLVED_____

A LITTLE RESOLVED_____

NOT RESOLVED AT ALL_____

IN YOUR ESTIMATION, WHAT PROPORTION OF TIME IN INDIVIDUAL THERAPY DO YOU SPEND DEALING EXPLICITLY WITH YOUR INCEST ISSUES. THIS COULD INVOLVE DEALING WITH THE ACTUAL INCIDENT(S) OF INCEST, YOUR FEELINGS AND THOUGHTS ABOUT THE INCEST, DIFFICULTIES IN YOUR PRESENT LIFE WHICH YOU ATTRIBUTE TO THE INCEST, OR OTHER ISSUES THAT YOU FEEL ARE INCEST RELATED SUCH AS DEALING WITH FAMILY MEMBERS ETC?

75 - 100%_____

50 - 75%_____

25 - 50%_____

0 - 25%_____

AS BEST AS YOU CAN, COULD YOU BRIEFLY DESCRIBE SOME OF THE THINGS THAT YOU AND YOUR THERAPIST DO IN INDIVIDUAL THERAPY.

_____

_____

_____

_____

HAS YOUR ABUSER OR ABUSERS EVER ACKNOWLEDGED THEIR RESPONSIBILITY IN THE ABUSE? YES_____

NO_____

HAVE YOU EVER EXPERIENCED SEXUAL ABUSE AS AN ADULT FROM SOMEONE NOT INVOLVED IN YOUR EARLY INCEST EXPERIENCE?

YES_____

NO_____

IF YES, HOW WOULD YOU CLASSIFY THE SEXUAL ABUSE

RAPE BY A STRANGER?_____

SEXUAL HARASSMENT AT WORK?_____

UNWANTED SEXUAL OVERTURES FROM FRIENDS OR DATES?_____

RAPE BY SOMEONE KNOWN TO ME?_____

OTHER? (PLEASE SPECIFY)_____

HAVE YOU EVER BEEN PHYSICALLY ABUSED AS AN ADULT BY SOMEONE NOT INVOLVED IN YOUR EARLY INCEST EXPERIENCE?

YES_____

NO_____

HAVE YOU EVER THOUGHT ABOUT SUICIDE? YES_____

NO_____

IF YES, HOW OFTEN HAVE YOU THOUGHT ABOUT IT?

ALL OF THE TIME_____

VERY OFTEN_____

FAIRLY OFTEN_____

OCCASIONALLY_____

RARELY_____

IF YES, HAVE YOU EVER ATTEMPTED SUICIDE? YES_____

NO_____

DO YOU FEEL THAT YOU HAVE EVER HAD A PROBLEM WITH DRUGS OR ALCOHOL?

YES_____

NO_____

UNSURE_____

HAVE YOU EVER BEEN TREATED FOR A DRUG OR ALCOHOL-RELATED PROBLEM?

YES_____

NO_____

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?

GRAMMAR OR PUBLIC SCHOOL_____

HIGH SCHOOL_____

COMMUNITY COLLEGE_____

UNIVERSITY DEGREE_____

OVERALL, HOW UPSET WERE YOU BY YOUR INCEST EXPERIENCE AT THE TIME?

EXTREMELY UPSET_____

VERY UPSET_____

SOMEWHAT UPSET_____

NOT VERY UPSET_____

LOOKING BACK ON IT NOW, HOW MUCH EFFECT WOULD YOU SAY THAT YOUR INCEST EXPERIENCE HAS HAD ON YOUR LIFE?

A GREAT EFFECT_____

SOME EFFECT _____

A LITTLE EFFECT_____

NO EFFECT _____

THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY.

Appendix E

DESCRIPTIVE DATA - POST GROUP

CODE NUMBER_____

HAVE YOU EVER EXPERIENCED SEXUAL ABUSE AS AN ADULT FROM SOMEONE NOT INVOLVED IN YOUR EARLY INCEST EXPERIENCE?

YES_____

NO_____

IF YES, HOW WOULD YOU CLASSIFY THE SEXUAL ABUSE

RAPE BY A STRANGER?_____

SEXUAL HARASSMENT AT WORK?_____

UNWANTED SEXUAL OVERTURES FROM FRIENDS OR DATES?_____

RAPE BY SOMEONE KNOWN TO ME?_____

OTHER? (PLEASE SPECIFY)_____

HAVE YOU EVER BEEN PHYSICALLY ABUSED AS AN ADULT BY SOMEONE NOT INVOLVED IN YOUR EARLY INCEST EXPERIENCE?

YES_____

NO_____

HAVE YOU EVER THOUGHT ABOUT SUICIDE? YES_____

NO_____

IF YES, HOW OFTEN HAVE YOU THOUGHT ABOUT IT?

ALL THE TIME_____

VERY OFTEN_____

FAIRLY OFTEN_____

OCCASIONALLY_____

RARELY_____

IF YES, HAVE YOU EVER ATTEMPTED SUICIDE? YES_____

NO_____

HAS BEING IN THE GROUP INCREASED OR DECREASED YOUR THOUGHTS ABOUT SUICIDE?

INCREASED_____

DECREASED_____

NO DIFFERENCE_____

DO YOU FEEL THAT YOU HAVE EVER HAD A PROBLEM WITH DRUGS OR ALCOHOL?

YES_____

NO_____

UNSURE_____

HAVE YOU EVER BEEN TREATED FOR A DRUG OR ALCOHOL-RELATED PROBLEM?

