Rewriting the Story: The Development and Evaluation of a Group Treatment Program for Adolescent Girls who have Experienced Sexual Abuse

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This thesis is presented in partial fulfilment of the requirements for the degree of Doctor of Psychology, Murdoch University

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I declare that this thesis is my own account of my research and contains as its main content, work which has not previously been submitted for a degree at any tertiary education institution.

Kellie Cassidy
Abstract

Although group treatment is often advocated for survivors of childhood sexual abuse (CSA), few studies have examined the effects of such treatments, particularly with adolescents. Yet adolescence is an important time for survivors of CSA as this is when they may truly begin to process what it means to have been sexually abused as a child (Berliner, 1991; Thun, Sims, Adams, & Webb, 2002). Consequently, this study sought to evaluate and develop best practice evidence for group treatment of adolescent girls who have experienced sexual abuse. The study used both a developmental intervention research approach to guide the development of a best practice intervention; and an action research, mixed methods program evaluation to achieve detailed examination of a small number of client cases so as to ethically assess the effectiveness of the intervention. In keeping with the intervention research approach and with the aim of providing specific knowledge about treatment for CSA survivors that was unattainable through reviewing treatment outcome studies, an initial study was undertaken which retrospectively and prospectively assessed a locally available treatment program for adolescent girls. This study found the locally available treatment approach was unlikely to have been effective at alleviating distress associated with CSA but that past participants and their mothers felt that such a program is important. Recommendations were made on the elements necessary to construct a more clinically responsive and effective treatment. A 16 week Trauma Focused Cognitive Behavioural group treatment program was then developed. This pilot treatment program was evaluated in Study 2, using both formative and summative program evaluation methods with four adolescent girls (aged 13-18). The summative findings support the utility of the treatment program and positive benefits were noted for each group participant, including reductions in symptoms of depression, anxiety and PTSD. The formative findings indicated that the treatment program was in need of further refinement. This included altering some session content, placing more focus on group process and including parents in the treatment. The
recommendations of Study 2 were subsequently implemented and the revised treatment program was evaluated by experts in the field to enhance its content validity. The treatment program was then further evaluated in Study 3 using similar evaluation methods with five girls aged 12-15. Clinically significant changes were obtained for four of these five participants, as indicated by triangulation of data from the participants, their parents and group facilitators. Formative findings indicated that the program used in Study 3 was a significant improvement on the program used in Study 2. The major curative factor for participants appeared to lie in the group process and attendance at the program. Treatment was found to have a high degree of acceptability according to participants, parents and facilitators and was implemented with integrity, although flexibility and individualisation were important. The benefits of the research approach in terms of critical reflection, functionally relevant data, within and across case analysis and contextualisation are discussed. As the findings of this series of studies highlight, positive benefits were apparent for each participant and thus it is concluded that group treatment is a viable option for adolescent survivors of CSA.
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CHAPTER 1

INTRODUCTION AND INTEGRATIVE REVIEW OF

CHILDHOOD SEXUAL ABUSE LITERATURE AS IT

RELATES TO GROUP TREATMENT
I am still affected by the abuse by being scared of almost everybody. I have a real
difficult time trusting anyone. I remember my abuse very frequently like I am really there.
My feelings that I carry now are mainly jumbled. My self worth is still pretty low. I have a
hard time feeling like I deserve anything. I have a difficult time with all the relationships I
have developed. I get nervous when people get too close, physically and emotionally.
That's why so many of my relationships have disappeared. Even with my family, if things
are going well I always end up doing something wrong or stupid and ruining it. But I do it
unconsciously. My feelings towards sexuality come out in my eating disorder. I don't
want to be attractive, I don't want hips, breasts or a butt. Thinking about sex makes me
nauseous (Teen survivor of sexual abuse, Munson & Riskin, 1995, p.10).

Child sexual abuse (CSA) is defined as “any act which exposes a child to, or involves a
child in, sexual processes beyond his or her understanding or contrary to accepted
community standards” (Angus & Woodward 1995, p.46). As the opening quote illustrates,
the impact of CSA is significant, and associated with a myriad of serious psycho-bio-social
problems including Post Traumatic Stress Disorder (PTSD), depression and anxiety
(Putnam, 2003). Research clearly indicates that there is a diversity of manifestations
associated with CSA and that there is no ‘sexual abuse syndrome’ or one symptom that
clearly delineates a child as having been sexually abused (Green, 1993). It is difficult to
ascertain what the impact of CSA may be for any given child and this poses some dilemmas
when looking to evaluate treatment. Some children are likely to be highly symptomatic and
may be diagnosed with a number of DSM-IV disorders, other children may only present with
subclinical symptoms, whilst others still, may be asymptomatic at any one point in time
(Kendall-Tackett, Williams & Finkelhor, 1993). Some symptoms may not surface until many
years after the experience of sexual abuse (Putnam, 2003). What is clear, is that CSA has a
significant impact on most survivors at some point in their lives.
Although long term empirical evidence is lacking, the research to date tends to suggest that the negative sequelae of sexual abuse may be mediated by developmental stages. That is, at different stages in life, survivors may re-examine and re-experience what it means to have been sexually abused. Whilst treatment provided shortly after the disclosure of sexual abuse may be effective at symptom alleviation (e.g. Cohen & Mannarino, 1996b; 1997), it is argued that when these children move into adolescence they may again present with symptoms associated with their experience of sexual abuse (James, 1989). Conversely, previously asymptomatic children may present with symptoms during adolescence. It is suggested that further processing of the abusive experience may be required throughout the lifespan and so a developmentally sequenced approach to treatment is recommended. James (1989, p.5) argues that for CSA survivors “sequenced treatment is necessary because past traumatic events will have different or additional meaning to a child as he matures, which can impair the process of development.” In particular it is proposed that true traumatisation does not occur until a child is at a developmental stage where they can truly comprehend the nature of their victimisation (Berliner, 1991). As noted by Thun et al. (2002) it can be argued that adolescence is likely to be the first time that survivors of CSA will reflect on the events of their childhood and fully comprehend the extent of what it means to be sexually abused. In addition, the developmental tasks of adolescence such as development of identity, onset of puberty, and the move to romantic relationships are likely to highlight the impact of CSA. Consequently the presence of psycho-bio-social sequelae associated with CSA may interfere with school performance, developing a meaningful peer group or working through other tasks of adolescence, thereby further impacting on development in the short and long term (Thun et al., 2002). By providing treatment during adolescence, survivors may be able to engage more effectively in life and more serious consequences of CSA may be prevented in the future (James, 1989). Thus treatment
during adolescence will be the focus of this study. For pragmatic reasons associated with the fact that girls are one and a half to three times as likely to have experienced CSA than boys (Finkelhor, 1994) and that it may be inappropriate to have both adolescent boys and girls within the one treatment group (Trolley, 1995), adolescent girls will be the focus of the current research.

Over the past two decades many different treatment models and modalities for CSA survivors have been evaluated (e.g. Berliner & Saunders, 1996; Cohen & Mannarino, 1996b, 1997, 1998b, 2000; Deblinger, Stauffer & Steer, 2001), although few have categorically demonstrated that treatments for CSA survivors actually ‘work’ (according to the metric of empirically supported treatments). Recent research however has shown that individual Trauma Focused Cognitive Behavioural Therapy is effective with this population (Cohen, Deblinger, Mannarino & Steer, 2004). Whilst some group treatment models have been shown to be effective in alleviating CSA sequelae (e.g. Berliner & Saunders, 1996; Deblinger et al., 2001), the majority of this research has been undertaken with children rather than adolescents and there has been no attempt at replication.

Group treatment appears to be suited to adolescence given the developmental tasks of this life stage, such as individuation from the family and identification with ones peers (Sirles, Walsma, Lytle-Barnaby & Lander, 1988). Furthermore, group therapy “provides opportunities for young people to share their experiences, have their feelings validated and gain a sense of normalisation regarding their feelings and reactions [associated with CSA]...as well as a challenge to the secrecy and shame that so often shrouds the lives of these young people” (Kambouridis & Jevtic, 2002, p.120). As such group therapy will be the focus of this thesis. The overall aim of the current project is therefore to evaluate the effectiveness of group treatment for young adolescent girls who have experienced sexual
abuse. On the basis of this evaluation, the project will then aim to extend best practice by refining or developing a program to ensure that it is evidence based and meets the needs of this vulnerable population.

To this end, a comprehensive review was initially undertaken to draw together what is ‘known’ and what is not yet known by researchers and practitioners. The overarching aim of this review is to determine: what treatments work? and why and how do they work?

1.1 Approaching the Review

There are several different methods available for synthesising research in a particular area. Most methods favour quantitative evidence or even omit qualitative evidence. As clinicians working in the field, we often rely on practice parameters and treatment guidelines based on the findings of systematic reviews and meta analyses that typically exclude all forms of evidence other than experimental designs (Whittemore & Knafl, 2005). Moreover, these types of review typically report on experimental designs that ‘work’ (i.e. have successful outcomes). In an area of research such as medicine where the parameters of the disorder/disease and the treatment may be well defined and the research base considerable, such an approach can be useful. However in the area of CSA this is not the case (i.e. the evidence base is small and the sequelae associated with CSA are not linear), and may lead to the conclusion that little is known. As Dixon-Woods, Agarwal, Jones, Young and Sutton (2005, p.45) argue, “excluding any type of evidence on the grounds of its methodology could have potentially important consequences”, particularly in an applied field where empiricist methodologies may be hard to apply and may obscure important idiographic detail. Moreover, as Freyd et al. (2005, p.501) discuss, “research on CSA is distributed across numerous disciplines, which results in fragmented knowledge that it is often infused with unstated value judgements.” Also, as will be presented later (see Table
1.1) after extensive research I could only locate eight studies for review which evaluated group treatment for young adolescent CSA survivors in a community setting (three other studies were conducted in institutional settings). Therefore it became apparent that an iterative approach to review was necessary. That is, given the limited evidence on which to base the current research, other evidence needed to be sourced to shed light on this endeavour and provide a sufficiently comprehensive knowledge base. Specifically, treatment for younger children and individual treatments were considered, as were evaluations of programs in non-community based settings and non treatment focused CSA literature. It was important at this juncture to take an expansive approach to reviewing and synthesising the available knowledge rather than following the literature review tradition of being reductionistic and empirically focused. In taking an expansive approach, the review in this thesis is intended to provide a fuller picture and a more comprehensive understanding of CSA related phenomena, particularly in regard to intervention research. It is important that this review encapsulates and considers all known, relevant information of treatment for adolescent CSA survivors including, what works and what doesn’t, since the information will be used to direct the evaluation of a treatment program and the extension of best practice for this population.

In acknowledging Noblit and Hare’s (1988, p.15) criticism that “literature reviews in practice are more rituals than substantive accomplishments”, this review forms an integral part of the research process and has been undertaken as a study in itself (Suri, 1999). In addition to illustrating how this project will add to the existing treatment knowledge base (which is the aim of most reviews), it also aims to create a fuller understanding of the phenomena under investigation so as to better enhance evidence based practice in this area. These are the dual aims of this project. In acknowledging the variable success of existing treatment approaches this study will not merely apply an existing treatment to a new age-group (i.e.
adolescents) but will take a critically developmental approach to treatment evolution. Given the current state of knowledge in CSA research, empirical, conceptual and theoretical articles were included to broaden the dialectic expanse and depth of a potentially limited field. Figure 1.1 summarises the iterative approach taken to accessing and reviewing literature. Prior to undertaking this review of CSA, I will present a rationale for the approach taken to the review (of treatment programs in particular) and discuss the importance of methodological rigour in literature reviews.

**Figure 1.1.** Iterative spiral outlining literature accessed in order to undertake an integrative review of evidence that could contribute to understanding adolescent CSA survivor group treatment possibilities.

Whittemore and Knafl (2002, p.547) define an integrative review as “an approach that allows for the inclusion of diverse methodologies (i.e. experimental and non-experimental) and has the potential to play a greater role in evidence-based practice…” An integrative review approach has been adopted in the current study as it allows for deep exploration to determine what is known and not known in a field that is in many ways in its infancy. In this sense the review is also a review of *knowledge* as opposed to *research* as it draws on
diverse sources of information such as practice articles, treatment guidelines and research articles. Furthermore, research findings will be judged against an additional metric. That is, in traditional literature reviews individual studies are judged for the most part on: their methodology and the strength of their research design (Noblit & Hare, 1988); on summative aspects (i.e. judging overall outcome); and matters of efficacy or effectiveness (i.e. does the treatment work? Which treatment is the most appropriate treatment to use?). Whilst this is certainly important when determining matters of causality, it can often overlook formative factors, that is, why and how a treatment works or doesn’t work. In considering this, it is suggested that treatment content, treatment process, treatment acceptability, treatment integrity and implementation, measurement issues and the phenomenological experience of participants are all critically considered when evaluating treatment programs. To this end, the current review whilst paying attention to methodological rigour, will also focus on these other important aspects of research and how they enhance our understanding of treatment for CSA survivors. It is only by taking such an integrated approach that the governing questions of the review (i.e. What treatments work? Why and how do they work?) may be fully answered.

In approaching this review as ‘research of research’, standards of methodological rigour must be applied (Suri, 1999; Whittemore & Knafl, 2005). This review is, in essence, a retrospective observational study and as such is open to both systematic and random error (e.g. researcher bias, incomplete literature search, inaccurate synthesis) (Whittemore & Knafl, 2005). Thus methods have been applied to minimise the effects of such error. Whilst this occurs in systematic reviews and meta analyses by restricting error variance, this is more difficult to achieve when one aims to include data from diverse methodological sources. In order to minimise such effects it is important to make the potential sources of error knowable, to make explicit how the review was undertaken in terms of the way
literature was sought, evaluated and integrated. This includes making it known who the reviewer is, to eliminate researcher bias and allow the reader to make an informed decision about the conclusions drawn. Therefore, it is relevant for the reader to know that I am a Clinical Psychologist (Registrar) with a background mostly grounded in the cognitive behavioural tradition. At the time of writing, I have had two years experience working individually and in group settings with children and adolescents who have experienced sexual abuse. In addition to this I have completed all coursework and placements for the degree and currently work in a child and adolescent mental health clinic.

As indicated above it is important to make explicit the way in which relevant research articles were identified for this review so as to eliminate error and bias. Therefore, an extensive literature search was undertaken initially by using key word searches (those key words being ‘child’, ‘adolescent’, ‘sexual abuse’, ‘treatment’, ‘group’ as per Figure 1.1) in the PsychINFO, Proquest, Expanded Academic and PubMed databases. In addition to the initial database search, a search of key authors in the area and relevant references cited in papers identified was also completed. Unpublished works were excluded due to the difficulties and costs in accessing them.

Once identified, reports were considered in terms of their methodology, informational value, representativeness and authenticity (Whittemore & Knafl, 2005). Data was then extracted to elicit what is known about treatment for this population in terms of efficacy, effectiveness, content and process. With respect to group treatment research, data tables were developed to display relevant information from each research study (see Table 1.1). Studies were then iteratively compared and contrasted and critically analysed. Only then were conclusions drawn about the state of group intervention research with adolescent CSA survivors and salient difficulties in conducting research with CSA survivors identified. Thus the outcome of
this approach to reviewing research is a supporting body of knowledge and comprehensive understanding of CSA treatment possibilities.

The purpose of the remainder of this chapter is to examine what is known about child sexual abuse generally, and group treatment programs for adolescents specifically. I will begin by discussing the various definitions of CSA and estimates in relation to the size of the problem. Evidence concerning the impact of CSA will then be considered. This preliminary analysis will provide the background to the major focus of the review, namely an examination of existing treatment programs for CSA which determines not only how efficacious/effective treatment is for CSA survivors, but also what makes these treatments work. This chapter will conclude with a discussion of methodological issues pertaining to treatment program research for CSA. The rationale for the current project will then be presented.

1.2 Background to the Problem

The following section highlights the breadth and depth of sexual abuse phenomena and endeavours to illustrate why this is such an important area of research. I will begin by discussing the difficulties that are inherent in defining and estimating the size of CSA. The size and scope of CSA are then reported. I will then conclude with a discussion of the research attesting to the impact of CSA in terms of psycho-bio-social consequences.

1.2.1 Definition

Child sexual abuse is the term used to describe the use of a child for sexual gratification by an adult or significantly older child/adolescent (Tower, 1989). It is generally accepted that these acts are intended to erotically arouse the adult or older child, generally without consideration for the reactions or choices of the child and without consideration for the
effects of the act upon the child. Any such act is considered by most communities to be a gross violation of the rights of the child (Nelson-Gardell, 2001). The key elements of any definition of child sexual abuse include 1) the involvement of a child and 2) an older person (generally 5 or more years older), 3) in sexual acts beyond the child’s knowledge and comprehension (Wolfe & Birt, 1997). Definitions vary, however, in terms of the upper age limit defining childhood, and the behaviours that are considered to constitute sexual abuse (Wolfe & Birt, 1997). Some define childhood as ending at age 16, others at age 18. The extent of acts that are considered to constitute child sexual abuse are wide-ranging and include genital/anal intercourse, attempted intercourse, oral genital contact, digital penetration, fondling, exposure/voeureism, sexual talk and innuendo, pornography and prostitution (Tower, 1989).

Variations in beliefs about what constitutes sexual abuse and how it can be defined create difficulty for both researchers and practitioners. One must be cognizant when comparing research, as variations in definition can have a significant impact on our understanding of the phenomena. Andrews, Gould and Corry (2002) argue that such difficulties can be overcome by defining CSA according to three levels of severity: (1) non contact abuse (2) contact abuse and (3) penetrative abuse. This classification system will be used when presenting results of this research so that a more consistent interpretation of the findings can be undertaken.

For the purposes of this study, child sexual abuse is defined as any sexual contact or attempted sexual contact with a child or adolescent by a person who is in a position of power or authority. This definition has been adopted so as to encapsulate both sibling and peer abuse. Non contact abuse has not been included in the current definition for ethical reasons in that it was determined that non contact abuse would be likely to have different
outcomes in terms of attending a group treatment program where it may be traumatising for adolescents who have experienced non contact abuse to hear the stories of those who have experienced contact/penetrative abuse.

1.2.2 Epidemiology

In Australia in the 2002/2003 period there were 40,416 substantiated cases of child abuse and neglect. Of these, 4137 (10.23%) were cases of sexual abuse (AIHW, 2004). In Western Australia alone in 2002/2003, the Department for Community Development received 837 allegations of CSA. Of these, 28% (221) were substantiated. The victimisation rate across Australia in the 2002/2003 period ranged from 1.8 per 1000 in Tasmania to 10.1 per 1000 in Queensland. Variations in incidence and victimisation estimates across states are largely due to differences in the definition of maltreatment adopted and policies and approaches to child protection matters such as mandatory reporting (AIHW, 2004). These figures of incidence may be a gross underestimate of the true nature of CSA as they only indicate the number of new cases reported to child protection services in a given year. In contrast estimates of prevalence represent the total number of people who have experienced CSA at a given time and are not limited to cases reported to child protection services as this information is generally collected retrospectively.

Estimates of the prevalence of CSA are disparate and range from 3 to 62% of children being affected (Wolfe & Birt, 1997). The most widely accepted prevalence rates for CSA are one in four females and one in eight males. However it is estimated that less than 50% of survivors of CSA ever disclose their experience(s) (Putnam, 2003), therefore making accurate estimates of prevalence difficult to generate. Prevalence is typically estimated by surveying a defined population about whether they have experienced CSA in their lifetime. Gaining an accurate estimate of prevalence of CSA is compounded by: the type of research
design typically used (i.e. retrospective survey); the type of sample (often clinic or university samples rather than general population); the inability to control for extraneous factors (e.g. other forms of trauma); and variable definitions of CSA (Briere & Elliot, 1993; Wolfe & Birt, 1997).

More recent estimates of prevalence however are based on population studies (as opposed to clinical or university samples which limit the representativeness of the sample) and so provide more reliable and representative figures. For example, Andrews et al. (2002) reported the Australian prevalence rate of CSA to be 5.1% for males and 27.5% for females (inclusive of both penetrative and non penetrative abuse). In another population based Australian sample, Dunne, Purdie, Cook, Boyle and Najman (2003) reported prevalence at 12% for females and 4% for men with regard to unwanted penetrative experiences. Non penetrative CSA occurred in 33.6% of women and 15.9% of men.

Ferguson, Lynsky and Horwood (1996) examined the prevalence of CSA in New Zealand in a birth cohort of 18 year olds. Prevalence was reported at 17.3% for females and 3.4% for males. Such a study is important as it has been measured prospectively rather than retrospectively. As data had been collected across the life span of participants, analyses could be conducted that associated psycho-bio-social risks with CSA. These risk factors were: being female, exposed to marital conflict, low parental attachment, paternal overprotection and having parents with alcohol problems.

Although the epidemiological studies do not present a clear picture of the incidence and prevalence of CSA, even if the lowest rates are considered, the conclusion is clear: sexual abuse is a significant problem which must be addressed.
1.2.3 The Impact of Child Sexual Abuse

There is an increasing body of research pertaining to the pervasive impact of CSA upon the psychological development of survivors in conjunction with the social, behavioural and emotional problems it causes. I will endeavour to provide a brief outline of the most common psycho-bio-social outcomes related to CSA, and discuss how these outcomes may be affected by developmental stage and other mediating factors. This outline will illustrate the importance of treatment for CSA survivors, and more specifically, will identify the major targets of successful treatment. The reader is referred to Browne and Finkelhor (1986), Green (1993), Kendall-Tackett et al. (1993) or Stevenson (1999) for a more detailed coverage of the literature on the impact of CSA. It is anticipated that in presenting this information, the true impact of CSA is not diminished by the nature of research (i.e. trivialised to a series of figures and statistics as opposed to being seen as a real world problem with significant impact).

The negative sequelae associated with CSA are wide-ranging. Psychological symptoms exhibited by child and adolescent survivors include anger, fear, dissociation and sadness (Green, 1993; Stevenson, 1999). Behavioural manifestations include enuresis, encopresis, truancy, running away, aggression, withdrawal, non-compliance, sexualised behaviour, sexual promiscuity, antisocial behaviour, school failure/low academic performance, substance abuse, self harm and suicidal ideation (Browne & Finkelhor, 1986; Kendall-Tackett et al., 1993). Interpersonal difficulties are also apparent (Trickett & Putnam, 1998). Associated psychiatric disorders include post traumatic stress disorder, major depression, anxiety disorders, conduct disorder and personality disorders (Browne & Finkelhor, 1986; Kendall-Tackett et al., 1993). Physiological symptoms such as headaches and stomach aches are also frequent (Browne & Finkelhor, 1986). Cognitive distortions (e.g. 'I am bad'
‘It’s all my fault this happened’) are common place as a child or adolescent attempts to make sense of the events that took place. Children may try to rationalise what happened by examining what they did or could have done to change the situation. Expectations about the world being a dangerous place may also develop as children attempt to protect themselves from anticipated future traumatic events. Children often learn not to trust others, furthermore they may develop negative views of themselves, blaming themselves for what took place (Deblinger & Heflin, 1996). More recently physical and neurobiological sequelae have also been investigated in CSA survivors and have included, for example, immunological dysfunction, dysregulated cortisol and lower hippocampal density (see Glaser (2000) for a review of this literature).

The sequelae listed above are extensive and demonstrate that the impact of being sexually abused is variable and in some senses unpredictable (i.e. in terms of the extent and type of symptomology if any). Child and adolescent responses to CSA vary greatly and are dependent on a multitude of factors such as the severity of abuse, reactions of family to disclosure, attachment and attributional style (Nurcombe, 2000). Although there is some degree of consensus surrounding typical short and long term effects of CSA, it should be noted that some children (up to 40%, according to Putnam, 2003) who have been sexually abused may be asymptomatic. Similarly, children who have not been abused may also present with the symptoms listed above. As such there is no identifiable ‘child sexual abuse syndrome’ associated with CSA (Green, 1993; Kendall -Tackett et al., 1993).

Whilst some children may not initially present with any symptoms related to their experience of sexual abuse, symptoms may become apparent over time. This phenomenon is termed a ‘sleeper effect’ (Putnam, 2003). It is thought that 10-20% of asymptomatic children will deteriorate over a 12 to 18 month period from their initial disclosure of CSA (Finkelhor &
Berliner, 1995). It is argued that symptoms may only become apparent when the child is at a developmental level where they can comprehend the events that took place (Berliner, 1991). In this sense the process of coming to terms with CSA may be a lifelong experience as new issues are encountered with each new developmental stage (e.g. transitioning to romantic relationships; becoming a mother) (Cichetti & Toth, 1995; Nelson et al., 2002; Jones & Ramchandani, 1999; Ross & O’Carroll, 2004; Wolfe & Birt, 1997). Kendall-Tackett et al. (1993) in their systematic review of empirical studies regarding the effects of CSA, investigated effects based upon three age-groups of children: pre-schoolers, school-aged, and adolescents. Depending upon the symptom and age group, sample sizes ranged from 3 to 999. They found that preschoolers were more likely to exhibit nightmares, anxiety and general behaviour problems. School aged children were more likely to be aggressive, have nightmares and be fearful. Adolescents were reported to be depressed, withdrawn, suicidal, have low self esteem, somatic complaints, abuse substances, be self injurious and run away more often. They also found that, generally, initial symptoms in children such as sleep disturbance or nocturnal enuresis may abate quickly, while other symptoms such as aggression or disobedience may worsen over time.

In many cases, symptoms and outcomes of CSA may persist. For example Tebutt, Swanston, Oates and O’Toole (1997) in a five year longitudinal study of 68 children and adolescents (aged 5-15 years at intake) who had presented to a child protection unit for sexual abuse, found that there were no significant changes in depression, self esteem or behaviour over the five year period. This observation was made in both child and parent reported data. While some children were shown to improve, just as many deteriorated. For example 10 children (44%) who were depressed at intake improved at 5 years, however 12 children (41%) who were asymptomatic at baseline were found to be depressed at 5 year follow-up. The finding is even more striking in that all participants had received treatment
very early on following their disclosure (although the type, quality and duration of treatment they received was variable and no details of the treatments were provided). As the researchers indicate, this has serious implications for the provision of treatment and in ensuring that treatment is effective. The findings also suggest that many children have persisting problems associated with CSA well into the future and are likely to need ongoing therapeutic input at different times in their lives such as during transitional stages. It is not easy to predict in a linear fashion which children are likely to require most assistance. Although the study suggests that children who initially present with low self esteem and depression are more likely to remain symptomatic five years later.

However, other longitudinal studies suggest that children do improve (e.g. Gomez-Schwartz, Horowitz, Cardarelli, & Sauzier, 1990; Mannarino, Cohen, Smith & Moore-Motily, 1991). In a review of longitudinal studies Kendall-Tackett et al. (1993) concludes that only 10-24% of children appear to worsen over the course of time whilst 50 to 66% improved and became less symptomatic. However the results may not truly denote the course of dysfunction associated with CSA, as only one of the studies included in Kendall-Tackett’s review extended beyond 18 months follow-up. As previously suggested it may be that different symptoms arise at different developmental stages, thus the need for longitudinal data that measures the impact of CSA across the course of childhood and adolescence is important. Retrospective accounts of adult survivors of CSA suggest that psychiatric disorders persist into adulthood (Beitchman et al., 1992; Cahill, Llewelyn & Pearson, 1991; Gold, 1986). These studies however may be limited by recall bias and the fact that the aetiology of psychiatric disorder may be confounded by other life events not assessed. Furthermore it is unclear what role treatment may have played in these studies (Nurcombe, 2000). However the New Zealand birth cohort study (Ferguson, Horwood & Lynsky, 1996)
presented in the following paragraphs provides clear evidence that the impact of CSA can persist into adulthood.

Ferguson and colleagues (1996) studied a birth cohort of 1019 children from New Zealand at yearly intervals from birth to the age of 16 collecting data on relevant confounding variables at each stage. At the age of 18, participants were contacted and assessed concerning their exposure to CSA and their current psychological status. The study confirmed via logistic regression methods that higher rates of psychiatric disorder are the direct result of CSA and not other confounding factors. This includes higher rates of depression, anxiety, conduct disorder, substance use disorder and suicidal behaviours as compared to non abused participants. Furthermore, Ferguson, Horwood, et al. (1996) found that those participants who experienced more severe forms of CSA (i.e. penetration) had a higher risk of developing a psychiatric disorder. In fact participants with contact CSA were between 2.7 and 11.9 times more likely than their non abused counterparts to experience a psychiatric disorder by the time they were 18 years of age. Such differences were found to persist when controlling for other extraneous factors (e.g. adverse life events, parental conflict, parental attachment, psychiatric illness of parent) which may have also influenced the increased likelihood of psychiatric disorder.

The evidence presented by Ferguson and colleagues (1996) suggests that sexual abuse is a significant risk factor for mental health problems in childhood irrespective of confounding life factors. However their study cannot explain nor predict the large variability in mental health outcomes among child and adolescent survivors. Thus beyond knowing that CSA is a risk factor for psychiatric illness, what other risk factors are associated with a poor outcome from sexual abuse? Early research attempted to explain this variability in outcomes by focusing specifically on abuse related variables such as severity and duration.
While these factors were found to be relevant, they explained little of the variance in symptom variability or severity (Beitchman et al., 1991; Kendall-Tackett et al., 1993).

Many different theories and models have been developed over the years that attempt to account for and explain the individual differences in sequelae associated with CSA. For the most part however these theories have been unable to account for all aspects of CSA sequelae or do not lend themselves to being empirically tested (Spacarelli, 1994). For example the PTSD model (Horowitz, 1979; McCann & Pearlman, 1990; Foa, Steketee & Rothbaum, 1989) poorly accounts for outcomes other than PTSD, yet research has shown that only one half of children present with symptoms characteristic of PTSD following CSA (Kiser, Heston, Millsap, & Pruitt, 1991). Spaccarelli (1994) argues that integrative approaches to determining outcome from CSA are required which account for abuse related variables, variables of the individual child and the family environment. In this sense the outcome of abuse is determined via a matrix of variables and takes into account the abuse experience and its impact on the child’s family and environment. This is known as the Transactional Model (Nurcombe, 2000; Spaccarelli, 1994).

The Transactional Model suggests that a child’s “development proceeds through a series of person-environment transactions that determine a course or trajectory predicting healthy or psychopathological outcomes (Spaccarelli, 1994, p.343).” A modification of Spacarelli’s original model proposed by Nurcombe, Wooding, Marrington, Bickman and Roberts (2000) is depicted in Figure 1.2. This adapted model proposes that the outcome of CSA is affected by antecedent factors operating prior to the abuse (e.g. familial conflict), that interact with abuse related stressors (e.g. duration, severity) and post disclosure stressors (e.g. parental psychopathology, level of parental support and belief of disclosure). The combination of
each of these factors then influences the child’s ability to cope with the situation and associated mediating factors.

Figure 1.2. A transactional model of CSA outcome (Nurcombe et al., 2000, p.95).

According to this model and other research into risk factors, the following indicators are likely to be associated with a poorer outcome from CSA:

- **Antecedent factors**
  
  Poor family functioning prior to abuse including domestic violence, emotional abuse, neglect, parental substance abuse, parental psychopathology and marital distress/breakdown (Nelson et al., 2002; Nurcombe, 2000)

- **Abuse related factors**
  
  Close relationship to perpetrator (Kendall -Tackett et al., 1993)
  
  Use of force and threat (Kendall -Tackett et al., 1993)
  
  Penetration (Adams-Tucker, 1982)
  
  Longer duration/frequency (Kendall -Tackett et al., 1993; Mennen, 1993)

- **Events subsequent to exposure**
  
  Lack of support from non offending parent (Gomes-Schwartz et al., 1990)
Parent emotional reaction (Mannarino & Cohen, 1996)

Giving court testimony (Runyan, Everson, Edelsohn, Hunter & Counter, 1988)

Involvement of authorities (Wyatt, Newcomb, & Notgrass, 1991)

- Mediating factors

  Attitude to self (e.g. I’m bad) and coping style (emotion focused) (Coffey, Leitenberg, Hening, Turner & Bennett, 1996; Johnson & Kenkel, 1991)
  Poor attachment (Shapiro & Levendosky, 1999)
  Attributional style (Feiring, Taska & Lewis, 2002; Mannarino & Cohen, 1996)
  Negative self concept (Coffey et al., 1996)
  Self blame (Spacarelli & Kim, 1995)
  External locus of control (Mennen, 1993)
  Suppression, Denial (Caffaro-Rouget, Lang & Van Santen, 1989)
  Avoidance, Dissociation, Conversion/somatisation (Johnson & Kenkel, 1991)
  Externalisation and acting out (Glod & Teicher, 1996)
  Alcohol/drug abuse (Singer, Petchers & Hussey, 1989)

This transactional model is most appealing as it encompasses the majority of abuse related outcomes associated with CSA, does not assume that all children will experience psychopathology as a result of CSA, allows for individual differences in presentation, does not solely focus on the abuse experience and it is possible to empirically test its tenets (Nurcombe, 2000). Furthermore the model has the potential for predicting which children may have a poorer outcome than others and may require more intensive treatment. Unfortunately, this potential has not been tested to date [research is underway at the University of Queensland (see Nurcombe et al., 2000)], though it has strong conceptual support and is strengthened by the empirical support for the transactional model more
broadly (i.e. research on antecedent, abuse, post disclosure and mediating factors more generally). Most importantly the model can be applied to direct the focus of treatment paradigms. It would seem to be important to consider each of the factors proposed by the transactional model throughout the therapeutic process (Barker-Collo & Read, 2003). Whilst intervention cannot target antecedent and abuse related factors, post disclosure stressors and mediating factors can be targeted. It is noted that some of these factors relate to the child and others relate to non offending parents. Thus depending on the particular stage at which treatment is received, treatment may be able to target both parent and child. Parents may benefit from assistance with providing support to their children, dealing with their own feelings about the abuse and treating any psychopathology of their own. With regard to children, the model proposes addressing affect regulation, maladaptive coping skills, issues related to the trauma and maladaptive cognitions with regard to self, others and the world (Nurcombe, 2000; Nurcombe et al., 2000).

1.2.4 Summary

CSA is a significant problem which affects many children and adolescents. Its impact is difficult to predict for any individual child, although collectively the evidence suggests that the effects of CSA can be both devastating and life altering. Sexually abused children and adolescents may display a wide range of behavioural and emotional problems and report more internalising and externalising problems than do their non-abused peers. Approximately 40% of children may be asymptomatic following CSA, however up to 50% of these children are expected to deteriorate over time. Some research suggests that the impact of CSA at any given time may depend on the age and developmental stage of the child (Berliner, 1991). Furthermore it is suggested that the impact of CSA may be more prominent at different stages in an individual's life, although there is no longitudinal data to fully support this hypothesis. Nevertheless it would be consistent with developmental
theories to suggest that adolescence is a life stage predominately associated with the
development of sexuality and sexual awareness and so may magnify past experiences of
sexual abuse (Chandy, Blum & Resnick, 1996; Thun, Sims, Adams & Webb, 2002). CSA
does not occur in a vacuum and so contextual variables are important and must be taken
into consideration when providing treatment. The fact that a high percentage of children are
continuing to be symptomatic even after receiving treatment suggests that further efforts
must be made to ensure that the most effective treatment is being provided and that
survivors are utilising such treatment.

Overall, it can be concluded that CSA has multifaceted effects that cannot easily be
accounted for by any one core symptom or syndrome. This has significant implications for
treatment development and provision.

1.3 Treatment of Children & Adolescents

The evidence presented thus far clearly indicates that CSA is a significant problem that
requires intervention to assist survivors in dealing with their experience and attempting to
prevent the negative sequelae associated with CSA, particularly in the long term. Treatment
for children who have experienced CSA is provided in a variety of formats including
individual and group therapy. I will now review treatment outcome studies for CSA. In
reviewing these studies, both individual and group therapy modalities are examined as
there is a limited amount of research available on group treatments and many elements of
individual therapy are likely to be applicable to group therapy (e.g. techniques and models).
Given the current study’s focus on group therapy, a more intensive review of the group work
literature will be given. Although the focus of the current project is adolescents, much of the
literature on children was also reviewed due to many studies including both populations in
the one study and a dearth of research on adolescents.
First, a summative review of treatment outcome studies will be presented. The aim of a summative review is to focus on treatment outcome and answer the question, “Does this treatment work and is it superior to other treatments?” After reviewing the merits of this approach to evaluation, a formative review of programs will be undertaken. The formative review aims to look more closely at the treatment programs to assess key factors which are important to their success (i.e. what makes them work). Following this, conclusions will be discussed about group therapy for adolescents who have experienced CSA which will assist in evaluating and enhancing evidence based practice for this population.

### 1.3.1 A Summative Review of Treatment Outcome Studies for CSA Survivors

In the following review of treatments for child and adolescent CSA survivors, the summative aspects of the treatments will be examined. The summative aspects refer to treatment outcome and efficacy. The majority of studies to be presented in this review have attempted to demonstrate causality using methods which fall under the experimental paradigm (e.g. randomised controlled trials, quasi experimental studies, pre/post designs). Within this paradigm it is said that for a treatment to be proven to ‘work’ it must have been evaluated in a randomised controlled trial or at a minimum approximated in a quasi experimental study (Chambless et al., 1996; Chambless & Hollon, 1998). Given that the studies to be presented have primarily used this paradigm, and given that the aim of this section is to evaluate efficacy, a focus will be primarily placed upon quasi and experimental studies. Nevertheless from the outset it is recognised that such an approach may achieve little else than showing that the treatment works, without being able to elaborate on how or why. Moreover, treatments that don’t work may be wholly dismissed though some elements may
have been functioning well. These points will be explored in later sections of this review in relation to other paradigms and approaches to evaluating treatment outcome.

A number of large scale reviews indicate that treatment with survivors of CSA is effective (Finkelhor & Berliner, 1995; Nurcombe, 2000; Nurcombe et al., 2000; Putnam, 2003; Saywitz et al., 2000). Nevertheless it is important to understand what this research tells us about the core elements of treatment with this population. This section begins with a review of individual therapy before moving onto group therapy. Given that the state of research for individual therapy with this population is much more advanced than group therapy, and individual therapy is not the main focus of this project, I will focus my review of individual treatments for CSA survivors on randomised controlled trials of treatment outcome. Whilst the problems with only focusing on this type of research design are noted (and further elaborated upon in section 1.3.2), particularly within the context of an integrative review, the aim of reviewing individual therapy studies is merely to establish whether individual therapy with CSA survivors has been shown to be efficacious, and if so, what models of treatment have achieved this. In contrast my review of group treatment programs will be more expansive and detailed given their more direct relevance to this project.

Individual therapy

A number of randomised controlled trials have begun to report on the efficacy of individual therapy for children and adolescents who have experienced sexual abuse and present with relatively high levels of symptomology. With few exceptions, this research has focused on establishing the effectiveness of Trauma Focussed Cognitive Behavioural Therapy (TFCBT). TFCBT is an approach to therapy which utilises cognitive behavioural principles and applies them to abuse related behaviours and cognitions. Gradual exposure to abuse related reminders and memories and the development of a trauma narrative are at the heart of this
approach. The approach incorporates psycho-education in relation to sexual abuse and personal safety, the teaching of skills (e.g. coping) and specific therapeutic components (Cohen et al., 2000; Deblinger & Heflin, 1996). Collectively these studies show that TFCBT is effective in decreasing PTSD (Celano, Hazzard, Webb & McCall, 1996; Cohen et al., 2004; Cohen & Mannarino, 1996b, 1997, 1998b; Cohen, Mannarino & Knudsen 2005; Deblinger, Lippman & Steer, 1996; Deblinger, Steer & Lippman, 1999; King et al., 2000), depression (Cohen et al., 1998b; Cohen et al., 2005; Deblinger et al., 1996), anxiety (Cohen, Mannarino & Knudson, 2005; King et al., 2000) and behaviour problems (Cohen et al., 1996b; Deblinger et al., 1996) in both preschool and school aged children. Furthermore, TFCBT has been shown to be more effective than non directive supportive therapy (Cohen & Mannarino, 1996b, 1997), community care (Deblinger et al., 1996) and a waitlist control (King et al., 2000). Treatment effects have also been shown to maintain up to two years following treatment (Deblinger, et al., 1999). In six of the eight main studies identified above, participants had to meet a minimum level of symptomology (e.g. at least 3 DSM-IV PTSD symptoms) before being included in the research. Thus the effect of such treatment on children who do not meet clinical levels of distress or are asymptomatic is unknown.

As an exemplar of this research, a large scale multisite randomised controlled trial of TFCBT versus Child Centred Therapy will be discussed. Cohen et al. (2004) conducted a study of 229 children aged 8-14yrs who had experienced sexual abuse and met at least five criteria for DSM-IV defined PTSD. Children were randomly assigned to the treatment conditions and received a maximum of 12 sessions. In both cases children and parents received treatment. Children receiving TFCBT showed significantly greater reductions in PTSD symptoms, depression and total behaviour problems than those receiving Child Centred Therapy. Clinically significant changes were also analysed by assessing the number of children who remained symptomatic following treatment. At post test 21% of
TFCBT children still met criteria for PTSD as opposed to 46% of children receiving Child Centred Therapy. This difference was statistically significant given that rates of PTSD at pre test were comparable (84% and 91% respectively). Parent functioning was also shown to be significantly more improved in the TFCBT group with reductions in ratings of depression, abuse related distress and improved parent support and parenting practices. This study is significant given the large number of participants, the geographically distinct regions, the number and diversity of therapists and the type of population included. Thus it is expected that the findings of this study would be quite robust for clinical samples.

Randomised controlled trials of treatment models other than TFCBT are rare. In one such study 14 girls aged 12-13yrs were randomly assigned to receive up to 12 sessions of either CBT or Eye Movement Desensitisation and Reprocessing (EMDR) (Jaberghaderi, Greenwald, Rubin, Zand & Dolatabadi, 2004). Both CBT and EMDR were shown to be effective at alleviating PTSD related symptoms and behaviour problems. In another study (Downing, Jenkins & Fisher, 1988) 22 sexually abused children were randomly assigned to either psychodynamic therapy or behavioural reinforcement therapy. Reinforcement therapy was found to result in significantly greater improvements in sleep, enuresis, sexualised and general behaviour problems when compared to psychodynamic therapy. Taken together these two studies, in addition to the evidence for Child Centred Therapy, provide some preliminary evidence to suggest that therapies other than CBT are effective in improving CSA related sequelae, however further research is required.

Overall, this body of research provides good evidence for the efficacy of CBT based individual treatment for children and adolescents who have experienced sexual abuse. The majority of this research appears to have been conducted on younger children as opposed to adolescents, perhaps because children in these studies received treatment shortly after
their disclosure of sexual abuse. It is unclear whether the treatment is also applicable to children who seek treatment many years following their disclosure.

Group Therapy

Group treatment outcome studies for CSA survivors are summarised in Table 1.1. The table has been organised by research methodology (i.e. case studies, pre- and post-test, quasi experimental designs, and experimental designs). In analysing the findings of each of the studies presented in Table 1.1 there appears to be an increasing amount of evidence to suggest that group therapy with CSA survivors ‘works.’ As previously indicated, a major focus has been placed upon quasi and experimental studies in this section in an attempt to elucidate whether treatment for CSA survivors has positive outcomes.