YES_____

NO_____

HAVE YOU REMAINED IN INDIVIDUAL THERAPY THROUGHOUT THE 20 WEEK GROUP PROGRAM?

YES_____

NO_____

IF YES, COULD YOU ESTIMATE THE NUMBER OF SESSIONS OF INDIVIDUAL THERAPY YOU HAVE HAD DURING THE 20 WEEK PROGRAM, IF ANY?

_____

WERE YOUR INDIVIDUAL SESSIONS HELD

DAILY_____

TWICE A WEEK_____

ONCE A WEEK_____

ONCE EVERY TWO WEEKS_____

MONTHLY_____

OTHER (PLEASE SPECIFY)_____

DID YOU HAVE ANY CONTACT WITH YOUR INDIVIDUAL THERAPIST OUTSIDE OF THE ACTUAL THERAPY SESSION?

YES_____

NO_____

IF YES, COULD YOU ESTIMATE THE NUMBER OF TIMES THAT THIS OCCURRED_____

IF YOU REMAINED IN INDIVIDUAL THERAPY DURING THE GROUP TREATMENT PROGRAM, DO YOU FEEL THAT INDIVIDUAL THERAPY INCREASED OR DECREASED THE AMOUNT OF HELP THAT YOU RECEIVED WHILE YOU WERE IN THE GROUP?

GREATLY INCREASED_____

MODERATELY INCREASED_____

NEITHER INCREASED NOR DECREASED_____

MODERATELY DECREASED_____

GREATLY DECREASED_____

IF YOU REMAINED IN INDIVIDUAL THERAPY DURING THE GROUP TREATMENT PROGRAM, DO YOU FEEL THAT THE GROUP INCREASED OR DECREASED THE AMOUNT OF HELP THAT YOU RECEIVED WHILE YOU WERE IN INDIVIDUAL THERAPY?

GREATLY INCREASED_____

MODERATELY INCREASED_____

NEITHER INCREASED NOR DECREASED_____

MODERATELY DECREASED_____

GREATLY DECREASED_____

DO YOU INTEND TO CONTINUE INDIVIDUAL THERAPY AFTER THE GROUP IS FINISHED?

YES_____

NO_____

DON'T KNOW_____

DO YOU FEEL THAT INDIVIDUAL THERAPY IS NECESSARY WHILE GOING THROUGH THE GROUP EXPERIENCE?

YES_____

NO_____

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?

GRAMMAR OR PUBLIC SCHOOL_____

HIGH SCHOOL_____

COMMUNITY COLLEGE_____

UNIVERSITY DEGREE_____

COULD YOU PLEASE RATE YOUR GROUP EXPERIENCE ON THE FOLLOWING SCALE:

THE EXPERIENCE THAT I HAD IN THE GROUP HAS BEEN:

EXTREMELY HELPFUL_____

VERY HELPFUL_____

MODERATELY HELPFUL_____

ONLY SLIGHTLY HELPFUL_____

NOT HELPFUL AT ALL_____

WHAT I FOUND MOST HELPFUL ABOUT THE GROUP WAS_____

_____

_____

_____

WHAT I FOUND LEAST HELPFUL ABOUT THE GROUP WAS_____

_____

_____

_____

PLEASE USE THE NEXT PAGE IF YOU WISH TO MAKE ANY FURTHER COMMENTS.

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.

Appendix F

DESCRIPTIVE DATA - PRE GROUP

CODE NUMBER_____

YOU PREVIOUSLY FILLED OUT SEVERAL QUESTIONNAIRES FOR THIS STUDY ON_____.

HAVE YOU REMAINED IN INDIVIDUAL THERAPY SINCE THE ABOVE DATE?

YES_____

NO_____

IF YES, COULD YOU ESTIMATE HOW MANY SESSIONS OF INDIVIDUAL THERAPY THAT YOU HAVE HAD OVER THAT TIME?_____

IF NO, DID YOU RECEIVE ANY SESSIONS OF INDIVIDUAL THERAPY?

YES_____

NO_____

HOW MANY_____

IF YOU REMAINED IN INDIVIDUAL THERAPY SINCE THE ABOVE DATE, WERE YOUR INDIVIDUAL SESSIONS HELD

DAILY_____

TWICE A WEEK_____

ONCE A WEEK_____

ONCE EVERY TWO WEEKS_____

MONTHLY_____

OTHER (PLEASE SPECIFY)_____

IN YOUR ESTIMATION, WHAT PROPORTION OF TIME IN INDIVIDUAL THERAPY WAS SPENT DEALING EXPLICITLY WITH YOUR INCEST ISSUES. THIS COULD INVOLVE DEALING WITH THE ACTUAL INCIDENT(S) OF INCEST, YOUR FEELINGS AND THOUGHTS ABOUT THE INCEST, DIFFICULTIES IN YOUR PRESENT LIFE WHICH YOU ATTRIBUTE TO THE INCEST, OR OTHER ISSUES THAT ARE INCEST RELATED SUCH AS DEALING WITH FAMILY MEMBERS, ETC.

75 - 100%_____

50 - 75% _____

25 - 50% _____

0 - 25% _____

DID YOU HAVE ANY CONTACTS WITH YOUR THERAPIST OUTSIDE OF REGULARLY SCHEDULED SESSIONS?