Seven quasi or experimental studies which evaluate group treatment for CSA with children and/or adolescents were identified (Berliner & Saunders, 1996; Deblinger et al., 2001; McGain & McKinsey, 1995; Rust & Troupe, 1991; Thun et al., 2002; Trowell et al., 2002; Verleur, 1986). Collectively these studies show that group therapy is effective in improving self esteem (Rust & Troupe, 1991; Thun et al., 2002; Verleur, Hughes & Doubkin deRios, 1986) and decreasing behaviour problems (Berliner & Saunders, 1996; Deblinger et al., 2001; McGain & McKinsey, 1995), depression (Berliner & Saunders, 1996; Trowell et al., 2002), anxiety (Berliner & Saunders, 1996; McGain & McKinsey, 1995), sexualised behaviour (Berliner & Saunders, 1996; Deblinger et al., 2001) and PTSD (Berliner & Saunders, 1996; Deblinger et al., 2001; Trowell et al., 2002), with children aged 2 through to 18 years. As presented in the following paragraphs, this has been established against waitlist control conditions and in comparison to other treatment techniques. Pre/post designs presented in Table 1.1 also add some weight to the argument that group therapy is effective.
Table 1.1  Overview of Group Treatment Studies for Child and Adolescent CSA Survivors

<table>
<thead>
<tr>
<th>Study</th>
<th>Type</th>
<th>Treatment</th>
<th>N</th>
<th>Study type</th>
<th>Measures</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Furniss et al. (1988)</td>
<td>Group</td>
<td>Analytic open ended semi structured</td>
<td>10</td>
<td>Case study</td>
<td>Observation by group leader</td>
<td>‘viable and valuable’ ↓ anxiety; ↓ sexualised behaviour; ↑ SE; ↑ trust; ↑ relationships</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>7mths – 2yrs</td>
<td></td>
<td>(inc. 5yr FU)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>12-15yrs</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Berman (1990)</td>
<td>Group</td>
<td>Insight oriented Open Structured 54 sessions</td>
<td>11</td>
<td>Case study</td>
<td>Group Goals Individual Goals</td>
<td>Considerable growth 66% working on high level goals</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9-12yrs</td>
<td></td>
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</tr>
<tr>
<td>Corder et al. (1990)</td>
<td>Group</td>
<td>Unspecified* Structured 20 weeks</td>
<td>8</td>
<td>Case study</td>
<td>Anecdotal interviews with parents, teachers and social workers</td>
<td>↓ in symptoms reported</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6-9 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poels (1996)</td>
<td>Group</td>
<td>Unspecified* Structured Closed 4 weeks</td>
<td>5</td>
<td>Case study</td>
<td>Observation by group leader</td>
<td>Author concludes that aims were achieved</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10-12yrs</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Heiman &amp; Ettin (2001)</td>
<td>Group</td>
<td>Analytic/Process oriented Structured 11 weeks</td>
<td>7</td>
<td>Case study</td>
<td>Observation by group leader</td>
<td>“positive based on one month follow-up”</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8-11yrs</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Ashby et al. (1987)</td>
<td>Group</td>
<td>Integrated 10 sessions</td>
<td>9</td>
<td>Pre/Post Evaluation</td>
<td>PHCSC Session evaluations Social worker ratings</td>
<td>Av. rating 9.8/11 for acceptability Gains in SE av. 10 points</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13-17yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kitchur &amp; Bell (1989)</td>
<td>Group</td>
<td>Unspecified* Closed Semi structured</td>
<td>7</td>
<td>Pre/Post Case study</td>
<td>PHCSC CBCL Parent report</td>
<td>Statistical change in PHSCS; reports from parents also encouraging</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>16 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11-12yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study (cont.)</td>
<td>Type (cont.)</td>
<td>Treatment (cont.)</td>
<td>N (cont.)</td>
<td>Study type (cont.)</td>
<td>Measures (cont.)</td>
<td>Outcome (cont.)</td>
</tr>
<tr>
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</tr>
<tr>
<td>Nelki &amp; Watters (1989)</td>
<td>Group Female 4-8yrs</td>
<td>Unspecified* Closed Structured 9 weeks Parallel parent group</td>
<td>6</td>
<td>Pre/Post</td>
<td>Problem checklist Drawings Parent interviews Observations</td>
<td>6 of 9 aims achieved Statistically significant reductions in problems reported</td>
</tr>
<tr>
<td>Hiebert Murphy et al. (1992)</td>
<td>Group Female 7-9yrs</td>
<td>Unspecified* Closed Structured 9 weeks</td>
<td>5</td>
<td>Pre/post case study</td>
<td>CBCL SEI RCMAS CLQ Sexual behaviour</td>
<td>↓ internalising 5/5 ↓ externalising 4/5 ↓ sexual behaviour 3/3 ↑ loneliness 4/5 Inconsistent for anxiety &amp; self esteem</td>
</tr>
<tr>
<td>De Luca et al. (1993)</td>
<td>Group Female 10-11yrs</td>
<td>Unspecified* Closed Structured 10 weeks</td>
<td>7</td>
<td>Pre/Post/Follow-up</td>
<td>SEI RCMAS CLQ CBCL</td>
<td>Significant ↑ in self esteem, anxiety &amp; behaviour No ↑ in loneliness</td>
</tr>
<tr>
<td>Hall-Marley &amp; Damon (1993)</td>
<td>Group Male Female 4-7yrs</td>
<td>Integrated – play therapy (12-18mths)</td>
<td>13</td>
<td>Pre/Post</td>
<td>CBCL CSBI</td>
<td>Significant improvement in behaviour and sexual behaviour</td>
</tr>
<tr>
<td>Hack et al. (1994)</td>
<td>Group Male 8-11yrs</td>
<td>Unspecified* Structured interventions</td>
<td>6</td>
<td>Pre/Post/ 7 month Follow-up</td>
<td>CBCL CDI RCMAS SEI</td>
<td>↓ anxiety and depression ↑ self esteem clinically significant change; CBCL maintained</td>
</tr>
<tr>
<td>Lindon &amp; Nourse (1994)</td>
<td>Group Female 13-17yrs</td>
<td>Unspecified* Structured intake interview and observation of emotional symptoms Self report outcome and FU questionnaire Progress notes</td>
<td>9</td>
<td>Pre/Post/ Follow-up</td>
<td></td>
<td>↓ anxiety, guilt, shame ↑ self esteem and trust improvement maintained at 6 month FU</td>
</tr>
<tr>
<td>Sinclair et al. (1995)</td>
<td>Group Female 13-18yrs</td>
<td>Structured 34</td>
<td>Pre/Post</td>
<td>YSR-PTSD CBCL-PTSD RADS SPPA</td>
<td>↓ externalising &amp; PTSD ↑ self concept</td>
<td></td>
</tr>
<tr>
<td>Study (cont.)</td>
<td>Type (cont.)</td>
<td>Treatment (cont.)</td>
<td>N (cont.)</td>
<td>Study type (cont.)</td>
<td>Measures (cont.)</td>
<td>Outcome (cont.)</td>
</tr>
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</tr>
<tr>
<td>Kruczek &amp; Vitanza (1999)</td>
<td>Group Female 13-18yrs</td>
<td>Inpatient Solution focused/Ericksonian Open Structured 7 sessions</td>
<td>41</td>
<td>Pre/Post/3 month Follow-up</td>
<td>Solution focused recovery scale Mastery scale</td>
<td>↑ on SFRC ind ↑ in adaptive functioning No change on skill level</td>
</tr>
<tr>
<td>Kambouridis &amp; Jevtic (2002)</td>
<td>Group Female 13-17yrs</td>
<td>Narrative therapy 10 weeks</td>
<td>15</td>
<td>Mixed Design Pre/Post</td>
<td>TSCC SPPA CITES CBCL Parent interviews</td>
<td>Statistical change in SPPA; ↓ depression; ↓ self blame; ↓ anger; ↓ behaviour problems</td>
</tr>
<tr>
<td>Arnold et al. (2003)</td>
<td>Group &amp; Individual Female 12-17yrs</td>
<td>CBT Incarcerated Mean 26wks</td>
<td>100 45 received Tx</td>
<td>Pre/Post</td>
<td>MAAS</td>
<td>significant change on 14/16 subscales of MAAS at post test</td>
</tr>
<tr>
<td>Rust &amp; Troupe (1991)</td>
<td>Group Female 9-18yrs</td>
<td>Unspecified Open 6 months minimum</td>
<td>25</td>
<td>Pre/Post Matched control group (non abuse)</td>
<td>School ach. – SAT Piers Harris</td>
<td>↑ self concept ↑ school success</td>
</tr>
<tr>
<td>McGain &amp; McKinze (1995)</td>
<td>Group Female 9-12yrs</td>
<td>Unspecified* 9-12 months</td>
<td>30</td>
<td>Pre/Post Matched control waitlist</td>
<td>ECBI RBPC</td>
<td>↓ anxiety ↓ conduct disorder ↓ social aggression ↑ attn/concentration</td>
</tr>
<tr>
<td>Verleur et al. (1986)</td>
<td>Group Female 13-17yrs</td>
<td>Sex Ed v. No Tx Group therapy Closed 24 weeks</td>
<td>30 (15 each group)</td>
<td>Pre/Post Matched sample</td>
<td>CSI APSAS (sex knowledge) Clinical Observation</td>
<td>Tx group had more self esteem and were more sexually aware than control</td>
</tr>
<tr>
<td>Berliner &amp; Saunders (1996)</td>
<td>Group 4-13yrs Male Female</td>
<td>CBT v CBT plus SIT/exposure Parent support group Closed Structured 10 weeks</td>
<td>80 at 2yrs</td>
<td>Pre/Post/1yr &amp; 2yr FU Random alloc.</td>
<td>FSSC-R SAFE RCMAS CBCL CDI CSBI</td>
<td>Both groups improved No difference found between two groups on fear/anxiety measures</td>
</tr>
<tr>
<td>Study (cont.)</td>
<td>Type (cont.)</td>
<td>Treatment (cont.)</td>
<td>N (cont.)</td>
<td>Study type (cont.)</td>
<td>Measures (cont.)</td>
<td>Outcome (cont.)</td>
</tr>
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</tr>
<tr>
<td>Deblinger et al. (2001)</td>
<td>Group Male and Female plus mothers 2-8yrs</td>
<td>CBT v Supportive therapy Closed Structured 11 weeks</td>
<td>44</td>
<td>Pre/Post/ Follow-up Random alloc.</td>
<td>MBSS SCL-90 IES PERQ PPQ SSQ TSQ K-SADS PTSD CBCL CSBI WIST</td>
<td>Both treatments effective – CBT more effective Demonstrates utility of parent involvement</td>
</tr>
<tr>
<td>Thun et al. (2002)</td>
<td>Group Female 16-18yrs</td>
<td>Lindon &amp; Nourse (1994) model Structured Closed Goal Oriented 12 weeks</td>
<td>13</td>
<td>Pre/Post Random alloc. Exp or control</td>
<td>Personal History Q Offer Self Image Q</td>
<td>no findings with ANCOVA; mean trend analysis suggests change in exp. group on impulse control</td>
</tr>
<tr>
<td>Trowell et al. (2002)</td>
<td>Group v. Ind Female 6-14yrs</td>
<td>Educative v. Analytic 18 sessions group 30 sessions individual</td>
<td>71</td>
<td>Pre/Post Random alloc.</td>
<td>K-SADS PTSD K-GAS</td>
<td>Reduction in symptoms in both groups. Ind. group lead to greater ↓ PTSD symptoms</td>
</tr>
</tbody>
</table>

* whilst unspecified the theoretical model appears to approximate CBT.
Group Therapy (continued)

Two studies evaluated their treatments against a true waitlist control condition (Thun et al., 2002; Verleur et al., 1986). Such an achievement is not usually possible in CSA research due to the ethics of withholding treatment. However, as both of these studies were conducted in residential treatment settings this problem was overcome. Thun et al. report that their control group were offered individual counselling instead of group therapy but that none of the participants took up this offer [this may have impacted the results as these people refused treatment (i.e. they may be different in some way)]. No discussion of the control group was given for the other study. Verleur et al. found that participants in the experimental group had significantly higher ratings of self esteem and knowledge of human sexuality than the control condition following attendance at a 24 week group. Thun et al. found no statistically significant differences between experimental and control conditions at post test on a measure of self image (impulse control, self confidence, self reliance and body image). However, mean trend analysis did show improvements in impulse control for the experimental group. Such a factor is important as low impulse control has been associated with low self esteem, lack of insight and sexual revictimisation in CSA survivors (Cole & Putnam, 1992). Whilst these two studies provide the strongest evidence for efficacy in terms of research design, they are seriously flawed by the use of statistical methodology with small numbers of participants and subsequent lack of statistical power. In terms of measures used, it is noted that both studies have limited outcome to a very specific set of symptoms/behaviours (self esteem, self image, sexual knowledge). Whilst some of these measures are very functional, it is likely that they are too specific to truly capture the array of sequelae that adolescent CSA survivors present.

Three studies (Deblinger et al., 2001; Trowell et al., 2002; Berliner & Saunders, 1996) have attempted to compare treatments. One study compared a TFCBT based group with a
supportive group for parents and children aged 2-8yrs (Deblinger et al., 2001). The study found that both treatment approaches were effective in alleviating parent reported distress in their children. Clinical improvement was sustained at three month follow-up for both groups. Whilst significant changes were noted in both groups, it appears that the effect sizes for the CBT group were larger, suggesting the superiority of this treatment.

Trowell et al. (2002) found that while both individual and group treatments showed substantial reductions in symptoms for 71 females aged 6-14 years, individual therapy was shown to be superior in improving PTSD related symptoms in their study. Nonetheless it is unclear whether this was due to the difference in treatment modality (individual v. group), treatment type (the group program was educative and the individual program was analytic), or length of treatment (18 group v. 30 individual sessions). Furthermore it could be argued that group and individual therapy serve different purposes in that group therapy could more specifically target feelings of isolation and ‘differentness’ while individual therapy would be more focused on symptom alleviation and the specifics of the child’s experience.

Berliner and Saunders (1996) attempted to determine which components of treatment were responsible for change in self reported symptoms by evaluating whether the addition of exposure procedures and stress inoculation training led to significantly better outcomes than standard CBT. Participants in both the enhanced (n=48) and standard (n=32) treatment groups were found to improve significantly over time on measures of depression, behavioural problems and sexual behaviour. Treatment gains were maintained over a period of two years. However no significant differences were found for fear or anxiety suggesting that the addition of stress inoculation training was unnecessary. The researchers hypothesise that this may be due to the fact that few children in the study were sufficiently anxious at pre test (i.e. within the clinical range). The researchers also suggest
that perhaps their enhanced treatment was not meaningfully different to their standard treatment. Overall the results do add weight to other studies presented which suggest that CBT is a viable treatment with this population.

Taken together the body of research presented in Table 1.1 provides evidence suggesting that group treatment with CSA survivors can be effective. Furthermore it shows that a variety of treatment approaches may be effective. Despite providing evidence that these treatment approaches seem to work, some limitations are noted. Firstly, a wide array of outcome measures have been used. This is perhaps evidence that an experience of CSA leads to a very wide array of symptoms and outcomes and it is perhaps difficult to capture all of them. Secondly, scoring within the clinical range on a battery of standardised measures was not always a requirement for treatment in the studies and as such measuring treatment outcome by symptom reduction may have been difficult. Thirdly, few studies report how many participants did not show improvements or showed decrement in wellbeing. In sum, studies have primarily tried to capture group differences (i.e. nomothetic) as opposed to tracking individual change (i.e. idiographic) which limits the conclusions that may be drawn in groups with such heterogenous, often non-clinical presentations. Finally, it is noted that the research presented in Table 1.1 do not always clearly indicate whether group therapy was received as a stand alone treatment, in combination with individual treatment or following individual treatment. Thus it is recognised that there may be confounding factors and a clear statement about group therapy’s efficacy and when it should be applied can not be made.

An overall observation of the research reviewed to this point shows that more research appears to have been conducted on individual therapy than group therapy in the past 10 years. Perhaps this is because individual work is identified as more suited to the tasks of
therapy following disclosure (i.e. alleviating initial distress and high levels of psychopathology). Group therapy may be best suited as an adjunctive therapy particularly with adolescents who have had prior therapy and are re-experiencing symptoms associated with their sexual abuse. This statement is based upon both clinical acumen and observation of other treatment services (e.g. Kambouridis & Jevtic, 2001) and there is no evidence in the CSA research to suggest whether group therapy should be a stand alone treatment or adjunctive. I would argue however that group therapy is uniquely placed in that it can achieve goals that individual therapy may not. Most notably in its ability to reduce feelings of isolation, secrecy and differentness that are common among CSA survivors (deYoung & Corbin, 1994; Furniss, Bingley-Miller & Van Elburg, 1988; Hiebert-Murphy, De Luca & Runtz, 1992; Knittle & Tuana, 1980; Kruzeck & Vitanza, 1999; Trolley, 1995). However it is also recognised that group therapy may not be able to provide an adequate level of attention to each participant when high levels of distress and psychopathology are present.

It is important to note at this juncture that often the aim of treatment with CSA survivors is to process the experience. To ‘process’ is to make sense of the experience and to symbolise and reflect on it and give it new (less distressing) meaning (Nelson-Gardell, 2001). That is, the aim of treatment may not necessarily be symptom alleviation as up to 40% of survivors may be asymptomatic. Instead a more appropriate aim of treatment is to deal with the strong emotions associated with CSA (e.g. guilt, blame, shame) that are not necessarily associated with symptoms of a psychological disorder which may be captured on a standardised measure. In addition many approaches would argue that therapy is intended to allow survivors to construct a coherent narrative of the events that took place and provide a framework for understanding the thoughts and feelings associated with it (Kambouridis & Jevtic, 2002; Wilson & Hutton, 1992).
These observations about treatment for CSA and the efficacy studies presented, suggest that a purely nomothetic symptom based approach to measuring the impact of treatments may not be ‘ideal’ or ‘sufficient’ as it may mask a different kind of change process that may be occurring. This is considered in greater detail in the following sections both in terms of research design and measures of success.

1.3.2 Evaluating the Evidence for the Effectiveness of CSA Interventions

The following section evaluates how useful the information presented in the previous section is in terms of what it tells us (as clinicians) about treatment for CSA survivors. Psychologists are committed to identifying and using treatments that ‘work’. Research into treatment interventions is important to ensure improved client outcomes and accountability for psychological services. Just as medical doctors would not give medication to patients prior to that medication undergoing rigorous research, so too should psychologists research their methods of treatments to ensure they are empirically sound. Yet in the area of CSA intervention, two points are apparent. Firstly while there is evidence to suggest that group therapy for CSA can be effective, most treatments presented in Table 1.1 have only been evaluated once and with one age group. Secondly, there are many commercially available treatments that to my knowledge have not undergone any evaluation (e.g. Mandell & Damon, 1989; Munson & Riskin, 1995) and so we cannot be assured of their effectiveness. As such one of the major aims of the current research is to establish an evidenced based group treatment program for young adolescent girls who have experienced sexual abuse. However, the question remains as to what qualifies as evidence for determining what works (Norcross, 2002).

The ‘gold standard’ of evidence advocated by psychologists for determining what works in therapy is the randomised controlled trial (Chambless & Hollon, 1998). This standard has
merit in its ability to demonstrate cause and effect, rule out threats to internal validity and draw conclusions about the efficacy of a treatment program within the contextual constraints under which the program was run. Treatments are said to be Empirically Supported when they have been shown to be efficacious in treating a specific diagnosable DSM-IV disorder in two randomised controlled trials or a series of case studies (Chambless et al., 1996; Chambless & Hollon, 1998). However many psychologists (e.g. Levant, 2005a; McCall & Green, 2004; Messer, 2004; Norcross, 2002) have raised concerns about evaluating treatments only on this basis. In particular these concerns surround the following points: (i) the lack of external validity in randomised controlled trials; (ii) the form of evidence used to support empirically supported treatments and the narrow focus on one particular research design; (iii) the over emphasis on therapeutic models and techniques and the under emphasis of common factors inherent across approaches; and (iv) the over emphasis on outcome and under emphasis on program implementation and process factors. Given the relevance of these concerns to CSA intervention research, this section will evaluate the utility of randomised controlled designs with CSA survivors.

Empirically supported treatments are, by definition, evaluated using carefully screened homogenous groups that meet diagnostic criteria for a single axis 1 DSM-IV disorder. Yet, as mentioned earlier, CSA is not associated with a single axis 1 DSM-IV disorder. CSA survivors are more likely to present for treatment with a cluster of symptoms which may not meet criteria for any DSM-IV disorder. This is consistent with psychotherapy in general, in which it is expected that one third to one half of all clients presenting for treatment do not meet criteria for a DSM-IV diagnosis (Messer, 2004; Westen, Novotny & Thompson-Brenner, 2004). Furthermore clients are often referred for treatment due to the experience of sexual abuse as opposed to a presenting disorder (i.e. to process the experience) and as previously indicated they may even be asymptomatic. Some researchers have tried to
manage this by only focusing on PTSD related symptoms and using PTSD as the main outcome variable (Cohen et al., 2004; Deblinger et al., 1996; Deblinger et al., 1999). However as previously discussed only 50% of children are likely to present with a PTSD formulation. The question follows then as to whether we need to develop an empirically supported treatment for each sequelae associated with CSA. CSA survivors are not a homogenous group and their presenting problems are likely to be wide ranging. Nevertheless there are many similarities between CSA survivors in terms of common feelings such as guilt and shame, and it would seem counterproductive to produce different treatments for each of the sequelae associated with CSA. Targets for intervention may be achieved largely through the process of therapy as opposed to a focus on particular symptom constellations (e.g. depression, PTSD). Thus the use of a randomised controlled trial becomes difficult as many of its basic criteria are violated by this heterogenous population.

In addition to strict inclusion/exclusion criteria, randomised controlled trials require that participants be randomly assigned to treatment groups. Random assignment is difficult to achieve both pragmatically and ethically in CSA research (Briere, 1992; Lipsey & Cordray, 2000). Whilst random assignment to treatment groups has been achieved in some group intervention studies for CSA as outlined earlier (cf. Berliner & Saunders, 1996; Deblinger et al., 2001; Thun et al., 2002; Trowell et al., 2002), they are the exception rather than the norm and do not usually occur in a community setting. Random assignment is difficult to achieve because of ethical issues associated with assigning participants to a waitlist when they have experienced CSA. To overcome this, studies have achieved random assignment by assigning control participants to a comparison condition such as a different type of treatment (e.g. Berliner & Saunders, 1996; Deblinger et al., 2001; Trowell et al., 2002). However this has limitations of its own, such as establishing that the alternate treatment
condition is sufficiently different from the experimental treatment and that it is an equally justifiable ethical alternative. Finally on a pragmatic level, the rate of referrals may not be sufficient for random assignment to one group or another. Also ethically if a client seems to have features that do not seem suited to one treatment (e.g. a group format) questions are raised about the ethics of random assignment.

A third criterion that is required in a randomised controlled trial is that the treatment is uniformly applied to each participant. This is difficult to achieve in psychological research whilst fulfilling our ethical obligations to clients and is infrequently evaluated in the literature. Measures of treatment fidelity, satisfaction and utilisation are very rarely reported and yet the assumption is that the treatment has been uniformly applied to each participant (McCall & Green, 2004). Furthermore treatment flexibility and individualisation may be a necessity and the most ethically responsible response in certain situations, particularly when treating CSA survivors who have varied presenting problems. In addition, the chaos which often surrounds clients with this background (Saywitz, Mannarino, Berliner & Cohen, 2000) suggests that there will be many unexpected and individual problems which clinicians will have to deal with in order to provide ethical practice (Ashby et al., 1987). As such it would seem that it is difficult to justify or implement uniformly applied treatments with this population. Rather, such individualisation and departure from the ‘standard’ treatment needs to be identified and measured to determine the impact on the outcome of the program.

The measures used in randomised controlled trials are expected to have good reliability, validity and relevance to the goals of treatment. Briere (1996a) argues that CSA outcome research should include several measures of psychological functioning due to the wide ranging effects of CSA. Furthermore he suggests that measures should assess both child
and parent to ensure a valid assessment of child functioning. Whilst this is certainly true, the fact that treatment is often designed to process the experience of CSA as opposed to specifically targeting the symptoms that may be present, particularly in group therapy, presents further challenges for outcome research in terms of using available standardised psychological adjustment assessment tools. Assessment tools that have been used in much of the CSA research to date may have lacked sensitivity to pick up the changes that may occur as a result of the intervention. This is due to the likelihood of ceiling and floor effects, sleeper effects and the inability of a measure to target the myriad of symptoms potentially associated with CSA (Briere, 1992; Finkelhor & Berliner, 1995; Putnam, 2003; Ramchandani & Jones, 2003). Finally, standardised assessment tools reported in the outcome literature fail to capture the group process which is more than likely a significant contributor to the outcome of a treatment program particularly in group therapy.

Ramchandani and Jones (2003) suggest that a broader perspective must be taken beyond the outcome measures currently used in research on the efficacy of treatment with CSA survivors. Children and adolescent CSA survivors may be more likely to present with a range of emotional and behavioural difficulties commonly termed risk factors (e.g. binge drinking, truancy, relationship difficulties). They suggest that measures of adjustment in general may be more pertinent and functionally relevant. For example the capacity to make friends, to develop relationships with family members, to concentrate at school, to avoid substance abuse and sexual promiscuity. This suggestion could also be extended to the research program itself.

An assessment of improvement in targeted knowledge (i.e. what has been learnt in session) may also be another way of demonstrating the impact of an intervention given that knowledge or learning is a precursor to behavioural and emotional change. If an adolescent
is unable to recall or synthesise the major tenets of their treatment, then arguably clinically relevant change is unlikely to occur. Similarly when change does occur in symptoms, it seems important to know what learning has contributed to this – was it one specific concept, or all of the material presented in a program? This understanding stems from Blooms (1956) taxonomy of cognitive learning which suggests that there are six different types of learning that are arranged in a hierarchical sequence, namely: recall, comprehension, application, analysis, synthesis and evaluation. Ideally clinicians would like clients to go beyond recalling the information presented and grasping its meaning to actually being able to apply their learning to their life beyond the treatment, to apply it in novel ways and make their own links about what the information means in terms of being a survivor of sexual abuse.

In addition to determining that outcome measures are functionally relevant, it is also argued that treatment outcomes should be assessed according to whether they are clinically significant as opposed to statistically significant. That is, just because a statistically significant difference has been identified between a treatment and a control condition, this does not necessarily mean that the participants in the treatment group would be judged by clinicians to be doing well (Jacobson & Truax, 1991). In addition, statistical significance of change in a group, offers no information about the variability in responses across the participants who received the treatment (Finkelhor & Berliner, 1995). Clinically significant change is defined as “the extent to which therapy moves someone outside the range of the dysfunctional population or within the range of the functional population” (Jacobsen & Traux, 1991, p.12). A number of methods for measuring clinically significant change have been proposed. One method is to calculate the number of participants that have improved, remained unchanged or deteriorated. At the simplest level this could be measured by determining whether a participant has shifted from the clinical to non-clinical range on a
given measure or by the number of standard deviations they have shifted. For example in a study by Berliner and Saunders (1996) a shift of one or more standard deviations on psychometric measures was deemed clinically significant. A similar notion will be applied in the current study. With respect to using more functionally relevant, idiographically responsive measures, clinically significant change may be the absence of problematic manifestations of behaviour (e.g. substance abuse) at the completion of treatment (if this was problematic to begin with for a given individual). Measures of clinically significant change are useful in that they can help to determine which participants did not fare well in treatment (Finkelhor & Berliner, 1995). Such data seems particularly relevant to clinicians who are trying to assess the utility of a treatment.

Another important factor to mention with randomised controlled trials is the way in which treatment drop-outs are handled in the analysis. This is particularly relevant in the area of CSA treatment given the high level of reported drop out (Finkelhor & Berliner, 1995). Whilst some larger scale outcome studies have used ‘intent to treat’ analyses (i.e. include drop-outs in the analysis) (e.g. Cohen, 2004) the majority included in this review have not and this may have seriously inflated the results of these studies. Finkelhor and Berliner argue that it is important that we begin to more clearly understand why clients drop out of treatment. This may be better understood in the context of studies which can assess the contextual factors associated with treatment.

Thus, whilst randomised controlled trials and quasi experimental outcome studies have been used in CSA outcome research, the information presented above suggests that this approach to evaluation may be less than ideal given the ecological violations associated with randomised controlled trials. Therefore randomised controlled trials should not be
automatically elevated to a privileged status in terms of contribution to applied practice. Alternate ways of measuring outcome with this population need to be explored.

In addition to the problems already discussed, there are other concerns with empirically supported treatments. Specifically it is argued that empirically supported treatments only focus on treatment outcome in terms of symptom reduction and how particular types of therapy (e.g. CBT, psychoanalytic, narrative) or therapy techniques (e.g. gradual exposure, cognitive restructuring) achieve therapeutic change with little consideration of what are termed ‘common factors’ in psychotherapy or indeed the process of psychotherapy and what occurs ‘in’ or ‘across’ sessions (Lambert & Barley, 2002; Messer, 2004; Norcross, 2002; Yalom, 1995). Common factors are so named because they cut across different therapies and theoretical positions. Common factors focus on the interrelated and interdependent relationship between, and the impact of, therapist attributes (e.g. competence, skill, personal qualities, interpersonal style), facilitative conditions (e.g. empathy, warmth, positive regard) and the therapist-client relationship (i.e. therapeutic alliance) (Lambert & Barley, 2002). Research into each of these factors has shown that they account for a large proportion of the variance in treatment outcome (Lambert & Barley, 2002).

Lambert and Barley (2002) reviewed the psychotherapy outcome literature and concluded that there are a number of factors which mediate outcome of psychotherapy in general. These include extratherapeutic factors (e.g. use of self help, quality of social support, spontaneous remission, client motivation and psychological mindedness), expectancy from the client (i.e. placebo effect), therapeutic techniques (e.g. cognitive behavioural methods, psychodynamic methods, humanistic methods), and common factors (as described above). Based on this body of literature Lambert and Barley have determined the comparative
importance of each factor. These are summarised in Figure 1.3. It is noted that the percentages presented in Figure 1.3 are estimates and were not derived from formal meta-analytic techniques. The percentages are based on decades of research and were derived by averaging the size of each predictor’s contribution across more than 100 studies. Despite the crude methods used to calculate Figure 1.3, the research evidence presented by Lambert and Barley suggests that common factors account for twice as much of the variance in successful outcome from psychotherapy than a specific technique. This approach does not suggest that specific techniques are not important for they are needed in order to provide a coherent treatment, but what it does suggest is that common factors have a greater impact on the outcome of therapy than do techniques, and so it would be remiss not to measure such important factors when trying to measure the impact of treatment. Thus where possible both technique and common factors should be measured as they both impact on treatment outcome (Messer & Wampold, 2002).

![Figure 1.3. Percentage of improvement in psychotherapy patients as a function of therapeutic factors (Lambert & Barley, 2002, p.18).](image)

In addition to common factors, within group therapy there is also the interplay and overlap of group process. That is, each of the common factors described are likely to affect, and be affected by, the process of the group. Group process is defined by Corey and Corey (2006, p.5) as
all elements basic to the unfolding of a group from the time it begins to its termination. Group process pertains to dynamics such as the norms that govern the group, the level of cohesion in the group, how trust it generated, how resistance is manifested, how conflict emerges and is dealt with, the forces that bring about healing, intermember reactions, and the various stages in the group development.

Yalom (1995) suggests that curative experiences in group therapy often come from group members recognising that others have had similar experiences, revealing personal experiences, gaining insight, and helping others gain insight as opposed to the ‘treatment’ per se. Given the interdependence of common factors and group process, it is argued that similar to common factors, group process is possibly more likely to affect the outcome of therapy than treatment technique. Thus group process seems important to measure when assessing the effectiveness of a group program and the elements which make it effective.

To date, group process and common factors of therapy have not be evaluated systematically in the CSA area, however a number of authors have published clinical practice articles which discuss the importance of these factors (e.g. Gilbert, 1988; Heiman & Ettin, 2001). For example, Heiman and Ettin clearly outline the ways in which they created a safe place for therapy to be conducted in, developed group cohesion, managed the strong affect of group members and facilitated group members disclosure of their abusive experience in an 11 week group program for girls aged 8-11 years. The importance of harnessing group dynamics and processes with this population is exemplified in this article. It would seem important given the evidence presented, that treatment process and common factors be assessed when evaluating the outcome of treatments for CSA survivors as these
are likely to have a significant impact on outcome, particularly in the context of a group treatment.

In evaluating a treatment program, it is also important to determine what components of a treatment aid in positive outcomes and what factors are relevant to its successful implementation. In a randomised controlled trial this is usually achieved by comparing a treatment with and without particular components [e.g. Berliner & Saunders (1996) compared enhanced and standard CBT]. This is a useful approach in the long term but does not accommodate an accountable approach to monitoring and being responsive to, treatment progress as it unfolds. It is argued that prior to this type of comparison research occurring, exploratory research should be conducted and published that outlines components of treatments and implementation factors that are relevant and which monitors progress in each session. McCall and Green (2004) note that by placing greater emphasis on program implementation, clinicians are able to learn what can realistically be implemented and what is effective for different types of clients. This approach allows for refinements of the treatment before large scale outcome studies are undertaken. Such information is relevant to clinicians who plan to implement these treatments. For example it is relevant for clinicians to know whether there will be problems encountered in implementation, barriers to success, and whether the program requires individualisation. This will be discussed further in Chapter 2 but is raised at this point so that in reviewing the treatment outcome studies for CSA it can be determined if such an approach has occurred (i.e. whether researchers have paid attention to implementation factors in CSA treatment research).

Further evidence that basing the success of interventions only on the results of empirically supported treatments as has been demonstrated in the United States where insurance
companies would only fund treatments which appeared on Division 12’s (clinical psychology) list of empirically supported treatments (Levant, 2005a). As such the American Psychological Association (APA, 2005) has adopted a much broader approach to treatment accountability termed evidence based practice. Evidence based practice in psychology is defined by the APA (2005, p.1) as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences.” Evidence based practice considers the treatment method, individual psychologist, treatment relationship and the client as vital contributors to the success of psychological practice (Levant, 2005b). The policy further notes that evidence must be drawn from a variety of research designs and methodologies to truly attest to a treatments effectiveness. Such an approach has been adopted in the current research.

Taken as a whole, while randomised controlled trials are useful in determining that a treatment is efficacious with a specified DSM-IV diagnosis, there are many factors which may compromise their use and interpretability in CSA outcome research. Whilst randomised controlled trials have made an important contribution, broader research designs may be equally and usefully applied to determining what works for CSA survivors. A viable alternate to purely experimental designs are mixed methods designs which utilise the strengths of both qualitative and quantitative data. A mixed method evaluation argues that simple, linear explanations of cause and effect (i.e. x leads to y) are unrealistic in an applied setting, as they ignore the complexities of therapy and the potential for other factors to mediate change. A mixed methods approach to determining ‘what works’ argues that the choice of research method depends on the developmental stage of the program being evaluated (Chatterji, 2005). The aim of a mixed methods evaluation not only sets out to determine that a program works, but for what reasons and under which conditions the program works (i.e. by considering summative and formative outcomes). That is, a mixed methods approach to
evaluation aims to be more illuminating and presents a more holistic picture of the impact of a program by using multiple research methods to strengthen the quality of evidence and thereby the interpretations made (see Chapter 2 for more detail about these processes).

A mixed methods approach argues that in evaluating interventions there are a number of factors which should be considered in addition to whether participants had improved outcomes on standardised measures of psychological symptomology as has been presented in the previous section. These factors include assessing the nature and the impact of the content and the process of the treatment; measuring outcomes that are functionally relevant and clinically significant; evaluating the extent to which the treatment is utilised and accepted by consumers; and assessing the extent to which the treatment is uniformly applied. The next iteration in this research of the research will be a formative review. Treatment programs presented in Table 1.1 will be reviewed formatively to examine the extent to which the factors discussed have already been considered in CSA intervention research. In addition to these factors, this formative review will also attempt to determine if the phenomenological experience of treatment has been assessed as a predictor of outcome and an indicator of the relevance of treatment components.

1.3.3 Formative Review of CSA Treatments

A formative review, complimentary to the summative review presented above will now be provided. This review examines the key features of treatment programs for CSA survivors that may be associated with the effectiveness of that treatment. As none of the studies presented in Table 1.1 have actually completed a formative evaluation, the proceeding review will dissect the available treatment studies in an attempt to try and understand what factors are associated with a positive treatment outcome and where improvements may
need to be made. As indicated above this review will consider factors associated with treatment content, process, integrity, acceptability, experience and assessment.

With regards to treatment content, the summative review above demonstrated that a number of different treatments had a positive impact on participant outcome. Two of the treatment studies utilised a TFCBT approach, one was analytic, one was integrative (i.e. appeared to use a collection of approaches including CBT, analytic and client-centred approaches) and three were unspecified. When the case studies and pre/post studies are added to the mix of treatments available an even wider variety of approaches have been used. These include narrative therapy, play therapy and solution focused Ericksonian approaches. As a general observation, a number of the studies presented in Table 1.1 did not appear to ascribe to any particular theoretical model. Whilst a number of different approaches have been indicated, there appears to be a large degree of commonality in content between the treatments. Specifically, the majority of treatments appear to cite the following goals for treatment:

- To disclose and discuss the abusive experience
- To identify and process emotions associated with CSA
- To alleviate the shame and guilt associated with CSA
- To improve self esteem
- To alleviate symptoms associated with CSA (e.g. depression)
- To learn coping skills and correct cognitive distortions
- To learn self protection skills
- To learn about sexuality and sex education
- To discuss the dynamics of abusive experience
- To improve family and social relationships
In addition to these specific goals the primary aim of most group therapies was to increase protective factors and decrease risk factors known to be associated with CSA and aid in decreasing the emotional, cognitive and behavioural effects of CSA. Thus despite differing backgrounds and approach, the various treatments appear to be trying to achieve the same goals.

Given the degree of similarity in treatment goals across the treatments presented, it is conceivable that a large proportion of the change in participants is attributable to common factors and group process rather than a specific treatment model. Common factors and group process variables are discussed in many of the articles on CSA but to date have not been empirically assessed. However, case studies and narrative descriptions of group treatment with CSA survivors are useful in this regard. For instance in the description provided by Kitchur and Bell (1989) the authors provide a session by session account of their 16 week program. Throughout this description the authors highlight what they found to work (e.g. games to relieve anxiety) and not work (e.g. unstructured therapy activities) in session. Implementation issues such as transportation of clients and resistance of parents were also noted. The authors also note the impact of contextual factors on the effectiveness of therapy (e.g. during the course of the group three children moved, one child’s house burned down, one child was placed into foster care). Group process was noted in terms of the way in which group identity and cohesiveness emerged. Factors such as these are important in understanding a treatment program, particularly for clinicians who may be planning to implement the program themselves. It is important that future research systematically assesses these types of factors in treatment outcome research.

Treatment integrity is another factor which is infrequently discussed in regard to CSA treatments. Treatment integrity is the extent to which a treatment program is implemented
as planned. As indicated in the previous section, many factors may prevent this. Only two studies from Table 1.1. (Berliner & Saunders, 1996; Deblinger et al., 2001) report on mechanisms put in place to ensure treatment integrity. These studies describe the use of treatment manuals, training of therapists, and the taping of sessions for review via the use of treatment component checklists. Both studies report that there were no major deviations from the treatment model and that the intervention was implemented as planned. Perhaps this lack of deviation is in fact because of the age of the children or that there may not have been as many competing demands on treatment. Another explanation is that the high degree of integrity occurred as a by-product of both studies being randomised controlled trials with narrowly defined client groups and commitment to standardisation rather than client responsiveness.

Nevertheless, my clinical experience suggests that there are many factors which inhibit the ‘exact’ implementation of a treatment program in a community context. Whilst treatment integrity is important, treatments also need to be flexible and cater for the presenting needs of individual clients. To adhere too closely to the treatment manual is to risk both treatment outcome and treatment acceptability (Natasi et al., 2000). That is, if the competing demands of therapy are not attended to, then treatment is unlikely to be effective either because the competing demands do not allow the client to change or the client does not feel supported by the therapist. Similarly if treatment is not considered acceptable to clients then they are more likely to drop out or fail to generalise their therapeutic experience, thereby also impacting on treatment effectiveness. Treatment integrity should be achieved by preserving key elements and varying non critical elements (Natasi et al., 2000) or by developing a responsive methodology that encourages the development of the program as it progresses (this will be discussed in later chapters in the context of the current study). It is worthwhile to know how this process of adaptation occurs within a treatment program, as it has
implications for the conclusions drawn and more importantly provides valuable information to clinicians about obstacles to effective treatment. Thus in addition to treatment content and process, treatment integrity is also an important factor to consider when evaluating treatments with this population which to this point has not been adequately assessed.

In assessing treatment programs, very little focus has been placed on the views and opinions of the consumers of CSA treatments (i.e. children, adolescents and parents) to inform researchers of what should be included in therapy and how beneficial therapy was. A starting point for this, is in measuring the acceptability of the treatment. Acceptability is defined as “judgements by consumers about the extent to which the treatment is appropriate, fair and reasonable for the problem. Acceptability focuses on the procedures, treatment components, and what is actually done to achieve change” (Kazdin, Marciano & Whitley, 2005, p.726). The acceptability of an intervention by consumers is critical to the effective implementation and effectiveness of the intervention (Natasi et al., 2000). Acceptability is therefore an important concept to measure in intervention research, however it seems to be infrequently reported or reported after a treatment has been shown to be efficacious rather than as it develops (Natasi & Schensul, 2005). Yet if this had been measured earlier in the development and evaluation process, it may have provided valuable information on ways in which to further improve the treatment or may have prevented drop-outs which, notably, are often excluded for the estimations of success in randomised control trial studies. In some sense, treatment acceptability is also an indicator of treatment process and the therapeutic alliance (Kazdin et al., 2005).

Two of the experimental studies discussed above included some measure of treatment acceptability or consumer satisfaction. Both Deblinger et al. (2001) and Trowell et al. (2002) report that their group treatments were acceptable to parents. Trowell et al. report that
satisfaction was high and led to high engagement with the treatment. However there is no mention of how this was assessed or how ‘high’ satisfaction was. Deblinger et al. made use of a therapy satisfaction questionnaire in their study, however the results of this survey were poorly reported in terms of being able to assess these results independently of their assertions. The researchers indicate that parents were more satisfied with CBT than supportive therapy but overall satisfaction appeared quite high with both treatments. Thus whilst these researchers attempted to measure this important concept of satisfaction, they have failed to report on it in such a way that the results were meaningful. Another study by Ashby et al. (1987) found that the mean rating of acceptability for their program was 9.8/11 indicating that the treatment was very acceptable to adolescent American Indian girls. The participants reported that they found the ‘talking circle’ to be the most helpful aspect of the program. This was a ritualised process which gave the girls an opportunity to express feelings and concerns about sexual abuse. The process was facilitated by a ‘talking feather’ which gave each girl permission to speak.

Horowitz, Putnam, Noll, and Trickett (1997) also attempted to investigate the factors which affect treatment utilisation and perception by sexually abused girls as these factors were considered ‘filters’ of treatment efficacy. The researchers found that treatment utilisation and continuation were affected by the type of abuse experienced and the level of child psychopathology (i.e. children with more serious abuse/psychopathology remain in treatment longer). Family functioning, age, socioeconomic status and ethnic minority status did not predict total sessions of therapy in the study. With regard to parental perception of treatment, 72% of parents in their study voiced positive perceptions of therapy. Benefits of therapy cited by participants included improved behaviour, children learning to understand abuse, getting the story out, allowing children to express feelings, and allowing children to learn they are not alone. Benefits to the family were also noted. The remaining 28% of
participants reported either neutral/mixed perceptions of therapy or negative perceptions. Negative aspects included cost, time, distance, emotional upset, poor therapeutic alliance and confidentiality issues. For the most part, parents rated the treatment their children received as acceptable. Horowitz et al.'s study could have been strengthened by asking children and adolescents directly about their views and opinions of the treatment they received. Such an approach seems logical given that treatment focused upon children’s processing of abuse. Wieland (1997) argues that this processing is internal and as such does not lend itself to quantifiable data. Qualitative approaches may be more suitable to overcoming such barriers and measuring the lived experience of children and adolescents in therapy. As Nelson-Gardell (2001) states

the literature lacks personal accounts from children and teenagers about what helps survivors to cope. Listening to those directly affected by sexual abuse can tell us what has helped them. Attending to their words can validate the work professionals do and suggest new work to be done (p.403).

There is an increasing amount of qualitative literature being produced which pertains to CSA survivors. With the exception of one study (Nelson-Gardell, 2001) these articles all relate to adults. Nelson-Gardell used focus group methodology to ask 34 female survivors of CSA aged 10 to 18 years, what they thought helped in group and who they thought helped them in their recovery. Participants were recruited from agencies offering treatment to CSA survivors. Focus groups consisted of girls from ongoing therapy groups so the participants knew each other. Four themes were identified from the focus groups and have important implications for the practice of group therapy. The major theme “believing defines help and support” implies that the therapeutic alliance is of paramount importance to enable girls to talk about their experience of abuse. Validation of girls lived experience and the normalcy of their thoughts and feelings in relation to their trauma is what they considered to
be the most important. Being believed was synonymous with being helped. The second theme, "talking about what happened helps" acknowledges that girls understand that it is important for their abuse not to remain a secret. This provides some validation to the approach which most therapists use (i.e. getting children to talk about their abuse) but may often be wary about, given how emotionally painful it may be. This perspective on treatment also suggests that gradual exposure techniques used in TFCBT are likely to be a good way of allowing girls to approach their memories of abuse as they can become less emotionally laden over time. Similarly the third theme, "talking about feelings helps", also mirrors components of TFCBT in that affective processing is considered integral to the approach. Girls in the study reported that they felt that they needed to discuss their feelings about CSA for if they didn't, it may have negative consequences in the future. Finally the fourth theme, "group helps (but no one wanted to go)" implies that the girls considered group treatment for CSA to be both worthwhile and effective, even though the second aspect of the theme suggests that "no one wanted to go". Quotes presented within the paper from participants seem to exemplify the belief that it is easier to talk to those who have experienced similar trauma and that group treatment is preferred to individual treatment. The fact that girls did not initially want to attend is interesting and unfortunately has not been expanded upon by the researcher. Such a feeling is understandable as attending a group would be quite anxiety provoking. Nevertheless it would be beneficial to understand what else may prevent girls from wanting to attend treatment so that these problems may be overcome. Overall the study provides some interesting insight to the views of children and adolescents who attended group therapy. Regrettably, no detail is provided about the type of group therapy each of the participants received. Such information is considered important as the type of group therapy may have mediated the views of the participants. It would also have been useful to have considered such views against a quantitative data set measuring how each girl was functioning psycho-bio-socially, to determine if the
components the girls suggest are important to them (i.e. the four themes presented), were effective as measured by standardised assessment tools. This type of data triangulation would strengthen the inferences made from the data.

Kambouridis and Jevtic (2002; 2003) using post group interviews and reports during sessions found that group treatment was acceptable to 13-17 year old participants. Participants completed a one page evaluation at a post group interview asking them to rate on a Likert scale whether they found group helpful, whether the information presented was accessible, their opinion on the activities and their feelings about attending. The researchers do not report on the findings of this scale in a quantitative sense, which would have been useful. Similar to Nelson-Gardell (2001), the researchers found that participants felt a high level of discomfort about attending the group in the initial stages but that over the course of the group this feeling disappeared and participants felt as if they belonged. This sense of belonging seemed to be afforded by the sense of safety and support that the group provided. The opportunity to share thoughts and meet and make friends with others with similar experiences was considered one of the most significant factors that made the group a valuable experience. This study has further merit in that it used mixed methodology (i.e. triangulating both qualitative and quantitative data) (Tashakkori & Teddlie, 2003) to assess the outcome of the group. Three groups of adolescent girls (13-17 years) attended a 10 week narrative therapy program. At post test participants reported that they felt an increased sense of competence and a decrease in depression and anger. However changes were not found for other important CSA sequelae (e.g. anxiety, PTSD, dissociation, sexual concerns). Parental ratings on the Child Behaviour Checklist also showed no significant differences from pre to post test suggesting little change. Qualitative data however demonstrated that the group decreased the girl’s sense of isolation and removed the shroud of secrecy associated with CSA. Furthermore participants reported that
the group had helped them change their beliefs about themselves, their experience of abuse and other beliefs about sexual abuse. The qualitative aspect of this study adds impact to its findings. Although change was not depicted on all outcome measures, the study captures the way in which participant’s attitudes changed and the way in which their views about sexual abuse were challenged and removed as constraining factors. This highlights what was being discussed in section 1.3.2 with regards to outcome measurement in CSA studies. The qualitative aspects of this study allow for many factors to be captured which were not captured using a questionnaire either standardised or non-standardised. This study suggests that a mixed methods approach has much to offer in terms of comprehensively and holistically assessing what it is about group programs that works. A mixed methods approach to CSA intervention research could allow for treatment efficacy, content, process, integrity and acceptability to all be measured within the one study, making for a more valid and robust dataset by counterbalancing the limitations of each method.

To this point I have suggested that in addition to treatment efficacy (as presented in section 1.3.1) it is important to assess treatment integrity, implementation and acceptability factors when evaluating group therapy. By assessing each of these factors, a better understanding of the treatment being evaluated can be gained. On the basis of the review I have conducted, I know of no study which has been able to encapsulate all of these factors. In addition to these factors and as argued in section 1.3.2, the way in which outcome from CSA interventions is assessed is also paramount given the inherent problems presented. Consideration to the way in which past CSA group treatment research has assessed outcome will now be given.

As previously discussed, the assessment tools used in treatment outcome research in CSA are problematic. Most studies have only used generic standardised assessments such as
measures of self esteem (e.g. Piers Harris Self Concept Scale, Coopersmith Self Esteem Inventory), depression (e.g. Child Depression Inventory), anxiety (e.g. Revised Child Manifest Anxiety Scale) and behaviour (e.g. Child Behaviour Checklist). Kambouridis and Jevtic (2002) were the only researchers to utilise the Trauma Symptom Checklist for Children (TSCC; Briere, 1996b) to assess treatment outcome. This is surprising given that this is a standardised tool designed to specifically measure abuse related sequelae. In addition, many of the treatment studies reviewed used standardised measures in which participants did not meet the criteria for clinical distress (e.g. Berliner & Saunders, 1996). In such instances it is difficult to determine what impact a treatment has had, as the child was not clinically symptomatic to begin with. By measuring more functionally relevant variables this may be overcome. This problem may also be overcome by measuring clinically significant change and using qualitative accounts of treatment change as indicated in the studies discussed below.

A few studies report the use of functionally relevant variables in their assessment of treatment outcome (e.g. Furniss et al., 1988; Lindon & Nourse, 1994; Corder, Haizlip & DeBoer, 1990). Relevant variables include symptoms present, peer relationships, parent relationship, living arrangements, legal status and revictimisation. For the most part these data appear to have been obtained from post intervention interviews and were not systematically assessed. However, functionally relevant data was systematically assessed by both Kruzeck and Vitanza (1999) and Nelki and Watters (1989). Kruczek and Vitanza measured treatment outcome via the use of a recovery scale. This scale was completed by participants and measured their ability to cope as suggested by items such as being able to attend school, hold hands with a loved one, and keep oneself physically safe. In the study by Nelki and Watters, parents were provided with a problem checklist. The checklist consisted of 33 known symptoms associated with CSA such as clingingness, sexual play and
low confidence. Unfortunately the scale is not better described in terms of its contents. Perhaps both studies may have been improved if data from both parents and girls were compared (triangulated) so as to attain a more comprehensive representation of functioning. Convergence of two sources of data strengthens the veracity of the inference (Patton, 1990). This degree of rigour is important in assessing the level of sub clinical symptoms that may be present, particularly where processes such as denial may be present.

Berliner and Saunders (1996) are the only researchers to assess whether shifts in measures of anxiety, depression, sexual behaviour and problem behaviour from pre intervention to post intervention were clinically significant in a study of CSA. Change was measured as shift of one or more standard deviations on each of the outcome measures and participants were classified as improving, staying the same or deteriorating. Depending on the measure used, between 5 and 15% of children were shown to deteriorate across the 2 years of the study. Such a finding would not have been known if only statistical significance was focused upon as in this study statistical significance showed that treatment was effective. A significant proportion of participants in the study also showed no change in either direction again highlighting the floor effects of standardised assessment measures. In the study by Hiebert-Murphy et al. (1992) clinically significant change was also assessed. In this study mean clinical change and change for each participant in the study were presented graphically and in tabular form. As with the previous study, the treatment was not uniformly effective for all participants.

Two studies assessed the knowledge clients gained as a result of attending a CSA program. In one study this was accomplished with the use of vignettes to assess a child’s ability to respond to, and assess, abusive situations (Deblinger et al., 2001). Another study
assessed the degree to which client's attained knowledge of sexual health and sexual awareness in a six month group (Verleur et al., 1986). Measures of targeted treatment content are useful in that it is possible to determine areas of content that may need improvement and may suggest why post intervention behavioural change has not occurred if treatment knowledge has not been acquired.