YES_____

NO_____

IF YES, COULD YOU ESTIMATE THE NUMBER OF TIMES THAT THIS OCCURRED_____?

HOW RESOLVED DO YOU THINK YOUR INCEST ISSUES ARE NOW BEFORE THE START OF THE GROUP?

MOSTLY RESOLVED_____

SOMEWHAT RESOLVED_____

A LITTLE RESOLVED_____

NOT AT ALL RESOLVED_____

DO YOU INTEND TO CONTINUE INDIVIDUAL THERAPY WHILE YOU PARTICIPATE IN THE GROUP?

YES_____

NO_____

DON'T KNOW_____

HAVE YOU PARTICIPATED IN ANY OTHER GROUPS OVER THE LAST FIVE MONTHS THAT MET ON A REGULAR BASIS? (e.g., ASSERTIVENESS TRAINING, A.A., AL ANON, ETC.)

YES_____

NO_____

IF YES, HAVE YOU FOUND ANY OF THESE GROUPS TO BE HELPFUL IN DEALING WITH YOUR INCEST EXPERIENCE? YES_____

NO_____

COULD YOU PROVIDE THE NAME OF THE GROUP THAT YOU PARTICIPATED IN_____

THANK YOU FOR YOUR PARTICIPATION

Appendix G

DESCRIPTIVE DATA - SIX-MONTH FOLLOW UP

CODE NO._____

HAVE YOU REMAINED IN INDIVIDUAL THERAPY THROUGHOUT THE PAST SIX MONTHS?

YES_____

NO_____

IF YES, COULD YOU ESTIMATE THE NUMBER OF SESSIONS OF INDIVIDUAL THERAPY YOU HAVE HAD OVER THE LAST SIX MONTHS_____

IF NO, DID YOU RECEIVE ANY SESSIONS OF INDIVIDUAL THERAPY OVER THE LAST SIX MONTHS?

YES_____

NO_____

APPROXIMATELY HOW MANY_____

IF YOU REMAINED IN INDIVIDUAL THERAPY THROUGHOUT THE LAST SIX MONTHS, WERE YOUR
SESSIONS OF INDIVIDUAL THERAPY HELD

DAILY_____

TWICE A WEEK_____

ONCE A WEEK_____

ONCE EVERY TWO WEEKS_____

MONTHLY_____

OTHER (PLEASE SPECIFY)_____

IF YOU REMAINED IN INDIVIDUAL THERAPY FOR THE LAST SIX MONTHS, DO YOU FEEL THAT YOUR GROUP EXPERIENCE HELPED YOU DEAL WITH YOUR INCEST EXPERIENCE IN INDIVIDUAL THERAPY?

YES, A GREAT DEAL_____

YES, A MODERATE AMOUNT_____

NO DIFFERENCE_____

IT HAS MADE IT MORE DIFFICULT
TO DEAL WITH MY INCEST EXPERIENCE_____

HOW RESOLVED DO YOU THINK YOU INCEST ISSUES ARE NOW AS COMPARED TO WHEN THE GROUP ENDED?

MOSTLY RESOLVED_____

SOMEWHAT RESOLVED_____

A LITTLE RESOLVED_____

NOT RESOLVED AT ALL_____

HAVE YOU JOINED ANY OTHER GROUPS OVER THE LAST SIX MONTHS THAT MEET ON A REGULAR BASIS? (E.G., GRADS GROUP, A.A., ASSERTIVENESS TRAINING, AL ANON, ETC.)

YES_____

NO_____

IF YES, COULD YOU PROVIDE THE NAME OF THE GROUP THAT YOU HAVE JOINED?

_____

HAVE YOU FOUND THIS **NEW** GROUP TO BE HELPFUL IN DEALING WITH YOUR INCEST EXPERIENCE?

YES_____

NO_____

ON LOOKING BACK TO YOUR EXPERIENCE IN THE "VICTIM TO SURVIVOR" GROUP COULD YOU PLEASE RATE YOUR FEELINGS ABOUT THE GROUP.

THE EXPERIENCE THAT I HAD IN THE GROUP WAS:

EXTREMELY HELPFUL_____

VERY HELPFUL_____

MODERATELY HELPFUL_____

ONLY SLIGHTLY HELPFUL_____

NOT HELPFUL AT ALL_____

HAVE YOU KEPT IN CONTACT WITH OTHER GROUP MEMBERS FOLLOWING THE COMPLETION OF THE GROUP?

YES_____

NO_____

Appendix H

MEASURES

1. Beck Depression Inventory (BDI)
2. Centre for Epidemiological Studies - Depression Scale (CES-D)
3. Brief Symptom Inventory (BSI)
4. Impact of Events Scale (IES)
5. Self Description Questionnaire (SDQ)
6. Attachment Questionnaire (AQ)
7. Perceived Social Support Scale (PSS)
8. Parental Bonding Index (PBI)

CODE NO._____

PLEASE READ EACH GROUP OF STATEMENTS CAREFULLY. THEN PICK OUT THE ONE STATEMENT IN EACH GROUP WHICH BEST DESCRIBES THE WAY YOU HAVE BEEN FEELING THE PAST WEEK, INCLUDING TODAY! CIRCLE THE NUMBER BESIDE THE STATEMENT YOU PICKED. IF SEVERAL STATEMENTS IN THE GROUP SEEM TO APPLY EQUALLY WELL, CIRCLE EACH ONE. BE SURE TO READ ALL THE STATEMENTS IN EACH GROUP BEFORE MAKING YOUR CHOICE.

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel that I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated by things than I ever am.
    1 I am slightly more irritated now than usual.
    2 I am quite annoyed or irritated a good deal of the time.
    3 I feel irritated all the time now.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make decisions at all anymore.

14. 0 I don't feel that I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearance that make me look unattractive.
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.

16. 0 I can sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up one-two hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
    1 I have lost more than five pounds.
    2 I have lost more than 10 pounds.
    3 I have lost more than 15 pounds.

    I am purposely trying to lose wight by eating less.

    Yes_____ No_____

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex than I used to be.
    2 I am much less interested in sex now.
    3 I have lost interest in sex completely.

THANK YOU FOR PARTICIPATING IN THIS STUDY

CODE NO:_____

CIRCLE THE NUMBER FOR EACH STATEMENT WHICH BEST DESCRIBES HOW OFTEN YOU FELT OR BEHAVED THIS WAY - DURING THE PAST WEEK.

	Rarely or None of the Time	Some or a Little of the Time	Occasionally or a Moderate Amount of Time	Most or All of the Time
DURING THE PAST WEEK:				
1. I was bothered by things that usually don't bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt that I was just as good as other people.	0	1	2	3
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3

	Rarely or None of the Time	Some or a Little of the Time	Occasionally or a Moderate Amount of Time	Most or All of the Time
DURING THE PAST WEEK:				
8. I felt hopeful about the future.	0	1	2	3
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	0	1	2	3
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	0	1	2	3
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people disliked me.	0	1	2	3

	Rarely or None of the Time	Some or a Little of the Time	Occasionally or a Moderate Amount of Time	Most or All or the Time
DURING THE PAST WEEK:				
20. I could not get "going".	0	1	2	3

CODE NO:_____

BELOW IS A LIST OF PROBLEMS PEOPLE SOMETIMES HAVE.

PLEASE READ EACH ONE CAREFULLY, AND CIRCLE THE NUMBER TO THE RIGHT THAT BEST DESCRIBES HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. CIRCLE ONLY ONE NUMBER FOR EACH PROBLEM AND DO NOT SKIP ANY ITEMS.

HOW MUCH WERE YOU DISTRESSED BY:

Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
0	1	2	3	4

1.	Nervousness or shakiness inside	0	1	2	3	4
2.	Faintness or dizziness	0	1	2	3	4
3.	The idea that someone else can control your thoughts	0	1	2	3	4
4.	Feeling others are to blame for most of your thoughts	0	1	2	3	4
5.	Trouble remembering things	0	1	2	3	4
6.	Feeling annoyed or irritated	0	1	2	3	4
7.	Pains in heart or chest	0	1	2	3	4
8.	Feeling afraid in open spaces	0	1	2	3	4
9.	Thoughts of ending your life	0	1	2	3	4
10.	Feeling that most people cannot be trusted	0	1	2	3	4

Not At All 0	A Little Bit 1	Moderately 2	Quite A Bit 3	Extremely 4

11.	Poor appetite	0	1	2	3	4
12.	Suddenly scared for no reason	0	1	2	3	4
13.	Temper outbursts that you could not control	0	1	2	3	4
14.	Feeling lonely even when you are with people	0	1	2	3	4
15.	Feeling blocked in getting things done	0	1	2	3	4
16.	Feeling lonely	0	1	2	3	4
17.	Feeling blue	0	1	2	3	4
18.	Feeling no interest in things	0	1	2	3	4
19.	Feeling fearful	0	1	2	3	4
20.	Your feelings being easily hurt	0	1	2	3	4
21.	Feeling that people are unfriendly or dislike you	0	1	2	3	4
22.	Feeling inferior to others	0	1	2	3	4
23.	Nausea or upset stomach	0	1	2	3	4
24.	Feeling that you are watched or talked about by others	0	1	2	3	4
25.	Trouble falling asleep	0	1	2	3	4

Not At All 0	A Little Bit 1	Moderately 2	Quite A Bit 3	Extremely 4

26.	Having to check and double check what you do	0	1	2	3	4
27.	Difficulty making decisions	0	1	2	3	4
28.	Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4
29.	Trouble getting your breath	0	1	2	3	4
30.	Hot or cold spells	0	1	2	3	4
31.	Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
32.	Your mind going blank	0	1	2	3	4
33.	Numbness or tingling in parts of your body	0	1	2	3	4
34.	The idea that you should be punished for your sins	0	1	2	3	4
35.	Feeling hopeless about the future	0	1	2	3	4
36.	Trouble concentrating	0	1	2	3	4
37.	Feeling weak in parts of your body	0	1	2	3	4
38.	Feeling tense or keyed up	0	1	2	3	4
39.	Thoughts of death or dying	0	1	2	3	4
40.	Having urges to beat, injure, or harm someone	0	1	2	3	4

Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
0	1	2	3	4

41.	Having urges to break or smash things	0	1	2	3	4
42.	Feeling very self-conscious with others	0	1	2	3	4
43.	Feeling uneasy in crowds	0	1	2	3	4
44.	Never feeling close to another person	0	1	2	3	4
45.	Spells of terror or panic	0	1	2	3	4
46.	Getting into frequent arguments	0	1	2	3	4
47.	Feeling nervous when you are left alone	0	1	2	3	4
48.	Others not giving you proper credit for your achievements	0	1	2	3	4
49.	Feeling so restless you couldn't sit still	0	1	2	3	4
50.	Feelings of worthlessness	0	1	2	3	4
51.	Feeling that people will take advantage of you if you let them	0	1	2	3	4
52.	Feelings of guilt	0	1	2	3	4
53.	The idea that something is wrong with your mind	0	1	2	3	4