Few studies have used group leaders as a source of data about the outcome of treatment. The ones that have are for the most part qualitative observations that have not necessarily been systematically recorded. An exception is Ashby et al. (1987). This study reports that at the completion of each treatment session, group leaders recorded the degree to which participants were involved in the session and the accomplishments that each made. This approach is useful in its ability to comprehensively track each participant's progress and assess the impact of group process on each participant and to underpin an accountable, responsive approach to treatment planning.

In attending to the factors highlighted above in terms of assessment, a better understanding of the impact of a treatment can be attained. That is, by using both standardised and non standardised measures of outcome, assessing functionally relevant data, knowledge of treatment outcome and clinically significant change, a more coherent evaluation of how a treatment program is working can be undertaken.

One final point of divergence between studies is worth considering at this point. This relates to whether parents were included in the treatment process. Three of the studies presented in Table 1.1 include a concurrent parent group within their intervention. Two of these studies (Berliner & Saunders, 1996; Nelki & Waters, 1989) merely mention that they have included a parallel parent program but provide little detail of program content. They also do
not assess the programs summatively or formatively. In contrast, Deblinger et al. (2001) provide a good overview of their cognitive behavioural parent program and assess it summatively against a supportive parent group. The goals of the cognitive behavioural parent program are adequately described and include assisting parents to cope with their own emotional reaction, improving open communication between parent and child, and providing parents with behaviour management skills. As with the child group discussed in the summative review, parents in both treatment groups were found to derive benefit from therapy, however effect sizes suggest that the CBT group had greater impact. Mothers in the CBT group reported fewer intrusive thoughts about CSA and fewer negative reactions at post testing. No formative evaluation of the program was undertaken.

Given the variable parent involvement in group therapy studies, parental involvement in individual therapy with CSA survivors will be briefly considered. A greater body of evidence (e.g. Cohen & Mannarino, 1996b; 1998b; 2000; Deblinger et al., 1996) exists for individual therapy and suggests that parents play an important role in their children’s post abuse adjustment and ability to obtain benefit from therapy. For example in a study by Deblinger et al. the participation of mothers in CBT was associated with improvements in parenting skill and a corresponding reduction in externalising behaviour in their children.

As presented in the transactional model (in section 1.2.3), non offending parents’ ability to support their child, manage their own reactions to the abuse and access social support are considered significant moderators of children’s outcome from CSA (Deblinger et al., 1999; Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989; Heriot, 1996). Hence, clinical wisdom and research suggests that it may be useful to include parents in interventions so that they can learn how to best support their children. In addition to supporting children, additional benefits of providing parents with treatment are that parents can learn to manage their own
distressing emotions and the impact associated with any secondary traumatisation experienced (Cocoran, 2004). On the basis of a review by Cocoran (2004) and a more recent literature search which I conducted, there do not appear to have been any studies that have included parents in adolescent CSA interventions.

1.3.4 Conclusions Regarding Treatment for Child and Adolescent CSA Survivors

Taken together, the research presented above demonstrates findings that are consistent with the belief that therapeutic intervention with children and adolescents who have experienced sexual abuse can be beneficial and can aid in the recovery process (Cohen & Deblinger, 2004; Reeker et al., 1997). In contrast to the findings for group therapy, there is strong evidence that TFCBT is an efficacious approach in individual therapy. Even so, this has not been adequately assessed with the adolescent population. To date there is no model that has led the way in group therapy with only one treatment method having being evaluated more than once (i.e. TFCBT). Beyond concluding that there is evidence to suggest that treatment with CSA survivors works, few studies included assessment of what makes treatment work or differential effectiveness for each participant.

The conclusion to be drawn from the review presented here is that further research to establish how effective group treatment is with CSA survivors is required. Given that group treatment for CSA survivors is largely in its infancy, it is argued that in conducting outcome research, there be focus on both establishing whether the treatment works (i.e. is effective at achieving its stated aims) and if it does, why it works. With regard to establishing that the treatment is effective, the evidence presented here suggests that this can be achieved by using multiple informants and methods of data collection which include qualitative and quantitative data. Assessment measures should be both standardised and functionally
relevant and clinically significant change should be assessed at both group and individual levels. In addition to assessing treatment outcome, this review suggested that factors which may mediate the success of treatment should also be assessed so as to ensure the best possible outcome for clients and to improve the treatment itself. This can be achieved by assessing treatment content, process, integrity, and acceptability. To some extent researchers have attempted to do this within the group treatment studies presented here, but not extensively and not with the intended purpose of reflectively improving the treatment and ensuring that it meets the needs of clients.

Thus the aim of the current research is to assess each of these factors in an effort to establish an evidence based treatment for adolescent CSA survivors. The rationale and aims of the study are further considered in the following section.

1.4 RATIONALE & AIMS OF THE RESEARCH

Upwards of 4000 children are sexually abused in Australia every year and these are only the cases that are reported to child protection services. These children, depending on the contextual factors associated with their experience of abuse, are more than likely to present with a wide range of psycho-bio-social sequelae which will have a negative impact on their wellbeing at some point in time. Although not conclusive, the research presented here suggests that treatment for these children will assist in alleviating the distress associated with sexual abuse. In particular, group treatment appears to be a potentially viable treatment approach for adolescent survivors of CSA.

As indicated earlier, adolescents were identified as the target group for this research due to the small amount of evidence available for group treatment with this population (10 out of 24 articles presented) and the overall concern that survivors of CSA may find this
developmental stage difficult as they begin to establish a different or additional meaning to their experience of sexual abuse. In addition group therapy was prioritised as it ‘fits’ with the developmental tasks of this life stage and is most beneficial in its ability to diminish the isolation which survivors experience, something which may be particularly salient as an adolescent.

Whilst the group treatment studies reviewed here provided evidence for the utility of a group treatment approach, there was little replication across the studies of any one treatment model, perhaps with the exception of TFCBT. Two studies (Berliner & Saunders, 1996; Deblinger et al., 2001) appear to have taken a TFCBT approach, however both were with young children. One study (Sinclair et al., 1995) appears to have approximated a TFCBT approach with adolescents but little detail is given about the approach that would allow replication. In the absence of a clear alternative approach and when combined with the research evidence for TFCBT in individual therapy, this approach appears to have some merit and is worthy of further evaluation with an adolescent client group. Thus in establishing evidence based treatment for adolescent CSA survivors in this study, a TFCBT may provide a good theoretical basis.

Many obstacles were highlighted in this review that are salient in planning to evaluate a treatment for CSA survivors and establish evidence based practice. At the heart of these, is the heterogeneity of CSA survivors. Research in the area of child sexual abuse presents many challenges, clinically, ethically, pragmatically, and thus in turn methodologically. The argument of the current study is that treatment programs should be created and validated incrementally, iteratively and developmentally. That is, the treatment should go through specified stages of development, evaluation and refinement so as to ensure that the most effective treatment possible is being provided to clients. More importantly however, the
iterations which a treatment goes through are guided by emerging empirical data that is contextually linked through detailed evaluation of each client’s progress. To do this one must use a methodology that can capture all of these important factors. The approach advocated in the current research prioritises evidence based treatments over empirically supported treatments (Levant, 2005). This approach promotes the use of a variety of research designs and methodologies rather than focusing only on the evidence produced by randomised controlled trials. Furthermore it considers the treatment method, individual psychologist, treatment relationship and the client to all be vital contributors to the success of psychological practice. If all of these factors are important for a successful outcome, then where possible all factors should be measured in treatment outcome research.

The taxonomy presented in Figure 1.4 provides a summary of the research parameters used in the studies of group treatment reviewed here. As it illustrates, many different approaches to the measurement of treatment outcome have been taken. However it is the argument of the current study that rather than just evaluating a program summatively (i.e. assessing that it was effective at decreasing symptoms at the end of the treatment), treatment programs under development should also be assessed formatively using multimodal mixed methods of assessment. This process allows for such things as session content, group process and common factors of therapy, consumer feedback and treatment fidelity to be assessed. As previously described, each of these factors is likely to influence the effectiveness of a treatment program and to date they have not been fully taken into consideration. Thus, overlayed on the taxonomy in Figure 1.4 is (i) shading to indicate which parameters will be considered in the current series of studies and (ii) dashed boxes to indicate novel additions utilised in the current study that I have selected in response to limitations identified in previous studies. The merits of these novel additions will be explained in greater detail in Chapter 2.
In order to comprehensively evaluate and extend best practice for a clinically responsive intervention programme for adolescent girls who have experienced sexual abuse, this study will be divided into five stages. Given the deliberate approach to intervention evaluation, design and development, each stage of the process builds upon the previous stage. This process is further highlighted in Chapter 2. The five stages of the current research will be:
Study 1

The overarching aim of Study 1 is to evaluate an established group intervention program that is provided locally by a community based agency for adolescent girls who have experienced sexual abuse. An existing, locally available treatment program was chosen to be evaluated as a starting point for the establishment of an evidence based treatment for a number of reasons. By evaluating an existing program, in the absence of other alternatives (as presented earlier) the creation of a new program is avoided when a potentially viable one already exists. More importantly, evaluating an existing program in vivo has many advantages over evaluating programs presented in the treatment literature in terms of gaining insight into variables that affect the success of group intervention with adolescent girls who have experienced sexual abuse. From the outset it is noted that the staff associated with this local program welcomed evaluation due to the fact that this program has undergone many changes since its inception and they were unsure if the program met best practice standards or was meeting the needs of the adolescent girls to whom it was provided. Thus it is expected that at a minimum, further refinement of this program may be required to meet best practice standards. In addition, this program had not previously undergone any rigorous evaluation.

To evaluate this local program, Study 1 will involve a retrospective analysis of archival data from the community based agency, a prospective evaluation with past participants of the program and a review against best practice guidelines. In doing so a decision can be made on the viability of the existing program. Thus, Study 1 will provide the platform for the remainder of this project in terms of establishing an evidence based program for CSA. Depending on the findings of Study 1, the remainder of the project will progress in one of two ways. Either the existing program will be refined and modified, or if unsalvageable in terms of...
meeting existing best practice standards, a new treatment program will be developed. This is discussed in the remaining phases of the project below.

- **Refinement or Development of a treatment program**

By synthesising the results of Study 1 with conclusions drawn from the current review of existing treatment programs, and my clinical experience, an evidence based group treatment program will then be developed for adolescent girls aged 12-15 years who have experienced sexual abuse within their lifetime. This program will either be developed by refining the existing program presented in Study 1 or by developing a new treatment program which meets with the best practice standards presented in this thesis. Regardless of outcome, the program will be evaluated in Study 2, refined and further evaluated in Study 3 in an attempt to establish an evidence based program.

- **Study 2**

The aim of Study 2 is to pilot and evaluate the group treatment program developed following Study 1. Study 2 attempts to answer two overarching questions, Does the program work? What makes the program work? Specifically Study 2 aims to:

  i) conduct a formative analysis to describe and assess the effectiveness of the program through its development by critically assessing each session of the program. This involves an analysis of the program’s components, group process and barriers to completion;

  ii) conduct a summative analysis assessing the effectiveness of the program as a whole;

  iii) identify changes and modifications to be made to the treatment program.
Refinement and Expert Evaluation

Using the results and recommendations of Study 2, the treatment program will undergo critical examination and modification to ensure that the program is as efficacious as possible and meets the needs of its client group. In addition, it is important to ensure that the program will be accepted by those likely to use it (i.e. clinicians in the field) and that the content of the program is considered valid. To achieve this, the program will be sent to practitioners and experts in the field for evaluation. Following this process it is expected that the program will undergo further modification on the basis of the recommendations made by these experts. This finalised program will then be evaluated with another group of adolescent girls in Study 3.

Study 3

Study 3 aims to further evaluate the modified treatment program from both formative and summative perspectives. In essence Study 3 is a replication of Study 2. However given the approach taken in the current study it is conceivable that changes to the research methods may occur between Study 2 and 3. For example through a process of critical reflection it may be necessary to change the outcome measures being used to ensure the most relevant data is collected. In addition to aiming to assess whether the treatment program remains effective following Study 2, Study 3 also aims to investigate the benefits of critical reflection and the iterative process being taken to intervention design and development. That is, the aim is to assess whether the treatment used in Study 3 is superior to that of Study 2.

The overarching aim of the current research program is to further develop best practice for group treatments for CSA and produce an effective treatment program that is evidence based. The following chapter discusses the methodological considerations which are important in undertaking this research.
CHAPTER 2

METHODOLOGICAL CONSIDERATIONS

IN DESIGN, MEASUREMENT AND ANALYSIS
Everything is related to everything else in a flowing, even organic fashion, making coherence and organisation a difficult and problematic human task. But in order to have any kind of understanding, we humans require that some sort of order be imposed upon that flux. No order fits perfectly. All order is provisional and partial. Nonetheless, understanding requires order, provisional and partial as it may be. (Lofland, 1971, p.123)

This chapter outlines the methodological considerations that underpin the current research. As highlighted in Chapter 1 there are inherent constraints in treatment outcome research with sexual abuse survivors, and many factors must be considered in addition to treatment efficacy when evaluating the merit and worth of a treatment program. Furthermore, as always, the chosen methodological path excludes many other lines of investigation. Patton (1990, p.150) asserts that “purpose is the controlling force in research.” Teddlie and Tashakkori (2003, p.21) term this the “dictatorship of the research question.” These maxims were the driving force behind the decisions about design, measurement, analysis and reporting in the current project.

As the purpose of this research is to establish an evidence-based group intervention program for adolescent girls who have experienced sexual abuse, then the research methodology must facilitate both evaluation and developmental aspects of this process. In addition the methodology needs to be able to assess the overall effectiveness of the treatment, the relative contribution of treatment components, the contribution of group process and common factors (e.g. therapeutic relationship), the fidelity and integrity of the treatment and how acceptable it is to consumers. Furthermore it is important to capture the phenomenological experience of clients/participants. As explained in Chapter 1, listening to the voices of survivors allows them to either validate or nullify the work that we as
professionals do, and can lead our work in new directions (Nelson-Gardell, 2001). Thus in the current research a developmental intervention (Rothman & Thomas, 1994), action research (Dick, 1993; Kidd & Kral, 2005) approach to program evaluation was deemed most appropriate when used in conjunction with mixed methods (Tashakkori & Teddlie, 2003). A visual representation of this design is found in Figure 2.1. This chapter provides a rationale for the selection of these methods and discusses how each of the components fits together and will be used in this project.

Figure 2.1. Visual representation of the research design used in the current study.
2.1 LEARNING TO WALK BEFORE YOU CAN RUN – A SEQUENTIALLY PHASED APPROACH TO TREATMENT DEVELOPMENT AND OUTCOME RESEARCH

Gendlin (1986) argues that clinical research is often guilty of verification without exploration. That is, that we are often too quick to evaluate treatments using large scale experimental designs before really exploring them and their effects in small scale studies. Worse still, we may fail to conduct any empirical research at all before making treatment commercially available. These two situations for a clinician pose particular problems. In the first instance simply knowing that the treatment works says nothing about the intricacies of the treatment and how it works. In the second instance clinicians are faced with the difficulty of whether to implement a treatment which hasn’t been proven to work. As such it is important that treatments go through rigorous developmental stages of evaluation to ensure that they work. This incremental, iterative approach is advocated in the current research. As indicated in Chapter 1, the current research will start with a locally available treatment which is in need of evaluation and further development for it to become evidence based and meet best practice standards.

Models of treatment development and clinical outcome research suggest that in the initial stages of development and evaluation, it is important to engage in exploratory studies with small numbers of participants in order to test hypotheses, get instant feedback and rich information that can direct future pursuits. Whilst this may occur, the findings of such studies are infrequently published and yet these findings are likely to be very valuable to clinicians in the field. Gendlin (1986) asserts that “when something is found, complex methods of verification are [then] instituted” (p.133). In this way psychotherapy research is improved when much deeper knowledge is developed. Hence what is being advocated is that when treatments are being developed, exploratory studies should be conducted (and published) to provide clinicians with rich information about what makes the treatment work...
or not work. McCall and Green (2004) note that by placing greater emphasis on program implementation, clinicians are able to learn what can be realistically implemented and what is effective for different types of clients. Such information is relevant to clinicians who plan to implement these treatments. For example it is relevant for clinicians to know if there will be problems encountered in implementation, if there are barriers to success, and if the program requires individualisation. The approach to the design and development of interventions taken by Rothman and Thomas (1994) is one such example of how to address these issues and is known as the intervention research approach. This approach has sometimes been referred to as developmental intervention research (e.g. Meier & Comer, 2005; Yoshioka, 1999) as the name more truly captures the iterative process which the treatment program undertakes. As such this term will be used hereafter.

The developmental intervention research approach is a “planned and systematic method for capturing innovation in direct practice [and] involves the design of a viable intervention prototype, a reiterative process of testing and refinement, and finally an evaluation of its effectiveness” (Yoshioka, 1999, p.115). In this framework, the process of iteration is considered vital to the development of a superior evidence based treatment. There are six main phases to the design, development and evaluation of an intervention as presented in Figure 2.2. The first five phases are of relevance in the current research program as detailed below.

![Figure 2.2. Phases of the intervention research approach (Fawcett et al., 1994, p. 28).](image-url)
Phase one typically involves an analysis of the extent of the problem and who it effects. It includes identifying prevalence/incidence, component aspects, causal factors and the effects of the problem (Fawcett et al., 1994; Rothman & Thomas, 1994; Thomas, 1984). Within the current study this process was undertaken in the form of the review presented in Chapter 1. This review revealed that CSA is a significant problem which requires intervention to help prevent a wide range of negative sequelae that have been found to be associated with the aftermath of CSA. Moreover that the principal problem in treatment planning is the diversity of client presentation.

In phase two a review of existing treatment programs is suggested. The goal of phase two of the current project is to identify treatment programs that currently exist and determine what has and has not worked in the past. That is, identifying and reviewing the treatments already available to determine if and how they meet the needs of the client group. Treatment programs may not need to be developed if effective options already exist. The initial phases of this process were undertaken in Chapter 1 by examining the research evidence for existing group treatment programs for CSA survivors. This will be further extended in Study 1 (as described in Chapter 3) by examining a local community based program as a natural example of an, as yet unevaluated program (Fawcett et al., 1994).

In phase three of developmental intervention research, a pilot treatment program is developed on the basis of the information gathered in phases one and two. As previously indicated, depending on the results of Study 1 this pilot treatment may either be a refinement of the local existing program or it may be a newly developed program. The pilot treatment will be described in Chapter 4.
In phase four of developmental intervention research the treatment program developed in phase three is pilot tested. This phase appears tantamount to a formative analysis as it involves identifying what is and is not working with the intervention as it proceeds. A problem solving process is then used to select viable options to improve the treatment. Phase four may take a considerable amount of time as the treatment is constantly refined with each evaluation of each session of the program as it progresses, and of the program as a whole. Phase five allows for further refinement of the treatment program by using a summative approach to determine the effectiveness of the treatment. In the current project phases four and five will be combined and formative and summative evaluation will be conducted in unison in Study 2 (described in Chapter 5) and Study 3 (in Chapter 7).

The diagram presented in Figure 2.2 will be presented at the beginning of each chapter of this thesis as a way of identifying which stage the research is at by shading completed phases and highlighting the current stage. In cases where the phase of developmental intervention research spans more than one chapter/study, patterns will be used to indicate the extent to which the phase is complete. Finally, the figure will be presented in the general discussion (Chapter 9) to indicate the state of research on completion.

Whilst phases four and five involve evaluation, Rothman and Thomas (1994) do not specify any particular research design as this choice is dependent upon the type of intervention that has been developed and the circumstances under which it is implemented. The model also does not discuss criteria an intervention should achieve prior to moving into the dissemination phase. Thus the developmental intervention research method appears most relevant to providing a focus for the development of a treatment program, however further guidance is needed on the research design. In the current project, the approach which appears to fit best is an action research program evaluation method. For the most part,
action research and developmental intervention research are very similar processes. Conceivably if they had come from the same discipline, in terms of their conceptual basis, they may in fact be called the same thing. There are however subtle differences with the former providing an approach to program evaluation that complements the developmental intervention approach to program development.

2.2 RESEARCH DESIGN FEATURES & LEVELS OF EXPLANATION
The aim of this section is to unravel each level of the research design as presented in Figure 2.1. The section begins with the paradigm level of Figure 2.1 before proceeding to methodology, methods, data analysis, quality and presentation of results.

Paradigm

Action Research
The overarching paradigm chosen for this study fits within the realm of action research. Action research may be defined as “a period of inquiry, which describes, interprets and explains social situations while executing a change intervention aimed at improvement and involvement” (Waterman, Tillen, Dickson & de Koning, 2001, p.11). Dick (2002, p.2) further adds that the aim of action research is, as it name describes, “to achieve both action and research outcomes within a single study.” Action research ranges in its focus along the continuum from action to research. Depending on the nature of the study the outcomes may be more explicitly focused on one or the other. In either case it is desirable that action informs research and research informs action. Action research is based on two core concepts, namely cyclic processes and collaboration/participation with stakeholders.
Reflexivity is at the core of action research and it works upon a cycle of Plan – Act – Observe – Reflect (Kemmis & McTaggart, 1988) as demonstrated in Figure 2.3. This figure shows how action research evolves through cycles. The rising line represents the goal of continuous improvement and development of, in the case of the current study, the treatment program (Crane & Richardson, 2000). The successive cycles become larger reflecting the way the process changes over time as knowledge expands and more is understood about the phenomena under investigation. The most important aspect of the model is the critical reflection which takes place prior to moving on to successive cycles (Dick, 2002). During this reflection it is important to ask such questions as: What worked? What didn’t work? How might the process be improved? What is now known that wasn’t known before? This reflection is then followed by further action based upon the “understanding achieved, the conclusions drawn, [and] the plans developed ... These are tested in action” (Dick, 2002, p.5).

Figure 2.3. An overview of the action research cycle for the current study (Adapted from Crane & Richardson, 2000).
Action research usually involves both collaboration and participation. Just as the amount of action and research vary in any given study, so too does the level of collaboration and participation (Waterman et al., 2001). Collaboration and participation also feature in the developmental intervention approach (Fawcett et al., 1994) but is not given the same level of importance as in action research. In the current study collaboration will occur at a number of points. Prior to beginning the research, staff from a local group treatment program for CSA survivors will be consulted on the design of the study and the development of some of the assessments. These staff will also be involved in the selection of clients for Study 2. At a later stage between studies 2 and 3, practitioners and experts in the field will also be consulted on the development of the treatment program itself. In terms of participation, a distinction between the researcher and the participants will be apparent. It will be impossible to involve the participants (adolescent survivors of CSA) in all aspects of the initial design and management of the project. As such the project is designed so that group participants can have as much input as possible into the further development of the treatment program. In Study 1 this involves asking survivors who had previously been involved in treatment programs what they found useful about the program they had attended. In Studies 2 and 3 participants will be involved by evaluating the treatment program as it progresses and indicating what they feel is and is not working. In this framework, participants are designated ‘experts’ whose opinion is highly valued by the researcher/practitioner.

Ultimately an action research approach will be taken due to its ability to meet the dual purposes of the research as indicated in phases four and five of the developmental intervention approach. That is, to evaluate the treatment program at a micro/formative and
macro/summative level rather than only at macro level as occurs in most clinical outcome research. The micro/formative approach is considered especially important as it allows assessment of each component of the treatment program, something which to date is missing within the CSA literature. As Yoshioka (1999, p.117) remarks “rather than developing an intervention protocol a priori, the specification of protocol components grows out of the documentation of service delivery experiences, observation, and monitoring of the treatment process and, as such, is a reflection of needs, concerns, and circumstances of a current client group.” This is the stage at which most of the ‘action’ occurs as each aspect of the treatment program is constantly being evaluated, refined and re-evaluated. The macro results are however also important. There is no point in improving a program using micro formative methods if the program does not show at least some potential to create positive change in each of the participants, which is the ultimate aim of the any treatment. Thus the macro level involves evaluating the participants prior to and following the implementation of the treatment program to assess change on relevant measures of outcome.

Action research is ideal for the current research in its ability to be responsive (Dick, 2002) and its capacity to allow the treatment program to be flexible and adaptable to the needs of the client group whilst it progresses. That is, the outcomes of each session can be fed back into program planning for subsequent sessions rather than waiting until the end of the program to assess program utility. Action research was also chosen, as the duty of care and ethical consideration of the participants is my priority on account of the vulnerability of the client group in general and the untested nature of the treatment program to be used in Studies 2 and 3 of the project. In addition, the use of such an approach allows for the assessment of functionally relevant data, and assesses exchanges and process issues within the group that contribute to outcome of each session but cannot be measured by standardised assessment tools (Richardson, 2003). By collecting such information, the
needs of the client group can be better targeted and a treatment program can be developed which is more likely to be effective.

Action research is not a method per se but rather it is an overarching paradigm which subsumes a variety of approaches to research methodology. Action research creates the context in which knowledge is developed and change occurs (Kidd & Kral, 2005). As Dick (1993) highlights and summarises in Figure 2.4, within the paradigm of action research there are numerous methodologies (e.g. evaluation, soft systems analysis, action science) and an even greater range of methods of data collection and analysis (e.g. surveys, interviews, documents) on which to draw. Whilst action research is often qualitatively based (Kidd & Kral, 2005), the approach of action research allows both qualitative and quantitative data to be included in the one study. For the current project, a mixed methods approach to program evaluation was chosen as the appropriate methodology and is described below.

Figure 2.4. Within each paradigm of research are several methodologies, each drawing on a number of methods for data collection (Dick, 1993).
Methodology Level

Mixed methods

At the simplest level, mixed methods research involves combining both qualitative and quantitative methods of data collection and analysis in the same study. At a deeper level however, mixed methods research depends on a number of factors which direct the outcome of the research. As discussed above, the driving force of the research remains the research purpose. However choices surrounding data collection, data priority, and the point at which ‘mixing’ occurs are all relevant to the final outcome and choices made at each juncture then exclude other lines of investigation (Onwuegubuzie & Teddlie, 2003). By combining qualitative and quantitative data a process of triangulation is afforded, thereby building on the complimentary strengths of each method to increase the reliability and validity of the research findings (Richardson, 2003). Triangulation is a way of drawing inferences and validating findings by showing that independent measures of a concept concur (Miles & Huberman, 1994). Triangulation can occur by combining and comparing multiple data sources (e.g. people, places, times), data methods (e.g. observations, assessment tools, interviews), researchers (e.g. investigator A or B) and data type (i.e. qualitative or quantitative) (Tashakkori & Teddlie, 2003). The process of triangulation is perhaps the most important and advantageous aspect of the mixed methods approach, particularly in the present context. In order to achieve the goals of the project a mixed method approach is deemed necessary in order to capture both macro and micro processes of the treatment and its outcome for each unique and complex individual.

Tashakkori and Teddlie (2003) argue that the utility of a mixed methods approach is evident in its ability to: answer questions which other studies cannot within the one study; provide stronger inferences; and the opportunity to explore convergent and divergent evidence in
the one study. A mixed methods study can ask both confirmatory and exploratory questions at the one time. For example in the current study the following questions can be posed:

- What is the program's effect on outcome variables? (confirmatory)
- What can we learn about the participants and the program? (exploratory)
- How did the different strategies influence the results? (exploratory)

Ordinarily clinical outcome research would only be able to ask the first question. However, with the addition of qualitative data and a developmental intervention action research approach, more detailed information about the treatment program can be ascertained. That is, mixed methods allows you to “get more out of the data” (Onwuegbuzie & Teddlie, 2003, p.353) which generates greater meaning and understanding of the complexity of the treatment program and its impact. The mixed method approach also facilitates the ‘action’ side of the research by highlighting inconsistencies, discrepancies and areas of need within the evaluation. This leads to the modifications and iterations that are inherent in an action research approach. The combination of qualitative and quantitative data also opens the possibility of obtaining divergent findings. These findings are valuable in that they can lead to the re-evaluation of the theoretical underpinnings of the phenomena under investigation.

In program evaluation and development it is the micro level of analysis that is often the most important.

As previously highlighted, the point at which mixing occurs in a study that utilises both qualitative and quantitative data is important. There are many different mixed methodology models which take different approaches to mixing (Onwuegbuzie & Teddlie, 2003). The model most suited to the current research is a ‘fully integrated mixed model design’ (Tashakkori & Teddlie, 2003) as presented in Figure 2.5. This type of model is warranted when both confirmatory and exploratory questions are asked within the one study (as occurs in the current project). Quantitative and qualitative data may be collected
concurrently or sequentially using the design to direct one another and answer multiple approach questions. The data may also be *qualitised* (converted from quantitative to qualitative) or *quantatised* (converted from qualitative to quantitative) as indicated by the dashed lines which zigzag across Figure 2.5. Inferences are made on the basis of the data and combined to form a meta-inference, thus the weight of both types of data is considered important. This model best aligns with an action research approach as it allows for the possibility of multiple iterations. That is, throughout the process of data collection, analysis and inference, evaluations are constantly being made about the findings which may or may not lead to further data collection. The way in which this model will be applied in the current project is described below.

*Figure 2.5. Fully Integrated mixed model design (Tashakkori & Teddlie, 2003, p.690). Note – broken lines indicate iterative process in which inferences and outcomes may point to further data collection – rectangles represent qualitative and ovals represent quantitative.*
The fully integrated model can be applied to this overall project when each study combines to form a meta inference (i.e. the main conclusions of the five phases of the project). Furthermore the model can be applied to both the macro and micro processes of each of the three studies of the current project. For example in Study 2 qualitative and quantitative data will be collected concurrently during each session of the treatment program to determine which elements of the program are most useful. At the conclusion of each session this data will be analysed and inferences made about the session. This information will then be fed into the subsequent sessions and may mean that changes to the treatment program take place. Data collection and this reflective spiral will continue until the end of the treatment program. The inferences made across the program will then be combined to form a meta inference about the treatment program and its components. Information from this aspect of Study 2 will then be fed into and modify the approach taken in Study 3, this may be both in terms of the type of data collected and the treatment itself. Thus the model depicts the importance of iteration through the project and the way in which the depth of knowledge and meaning is created through this process.

Program Evaluation

At the heart of the current study is an evaluation of a treatment program. As such the methods selected to evaluate the program are important. Stufflebeam (2001) asserts that evaluation is “a study designed and conducted to assist some audience to assess an objects merit and worth” (p. 11, italics in original). Posavac and Carey (1992) add that program evaluation is used to determine whether a “service is needed and likely to be used, whether it is sufficiently intense to meet the unmet need identified, whether the service is offered as planned, and whether the service actually does help people…”(p.1). This is exactly what is intended for the current research project. That is, we want to determine
whether the treatment program actually helps adolescent girls to work through their experience of sexual abuse; whether the girls and their parents consider the treatment worthwhile; and whether the treatment is being implemented as planned, and if not, we need to know what the barriers to success are.

Based on Stufflebeam’s (2001) taxonomy the most relevant evaluation approach is what he terms a decision/accountability oriented approach which is used to “proactively help improve a program as well as retroactively…judge its merit and worth” (Stufflebeam, 2001, p. 42). The decision/accountability approach fits with the action research paradigm in that it engages relevant stakeholders in the research process. In the context of the current project this will include clients, facilitators and parents/guardians. The approach also opens itself to the use of many approaches to data collection (questionnaires, observations, interviews, case studies) which again is in keeping with action research and mixed methodology and permits the use of triangulation. This approach advocates balancing the use of qualitative and quantitative methods and is most applicable when both formative and summative evaluations are desired (Stufflebeam, 2001). That is, when a focus on both the overall outcomes of the program and each component of the program is required, as will occur in current project. Given the importance of both formative and summative evaluation within the decision accountability approach, it is worthwhile exploring the merits of both in greater detail.

As briefly discussed earlier, formative evaluation is a type of evaluation which is used to assess and improve an intervention, particularly when it is still being developed (Scriven, 1991; Sharp & Frechtling, 1997). This is sometimes also termed a process evaluation (Hawe, Degeling, & Hall, 1990). A formative evaluation allows for all aspects of program delivery to be assessed such as session content, attendance, feedback, fidelity and
satisfaction, all of which can then contribute to program improvement (Sharp & Frechtling, 1997). The approach allows for developmental hypothesis testing to take place, assesses functionally relevant data, and provides a method for assessing the group process issues that are rarely measured in outcome studies but are known to contribute to outcome (Richardson, 2003; Sharp & Frechtling, 1997). Most importantly the formative approach allows for each component of the program to be measured and evaluated (Hawe et al., 1990). This approach then provides data that can be fed back into the program. Formative evaluations are important as it is impossible to conclude that a program is ineffective if program implementation factors have not been assessed (Hawe et al., 1990). After an initial formative evaluation, Hawe et al. suggest that this form of evaluation should continue as a measure of quality assurance.

Formative evaluation will be utilised throughout the current project. In Study 1 it will be used to retrospectively and prospectively evaluate an existing treatment program that had previously been used in the community and that is likely to require improvement. In Studies 2 and 3 where the pilot treatment program will be evaluated, formative evaluation will be used during each treatment session to determine factors such as: the extent to which the program is delivered to plan; the atmosphere of the group and issues related to group process; the barriers to successful implementation; the extent to which the program is understood; the level of satisfaction with the components; areas of the program that need to be changed; and the experience of participation in the group for facilitators and participants.

The summative evaluation assesses the overall success/effectiveness of the program (Scriven, 1991). Summative evaluations are often used to serve the purpose of making judgements about critical aspects of a program (Rossi, Freeman & Lipsey, 1999). The purpose of a summative evaluation is largely to determine if indeed the program is
achieving the intended outcomes (Sharp & Frechtling, 1997). Various methods can be used to undertake a summative evaluation including the use of an experimental design. Again this depends on the purpose of the evaluation and pragmatic considerations such as whether there is a control group available.

Summative evaluation by way of a simple A-B-A accountability case study design will be utilised in Studies 2 and 3. That is, participants will be assessed prior to and following the treatment program. This summative case study method allows for the clinical effectiveness of the program to be evaluated, whilst also showing any changes inherent in the individual participants with small sample sizes (Galassi & Gersch, 1993; Roth & Fongay, 1996). That is, data can be analysed both across and within each case (this is discussed further in the analysis section) but will not be compared to another treatment or waitlist control condition.

As Galassi and Gersh (1993) point out, there is little basis for the common belief that single case designs are less scientifically valid than other methodologies which use a control condition. Control is used to meet the condition of causal inference. That is to rule out threats to internal validity and categorically say that the independent variable led to changes in the dependant variable (Shaughnessy & Zechmeister, 1997). Kazdin (2003) reports that the strength of inferences made from uncontrolled case studies can be greatly improved by systematically collecting data, assessing on multiple occasions, using multiple subjects, and knowing about the stability of the disorder and effects associated with the treatment, thereby reducing the threats to internal validity (history, maturation, testing, instrumentation, statistical regression). Thus in the current project the use of multiple cases/informants and repeated multiple measures before and after the treatment program will be used to reduce the threats to internal validity. In addition the use of mixed methodology and the process of data inference and legitimation as described later in this chapter provide a viable alternative
to a control condition. Finally it could also be argued that a control group may not be worthwhile given the variability of psychopathology for CSA survivors as presented in Chapter 1. One of the assumptions of having both a treatment and control condition is that the individual differences between participants will even out across the groups by randomly assigning them (Shaughnessy & Zechmeister, 1997). However given the vast array of CSA sequelae this may be unlikely unless the groups are screened for a particular symptom cluster (e.g. PTSD) which as previously discussed does not seem appropriate as the treatment would then only be efficacious for survivors with that particular symptom.

In the current study participants will be girls who have received prior individual counselling for CSA but who are still in need of further help. This requirement is both a mandate of the community based agency involved and the most ethically appropriate approach given the untested nature of the treatment and previously presented arguments indicating that group therapy can not meet all clients’ needs, particularly if they are severely distressed. Thus it is expected that given these clients have had prior therapy, they have experienced difficulties in the past in relation to their CSA, and quite likely when presenting for this treatment, will either have newly manifesting symptoms or have been dealing with their presenting problems for a long period of time with little amelioration. Given this situation, it is more plausible that any change during the assessment period will be associated with the treatment and not simply the passage of time. Evidence based projections about future performance in relation to the presenting problems associated with sexual abuse, also suggest that if the problems have been present for an extended period of time, the changes i) are unlikely to occur without treatment and ii) are likely to be gradual given the length of time they have been present. In addition, as discussed in Chapter 1, the symptomology of each participant may also be compounded by their developmental stage (i.e. adolescence). Under such circumstances, change is likely to be difficult to induce and difficult to assess in
the short term. Nevertheless, despite these difficulties this is still a population in need and as such the benefits of providing treatment far outweigh any limitations. Indeed the context described makes any changes that occur in participants more plausible and significant given the barriers to change that are present.

In designing a study, researchers should predict and plan for the ways in which treatment effects are likely to occur. In the context of the current research it seemed likely that a ‘sleeper’ effect (Hawe, et al., 1990) would occur, in that the full effects of the program would not be apparent until some time after the completion of the program. This effect was hypothesised on the basis that it would take group participants time to consolidate what they had learned and experienced in the program and put it into practice. Furthermore the evidence provided by Tebutt et al. (1997) clearly demonstrates that change can be difficult to induce. In their study just as many children improved as deteriorated. As such, three month post intervention assessments are considered particularly important in the current project given the real world context of this research. Moreover, assessing precursors to behavioural change is important, specifically assessing new knowledge and what is learnt from sessions is central. Given that more significant changes (e.g. a reduction in depression or risk factors) may be unlikely in a short space of time, the assessment of precursors to behavioural change allows the impact of the treatment to still be evaluated. Consequently if precursors are demonstrated, it is at least possible that behavioural change follows when knowledge becomes consolidated. In the context of CSA this knowledge is likely to include a factual understanding of: what CSA is, who it happens to and how frequently; offending behaviour; effects and impact of CSA; shame and guilt; sexuality and sex education; and coping skills.
The focus of summative evaluations in the current study includes consideration of the following factors: the extent to which the program meets the overall goals and objectives; the extent to which participants change on standardised and non-standardised measures associated with CSA sequelae; the extent of clinically significant change; knowledge of core treatment components attained; whether the program is equally effective for each participant; the impact of drop outs (if any); and the extent to which type of CSA mediates outcome.

Participant researcher

An essential element of the current project is my dual role as both researcher/evaluator and clinician. In this sense I am also a participant in the research process. The role of participant researcher is critical to the success of the project and is fundamental to an action research approach (Dick, 2002).

Patton (1990) argues that the participant researcher is an advantageous position for a number of reasons. Firstly, the researcher is better able to understand the context in which the program operates. By understanding the context, one is able to more adequately present a holistic perspective. Secondly, direct observation prevents prior conceptualisations which cloud the researcher’s judgment and as such allows an evaluator to be “open, discovery oriented, and inductive in approach” (Patton, 1990, p.203). Thirdly, Patton asserts that observational work allows for the process of a program to be ‘measured’. Fourthly it is possible to access information which participants may be unwilling to provide or perhaps are even unaware of (e.g. the way in which participants interact in group). This may be particularly relevant when dealing with participants with mental health issues or those who lack in insight and therefore are unable to report these issues themselves. Finally, when combined with other ‘data’, interpretation is aided by the knowledge and understanding of the participant observer’s interpretation and as such a
more comprehensive view of the program being studied can be presented. Overall this presents an opportunity to gather data to allow what is termed “thick description” (Patton, 1990, p.375). Thick description contributes to the rigour in qualitative analysis as it describes the data in such a way that others can make their own interpretations. That is, it addresses the element of researcher bias by allowing the reader to make their own interpretations of the researchers observations as is further indicated below.

Elliot, Fischer and Rennie (1999, p.221) highlight the importance of the researcher “owning one’s own perspective.” That is, that qualitative researchers need to state their theoretical orientation, personal values and assumptions prior to commencing the research, as well as those that become apparent during the process. Researcher bias is difficult to control, but by stating the position of the researcher the reader is left to interpret the conclusions drawn in an informed way. Thus in best accounting for these potential effects, salient features of my background are now described.

As previously indicated in Chapter 1, I am a doctoral level Clinical Psychology student enrolled at Murdoch University. Prior to beginning the project I had completed a six month practicum placement at PACTS (Parents and Children’s Therapeutic Service) dealing specifically with children and adolescents who had experienced sexual abuse (it is a PACTS program which is initially evaluated in the current project). During this time I began to develop a certain framework and hypotheses regarding what may and may not be beneficial in working with adolescent survivors of sexual abuse within a group format. This informed the evaluation framework and program development to follow. In addition to this experience working specifically with CSA survivors, I have completed all coursework for my clinical postgraduate degree and also had three years experience working as a trainee in
child and adolescent mental health clinic, with children with disabilities and in a community based adult mental health clinic.

**Method Level**

To conduct an action oriented mixed method evaluation, evidence must be gathered from numerous data sources (Dick, 2002; Tashakkori & Teddlie, 2003). This is central to the process of triangulation and underpins the notion of rigour (Patton, 1990). Multiple informants are necessary as are multiple methods of assessment as is reflected below.

**Multiple informants / Participants**

In the current project, data will be sourced from several primary informants (where available) including: adolescent girls who have experienced CSA; their non offending parent(s); and group facilitators (Study 2 & 3). Triangulation of these three data sources is central to the evaluation. Experts and practitioners in the field will also be used in the project to evaluate the treatment program thereby enhancing its content validity.

**Multiple assessments**

The inherent difficulties with summative/outcome assessment in CSA research were discussed in Chapter 1. To briefly recapitulate, standardised measures of psychological functioning may be inadequate to use in CSA research due to constraints with regard to their sensitivity in identifying subclinical problems and ceiling and floor effects, particularly when they are used as sole measures of outcome. Whilst abuse specific measures such as the Trauma Symptom Checklist for Children (Briere, 1996b) are helpful, they may not capture many of the difficulties that CSA survivors experience on a day to day level (e.g. binge drinking, truancy, relationship difficulties). As such a combination of standardised and researcher developed functional assessment tools are deemed appropriate for this investigation, to fully capture clinical change within each participant. Furthermore the
measures selected are both qualitative and quantitative in nature and include participant observation by the group facilitators. As previously mentioned in the discussion about summative program evaluation, these assessments will be repeated on numerous occasions to increase the validity of the findings of the current research.

In terms of formative evaluation, assessments of both treatment content and process will be developed specifically for the study. Group participants will be asked to complete questionnaires following each group session. These will be designed to capture the relevance of the session content and the impact of the session. This will also facilitate the participation side of action research, in that CSA survivors will be asked directly whether or not the process they go through is helpful and beneficial. Facilitators will also complete questionnaires designed to capture session direction, orientation, atmosphere, dynamics, strengths, weaknesses and the cohesiveness, trust, enjoyment and sense of belonging of the participants. Assessment of the process is also considered essential in Studies 2 and 3 particularly given that simply attending a group for CSA survivors is likely to decrease the stigma and isolation so commonly associated with CSA which may be strongly linked to psychological difficulty (Trolley, 1995). Group process will be largely recorded via observation by the group facilitators.

It should be noted that in keeping with action research, all questionnaires developed for the study will be developed in conjunction with key stakeholders (i.e. staff from PACTS and research supervisors) to ensure that they meet the needs of the study and are appropriate for adolescent CSA survivors to complete.
Data Analysis & Data Quality Level

Within the mixed methods approach, data analysis can occur at any juncture in the data collection process. Data analysis is a cyclical process which involves data collection, analysis, interpretation and legitimation as described in the fully integrated mixed model presented earlier (Tashakkori & Teddlie, 2003). Data analysis in mixed methods is a continuous iterative endeavour (Onwuegbuzie & Teddlie, 2003). Prior to analysing data, decisions must be made explicit as to how the analysis will be approached, its purpose and focus (Onwuegbuzie & Teddlie, 2003). In the current research the primary purpose of using mixed methodology and multiple methods is to triangulate formative and summative data. A case oriented (as opposed to variable oriented) approach to analysis is also planned for summative data. A case oriented approach analyses data within and across cases (Miles & Huberman, 1994). A within case analysis will be conducted in Studies 2 and 3 using participant portfolios (Barnett et al., 1999). The portfolio method allows for the incorporation of multiple data sources, types and phases and seemingly disparate pieces of information to be pieced together to form a more reliable and valid picture of participant change. Data for each participant will be presented in a portfolio and compared against the goals of the treatment program, to determine whether involvement in the program is effective for each participant individually. In addition to the within case analysis, cross case analysis will also be conducted. This involves combining and comparing the results of the study across participants to assess the overall impact and effectiveness of the treatment program at a global level (i.e. was it effective for all participants? Was it effective in the same ways?). The formative evaluation will also involve analysing data about the program in general. That is, it will assess the components of the program and each participant’s views and opinions of them.
Onwuegbuzie and Teddlie (2003) propose the following seven steps to the analysis of mixed methods data. Note that not all steps may be required as analysis is not a linear process.

1. Data reduction – a reduction of what ever data has been collected. For example descriptive statistics for quantitative data and content analysis for qualitative data.

2. Data display – this stage involves reducing the data into what Miles and Huberman (1994, p.11) describe as a “gestalt or easily understood configuration.” For quantitative data this may be a table or graph, for qualitative data it may include a matrix, chart or rubric. Data interpretation may begin at this stage when the information displayed is so comprehensible as to not require transformation, correlation, consolidation, comparison or integration.

3. Data transformation – data types may be either *qualitised* and/or *quantitised* (Tashakkori & Teddlie, 1998). This may not be relevant in all data analyses.

4. Data correlation – likened to triangulation, this stage involves correlating the qualitative and quantitative data and usually follows from data transformation.

5. Data consolidation – instead of using correlation the researcher may decide to create new or consolidated variables by combining data forms.

6. Data comparison – the researcher may be unable to correlate or consolidate the data, in these instances data comparison is recommended. This involves comparing data from different sources and again is associated with triangulation.

7. Data integration – all data are integrated into a coherent whole and form the basis for data interpretation and inference.

The process as it pertains to the current project is depicted in Figure 2.6. Given the nature of the project and the outcome variables to be collected, it is not expected that data consolidation will be required in the current research and so it has been omitted from Figure
2.6. Data reduction, display, comparison and integration are likely to be the primary methods of analysis as these approaches will allow a potentially large dataset to become manageable and are primarily focused on the triangulation of data sources which serves to increase the validity of the findings as further indicated below.

Following on from step seven in the data analysis process above, are the processes of inference/interpretation and legitimation (Onwuegbuzie & Teddlie, 2003). Inferences in mixed method terminology refer to the inductively and deductively derived outcomes of the study and the interpretations of the data set. Once these have been made, the process of legitimation must be undertaken. The process of legitimation is about determining whether results are sturdy (i.e. able to withstand alternate explanation), plausible (i.e. make good sense), and confirmable (i.e. defensible) (Miles & Huberman, 1994). In the quantitative tradition this may be referred to as validity, in the qualitative tradition it is equated with credibility. In mixed methods, Tashakkori and Teddlie (2003) refer to this as inference quality, a collective term to encompass validity and credibility. In both qualitative and quantitative traditions the concept of rigour is central. Rigour necessitates that researchers are fully accountable at each stage of the research process. Rigour is largely achieved through the process of iteration and triangulation. In the current study this is achieved by using multiple informants and multiple measures to evaluate the phenomena of interest. Furthermore the data will be constantly analysed and alternate explanations for results will be constantly sought.
It is feasible that the process of legitimation may necessitate further data collection and further cycles of research (Onwuegbuzie & Teddlie, 2003). This process of iteration is at the heart of both action research and mixed methods approaches (Dick, 2002; Tashakkori & Teddlie, 2003). Such an approach increases the validity of the findings because the interpretations made by the researcher are constantly being tested and held up for further evaluation. Furthermore in the current study these cycles will occur at micro and macro levels of analysis. At a macro level the findings of each study will direct the next. For example the findings of Study 2 will direct the way in which Study 3 proceeds.

The process of legitimation is also served via triangulation. Triangulation further increases the quality and accuracy of the findings and reduces systematic bias by checking findings
against other sources and perspectives (Patton, 1990). Within the present study multiple sources and modes of evidence will be collected and evaluated. A matrix of data sources and methods will be constructed to assist this process where possible. This will allow me to determine whether the findings converge or diverge.

In addition to iteration and triangulation, other tactics proposed by Miles and Huberman (1994) will be used to enhance the confirmability of the findings in the current study. Specifically these include:

1. Weighting the evidence (i.e. identifying the strength of the data on which conclusions are based)
2. Looking for outliers, negative evidence, extreme cases (as protection against self selection biases and signs of divergence which may alter conclusions drawn)
3. Replication (i.e. checking data across cases and across studies)

2.3 SUMMARY & CONCLUSIONS

In attempting to undertake a study which aims to achieve both the enhancement and/or development of a program and the evaluation of its effectiveness, a novel approach to research design needs to be taken in order to encapsulate all facets of the study. In addition, the choice of design is complicated by inherent constraints presented by survivors of CSA. At the centre of the treatment development process is the use of multiple iterations and the idea of testing the treatment by putting it into practice, directly evaluating its impact and using the empirical results to refine the treatment further. This ongoing cycle will occur at both a micro and macro level. By doing so a treatment program will be produced that is based in evidence and is shown to be effective.
Messer (2004) argues that “as practitioners, we cannot manage without nomothetic and idiographic data, findings based on qualitative and quantitative method, and a mixture of scientific and humanistic outlooks…” (p.586 italics in original). McCall and Green (2004, p. 3) further add that “research methods are tools that can be variously applied depending on the developmental stage of knowledge in a particular area, the type of research question being asked, and the ecological context of the research.” In the context of the current research, the knowledge base is small, the research asks both confirmatory and exploratory questions and the research environment is community based with highly vulnerable participants who have experienced trauma and may be presenting with a wide range of difficulties. Consequently, the project must be designed in such a way to meet these demands. A development intervention, action research approach to program evaluation can achieve this.

Once these different processes have been undertaken we are in a better position to truly say that a treatment program is both efficacious and effective and should be utilised. This should occur via a process of methodological triangulation. Schorr and Yankelovich (2000, p.B7) concur that “many new approaches now are becoming available for evaluating whether complex programs work…Quarrels over which method represents ‘the gold standard’ make no more sense than arguing about whether hammers are superior to saws. The choice depends on whether you want to drive in a nail or cut a board.”

Now that the overall design of the study and decisions about methodology, method and data analysis have been presented, the specific methodology for each study will be presented in subsequent chapters.
CHAPTER 3

STUDY 1: A RETROSPECTIVE ANALYSIS

OF THE P.A.C.T.S GIRLS GROUP
Why can’t I just put the sexual abuse behind me? What’s past is past. I don’t see any use in talking about it. I just want to go on with my life (Teen survivor, Munson & Riskin, 1995, p. 7).

Phase one of the developmental intervention process presented in Chapter 1 highlighted the extent of CSA along with component aspects, causal factors and effects of CSA. The review concluded that CSA is a significant problem and that CSA survivors are likely to benefit from psychological intervention in order to ameliorate associated sequelae. The review of treatment literature presented in Chapter 1 also highlighted some of the shortcomings of existing interventions for CSA survivors, and adolescents in particular. This understanding forms the bedrock for phase two of the developmental intervention research process. The remaining components of phase two require that natural examples (i.e. existing treatment programs) and functional elements of successful models are identified and evaluated. This is the focus of Study 1 and is described in this chapter.

The proposition of the developmental intervention approach is that by studying natural examples of a how a problem has been or is being approached, useful and rich information is obtained. Insight into variables that affect the success of an intervention and the reasons why it may or may not succeed are then afforded (Fawcett et al., 1994). In this vein, by studying unsuccessful programs and practices, knowledge is also advanced (Thomas, 1984). In the current study, a locally available group treatment program for adolescent girls who have experienced sexual abuse was identified as an ideal natural example. Indeed, this program (the Parents and Children’s Therapeutic Service [PACTS] adolescent girls group) was the only one of its kind operating in the Perth metropolitan area at the time of this research. It was the only place that adolescent girls could seek the support of other adolescent CSA survivors. Upon commencement of this study, this program had not
undergone a methodologically rigorous evaluation and as such there was no ‘hard’ evidence that the program was achieving its goals and, most importantly, doing no harm. Furthermore the agency identified that the program had been run in many differing ways over the five years since its inception. These various formats included an unstructured youth group format, the Promoting Adolescent Sexual Health (PASH) program (FPWA, 2000) and a hybrid of Munson and Riskin’s (1995) and Mandell and Damon’s (1989) programs (these programs are described in greater detail in section 3.4.3). To my knowledge none of these programs had been empirically evaluated to date. Thus the aim of Study 1 is to evaluate the PACTS program. In conducting an evaluation of this naturally occurring program, the views and concerns of consumers of the service will be tapped, functioning and non-functioning components of the treatment identified, a comparison with best practice treatment literature undertaken and most importantly, this approach ensures that the proverbial wheel is not reinvented in the current projects attempt to establish an evidence based treatment for adolescent survivors of CSA.

In addition to studying natural examples, the developmental intervention approach suggests that it is also important to compare the critical features of past programs as it allows for a synthesis of knowledge and directs the design of future programs. In undertaking this process, model programs that have been successful in changing targeted behaviours and outcomes should be identified. The review in Chapter 1 determined that the most successful programs to date for CSA survivors are those based on TFCBT (e.g. Berliner & Saunders, 1996; Deblinger et al., 2001). Nevertheless other models have also been shown to be somewhat effective and may have elements to add (e.g. Kambouridis & Jevtic, 2002; Lindon & Nourse, 1994). In identifying successful models, specific procedures used in these programs should be noted, including intervention aims and techniques, common factors such as the therapeutic relationship, specific components of the treatment (e.g. group
composition and structure) and so forth. Barriers to success should also be identified where possible. Furthermore it is important to identify unsuccessful models and determine if there is anything about these programs which should be omitted. The following section begins with a recap of the knowledge identified in Chapter 1 with regard to treatment programs. A synthesis of other important functional elements of group treatment for CSA survivors is then presented. This information is then used as a metric against which to evaluate the PACTS girls group.

3.1 Identifying Functional Elements of Successful Models

Prior to reviewing the functional elements of successful treatment models for CSA survivors, it is useful to recapitulate what is already known about group treatment from Chapter 1. The review of group treatment for survivors of CSA suggested that this modality of therapy has been shown to be beneficial in alleviating distress across a wide range of symptoms (e.g. depression, anxiety, PTSD) (e.g. Berliner & Saunders, 1996; Deblinger et al., 2001; Kambouridis & Jevtic, 2002; Sinclair et al., 1995). Whilst a number of different treatment approaches were available for CSA survivors, there appeared to be a great deal of similarity across the treatments. Specifically the majority of treatments had similar objectives as described below:\footnote{Refer to page 49 of Chapter 1 for further details}:

- To disclose and discuss the abusive experience
- To identify and process emotions associated with CSA
- To alleviate the shame and guilt associated with CSA
- To improve self esteem
- To alleviate symptoms associated with CSA (e.g. depression)
- To learn coping skills and correct cognitive distortions
- To learn self protection skills
- To learn about sexuality and sex education
- To discuss the dynamics of the abusive experience
- To improve family and social relationships
Overall it was suggested that treatment should teach skills, as well as have educative and therapeutic components (e.g. Lindon & Nourse, 1994). Many of the goals presented were consistent with what adolescents themselves reported to be important in treatment, that is, being believed and supported, having the opportunity to talk about the abuse specifically, and being able to talk about feelings and attending a group with people who share similar experiences (Nelson-Gardell, 2001). Thus whilst no empirical evidence was available to support this, it is argued in this thesis that group process and common factors are particularly important to the outcome of therapy. These factors are more difficult to focus on in the review to follow due to the lack of research into this topic with CSA group programs, but it is noted that these factors are important to consider when evaluating what makes a program successful.

As highlighted in Chapter 1, little research in the area of group treatment for CSA survivors has focused specifically on what makes treatments work, thus it is useful to analyse the specific components/elements and clinical consensus across treatments about the factors that are likely to be important. In addition to the specific treatment model and its aims and objectives, it is also important to consider factors such as group composition (i.e. number of participants, age of participants, gender, type of abusive experience); facilitation (i.e. number and gender of facilitators); and structure (i.e. open versus closed membership, structured versus unstructured format, length of treatment, refreshments). Such factors are important as they have the potential to impact on the outcome of the treatment. Furthermore an understanding of these factors must be gained in order to direct the evaluation of the PACTS girls group and make decisions about the programs viability to become an evidence based treatment. Each of these factors will now be considered.
3.1.1 Model Programs for CSA Group Therapy

General approach

The National Crime Victims Research and Treatment Centre has recently undertaken an intensive review of available interventions for children who have experienced physical or sexual abuse and have produced guidelines to ensure that evidence based treatment is being provided to child and adolescent survivors of abuse (Saunders, Berliner & Hanson, 2004). The review was undertaken by a committee of well known researchers and practitioners in the United States (e.g. Lucy Berliner, Judith Cohen, Esther Deblinger & Anthony Mannarino). Interventions were classified according to the theoretical, clinical and empirical support available for their use. Treatments received a rating of (1) well supported and efficacious; (2) supported and probably efficacious; (3) supported and acceptable; (4) promising and acceptable; (5) innovative or novel; or (6) concerning treatment. Classification was based on whether there was a sound theoretical basis to the treatment; a substantial clinical-anecdotal literature for the treatment; the treatment was accepted in clinical practice; there was no report of substantial risk of harm; the treatment was manualised; at least two randomised controlled trials had been conducted indicating efficacy of the treatment; and the overall weight of treatment outcome studies supported the efficacy of the treatment (Saunders et al., 2004). These guidelines suggest that treatments that have been demonstrated to be successful adhere to the following six fundamental principles:

- They are goal directed – using specific measurement techniques to identify problems and create treatment plans;
- They are structured – using specific procedures and techniques;
- They involve skill building – children are taught specific skills to manage distress and behavioural disturbance;
• They involve repetitive practice with therapist feedback;

• Key components include:
  o Emotional identification, processing and regulation;
  o Anxiety management skills;
  o Identification and alteration of maladaptive cognitions;
  o Problem solving skills;

• They address the child’s environment (where possible).

(See Saunders et al., 2004, p.104-105 for further details)

Furthermore the guidelines propose 22 treatment principles that the authors suggest should be followed to ensure that the treatment is both evidence based and ethically responsible (see Saunders et al., 2004, p.106-108). The principles most relevant to the current research are highlighted below:

• Interventions should be based on well conducted assessments of both abuse related and general mental health;

• Interventions should be abuse informed – that is, interventions should specifically address the abusive incident and the resultant emotions, behaviours and cognitions;

• Abuse related problems should be the central organising focus of treatment;

• Treatment length should be short to moderate – 12 to 24 sessions;

• Treatment should incorporate preventative strategies (e.g. to prevent revictimisation or future risk taking behaviour).

It is noted that the interventions which best espouse these principles are those which utilise cognitive behavioural techniques and procedures. It is acknowledged that these recommendations may be limited by a lack of systematic evaluation of alternative treatment models and a publication bias towards CBT (DeRubeis & Crits-Christoph, 1998). However, the fact that the guidelines were produced by a committee of experts from diverse fields...
adds significant credibility to the recommendations that have been made. Overall these guidelines and recommendations appear to provide a sound approach to evaluating a treatment program for CSA survivors and so they were used in this study as a standard against which to evaluate the PACTS girls group.

One limitation of the review conducted by Saunders et al. is that they did not consider common factors and therapeutic process as substantial factors accounting for a large proportion of the variability in treatment outcome. The approach taken by Saunders et al. is certainly more aligned with an empirically supported treatment approach (as opposed to evidence based practice) but nevertheless the guidelines produced and presented here do appear to be sound and form a solid base for evaluating best practice. Whilst it would have been appropriate to include process and common factors at this point, as indicated previously these factors are yet to be systematically explored with the CSA population thus we can only speculate from other research that in addition to the guidelines presented by Saunders et al. that group process and common factors will also be important to consider in evaluating the impact of a treatment program.

Specific model

In addition to the general guidelines presented above, it is important that a specific treatment model or models are also identified to guide best practice. The evidence presented in Chapter 1 suggested that TFCBT was one appropriate treatment model for CSA survivors. This is further supported by the findings of Saunders et al. (2004), where TFCBT was the only treatment of the 24 reviewed to receive a rating of ‘well supported efficacious.’ It is for this reason, as stated in Chapter 1, TFCBT will be identified as the treatment model and theoretical basis for best practice in this project. As such it is useful at
this point to review the major tenets of a TFCBT approach so that the PACTS program can also be evaluated against these tenets.

TFCBT is conceived as the incorporation of well established intervention strategies to target the specific presenting symptoms of CSA survivors, plus the inclusion of abuse focused education and preventative strategies (Saywitz et al., 2000). Finkelhor and Berliner (1995, p.1419) conclude that the general elements of abuse specific treatments are:

1. Encouraging the expression of abuse related feelings (e.g. anger, ambivalence, fear);
2. Clarifying erroneous beliefs that might lead to negative attributions about self or others (e.g. self blame);
3. Teaching abuse prevention skills;
4. Diminishing the sense of stigma and isolation through reassurance or exposure to other victims (e.g. through group therapy).

Finkelhor and Berliner also indicate that there are a number of assumptions which underlie this approach. These include that the abusive experience has specific outcomes and effects; that therapeutic intervention should aim to be both ameliorative and preventative; and that it is helpful for children and adolescents to understand the link between their abusive experience and their current distress. TFCBT typically has four main therapeutic components. These include coping skills training, gradual exposure and direct discussion of the abusive experience, cognitive and affective processing and educational components (related to CSA, sexuality and personal safety) (Deblinger & Heflin, 1996; Cohen et al., 2000). The aims and objectives of TFCBT are typically the same as those presented in section 3.1.

Whilst the guidelines presented by Saunders et al. (2004) and the specific elements of the TFCBT treatment approach detail the best practice intervention to be taken, it is also of
practical use to understand what the research evidence and/or clinical consensus tells us about the nuts and bolts of group therapy in terms of composition, facilitation and structure. These are examined in the following section.

### 3.1.2 Specific Components

This section aims to specify the components of group therapy necessary to conduct a group for CSA survivors. Specifically this section is interested in what group therapy should ‘look like’ in terms of its structure, who runs it, who attends it and for how long. Each of these factors are likely to mediate treatment outcome. It should be noted that the proceeding discussion is based primarily on theoretical argument, evidence from other areas of clinical practice, and clinical acumen rather than empirical evidence, as to my knowledge there is no primary research which specifically investigates each of these elements for CSA interventions. Thus the validity of the conclusions drawn in this section will be evaluated through successive stages of the current research.

**Group composition**

Group composition factors are very important to consider in the development of a treatment group. While many clinicians have commented on what they feel is the appropriate composition for a group of children or adolescents who have been sexually abused, no empirical research to my knowledge, has yet investigated these factors. As such the information presented below represents consensus in the literature.

- **Optimum Number of Participants**

  The size of any therapeutic group depends upon the age of the clients, experience of the leader(s), the type of group and the focus of the group. The general group treatment literature suggests that for an adolescent group 6-8 members would be appropriate (Corey
& Corey, 2006). A number of other researchers also suggest that a group size of 6-8 members is optimal to facilitate group process with child and adolescent CSA survivors (Berliner & Ernst, 1984; De Luca, Boyes, Furer, Grayston & Hiebert-Murphy, 1992). de Young and Corbin (1994) suggest that a trauma focused adolescent group should have no more than six members due to the nature of the material likely to be covered in the group.

- **Age of Participants**

Due to the developmental needs of different age groups it is optimal to ensure that children are grouped accordingly (Sirles, et al., 1988). However as Trolley (1995) suggests, rather than focusing on a specific age range it is best to evaluate the developmental level of each potential group participant and the needs that are required of the group. As a guide Trolley (1995) suggests that 12-18 years is functional for an adolescent group. It is noted that the majority of group treatments for adolescents presented in Table 1.1 concur with this recommendation (with the exception of Furniss et al. 1988 & Thun et al., 2002). However I would argue that it may be more beneficial to split this into two age groups of 12-15 and 16-18 years given the differing developmental focus of middle and late adolescence (Peterson, 1996). Typically middle adolescence is more focused on physical changes and body image and teens are much more likely to take risks and be influenced by their peers. In contrast in late adolescence, teenagers can be expected to be much more independent, have greater capacity for abstract thought and be more focused on individuation. As such their focus for therapy is also likely to be different.

- **Gender of group members**

The majority of group programs recommend same sex groups. Only 3 of the 24 articles reviewed in Chapter 1 included both males and females in their groups. In all of these cases the groups were for children under the age of 13. From a clinical perspective it would seem
that it is most appropriate for adolescent groups to be of the same gender as opposed to mixed groups, to manage discomfort or the potential for seductive behaviour.

- **Type of abusive experience**

  The notion that children or adolescents who have been sexually assaulted (i.e. raped) may not be appropriate to join a group with children or adolescents who have experienced ongoing sexual abuse is discussed in the clinical practice literature (deYoung & Corbin, 1994). Similarly, differences are discussed between intra and extra familial abuse. Little explanation is offered as to why these two forms of abuse should be delineated. Ultimately this may be an issue for the agency as many of the issues faced by these respective groups are similar. For example, it may make more sense to determine the inclusion of a group member based on their level of distress and the impact of CSA on their life rather than the type of abuse they have experienced (Hazzard, King & Webb, 1986). It may be more likely that children who have been sexually abused over a period of time may require more extensive intervention perhaps in the form of individual therapy. But as the transactional model (Nurcombe et al., 2000) attests, the outcome of CSA is likely to be mediated by a number of factors some of which are related to the abuse experience, but that post disclosure factors and factors related to the individual child are equally important. An in depth intake interview is required to determine if the child is appropriate for a group rather than excluding them based on their experience. That is, it is more important to investigate the way in which the experience has impacted upon the child or adolescent rather than including or excluding them from therapy based on the type of experience endured. However it is also recognised that group therapy should not be traumatising and as such contact and non contact sexual abuse survivors are unlikely to be appropriate in the same group.
• Other Factors

In considering the inclusion of a survivor of CSA in a group program there are a number of other factors that should also be taken into consideration. They include whether the child has a support system available, whether they have some level of insight to be able to work effectively in the group and most importantly whether they understand the nature of the group and have a willingness to disclose their story when they attend (deYoung & Corbin, 1994). Finally it is also important to consider the child’s environment and that they are safe from further harm (deYoung & Corbin, 1994).

In drawing the information about group composition factors together, it seems that a group therapy program for adolescent CSA survivors is likely to work best with between 6-8 participants aged 12-15 or 16-18 years and be of the same gender. Beyond these factors, it is suggested that potential group members are carefully screened before admitting them to a group to ensure that (i) the survivor is ready for and will cope with the group environment and (ii) that the type of abusive experience between group members is not too dissimilar to prevent traumatisation of survivors who have experienced less severe forms of abuse.

Group Facilitation

Most of the groups reviewed in Chapter 1 used two female therapists. There is disagreement about the appropriateness of having a male therapist facilitate a girls group and vice versa for boys (Berliner & Ernst, 1984; deYoung & Corbin, 1994). Trolley (1995) suggests that the inclusion of male leaders in an adolescent girls group can induce seductive behaviour and create discomfort. It is thought that two females would generate more trust and openness within this type of group (deYoung & Corbin, 1994; Donaldson & Cordes-Green, 1994). On the other hand it could be argued that having a male facilitator may assist group members with a corrective experience in terms of having a healthy male
role model in their lives (Hazzard et al., 1986; Trolley, 1995). Ultimately I would argue that what may be the most important characteristic is that facilitators are warm, empathic, understand the dynamics of CSA and are comfortable with the subject material. This decision may also have to be pragmatically based upon the staff available to facilitate such a program. Nevertheless the most conservative position to take would be to have facilitators of the same gender as the group participants when working with adolescents to eliminate any potential difficulties and allow participants the maximum potential to process their experience of CSA.

In general practice, a co-leadership model is the rule rather than the exception. Co-leadership has many advantages, most importantly the ability to give balanced attention to both group content and process (Poels, 1996). Other advantages include having more resources available to the group, division of labour, and role modelling to the group. A sense of permanency can also be conveyed as the group can continue even when a therapist is absent (De Luca et al., 1992; Kitchur & Bell, 1989).

Until further empirical investigation has looked into this issue, a conservative position might suggest that group therapy for adolescent CSA survivors is facilitated by two clinicians that are the same sex as the participants in the program.

**Group Structure**

- Length of treatment

Of the articles reviewed in Chapter 1, the length of treatment ranges from four weeks through to two years. The length of each session is also variable ranging from 50 minutes to all day sessions. Treatment length is likely to depend upon the theoretical model, aims of the treatment and also the resources available (Donaldson & Cordes-Green, 1994).
Treatment length may also depend upon whether the group has open or closed membership and the level of structure as described below. The treatment guidelines for CSA suggest that a short to moderate (12-24 sessions) length of treatment is most appropriate depending on the presenting problem (Saunders et al., 2004). It would be expected that short term groups i) minimise the level of client dependence; ii) maximise the level of commitment from participants; and iii) provide clear boundaries that are typically lacking in many of these children’s families. As such short to moderate treatment length (12-24 sessions) is optimal in the current context.

- **Open v. Closed membership**

  Group therapy may either have open or closed membership. In open membership groups new members may be added throughout the course of the program. Open groups appear to have been used in the treatments presented in Table 1.1 when therapy was provided over a longer period of time and were usually treatment modalities other than CBT. There is little empirical evidence to suggest that open or closed membership is more advantageous for CSA survivors. Trolley (1995) points out, closed groups are preferable given the intensity of, and trust associated with, CSA group’s in which highly personal and traumatic information is divulged. In addition it may be unrealistic to expect young women to attend a program for a lengthy period of time. Given the short term nature of most therapeutic interactions (as recommended above by Saunders et al. 2004), a closed group appears to be most appropriate.

- **Structured v. Unstructured format**

  Structured treatment programs typically have set topics for each session of the program. Structured approaches to treatment are generally employed when the duration of therapy is limited. This is to ensure that the group members gain the maximum amount of exposure to
relevant issues and do not get distracted in irrelevant tasks. The following advantages of a structured approach are highlighted by Trolley (1995, p.108):

- Highly intense emotional issues related to the abuse are provided with an avenue to be explored via concrete materials
- Tangents are decreased and focus on pertinent issues is enhanced

A structured approach also:

- Increases the involvement of quiet members
- Activates group process when the group becomes stuck
- Assigned homework can speed up the process, clarify issues and foster feelings of control

Some cautions to a structured approach are also warranted. Facilitators need to be aware that the group does not become too rigid, that the group is able to complete the tasks assigned, and that the tasks fit with the needs of the group rather than merely ascribing to the next page of the treatment manual (Trolley, 1995). Given the previous recommendation for a short term, time limited treatment approach with adolescent girls, a structured approach to treatment is also recommended.

- Refreshments

Whilst it may seem like a trivial issue, whether refreshments are provided is important. The provision of refreshment is seen as a symbol of nurturance and can thus be very meaningful to the group members. It is also thought that snack time provides group members with the opportunity to develop their social skills and relationships with other members of the group (Hazzard et al., 1986; Poels, 1996)

Thus in terms of structuring a treatment program for CSA survivors the available evidence suggests that decisions must be largely based on the length of the treatment. Given the
CSA treatment guidelines (Saunders et al., 2004) suggest a short to moderate length, it follows that the treatment should also have closed group membership and structured activities. The treatment should also include refreshments.

### 3.1.3 Treatment Failures

Perhaps due to a publication bias it was very difficult to identify any true treatment failures which may help to direct what to avoid or omit in a treatment program for adolescent girls. However there is some research to suggest that some CSA sequelae (e.g. sexualised behaviour) are more resistant to intervention than other sequelae (e.g. encopresis or enuresis) (Lanktree & Briere, 1995; Finkelhor & Berliner, 1995). Finkelhor and Berliner (1995) report that there is a need to determine and understand treatment failures.

### 3.1.4 Summary of Treatment Issues

On the basis of this review, it appears that a trauma focused group therapy for 6-8 adolescent girls aged 12-15 years is a valid approach to intervention with this population. Furthermore the consensus of the literature reviewed suggests this treatment should be closed, structured, approximately 12-24 sessions in length, facilitated by two female therapists, and include skills, educative and therapeutic components. This information is summarised in Table 3.1 and is used as the best practice standard against which to judge the PACTS program in the current study and guide the establishment of an evidence based treatment. It is recognised, and was stated from the outset, that the literature on which these conclusions are based was not extensive and that the possibility of other options are viable alternatives, particularly the role of group process and common factors of therapy. However it was important to develop some guidelines on which to base the evaluation.
Table 3.1 Overview of Best Practice Principles for CSA Group Therapy with Adolescent Girls

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Consensus of the available evidence</th>
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<tbody>
<tr>
<td><strong>General Principles</strong></td>
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<tr>
<td>Theoretical model</td>
<td>TFCBT</td>
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<tr>
<td>Aims and Objectives</td>
<td></td>
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<tr>
<td>General</td>
<td>Clearly stated</td>
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<td>Skills</td>
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<td>Educative</td>
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<tr>
<td>Therapeutic</td>
<td></td>
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<tr>
<td>Specific</td>
<td></td>
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<tr>
<td>To disclose and discuss the abusive experience</td>
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<tr>
<td>To identify and process emotions associated with CSA</td>
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<tr>
<td>To alleviate the shame and guilt associated with CSA</td>
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<td>To improve self esteem</td>
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<td>To alleviate symptoms associated with CSA</td>
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<td>To improve family and social relationships</td>
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<tr>
<td>Assessment</td>
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<td>Intake assessment to make judgement of inclusion</td>
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<tr>
<td>Pre and post group</td>
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<tr>
<td>Assessment to guide treatment</td>
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<td><strong>Group Composition</strong></td>
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<td>Number of Participants</td>
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<td>Age of Participants</td>
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<td>Gender</td>
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<td><strong>Facilitation</strong></td>
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<tr>
<td>Duration</td>
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<tr>
<td>Refreshments</td>
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</tr>
</tbody>
</table>

3.2 AIMS & RATIONALE OF STUDY 1

The aim of Study 1 is to evaluate a locally available group treatment program for adolescent girls who have experienced sexual abuse. The main purpose of evaluating this program in Study 1 is to determine if the PACTS program in its current state is robust enough to
undergo evaluation or whether it requires refinement first. That is, Study 1 will try to
determine if the PACTS program has been successful in the past and if it fits with best
practice criteria outlined. If so, the PACTS program will be used in Study 2 and 3 in an
attempt to rigorously evaluate it and demonstrate that it is evidence based. If however the
findings of this study suggest that the PACTS program does not meet best practice or has
not been successful, a new program will be developed. If this second scenario is true, the
information gathered from this evaluation will be valuable in that specific knowledge about
treatment for CSA survivors can be drawn together which is simply unattainable through
reviewing treatment outcome studies. Recommendations can then be made as to the
potentially useful elements of the PACTS program. In undertaking this evaluation, where
possible the principles of evidence based practice will be applied. That is, consideration will
be given not only to the treatment program and how it affected the outcome of past clients,
but also the role of group process and common factors and their impact on outcome.
However, it is noted that given that this study is largely retrospective, it may not always be
possible to assess such factors.

To evaluate the PACTS program, key indicators of program success as identified from
Chapter 1 will be used. These include evidence of successful completion of the program,
alleviation of distress and negative sequelae, acceptability of treatment and knowledge
retention. In addition the program will be evaluated against best practice treatment as
identified in the literature review. The evaluation of the PACTS program will take a three
phased approach as indicated below.

Firstly, a review of archival data will be undertaken that pertains to the PACTS adolescent
girls group participants. It is hoped that by assessing these data a clearer picture of the past
groups will be provided and a sense gained of whether the past groups had been
successful. Secondly, it is planned that past participants of the PACTS adolescent girls group and a non-offending parent be followed up via a survey to determine current functioning, satisfaction with the program and knowledge retention. This datum would elaborate upon and compliment the evidence collected from the archival data. Finally, the curricula used by PACTS in their girl’s group program will be compared to best practice treatment literature for children and adolescents who have experienced CSA as presented in Table 3.1.

Specifically the study aims to answer the following questions:

- Is the PACTS program effective in alleviating distress and helping adolescent CSA survivors to process their experience of sexual abuse?
- If the program is effective, what elements of the program make it effective/successful? If the program is not effective, what elements of the program make it ineffective/unsuccessful?
- What do past participants and their mothers think about the program? What elements do they feel should be included in an adolescent CSA survivor group therapy program?
- Does the past curriculum used by PACTS fit within best practice guidelines presented for adolescent girls who have experienced sexual abuse?

Dependant on the answers to these questions and the conclusions drawn in this study, decisions can be made on how the remainder of this project will progress.

3.3 Method

3.3.1 Research Design & Analysis
The design used in Study 1 was a retrospective program evaluation using both prospectively and retrospectively collected data. As explained above, this evaluation involved collecting data from three separate sources, namely, archival program statistics, past participants of the program and a review against best practice evidence.

Archival data was provided by PACTS for analysis. The data were analysed qualitatively and combined with information provided by PACTS staff to give a picture of past groups and how effective they had been. Information was collected from past participants via a mail out survey, these data were analysed quantitatively and qualitatively. Finally the review of PACTS curricula was conducted by comparing how similar it was to the elements outlined in Table 3.1. These three information sets (archival data, past participant report and comparison with best practice) were then triangulated (see Figure 3.1) to provide a clearer picture of the functional elements of the PACTS adolescent girls group. It also allowed for recommendations to be made about the refinement and/or development of the treatment program to be used in Study 2. The process of triangulation contributed to the verification and validation process of this evaluation. That is, it allowed for the consistency of the findings generated by the three separate sets of information to be compared to determine if the results converged or diverged (Patton, 1990). By combining these three data sets a more comprehensive understanding of the PACTS program will be provided.

Figure 3.1. Depiction of the triangulation process that occurred following data collection to form recommendations for the new treatment program.
3.3.2 Participants

Although not research participants in its truest sense, archival data were made available by the PACTS agency for 23 adolescent girls who had attended the girl’s group program between 2000 and 2003. These girls ranged in age from 12 to 15 years.

In the second phase of this project, past participants of the PACTS girls groups and their primary carer were invited to participate in the prospective evaluation of the PACTS group. Twenty past participants² of the girls group were identified for inclusion in the study by PACTS staff however, current contact details were only available for 10 of these girls. Eight families verbally agreed to take part in the research however, only four parent responses and one adolescent response set were received despite numerous attempts to follow-up these participants (see procedure section).

As such four mothers and one adolescent took part in this phase of the research. The mothers of the adolescents who did not respond (n=3) reported that their daughters did not want to complete the questionnaire because it would be too difficult/painful for them to do so. Details of the participants who returned the survey are as follows:

MO1 – daughter 17yrs attended 10 sessions
MO4 – daughter 17yrs attended 19 sessions
MO5 – daughter 14yrs attended 30+ sessions (~1yr)
MO6 – daughter 15yrs attended 30 sessions (~1yr)

( Note. the participant’s daughters did not necessarily attend the same group; ages are age at the time of assessment not the age when attending the group)

MO5’s daughter also responded to the questionnaire. This participant took part in the most recent group run at PACTS in 2003.

² no explanation was offered by PACTS as to why 23 participants attended group but only 20 were identified by for inclusion in the prospective study
3.3.3 Measures

To assess the impact of past PACTS girls groups, background information was provided by the manager of PACTS and data in the archival database was examined. PACTS staff had recorded this data at the time clients were discharged from the service and included the following information:

- Service received (These were three options: girls group, individual therapy, protective behaviours)
- Reason for leaving the service (service completed, client withdrew, client referred back to referrer, other)
- Outcome (goal achieved, didn’t complete recommended program, referred on, plan changed, other)
- Number of hours of service received
- Risk of future abuse – the therapist made a rating on a five point scale from low to high
- Residual effects of trauma – rated on a five point scale from low to high. Lower scores indicate that the client feels guilt, self blame, has behavioural difficulties and little support. High scores indicate that the client felt no guilt or blame associated with CSA and had good support systems.

As mentioned in Chapter 2, all assessment tools that were developed for this study went through a process of evaluation with key stakeholders and my research supervisors to ensure that they met the needs of the study and were appropriate for a vulnerable client group. All measures are described below and can be found in Appendix A (with the exception of the TSCC as this is a copyrighted tool). To measure current functioning, knowledge retention and satisfaction with the program, each past participant was asked to complete the Trauma Symptom Checklist for Children (Briere, 1996b) and Resilience Scale (Wagnild & Young, 1993). The assessment of functioning, knowledge and satisfaction could
not be achieved with available psychometrically valid tests, thus psychometric tools were supplemented by measures which I developed in consultation with my supervisor and PACTS staff. Additionally a demographics survey was undertaken and a questionnaire designed to assess retention of knowledge of group content. Risk factors and mood were also assessed. A Consumer Satisfaction Questionnaire was also constructed. Parents were asked to complete the Risk Factors and Mood Questionnaire and the Consumer Satisfaction Questionnaire only as the other scales do not have parent versions. Measures are summarised in Table 3.2 and discussed below.

Table 3.2. Summary of Measures used with Past Participants and their Mothers

<table>
<thead>
<tr>
<th></th>
<th>Trauma Symptom Checklist</th>
<th>Resilience</th>
<th>Retention of Knowledge</th>
<th>Demographic Risk and Mood</th>
<th>Risk Factors and Mood</th>
<th>Consumer Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Parent</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Psychometric tools:

*Trauma Symptom Checklist for Children (TSCC; Briere, 1996b)*

The TSCC is a 54 item self report instrument which consists of six subscales: anxiety, depression, PTSD, sexual concerns, dissociation and anger. Scores are presented as T-scores with scores above 65 considered within the clinical range; except for the sexual concern subscale where the cut off score is 70 (these cut points are represented by a dashed line on all graphs of TSCC data). Research on the TSCC suggests that it is both reliable and valid (Elliot & Briere, 1994; Friedrich, 1991; Singer, Anglin, Song, & Lunghofer, 1995). The TSCC has demonstrated high internal consistency with correlations of clinical scales in the range of .77 to .89. Convergent and discriminant validity have also been established by analyses of covariance with other available measures (e.g. CDI, CBCL, RCMAS, CITES-R) (Briere, 1996b; Evans, Briere, Boggiano & Barrett, 1994). Criterion
validity is also established (Briere, 1996b). The TSCC has been widely used within the CSA literature and was developed specifically for this purpose. It has advantages over generic measures of psychological functioning as it is sensitive to abuse specific symptomology. The TSCC measures the most common outcomes associated with childhood sexual abuse as indicated by its subscales listed above. The TSCC was used in this study as a measure of current psychological functioning. Given this scale's specific focus upon trauma related sequelae, it is argued that participants scoring within the clinical range on this measure are likely to not be coping with, or hadn't fully dealt with, their experience of sexual abuse.

Resilience Scale (Wagnild & Young, 1993)

The Resilience Scale is a 25 item self report questionnaire. All items are positively worded and responses are recorded on a 7 point Likert scale from 1 (agree) to 7 (disagree). Internal consistency is adequate (.76-.91) and correlations appear stable over time. Concurrent validity has also been demonstrated (Wagnild & Young, 1993). Principal axis factoring showed that the scale measures a single global resilience factor (Neil & Dias, 2001). Possible scores range from 25 to 175. Higher scores indicate a higher degree of resilience. There are no norms available for the scale however it is one of the few resilience scales available which is suitable for use with adolescents. The Resilience Scale was primarily used in the current study to assess the resilience of participants. It was expected that participation in a program such as the PACTS girls group would result in higher resilience scores. Scores above 100 on the scale were considered to demonstrate resilience as this was the mid point for the scale and no other criteria were available. The scale was included as resilience is a known mediator in the outcome of CSA (Spacarelli & Kim, 1995).

Tools developed for this study:

Demographics survey
Basic demographic data were also collected from the participants. This included living arrangements, occupation, relationship with the perpetrator, school performance, friendships, reasons for attending the group and understanding of the purpose of the group.

Retention of Knowledge of Group Content

To determine what past participants could recall from the program an open ended questionnaire was constructed. Given the potential for past participants from different treatment groups taking part in the research, the questionnaire needed to be designed to measure the different curricula (i.e. PASH or hybrid program) that these girls may have received. In this questionnaire participants were presented with a list of possible topics covered in the program and were asked to indicate which of those topics they could recall. If a topic was indicated, the participant was asked to write down what they could recall from that topic. Finally a 7 point Likert scale was presented at the end of the questionnaire, asking the participant how much they felt they could recall from the program ranging from 1 (nothing) to 7 (all of what was learned). It was important to attempt to measure retention of knowledge as one would expect that if the participant had no knowledge of the program they are less likely to have made functional gains in terms of moving through their experience of CSA or overcoming associated sequelae.

Risk Factors and Mood Questionnaire (adolescent and parent version)

To measure the wide array of behavioural symptoms often associated with CSA that are not necessarily associated with a DSM-IV diagnostic disorder, I compiled a list of known age relevant risk factors and associated behavioural manifestations based upon the CSA impact literature discussed in the Chapter 1. The list included items such as substance abuse, trouble with the police, suicide attempts, suspension and revictimisation. A total of 27 items were included on the list. Participants were asked to indicate their responses based on the
frequency of these behaviours in the preceding three months, on a scale which included the following options: never, sometimes, often or don’t know.

To assess emotions, attributions and cognitive distortions that are often reported as sequelae of CSA, participants were presented with a mood scale. This scale was developed on the basis of the impact literature and tapped the following 12 feelings and thoughts: happy, relaxed, unwanted, misunderstood, angry, guilty, different, in-control, ashamed alone, safe and confident. A mix of positive and negative feelings were presented. Participants were asked to respond to the question “In the past 7 days have you/your daughter felt …” on a 7 point scale ranging from 1 (not at all) to 7 (most of the time). This measure was included in the current battery as a way of determining current functioning and current impact as a result of CSA.

*Consumer Satisfaction Questionnaire (adolescent and parent version) (CSQ)*

A CSQ consisting of 11 questions rated on a 7 point scale was also administered. These questions aimed to assess the level of satisfaction and acceptability of the treatment. Assessing consumer satisfaction is also one way of assessing process and common factors retrospectively. The scale asks consumers to rate the quality of the service they received, the extent to which it met their needs, how much they enjoyed attending, how satisfied they are and how beneficial the program was. The scale is scored out of 77. Higher scores indicate greater satisfaction with the program. Six open-ended questions were also included. These questions assessed participant’s/parents likes and dislikes relating to the program; changes they would make; and whether they would recommend the group to other girls.
3.3.4 Procedure

The three phases of Study 1 (i.e. the archival review, past participant’s survey and best practice review) were undertaken concurrently. To conduct the archival review, PACTS staff provided me with non-identifying archival data for the purposes of reviewing the effectiveness of past girls groups. To undertake the review of the past girls groups, PACTS staff contacted past participants and asked them to take part in a review of the program. The participants were offered various methods by which they could provide the data (mail out, telephone interview, face to face meeting). All past participants who consented to the study chose a mail out. Included in the mail out was a letter from PACTS outlining the purpose of the project, a copy of the participant information sheet and consent form from the researcher, as well as the questionnaires outlined above (available in appendices A & B). If participants had not returned their assessment package within two weeks they were contacted by PACTS staff to determine the reason for the delay. Alternate data collection methods were again offered at this point, however all outstanding participants again chose to complete the data via mail out. In two instances the questionnaires were re-sent to the family as they had been misplaced. Participants were given another two weeks to respond before being contacted again by PACTS staff. Participants were not contacted again if the materials were not returned, as it was felt that this would be too intrusive. Finally, the PACTS girl’s group curricula was compared to that of best practice as presented in Table 3.1. This involved sorting through the PACTS treatment program and comparing and contrasting its contents and structure with that presented in Table 3.1. This information was then summarised in a table of its own. Once all data were collected and analysed, it was triangulated to answer the research questions and form recommendations for the future of the program as described in 3.3.1.
3.4 Results & Discussion

3.4.1 Program Statistics

As an initial starting point, archival data collected by facilitators of past groups was analysed. Data were available for the years covering 2001 – 2003. Four girls groups were run over these three years, with a total of 23 participants. Summary information for each of these groups is presented in Table 3.3.

Table 3.3 Overview of the Girls Group Programs run at PACTS from 2001 to 2003

<table>
<thead>
<tr>
<th>Curriculum</th>
<th>Year</th>
<th>No. of referrals</th>
<th>No. of completers</th>
<th>No. of successful completers*</th>
<th>No. of sessions</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>2001</td>
<td>10</td>
<td>7</td>
<td>5</td>
<td>Variable: 4-33</td>
<td>Open membership</td>
</tr>
<tr>
<td>Unknown</td>
<td>2002</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>Variable: 1-33</td>
<td>Open Membership</td>
</tr>
<tr>
<td>PASH; Unstructured</td>
<td>2003</td>
<td>7</td>
<td>4</td>
<td>0</td>
<td>Variable: 6-20</td>
<td>Facilitator resigned; group finished prematurely</td>
</tr>
<tr>
<td>Hybrid Mandell &amp; Damon;</td>
<td>2003 Term 4</td>
<td>4</td>
<td></td>
<td>Statistics not appropriate as group was disbanded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Munson &amp; Riskin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* According to ratings by facilitators at discharge

The data shows that of 27 girls referred to the program, 23 girls began the program, 16 completed the program and only 6 girls successfully completed the program according to subjective facilitator ratings of outcome. One interpretation of such a finding is that the PACTS Girls Group program was not successful at achieving its stated aims. However given the crude methods by which successful completion was assessed (i.e. ratings of: goal achieved, didn’t complete recommended program, referred on, plan changed, other) this is perhaps a dubious conclusion. Moreover analysis of each individual participant’s profile suggests that the majority of participants continued to attend for more than ten hours of
intervention which suggests that they were receiving something beneficial from the group. Thus perhaps the rating scale of outcome was ineffective and did not measure the aspects of successful program completion comprehensively. That is, success had been measured only on the fact that the participant completed the program and that the clinician felt that the residual effects of trauma had been reduced. Whilst the clinician’s opinion is valuable, outcome should not be purely based on the findings of one measure or the opinion of one person. As indicated in Chapter 1, it is recommended that outcome from CSA interventions be assessed by using multiple measures and multiple informants. Furthermore pre-intervention measures must be taken as a point of comparison (which did not occur at PACTS) as it may be unrealistic to expect full symptom alleviation. Thus few conclusions could be accurately drawn from the data routinely collected by this agency. This highlights one of the major difficulties in this field, namely that many programs are run with little data gathered regarding its impact or outcome.

Information provided by the manager of PACTS indicated that the girl’s group program had undergone a number of transitions and the curricula had changed on the basis of the staff member providing the program. At least two of the groups appear to have been open membership groups and it is difficult to ascertain the length of each group and the reasons participants stopped attending the group. Another observation taken from reviewing the database and information provided by the manager of PACTS is that the group suffered from drop-outs, inappropriate referrals and/or relatively low numbers in general. The number of referrals also appeared to have declined noticeably over the years. Without knowing the history of the program it is difficult to make an interpretation of causal factors for this. One plausible explanation is that it is difficult to engage adolescent girls in the process of a group program. Research also indicates that the thought of attending a group is quite anxiety provoking for adolescent girls (Kambouridis & Jevtic, 2002; Nelson-Gardell,
2001). Drop-outs may also have been associated with inappropriate screening methods and may suggest that the program was not appropriate for all adolescent CSA survivors. Notably there was no assessment of clients pre-existing level of symptomatology or the nature of those symptoms.

These results highlight the importance of ongoing accountability and responsibility and the need to evaluate every treatment that is provided to clients simply for the purposes of quality assurance and program improvement. This program continued to receive funding and was providing treatment to a highly vulnerable population and yet the only available evidence to this point appears to suggest that only 6 of 23 participants received benefit. If more appropriate formative evaluation of outcome had occurred following each treatment group, then areas of concern with the program could be identified, documented and the program improved to ensure that the participants were receiving the most benefit.

Overall the archival data presented a very ambiguous picture of the past PACTS girls groups. Assistance was sought from PACTS staff to help unravel this ambiguity however no adequate description was offered. At a minimum the available information suggests that further evaluation of the program is necessary. Hence, it was important to gather further data about the success of the program from past participants. This formed the second phase of this study.

### 3.4.2 Follow-up of Past Participants of the Girls Group and their Mothers

By investigating the experience of the PACTS girls groups from past participants and their mothers directly, information about what consumer’s value in a group treatment program for CSA survivors may be gleaned. The following sections present the reports from one past participant and four mothers about their experience of the PACTS Girls Group.
Response from a past participant

Past participants of the PACTS girls group were asked to complete questionnaires to determine their current level of functioning, knowledge of the program in which they participated and satisfaction with that program. One adolescent girl (PA5) (from a total of eight who agreed to participate) returned the questionnaire package. Her results are presented below. Three other girls whose mothers participated in this survey chose not to participate. Their mothers reported that their daughters felt it would be too distressing or would bring back painful memories when they currently perceived themselves to be functioning well. Two plausible explanations for this are that either the group was not in fact successful in assisting these girls with processing their experience of sexual abuse or that the girls did not feel an affinity or a connection to PACTS. In either case, this may indicate that the group program was not effective at helping these girls to move forward from their experience of CSA. In addition, the response from some parents that the questionnaire would bring back painful memories when their daughters were functioning well, suggests that adequate processing of CSA had not been achieved. With adequate processing it would be expected that these girls would be able to think and talk about their experience of abuse without fear of becoming distressed or overwhelmed.

It should be noted that PA5 participated in two groups, those run in semesters one and two of 2003 (one year prior to data collection). She therefore attended the group for a long period of time (4 terms). She attended three terms in the ‘PASH’ program which was largely informal. A change in staff at PACTS (term 4 2003) resulted in a change in the curriculum and the way group was run. The new staff members ran the group in a highly structured format, in contrast to the previous facilitator. It is reported in the file notes that the group members led a ‘revolt’ against the new facilitator and threatened to harm her. As a result of this and a group member leaving the group, the group was disbanded. Conceivably the girls
did not like the new structured format of the group, or their reaction was associated with the departure of the old facilitator. It is possible that after such a long time the girls had formed a strong attachment to the previous facilitator and the reaction may have been associated with this (e.g. grief and/or resentment) rather than the new curriculum. This interpretation is consistent with the comment made by the parent of PA5. She notes that “when the group finished she basically went off the rails – panic attacks, running away, self harm. It was like she lost her safety net or emotional outlet.” This comment also raises concerns about long term therapy with this population and the potential for vulnerable clients to form strong attachments with therapists. The general flavour of this past participant’s responses are very negative and angry in relation to PACTS as presented below.

The findings of the TSCC indicate that this girl was in the clinical range for all subscales except PTSD and anger, although anger was borderline (see Figure 3.2). This indicated a significant amount of psychological distress, which is emphasised by her reports of suicidal ideation on the TSCC. On account of this report, procedures were put in place whereby the participant’s mother was informed that her child was at risk and appropriate referral possibilities were provided. MO5 was keenly aware that her daughter was at risk prior to the phone call and noted that to date no service had helped her daughter.

![Figure 3.2. PA5’s Trauma Symptom Checklist subscales presented as T – scores.](Note. The dashed line represents the clinical cut point for the scale).
In addition to the TSCC, PA5 indicated that a number of risk factors associated with CSA were present (e.g. sleeping and eating problems, self harm, truancy, unwanted sexual advances etc.) and that she did not feel in control of life and reported that she dissociated frequently. Her emotions over the week preceding data collection demonstrated that she felt misunderstood, guilty, different, alone and unsafe (see Figure 3.3). These ratings are very similar to her mother’s ratings of PA5’s emotions and provide further evidence that PA5 was not coping, as shown in Figure 3.2. She further indicated that she was still in need of counselling. Her resilience scale score was 107/175 which was adequate and perhaps in contrast to her ratings of psychological distress as it is expected that those who are resilient would be less likely to present with psychological distress. However her resilience score may have been associated with other protective factors in her life such as the close relationship she had with her mother and religious beliefs and affiliation.