THANK YOU VERY MUCH FOR YOUR PARTICIPATION

CODE NO:_____

IMPACT OF EVENT SCALE

BELOW ARE A LIST OF COMMENTS MADE BY PEOPLE AFTER STRESSFUL LIFE EVENTS. PLEASE CHECK EACH ITEM, INDICATING HOW FREQUENTLY THESE COMMENTS WERE TRUE FOR YOU <u>DURING THE PAST MONTH</u> IN REGARDS TO YOUR THOUGHTS ABOUT <u>YOUR INCEST EXPERIENCE</u>. IF THEY DID NOT OCCUR DURING THIS TIME PERIOD, PLEASE MARK THE "NOT AT ALL" COLUMN.

	Not at all	Rarely	Sometimes	Often
1. I thought about it when I didn't mean to.	0	1	2	3
2. I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3
3. I tried to remove it from my memory.	0	1	2	3
4. I had trouble falling asleep or staying asleep because pictures or thoughts of it came into my mind.	0	1	2	3
5. I had waves of strong feelings about it.	0	1	2	3
6. I had dreams about it.	0	1	2	3
7. I stayed away from reminders of it.	0	1	2	3
8. I felt as if it hadn't happened or it wasn't real.	0	1	2	3
9. I tried not to talk about it.	0	1	2	3
10. Pictures about it popped into my mind.	0	1	2	3

	Not at all	Rarely	Sometimes	Often
11. Other things kept making me think about it.	0	1	2	3
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3
13. I tried not to think about it.	0	1	2	3
14. Any reminder brought back feelings about it.	0	1	2	3
15. My feelings about it were kind of numb.	0	1	2	3

CODE NO:_____

PLEASE ENTER NEXT TO EACH STATEMENT THE NUMBER WHICH DESCRIBES YOUR FEELINGS ABOUT YOURSELF AT THIS TIME.

1. Definitely False
2. False
3. Mostly False
4. More False Than True
5. More True Than False
6. Mostly True
7. True
8. Definitely True

1. Overall, I have a lot of respect for myself. _____

2. I get a lot of attention from members of the opposite sex. _____

3. I am usually pretty calm and relaxed. _____

4. I have few friends of the same sex that I can really count on. _____

5. Overall, I lack self-confidence. _____

6. I find it difficult to meet members of the opposite sex whom I like. _____

7. I worry a lot. _____

8. I am comfortable talking to members of the same sex. _____

9. Overall, I am pretty accepting of myself. _____

10. I have lots of friends of the opposite sex. _____

1. Definitely False
2. False
3. Mostly False
4. More False Than True
5. More True Than False
6. Mostly True
7. True
8. Definitely True

11. I am happy most of the time. _____

12. I don't get along very well with other members of the same sex. _____

13. Overall, I don't have much respect for myself. _____

14. Most of my friends are more comfortable with members of the opposite sex than I am. _____

15. I am anxious much of the time. _____

16. I make friends easily with members of the same sex. _____

17. Overall, I have a lot of self-confidence. _____

18. I am comfortable talking to members of the opposite sex. _____

19. I hardly ever feel depressed. _____

20. Other members of the same sex find me boring. _____

1. Definitely False
2. False
3. Mostly False
4. More False Than True
5. More True Than False
6. Mostly True
7. True
8. Definitely True

21. Overall, I have a very good self-concept. _____

22. I am quite shy with members of the opposite sex. _____

23. I tend to be high-strung, tense and restless. _____

24. I share lots of activities with members of the same sex. _____

25. Overall, nothing that I do is very important. _____

26. I make friends easily with members of the opposite sex. _____

27. I do not spend a lot of time worrying about things. _____

28. Not many people of the same sex like me. _____

29. Overall, I have pretty positive feelings about myself. _____

30. I am often depressed. _____

31. I am popular with other members of the same sex. _____

1. Definitely False
2. False
3. Mostly False
4. More False Than True
5. More True Than False
6. Mostly True
7. True
8. Definitely True

32. Overall, I have a very poor self-concept. _____

33. I am comfortable being affectionate with members of the opposite sex. _____

34. I am inclined toward being an optimist. _____

35. Overall, I have pretty negative feelings about myself. _____

36. I never seem to have much in common with members of the opposite sex. _____

37. I tend to be a very nervous person. _____

38. I have lots of friends of the same sex. _____

39. Overall, I do lots of things that are important. _____

40. Overall, I am not very accepting of myself. _____

41. I have had lots of feelings of inadequacy about relating to members of the opposite sex. _____

42. Most people have more friends of the same sex than I do. _____

THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY

CODE NO:_____

In this questionnaire, you will find questions about your relationship to one special person in your life. We call this special person your "attachment figure". By attachment figure, we mean:

- Most likely, the person you are living with or romantically involved with.
- The person you'd be most likely to turn to for comfort, help, advice, love, or understanding.
- The person you'd be most likely to depend on, and who may depend on you for some things.

To answer the following question, think of the person you feel closest to right now.

Is there someone in you life right now whom you would describe as your attachment figure?