Overall the results provided by this girl suggested that she was facing a significant amount of distress, which she reported was associated with her experience of CSA. Her mother’s report concurs with this.
In terms of her satisfaction with the program, PA5’s responses were somewhat contradictory. For example she reported that she felt she benefited greatly from the group giving a score of 7/7, but overall she only scored 17/77 on the CSQ which suggests dissatisfaction with the service she received. This discrepancy may relate to whether she was rating semester one or semester two of the program. On account of PA5’s psychological state this disparity was not followed up with her as both PACTS, my supervisor and I felt it to be too intrusive. The ratings may be related to her current level of functioning. Given her level of distress she may have felt that the group was not helpful as she was still suffering despite attending a group for a long time which was intended to alleviate such suffering. Overall she reported feeling very dissatisfied with the service she received and would not recommend the program to other girls unless the original facilitator returned. She further added that the facilitators\(^3\) of the semester two program were “evil.”

With regard to the content of the program and the level of knowledge retained by the participant, she indicated that she could remember little of what was covered in the program despite attending the program for almost one year and completing the group less than a year prior to the current study. On a Likert scale ranging from 1 (remember nothing) to 7 (remember everything) she indicated a 3. This is despite demonstrating in the open ended section of the measure that she could recall much of the program contents. This included reproduction and contraception, sexually transmitted infections, sexuality, definition of sexual abuse, effects of CSA and the effects of CSA on relationships with others. It is interesting to note, but perhaps not surprising, that she could best remember the sexual health aspects of the program. This is likely due to the PASH curricula used in semester one of the 2003 program which had a primary focus on sexual health. However an alternate explanation is that the sexual health components had also been taught within the school environment which assisted her to retain the information. PA5 indicated that she recalled

\(^3\) the PASH program had one facilitator but the second program (term 4 2003) had two facilitators
little to nothing of the following topics: self esteem, assertiveness, conflict resolution and coping skills. It is possible that either these topics were not covered in the group that PA5 attended or she simply could not recall them. In either case, core elements of a TFCBT approach seemed not to have been acquired by this client.

The participant reported that the content of the group was what she expected to receive and that she understood that the purpose of the group was for girls to discuss their thoughts and concerns about CSA. In particular she noted that she wanted the group to provide her with assistance to manage the court process. The participant was asked on the questionnaire what she felt would be important to include in the group program if it were changed. She suggested that the group should cover in order of priority: i) processing of abuse ii) protection from further abuse iii) self esteem iv) coping skills v) improving relationships vi) friendships vii) sexual health and viii) communication. It is interesting that sexual health is so low on her priority list given that this was the bulk of what she received and remembered in the first semester of her program.

Mother’s responses

Four mothers completed a consumer satisfaction questionnaire and a risk factor and mood questionnaire relating to their daughter. A relatively high degree of satisfaction with the service was reported by three of the four mothers as indicated in Table 3.4. Interestingly PA5’s mother was much less satisfied with the program than the other mothers and this perhaps reflected the fact that her daughter remained symptomatic following attendance at the program.

Further inspection of the consumer satisfaction questionnaire showed that mothers gave lower ratings on the skills their daughters obtained after attending the group and their ability to deal better with life and family, relative to ratings of satisfaction with the program in
general. Two of the four mothers reported that they did not think the group was effective in helping their daughter to process their experience of CSA (MO4 & MO5), and another was unsure if the group was effective in doing this (MO1). That is, only one mother felt the group was effective in helping her daughter to process her experience of sexual abuse, which was the main stated aim of the program. In addition to feeling that the program was ineffective in this regard, three of the mothers (all except MO6) also indicated that the program was in need of changes. Despite this, three of the four mothers (all except MO5) indicated they would recommend the program to other families. This suggests that mothers feel that the program does serve an important function in the lives of these teenage girls, albeit not in specific attempts to alleviate or process CSA sequelae.

Table 3.4  Mothers Total Consumer Satisfaction Ratings

<table>
<thead>
<tr>
<th>Mother</th>
<th>CSQ /77</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>69</td>
</tr>
<tr>
<td>4</td>
<td>57</td>
</tr>
<tr>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>6</td>
<td>67</td>
</tr>
</tbody>
</table>

All four mothers reported feeling isolated from the group and unsure about what took place in the program. One mother noted “as a mother I often felt alienated from the program, particularly as I believe some healing together would benefit all.” Such observations from mothers reflects the consensus which is beginning to form on the basis of evidence presented in Chapter 1 which indicates that it is important to run concurrent parent programs when children and adolescents attend group therapy programs for CSA (Cocoran, 2004; Cohen & Mannarino, 1996a; 1998a). In addition to knowing what is going on in the group, the evidence suggests that if parents have the ability to support their children (Deblinger et al., 1999; Everson et al., 1989; Heriot, 1996), manage their own reactions to the abuse (Cohen & Mannarino, 1996a; Deblinger et al., 1999; Newberger, Gremy, Waternaux & Newberger, 1993), and access social support (DeVoss & Newlon,
1986) then their children will have better outcomes from CSA. Thus the addition of a concurrent parent group for the PACTS program may be worthwhile.

In terms of current functioning, all mothers reported that their daughters were having continued difficulties coping with some aspects of their lives as evidenced by the risk factors and the emotional difficulties reported. All four mothers reported a number of risk factors present for their daughters. In particular all four mothers indicated that their daughters had problems sleeping and concentrating and three mothers reported that their daughters had found themselves in dangerous situations in the month preceding data collection. Other risk factors reported by the mothers are more contextualised to the individual girls but included binge eating, defiance, suicidal ideation and alcohol abuse. The results of the emotion scale are presented in Figure 3.4. Similar to the risk factors, it is difficult to group the results of this measure as they appear to reflect different symptom constellations for each girl. Overall the ratings of their daughter’s happiness and relaxation appear to be particularly low. The mothers also indicate that their daughters feel angry and misunderstood. At a glance it appears that MO5’s daughter is coping least well.

![Figure 3.4. Mothers ratings of their daughter's emotions in the past week.](image-url)
The data provided by the mothers on both the mood, risk factor and consumer satisfaction questionnaires for the most part appeared in many ways to be contradictory but the flavour of the responses when taken together suggest the following:

(i) a belief that their daughter did in fact need assistance in processing their experiences of CSA

“[they] need something to help them feel less alone…to know there are others like them and to give them hope and encouragement – to walk the journey… to celebrate and grieve” (MO5)

(ii) a belief that a program such as the one at PACTS is a very important opportunity for such assistance to be provided

“Anything that allows children the opportunity to talk about their abuse in a safe environment, and be shown skills to help them deal with day to day life and issues that arise is important and should be provided” (MO1)

(iii) a belief that attendance at the group seemed to have some benefit for their daughter – this benefit appears to be in the supportive nature of the group and the ability to discuss feelings with others who have had a similar experience

“My daughter’s confidence/self esteem has risen considerably [as a result of the group]…It gave my daughter the opportunity to get her fears, anxieties and feelings of guilt out in the open” (MO4)

(iv) their daughter’s still seem to need significant assistance in processing their abuse after completing the group and so they conclude that the program did not fully meet their needs

“I feel my daughter has not yet solved her problem” (MO6)

“I don’t feel [my daughter] believes that the program helped in this regard [processing sexual abuse]” (MO4)
their ratings would seem to be supportive of a revamped program perhaps involving parallel parent involvement and more intensive contact with the girls

“I don’t exactly know what was taught/done/practised in the program but I know my daughter enjoyed going” (MO4)

“the girls need affirming and also time to let off steam and express themselves – in whatever way works for them. Out in the real world they have to hold it all together. In this group it should be ok to be real and still be accepted” (MO5)

Summary of past participant and mothers responses

Consistent with the findings of archival data presented in section 3.4.1, none of the four mothers indicated that their daughters were currently coping well. The sole past participant who responded also indicated that she was experiencing a significant amount of difficulty in terms of psychological functioning. In addition to this information, the fact that only one past participant and four mothers responded to the survey, offers a powerful suggestion that the group may have been ineffective, or at least did not create a sense of connectedness between program and participants.

Despite this, all five respondents indicated that having access to such an intervention in adolescence is important and that adolescents do in fact need access to such a program. The parents and past participant responses appear to suggest implementing a modified program which is more targeted at processing CSA than the previous groups they were involved in. From the perspective of the past participant, she felt the content of the program she attended was largely appropriate, although she reported abuse processing and personal safety skills should be the main priority of such a group. Mothers also highlighted their need to better understand what occurs in the group so that they can better support their daughters.
The importance of coping skills and generalisation of skills are indicated by the past participant. She reports that she can recall nothing of these skills and it is conceivable that they were not covered in her program. As the review in section 3.1 highlights, coping skills are crucial to any treatment program with CSA survivors (e.g. Deblinger & Heflin, 1996) and this may help to explain why PA5 was not coping well at the time of data collection. In addition to coping skills, this participant did not recall completing modules on relationships or self esteem. These are also highlighted as being important in the best practice evidence presented previously (e.g. Ashby et al., 1987; London & Nourse, 1994).

Even so, the utility of these findings are hindered by the low response rate and limited available information on the programs presented. The interpretation of such a result could suggest that there was, minimally, an insufficiently positive connection established with participants in the group such that they felt no inclination to comment on the group. Or perhaps the group was ineffective in assisting the girls to process their abuse such that they were still reluctant to reflect on that experience, even in the context of what was intended to be, a supportive group experience. Nevertheless other alternative less pathologising explanations can not be ruled out (e.g. they simply were too busy to complete it).

It is recognised that there are a number of mediating factors that may have hindered the data collection process. These include: i) length of time since completing the group (in some cases up to four years) ii) a sense of connection to the facilitators rather than the organisation iii) the adolescent or family’s current level of functioning. Nevertheless, a successful program would be expected to garner more support from those whom it had helped and this issue ought to be considered seriously as informative evaluation data in the current context.
3.4.3 Review of Past Curricula of the PACTS Girls Group

As mentioned previously two main curricula were identified as having been used with past groups at PACTS. The first was the PASH program (FPWA, 2000). The second curriculum was a hybrid and contained over three quarters of published resources that had been taken from Munson and Riskin (1995) and Mandell and Damon’s (1989) programs. The remainder of the program seems to have been produced by PACTS staff. These programs are briefly described below.

The PASH program incorporates a mixture of information, exploration of attitudes and values, relationships, gender issues, communication and assertiveness skills. However, there is nothing regarding sexual abuse in this program. In reviewing the PASH program for this evaluation it was determined that PASH was not designed specifically for sexually abused adolescents. It is in fact a program for young people to learn about sexuality and sexual health. The curriculum presented in 2003 appears to have added sessions on CSA and protective behaviours but it is unclear exactly what this material was as I was only provided with a program timetable which listed the topic of each session. On the basis of this information alone, this curricula was not evaluated any further as it is already determined that this program is not intended specifically for CSA survivors nor helps them to process their experience of CSA.

A resource manual of the second curriculum was made available for review. It is noted that this manual consisted only of worksheets for each session and in some instances session plans. However the objectives of the sessions were not stated (i.e. it was not a fully operational manual and as such information had to be assumed). The manager of PACTS indicated that the broad aim of this curriculum was to decrease the isolation among CSA survivors and to help alleviate the effects of CSA. The objectives of the program however
were judged on the basis of what I thought the worksheets were trying to achieve. The second curriculum covered the following topics: friendship, feelings, self esteem, what is sexual abuse, effects of sexual abuse, secrets, disclosure of abusive experience, shame and guilt and memories. As the curriculum was based on hybrid sources it appeared to have a mixed theoretical basis and no clearly stated outcome goals. To my knowledge neither of the two commercially available programs (i.e. Munson & Riskin, 1995; Mandell & Damon, 1989) have been systematically evaluated. Furthermore the Mandell and Damon program is intended for school age children rather than adolescents.

The hybrid program will now be evaluated in greater detail according to the best practice criterion outlined in Table 3.1. Table 3.5 summarises how this curricula compared to best practice guidelines.

Table 3.5 *Comparison of Best Practice Criteria with the PACTS Girls Group Curricula*

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Consensus of Evidence</th>
<th>PACTS Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Principles</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theoretical model</td>
<td>TFCBT</td>
<td>×</td>
</tr>
<tr>
<td>Aims and Objectives</td>
<td>Clearly stated</td>
<td>×</td>
</tr>
<tr>
<td>General</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>Educative</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Therapeutic</td>
<td></td>
<td>Partially</td>
</tr>
<tr>
<td>Specific</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To disclose and discuss the abusive experience</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>To identify and process emotions associated with CSA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>To alleviate the shame and guilt associated with CSA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>To improve self esteem</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>To alleviate symptoms associated with CSA</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>To learn coping skills and correct cognitive distortions</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>To learn self protection skills</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>To learn about sexuality and sex education</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>To discuss the dynamics of the abusive experience</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>To improve family and social relationships</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake assessment</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Pre and post group</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>Assessment to guide treatment</td>
<td>×</td>
<td></td>
</tr>
</tbody>
</table>
**Dimensions** | **Consensus of Evidence** | **PACTS Program**
---|---|---
**Group Composition**  
Number of Participants | 6-8 | 4-6
Age of Participants | 12-15yrs | ✓
Gender | Same sex | ✓
Type of abusive experience | Not limited but similar to one another | ✓
**Facilitation**  
Gender | Same Sex as participants | ✓
Number of therapists | Two | ✓
**Structure**  
Open v. Closed | Closed | Variable
Structured v. Unstructured | Structured | Variable
Duration | 12-24 sessions | Variable
Refreshments | Yes | ✓

**Theoretical underpinning**

Perhaps one of the most obvious things lacking in the PACTS program was a definite theoretical underpinning. The program draws upon a hybrid of sources and with the exception of Mandell and Damon (1989) these sources appear to come from mixed origins. Furthermore, as previously mentioned, none of the programs used are known to be effective in assisting girls to manage their experience of CSA. Given that a TFCBT approach is being advocated as best practice here, it is useful to compare this hybrid program to TFCBT. The four major components of a TFCBT are gradual exposure to CSA; coping skills training; cognitive and affective processing of CSA; and education about CSA, personal safety and sexuality. The hybrid program used by PACTS appeared to use some of the concepts of gradual exposure in that the amount of CSA related content increased over the course of sessions and culminated in a disclosure. The program also has a strong educative component which includes personal safety, sexuality and CSA in general. In contrast the program gives little attention to coping skills training and cognitive and affective processing as discussed further below.
Aims and objectives

It is important for a program to have predetermined aims and objectives to ensure that any changes which occur during therapy are measurable and that replication is possible (Chambless & Hollon, 1998). In reviewing the past curricula used at PACTS, there were no clearly stated aims or objectives. Whilst the manager of PACTS indicated the broad aims of the program to be associated with processing CSA and decreasing isolation among survivors, such aims should be more readily available to any clinician who picks up the program. In comparing the PACTS curricula with the most commonly cited aims and objectives listed in Table 3.5, the past curricula appears to target six of these 10 objectives. As the objectives of the program were not specifically stated, I could only assume the objectives on the basis of the activities in the program and what I thought they were trying to achieve, thus my analysis may not be entirely accurate. Of most concern is the program’s failure to focus on coping skills and provide a skills component in general. The evidence suggests the following skills should be included in a CSA program: problem solving, emotional identification, processing and regulation, anxiety management skills and identification and alteration of maladaptive cognitions (e.g. Deblinger & Heflin, 1996; Cohen et al., 2000; Saunders et al., 2004). The PACTS program only targets emotion identification.

Assessment guiding intervention

Best practice evidence suggests that interventions be based on well conducted assessments of both abuse related (e.g. attributions about CSA) and general mental health (e.g. depression, anxiety). No assessment beyond an intake interview was used in the PACTS programs. This interview assessed potential participant’s eligibility and readiness for joining a group program which is important. This was determined by assessing the participant’s level of insight and ability to talk about their experience of CSA. In addition to assessment prior to beginning a group program, evidence suggests that assessment tools
should, minimally, be readministered at post intervention to ascertain whether changes have occurred after the group. Best practice guidelines (Saunders et al., 2004) ideally suggest assessment occur routinely for all clients and not just in the context of a program evaluation. This type of evaluation did not occur in the PACTS program.

**Duration**

The duration of a program depends on a number of other factors such as the theoretical orientation and whether it is an open or closed group (Corey & Corey, 2006). In general however the evidence previously presented suggests that programs shown to be efficacious have a short to moderate time frame of 12-24 sessions (although this figure encapsulates both group and individual treatment modalities and so it should be assumed that this is 12-24 hours of service). Past groups run at PACTS appear to have run for a considerably longer period of time. For example the Semester one 2003 group appears to have run for 25 sessions (37.5hrs) over three school terms (35 weeks in total). This appears to be a particularly long period of time and a significant commitment on the part of the participants. One wonders whether such a long duration is wise given the propensity of many CSA survivors to form strong attachments with the facilitators which may cause further difficulty when the group does end (as appears to have occurred for the participant described earlier). In addition the strain on resources and the ability of the facilitators to sustain the energy required to facilitate week in and week out is likely to be tested after such a period of time. Thus it is recommended that the duration the PACTS program be reduced in length.

**Open v. Closed membership**

It appears that in the past, PACTS groups were run as open groups although this is not totally clear. An open membership group with this population could be very difficult for someone to join the group at a later stage in the process, firstly because they may not have
the requisite coping skills to handle sensitive topics when discussed but more importantly it may alter the group dynamics and therefore hinder the success of the program. Furthermore if the duration of the program is short term as the best practice guidelines suggest, then membership should be closed.

*Structured v. Unstructured*

As presented earlier, structured groups are recommended when the duration of the program is short term. Within a group of girls who have experienced sexual abuse it is important to provide a level of structure which offers a sense of safety, security and most importantly containment (Trolley, 1995). Past PACTS groups vary in their degree of structure and range from a very unstructured to a highly structured format, dependant on the background of the facilitator. The hybrid program reviewed here appears to have been quite a structured program with set activities and worksheets in each session and this is in keeping with best practice guidelines.

*Facilitators*

Past groups run at PACTS appear to have been run by one or two female facilitators with either a social work or psychology background. The level of training and experience of such facilitators is unknown. The use of two female facilitators appears appropriate however it is important that the PACTS facilitators also have relevant training and/or supervision to conduct such a group.

This review highlights the ways in which the PACTS curricula is both similar and different to best practice evidence for the treatment of adolescent girls who have experienced sexual abuse. In terms of similarities, the number of group participants, gender of those participants and the use of two female facilitators was adequate relative to best practice
guidelines. With regards to differences however, the past curricula were not based upon a strong theoretical background, nor was it based on evidence based practice (i.e. the programs used had not been researched to determine effectiveness), participants were not adequately assessed prior to the program to guide treatment, participants were not assessed following the program to assess its effectiveness, the length of the program was too long, membership was not closed, and the program has varied in its level of structure. Most of the aims and objectives were appropriate but the curricula did not appear to target coping skills in particular. Overall the review of past curricula suggests a number of changes be made to the program to ensure that a best practice treatment is delivered and that clients of the service receive an efficacious and ethical treatment which fits with best practice recommendations.

3.5 SUMMARY & RECOMMENDATIONS FOR A NEW CURRICULUM

On the basis of this study, in triangulating the three available data sources, little support has been garnered for the PACTS Girls Group 2000-2003 curricula. There appears to be strong support from one past participant and four mothers that such a group is necessary and wanted, however there is little evidence to show that the curricula held much value in terms of assisting girls to process their experience of abuse. The data indicates that a group treatment program for adolescent girls who have experienced sexual abuse serves an important function and should continue to be offered. While the nature of this function is not clear at this point, it is plausible that the mere act of attending a group with others who have had similar experiences of sexual abuse has curative properties. Whilst this conclusion is based on a very limited amount of data, in qualitative research what is available as well as what is missing is considered informative (Patton, 1990). In this case, the lack of participants and parents willing to participate is noteworthy. The recommendation that adolescent CSA survivor therapy groups are important and should continue to be provided
is also strongly supported by the research literature (Heiman & Ettin, 2001; Knittle & Tuana, 1980; Lomanaco et al., 2000).

The data also shows that increased parental involvement may be advantageous as it allows parents to act as facilitative change agents and empowers them to reconnect with their daughters. It is a positive sign to see parents interested in taking part in the therapeutic change process. This finding is also in keeping with the research evidence to date (e.g. Cocoran, 2004) and suggests that future programs include a parallel parent program or perhaps even joint parent-child sessions.

In terms of the curricula itself, the findings of the review relative to best practice criteria indicate that the past curricula in their absolute state were not adequate to meet the needs of the population. The use of the PASH program for this population was inappropriate. The hybrid program on the other hand did have many elements consistent with best practice recommendations and these elements could be retained. In particular the hybrid program targeted six of the ten treatment objectives proposed in Table 3.1. The program also had a very strong educative component. The lone past participant of this evaluation suggested that the program should focus primarily upon helping girls to process their experience of CSA. Thus the overall recommendation is that significant modifications to the treatment program are warranted to better reflect best practice guidelines and in particular could be more abuse specific. It is worthwhile noting at this point that the PACTS girls group is the only one of its kind operating in Perth, Western Australia, and whilst it is in need of modification and enhanced evaluation, the agency should be acknowledged for attempting to provide a service to adolescent girls when others have not, and for their openness in having the program evaluated.
The overall findings of the study highlight the significance of non evaluated interventions with vulnerable populations. One girl actively stated that she had been negatively affected by attending the group and four mothers indicated that the group had not fully met their daughter’s needs. This finding signifies the importance of constant micro and macro evaluation of treatment programs. For this very reason the developmental intervention, action research approach was adopted in the current study to ensure that a treatment was developed that adequately meets the needs of the client group. The findings from the archival review also illustrates the importance of using multiple methods and sources for measuring treatment outcome rather than merely using one indicator. That is, if more accurate measures had been taken from facilitators, parents and group participants both before and after the group program on a number of different measures which match with the aims of the group program, more could have been concluded about the utility of the PACTS program run 2000-2003.

It is unfortunate that more information could not be gained from this study. Such information may have reflected more kindly on the outcomes of the program to date. The limitations stemming from sparse detail of previous groups run at PACTS and the low number of participants in the retrospective analysis are recognised. As well as the limitations inherent in the routine gathering of subjective discharge statistics. In addition it is recognised that in the absence of a comprehensive treatment manual, I was unable to fully evaluate the treatment program. Nevertheless as mentioned earlier the importance of this ‘missing’ data should not be undervalued as being informative and indeed adds to the conclusions drawn about the program.

In combining phase one and two of the developmental intervention process, by considering data both in its presence and absence, it is recommended that a new treatment program be developed rather than modifying the PACTS program. It is recommended that this new
program is designed and developed with the best practice guidelines presented in Table 3.1 in mind, and in keeping with phase three of developmental intervention research. It is suggested that this new treatment program draw upon elements of the PACTS hybrid program as many of the activities are relevant to achieving the objectives stated in Table 3.1. The following chapter presents the new treatment program.
CHAPTER 4

DEVELOPMENT OF A NEW ADOLESCENT GIRLS GROUP TREATMENT PROGRAM
In Chapter 1, a review of the literature revealed that at present there are very few effective group therapy programs available for adolescent girls who have experienced sexual abuse. This impression was confirmed in Study 1 when only one local example could be found in a city of over one million people. This is despite the impact that CSA has on an adolescent's life. Much of the focus of treatment research has been targeted at children and adults. This is surprising given that adolescence is a time when the effects of CSA may become more salient or reoccur given the psycho-bio-social transitions at this developmental stage. Evidence suggests that CSA disrupts developmental pathways and as such problems may manifest at this stage (Cicchetti & Toth, 1995).

In addition to the issues identified in the literature review, the key findings of Study 1 suggested that an adolescent group program is 'valued' by parents and girls even when the program isn't seen as effective. Given Study 1’s finding that the PACTS program did not meet best practice criteria and had little supporting evidence to suggest that it has been effective, a new treatment program will now be developed. This is in keeping with phase three of developmental intervention research. To this point, this thesis has synthesised a large body of knowledge in relation to treatment for CSA survivors. This knowledge must now be translated into application and provide direction in terms of the design of a new treatment program. This chapter outlines the decisions made concerning design and construction of the new program and a rationale for each of the components included. The overall aim of this phase of the research is to develop a best practice group treatment program for adolescent girls aged 12-15 years who have experienced sexual abuse.

4.1 Design and Construction
In designing and constructing the new treatment program primary consideration is given to selecting an appropriate theoretical model and treatment modality, as well as issues
surrounding manualisation. The evidence reviewed earlier in terms of best practice treatment for CSA survivors and the results of Study 1 are paramount in this endeavour. A summary of core elements of the treatment will be provided here.

4.1.1 Theoretical Considerations

The development of the treatment program is guided by the transactional model proposed by Nurcombe et al. (2000). As previously indicated in Chapter 1, the transactional model of psychopathology of child sexual abuse posits that there are moderating (antecedent and abuse related) and mediating (post disclosure and child centred) factors which combine to determine outcome from sexual abuse. It is recognised that treatment cannot influence the antecedent or abuse related factors as these are fixed. However treatment can target post disclosure and mediating factors (Nurcombe et al., 2000). Nurcombe et al. suggest that these factors include i) quality of parent support; ii) parental attributions; iii) parental psychopathology (parent coping style); iv) maladaptive attitudes towards self; v) maladaptive attitude towards others; vi) traumatic state; vii) dysregulation of affect, impulse and self; and viii) maladaptive coping style. A TFCBT approach appears to fit nicely within the transactional model and encompasses the factors listed above. Furthermore as presented in Chapter 1, TFCBT is the model with the most research evidence available.

Deblinger and Heflin (1996, p.4-5) assert that TFCBT is suited to the treatment of children and adolescents who have experienced CSA for a number of reasons. Namely it:

- can cater for a wide variety of psychological difficulties, a critical factor given the wide variety of sequelae associated with CSA.
- is highly flexible as CBT targets cognitive, behavioural and emotional realms
- has face validity with clients – therefore giving a sense of control to the client – which is very important given that control may have been taken away in the past
is a collaborative endeavour and is empowering
provides skills that can be used in the future
provides a strong evidence base for its use in CSA and psychopathology in general

As highlighted previously it is recommended that CBT with CSA survivors is trauma/abuse focused. More specifically the treatment should encourage the expression of abuse related feelings, clarifying erroneous beliefs that might lead to negative attributions about self or others, diminishing the sense of stigma and isolation and teach abuse prevention skills (Deblinger & Heflin, 1996; Finkelhor & Berliner, 1995). Hence the treatment to be developed here will have an inherent TFCBT focus and be based primarily on Deblinger and Heflin (1996) and Cohen, Mannarino, & Deblinger’s (2006) cognitive behavioural program for CSA survivors. It will also incorporate some of the strengths of other pre existing programs as at face value it appears they will work well in a group context, be more age appropriate and/or accentuate certain objectives better than activities from a TFCBT program. These include activities from Munson and Riskin (1995), Mandell and Damon (1989), Ollier and Hobday (2004) and the PACTS hybrid program. Ideas may also be taken from many of the clinical practice articles published within the literature (e.g. Ashby et al., 1987; deYoung & Corbin, 1994; Trolley, 1995; Wilson & Hutton, 1992). Furthermore it is of utmost importance that in designing the treatment, consideration is given to the child physical and sexual abuse treatment guidelines as these were developed by experts in the field and on the basis of the treatment research (Saunders et al., 2004).

### 4.1.2 Adjunctive Group Therapy

As discussed in Chapter 1 group therapy has been identified as the treatment modality for this project. To briefly recapitulate the argument from Chapter 1, group therapy was chosen as it is recognised that the very act of attending a group with individuals who have travelled
a similar journey can be healing in itself as survivors of CSA often hide in shame, keeping their secret and isolating themselves (deYoung & Corbin, 1994; Wilson & Hutton, 1992). The group environment is also congruent with the developmental tasks of adolescence as it allows girls to gain advice and support from peers rather than from within the family context (Knittle & Tuana, 1980; Thun et al., 2002). A group can also provide its members with validation and normalisation of feelings. Group process allows for the development of normalcy, a regular routine and an environment where adolescents can have some sense of control (Hazzard et al., 1986). Thus a group as seen as ideal for this population.

Another important design consideration for the treatment program is whether the treatment will be a stand alone treatment or adjunctive to individual therapy. As noted in Chapter 1, few previous studies have clearly outlined whether their treatments were adjunctive. It is important to determine this from an ethical stand point but also from an evaluation stand point. If the treatment is adjunctive or if the participants have had prior therapy, this may interfere with effectiveness and the degree to which one can argue the impact of the group program as the impetus for change. Thus a decision must be made as to whether the new treatment program will be adjunctive.

Given that this treatment will be targeted at adolescents, it is conceivable that they may have received treatment shortly after their initial disclosure, which may have occurred many years before they seek the current treatment. Thus it is conceivable that they will have already received some therapy in the past which was intended to help them process their experience. As such a group format may serve as a refresher of skills learnt as children or perhaps facilitate further processing of CSA that was unattainable as a child. From the outset it may then be difficult for the treatment to be entirely a stand alone treatment. More
importantly however the treatment may not be appropriate as a stand alone treatment as described below.

Ethically adjunctive treatment may be most appropriate given the sensitive nature of the group and the limited ability of a group program to provide one on one attention if participants have received no prior therapy. Individual therapy is considered most suited to dealing with the initial crisis and high levels of psychopathology often associated with CSA. Group therapy is considered more of an opportunity to develop skills and work on aspects of CSA that are difficult to obtain in individual therapy (e.g. decreasing the sense of isolation and ‘differentness’). It would seem important that participants have undertaken some trauma processing prior to attending the group as it is not possible to give them the individual attention they may need in a group context. In addition it is noted that without prior individual therapy participants may not be ready for group. To be ‘ready’ they must have a willingness to talk about CSA, to share their experience with others and to examine the impact of CSA. Such a task may be very difficult if the experience has not been spoken about or explored before in a safe environment. Also, given the recommendation of a time limited, structured approach to treatment advocated in Chapter 3, it can be expected that participants would need to process the material from the program quite quickly, again this may be unattainable without prior therapy which has given them some insight into their experience of CSA. Finally, it is also noted that the program will be evaluated in conjunction with PACTS in Study 2 and it is mandated by PACTS that participants have had prior individual therapy before beginning a group program. Given these considerations the treatment program to be developed will be an adjunctive program in the sense that participants must have undertaken some trauma processing prior to joining the group.
4.1.3 Manualisation

The development of a treatment manual is considered necessary in order to standardise treatment approaches, widely disseminate treatments to practitioners, train practitioners in specific clinical procedures and ensure the quality of the treatment provided (Wilson, 1998). However, manualisation of treatment is met with resistance in some quarters as manuals can lead to rigidity and inflexibility in treatment delivery and underemphasise the importance of common factors such as the therapeutic alliance and therapist skill (Strupp & Anderson, 1997).

Such is the bind in the current research. I recognise that manualisation, particularly in the realm of research, is important. However as previously discussed much of the curative processes that occur in group therapy are due to the process of the group (Yalom, 1995). Furthermore the treatment must be able to handle the potential of a wide array of presenting problems in group members, and as such needs to be flexible and have the potential to be individualised. The decision to manualise the program was reached for the following reasons i) a relatively high level of structure is recommended with this population as discussed in Chapter 3 ii) it will be a closed time limited program and to achieve the aims of the program objectives need to be achieved in a timely fashion iii) a manual will facilitate provision of the treatment to other practitioners and iv) a manual will alleviate problems experienced with the program in Study 1 where facilitators had run different programs with no specified aims or objectives.

It is noted that while the program will be manualised, treatment individuation and flexibility are considered paramount and presenting issues will take priority over the manual (which is in keeping with the ethical requirements of all psychologists anyhow). That is, the facilitators of the program must respond to the needs of clients as they present (even if these needs
are not directly related to CSA) and not to rigidly adhere to what is specified in the treatment manual. The process of natural adaptation as proposed by Natasi et al. (2000) will therefore be adopted. Natural adaptation involves “the modification or adaptation of a pre-designed intervention to fit the needs and resources of the specific participants in the natural context” (Natasi et al. 2000, p.216). This process acknowledges that treatment integrity is important in the context of empirical research, and aims to maintain integrity by preserving the key elements of a program but allowing flexibility through the variation of non critical elements (e.g. mode of presentation). In this approach integrity is not relinquished but treatment acceptability and ethical practice are promoted. As previously indicated in Chapter 1 it is important that consumers find an intervention acceptable as this impacts on effectiveness.

4.2 Key Components of the Treatment

On the basis of the literature review presented in Chapter 1, the key components identified for the treatment program are coping skills training, gradual exposure and affective processing and education. This is in keeping with the approach of Deblinger and Heflin (1996) and Lindon and Nourse (1994). Each component is described below along with other relevant considerations for the program.

Coping skills training

Coping skills are considered a necessary prerequisite for effectively responding to the distress that may be generated by the CSA experience in general and the processing of that experience in group therapy (Cahill et al., 1991). Essential skills include emotional expression, cognitive coping, stress management and relaxation (Deblinger & Heflin, 1996).
Gradual exposure and cognitive and affective processing

Gradual exposure to CSA experiences is a procedure developed by Deblinger and Heflin (1996) which combines aspects of prolonged exposure and systematic desensitisation and aims to assist CSA survivors in processing their experience of abuse. Gradual exposure works by exposing clients to increasingly more distressing abuse related stimuli and alleviating this distress at each juncture. This may be more difficult to achieve in group therapy as it is not feasible for each participant to work through their own hierarchies. To overcome this problem, a generic hierarchy will be built into the program that gradually introduces more and more sexual abuse related material over time (this is further detailed below). It is expected that much of the trauma processing will have been achieved in individual therapy prior to embarking on group work and as such this process does not need to be as specific.

Gradual exposure in this context typically begins with more benign material such as education about sexual abuse and culminates in the telling of each girl’s ‘story’ (Deblinger & Heflin, 1996; deYoung & Corbin, 1994). Disclosure of the abuse experience is considered vital to the program. Therapists may be reluctant to undertake such a process due to a belief that it may retraumatise the child (deYoung & Corbin, 1994). However a reluctance on the part of therapists may be interpreted by children and adolescents as an inability to deal with the details and as such strengthens beliefs within the child that their experience should not be discussed.

The central idea behind gradual exposure is that by the end of therapy the adolescent will be able to confront abuse related material without significant distress (Deblinger & Heflin, 1996). This occurs by disrupting the maladaptive associations between abuse related cues and extreme negative emotions. In the words of deYoung and Corbin (1994, p143) “in
telling, secretiveness can be transformed into openness, shame into self-satisfaction, confusion into certainty, numbness into expression, and bewilderment into meaning.” The process of telling the story allows new associations to be made as the adolescent learns that they are in control and have the strength to cope with distress. Importantly it also replaces maladaptive coping responses (e.g. avoidance) with more adaptive coping responses (Deblinger & Heflin, 1996).

Once the gradual exposure is underway, it opens the adolescent to be able to process their experience and attempt to make sense of it. This process is important as confusing and conflicted emotions, distorted and maladaptive beliefs about themselves, sex, relationships and the world often ensue when children and adolescents are not helped to process their experience. In TFCBT this is achieved primarily through cognitive therapy and encourages the identification and disputation of maladaptive thoughts. In group therapy this is more difficult to achieve and again it is hoped that much of this processing may have taken place in individual therapy. However, the challenging of such beliefs is also afforded through the group process in general and the educational components of the program. In the new treatment program, affective processing is also undertaken by using creative expression techniques such as letters to the perpetrators, poetry, drawings, art and craft. These methods will be used as an alternative to ‘talking’ therapy as many adolescents may find it difficult to verbally express how they are feeling about their experience of abuse, particularly in the earlier stages of the group.

Education

The educational components of the treatment aim to dispel common myths about sexual abuse that are held in society. Specifically the treatment aims to answer questions about what sexual abuse is, why it occurs, who sexually abuses children, why do they do it, how
children feel afterwards and why they don’t tell. Such answers are very important in the
disputation process described above. Education is also provided around healthy sexuality.
Again there may be many commonly held myths associated with this topic which may cause
adolescents concern. These may include fears about having sex in the future, concerns
about virginity and mistrust of men. Furthermore as promiscuity is often an issue, basic
education about sexual health is also important. Finally education is provided in the
program about enhancing personal safety. Many of the activities for this component of the
program will be drawn from the PACTS hybrid program as this is what it did well.

Key intervention techniques and strategies used across the sessions

A relatively structured program is recommended in the clinical practice literature for CSA
interventions. As Sirles et al. (1988) points out, while adolescents are more capable of “talk”
therapy and can function with less structure, often there is an expressed preference for task
oriented therapy in CSA survivors. Thus in the current program this structure will be
facilitated by providing specific activities which are designed to aid in the attainment of the
program objectives. These activities include group discussion, worksheets, structured role
plays, individual and paired work and creative expression activities (e.g. poetry, drawings
and short stories).

Role of the therapist

The group will be facilitated by two female therapists who have appropriate qualifications
and experience in both working with CSA survivors and group facilitation in general. The
major role of the therapists is to

normalize thoughts and feelings, reorganize perceptions, and provide a new
interpretive frame that relieves [survivors] of responsibility, acknowledges and
works through feelings, and provides [survivors] with a new way of thinking
about the sexual abuse story they have shared. In doing so, traumatic memories are transformed so that they may be more easily incorporated into children’s lives (deYoung & Corbin, 1994, p.151)

It is intended that therapists act as role models for the group. That is, they will model basic listening skills, empathic and respectful responding, problem solving, appropriate emotional expression and coping skills and boundary setting. The therapist’s role will be to show the group members how to use the group appropriately and how to apply the skills they are learning to everyday examples.

Group member selection

In keeping with best practice recommendations the program will be designed specifically for adolescent girls aged 12-15 years. The group will be open to all girls who have experienced sexual abuse regardless of type (e.g. one off assault, intra familial, extra familial) provided that the experiences are not too disparate between members of any given group (e.g. it is recommended that the group not include contact and non contact sexual abuse victims in the one group). More importantly the inclusion or exclusion of a potential group member will be made on the basis of clinical judgement surrounding the needs and readiness of the individual participants to engage in group therapy. Specifically, participants must be assessed to ensure that they will be able to cope with the demands of the program and have the capacity to both tell their own story and hear other girls tell theirs.

For legal reasons only girls whose abuse has been substantiated by either the police or the Department for Community Development (child welfare agency) will be eligible to attend the group. This is to ensure that any pending court cases are not hampered by the attendance at the group. All group members will undergo assessment prior to and following the group
program, to ensure that the group can be best tailored to the needs of all members and so that the utility of the program can be continued to be evaluated on an ongoing basis.

Other relevant factors

It is recognised that many of the activities presented in the sessions may require a certain level of literacy and so it is important that all activities can be adapted to suit the needs of the group. The majority of activities will initially begin with a group discussion before the group takes part in any writing activities. Furthermore the information will be written so that group members can reflect on it after completing the group, so that they have accurate information and a means of reminding themselves what was covered in the program. In the activities that do require writing, facilitators will need to provide extra assistance to group members who require it.

Each group member will be provided with a workbook which consists of all worksheets and handouts used in the program. This serves two purposes, firstly it allows girls to take home the work from each session and continue to process its contents through the week or to perhaps share it with parents. Secondly it serves as a reference point later on when they may be struggling or wish to reflect on the group to further process their experience. As previously indicated there is the potential for sequelae associated with the experience of abuse to represent at different times through a survivor’s lifespan, particularly during transitional periods which may again alter what it means to have experienced sexual abuse as a child and so it may be useful to have the information covered in group as a reference. As a final point it is important that refreshments be offered within each session. As previously mentioned this offers the girls time to socialise with one another, provides nurturance and on a pragmatic level the group will more than likely be run after school when the girls may be in need of some sustenance.
4.3 COLLABORATION AND EXPERT INVOLVEMENT

In keeping with the action research approach it was important to involve stakeholders at this point to improve content validity of the program and draw upon the wealth of knowledge from practitioners who have previously worked with this population. Hence, following the construction of the program, the manual was provided to both staff at PACTS (psychologists and social workers) and to a research supervisor (CR; who is also a clinical psychologist) for feedback. Minimal changes were suggested by these practitioners. Following the initial pilot evaluation of the new program in Study 2, the program will also undergo a more intensive evaluation by experts in the field who are external to the current project (see Chapter 6).

Ideally, and in keeping with the participatory model, it was the intention to also have consumers (i.e. adolescent CSA survivors) comment on the program at this point. However given the difficulties in engaging past group participants in Study 1 it was decided that this process would be undertaken within the formative evaluation of Study 2.

4.4 THE ADOLESCENT GIRLS GROUP TREATMENT

On the basis of the evidence evaluated in the literature review, the results of Study 1 and the information presented above, I constructed a pilot group treatment program. As noted in section 4.1.1 the theoretical basis of this treatment program is not unique and many of the activities and techniques included in the program are from other sources (all have been duly acknowledged in the treatment program). The unique aspects of this program which I have contributed are in the way the program has been structured and combined to meet the needs of adolescent girls.
The program consists of 16 one and a half hour sessions. The program is intended for six to eight, 12-15 year old girls who have experienced sexual abuse. The program was designed to be facilitated by two female therapists with suitable training in the area. A therapist manual may be found in Appendix C. The following section presents the aims and objectives of the program and describes briefly the content of each session.

The aims and objectives of the program were as follows:

Aims

- To decrease known risk factors associated with CSA
- To increase protective factors associated with better outcome from CSA
- To decrease emotional, cognitive and behavioural effects of CSA
- To process the experience of CSA and give it new meaning

Objectives

- Increase emotional expression skills and process emotions associated with CSA
- Increase relaxation skills and knowledge
- Increase cognitive coping skills and knowledge
- Increase personal safety knowledge and skills
- Increase understanding/knowledge and provide education regarding child sexual abuse and its dynamics
- Increase understanding/knowledge and provide education regarding healthy sexuality
- Increase self esteem
- Increase assertiveness
- Increase peer and family relation skills
- Decrease emotional and behavioural difficulties
- Decrease avoidance and social isolation
- Decrease feelings of self blame and shame

In keeping with the gradual exposure approach, the program was designed in such a way that it begins by providing skills that can be used in life in general as opposed to sexual
abuse related trauma specifically. These skills are likely to build resilience and better coping for group members before difficult issues are tackled. All sessions are intended to discuss sexual abuse however the intensity with which this is discussed is built over time and culminates in session 8 before then reducing in intensity over the remaining sessions. In doing so, the process of containment is built into the program. This sense of containment is built both into each session and the program as a whole as depicted in Figure 4.1.

![Figure 4.1. Depiction of the process of therapy both in terms of the overall structure and individual sessions (Campbell, 2005).](image)

The 16 sessions are outlined in Table 4.1 and described below.

<table>
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<tr>
<th>Session</th>
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<td>9</td>
<td>Memories and Nightmares</td>
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<tr>
<td>2</td>
<td>Coping Skills</td>
<td>10</td>
<td>Protective Behaviours</td>
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<td>3</td>
<td>Managing Emotions</td>
<td>11</td>
<td>Healthy Sexuality</td>
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<td>4</td>
<td>Self Esteem</td>
<td>12</td>
<td>Stuck Feelings</td>
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<td>5</td>
<td>Cognitive Coping Skills</td>
<td>13</td>
<td>Communication and Conflict Resolution</td>
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<td>6</td>
<td>Education regarding CSA</td>
<td>14</td>
<td>Relationships and Friends</td>
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<td>7</td>
<td>Secrets, Shame and Guilt 1</td>
<td>15</td>
<td>Planning for the future</td>
</tr>
<tr>
<td>8</td>
<td>Secrets, Shame and Guilt 2</td>
<td>16</td>
<td>Group closure and post test</td>
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</table>
Session 1 “Welcome to group”, involves a process of introductions, rapport and trust building, the development of group rules, and a discussion of confidentiality. An emphasis on the rationale behind the program is presented and participants are informed about how the group will progress across the 16 weeks. As such a brief opportunity for disclosure occurs in session 1 to decrease general anxiety and to demonstrate to the group members that everyone in group has had a similar experience and that they are not alone. This then sets the scene for ensuing weeks.

Session 2 “Coping skills” involves the teaching of skills to help cope with distressing situations or memories associated with CSA and life in general. These skills are considered central to the program and as such are taught in the beginning stages. The session involves learning techniques to manage stress, solve problems, prevent depression and relax.

Session 3 “Managing emotions” aims to teach the group members how to express, understand and manage strong emotions. The link between what we think, what we do and how we feel is also explored. The main aim of the session is to convey that feelings are normal, they are neither good nor bad and that there are helpful and unhelpful ways of expressing feelings. Ultimately the session aims to teach that it is important to give all emotions a voice as young women are often taught that some feelings should not be expressed.

Session 4 “Self esteem” aims to help group members to tap inner strengths and boost their self esteem. The role of positive affirmations and self talk is examined. Session 5 “Coping and thinking” continues with the teaching of coping skills by focusing on the link between thoughts, feelings and events. The session teaches about the role of automatic thoughts and the effect that they can have on both mood and behaviour. Group members are
encouraged to begin monitoring their thoughts for ‘thinking errors’ and begin to learn to challenge these. These skills appear necessary to help overcome many of the attributions often associated with CSA (e.g. self blame).

Session 6 “Facts about abuse” is primarily educative in nature. The session aims to provide a definition of sexual abuse, discuss why people sexually abuse children, and understand the wide range of psycho-bio-social effects associated with CSA. The session attempts to provide factual information which can begin to assist in eliminating attributions and cognitions associated with CSA and dispelling many common myths. For many, the session will be about linking current behaviours and emotions with CSA.

Sessions 7 and 8 “Secrets, shame and guilt” are the penultimate sessions of the program. The expectation is that the skills learnt in the preceding sessions will be used to assist the girls in coping with these two sessions. Session 7 focuses on the benefits and difficulties of telling the secret. The process and impact of the group member’s disclosures is discussed. Specifically the session is focused on empowering and validating the group members for the steps they took to make their disclosures. Furthermore the session is about recognising strength and overcoming powerlessness. Group members are encouraged to safely share their secret with important people in their lives so that the secret no longer has any power. The first part of the session also focuses on shame and guilt and assists girls in overcoming these paralysing feelings.

In session 8, the group members are invited to share their experience of abuse with the group. Telling must be more than simple reciting of facts. The disclosure should be rich in details of thoughts, feelings, sensations and images if it is to be of therapeutic benefit and assist in the resolution of trauma. It is important that a strong rationale is put forth to the
group as to why this process is necessary. It is also important for the facilitators to acknowledge to the group that everyone’s story is unique and that stories are not evaluated according to their level of severity or harm (deYoung and Corbin, 1994).

Session 9 “Memories and nightmares” covers flashbacks, memories, nightmares and triggers related to experiences of sexual abuse. Skills are taught to help girls cope with these experiences when they occur.

Session 10 “Protective behaviours” covers the two major themes of protective behaviours – specifically, ‘We all have the right to feel safe all of the time’ and ‘Nothing is so awful that we can’t talk about it with someone’. The session is taught primarily in the context of personal safety as it is known that risk taking among this cohort is common (Luster & Small, 1997; Raj, Silverman & Amaro, 2000). As such the session focuses on the development of personal safety rules and plans so that placing themselves in dangerous situations may be avoided.

Session 11 “Healthy sexuality” is covered in the program as survivors of sexual abuse are often confused about what is and is not appropriate sexual behaviour. They may also be uncomfortable about sexual contact. These fears and concerns are addressed. The session also covers sexually transmitted infections, pregnancy, sexuality and relationships with males. Session 12 “Stuck feelings” covers three major feelings that are often experienced after sexual abuse, namely anger, sadness and anxiety. The session aims to normalise and reframe each of these feelings and attempts to develop adaptive ways of expressing and dealing with them.
Session 13 “Communication and conflict resolution” focuses on helping girls to develop requisite skills which may inhibit their ability to have happy fulfilling relationships. The session also begins to explore the role of trust in relationships in preparation for the next session. The group concludes with role plays highlighting the difference between submission, assertion and aggression. Session 14 “Relationships and friendships” explores the role of family and friends and the impact that CSA may have had in these relationships. The group is encouraged to see that family and friends are important sources of support. A focus on ways to rebuild relationships that have been adversely affected is also undertaken.

Session 15 “Planning for the future” teaches group members the important skill of setting goals. A six stage goal setting model is taught to the group and they are encouraged to begin setting goals in their own lives. Time is also spent in this session on relapse prevention.

Session 16 “Wind up and group party” provides group members with an opportunity to say goodbye to one another and to tie up any loose ends. Feelings about finishing the group are explored and a review of each of the topics covered is also undertaken. Girls are invited to identify the ways in which they have changed as a result of attending the group and facilitators also provide feedback to this effect. Finally the group is given the opportunity to have a small ‘party’ to end their time in group.

4.5 Conclusions

The new Adolescent Girls group program meets with the best practice standards presented in Table 3.1 and the recommendations made at the conclusion of Study 1, with one notable exception, namely the involvement of non offending parents. The inclusion of a parent program was considered to be beyond the resources of the current project, however their
utility is recognised. Hence a brief package was developed for caretakers that described in
detail the content of each session and provided practical strategies to parents about ways
to support their daughters through the process of the group (see Appendix C).

On the whole the feedback about this treatment program to this point was very positive (as
described in section 4.3). All who reviewed it gave supportive feedback. Perhaps the
biggest indicator of this was PACTS commitment to adopt the program into its service in
preference to the programs they had been using. The adolescent girl’s group treatment will
now be piloted in Study 2 of the research.
CHAPTER 5

STUDY 2: EVALUATING THE EFFECTIVENESS OF THE ADOLESCENT GIRLS GROUP PROGRAM
You have torn my family apart and wrecked my childhood life. Unlike all those other kids who can look back at their childhood life and remember teddies and fun things. All I can remember is my mum and dad fighting because you decided that you wanted to have my mum all to yourself. Then all the other parts of when they are not fighting the only other things I remember is you abusing me (excerpt taken from a letter to the perpetrator, Girls Group participant, 2005).

Of the problems highlighted in Chapter 1 with regard to group treatment programs for CSA, perhaps most relevant at this juncture are the limitations of the evaluative techniques used in the group outcome studies. Treatments presented in Table 1.1 were said to be effective in achieving their aims but there was little indication of what made them effective. Furthermore, measures of effectiveness were based primarily on the reduction of psychological symptoms as measured by standardised assessment measures (e.g. Berliner & Saunders, 1996; De Luca et al., 1993; Sinclair et al., 1995). As argued in Chapter 1, this gives little indication of the real impact of therapy and does not take into consideration the heterogeneity of children who have been sexually abused. The current study endeavours to overcome some of the limitations of past research by using a research methodology which allows for the heterogeneity of participants and an approach to assessment and measurement of treatment outcome which is more holistic than simply measuring symptom reduction. Overall, this stage of the research aims to assess whether the new treatment program described in the previous chapter, is effective in helping adolescent survivors of CSA to alleviate distress and negative sequelae associated with CSA and develop new meaning around what it means to have been sexually abused as a child.

In overcoming the problems and restrictions of past outcome studies in this area, the current study will assess effectiveness in a more comprehensive manner. The evaluation will aim to measure both formative and summative aspects of the program, the way in which
both treatment content and process contribute to outcome, the experience of participants, the role of the facilitators and how acceptable consumers and facilitators consider the treatment to be. As highlighted at the beginning of this chapter, this study targets both phase four and phase five of the developmental intervention approach. However, as this is the first evaluation of the pilot treatment, principal importance will be given to the formative evaluation, which is in keeping with phase four.

Phase four of the developmental intervention research model aims to pilot test the intervention that has been designed in phase three. As Thomas (1984) asserts “design [of interventions] is tentative and exploratory, requiring further application, testing and validation” (p.152). Ostrofsky (1977) further adds that “design implies an iterative problem solving process” (p.6). Thus phase four of developmental intervention research is synonymous with what is otherwise known as a formative evaluation (Scriven, 1991). The aim of a formative evaluation is to determine how an intervention may be improved. It involves evaluating the intervention at a micro level and assessing all of the elements that may be helping or hindering the success of the program. In keeping with the concept of iteration and problem solving, when problems with the intervention are identified they are (if possible) immediately fixed and fed back into the cycle of evaluation (Fawcett et al., 1994; Richardson, 2003). Given the pilot nature of the current treatment program this appears to be the most ethical and responsive approach to take. Within the formative evaluation, both treatment content and process will be considered. Furthermore the views and opinions of both group participants and facilitators will be tapped to provide an important insight into what they feel is and is not working. The lived experience of therapy will also be measured using this approach (Sharp & Frechtling, 1997; Richardson, 2003). A formative approach will also allow for treatment integrity to be measured.
Whilst the formative evaluation is of principal importance at this stage of the development of the intervention, it is also important to show that the treatment is effective at achieving its stated aims by way of a summative evaluation. In Study 2 this will involve assessing participants prior to the intervention, immediately following the intervention and three months post intervention on a series of standardised and non-standardised questionnaires and via facilitator observation. Consistent with this approach, effectiveness of the intervention will be assessed by triangulating data from multiple sources. In addition to psychometric assessment, weight will be given to functionally relevant measures and evidence of clinically significant change. As a high degree of variability of symptomology is expected across participants in the group, within case analysis of treatment outcome will be important. This allows contextual information to be added to the data to better explain outcome and the reasons the treatment is or is not successful. For example in the study by Hack et al. (1994) it was noted that the treatment program was effective for five out of six children. In the case of the sixth child, a second perpetrator had been residing in the family home thereby impacting on the child’s psychological functioning and diminishing the effect of the group program. This highlights the importance of examining data trends on a case by case basis and is imperative at this stage of the development cycle for the current study when we are trying to determine whether the program is effective.

In drawing each of these elements together the current study aims to:

i) Conduct a formative analysis to describe and assess the effectiveness of the program through its development. This includes:

a. Component analysis
   i. Session evaluations
   ii. Knowledge attainment and retention

b. Process evaluation
   i. Facilitator observation of group

c. Evaluation of barriers to implementation and completion of the program
ii) Conduct a summative analysis within and across cases to assess the effectiveness of the program as a whole. The following summative program objectives were identified:

- To reduce subjective distress associated with the experience of CSA
- To reduce known risk factors associated with CSA
- To increase protective factors associated with better outcome from CSA
- To decrease emotional, cognitive and behavioural effects of CSA
- To explore the role resilience plays in mediating the effects and outcome of CSA

iii) Identify changes and modifications to be made to the treatment program

As with Study 1, this study will be conducted in collaboration with PACTS. PACTS will provide the venue for the group and a staff member as a co-facilitator. PACTS staff will also assist in the recruitment of group participants and will be involved in each phase of the research. As the program is run through PACTS it must meet with the mandates of this agency.

5.1 Method

5.1.1 Research Design

The strengths of a number of methodologies, both qualitative and quantitative, were drawn upon in designing this study. As described in Chapter 2 an action research approach to program evaluation was adopted. This approach includes both formative and summative evaluation methods to allow the program to be further developed while also demonstrating that it is effective.
In order to increase the reliability, validity and utility of the findings a mixed methods approach was used triangulating the qualitative and quantitative data. A simple A-B-A accountability case study design was used to capitalise on the strengths of the mixed methods approach and further strengthen the validity of the conclusions drawn. Many factors influenced this decision. In terms of the Western Australian context, a quasi or experimental design was not possible as referrals were such that there was an insufficient waitlist control group and no comparable groups operating in Perth to act as a comparison group. In addition, the power of the study with such a small number of potential participants would have been such that non-significant results would be likely. Furthermore given the pilot nature of the treatment being evaluated, a significant emphasis needed to be placed upon formative evaluation in order to improve the treatment further. As such a quasi or experimental design was unachievable in the local context and more importantly was inappropriate to achieve the aims of the current research. The chosen methodology is likely to be much more functional and produce much more useable results than an experimental design could achieve. In addition as discussed in Chapter 2, the design chosen overcomes many of the threats to internal validity by triangulating data and sources (Patton, 1990).

To overcome the difficulties related to spontaneous remission in a pre and post intervention outcome study that does not have a control condition Trowell et al. (2002) argue that the following should be specified in outcome research with CSA survivors – i) the severity of the abuse experience; ii) nature and complexity of family dysfunction; iii) length of time since last abuse episode; iv) level of protection after disclosure and v) severity of psychopathology at intake. Spontaneous remission is highly unlikely if a significant period of time has passed since disclosure and psychological difficulties are still present (Trowell et al., 2002). By reporting such factors, the argument for the utility of the treatment when improvements are noted at treatment end, can be strengthened. Hence, such factors are
reported in the current study. It should be noted however that some details are not reported to protect the anonymity of the participants. In addition to the factors listed above the process of triangulation also combats the argument for spontaneous remission and strengthens the validity of the findings.

5.1.2 Participants

Participants for this study included group facilitators and the adolescent girls taking part in the group. Group therapy sessions were facilitated by me (FA1) and a psychologist from PACTS (FA2). Both facilitators had experience in working with children and adolescents who had been sexually abused.

Inclusion criteria for the group included:

- Adolescent girls aged 12-15yrs
- Experience of sexual abuse within their lifetime substantiated by the Department for Community Development or Police
- Prior or concurrent individual counselling for sexual abuse
- Current issues or symptomology related to CSA
- Willingness to join the group and discuss their experience of CSA

Five female adolescents with an average age of 14.8 years (range 13-18yrs\(^4\)) participated in the group. One girl dropped out following the initial session and so has not been included in the analyses beyond noting and considering this fact. Four of the group participants were referred by the Department for Community Development. One was referred by a school psychologist.

Five potential participants were excluded from the group: two girls did not meet the age criteria, one girl did not appear to be currently affected by her abuse, one girl did not appear ready for group therapy (on account of insufficient individual therapy) and one girl’s

\(^4\) As will be elaborated on the next page, one 18 year old girl was included despite the age cut off of 15 years as she had an intellectual disability which made her mental age close to that of other group participants
experience was too disparate to the other members of the group and it was felt the other girl’s experiences may be traumatising for her. With the exception of the girls who did not meet age criteria, the remaining three participants all underwent an intake interview prior to being excluded and were offered individual therapy if they were not already engaged in this process.

The group participant profiles were as follows:

- Participant 1 (PA1) – 18 year old female with a mild intellectual disability. It is estimated that she was functioning at a 12 year old level for most tasks. For these reasons she was included in the group. PA1 presented with some symptoms of anxiety but largely joined the group for assistance in processing CSA. PA1 had experienced sexual abuse at three separate times in her life by three separate perpetrators (her step father, foster carer and a work colleague). The most significant was perpetrated by her step father and occurred between the ages 3-9 years. PA1 also experienced extreme neglect, physical and emotional abuse at this time. At the time of the group PA1 was living with a foster carer. However approximately half way through the group she moved out and lived alone.

- Participant 2 (PA2) – 13 year old female presented with anxiety, low self esteem and instances of self harm. PA2 and her two older siblings were sexually abused by their father. Severe threats and force were used during the abuse which occurred over a number of years. PA2 was living with her mother at the time of the group program.

- Participant 3 (PA3) – 14 year old female presenting with depression and anxiety symptoms. PA3 was sexually abused by her older brother. He had been convicted for this and removed from the family home. This brother was reported to be severely
depressed at the time of the incident. PA3’s family still had contact with her brother at the time of the group. PA3 was reported to be a gifted child who deliberately tried not to excel in school.

- Participant 5 (PA5) – 14 year old female. PA5 was referred for assistance with self esteem, self care and to better understand her experience of abuse. PA5 was also reported to be promiscuous. A problematic relationship with her mother was also indicated. PA5 was sexually abused by her father over a number of years. Severe threats and force were used during the abuse. It is noted that PA2 and PA5 were sisters.

It was also intended that non offending parents would be included as participants in the study however this was not possible as described below:

- PA1 – in the initial stages PA1’s foster mother indicated verbally she would take part in the project. Yet she did not return the questionnaires. Due to relationship difficulties between PA1 and her foster mother, PA1 left home midway through the group so the foster mother was no longer an appropriate informant;

- PA3 – PA3’s mother indicated that she was too busy to take part in the project;

- PA2 and PA5 – PA2 and PA5’s mother verbally agreed to take part in the project but never returned any of the materials. Since no other parents were taking part this was not pursued further.
Given the importance of ongoing evaluation of the program for accountability purposes, it is important that this issue of engaging parents is addressed in the future, both in terms of service provision as well as research.

5.1.3 Procedure

Referrals to the program were invited via a flier which was sent to relevant agencies within the Perth metropolitan area (see Appendix D). This included the Department for Community Development, Sexual Assault Resource Centre, Child and Adolescent Mental Health Services, Police Child Abuse Unit, Child Witness Service, and School Psychologists. Referrals to the program were very slow and the program was delayed for over eight months, due to insufficient numbers. When a referral was received the adolescent and the caregiver were invited to an initial intake assessment at PACTS. Following the assessment the referral went to a team meeting to determine suitability for inclusion in the program, as is normal practice at PACTS. Once accepted into the program participants were provided with a participant information sheet and signed the consent form (see Appendix E).

The group ran once a week for 16 weeks, with a two week break midway to allow for school holidays. Each session ran for one and a half hours. Appendix F provides specific attendance details. Pre test data were collected in the first session. Post test data were collected in the final session. Follow-up data were collected 12 weeks after the conclusion of the group. Formative data were collected at the conclusion of each session.

5.1.4 Data Capture Methods

Two separate types of data were collected. Broadly these have been broken into summative and formative measures (see Table 5.1). A copy of the measures may be found in Appendix G (with the exception of the TSCC). It is noted at this point that many of the
assessment measures were constructed for the study (those marked with an asterisk in Table 5.1). As indicated in Chapter 2 each of these measures was constructed in collaboration with staff from PACTS, a research supervisor (a clinical psychologist) and consultation with relevant literature. In combining both the formative and summative data capture methods, it is noted that there were in excess of 11,000⁵ separate data points for each participant as well as observations of each participant.

Table 5.1 Overview of Data Capture Methods and Timing of Data Collection

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<tr>
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<td>Participants</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Session Knowledge*</td>
<td>Participants</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood monitoring*</td>
<td>Participants</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekly facilitator questionnaire*</td>
<td>Facilitators</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitator observation</td>
<td>Facilitators</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.1.4.1 Summative measures

Many of the summative measures used in Study 1 were also used in Study 2 as they are appropriate for assessing current functioning of CSA survivors. These included the Trauma Symptom Checklist for Children, Resilience Scale, Demographics Questionnaire and the

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⁵ This figure is calculated by multiplying the number of test items by the number of testing points
Risk and Mood assessment. In the interest of brevity these measures will not be discussed again. Three measures were added. These included the intake assessment, Knowledge Questionnaire and Facilitator Questionnaire. Each of these measures is discussed below.

**Intake assessment**

Prior to beginning the group each participant and their caretaker attended a semi structured intake interview. During this interview participants were assessed to determine whether they were eligible for the group, their readiness for group and the similarities of abusive experiences between participants. This was to ensure a good ‘fit’ between group members and to ensure duty of care for each participant.

Information collected during this interview included abuse information (duration, type, use of force, use of threats, relationship to the perpetrator), the participant’s relationship to non offending parent(s), response of the perpetrator and outcome of legal proceedings (if any). Other salient factors were also recorded such as relevant medical information and academic achievement.

**Knowledge Questionnaire**

A knowledge questionnaire was constructed to assess the degree to which the core content of the program was understood and retained. The questionnaire consisted of 40 items presented in various formats including multiple choice, true/false and open ended questions (e.g. Sexual abuse is defined as: a. Adults having sexual intercourse with children; b. Adults touching children’s genitals; c. Being raped or; d. Any sexual contact or attempting sexual contact with a child by an adult). Between two and three questions were constructed for each session of the program and the order of questions followed the order in which the sessions were delivered. Question format was chosen on the basis of what appeared to
best suit the session content and type of question being asked. The questionnaire is scored out of 59. A criterion of 80% correct or greater was defined as the marker for evidence of successful attainment of the program’s content. The criterion of 80% was chosen as it was found by a previous researcher that 100% achievement was unrealistic (Richardson, 2003).

Facilitator Questionnaire

The facilitator questionnaire was developed to assess: personal objectives prior to beginning the group; the degree to which these objectives were achieved; the degree to which the goals of the group were achieved by each group member; the facilitator’s level of satisfaction with the group program and its activities; and recommendations for future groups.

5.1.4.2 Formative measures

Consumer Satisfaction Questionnaire

This measure is identical to the one used in Study 1. Please refer to Chapter 3 for details of this measure.

Group Session Evaluations & Sessional Knowledge

At the conclusion of each group session, participants were asked to complete a brief evaluation of the session. This questionnaire was developed by the researcher and forms part of the treatment manual. The scale has been included as a way to assess: session content, process and common factors of therapy; ways to improve sessions; and as a way of measuring functional behaviour change and learning. Participants were asked to give ratings of their mood before and after the group, how much they felt they contributed to the session, the degree to which they felt they understood the session content, how useful certain aspects of the session were and an overall sense what they thought of the session.
Open ended questions were also included to gauge what were the most and least helpful aspects of the sessions, what they felt they had learned, and whether the information would be helpful in the future. A brief knowledge test was also included in each evaluation. Each of these consisted of two or three questions that related to information presented in the session. This number was required in order to ask at least one question about the different concepts or ideas presented in the session. These were similar to the items presented in the Knowledge Test used for summative purposes in terms of their degree of complexity and the underlying concepts they were intending to tap on the basis of session content. It was important to assess both immediate comprehension of core program content and delayed recall and retention of content. This is why both measures of knowledge are utilised.

The evaluation of each session also included the Session Evaluation Questionnaire (SEQ) constructed by Stiles (1980). The SEQ is a process measure which includes 21 items and measures ratings of a session in a 7 point bipolar adjective format. The SEQ results in four indices: Depth, Smoothness, Positivity and Arousal. Higher scores on depth and smoothness indicate a more powerful, valuable and comfortable session. Higher scores on positivity and arousal indicate the mood and emotion of the session. The SEQ has been determined to be reliable and valid (Reynolds et al., 1996; Stiles et al 1994; Stiles & Snow 1994). The SEQ is appropriate for both therapist and client to complete.

Weekly Mood Monitoring

Participants were asked to keep a daily record of their mood. This included their average mood for the day, their best mood and their worst mood. Ratings were made on an 8 point scale. Higher ratings indicated a better mood. Participants were also encouraged to make note of any events that occurred that may have contributed to their mood. Return rates for
this measure were very poor. As a result it was decided that if the monitoring was not returned the girls would be asked to rate their mood for the day of the group and the preceding two days.

**Facilitator Questionnaires**

At the conclusion of each session facilitators completed a questionnaire developed by the researcher. This questionnaire aimed to measure the direction, orientation and atmosphere of the session, the dynamics between the co-facilitators, as well as strengths and weaknesses of the session. Facilitators also evaluated their personal performance. The depth and smoothness indices of the session evaluation questionnaire (Stiles, 1980) was also included as described above in the group session evaluation.

Facilitators also made ratings of each group member according to their perceived level of motivation, contribution, mutual support, trust, enjoyment and sense of belonging. Group members were also assessed for the presence of any risk factors associated with CSA (e.g. self harm, alcohol abuse, truancy). These assessments were based on information the girls provided incidentally in the group.

**Facilitator Observation**

Observations of progress of group members were made at the conclusion of each session. In particular mood, presentation, and problems from the week were noted. Elements of the group process and common factors of therapy were also captured such as interactions between group members, interactions with facilitators, and response to the session’s activities. An attempt was also made to gauge the group’s level of understanding of the session’s topic. For example by observing the group members in structured role plays, an
5.2 Results and Discussion

SUMMATIVE EVALUATION

The following section presents the outcome data collected throughout the study. In accordance with the mixed methods accountability tradition, the within case analysis assesses change for each participant across the three assessment phases and is presented by way of participant portfolios to maintain the richness of contextualised data (Barnett et al., 1999). The within case analysis is followed by the cross case analysis and presents a summary of the quantitative and standardised assessment tools across participants. Relevant data and observations from facilitators are then presented.

5.2.1 Within Case Analysis - Participant Portfolios & Contextual Analysis

Access to this section has been restricted for a period of 36 months due to ethical issues associated with the data. Please contact the author should you require this information at kelshaun@bigpond.net.au

5.2.2 Cross Case Analysis

Below are the results from the quantitative assessment tools across each of the cases. As was anticipated and outlined above, there is a large degree of variability between participants in terms of their presenting problems and areas of concern. Given this degree of variability and the small sample size present, the use of inferential statistics was
considered inappropriate for the cross case analysis (Howitt & Cramer, 1997). Whilst it would have been potentially useful to use statistics as a way of giving a quick snapshot of the impact of the program at a global level, such an approach would have obscured the results rather than clarifying them. The reader is referred to the boxplots presented in Appendix H to verify the variability of data suggested here. On account of this and in the interest of brevity and completeness, a summary of each measure is presented with relevant case examples which exemplify the findings of the cross case analysis. Conclusions are drawn on this basis. Nevertheless, it is noted that the results are best understood in the context of the within case analysis presented above.

TSCC

With the exception of PA2 on two subscales (anxiety and sexual concern) and PA5 on one subscale (anger), improvements in TSCC subscale scores from pre-test to follow-up are evident for the participants (see Table 5.2).

Table 5.2  

<table>
<thead>
<tr>
<th>Subscale</th>
<th>PA1</th>
<th>PA2</th>
<th>PA3</th>
<th>PA5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Range</td>
<td>Normal</td>
<td>Normal</td>
<td>Clinical to Normal</td>
</tr>
<tr>
<td>Magnitude</td>
<td>-2</td>
<td>+10</td>
<td>-21*</td>
<td>-8</td>
</tr>
<tr>
<td>Depression</td>
<td>Range</td>
<td>Normal</td>
<td>Clinical</td>
<td>Clinical</td>
</tr>
<tr>
<td>Magnitude</td>
<td>0</td>
<td>-13*</td>
<td>-4</td>
<td>-9</td>
</tr>
<tr>
<td>Anger</td>
<td>Range</td>
<td>Normal</td>
<td>Clinical to Normal</td>
<td>Clinical to Normal</td>
</tr>
<tr>
<td>Magnitude</td>
<td>-3</td>
<td>-7</td>
<td>-5</td>
<td>+1</td>
</tr>
<tr>
<td>PTSD</td>
<td>Range</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Magnitude</td>
<td>-11*</td>
<td>0</td>
<td>-4</td>
<td>-6</td>
</tr>
<tr>
<td>Dissociation</td>
<td>Range</td>
<td>Normal</td>
<td>Clinical to Borderline</td>
<td>Clinical to Normal</td>
</tr>
<tr>
<td>Magnitude</td>
<td>-7</td>
<td>-5</td>
<td>-6</td>
<td>-7</td>
</tr>
<tr>
<td>Sexual Concern</td>
<td>Range</td>
<td>Normal</td>
<td>Normal to Clinical</td>
<td>Clinical to Normal</td>
</tr>
<tr>
<td>Magnitude</td>
<td>-18*</td>
<td>+5</td>
<td>-32*</td>
<td>-9</td>
</tr>
</tbody>
</table>

*denotes clinically significant change
It is noted that two of the participants were considerably more symptomatic than the other two which makes comparisons across the group more difficult and as Table 5.2 shows, some participants had greater change from pre test to follow-up than others. Any improvement of 10 points or more (i.e. one standard deviation) is considered clinically significant. Thus PA1 had clinically significant improvement in terms of PTSD and sexual concerns. PA2 had a clinically significant decline in depression and PA3 improved significantly in terms of anxiety and sexual concerns. All four girls showed declines in dissociation scores on the TSCC. Three of the four girls showed significant decreases on the sexual concerns index of the TSCC. Improvements in depression, PTSD and anger are also evident. Overall the results of this measure show considerable, and in many cases clinically significant changes in participant’s abuse related distress after their attendance at the treatment program.

**Emotions**

The mood scale measured participants emotions, attributions and cognitive distortions associated with CSA, which had been present in the week preceding data collection. In analysing the change from pre test to follow-up a number of changes are evident. Three of the four girls reported feeling less guilty, the other (PA1) indicated that she felt little guilt across the three testing phases. Three of the four girls also indicated they were more in control and confident at follow-up. Unexpectedly three of the four girls indicated that they felt increasingly misunderstood over the three testing periods. The fourth girl (PA3) decreased by 1 point but her rating remained high. This is difficult to interpret in the context of the other findings and perhaps requires further investigation. It may depend upon whom the girls felt they are being misunderstood by. One hypothesis may be that this feeling of misunderstanding has been created in the family environment (which in each of the girls in the study was lacking in support) being contrasted with the experiencing of a supportive,
trusting and understanding environment in group, but this hypothesis needs testing in future studies. Other changes across other scales on this measure are more disparate and as such are best interpreted in the context of the individual participants in 5.2.1. Overall it can be concluded that following the group there was a positive impact on the participant’s sense of control, confidence and feelings of guilt but a negative impact on feelings of being understood.

Risk Factors
All girls decreased in the number of risk factors (for a poorer outcome from CSA) relative to pre testing. In many cases it is noted that these risk factors did not disappear entirely but decreased in severity and/or frequency. At follow-up the risk factors appearing to be affecting most girls to some extent included: sleep problems, difficulty concentrating, risk taking, use of alcohol, trouble with family, mood swings and feelings of isolation. It is noted that all girls indicated that they had difficulty talking about their feelings at pre test as opposed to only one girl at follow-up. Similar declines with feeling ‘on guard’ and withdrawn are also apparent from pre test to follow-up for 3 of the 4 girls. As with the other scales, the nature of these changes are best considered within the context of the individual participants as each showed different risk factors and contextual situations which mediated these risk factors.

Knowledge
Generally, the knowledge test results suggested that knowledge was not sufficiently attained when using the criterion of at least 80% correct as previously defined in the method section. The extent of missing data (up to 50% for one participant) is difficult to interpret in the context of this test, but is explored further in section 5.2.5 with formative data provided from the sessional knowledge tests. Table 5.3 presents the scores on the knowledge test
across the three testing phases. Scores are presented as percentages. On account of the large portion of missing data, scores were also calculated based on the questions the participants attempted to answer. Whilst it is recognised that participants may not have answered the questions because they did not know the answer, the information presented in 5.2.5 suggests that this may not have been the case and further implicates the problematic nature of this type of assessment for this population.

Table 5.3 Percentage Correct on the Knowledge Test across the Three Testing Phases

<table>
<thead>
<tr>
<th>Participant</th>
<th>PA1</th>
<th>PA2</th>
<th>PA3</th>
<th>PA5</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Answered</td>
<td>100</td>
<td>73</td>
<td>75</td>
<td>58</td>
</tr>
<tr>
<td>% Correct</td>
<td>66</td>
<td>37.3</td>
<td>56</td>
<td>32</td>
</tr>
<tr>
<td>% Answered correctly</td>
<td>66</td>
<td>46.8</td>
<td>91.7</td>
<td>43.2</td>
</tr>
<tr>
<td>% Answered</td>
<td>100</td>
<td>81</td>
<td>77</td>
<td>56</td>
</tr>
<tr>
<td>% Correct</td>
<td>66</td>
<td>57</td>
<td>57</td>
<td>30.5</td>
</tr>
<tr>
<td>% Answered correctly</td>
<td>66</td>
<td>57</td>
<td>87.2</td>
<td>58</td>
</tr>
<tr>
<td>% Answered</td>
<td>100</td>
<td>70</td>
<td>64</td>
<td>75</td>
</tr>
<tr>
<td>% Correct</td>
<td>71</td>
<td>33.9</td>
<td>64</td>
<td>45</td>
</tr>
<tr>
<td>% Answered correctly</td>
<td>71</td>
<td>33.9</td>
<td>100</td>
<td>60</td>
</tr>
</tbody>
</table>

Note. % answered = the % of questions attempted; % correct = the % answered correctly out of the total possible on the questionnaire; % answered correctly is calculated by assessing the % correct out of those questions attempted.

Furthermore it is useful to know if the participants’ knowledge of the questions they chose to answer improved over time. PA1 is the only participant to attempt to answer all questions and her results show a very minimal improvement at follow-up. PA2 appears to have not maintained the knowledge which she had even prior to entering the program and her score at follow-up may in fact reflect the way in which she approached the test (see her portfolio for details). PA3’s knowledge remains largely unchanged, although it is positive that of the
questions she chose to answer at follow-up that she got them all correct. A slight improvement in knowledge across PA5’s scores is apparent. As was highlighted in the portfolio’s, these scores in general are in contrast to behavioural indicators of program knowledge observed by the facilitators and this process of data triangulation (and triangulation of sources) adds weight to the conclusion that the scale did not provide a valid reflection of participants knowledge.

Resilience

Participants’ responses on the resilience scale are difficult to interpret (see Table 5.4). Overall if a moderate score of 100 (range 25-175) is taken for this measure then three of the girls (PA1, PA2 and PA5) seem remarkably resilient given their life history. PA1 and PA5 appear to be more resilient than PA2 and PA3. There is some evidence to suggest that the two girls (PA1 & PA5) who scored better on the TSCC (and therefore were less psychologically distressed) also have higher resilience scores, perhaps suggesting that resilience is a mediator of CSA sequelae, however there is insufficient evidence to conclude this. However three of the girls appear to have declined on this measure at post test but improved at follow-up. The reverse is true for PA5. The scale itself was perhaps not appropriate and adds little to the understanding of the treatment program and therefore it is not recommended for use in future research.

Table 5.4  *Resilience Test Scores across the Three Testing Phases*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Pre Test</th>
<th>Post Test</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA1</td>
<td>138</td>
<td>127</td>
<td>144</td>
</tr>
<tr>
<td>PA2</td>
<td>95</td>
<td>92</td>
<td>113</td>
</tr>
<tr>
<td>PA3</td>
<td>85</td>
<td>70</td>
<td>85</td>
</tr>
<tr>
<td>PA5</td>
<td>102</td>
<td>125</td>
<td>100</td>
</tr>
</tbody>
</table>

*Note.* Potential scores range from 25 to 175. Items are rated on a 7 point Likert scale.
5.2.3 Facilitator Ratings of Outcome

In addition to the self report data from participants, contextual data and facilitator observation, the facilitators also completed independent ratings of outcome for each participant across the program objectives immediately following week 16 of the program. Overall these ratings suggest that each participant adequately attained the majority of the objectives of the program (with the exception of assertiveness and peer and family relation skills). This was rated on a 5 point scale of attainment, ranging from 1 (not attained) through 5 (high attainment). The ratings for each objective are presented in Table 5.5. According to the facilitators ratings, PA5 was ranked lowest (i.e. attained the least from the group) and PA3 was ranked highest (i.e. attained the most from the group). This is also reflective of the changes that occurred in the other measurement tools (e.g. TSCC – see portfolios in section 5.2.1).

Table 5.5  Facilitator Ratings of Program Objectives for each Participant at Post test

<table>
<thead>
<tr>
<th>Objective</th>
<th>PA1</th>
<th>PA2</th>
<th>PA3</th>
<th>PA4</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ↑ emotional expression skills and knowledge</td>
<td>FA1</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>2. ↑ relaxation skills and knowledge</td>
<td>FA1</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>3. ↑ cognitive coping skills and knowledge</td>
<td>FA1</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4. ↑ personal safety knowledge and skills</td>
<td>FA1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>5. ↑ understanding/knowledge regarding CSA</td>
<td>FA1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>6. ↑ understanding/knowledge regarding healthy sexuality</td>
<td>FA1</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
Group Treatment for Sexually Abused Adolescent Girls

<table>
<thead>
<tr>
<th>Objective</th>
<th>PA1</th>
<th>PA2</th>
<th>PA3</th>
<th>PA4</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. ↑ self esteem</td>
<td>FA1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3.00</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2.75</td>
</tr>
<tr>
<td>8. ↑ assertiveness</td>
<td>FA1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2.75</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2.00</td>
</tr>
<tr>
<td>9. ↑ peer and family relation skills</td>
<td>FA1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2.00</td>
</tr>
<tr>
<td>10. ↓ emotional and behavioural difficulties</td>
<td>FA1</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>3.00</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2.75</td>
</tr>
<tr>
<td>11. ↓ avoidance and social isolation</td>
<td>FA1</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4.00</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2.50</td>
</tr>
<tr>
<td>12. ↓ feelings of self blame and shame</td>
<td>FA1</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3.25</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2.75</td>
</tr>
</tbody>
</table>

Note. Scale ranges from 1 (not attained) to 5 (high attainment)

It is noted that the agreement between facilitators was high and only differed by more than one point on two occasions. This was for PA1 and PA5 on objective 11. In both instances I (FA1) felt that these two participants had attained this objective by rating them 4/5 whereas FA2 did not and rated 2/5. It is conceivable that the two facilitators approached this objective in a different way. I (FA1) considered this objective to be largely achieved through participant’s attendance at the program and willingness to disclose and discuss their experience with other survivors. FA2 perhaps did not conceive of this objective in this manner and considered it more in the context of the social lives of the girls.

In addition to rating the attainment of the core themes of the group, the facilitators also completed pre and post intervention ratings of the group aims (see Table 5.6). In an overall sense the facilitators felt that the group was ‘somewhat effective’ in i) decreasing risk factors associated with CSA ii) increasing protective factors and iii) decreasing known effects of CSA. These ratings were based on observations of the changes in each group member.
(e.g. general presentation, level of psychopathology, ability to function in the world) and the ratings made at post test on these factors and the specific objectives discussed above. The three major goals of the group were ranked by each facilitator on a 7 point scale from no change to great change. At post test all were ranked at 4 or 5 out of 7 suggesting some changes occurred but that the changes were not profound. This is possibly unsurprising given the nature of the group. That is, each participant was still suffering from the effects of CSA years after their abusive experience, despite undergoing individual counselling in relation to CSA. From the outset (as indicated by pre group ratings in Table 5.6) the facilitators did not expect that full symptom alleviation would occur directly following the attendance at the program for each group member. That is, the facilitators felt it unlikely even prior to the beginning of the group (on the basis of prior knowledge about the effects of CSA), that the sequelae of participants would be fully alleviated in a 16 week program which only focuses on the client and not the client’s environment.

Table 5.6 Facilitators Ratings of Estimated Attainment of Group Aims Pre and Post Group on a Scale of 1 to 7

<table>
<thead>
<tr>
<th>Facilitator</th>
<th>Expected Pre Group</th>
<th>Actual Post Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>FA1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>FA2</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>FA1</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>FA2</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>FA1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>FA2</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

*Note. Higher scores indicate greater attainment of aims*

It was thought that the change in participants would be slow and steady and continue beyond the completion of the group. A prediction was made by the facilitators at post testing that greater changes would be observed in the participants at 3 month follow-up after they had had time to consolidate their learning. This fits with the discussion presented in Chapter 2 in relation to real world effects and highlights the importance of predicting the way in
which the researcher expects the intervention to affect the participants. In this instance the prediction of a ‘sleeper effect’ (Hawe et al., 1990) was apt. Many of the scores across each participant were shown to continue to improve from post test to follow-up, although there are exceptions (e.g. PA2’s knowledge score). This is why the facilitators were only able to rate the program as ‘somewhat effective’ in achieving its aims.

5.2.4 Summary of Summative Findings

Some positive changes were apparent for each group member at the end of the group and also 3 months after the group had concluded. All group members showed some declines across the subscales of the TSCC. All had declines in dissociation and three of the four participants showed decreases in sexual concerns and symptoms of depression. The group members also reported being more in control, more confident and feeling less guilty after participating in the group. Finally all girls showed decreases in the number of factors associated with a poorer outcome from child sexual abuse (e.g. sleeping problems, eating problems, truancy, relationship difficulties, risk taking). Nevertheless many concerning and indeed problematic signs of maladjustment remained present following the intervention for each participant, despite their notable improvements and there was evidence of worsening performance on some indicators for some participants.

Change for each girl was idiosyncratic and often not reflected in all measures or even any formal measures but in structured and unstructured observations of the girls. For instance, the results of the knowledge questionnaire showed little change in participants understanding of core treatment components. Given such a finding one may have expected little change in other outcome measures (i.e. if the participants did not grasp the concepts of the sessions, then they would be less likely to make changes which would lead to symptom alleviation or changes in attributions about CSA). However the knowledge test scores
conflicted with both observations in session and facilitators ratings of program objectives. According to the facilitators each participant adequately attained each of the program objectives and this may be associated with the positive changes noted for each participant in their portfolios. The facilitator’s ratings of outcome indicated that PA3 made the most gains from the program and PA5 the least. This also appears to be consistent with the participants self report measures. Such a finding has important implications for the assessment tools used and indeed the approach taken to assessing efficacy of the program. That is, in future evaluations of this program greater focus may need to be placed upon observational measures and measures which are able to assess the extent to which participants are/have processed their experience, perhaps by capturing the expression of their story in creative pieces (e.g. poems and short stories). But it also points to the importance of the process of triangulation of several measures to strengthen the validity of inference.

All four girls suffered quite a severe level of abuse and each outcome after the 16 week program was quite different. It is interesting to note that the two sisters had very different presentations despite undergoing the same experience for the same length of time and within the same family. Perhaps this suggests other mediating factors such as personality may be involved in the outcome from treatment. Attributional style and coping style are also worth investigating.

Whilst positive outcomes are apparent in this program, a number of contradictory and counterintuitive results were also presented. For example all of the girls reported feeling more misunderstood following the program, yet this was not observed within the group environment by the facilitators and is in contrast to each girl’s reports about the importance of the group as a support mechanism. Their ratings may in fact reflect a contrast between
the supportive environment of group and other areas of their lives. Another example is the contrast between self reported knowledge of core content versus knowledge observed by the facilitators as well as application of knowledge within the group environment. These results highlight the importance of triangulation and not relying on one measure or one informant to direct the analysis of the findings presented. The importance of placing the results within the context of participant’s lives is also highlighted. For example PA3’s scores at post test only show minimal improvements. When these results are interpreted in the context of PA3’s family life (i.e. she was still having regular contact with her brother - the perpetrator), this appears to make much more sense. Similarly, many of PA1’s scores contrast with the gains she made (e.g. her failure to gain knowledge). As noted these are likely to be impacted upon by current life stressors (e.g. moving out of home, gaining full time employment) and her intellectual disability as opposed to the impact of her experience of CSA. The enmeshed environment in which PA2 and PA5 live was also a potential mediator of their outcome from the program. Each of these findings highlight the importance of contextualising findings and perhaps also highlight the need for treatments with this population to go beyond the individual client and also target the clients environment by targeting parents as facilitative change agents. The family environment of each participant appeared to be an important mediator of treatment outcome.

The contextualised nature of the data presented in the portfolios also highlighted elements of group process and common therapeutic factors that were important to the outcome of the treatment. For example some of the girls engaged well with one another but some did not. The impact of having sisters in the group was also noted. Some girls had stronger alliances with the facilitators than others. All the girls were relatively avoidant and found self disclosure difficult and this may be reflected in the fact that the group was not very cohesive. Each of these factors may explain why greater outcomes were not achieved from
attendance at the group. On the other hand the ‘universality’ (Yalom, 1995) of the group was highlighted in many of the girl’s comments and seemed to have positive effect. It is expected that process and common factors will be further captured and illuminated in the formative evaluation.

The utility of the Participant Portfolio methodology is further highlighted when it is considered that each participant initially presented with quite different symptoms and concerns. Such variability makes it difficult to compare outcomes across the group. By using the portfolio technique the magnitude of change in each participant is highlighted and a richer, more detailed description of the findings is gained. The results therefore demonstrate the impact for each participant following the group and show that this impact was significant in changing the trajectory of these girls’ lives. Whilst causality can not be clearly demonstrated using this methodology, these data would suggest that accounting for these changes by invoking spontaneous remission of symptoms is highly unlikely given that:

- All girls had had past individual counselling and there were still considerable concerns/issues that needed to be targeted;
- Symptoms had been present for a considerable period of time and as such were unlikely to disappear by themselves;
- Symptoms were significant enough in each case to impact on the girl’s ability to function in day to day life – e.g. losing work placements, performing poorly at school and self harming.

In sum, although there was a degree of ambiguity in the data, the results of the summative evaluation provide some evidence to support the effectiveness of the treatment program. There appears to be evidence that each participant made gains in processing their
experience of sexual abuse and in some instances subjective distress and risk factors associated with CSA also declined. There is also evidence to suggest that each participant gained relevant protective skills which are associated with a better outcome from CSA. Nevertheless each participant continued to present with concerning symptomology at follow-up. There was little evidence to support the use of the resilience measure as a mediator of outcome from CSA. These reservations and divergent findings give weight to the need for (i) program refinement and re-evaluation; (ii) the need to further improve assessment to accurately assess outcomes; and (iii) the importance of formative data in unpicking these interpretations. As indicated in earlier chapters the effectiveness of the program is likely to be mediated by a number of factors associated with the treatments acceptability, integrity, content and components and group process. These are assessed in the formative evaluation below.

**FORMATIVE EVALUATION**

This formative evaluation is based on the findings of the consumer satisfaction questionnaire and weekly session evaluations completed by participants, and the weekly facilitator questionnaires and observations made by facilitators. The formative evaluation is intended to assess each component of the treatment program, to identify areas in need of improvement and also assess factors which may be aiding or hindering the effectiveness of the program. The results of the formative analysis are presented below and culminate with recommendations about the way in which the treatment program should proceed.

**5.2.5 Program Evaluation and Component Analysis**

*Acceptability*

The most outstanding finding of the current study relates to the satisfaction level of the participants, as measured by the consumer satisfaction questionnaire. Their responses
indicated that the group was highly valued and the participants enjoyed attending. The mean acceptability rating of the group was 75% (range 60-87%), suggesting that the group was both beneficial and useful to participants. Table 5.7 highlights the specific findings of the consumer satisfaction questionnaire. Overall the participants were satisfied with the quality of the service they received and felt that it was a useful program. Only one participant felt that the group met few of her needs. The participants ratings also indicate that they were satisfied with the amount and type of help they received.

Table 5.7 Consumer Satisfaction Item Scores as Rated by Participants

<table>
<thead>
<tr>
<th>Item</th>
<th>N</th>
<th>Score /7 Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Service</td>
<td>1</td>
<td>4          average</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>5          good</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>7          excellent</td>
</tr>
<tr>
<td>Utility</td>
<td>1</td>
<td>4          average</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>5          somewhat useful</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>6          useful</td>
</tr>
<tr>
<td>Satisfaction with amount of help</td>
<td>1</td>
<td>4          neither satisfied or dissatisfied</td>
</tr>
<tr>
<td>received</td>
<td>1</td>
<td>6          satisfied</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>7          very satisfied</td>
</tr>
<tr>
<td>Satisfaction with type of help</td>
<td>1</td>
<td>4          neither satisfied or dissatisfied</td>
</tr>
<tr>
<td>received</td>
<td>1</td>
<td>5          generally satisfied</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>6          mostly satisfied</td>
</tr>
<tr>
<td>Extent program met needs</td>
<td>1</td>
<td>3          few needs met</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>6          most needs met</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>7          almost all needs met</td>
</tr>
<tr>
<td>Enjoyment of attending</td>
<td>1</td>
<td>4          a little</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>5          quite a bit</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>7          a lot</td>
</tr>
<tr>
<td>Overall satisfaction</td>
<td>1</td>
<td>4          neither satisfied or dissatisfied</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>5          mostly satisfied</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>6          satisfied</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>7          very satisfied</td>
</tr>
</tbody>
</table>

In addition to the findings presented in Table 5.7, the girls also indicated that the group was effective in: helping them to deal with their lives (1 a little [4/7]; 2 somewhat [5/7]; 1 quite a lot [6/7]); deal with family (3 somewhat [5/7]; 1 a great deal [7/7]); handle relationships (1 a little [4/7]; 2 somewhat [5/7]; 1 quite a lot [6/7]); and develop skills to use
in life (1 a little [4/7]; 2 somewhat [5/7]; 1 quite a lot [6/7]). All four girls indicated that they would recommend the group to other girls who had experienced sexual abuse. One participant noted that the group “helps get you through.” With the exception of one rating (PA2’s rating that the program met few of her needs) all ratings were at or above 4/7 indicating that the girls were satisfied with the program.

SEQ

Session depth, smoothness, arousal and positivity were calculated. Each scale was scored on a scale which ranges from 1 to 7, with higher scores indicating a more favourable rating of the session. It is noted from the outset that only one participant and as a result one facilitator, were present for session 8 and the SEQ graphs reflect this.

Depth is a measure of how powerful and valuable versus weak and worthless each session was. The overall mean depth rating for the participants across the 16 sessions was 4.24 (SD = 0.46). Facilitators ratings were 4.24 (FA1) and 4.46 (FA2). Facilitators indicated that week 6 (‘What is CSA?’), 10 (‘Secrets, shame and guilt 1’) and 12 (‘Secrets, shame and guilt 2’/‘Memories and Nightmares’) were the deepest sessions (see Figure 5.10). Participant ratings of session depth were less clear as seen in Figure 5.9.

![Figure 5.9. Session depth for participants.](image-url)
No session was ever rated below 3, indicating that none of the sessions were considered to be “weak” or “worthless”. There were no obvious sessions that all participants felt were deeper than another, which once again demonstrates the individuality of each participant’s situation. PA3 consistently rated the sessions more highly than other participants. There appears to be no specific reason for this although it could be proposed that either she felt more strongly about the sessions than the other girls or given the subjective nature of the scale she simply interpreted it differently to the others.

Figure 5.10. Session depth for facilitators.

Figure 5.11. Session Smoothness for participants.
Figure 5.12. Session Smoothness for facilitators.

Arousal and positivity are measures of post session mood. These ratings were only completed by participants. The ratings of arousal and positivity across each session are presented in Figures 5.13 and 5.14.

Figure 5.13. Participant ratings of session arousal.

The mean level of arousal was 3.68 (SD = 0.54). The mean level of positivity was 4.21 (SD = 0.70). This suggests that following each session the group participants were feeling ‘ok.’ This is in line with other ratings of mood completed by the girls before and after each session. On average the girls appeared to rate their mood as ‘ok’ or ‘good’ on a 5-point
scale from Very Poor to Very Good. These ratings also suggest that in the majority of cases the girl’s mood stayed the same over the course of the session or in fact improved. Mood was only shown to decrease from pre session ratings on two occasions – for both PA1 and PA5 in week 12 (secrets 2/memories and nightmares) and PA2 in week 16 (finishing up).

![Figure 5.14. Participant’s ratings of session positivity.](image)

In sum, the results from the SEQ suggested that each session of the program was considered by both participants and facilitators to be appropriately deep and smooth. In addition the participants highlighted that each session had a positive impact on their mood. The favourable ratings of each session seem to indicate that the process factors operating were important factors in the outcome of the program and that the sessions sufficiently met the requirements and expectations of the participants. Such a finding also has implications in relation to the appropriateness of session content. That is, given that this was such a structured program, participants positive ratings are also likely to reflect the activities that they completed. This is further explored in subsequent sections.
Session Evaluation

Overall rating: An overall rating of each session was obtained from participants on a 5 point scale ranging from 1 (very good) to 5 (poor). Only one rating of 4 (not so good) and 5 (poor) were received across the 16 sessions from one participant (PA5). She rated session 5 (cognitive coping) as not so good. Of note, is that this rating appeared to reflect her pre-existing mood on the day. PA5 was absent for much of this session on account of being outside the room discussing current life stressors with one of the co-facilitators. PA5 also rated session 7 (stuck feelings) as poor. This coincided with her grieving the loss of three friends in a motor vehicle accident. If these two ratings are excluded the majority of ratings for the sessions fell into the good (n=28) or ok (n = 17) categories. Two ratings of very good were received. PA1 rated session 2 as very good. PA2 rated session 16 as very good.

In addition to the overall rating provided by participants, each session was rated by facilitators and participants on a 7 point adjective scale which ranged from bad to good. This item also forms part of the SEQ however it is not included in the indices discussed above as it tends to load differently for clients and therapists in factor analytic studies (Reynolds et al., 1996). Therapists tend to see the dimension as more indicative of session depth and clients tend to see it as indicative of smoothness. Higher scores indicate that the sessions were considered to be good. The overall mean good/bad rating for the 16 sessions was 5.00 (SD = 0.82) and 4.71 (SD = 0.82) for facilitators, and 4.67 (SD = 1.12) for group members. A session by session rating is presented in Figures 5.15 and 5.16. Such ratings suggest that overall the sessions were viewed as being good. This finding is open to interpretation given that bad and good are such global terms. Sessions 4, 6, 12, and 13 were rated highest by the facilitators. Session 6 (‘What is CSA?’) in particular was observed to be very good as the group were very involved and interactive and the session had a good ‘feel’ to it. It is more difficult to determine which sessions were preferred by
group members given that they did not all attend every session. PA3’s ratings were consistently higher than other participants.