Yes_____

No_____

Relationship to your attachment figure:

My attachment figure is my_____. (No names are necessary).

The questions about your relationship with your attachment figure begin on the next page. Please think about each question and answer carefully, but do not worry if some questions are hard to answer exactly. Remember, this questionnaire is not a test; there are no right or wrong answers. Do the best you can and trust your own judgments.

Thank you for your help.

1 strongly disagree	2 disagree	3 somewhat agree and somewhat disagree	4 agree	5 strongly agree

1. I feel comfortable with my attachment figure going away for a few days. _____

2. I turn to my attachment figure for many things, including comfort and reassurance. _____

3. I'm confident that my attachment figure will listen to me. _____

4. I enjoy helping my attachment figure whenever I can. _____

5. I have to force myself to keep going when my attachment figure is absent. _____

6. It's hard for me to believe that I'll always have my attachment figure's love. _____

7. I have to have my attachment figure with me when I'm upset. _____

8. I don't object when my attachment figure goes away for a few days. _____

9. I find it difficult to imagine turning to my attachment figure for help. _____

10. I'm confident that my attachment figure will try to understand my feelings. _____

11. I sympathize with my attachment figure when he/she is upset. _____

1 strongly disagree	2 disagree	3 somewhat agree and somewhat disagree	4 agree	5 strongly agree

12. The further I am from my attachment figure, the more insecure I feel. _____

13. I worry about losing my attachment figure. _____

14. When I'm upset, the most important thing is to be with my attachment figure. _____

15. I resent it when my attachment figure spends time away from me. _____

16. I talk things over with my attachment figure. _____

17. I worry that my attachment figure will let me down. _____

18. When my attachment figure feels insecure, I try to reassure him/her. _____

19. Being with my attachment figure is my only security in life. _____

20. I have a terrible fear that my relationship with my attachment figure will end. _____

21. I feel lost if I'm upset and my attachment is not around. _____

22. I feel abandoned when by attachment figure is away for a few days _____

1 strongly disagree	2 disagree	3 somewhat agree and somewhat disagree	4 agree	5 strongly agree

23. Things have to be really bad for me to ask by attachment figure for help. _____

24. When I'm upset, I am confident my attachment figure will be there to listen to me. _____

25. When my attachment figure needs to talk, he/she can count on me. _____

26. I can motivate myself when my attachment figure is away on a short trip. _____

27. I'm afraid that I will lose my attachment figure's love. _____

28. I'm not likely to run to my attachment figure every time I get upset. _____

29. I protest strongly when my attachment figure leaves on a trip. _____

30. I only turn to my attachment figure when I absolutely have to. _____

31. I can count on my attachment figure to be available if I need him/her. _____

32. I want to be available when my attachment figure needs me. _____

33. I feel much more insecure when my attachment figure is away. _____

1	2	3	4	5
strongly disagree	disagree	somewhat agree and somewhat disagree	agree	strongly agree

34. I'm confident that my attachment figure will always love me. _____

35. When I am anxious, I desperately need to be close to my attachment figure. _____

THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY

CODE NO:_____

THE STATEMENTS WHICH FOLLOW REFER TO FEELINGS AND EXPERIENCES WHICH OCCUR TO MOST PEOPLE AT ONE TIME OR ANOTHER IN THEIR RELATIONSHIPS WITH FRIENDS. FOR EACH STATEMENT THERE ARE THREE POSSIBLE ANSWERS: "YES," "NO," AND "DON'T KNOW". PLEASE CIRCLE THE ANSWER THAT YOU CHOOSE FOR EACH ITEM.

THANK YOU FOR YOUR PARTICIPATION.

1.	My friends give me the moral support I need.	Yes	No	Don't Know
2.	Most other people are closer to their friends than I am.	Yes	No	Don't Know
3.	My friends enjoy hearing about what I think.	Yes	No	Don't Know
4.	Certain friends come to me when they have problems or need advise.	Yes	No	Don't Know
5.	I rely on my friends for emotional support.	Yes	No	Don't Know
6.	If I felt that one or more of my friends were upset with me, I'd just keep it to myself.	Yes	No	Don't Know
7.	I feel that I'm on the fringe in my circle of friends.	Yes	No	Don't Know
8.	There is a friend I could go to if I were just feeling down, without feeling funny about it later.	Yes	No	Don't Know
9.	My friends and I are very open about what we think about things.	Yes	No	Don't Know
10.	My friends are sensitive to my personal needs.	Yes	No	Don't Know

11.	My friends come to me for emotional support.	Yes	No	Don't Know
12.	My friends are good at helping me solve problems.	Yes	No	Don't Know
13.	I have a deep sharing relationship with a number of friends.	Yes	No	Don't Know
14.	My friends get good ideas about how to do things or make things from me.	Yes	No	Don't Know
15.	When I confide in friends, it makes me feel uncomfortable.	Yes	No	Don't Know
16.	My friends seek me out for companionship.	Yes	No	Don't Know
17.	I think that my friends feel that I'm good at helping them solve problems.	Yes	No	Don't Know
18.	I don't have a relationship with a friend that is as intimate as other people's relationships with friends.	Yes	No	Don't Know
19.	I've recently gotten a good idea about how to do something from a friend.	Yes	No	Don't Know
20.	I wish my friends were much different.	Yes	No	Don't Know

PLEASE GO ON TO THE NEXT PAGE

THE STATEMENTS WHICH FOLLOW REFER TO FEELINGS AND EXPERIENCES WHICH OCCUR TO MOST PEOPLE AT ONE TIME OR ANOTHER IN THEIR RELATIONSHIPS WITH THEIR FAMILIES. FOR EACH STATEMENT THERE ARE THREE POSSIBLE ANSWERS: "YES," "NO," AND "DON'T KNOW". PLEASE CIRCLE THE ANSWER THAT YOU CHOOSE FOR EACH ITEM.