![Graph showing participant ratings of how good/bad the session was.](image)

*Figure 5.15. Participant ratings of how good/bad the session was.*

Session 9 (healthy sexuality) was rated lowest by facilitators (3 and 3.5 respectively). This is the only session rated below 4 by the facilitators. This session was rated in such a way for a variety of reasons. Firstly the participants approached the topic with a degree of immaturity and displayed this by acting out in the session. Secondly the facilitators did not feel overly knowledgeable with the content, particularly FA2. Thirdly the session was designed as a ‘refresher’ as it was assumed that such information would have been covered in health education at school. It appeared that either this information had not been taught or that the girls had been unable to take it in perhaps because of their experience of CSA.

Four ratings below 4 were given by the participants. It could be argued that these ratings may have reflected the girl’s internal mood states rather than their feelings about the session. For example in session 4, PA5 rated the session as a 3 when the other girls have rated 6’s and 7’s. In this session PA5’s mood was observed to be very flat and she chose not to participate in some activities but gave no indication of what was affecting her mood.
It was unlikely to be related to the material of the session in that this session focused upon self esteem. Thus the indication was that there were some inconsistencies in the ratings of how good or bad the sessions were.

**Usefulness:** Ratings of how useful each session was in helping the participants to understand the various themes of the program were obtained. These were rated on a 5 point scale from 1 (very useful) to 5 (not useful at all). The mean rating for all sessions was 2.14 ($SD = 0.88$) suggesting that all sessions were on average considered to be useful. Across the 16 sessions no themes were rated below 3 by either participants or facilitators indicating that all themes were considered at least somewhat useful to the group participants. More specifically there were 25 ratings of very useful, 26 ratings of useful and 31 ratings of somewhat useful.

![Bar chart showing facilitator ratings of how good/bad the session was.](image)

**Figure 5.16.** Facilitator ratings of how good/bad the session was.

**Understanding:** Participants were asked how easily they were able to understand each session. Only one instance of difficulty in understanding a session was reported. This was by PA2 in session 9 (healthy sexuality). It was observed in this session that PA2 had little knowledge of this subject material but was eager to learn. This concurs with the facilitators
feelings about the session as discussed in the previous section (overall rating) and has implications for the utility of such a session.

Participants were also asked in an open ended question if there was anything they did not understand from a session. This was reported on four occasions. PA1 indicated that there were parts of session 6 (‘What is CSA?’) and session 7 (‘Stuck feelings’) that she did not understand. PA5 indicated that there were parts of session 9 (‘Healthy sexuality’) and session 13 (‘Communication’) that she did not understand. Participants were asked to indicate specifically what activities or content they did not understand but no answers were given. It is possible however that the participants had difficulty articulating what it was that they did not understand.

Ratings by facilitators also suggest that the program content seemed to be understood on most occasions. Two exceptions are session 5 (cognitive coping) and session 9 (healthy sexuality) as discussed above. Based on observations of the way in which the girls approached the activities in session and the participant’s worksheets for the session, the facilitators concluded that the girls had some difficulty understanding the ABC model and that perhaps this was being taught in too much of an ‘adult’ way. However only one facilitator (FA2) was available to teach this session as the other facilitator (FA1) was occupied with a participant outside the room. This may have also had implications for the dynamic of the session. Changes will need to be made to these sessions to increase comprehension.

Helpful for future: On three occasions participants indicated that they did not learn anything helpful in the session that they would use in the future. In session 12 (secrets 2) PA1 indicated that she had not learnt anything helpful. However she did not explain her answer
any further. Given that this was the session in which the girls disclosed details of their abuse it could be hypothesised that such a rating is based on either mood state or an indication that she found the disclosure unhelpful. PA1 rated herself as feeling good before the session and not so good after the session.

PA2 indicated that she did not learn anything beneficial on two occasions, session 6 (‘What is CSA?’) and session 4 (‘Self esteem’). In session 6, PA2 indicated that she had not learnt anything because “i no [sic] all i need 2[sic] no [sic]” – regardless she rated the session as very useful. In session 4 no reason was given for her rating. Similar to session 6, she reported session 4 was useful, easily understood and that she had learnt more about self esteem. Hence her responses appear contradictory.

In 90% of instances participants indicated that they had learnt something that would be helpful in the future. However it is difficult to know what exactly the participants felt they had learned as they infrequently answered the open ended component of the question. This appeared to occur for most open ended questions in the assessment battery and may suggest that this style of questioning is not appropriate for adolescents. On the occasions that they did complete this aspect of the question, the participants indicated that they learned about or would use in the future the following: relaxation, problem solving, emotions, contraceptives, and thinking about safety. The most powerful responses to this question included “that I’m not the only one” (PA2 & 5 session 1 and 6); “it would all help me” (PA5 – session 3); “I learnt not to feel guilty” (PA1 – session 10); “it’s not my fault” (PA2 – session 10); and “I don’t have to be ashamed” (PA5 – session 10). On 14 occasions the participants failed to answer this question.
Mood pre and post session: Participants rated their mood prior to and immediately following each session on a 5 point scale from very good (1) to very poor (5). The mean mood ratings are presented in Figure 5.17. This demonstrates that participant’s mood on average only worsened in one session (Week 12). Unsurprisingly this was the session in which the disclosure took place. Hence the overall implication is that the sessions had a positive impact on the participants in terms of their acute internal mood states.

![Figure 5.17](image-url)  
*Figure 5.17. Mean ratings of mood before and after each session plus or minus one standard deviation.*

Qualitative feedback: Session evaluations consisted of a number of open ended questions that participants were invited to answer. In the majority of cases these questions were left blank and as such cannot be reported on. It is hypothesised that these questions were left blank because the participants were often in a hurry to leave at the end of sessions. However on the other hand they did not always leave the questions blank and so perhaps if the girls felt strongly enough they took the time to report their feelings and/or observations. As an example in each session the participants were able to identify at least one activity
which they reported they enjoyed or found helpful. Often these were different things for each participant.

The question pertaining to what was the least helpful aspect of the session was often left blank or the participants wrote “nothing.” The only times the participants indicated that there was something they did not enjoy about the session related to worksheets or the session evaluation questionnaire (i.e. things that involved writing). Hence it could be deduced on the basis of the other findings presented above that there was very little that the participants did not find helpful about the program.

Overall the session evaluations tend to suggest that each session of the program was well received by participants. Participants have suggested that the sessions were mostly understood, useful and helpful for the future. Based on the findings it is recommended that some changes be made to sessions 5 (‘cognitive coping’) and 11 (‘healthy sexuality’) in particular and to a lesser extent some activities in other sessions (e.g. session 6 ‘facts about CSA’ & 9 ‘memories and nightmares’).

Sessional Knowledge tests

Similar to the findings of the Summative Knowledge test little can be drawn from the results of the sessional knowledge tests. The results are inconclusive as on only 13 out of 52 occasions, did participants attempt more than 80% of the questions. Table 5.8 summarises the results of the sessional knowledge tests. At first glance this could suggest that the participants had no knowledge of the subject material. This is inconsistent with observations made in session of participant’s knowledge.
Table 5.8  Overview of the Sessional Knowledge Test Scores

<table>
<thead>
<tr>
<th>Session</th>
<th>Topic(s)</th>
<th>Responses</th>
<th>PA1</th>
<th>PA2</th>
<th>PA3</th>
<th>PA5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Problem solving</td>
<td>% correct</td>
<td>30</td>
<td>0</td>
<td>90</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Stress</td>
<td>% answered correct</td>
<td>50*</td>
<td>-</td>
<td>90^</td>
<td>40^</td>
</tr>
<tr>
<td></td>
<td>Relaxation</td>
<td>% answered</td>
<td>30</td>
<td>0</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>3</td>
<td>Feelings</td>
<td>% correct</td>
<td>0</td>
<td>0</td>
<td>X</td>
<td>33.33</td>
</tr>
<tr>
<td></td>
<td>% answered correct</td>
<td>-</td>
<td>100*</td>
<td>-</td>
<td>X</td>
<td>100*</td>
</tr>
<tr>
<td></td>
<td>% answered</td>
<td>0</td>
<td>33.33</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Self esteem</td>
<td>% correct</td>
<td>0</td>
<td>33.33</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>% answered correct</td>
<td>-</td>
<td>100^</td>
<td>-</td>
<td>X</td>
<td>100^</td>
</tr>
<tr>
<td></td>
<td>% answered</td>
<td>0</td>
<td>33.33</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Cognitive coping</td>
<td>% correct</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>% answered correct</td>
<td>-</td>
<td>-</td>
<td>50^</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>% answered</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>What is CSA</td>
<td>% correct</td>
<td>20</td>
<td>0</td>
<td>80</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>% answered correct</td>
<td>100^</td>
<td>0^</td>
<td>100^</td>
<td>0^</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% answered</td>
<td>20</td>
<td>20</td>
<td>80</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>7/8</td>
<td>Secrets</td>
<td>% correct</td>
<td>100</td>
<td>33.33</td>
<td>X</td>
<td>66.66</td>
</tr>
<tr>
<td></td>
<td>Shame</td>
<td>% answered correct</td>
<td>100^</td>
<td>100^</td>
<td>X</td>
<td>100^</td>
</tr>
<tr>
<td></td>
<td>Guilt</td>
<td>% answered</td>
<td>100</td>
<td>33.33</td>
<td>X</td>
<td>66.66</td>
</tr>
<tr>
<td>9</td>
<td>Memories</td>
<td>% correct</td>
<td>0</td>
<td>0</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>% answered correct</td>
<td>0^</td>
<td>25^</td>
<td>-</td>
<td>25^</td>
<td>0^</td>
</tr>
<tr>
<td></td>
<td>% answered</td>
<td>25</td>
<td>0</td>
<td>100</td>
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<tr>
<td>10</td>
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<td>% correct</td>
<td>100</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>% answered correct</td>
<td>100^</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
<td>% answered correct</td>
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<td>X</td>
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<td></td>
<td>% answered</td>
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<tr>
<td></td>
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<td>0</td>
<td>50</td>
<td>100</td>
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<td></td>
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<td>50</td>
<td>X</td>
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<td></td>
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<td>X</td>
<td>100</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>% answered</td>
<td>100</td>
<td>100</td>
<td>X</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Note. - no questions answered; ^ answered all questions; * partially answered questions; X absent from session
In analysing the questionnaire responses and process of completion more closely the following contextual points can be made:

- Participants chose not to answer questions that were open ended;
- On the whole when the questions were answered they were answered correctly;
- In some instances (where participants were being read the questions due to literacy issues) it was observed that participants answered questions according to what they would be most likely to do rather than what they understood to be the correct answer – e.g. get drunk to improve mood;
- Questionnaires were completed in the last 5 minutes of the session when girls were eager to leave;
- Questionnaires were perceived as school work – girls frequently noted on their session evaluations that it was the least favourite part of the session;
- Observation of girls in session and discussion with the girls suggests that their knowledge was superior to that indicated in the tests;
- Some of the questions may have been too specific and therefore it was perhaps unreasonable for the girls to know the answers;
- Questions may have been too focused on recall and not on application of knowledge as per Blooms Taxonomy (1956).

This has implications for future research and as such the following changes are recommended:

- Consider completing the knowledge test at the start of next session, perhaps learning is not consolidated by the end of the session or participants are too distracted with leaving;
- Greater supervision of girls as they complete the test will clarify whether non completion results from poor reading skills, low motivation or lack of knowledge;
- That marking of surveys occur directly after completion with correction of any wrong answers in the subsequent session review to ensure that the correct information is learnt;
• Use the same questions on both the summative (i.e. pre/post) and sessional knowledge questionnaire to more consistently assess change rather than attempting to develop parallel items;
• Revise the format of questions to minimise the use of open ended questions which appeared laborious to adolescents rather than ‘flexible’;
• Where possible ensure that the questions assess application of knowledge not just simply recall or comprehension of knowledge.

The data from this test and the summative knowledge test give good feedback on the way the information needs to be taught to facilitate learning. It also highlights the importance of homework tasks and the need for generalisation to be built into the program.

**Mood monitoring**

Participants were asked to monitor their mood each day for the duration of the program and return their weekly monitoring at each session. Participants failed to do this, and so were asked to complete the monitoring retrospectively in the session for the day of the session and the two days prior to the group (i.e. Saturday and Sunday). Overall the girls reported variable mood that appeared reactive to the various things happening in their lives as would be expected of any adolescent. On average their mood sat between 3 and 4 on a 7 point scale indicating a typical/normal mood most of the time. The results are difficult to interpret beyond this point.

**Facilitator Evaluation**

In relation to direction and orientation of the sessions, facilitators felt that the program was largely delivered as planned and with a high degree of fidelity. All or most of the program content was covered in each session. Ratings also indicate that the session plans were followed closely in the majority of sessions. Some changes to the program were required
and these are explained in section 5.2.6. The atmosphere of each session as rated by the facilitators suggests that the group was suitably cohesive, interested, friendly, cooperative, and open, although difficulties were noted in engaging the group in discussions. In the majority of sessions a nice balance between formality and informality was obtained.

In the process of completing the evaluation questionnaire the facilitators recorded the strengths, weaknesses and suggested improvements for each session in terms of both content and process. A summary of the data is presented in Appendix I. The data suggests overall the content of the program was well received and few changes need to be made. Many of the weaknesses related to the size of the group, rather than the content of the treatment program. That is the group often felt too small to get any in depth discussion occurring, perhaps because the participants felt too exposed. Lack of time was another consistent weakness. Many of the changes that are warranted on the basis of the facilitator observations appear to be related to group process. Craft and interactive activities such as role plays were highly valued by the group and were often observed to be a session’s strength.

In terms of process, the facilitators frequently noted throughout the program, the benefits associated with the trauma focused approach and the group modality in general (i.e. reduction on feelings of isolation and being different). This was particularly obvious in session 1 following the first brief disclosure from the girls about the experience of CSA. This activity had the intended impact of lowering the palpable anxiety in the room and allowing the girls to connect with one another. The observations made about the impact of merely attending a trauma focused group are consistent with beliefs expressed by the girls as presented earlier in their session evaluations.
Facilitators also completed ratings of satisfaction and acceptability of the program. These ratings, similar to the participants, also suggest that the group was acceptable and fulfilled its requirement. The ratings of satisfaction for the facilitators were 4.5 and 5.0/7 indicating that they were generally satisfied with the group. Discussions between facilitators since completing these ratings at post test (but prior to the 3 month follow-up), suggest that the facilitators felt that perhaps their ratings had been a little harsh and that it was only since they had had time to reflect on the outcomes and impact of the group that they realised this.

The facilitators had a good working relationship. Assigned roles were adhered to closely across the course of the program although both facilitators were good at assisting the other facilitator if needed. Furthermore the lead was shared equally between the facilitators. Each facilitator’s strengths and weaknesses were compensated by the other facilitator. For example, one of the facilitators had more expertise in sexual health and was thus able to add more to this session than the other facilitator. On a micro level, this manifested in the process of the group. Facilitators were able to add to points made by the other facilitator to strengthen or emphasise what had been said without looking like she was undermining the other facilitator.

The facilitators worked very well together and built a high level of rapport. This is surprising given that the facilitators only met each other two weeks before the group began and only had contact with one another on the day of the group. A good working relationship was developed between the facilitators over the course of the group and this is noted throughout each facilitator’s evaluations. The relationship was also commented on by the group members in session 15. The girls queried whether the facilitators were friends outside of work as they appeared to get along so well together.
The facilitators felt confident with their performance within the group and did not feel that the group was beyond their level of skill or expertise. Mean ratings of performance suggest that the facilitators felt that their presentation was on average “good” (on a 5 point scale of very poor to very good).

Observation of the group suggests that much of the success of the group was dependent upon the successful working relationship of the facilitators and the relationship that they each had with the participants. This concurs with research evidence presented previously which focuses on the importance of common factors and their impact on outcome from psychotherapy (Hubble, Duncan & Miller, 1999; Norcross, 2002). This is an important observation and has implications for facilitators chosen to facilitate future groups. That is, the facilitators need to be able to relate to one another and to the group. The age, gender and style of the facilitators were perhaps also a salient feature.

In terms of critiquing and improving the facilitation process, both facilitators recognised that in future groups they need to be more of a ‘leader’ and less of a ‘friend’ to participants in terms of ensuring that group rules are followed and a general structure is held within the group. Whilst problems related to this occurred infrequently, it needs to be kept in mind for future groups.

### 5.2.6 Program Observations and Feedback /Changes made to Group as it progressed

**Duty of Care**

Some changes were required during the course of the group due to the ethical obligations the facilitators had towards the group members. For example before the beginning of session 7 it was discovered that two of the group members (PA2 and PA5) had recently lost three of their friends in a fatal motor vehicle accident. Session 7 is ordinarily the session in
which the group is asked to disclose their experience of abuse to the other members. On the basis of this information the facilitators decided to instead implement session 12 at this time. Session 12 focuses on feelings such as sadness, anger, and worry. Some aspects of grief and self care were then worked into this session to best support the group members.

Given this change however, the order of the remaining group sessions had to be altered due to the impending school holidays (following session 9) and a 2 week break from group. It was decided that it would not be ethically responsible to have a two week break immediately following 2 weeks of discussing the specifics of sexual abuse. Thus some less challenging sessions were chosen for the three weeks prior to the break. The revised order of the program is presented in Table 5.9.

Table 5.9  Planned Versus Actual Order of Session Administration

<table>
<thead>
<tr>
<th>Planned Order</th>
<th>Actual Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Number</td>
<td>Topic</td>
</tr>
<tr>
<td>----------------</td>
<td>-------</td>
</tr>
<tr>
<td>1</td>
<td>Welcome to Group</td>
</tr>
<tr>
<td>2</td>
<td>Relaxation/Problem Solving</td>
</tr>
<tr>
<td>3</td>
<td>Feelings</td>
</tr>
<tr>
<td>4</td>
<td>Self Esteem</td>
</tr>
<tr>
<td>5</td>
<td>Coping &amp; Thinking</td>
</tr>
<tr>
<td>6</td>
<td>Facts about abuse</td>
</tr>
<tr>
<td>7</td>
<td>Secrets, Shame &amp; Guilt 1</td>
</tr>
<tr>
<td>8</td>
<td>Secrets, Shame &amp; Guilt 2</td>
</tr>
<tr>
<td>9</td>
<td>Memories &amp; Nightmares</td>
</tr>
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<td>10</td>
<td>Protective Behaviours</td>
</tr>
<tr>
<td>11</td>
<td>Healthy Sexuality</td>
</tr>
<tr>
<td>12</td>
<td>Stuck Feelings</td>
</tr>
<tr>
<td>13</td>
<td>Communication</td>
</tr>
<tr>
<td>14</td>
<td>Relationships &amp; Friendships</td>
</tr>
<tr>
<td>15</td>
<td>Planning for future</td>
</tr>
<tr>
<td>16</td>
<td>Finishing up</td>
</tr>
</tbody>
</table>
**Absences from group**

Absences from the group also resulted in the program being delivered in 15 sessions although 16 sessions were provided (see Appendix F). This occurred because two group members did not attend on the day of the penultimate session (session 8) in which the discussion of each girl’s experience of sexual abuse takes place. A decision was made by the facilitators to wait until the group members returned before running this session and as a result the session was used as a review as one of the group members had missed three sessions – it therefore allowed her to catch up and for the remaining group member to consolidate her knowledge. Table 5.9 outlined the planned order of the sessions and the actual order of the sessions. Whilst this was not ideal and has minor implications for the evaluation it was the most ethically responsible path and indicates the importance of flexibility in planning/providing such a program.

**Mode of Presentation**

It was originally planned that an overhead projector would be used in the group to display important material. However on account of the overhead being broken this approach was not used. In hindsight this is perhaps a good thing given the participants comments about aspects of the sessions feeling like school. Instead of using the overhead projector the facilitators often used poster sized paper to write down important things for the participants. This approach appeared to work well.

**Literacy/Schoolwork**

It was observed that 3 of the 4 participants had literacy issues that in some ways hindered their ability to fully take part in the group. Furthermore the participants frequently likened any worksheets in the group to school work. As such efforts were made where possible to
increase the energy level of the group by including more active tasks such as role plays and ice breaker activities, more art and craft activities and hold discussions rather than writing about thoughts and feelings. The first two of these strategies worked well and were observed to be appreciated by the group. Discussions in the group however were very difficult. Two reasons were hypothesised by the facilitators. Firstly it was a very small group and there was no room for anonymity. Secondly the dynamic between the two sisters made it difficult for them to open up and actively engage in such a small group.

It is important to note that much of the resistance to worksheets was directed towards the evaluation tools rather than the worksheets per se. Thus the implications for future research are that the worksheets in the program perhaps need little adjustment but that the evaluation tools need to be constructed and presented in a way that is age and ability appropriate.

Structure
The structure of the group sessions was initially very informal. The indication from the manager of PACTS was that the group had in the past been presented in a very informal manner where the group sat on the floor with pillows and cushions. This structure was followed as it was thought that adolescents would enjoy this and feel more comfortable about attending group. This was trialled for the first 10 weeks of the group until a decision was made by the facilitators that the girls could be participating more fully in activities and that the group could be functioning better. This involved changing to sitting at a large table with the facilitators specifically placed at points on the table (i.e. it was important for the facilitators not to sit next to each other but to be able to maintain eye contact with one another to relay information). In fitting with the informal structure of the group, the facilitators initially presented themselves in such a way that may be considered informal given their
role (as mentioned earlier in some ways presented as more ‘friends’ than ‘leaders’). The facilitators also made a decision at this time to take more of a leadership role in the sessions. The girls appeared to respond to these changes positively and engaged more in conversation which allowed the sessions to flow more freely thereby having an impact on the process of the group and the way the facilitators related to each member. In future group programs it is recommended that this set up begin from session 1.

**Time**

The length of each session (1.5 hours) appeared to be a consistent problem. Much of this may have been a result of participants arriving late for the group to begin. The facilitators could have been a little firmer in enforcing group’s rules such as prompt attendance. However this may have been out of the girl’s control. Overall most sessions would have benefited by being longer than 1.5 hours to allow for more discussion and time to adequately complete activities. More time would also ensure that a well conducted opening and closing ‘circle’ were undertaken. This process would likely assist with group cohesiveness as well as allowing the facilitators to better monitor the extent to which group members understood the treatment session. A session length of two hours is recommended for future groups.

**Focus on CSA**

As a general observation about the group and its content, it appears that a greater focus on CSA is required. That is, CSA needs to be woven into all of the activities of the program. Interestingly this was the feedback from PA2 and PA5 at the follow-up session. Both girls indicated that the program needed to “get to the point quicker.” There appeared to be relief when CSA was discussed as there was so much anxiety about it – however PA1 did not agree with this. Thus a balance needs to be achieved whereby the girls are continually
made aware of the purpose of the group (i.e. to process CSA) without being too confronting thereby meeting the needs and preferences of most group members. The observation of PA2 and PA5 is both important and interesting. The facilitators hesitation in focusing on CSA ‘too much’ or addressing this issue ‘too quickly or directly’ may have been experienced as avoidance and anxiety provoking by participants, possibly mirroring the avoidant behaviour of their parents when told of the abuse. Such an observation is valuable information for the facilitators in particular, who whilst having had prior experience in treating children and adolescents who had experienced CSA, still have much to learn.

5.2.7 Barriers Encountered

In order to fully understand the ways in which successful completion of the program may have been hindered, it is important to identify barriers to the successful implementation of the program. In the current study these barriers included recruitment of appropriate participants, participant’s attendance and prompt arrival to sessions, the role of family/social environment and the lack of generalisation of group content. Each of these barriers is discussed in turn with recommendations of how they may be overcome in future groups.

Recruitment/size of group

Perhaps the largest barrier to the group was recruitment. The small number of group participants had implications for how the group ran and hence the evaluation of the group program. As discussed in the method section for this study, recruitment for the project occurred over an eight month period, after which only five suitable participants were available. The number of participants in the group is important for ensuring a valid evaluation but more importantly so that the process of the group may be fully harnessed. In keeping with the recommendations of the research literature discussed previously, a group of 6 to 8 participants is recommended (as per the recommendations of the research
literature [e.g. Berliner & Ernst, 1984; De Luca et al., 1992]). For the purposes of research, up to ten participants may need to be included to allow for drop-outs, although this should be evaluated against the needs and dynamics of the group. The number of participants in the current study is acceptable given its pilot nature, however further research will be necessary to further validate the findings of this study as advocated by the developmental intervention framework.

The lack of referrals to the program raises a number of questions. Firstly “Is there a need for this program?” The short answer to this question is yes. The research details that sexual abuse is likely to have a number of effects across the lifespan (Cicchetti & Toth, 1995; Jones & Ramchandani, 1999; Ross & O’Carroll, 2004; Wolfe & Birt, 1997). That is, the onset of adolescence may raise particular concerns and problems for girls who were abused as children. Thus given that we know that substantiated sexual abuse occurs in approximately 250 children in Western Australia each year, one would argue that there is a need for this service. Furthermore in speaking to relevant agencies and practitioners in an attempt to gain referrals I have been largely met with excitement about the program and its worthiness and need in the mental health system. For example Ben Berrell from Mercy Reconnect and Tom Minto from Department for Community Development (personal communications, 2004).

The second question that follows on from the first is “If there is a need for the program, why has this not translated into referrals?” There are many reasons why this may be the case. In the first instance my observation from dealing with the relevant referral agencies is that many are overworked, understaffed and simply operate from crisis to crisis as clients present. A second reason may in fact be that adolescents who previously experienced CSA may not be open cases with Department for Community Development. This is not to say
that they are not currently experiencing difficulties in their lives related to the sexual abuse. So the referral sources identified may not have been ideal in this instance. Thirdly, feedback from Batyia Fisher from SARC (personal communication, 1 November 2004) and Helen Kambouridis from the Royal Melbourne Children’s Hospital (personal communication, 9 February 2005) suggest that referrals for adolescent’s group programs for CSA are difficult to come by because adolescents can be challenging to engage in services. Both of these services have in the past run adolescent CSA groups that after some time have been disbanded due to insufficient referrals. This is also in keeping with the results of Nelson-Gardell’s (2001) qualitative study which found that adolescents felt that group was highly beneficial but that no one wanted to attend initially. Fourthly, the inclusion criteria for the group may be too restrictive (albeit necessary) given that research suggests that only 50% of cases of CSA are actually reported to authorities. A final reason relates to perceptions about the agency running the group. PACTS may not be a first line of referral due to confusion about the nature of PACTS. Many people may assume that the agency is only for children who are wards of state as PACTS is the treatment arm of Parkerville Children’s Home (PCH) which was originally only a residential facility for these children.

So, what is the solution to ensure that such a program can be provided in the future? If the program is going to continue to be run through PACTS then some significant changes are recommended. These changes essentially centre around a need for PACTS to ‘market’ itself (as a separate entity to Parkerville Children’s Home) and become well known in the community for providing effective treatment to child and adolescent CSA survivors. This in turn would hopefully increase the likelihood of PACTS receiving future grants and sources of funding for the girls group program. Most potential referral agencies are unfamiliar with the programs that are run at PACTS. As an example PACTS or Parkerville Children’s Home does not appear on the Department of Justice website as an organisation that offers
support to victims of child abuse. It does not appear on any of the local government community pages and does not have a website of its own. It is noted that funding and staffing levels at PACTS may have prevented such things from being undertaken in the past. My personal experience of speaking with practitioners suggests that either i) the service is unknown or ii) there are other factors which prevent them from using PACTS (e.g. they associate it as being only for wards of state). Furthermore as mentioned above greater efforts need to be made at accessing girls who are not presenting to any agencies or counselling services. Such an approach may include advertising through newspaper advertisements to attract direct self referral.

Arriving on time and absences

One of the major barriers to the group both in terms of content and process was participants arriving to session on time, attending regularly and/or at the very least notifying the facilitators if they were not attending (Appendix F details absences). There were many occasions when time was wasted while waiting for a participant to arrive (usually PA3). The impact of absences may also be related to the size of the group: if the group had been larger then the impact of an absence would not have been so great. In future groups, the following changes are recommended to help attend to this problem: i) ensuring group rules are followed ii) stressing the importance of starting on time iii) stressing the importance of notifying group leaders of absences and iv) having structured opening and closing circles which start on time each session. Making phone calls to families during the week or the day before the session may also assist in increasing attendance. It could be argued that the length of time over which the group ran was too long for adolescents and their families to commit to. The group ran for 16 sessions over 18 weeks on account of school holidays. Shorter lengths of time (e.g. 10 to 12 weeks) or alternate ways of running the group (e.g. full day workshops) are suggested.
Notably however, the participants did attend most sessions which is perhaps a positive sign given the chaotic nature of these families. This suggests that the participants did value the program.

*Family Environment*

Another barrier that was observed for the participants of the group was their family environment. Research into mediators of treatment outcome in CSA suggests that children or adolescents who live in an unsupportive or chaotic family environment are likely to have a poorer outcome from treatment than children/adolescents who do not (Cohen & Mannarino, 1998a). It was observed in the current group that all four girls lived in situations that were likely to be hindering their progress in the group (for further details see participant portfolios section 5.2.1). The parents of these girls were very hard to engage and did not take part in the research project as outlined in the method section. Future research and use of the treatment program must attempt to garner more parental input as a standard feature of adolescent participation. At a minimum parents should receive caretaker packages which outline the treatment and give ideas on how to support their daughter throughout the group. Ideally parents would attend a parallel parents group that would run at the same time as the adolescent group.

*Generalisation of skills*

Another barrier was generalisation of skills. Research (Friedberg & McClure, 2002; Kazantzis & Lampropoulos, 2002; Tompkins, 2002) and clinical experience suggest that adolescents in therapy can be reluctant to complete formal homework and this program was no exception. In the end the facilitators stopped asking that it be completed. However it is recognised that generalisation needs to occur if the group is going to be maximally
effective. Although homework was not returned in the group, there was evidence that the girls were accessing their workbooks and using skills learned outside of group (e.g. listening to their relaxation tapes). Follow-up data also suggested signs of generalisation given that their scores on most summative measures continued to improve and reports of using strategies learned in the group were given.

A suggested change for future research and use of the treatment manual is to attempt to measure the generalisation of skills more systematically using a goal setting task titled “My Goals”. In session 1, each girl identifies 3 or 4 goals that they want to work on across the length of the program. For example a goal may be to feel less anxious. Each week the girls could be asked to record their progress towards each goal and the things they did outside of group to help them achieve their goals (e.g. practiced relaxation). The intent is to make goals individually relevant, thereby increasing each girl’s responsibility for the changes they aim to make in the group, increase generalisation, and measure what each girl does outside of group that relates to what they learned in the group.

5.2.8 Summary of Formative Findings

The current formative evaluation identified the areas of the treatment program that were and were not working. The approach taken here used both facilitators of the program and participants as informants in this process. This is important as the program needs to fit with the needs of those who use it. Both participants and facilitators were satisfied with the program and found it to be an acceptable treatment. Furthermore the findings suggest that the majority of session topics and content were appropriate and aided in the achievement of program aims. None of the sessions were considered inappropriate, weak or worthless and each session appeared to have a positive impact on the participants (perhaps with the exception of the session in which the disclosures took place which is to be expected). For
the most part participants indicated that sessions were useful and easily understood. It is noted that, similar to the summative findings, the participant’s responses to many questions about session content and process needed to be placed within the context of the participant life and characteristics (i.e. participant’s responses appeared to be mediated by their mood, external life events and avoidance of CSA in some cases). Strengths and weaknesses of each session were identified and improvements can be made along these dimensions, in particular changes to sessions 5 (cognitive coping) and 11 (healthy sexuality) were indicated. Furthermore the results suggest that the program must be more focused on CSA in each session.

Group process and the therapeutic relationship were identified as key features of program success by the facilitators and were reflected in SEQ ratings. The act of attending a group with other survivors appeared to have many benefits in itself as is evidenced by the participants responses across many of the sessions (e.g. “I’m not the only one”; “It’s not my fault”; “I don’t have to be ashamed”) and the facilitators observations of the girls in session. The group generally operated cohesively and with a positive atmosphere. It is felt however that the group could have been more cohesive and this may have led to greater outcomes. The role of the facilitators and the positive relationship with one another also appeared to impact on the programs’ outcome.

For the most part the program was implemented with a high degree of integrity but as indicated there were many issues which prevented the program from being delivered completely to plan. The flexibility which both the program and research design allowed is critical in this sense as it allowed for the duty of care of participants to be upheld whilst still implementing the program with fidelity. This flexibility also allowed other problems to be overcome such as literacy, mode of presentation and session structure. Barriers to
successful implementation and completion of the program included recruitment, absences, family environment, length of sessions and generalisation of skills. It is strongly recommended that ways to overcome these barriers be found.

By and large the formative evaluation has provided a wealth of information on which to base refinements to the program as indicated in the proceeding section.

5.3 Recommendations for Changes to the Program

In drawing together summative and formative evaluations, recommendations are made for refinement and modification of the program. These recommendations relate to group composition and structure, facilitation, content and process as outlined below:

Composition & Structure

- Increase the length of sessions to 2 hours;
- Decrease the length of the program to 10 to 12 weeks maximum;
- Ideal group size is 6-8 girls, perhaps recruiting 10 to allow for drop outs;

Facilitation

- Ensure careful selection of facilitators – facilitators need to have the ability to relate easily to the adolescents. The working relationship between the facilitators is also crucial;
- Facilitators maintain leadership role in sessions to ensure a smooth running of all sessions, to act as a role model to group participants and to allow maximum engagement in sessions;
Content & Process

- Continually bring the focus of the session back to CSA – bring CSA out in the open as much as possible;

- Session content should remain largely unchanged although it is recognised that some changes will be required if other recommendations (e.g. reducing the length of the program) are implemented. On the basis of the data presented this may include removing some of the emotion activities and altering the relationships and communication sessions, perhaps with the removal of the friendship activities – the summary of each sessions strengths and weaknesses (Appendix I) provide further evidence for this decision;

- Consider removing the ‘healthy sexuality’ session or having it as an adjunct session that can be included if it is determined to be necessary. If it is included, invite an expert in to run the session;

- Revise session 5 (cognitive coping) so that it is easier to understand;

- Persist with some level of homework if possible to aide generalisation;

- Minimise worksheets as much as possible;

- Monitor literacy levels in participants and adapt the session content and delivery as required;

- Include parent sessions – 2 to 3 may be an advantageous number to ensure that parents will attend. A parallel parent group would be ideal but it is recognised that pragmatically this may not be possible;

- Implement a more formalised approach to start and end each session – the inclusion of a structured opening circle and closing circle will serve three purposes. Firstly it has the potential to assist with retention of skills and knowledge; secondly it could assist with generalisation; and finally it could help facilitators to remain in control of the group;
• Provide more opportunity for discussion within the group – this will of course rely on the group size being large enough to foster meaningful discussion;

• Provide as many opportunities as possible for participants to take part in creative activities designed to address core objectives (e.g. art and craft, role plays, writing poems, listening to music);

• Monitor group process issues – based on the observations and findings of the present study the group process issues appear to be very important to the outcome of the program and more attention should be paid to them.

5.4 CONCLUSIONS

The current study has shown that this trauma focused group therapy program for adolescent girls is a viable model which is worthy of further evaluation and refinement. The current study demonstrated clinically significant changes in each of the participants including declines in subjective distress, risk factors and the overall emotional impact of CSA. More importantly however the study demonstrated the variability in outcome for each participant and the importance of a contextual case by case analysis of outcome. Furthermore the value of the formative evaluation approach is highlighted in its ability to direct the intervention and identify areas of concern, particularly the barriers to successful implementation. The approach is also important as it allows for the treatment to be individualised to meet with the ethical and pragmatic demands of the participants whilst not relinquishing treatment integrity.

Changes to the program are required as specified and are discussed in greater detail in the following chapter. Following these changes an expert evaluation of the program will be undertaken prior to further evaluation in Study 3.
CHAPTER 6

REFINEMENT & EXPERT EVALUATION

OF THE ADOLESCENT GIRLS GROUP PROGRAM
On the basis of the evaluation conducted in Study 2 (and as described in Chapter 5), 17 recommendations were suggested to refine and modify the program to better meet the needs of adolescent girls who have experienced sexual abuse. This chapter outlines the ways in which the treatment program was changed to accommodate these recommendations. Following this process, experts in the field were approached to conduct an expert evaluation of the modified program and provide feedback as to the validity of its content. Whilst an expert evaluation is not highlighted within the developmental intervention research approach, it would seem to be consistent with phase four in that an expert evaluation helps to determine if the treatment program is practicable and would be used by clinicians in the field. Furthermore an expert evaluation allows for the treatment program to be further refined prior to being implemented with this vulnerable population and evaluated once more (Rothman & Thomas, 1995). Importantly, this process also applies the two most significant aspects of action research, namely critical reflection and collaboration (in this instance with experts in the field).

6.1 Changes Made to the Program Following Study 2

Based on the findings of Study 2 it was felt that the program was too long and therefore it was recommended that the duration of the program be reduced from 16 to 12 weeks. Ideally it would have been good to reduce the program to 10 weeks to fit within a Western Australian school term. However it did not appear possible to achieve the aims and objectives of the program in only 10 sessions. To facilitate the change in program duration, a number of modifications were made. Firstly the session on sexuality was deleted entirely from the program. As discussed in Study 2, although issues related to sexuality are pertinent to adolescents who have experienced CSA, the session did not work well and was not in keeping with the rest of the program. The session on feelings was also deleted although some of the activities were retained and dispersed through the program as
emotion identification and regulation were considered important. The sessions on relationships and communication were combined but the activities on friends were removed as per the recommendations I made in Study 2 on the basis of the formative results (i.e. they did not seem to be sufficiently related to CSA or as important as other factors which could be provided in a finite program). The session on memories and nightmares was also combined with the session on protective behaviours as neither session appeared to require the time allocated.

Whilst the number of treatment sessions was reduced, session length was increased from 1.5 to 2 hours which effectively meant that the same number of hours of service was offered. This change facilitated greater flexibility in terms of session content and allowed for further changes to be made without greatly altering the general content of the sessions. Some of the changes included: a more formalised approach to the start and end of each session; a more focused approach to CSA by ensuring that examples in sessions were related back to CSA; session 5 (cognitive coping) was revised and the expertise of Barrett and colleagues (2000) *Friends for Youth* program was used to adapt the session so that it was more age appropriate and easier to understand. Lastly, greater opportunities for creative expression were introduced.

A recommendation from Study 2 was that worksheets should be minimised to prevent the sense that the group was like ‘school.’ Rather than removing the worksheets, it was decided that the facilitators could have more flexibility in the way they chose to administer the activities of the session provided that the objectives were achieved. For example it may be easier to simply discuss the issues on a worksheet and go around the group asking for responses from participants rather than asking the girls to write these answers on a worksheet. However worksheets and handouts can still be provided to the girls in a
workbook they take home and refer to when required. In this way three of the recommendations made in Study 2 were achieved (i.e. the demands upon a certain level of literacy are reduced, the number of worksheets used in session are reduced and the opportunities for discussion are increased). In addition to these changes, a number of activities were introduced in which the participants could use their creativity. For example writing poems, letters and short stories and art and craft activities (e.g. worry boxes). These activities were included in the hope that they would be more appealing to participants and less like school activities. They also have the potential to better capture participant’s narratives about being CSA survivors and the shifts that may occur over time in the group.

Concern was raised in Study 2 about the extent to which participants generalised the skills learned in group to their everyday lives. To further facilitate this process a number of changes will be introduced. Firstly the concept of “My Goals” has been developed. This process asks the participants to identify four goals at the beginning of the program which they would like to work on in the group and hopefully achieve. At each session, participants will be asked to rate the degree to which they have achieved their goal on a Likert scale which ranges from 0 to 100% achievement. Furthermore they will be asked to note down what they did outside of group to help achieve these goals (e.g. practiced relaxation). This process has the potential to increase the responsibility the participants take in achieving change as a result of attending the group. Furthermore by applying the skills learned in group during the week, it is hoped that the skills will generalise to produce long lasting change in the participants identified areas of concern and be available should the participant have problems in the future. In addition to the ‘My Goals’ activity, a formalised start to each session will be introduced to allow for an in-depth review of the previous session. In conjunction with the session evaluations which identify gaps in knowledge and areas of misunderstanding, this optimises opportunities for facilitators to ensure that
participants have understood and integrated the core concepts of each session. It is hoped that by doing this, the participants will be in a better position to have learned the objectives of the program and be in a position to apply them to their everyday lives.

The findings of Study 2 suggested that much of the success of the program was attributed to group process and common factors of therapy, in particular the therapeutic relationships established within the group. In an attempt to capture these salient features as much as possible, additions were made to the treatment manual to highlight factors pertaining to group process. A section was introduced at the beginning of the manual which oriented facilitators to the program. This section was intended to provide a better rationale for the program and highlight salient features which may not be inherently obvious in reading each session plan. Therapeutic considerations of each session were also noted throughout the manual. In addition to these factors, the importance of the facilitator’s level of training, facilitation skills and knowledge of CSA are highlighted. It is suggested that future facilitators of this program undergo training prior to implementing the program. This is to ensure that important factors relevant to group process and facilitation can be relayed as these factors are not always captured within a treatment manual.

Finally, in keeping with the recommendations of Studies 1 and 2, parent sessions were added to the program. Due to pragmatic limitations, at this stage only two parent sessions were offered. However it is hoped in the future that a comprehensive 12 week program for parents will be available. The overall aims of the parent sessions are to: i) engage parents in the process of the girls group so that they understand the importance of the group and what occurs in it; and ii) provide parents with strategies to support their daughter through the process of the group. It is recommended that the first session occur either prior to or at the same time as the first girl’s session. In this session a caretaker information package is
provided to parents and its contents explained. In session two parents are updated on their daughter's progress and further discussions are held on how to support their daughters. It is recommended that session two is held prior to session seven of the girls program in which disclosures take place. This is to ensure that parents are prepared to manage any fallout that may be associated with this session. It should be noted that the parent sessions are not intended as therapy sessions for parents. They are meant only as means of teaching parents how to support their daughters. Facilitators may wish to discuss referral options with parents if they feel that parents are in need of their own therapy.

6.2 Expert Evaluation

In order to enhance the content validity of the program, clinicians who work specifically with sexually abused adolescents were approached to evaluate the program following the changes mentioned above. Initially 10 international and interstate published researchers were approached via email. Three researchers, including one internationally renowned and highly prolific researcher/psychiatrist, agreed to take part. However one of these researchers withdrew from the evaluation after receiving the program citing time constraints as his reason for withdrawing. On account of the low response rate from researchers in the field, local clinicians from the Department of Community Development, Child and Adolescent Mental Health Service and Child Protection Unit were also approached. A further nine clinicians agreed to take part in the evaluation although only eight returned the questionnaire. Hence, in total one psychiatrist, eight clinical psychologists and one senior social worker took part in the review of the program. All of these clinicians had extensive experience in working with children and adolescents who had experienced sexual abuse.

The clinicians who took part in the evaluation were asked to review the program and complete a 13 item questionnaire (see Appendix J and Table 6.1). The questionnaire was
designed to assess the degree to which the respondents felt elements of the program were appropriate as rated on a 7 point scale (1 = strongly agree; 7 = strongly disagree). An additional three open ended questions were also included. These questions asked clinicians to comment on each session of the program, to make recommendations about the program and to make any other salient comments if so desired.

Table 6.1  *Mean and Range of Responses for each Item of the Expert Evaluation Questionnaire*

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean (/7)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>The overall aims are appropriate</td>
<td>1.70</td>
<td>1 - 3</td>
</tr>
<tr>
<td>The overall objectives are appropriate</td>
<td>1.90</td>
<td>1 - 3</td>
</tr>
<tr>
<td>The duration of the program is appropriate</td>
<td>2.20</td>
<td>1 - 3</td>
</tr>
<tr>
<td>The length of the sessions is appropriate</td>
<td>2.30</td>
<td>1 - 3</td>
</tr>
<tr>
<td>The use of two female facilitators is appropriate</td>
<td>1.80</td>
<td>1 - 4</td>
</tr>
<tr>
<td>The age range is appropriate</td>
<td>2.80</td>
<td>1 - 5</td>
</tr>
<tr>
<td>Providing the treatment as an adjunct is appropriate</td>
<td>2.40</td>
<td>1 - 4</td>
</tr>
<tr>
<td>Using a closed group format is appropriate</td>
<td>1.20</td>
<td>1 - 2</td>
</tr>
<tr>
<td>Used a structured group format is appropriate</td>
<td>1.80</td>
<td>1 - 3</td>
</tr>
<tr>
<td>The program fits with best practice recommendations</td>
<td>2.22</td>
<td>1 - 4</td>
</tr>
<tr>
<td>The program has an adequate focus on CSA</td>
<td>2.10</td>
<td>1 - 3</td>
</tr>
<tr>
<td>There is a need for this type of program</td>
<td>2.00</td>
<td>1 - 4</td>
</tr>
<tr>
<td>I would recommend this program to clients</td>
<td>2.10</td>
<td>1 - 4</td>
</tr>
</tbody>
</table>

*Note. 1 = strongly agree; 7 = strongly disagree*

Overall the clinician’s feedback about the program was very positive. Table 6.1 highlights the mean ratings for each of the quantitative items on the evaluation questionnaire. Given that all mean ratings fall below a rating of 3/7 (which corresponds to agree on the scale) it can safely be concluded that the clinicians felt that the program and its elements were appropriate and it was designed in such a way that it would meet the needs of the
population. Rather than discussing each item in turn, relevant comments from respondents will be highlighted and items on which any of the clinicians responded with a 4 (neither agree or disagree) or higher will be discussed.

One respondent reported a 4/7 for the item related to the use of female facilitators. This respondent stated:

> it can be argued that the presence of a male facilitator can be useful in breaking down stereotypes about males and provides a positive male role model for the girls who may not have come across men who are sensitive, caring and trustworthy… [this] is a general sentiment shared by many of my colleagues.

One other respondent also raised this concern in their comments but rated the item as a 3/7 indicating they somewhat agreed it was appropriate to have two female facilitators. The remaining respondents reported that they felt it was very appropriate to have two female facilitators and given the mean rating of 1.8, this is the consensus of the clinicians. The sentiment that males are appropriate facilitators for a girls group raised by these respondents is discussed in the CSA research literature. However as reviewed in Chapter 3, I could find no empirical research on the topic which specifically related to CSA. As highlighted in Chapter 3, the potential benefits of male clinicians in this type of group are apparent, but I am unsure whether they would outweigh the costs in terms of participants comfort and the potential for seductive behaviour. On the basis of this and the general consensus of the clinicians, a decision was made to adopt a conservative approach and run the new program with two female facilitators.

Two respondents indicated that they disagreed with the age range set for the group (12-15 years). They felt that the gap was too wide and that the girls may be at different
developmental stages/levels of maturity. As another respondent pointed out however “it would depend on the mix of ages and the level of ‘street smarts’.” This is consistent with the decision I made in Study 1 about the age range. The consensus of evidence presented in Chapter 3 suggested that an age range of 13-17 years would be appropriate. However I argued that this range was too wide given the development differences between early and late adolescence. I also argued that the most important factor to take into account was the mix of ages and level of maturity of participants, which is consistent with the quote above. This is evident with PA1 in Study 2 who was in fact 18 years of age but had the mental age of a girl aged 12-15 years (although this was related to intellectual disability). The majority of the respondents agreed that the age range was appropriate and so this range will remain unchanged in the new program.

Using the group program as an adjunct to individual therapy (received either prior to or concurrent to the group) was questioned by two respondents. One was of the opinion that if an adolescent had already received CBT based individual therapy then the program would overlap too much and therefore not be beneficial. Another believed that the treatment could perhaps stand alone depending upon the level of support available to the participants and the extent of the trauma they had experienced from sexual abuse. The majority of clinicians ($M = 2.4$) however felt that it was appropriate for the program to be adjunctive to individual therapy or for participants to have undergone individual therapy in their past. One respondent who also provides a group program for adolescent girls in Victoria noted “our experience has been that young women who had not had individual treatment made less progress and found the group more difficult than those who had or were still in individual treatment.” Another noted “if it were a stand alone treatment I wonder how much it would open things up for the client and then possibly leave them hanging if there were no other supports in place.” Again this highlights the importance of a skilful intake interview which
can identify whether the client is ready for individual therapy (as suggested in Chapter 4) and if the treatment program will meet the client’s needs. Hence the group program in Study 3 will remain as an adjunctive treatment program (i.e. participants will have to have completed some individual therapy/trauma processing before beginning the group).