1.	My family gives me the moral support I need.	Yes	No	Don't Know
2.	I get good ideas about how to do things or make things from my family.	Yes	No	Don't Know
3.	Most other people are closer to their family than I am.	Yes	No	Don't Know
4.	When I confide in the members of my family who are closest to me, I get the idea that it makes them uncomfortable.	Yes	No	Don't Know
5.	My family enjoys hearing about what I think.	Yes	No	Don't Know
6.	Members of my family share many of my interests.	Yes	No	Don't Know
7.	Certain members of my family come to me when they have problems or need advice.	Yes	No	Don't Know
8.	I rely on my family for emotional support.	Yes	No	Don't Know
9.	There is a member of my family I could go to if I were just feeling down, without feeling funny about it later.	Yes	No	Don't Know
10.	My family and I are very open about what we think about things.	Yes	No	Don't Know

11.	My family is sensitive to my personal needs.	Yes	No	Don't Know
12.	Members of my family come to me for emotional support.	Yes	No	Don't Know
13.	Members of my family are good at helping me solve problems.	Yes	No	Don't Know
14.	I have a deep sharing relationship with a number of members of my family.	Yes	No	Don't Know
15.	Members of my family get good ideas about how to do things or make things from me.	Yes	No	Don't Know
16.	When I confide in members of my family, it makes me uncomfortable.	Yes	No	Don't Know
17.	Members of my family seek me out for companionship.	Yes	No	Don't Know
18.	I think that my family feels that I'm good at helping them solve problems.	Yes	No	Don't Know
19.	I don't have a relationship with a member of my family that is as close as other people's relationships with family members.	Yes	No	Don't Know
20.	I wish my family were much different.	Yes	No	Don't Know

THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY

CODE NO:_____

THIS QUESTIONNAIRE LISTS VARIOUS ATTITUDES AND BEHAVIOURS OF YOUR PARENTS. WOULD YOU PLACE THE APPROPRIATE NUMBER NEXT TO THE STATEMENT WHICH MOST CLOSELY MATCHES YOUR REMEMBRANCE OF YOUR MOTHER (OR THE PERSON WHO WAS YOUR MOTHER-FIGURE) IN YOUR FIRST 16 YEARS. IF YOU DID NOT HAVE A MOTHER OR MOTHER-FIGURE DURING YOUR FIRST 16 YEARS, PLEASE SKIP THESE QUESTIONS.

MY MOTHER (OR MOTHER-FIGURE)

Very Like	Moderately Like	Moderately Unlike	Very Unlike
1	2	3	4

1. Spoke to me with a warm and friendly voice. ----------

2. Did not help me as much as I needed. ----------

3. Let me do those things I liked doing. ----------

4. Seemed emotionally cold to me. ----------

5. Appeared to understand my problems and worries. ----------

6. Was affectionate to me. ----------

7. Liked me to make my own decisions. ----------

8. Did not want me to grow up. ----------

9. Tried to control everything I did. ----------

10. Invaded my privacy ----------

11. Enjoyed talking things over with me. ----------

Very Like	Moderately Like	Moderately Unlike	Very Unlike
1	2	3	4

12. Frequently smiled at me. ----------

13. Tended to baby me. ----------

14. Did not seem to understand what I needed or wanted. ----------

15. Let me decide things for myself. ----------

16. Made me feel I wasn't wanted. ----------

17. Could make me feel better when I was upset. ----------

18. Did not talk with me very much. ----------

19. Tried to make me dependent on her. ----------

20. Felt I could not look after myself unless she was around. ----------

21. Gave me as much freedom as I wanted. ----------

22. Let me go out as often as I wanted. ----------

23. Was overprotective of me. ----------

24. Did not praise me. ----------

25. Let me dress in any way I pleased. ----------

CODE NO:_____

THIS QUESTIONNAIRE LISTS VARIOUS ATTITUDES AND BEHAVIOURS OF YOUR PARENTS. WOULD YOU PLACE THE APPROPRIATE NUMBER NEXT TO THE STATEMENT WHICH MOST CLOSELY MATCHES YOUR REMEMBRANCE OF YOUR FATHER (OR THE PERSON WHO WAS YOUR FATHER-FIGURE) IN YOUR FIRST 16 YEARS. IF YOU DID NOT HAVE A FATHER OR FATHER-FIGURE DURING YOUR FIRST 16 YEARS, PLEASE SKIP THESE QUESTIONS.

MY FATHER (OR FATHER-FIGURE)

Very Like	Moderately Like	Moderately Unlike	Very Unlike
1	2	3	4

1. Spoke to me with a warm and friendly voice. ----------
2. Did not help me as much as I needed. ----------
3. Let me do those things I liked doing. ----------
4. Seemed emotionally cold to me. ----------
5. Appeared to understand my problems and worries. ----------
6. Was affectionate to me. ----------
7. Liked me to make my own decisions. ----------
8. Did not want me to grow up. ----------
9. Tried to control everything I did. ----------
10. Invaded my privacy ----------
11. Enjoyed talking things over with me. ----------

Very Like	Moderately Like	Moderately Unlike	Very Unlike
1	2	3	4

12. Frequently smiled at me. ----------

13. Tended to baby me. ----------

14. Did not seem to understand what I needed or wanted. ----------

15. Let me decide things for myself. ----------

16. Made me feel I wasn't wanted. ----------

17. Could make me feel better when I was upset. ----------

18. Did not talk with me very much. ----------

19. Tried to make me dependent on him. ----------

20. Felt I could not look after myself unless he was around. ----------

21. Gave me as much freedom as I wanted. ----------

22. Let me go out as often as I wanted. ----------

23. Was overprotective of me. ----------

24. Did not praise me. ----------

25. Let me dress in any way I pleased. ----------

Appendix I

CODE NO._____

ON THE FOLLOWING PAGES IS A LIST OF ACTIVITIES OR EVENTS THAT YOU MAY HAVE PARTICIPATED IN DURING THE TIME THAT YOU WERE A MEMBER OF THE "VICTIM TO SURVIVOR GROUP".

COULD YOU PLEASE READ THE DESCRIPTION OF EACH ACTIVITY OR EVENT THAT IS LISTED AND INDICATE BY CHECKING EITHER **YES** OR **NO** WHETHER YOU PARTICIPATED IN THAT PARTICULAR ACTIVITY. IF YOU ARE UNSURE, PLEASE CHECK **UNSURE**.

NOTE: THIS QUESTIONNAIRE IS NOT A TEST. WE KNOW THAT YOU COMPLETED THE PROGRAM AND ARE FULLY AWARE OF WHAT WENT ON AT ALL TIMES. THIS QUESTIONNAIRE IS FOR RESEARCH PURPOSES ONLY AND IS BEING GIVEN IN ORDER TO INSURE THAT THE GROUP PROGRAM THAT YOU ATTENDED IS THE SAME AS THAT OUTLINED IN OUR RESEARCH DOCUMENTS.

1. I received a **Journal** from the group leaders during the first session and understood the purpose of the journal as explained by the group leaders.

YES_____

NO_____

UNSURE_____

2. During one meeting, I obtained a **Goal Sheet** from the group leaders and was asked to fill it out as part of our homework and return it to them.

YES_____

NO_____

UNSURE_____

3. I was given time to tell my **Story** to the group.

YES_____

NO_____

UNSURE_____

4. I was given the opportunity to **"check in"** and let the group know how I was at the start of each group meeting if I wished to.

YES_____

NO_____

UNSURE_____

5. I was informed that the **Marathon Session** would be longer than our regular meetings and was given the opportunity of being able to plan for this extra time if I needed to.

YES_____

NO_____

UNSURE_____

6. During one group session, I was given the opportunity to write in my journal things that I would like to say **"NO"** to and was able to share this with the group if I wanted to.

YES_____

NO_____

UNSURE_____

7. I was given the opportunity to participate in the **Group Hug** whenever I wished.

YES_____

NO_____

UNSURE_____

8. I was given the opportunity to work with one of the group leaders on a one-to-one basis about something that was important to me if I wished to. I could do this by myself while the other members of the group were there to support me.

YES_____

NO_____

UNSURE_____

9. I was given handouts - poetry and/or articles - to add to my Journal during several of the group meetings.

YES_____

NO_____

UNSURE_____

10. During one group meeting, we had a ceremony during which we used symbols of hope and rebirth such as seeds and crystals.

YES_____

NO_____

UNSURE_____

11. I was made aware when the group was coming to an end (i.e, how many sessions were left) and was given the opportunity to deal with my feelings about the ending of the group if I wished to do so.

YES_____

NO_____

UNSURE_____

12. I was given the opportunity to express myself at the end of each group meeting in the **Go Around** and to tell the other group members how I was feeling at that time if I wished to do so.

YES_____

NO_____

UNSURE_____

13. The group leaders generally made announcements at the beginning of the group (i.e., if someone was going to be absent).

YES_____

NO_____

UNSURE_____

14. I was given the opportunity to have my partner or a friend come to a special group session where they could discuss issues that were important to them with the group leaders.

YES_____

NO_____

UNSURE_____

15. At some of the group sessions, we were given homework to do during the following week.

YES_____

NO_____

UNSURE_____

16. During one group session, I was given the opportunity to learn how incest makes you feel blamed and responsible and was able to participate in an exercise were the group could talk about how each of us felt blamed and responsible as children and as adults. The words we used to describe our feelings were written on a flip-chart by one of the group leaders and then given back to us in as a typewritten handout the following week.

YES_____

NO_____

UNSURE_____

17. I participated in a **"Graduation"** ceremony during the last session were I received a rose and a diploma signifying that I had completed the "Victim to Survivor" group.

YES_____

NO_____

UNSURE_____

APPENDIX J

Cronbach's Alpha for Intrapersonal and Interpersonal Dependant Measures

Intrapersonal

BDI	.87
CES-D	.90
BSI-G	.96
IES-I	.82
IES-A	.71
SDQ-G	.94
SDQ-E	.89

Interpersonal

PSS-FA	.85
SDQ-SS	.82
SDQ-OS	.89
PSS-FR	.85
AQ-T	.89