With the exception of one respondent, the clinicians indicated that there is a need for the program. The dissenting respondent indicated that given the strong evidence for individual TFCBT that is emerging, particularly from her own research, there may not be a need for group therapy. However she also noted that as many therapists do use group therapy, it is important to research the efficacy of the model. To some extent I agree with this respondent’s comments however there is one fundamental issue that individual therapy cannot adequately achieve and that is reducing the sense of isolation and ‘differentness’ felt by survivors. Furthermore group therapy can often help with the consolidation of skills learned in individual therapy as it is often easier to take a more didactic approach. In addition and in keeping with the idea of treatment being developmentally sequenced (James, 1989), survivors of CSA may have received individual therapy during childhood but with the onset of adolescence, feel that they need further therapy to reconceptualise what CSA means in the context of life changes. Whilst further individual therapy may serve this purpose, group therapy may be more beneficial as it is more congruent with this life stage in terms of identification with peers, socialisation and the development of an individual identity (Gilbert, 1988). However it is noted that if a high level of psychopathology is present then the detailed attention which individual therapy can provide in terms of symptom alleviation may be best suited and this is why this program is adjunctive.

In terms of the Perth context, the need for group programs for CSA was highlighted by practitioners. For example “in Perth there is a lack of group programs for many children who
have experienced CSA not just adolescents. I think groups provide a great option for consolidation of issues/skills covered in individual therapy.” Furthermore the efficacy of individual therapy offered in Perth is unknown and it is unclear what model of therapy is being used by clinicians (i.e. are they using a TFCBT model?).

The respondent above who was unsure of the need for the program also wished to reserve judgement on whether she would recommend the program to clients until the research was completed and the program proven to be effective. This is understandable and is indeed the main focus of the research. Nevertheless all other respondents indicated that they would recommend the program to appropriate clients.

In response to an open ended question, many of the respondents raised concerns about the amount of content in the program. One respondent noted “all the topics and material used are highly appropriate, but I think there might be too much content so that process goals are not achieved.” This respondent suggested deleting sessions 4 (cognitive coping), 10 (communication and relationships) and 11 (planning for the future) from the program while continuing to have 12 sessions thereby spreading the content across these sessions. Another respondent, while suggesting that the content was a “bit much” noted “in my experience the most important thing that clients get out of these groups is the validation and sharing of experiences showing that they are not alone. Allow lots of time for this process and honour it!” Whilst many respondents felt that there was too much content in the program, only one indicated ways in which the content of the sessions could be reduced, perhaps because like myself they felt that all of the activities were highly relevant. It should be noted that not all of the advice from the experts was applied to the program as it was decided that it would be best to assess some of these suggestions empirically before implementing them. For example I am not convinced that removing sessions 4, 10 and 11
as suggested above is appropriate given the content of these sessions. For instance the primary purpose of session 11 is relapse prevention and preparation for group closure and this seems important. Thus it makes more sense to evaluate each of these sessions in Study 3 via formative methods to assess the utility of such suggestions.

It became apparent in reading many of the respondent’s comments that much of the content of the program remained implicit in my mind rather than being overtly obvious in the manual. One respondent perhaps picked up on this by noting “there are lots of skills that are applicable to any kind of coping which includes coping with CSA, maybe some of the examples or discussions could be more directed to CSA sequelae – I guess a lot of the discussion that goes on in the group isn’t written in the manual!” Upon reflecting on the activities and examples in the manual this may be the case particularly in the first four sessions. It is true that much of the group process, which is attributed to being a significant factor facilitating change in this program, cannot be effectively captured in the manual. However the manual should reflect more of CSA sequelae and process issues than it presently does. This also reflects the findings of Study 2 in that the program did not appear to focus enough on CSA. Whilst I made efforts to change this prior to circulating the program to experts, it was obviously still not clear in the treatment manual and as a result is in need of further refinement.

Some respondents were also concerned about the literacy requirements of the program. Again this may be a problem with the manual as opposed to the program as run here. The program in its introduction directly talks about literacy and the ways in which the program can be adapted to meet the needs of low literacy clients. This needs to be re-iterated throughout the manual. It is a strength of the current program that it is both flexible and can be individualised to meet the needs of the client. As discussed early in this chapter,
problems with literacy can be overcome by altering the way in which activities are undertaken and by using group discussion as opposed to worksheets.

Concern was also raised by some clinicians with regards to the intrusiveness of the session evaluations. It was not clearly stated in the manual that these were primarily for research purposes. It is anticipated that the session evaluations will remain in the finalised program as they are an important clinical tool, however they will not be as in depth as they are currently. For example the SEQ could be removed as could some of the open ended questions. In doing so the evaluations would still provide valuable information without being as time consuming or overbearing.

Finally some relevant comments and recommendations were made by the respondents about the program in general and the sessions specifically. These are summarised in Table 6.2. Other recommendations were also made by some respondents such as the wording of some of the worksheets. These have not been mentioned here but were taken into consideration in writing the new program.

<table>
<thead>
<tr>
<th>Session</th>
<th>Clinicians Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Program</td>
<td>Therapeutic considerations – good reminders for the nature of the experience for the young women</td>
</tr>
<tr>
<td></td>
<td>Parent package a good idea</td>
</tr>
<tr>
<td></td>
<td>Parent sessions are a good idea</td>
</tr>
<tr>
<td></td>
<td>Consider meeting with parents at pre, mid and post to increase support</td>
</tr>
<tr>
<td></td>
<td>Start of sessions – ask “what’s different about you this week?”</td>
</tr>
<tr>
<td></td>
<td>Worksheets are really useful, especially if girls are anxious. The content is presented in an age appropriate way – they should enjoy doing the activities</td>
</tr>
<tr>
<td></td>
<td>Liked the balance between exploring issues for the members, and providing strategies – empowering</td>
</tr>
<tr>
<td></td>
<td>Include a proforma for the pre group interview</td>
</tr>
<tr>
<td></td>
<td>Estimate times for each activity</td>
</tr>
<tr>
<td></td>
<td>Break in the session</td>
</tr>
<tr>
<td></td>
<td>Materials needed should be listed at beginning of the session plan</td>
</tr>
<tr>
<td>Session</td>
<td>Clinicians Comments (cont.)</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------</td>
</tr>
</tbody>
</table>
| General Program (cont.) | - Strongly encourage 3 month review  
- More role play and fun especially after intense sessions  
- Keep the group membership under 8  
- Group leader needs to control the level of emotional arousal to ensure that the group is in fact processing the CSA experience – see John Briere’s ‘therapeutic window’  
- Speak about abuse in every session – sharing is the most important aspect of the program |
| 1 Welcome to Group | - Very important to raise CSA in the first session  
- Ensure focus of first session is on engagement  
- Consider naming the group in week 2 rather than this session |
| 2 Coping Skills | - Remember that sometimes relaxation can trigger reactions in survivors of CSA and you need to be aware and have strategies to manage this in the group; prepare the girls that they may feel strange bodily sensations, ensure they have a safe place to go in their minds |
| 3 Self Esteem | - There is very good material in this session however it may be daunting for those with low literacy  
- The strength card activity looks good  
- What is the evidence for positive affirmations? |
| 4 Cognitive Coping | - There seems a lot of content that may be a challenge for at least some girls in terms of comprehension  
- Perhaps use the terms helpful/unhelpful thoughts as opposed to positive/negative thoughts  
- There is lots of new material in this session, it may require further repetition in future sessions |
| 5 Education about CSA | - Include more on grooming  
- This is a very heavy session perhaps include some of this stuff earlier  
- All appears very helpful although possibly overwhelming for some  
- Content is very good but a lot to get through.  
- Handout 5-3 – adolescents can also be offenders  
- Include Cathy Freeman as an e.g. of an abuse survivor  
- Aunt Agatha activity is excellent |
| 6 Secrets, Shame, Guilt 1 | - It is important to ask – how will you look after yourself today after this session  
- A helpful session  
- Shame and guilt are often extremely difficult for members to talk about. It is good that you have flexibility about how to proceed and means to manage negative reactions in session. It is also good that you prepare caregivers  
- Discuss with the girls it isn’t appropriate for everyone to know their experience especially at school;  
- Mixing of assault and abuse in manual  
- Be wary of labels such as disgusted |
| 7 Secrets, Shame, Guilt 2 | - Guide for disclosure is excellent  
- Re-evaluate the suggestion in therapeutic consideration that girls should leave the group |
### Group Treatment for Sexually Abused Adolescent Girls

#### Clinicians Comments (cont.)

<table>
<thead>
<tr>
<th>Session</th>
<th>Memories, Nightmares PB’s</th>
</tr>
</thead>
</table>
| 8       | • Ensure to differentiate EWS from panic  
|         | • This session appears to bring up a lot of memories – facilitators would need to keep alert  
|         | • Very important to include PB’s, Suitable timing of this topic.  
|         | • Perhaps memories and dreams should be earlier in the program |

<table>
<thead>
<tr>
<th>Session</th>
<th>Stuck feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>• Good information – perhaps a bit too much</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session</th>
<th>Communication Relationships</th>
</tr>
</thead>
</table>
| 10      | • A lot to cover in one session  
|         | • A helpful session  
|         | • Perhaps more about relationships that make you feel sad and/or angry |

<table>
<thead>
<tr>
<th>Session</th>
<th>Planning for the future</th>
</tr>
</thead>
</table>
| 11      | • Allow time in this session to discuss closure of the group, plan the party etc  
|         | • Good shift – manageable amount |

<table>
<thead>
<tr>
<th>Session</th>
<th>Group closure</th>
</tr>
</thead>
</table>
| 12      | • Helpful  
|         | • Good to see closing circle  
|         | • Discuss re-referral to individual counselling when required |

### 6.3 New Treatment Program

On the basis of the expert evaluation the treatment program was further refined in preparation for Study 3. The new program retained all of the major elements of the program designed for Study 2 and as such the aims and objectives of the program remain unchanged with the exception of one objective which was removed (i.e. healthy sexuality). Hence the aims and objectives will not be repeated here. The content of the new program is summarised in Table 6.3 and may be found in Appendix K.

#### Table 6.3 Contents of the New Treatment Program

<table>
<thead>
<tr>
<th>Session</th>
<th>Welcome to group</th>
<th>Topic &amp; Contents</th>
</tr>
</thead>
</table>
| 1       | Introduction     | • Ways to handle distress in and out of group  
|         | Ice breaker activity  
|         | Purpose and objectives of group  
|         | Group rules  
|         | Rapport building activity  
|         | Naming the perpetrator  
<p>|         | Closing Circle |</p>
<table>
<thead>
<tr>
<th>Session</th>
<th>Topic &amp; Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Relaxation, Problem Solving, Stress Management, Depression prevention</td>
</tr>
<tr>
<td></td>
<td>• Opening circle</td>
</tr>
<tr>
<td></td>
<td>• Rapport building</td>
</tr>
<tr>
<td></td>
<td>• Improving mood</td>
</tr>
<tr>
<td></td>
<td>• Problem solving</td>
</tr>
<tr>
<td></td>
<td>• Stress management</td>
</tr>
<tr>
<td></td>
<td>• Closing Circle</td>
</tr>
<tr>
<td>3</td>
<td>Self Esteem</td>
</tr>
<tr>
<td></td>
<td>• Opening Circle</td>
</tr>
<tr>
<td></td>
<td>• How I see myself</td>
</tr>
<tr>
<td></td>
<td>• Warm Fuzzies</td>
</tr>
<tr>
<td></td>
<td>• Strength Cards</td>
</tr>
<tr>
<td></td>
<td>• Positive affirmations</td>
</tr>
<tr>
<td></td>
<td>• Feelings</td>
</tr>
<tr>
<td></td>
<td>• Closing circle</td>
</tr>
<tr>
<td>4</td>
<td>Cognitive Coping Skills</td>
</tr>
<tr>
<td></td>
<td>• Thoughts feelings and behaviours</td>
</tr>
<tr>
<td></td>
<td>• Thinking errors, automatic thoughts and self talk</td>
</tr>
<tr>
<td></td>
<td>• Ways to achieve clear thinking</td>
</tr>
<tr>
<td></td>
<td>• Coping statements</td>
</tr>
<tr>
<td></td>
<td>• Closing Circle</td>
</tr>
<tr>
<td>5</td>
<td>Education regarding CSA</td>
</tr>
<tr>
<td></td>
<td>• Where do you stand</td>
</tr>
<tr>
<td></td>
<td>• What is sexual abuse/assault</td>
</tr>
<tr>
<td></td>
<td>• Who sexually abuses children</td>
</tr>
<tr>
<td></td>
<td>• Effects of sexual abuse</td>
</tr>
<tr>
<td></td>
<td>• Dear Aunt Agatha</td>
</tr>
<tr>
<td></td>
<td>• Questions for parents</td>
</tr>
<tr>
<td></td>
<td>• Before, After, Now</td>
</tr>
<tr>
<td></td>
<td>• Relaxation and debrief</td>
</tr>
<tr>
<td></td>
<td>• Closing circle</td>
</tr>
<tr>
<td>6</td>
<td>Secrets, Shame and Guilt 1</td>
</tr>
<tr>
<td></td>
<td>• Opening circle</td>
</tr>
<tr>
<td></td>
<td>• Shame and guilt</td>
</tr>
<tr>
<td></td>
<td>• Secrets</td>
</tr>
<tr>
<td></td>
<td>• Benefits and difficulties of telling</td>
</tr>
<tr>
<td></td>
<td>• Preparation for session 7</td>
</tr>
<tr>
<td></td>
<td>• Relaxation and debrief</td>
</tr>
<tr>
<td></td>
<td>• Closing circle</td>
</tr>
<tr>
<td>7</td>
<td>Secrets, Shame and Guilt 2</td>
</tr>
<tr>
<td></td>
<td>• Opening circle</td>
</tr>
<tr>
<td></td>
<td>• Who knows my secret</td>
</tr>
<tr>
<td></td>
<td>• Telling each other</td>
</tr>
<tr>
<td></td>
<td>• Letters to perpetrator</td>
</tr>
<tr>
<td></td>
<td>• Relaxation and debrief</td>
</tr>
<tr>
<td></td>
<td>• Closing circle</td>
</tr>
<tr>
<td>8</td>
<td>Memories and Nightmares &amp; Protective Behaviours</td>
</tr>
<tr>
<td></td>
<td>• Opening circle</td>
</tr>
<tr>
<td></td>
<td>• Discussion of previous session</td>
</tr>
<tr>
<td></td>
<td>• How did it end</td>
</tr>
<tr>
<td></td>
<td>• Memories and dreams</td>
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<td></td>
<td>• Draw a memory or dream</td>
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<td></td>
<td>• Sleep</td>
</tr>
<tr>
<td></td>
<td>• Protective behaviours - themes,</td>
</tr>
<tr>
<td></td>
<td>• Early warning signs, networks</td>
</tr>
<tr>
<td></td>
<td>• Personal safety</td>
</tr>
<tr>
<td></td>
<td>• Closing circle</td>
</tr>
<tr>
<td>9</td>
<td>Stuck Feelings</td>
</tr>
<tr>
<td></td>
<td>• Opening circle</td>
</tr>
<tr>
<td></td>
<td>• Effects of bottling emotions</td>
</tr>
<tr>
<td></td>
<td>• Feeling scared and anxious</td>
</tr>
<tr>
<td></td>
<td>• Feeling angry</td>
</tr>
<tr>
<td></td>
<td>• Feeling sad</td>
</tr>
<tr>
<td></td>
<td>• Journaling</td>
</tr>
<tr>
<td></td>
<td>• Closing circle</td>
</tr>
<tr>
<td>Session</td>
<td>Topic &amp; Contents</td>
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<tr>
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</tr>
<tr>
<td>10</td>
<td><strong>Communication &amp; Relationships</strong></td>
</tr>
<tr>
<td></td>
<td>• Opening circle</td>
</tr>
<tr>
<td></td>
<td>• Ice breaker</td>
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<tr>
<td></td>
<td>• Communication</td>
</tr>
<tr>
<td></td>
<td>• Assertiveness</td>
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<tr>
<td></td>
<td>• Conflict resolution</td>
</tr>
<tr>
<td></td>
<td>• Relationships</td>
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<tr>
<td></td>
<td>• Closing circle</td>
</tr>
<tr>
<td>11</td>
<td><strong>Planning for the future</strong></td>
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<tr>
<td></td>
<td>• Opening circle</td>
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<tr>
<td></td>
<td>• Goal setting</td>
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<tr>
<td></td>
<td>• Bad hair days</td>
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<tr>
<td></td>
<td>• Preparing for slip ups</td>
</tr>
<tr>
<td></td>
<td>• Preparation for closure and session 12</td>
</tr>
<tr>
<td></td>
<td>• A letter to me</td>
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<tr>
<td></td>
<td>• Closing circle</td>
</tr>
<tr>
<td>12</td>
<td><strong>Group closure and post test</strong></td>
</tr>
<tr>
<td></td>
<td>• Opening circle</td>
</tr>
<tr>
<td></td>
<td>• Review of program</td>
</tr>
<tr>
<td></td>
<td>• Exploring feelings about termination</td>
</tr>
<tr>
<td></td>
<td>• Since I've been in group</td>
</tr>
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<td></td>
<td>• Saying goodbye</td>
</tr>
<tr>
<td></td>
<td>• Party</td>
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<td></td>
<td>• Closing circle</td>
</tr>
</tbody>
</table>
CHAPTER 7

STUDY 3: FURTHER EVALUATION

OF THE ADOLESCENT GIRLS GROUP PROGRAM
Before my experience of sexual abuse I was happy and outgoing. I would get along with all the boys and passed all of my school work. After my experience of sexual abuse I am always angry or upset and I am really shy. It takes a long time before I let people come into my life and learn things about me. Now I hate how people come into my own personal space. Now I don’t get along with most boys and I fail every class that I have with a male teacher (Girls Group participant, 2005).

Study 3 is a continuation of phases four and five of the developmental intervention research approach which began in Study 2. In continuing these phases the primary aim of this iteration is to further evaluate (both formatively and summatively) the treatment program developed in Chapter 4. From the outset it is noted that Study 3 will be run from the Murdoch University Psychology Clinic and independently of PACTS. It was originally planned that the final stage of the project would be completed at PACTS but unfortunately after six months of attempting to recruit participants through PACTS only two suitable referrals had been attained and so the program was pursued independently.

The aims of the current study are similar to Study 2 and include:

i) Conducting a formative analysis to describe and assess the effectiveness of the revised program throughout its development by evaluating each component of the program, group processes and barriers to implementation. Particular emphasis will be placed upon sessions 4 (cognitive coping), 10 (communication and relationships) and 11 (preparing for the future) in line with recommendations made in the expert evaluation.

ii) Conducting a summative analysis to assess the effectiveness of the revised program as a whole. The following summative program objectives are identified:

- To reduce subjective distress associated with the experience of CSA
• To reduce known risk factors associated with CSA
• To increase protective factors associated with better outcomes from CSA
• To decrease emotional, cognitive and behavioural effects of CSA
• To assess the role that coping strategies and attributions play in mediating the effects and outcomes of CSA

iii) Identifying any additional changes and modifications to be made to the treatment program to further refine it (if required).

7.1 Method

7.1.1 Research Design

The research design utilised in this study was the same as the design used in Study 2 (i.e. a formative and summative program evaluation which utilised mixed methodology) with one exception. To further investigate the effectiveness of the treatment program and further counteract threats to internal validity, data were collected on four occasions (instead of three as in Study 2): baseline, pre intervention, post intervention and 3 month follow-up.

7.1.2 Participants

Participants for Study 3 included group facilitators, adolescent girls taking part in the group and their parents. Referrals were received from a school psychologist, individual counsellor, clinical psychologist from the Department for Community Development and a community youth worker. Inclusion criteria remained the same as Study 2. All referrals received were accepted into the program as they met the designated criteria. Table 7.1 provides a summary of the abuse related characteristics of each of the girls who attended the group and participated in this study. Further information for each participant may be found in the portfolio section (7.2.1).
Group therapy sessions were facilitated by myself and a psychologist from Murdoch University. Both facilitators had experience in working with adolescents and children who have experienced sexual abuse. Consistent with the action research mixed methods approach, facilitators were also participants in the research.

Four mothers and one step mother participated in the research. All mothers were observed to be very supportive of their daughters and their attendance at the group program.

Table 7.1  Summary of Relevant Characteristics of Participants

<table>
<thead>
<tr>
<th>ID</th>
<th>Age</th>
<th>Age of CSA onset</th>
<th>Duration</th>
<th>Age at disclosure of CSA</th>
<th>Perpetrator(s)</th>
<th>Form of Abuse</th>
<th>Presenting Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA1</td>
<td>13</td>
<td>6</td>
<td>~ 1 month</td>
<td>6</td>
<td>Family Friend</td>
<td>Contact no penetration</td>
<td>Low self esteem, anger, flashbacks, nightmares, flat affect, difficulty with emotional expression</td>
</tr>
<tr>
<td>PA2</td>
<td>14</td>
<td>*</td>
<td>*</td>
<td>10</td>
<td>Biological mothers partner; Maternal Uncle</td>
<td>Contact Penetrative</td>
<td>Anxiety, nightmares, sleep difficulties, flashbacks</td>
</tr>
<tr>
<td>PA3</td>
<td>12</td>
<td>4</td>
<td>5 years</td>
<td>10</td>
<td>Older brother</td>
<td>Contact Penetrative</td>
<td>Flat affect, mild anxiety, avoidance, lack of assertion</td>
</tr>
<tr>
<td>PA4</td>
<td>14</td>
<td>11</td>
<td>1 incident</td>
<td>13</td>
<td>Family friend</td>
<td>Contact Penetrative</td>
<td>Anxiety, depression, nightmares, mistrust of men, low self esteem</td>
</tr>
<tr>
<td>PA5</td>
<td>15</td>
<td>14</td>
<td>1.5hrs</td>
<td>15</td>
<td>7 male peers</td>
<td>Contact Penetrative</td>
<td>Nightmares, flashbacks</td>
</tr>
</tbody>
</table>

* details unavailable but duration was over 1 year
7.1.3 Procedure

Referrals to the program were invited via a flier (see Appendix L) sent to all relevant agencies within the Perth metropolitan area, including the Department for Community Development, Sexual Assault Resource Centre, Child and Adolescent Mental Health Services, Police Child Abuse Unit, Child Witness Service and School Psychologists. Alternate referral strategies were also utilised including articles in local newspapers (see Appendix L), emails to relevant staff and phone calls to agencies. Site visits were also conducted in some instances. Referrals to the program were slow, but not as slow as in Study 2. The group began within two and a half months of advertising the program as opposed to eight months for Study 2. When a referral was received, the participant’s primary caregiver was contacted via phone and screened to determine the participant’s appropriateness for inclusion in the program. An intake appointment was then arranged. At the intake appointment a more in-depth intake interview was undertaken. Consent to act as participants in the research aspects of the program were gained at this time (see Appendix M).

Consistent with the recommendations of Study 2, the group program for this study ran for 12 weeks (as opposed to 16 in Study 2) (see Appendix N for specific attendance details). Families were also contacted once per week via phone as a follow-up to the sessions (this also did not occur in Study 2). Baseline data were collected at the intake interview and pre test data were collected in the first session. There was an average of two weeks between baseline and pre test data collection. Post test data were collected in the final session. Follow-up data were collected 12 weeks after the conclusion of the group. Participants were invited to attend a booster session at 12 week follow-up. Only three participants attended this follow-up session, the remaining two provided their data via mail. Formative data were collected during and at the conclusion of each session. Two parent sessions were
conducted. These took place in conjunction with sessions 1 and 7 of the girl’s group program. These sessions were facilitated by an experienced Clinical Psychologist, who was also one of the research supervisors for this project.

7.1.4 Data Capture Methods

Similar to Study 2, both formative and summative data were collected. Table 7.2 presents an overview of the measures used in this study. The TSCC, Demographics, CSQ and summative facilitator questionnaire will not be discussed again as they remain unchanged from Study 2. Other measures used in Study 2 were altered and these changes are highlighted below. Two additional group participant measures were added whilst the resilience scale was not used. Parent data was utilised in the current study. Measures are presented in Appendix O. In combining both the formative and summative data capture methods, it is noted that there were in excess of 15,000\(^6\) separate data points for each participant as well as observations of each participant. That is, the conclusions to be drawn are based on a comprehensive data set, thereby increasing the validity of such conclusions about the lives of these girls.

Table 7.2  Overview of Data Capture Methods and Timing of Data Collection

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Assessor</th>
<th>Baseline</th>
<th>Pre Test</th>
<th>Intervention</th>
<th>Post Test</th>
<th>3mth Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summative Measures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TSCC</td>
<td>Group</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Knowledge test</td>
<td>Participants</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Demographics, Risk &amp; Mood assessment</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>CITES-R</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>ACS</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Parent Demographics, Risk &amp; Mood assessment</td>
<td>Parents</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>SDQ</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Facilitator Questionnaire</td>
<td>Facilitators</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

\(^6\) This figure is calculated by multiplying the number of test items by the number of testing points


## Formative Measures

<table>
<thead>
<tr>
<th>Assessment (cont.)</th>
<th>Assessor</th>
<th>Baseline Pre Test</th>
<th>Intervention</th>
<th>Post Test</th>
<th>3mth Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Evaluation</td>
<td>Group Participants</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Session Knowledge</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>My Goals</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSQ</td>
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</tr>
<tr>
<td>Weekly facilitator assessment</td>
<td>Facilitators</td>
<td></td>
<td></td>
<td>✓</td>
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</tr>
<tr>
<td>Facilitator observation</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Parent session evaluations</td>
<td>Parents</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Parent CSQ</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Parent session facilitator</td>
<td>Parent Group Facilitator</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

### 7.1.4.1 Summative measures

#### Knowledge test

In an attempt to overcome the problems with the knowledge measure that were identified in Study 2, the instrument was reconstructed for the current study. In developing the multiple choice assessment of knowledge of core themes of the program, it was important to assess the participant’s application of knowledge rather than straight recall of things that they had learned. So, Bloom's (1956) cognitive taxonomy was applied to ensure that what was being assessed was not just straight recall of information. Bloom’s cognitive taxonomy suggests that there are six kinds of learning arranged in a hierarchical sequence: recall, comprehension, application, analysis, synthesis, evaluation. Where possible, questions were constructed to measure application over comprehension and recall. For example the question “List three examples of early warning signs” from the Study 2 knowledge questionnaire was modified in Study 3 to “Julia is walking down a dark street alone late one night. She begins to get butterflies in her stomach, sweaty palms and her heart feels like it is going to jump out of her body. This is an example of a) her imagination b) early warning
signs c) a heart attack or d) worry. What should Julia do now? The resulting instrument consists of 35 questions which are scored out of a total of 45. As with the measure of knowledge in Study 2, a criterion of 80% correct was designated as the cut point for determining if relevant knowledge was attained.

Risk & Mood Assessment

This measure remained largely unchanged from Study 2. A series of questions were added to the adolescent version to assess the degree to which participants felt believed, supported, different, and blamed by significant people in their lives. These questions were based on the social support subscale of the CITES-R (Wolfe, Gentile, Michienzi, Sas & Wolfe, 1991) and were included as being believed and supported are known mediators of outcome from CSA (Cohen & Mannarino, 2000). Some questions were also added at follow-up to assess: contact with other members, use of techniques learned in group, use of workbook; the degree of perceived benefit from group; and perceived need for more counselling. In addition, a question which assessed self concept prior to group, after group and at follow-up on a Likert scale from 0-100 (ranging very poor to very good) was added. This question was included as a means of assessing whether the participants saw themselves differently after the group program. A more detailed measure of self concept was not included as it was felt that the assessment battery was too large already.

Children’s Impact of Traumatic Events Scale - Revised (CITES-R) (Wolfe, et al., 1991)

The CITES-R is a structured measure which aims to gather information regarding children/adolescents perceptions and attributions concerning their experience of sexual abuse. The measure consists of 11 subscales grouped into four main scales namely PTSD (intrusive thoughts, avoidance, sexual anxiety, and hyper arousal); Social Reactions
Group Treatment for Sexually Abused Adolescent Girls

(negative reactions by others, social support); Attributions (self blame/guilt, dangerous world, empowerment, vulnerability) and Eroticism (sexual feelings). The scale is typically presented in an interview format but for the current study was used as a self report instrument. The items and responses remained unchanged from the interview to self report format. Items are rated on a three point scale (very true, somewhat true or not true). Psychometric evaluation of each of the subscales of the CITES-R has found it to have good reliability and validity (Wolfe et al., 1991). Internal consistency of the Abuse Attributions scale was found to be moderately reliable ($\alpha = .78$), (Wolfe, et al., 1991). Evidence for convergent and discriminant validity of the CITES-R has been found in several studies (Wolfe, et al., 1991; Crouch, et al., 1999; Chaffin & Shultz, 2001). It is noted that contextual information or normative data were unavailable for this scale and as such in the current study the results are largely interpreted qualitatively (i.e. Did the scores decline? How high is the score in comparison to the total for the scale? Which questions did participants respond to?). For the purposes of the current research only the Attributions subscale of the CITES-R was used in order to keep the size of the assessment battery to a minimum and collect only relevant data. The reasons for choosing the attributions subscale are detailed below.

As indicated in Chapter 1, the transactional model identifies children’s attributions about CSA as a mediator of outcome (Nurcombe et al., 2000). Attributions such as self blame, guilt and feeling different have been found to correlate significantly with self reported symptomology in survivors of CSA (Mannarino & Cohen, 1996). In addition, the results of Study 2 suggested that CSA related attributions and maladaptive cognitions may have been mediating the impact of the treatment program and needed to be assessed more comprehensively to determine if the treatment was effective at modifying such attributions.

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7 the author of the CITES-R was contacted to source normative data but no reply was obtained; an attempt was also made to source the information from other researchers (e.g. Helen Kambouridis) who noted similar problems (i.e. unable to contact the author/find normative data).
Thus it could be argued that if participants attributions about CSA do not shift, then changes in symptomology may also be unlikely to shift. Accordingly it seems important to measure participants abuse related attributions. It was hypothesised in the current study that attributions related to CSA would become more positive following attendance at the program, as the program directly targets attributions using cognitive behavioural techniques.

Adolescent Coping Scale (ACS) (Frydenberg & Lewis, 1994)
The ACS is designed to measure the frequency of use of a variety of coping strategies typically used by adolescents. In the current study the 18 item specific short form was used (as opposed to the generic short form which does not ask participants to answer the items in response to how they cope to a specific stressor in this case CSA). Items are rated on a 5 point scale from ‘doesn’t apply or don’t use’ to ‘used a great deal’. The short form of the ACS has adequate reliability (internal consistency alpha range .66 to .69) and validity (Frydenberg & Lewis, 1994). The scale has three subscales: solving the problem, reference to others and non productive coping. Scores on solving the problem and non-productive coping range from 18-90 where 18 implies the strategy is not used at all and 90 indicates the strategy is used a great deal. Scores on reference to others range from 20 to 100 with similar indicators as the other two scales.

Similar to the CITES-R, this scale was included in the current study as coping strategies are identified as mediators of outcome from CSA in the transactional model (Nurcombe et al. 2000) and the findings of Study 2 indicated that measuring this concept may be important. Within the more general coping literature it is established that more active problem focused coping strategies (e.g. problem solving, help seeking, and positive thinking) are associated with good adaptation to stress while avoidant coping strategies, particularly cognitive
avoidance, are considered the most maladaptive and place adolescents at the highest risk for psychological dysfunction (Ebata & Moos, 1991; Herman-Stahl, Stemmer & Petersen, 1995). Such a finding has been reported to be particularly true with adolescent survivors of CSA (Bal, Van Oost, De Bourdeaudhuji & Crombez, 2003; Johnson & Kenkel, 1991; Spacarelli, 1994). Thus in the current study it was hypothesised that participants who were using more maladaptive forms of coping may be less well adjusted and may not cope as well with their experience of CSA. Furthermore it was hypothesized that coping skills would improve over the course of the study given the treatment programs focus on improving coping skills.

**Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997)**

The SDQ is a 25 item brief behavioural screening measure that is completed by parents. The instrument consists of two sections. The first section asks parents to rate their child or adolescent on five subscales namely emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and pro-social behaviour. The second section aims to assess the impact of the problems stated in the first section and enquires about chronicity, distress, social impairment and burden to others. The SDQ has been normed with children and adolescents from various countries and has been shown to have good reliability and validity. Internal consistency of the SDQ was found to be satisfactory (mean $\alpha = .73$) (Goodman, 2001). Evidence for convergent and discriminant validity has also been demonstrated. For instance The SDQ is highly correlated with the Child Behaviour Checklist and equals it in detecting internalising and externalising problems (Goodman & Scott, 1999). It has the added benefit of being short and is preferred by mothers (Goodman & Scott, 1999). In addition adequate validity has been demonstrated in an Australian sample (Hawes & Dadds, 2004). In the current study the SDQ was used as a measure of parent rated changes in participants on the five subscales.
Parent Demographics, Risk and Mood Questionnaires

For the most part the demographics, risk and mood questionnaires completed by parents are the same as the version completed by adolescents. Three major additions to the questionnaire were made in comparisons to the adolescent version. Firstly, the scale assesses parent’s perceptions of their daughter’s ability to make friends, manage relationships, talk about feelings, control body and personal space, cope with difficult situations, cope with CSA, solve problems and be assertive. Secondly, the questionnaire asks parents the degree to which they feel their daughter is coping with her experience of CSA on a 7 point Likert scale. Finally, at post intervention and follow-up additional questions were added which assessed the changes parents had observed in their daughters since the completion of the program.

7.1.4.2 Formative measures

Group Session Evaluations and Sessional Knowledge

The group session evaluations remained unchanged from Study 2 as they were determined to have adequately assessed the core elements of the sessions and provide relevant information. In contrast, the sessional knowledge tests underwent modification, both in its contents and the way it was implemented, in keeping with the summative knowledge test discussed above. That is, open ended questions were minimised, questions were altered to assess higher knowledge and the girls were informed of the importance of the questionnaires and were better supervised when they completed them in an attempt to minimise missing data and ad hoc answering. In addition, in Study 2 this measure, whilst tapping the core contents of the program, used different questions to the summative knowledge test. In this study however the same questions were used in both the formative and summative evaluation.
My Goals

As previously discussed the ‘My Goals’ assessment was developed to capture generalisation of skills learned in group and to increase participant's responsibility for change. Four goals were identified by each group member at the beginning of the program. These goals were then rated each week on a scale from 0 (not achieved) through to 100 (achieved completely). Participants were also asked to note the activities they had undertaken in the week to help them achieve their goal. Information provided by this measure was used to assess the degree of generalisation of treatment content and the degree to which participants felt they had achieved their goals.

Facilitator Questionnaire and Facilitator Observation

For the most part these measures remained unchanged from Study 2. However a greater focus was given to group process in Study 3 and as such more detail was noted about what occurred in each session. At the conclusion of each session as the primary facilitator, I completed a reflection of the session. This reflection included a general overview of the session, its positive and negative aspects, issues and problems that arose, observations about each participant (mood, engagement in the session, salient issues occurring outside of group, ability to cope with material presented), issues for facilitators, legal issues and plans for the following session. In completing these reflections, I reviewed the participant and facilitator session evaluations and triangulated this material. In doing so relevant issues that needed to be dealt with in the following session were noted.

Parent Session Participant and Facilitator Evaluations

At the conclusion of the two parent sessions, parents were asked to complete an evaluation of the session. It was hoped that this information would assist in directing the development
of future sessions. Specifically, parents were asked how beneficial the session was, how satisfied they were, how much they thought it would help in supporting their daughter, what were the most and least helpful aspects of the session, if the session met expectations, suggested improvements and their mood prior to and after session. Session depth and smoothness were also assessed using the SEQ. An adjective rating of how good/bad the session was on 7 point scale was also taken. The facilitator of the parent session was also asked to complete an evaluation. This evaluation is the same as the one completed by the facilitators of the adolescent group program.

*Parent CSQ*

This measure is identical to the adolescent version discussed in Study 2 and aims to assess parents’ level of satisfaction with the service their daughters received.

### 7.2 Results and Discussion

**SUMMATIVE EVALUATION**

This section will present all outcome data that was collected throughout Study 3. This includes quantitative and standardised assessments, contextual information for each participant and observations made by facilitators.

#### 7.2.1 Within Case Analysis – Participant portfolios and contextual analysis

Access to this section has been restricted for a period of 36 months due to ethical issues associated with the data. Please contact the author should you require this information at kelshaun@bigpond.net.au
7.2.2 Cross Case Analysis

As with the cross case analysis presented in Study 2, the variability of data across the participants would make the use of inferential statistics to summarise this data set meaningless. As such the results are presented as a narrative summary across cases for each outcome measure. The reader is referred to Appendix P for box plots which demonstrate this variability in the data.

From the outset it is noted that PA3 has been excluded from the analysis of the TSCC due to her scores violating the underreporting scale and hence not being valid. As such the results of only four participants will be reported for each subscale of the TSCC. It is noted that concern about the validity of other self report data provided by PA3 was questioned in her portfolio. This data will be included in the proceeding analysis as these other measures do not have a validity scale like the TSCC, and so I can not be assured that the results are invalid but assume that they are likely to be underreported. In addition unlike the TSCC which showed clinically significant change for PA3, the other self report measures show minimal change.

TSCC

Declines are evident across the majority of subscales of the TSCC for each participant (see Table 7.23). It was observed that from baseline to pre test, scores increased slightly (by an average of 3.5 points) perhaps because by joining the group program, the participant’s experience of sexual abuse was brought to the forefront of their minds and therefore was having a greater impact at this stage/time. On account of this finding, the proceeding discussion will use the pre test scores as the benchmark for measuring change.
Table 7.23

Magnitude and Direction of Change on TSCC Subscale T-scores from Pre test to Follow-up

<table>
<thead>
<tr>
<th>Participant</th>
<th>Anxiety</th>
<th>Depression</th>
<th>Anger</th>
<th>PTSD</th>
<th>Dissociation</th>
<th>Sexual Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA1</td>
<td>Range Normal</td>
<td>Normal Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal Normal</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Magnitude +2</td>
<td>-3</td>
<td>-14*</td>
<td>-8</td>
<td>-3</td>
<td>0</td>
</tr>
<tr>
<td>PA2</td>
<td>Range Normal</td>
<td>Normal Normal</td>
<td>Normal</td>
<td>Clinical to normal</td>
<td>Normal</td>
<td>Clinical to normal</td>
</tr>
<tr>
<td></td>
<td>Magnitude -9</td>
<td>-16*</td>
<td>-6</td>
<td>-17*</td>
<td>+6</td>
<td>-19*</td>
</tr>
<tr>
<td>PA4</td>
<td>Range Clinical to normal -17*</td>
<td>Clinical to normal</td>
<td>Clinical to normal -12*</td>
<td>Clinical to normal -21*</td>
<td>Clinical to normal -22*</td>
<td>Clinical to normal -19*</td>
</tr>
<tr>
<td></td>
<td>Magnitude -17*</td>
<td>-15*</td>
<td>-12*</td>
<td>-21*</td>
<td>-22*</td>
<td>-19*</td>
</tr>
<tr>
<td>PA5</td>
<td>Range Normal</td>
<td>Clinical to Normal</td>
<td>Normal</td>
<td>Clinical</td>
<td>Clinical</td>
<td>Clinical to normal</td>
</tr>
<tr>
<td></td>
<td>Magnitude -2</td>
<td>-7</td>
<td>-6</td>
<td>-3</td>
<td>+2</td>
<td>-19*</td>
</tr>
</tbody>
</table>

* denotes clinically significant change

All four girls show declines on the depression subscale with three of these showing changes that are clinically significant. Whilst PA5’s change is not greater than 10 points she has shifted from the clinical to non clinical range. All four girls also showed reduced scores on Anger and PTSD. On both scales, two girls showed clinically significant changes. Three of the four girls had clinically significant changes on the sexual concern subscale shifting from the clinical to normal range. The other girl had no change on this subscale but is within the normal range. Declines on the Anxiety scale are also evident from pre test to follow-up for 3 of the 4 girls. Only 1 girl showed clinically significant declines on the dissociation subscale at follow-up.

Only three instances of participants deteriorating on the TSCC are demonstrated. Two of these shifts (PA1 Anxiety & PA5 Dissociation) are only by two points and are therefore likely to reflect measurement error. The other however (PA2 dissociation), whilst not greater than 10 points, is substantial (6 points) and is in contrast to the gains she made on all other
subscapes. Overall the results of the TSCC show some convincing evidence of positive shifts that these participants made. Nevertheless the results also show that these outcomes cannot be interpreted in isolation, nor without contextual information, for if they were the results would be far less compelling.

*Emotions*

Three of the five participants reported feeling less alone, ashamed and angry after completing the program relative to baseline. Three of five also report being more relaxed, confident and happy from baseline to follow-up. Other results on the emotion scale are more disparate and specific to the individual cases (see Appendix P for graphs of this data). However, similar to the TSCC the analysis of this measure appears to be complicated by a spike in ratings at pre-test for most girls. It is hypothesised that this spike may relate to the time period over which participants were asked to rate their mood (i.e. 1 week). It is conceivable that their mood varied considerably over this time and a wider time period may have been helpful to get a more stable representation of mood. It is also possible that as suggested for the TSCC the spike is related to beginning the girls group. Overall it is quite difficult to capture changes across participants for this measure, particularly given the contextual factors present for some. In addition PA3’s results may not be an accurate account of her emotional world.

Parents also completed this measure. However there are no consistent patterns of change in these data across cases. If anything, the results suggest a slight negative trend (i.e. parents ratings of their daughters emotions indicate that the girls were more angry and more guilty following the program) (see Appendix P for graphs of this data). Conceivably this trend could have also indicated that parents had a greater awareness of their daughters emotional state. Or that as a result of the program the girls felt more comfortable
communicating with their parents and so more easily expressed how they were feeling which may then have been interpreted by parents as an increase in emotionality.

**Risk Factors**

The most common risk factors endorsed by *all* girls on at least one occasion were problems with sleeping, concentrating, trouble getting along with family, mood swings, isolation and feeling ‘on guard.’ Binge eating, throwing up after eating, being in dangerous situations, having trouble making friends, feeling withdrawn and having trouble talking about feelings were endorsed by four of the five girls. All other risk factors were endorsed less frequently or not at all (e.g. suspension from school, further sexual abuse, pregnancy, termination of pregnancy, contracting STI) (see Appendix P). In terms of shifts in risk factors endorsed at follow-up, the results are highly variable and are therefore best discussed in the context of each participant. In a general sense, three of the girls reported considerably fewer risk factors at follow-up relative to pre test. PA3’s shifts may have been somewhat unrealistic in comparison to the other girls again suggesting a degree of ambiguity in her data. Whilst the number of risk factors remained the same for PA4 and PA5, there appeared to be a shift in the severity/frequency of these risk factors.

Some of the risk factors reported by participants appear contradictory to other evidence collected as well as to parental report. For example, three of the girls report that on at least one occasion they ran away from home. However none of the parents except PA5’s mother at follow-up report that their daughters ran away from home. Furthermore given that the girls attended almost every group session, it seems unlikely that they ran away from home. Thus it is difficult to understand how the participants approached/answered some of these questions and this needs to be explored within each case. Three of the parents appear to have underrated the experiences of their daughter, while two parents demonstrated a
relatively good understanding of the difficulties their daughters faced. Finally it is noted that
the three point scale used in this measure is perhaps not adequate to truly delineate the
changes in each of the participants.

Knowledge

On the knowledge test, three of the five girls scored 80% correct or higher at follow-up as
opposed to no participants scoring above this designated criterion at baseline. The other
two girls showed no change in their knowledge scores at all from baseline to follow-up (see
Table 7.24). In examining this measure in finer detail, it is first noted that the baseline
scores (which were collected on average two weeks prior to the program beginning), were
relatively high to begin with suggesting the participants already understood much of the
information included in the program, perhaps from individual therapy. This finding is
somewhat concerning as one would expect that if the participants had a relatively good
understanding of the core concepts of the program that they would have translated this
knowledge into behavioural and emotional change, thereby not needing to attend the
program.

A second observation of this measure is that six questions were consistently answered
incorrectly by all participants. This included three questions related to cognitive coping, two
questions related to goal setting and one question which asked about feelings associated
with CSA. In relation to the questions which assessed the goal setting session, it is
suspected that the questions themselves were too abstract. The results from the questions
which assessed the cognitive aspects of the program, align with other data collected
formatively which together suggest that this concept was not grasped by the participants
and requires further refinement in the treatment manual. The responses to the questions
pertaining to CSA are most curious in that the results deviate from other evidence such as
verbalisations in session and completed worksheets suggesting that the participants fully understood that it is normal for CSA survivors to feel angry, scared and sad following CSA.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Baseline</th>
<th>Pre test</th>
<th>Post test</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>73</td>
<td>80</td>
<td>89</td>
<td>89</td>
</tr>
<tr>
<td>2</td>
<td>69</td>
<td>44</td>
<td>62</td>
<td>69</td>
</tr>
<tr>
<td>3</td>
<td>73</td>
<td>73</td>
<td>77</td>
<td>74</td>
</tr>
<tr>
<td>4</td>
<td>67</td>
<td>67</td>
<td>87</td>
<td>84</td>
</tr>
<tr>
<td>5</td>
<td>75</td>
<td>71</td>
<td>63</td>
<td>82</td>
</tr>
</tbody>
</table>

Some similar problems to Study 2 were still apparent with this measure. Most notably the participants in Study 3 like those in Study 2 showed low motivation to complete this measure. PA2 and PA5 in particular are noted to have missed a number of questions at various stages. Whilst this group is a great deal more literate than the previous group, there is still a significant reading component to the measure and this needs to be weighed against the benefits of measuring learning in this way.

CITES – R

The findings of the total CITES-R attribution scale score show that all participants’ attributions about sexual abuse become more positive following the group program such that they reported feeling less guilt and blame, less personal vulnerability and were more likely to view the world as a safe place following the group program. They were also more likely to feel empowered (see Appendix P for a graph of this data).
High scores on self blame/guilt reflect a greater tendency for individuals to blame themselves for CSA. Scores on this scale for four of the five girl’s decreased from pre test to follow-up, indicating little blame or guilt felt by the participants. The other girl (PA2) appears to have declined at post test but increased to pre test levels at follow-up. It is noted however that the scores were quite low to begin for all participants. Nevertheless these scores did decline and therefore suggest a shift in attributions of guilt and self blame associated with their experiences. PA3’s score on this subscale appear to be valid and consistent with other evidence.

The personal vulnerability scale reflects the degree of control individuals feel they have over stopping CSA, the degree to which they feel it may occur again and the extent they believe it happens to others. Again the scores on this scale were low across the testing phases indicating that the participants did not have any concerns. Three of the girls showed declines on this scale suggesting that prior to the program they were more inclined to think that they were vulnerable to further sexual abuse.

The dangerous world subscale indicates children’s concerns about whether adults can be trusted and if children will be sexually abused. One of the girls showed no change on this scale while three girls showed declines which indicates that after the program they believed that the world was a safer place. In contrast PA5 had a higher rating at follow-up (7/8) which indicated she felt the world is unsafe. As discussed in her portfolio, this more than likely related to her experience at this time of harassment from her perpetrators following her disclosure to the police.

High scores on the empowerment scale reflect a belief that sexual abuse can be prevented. Two of the girls had very high ratings on this scale across the testing phases. Two other
girls increased their ratings of empowerment over the course of the testing phases which indicates that they were increasingly more confident that sexual abuse can be prevented. PA4’s ratings remained unchanged. This is perhaps reflective of PA4’s lack of trauma processing prior to the group, lack of assertiveness skills and general low confidence in herself and her abilities. PA4’s ratings are perhaps an underestimate of her ability to prevent herself from further abuse.

As with other scales reported, there is a high degree of variability in the individual scores for the CITES-R. PA1 and PA3 appear to have scored considerably lower (i.e. they had more positive attributions) than the other participants, perhaps because the other participants had experienced more severe abuse. The main purpose of including the CITES-R attribution scale in this study was to assess if attributions were mediating treatment outcome. Given the low scores overall, it is difficult to assess if this was the case and it may perhaps suggest that they were not operating as mediators. However there is evidence to suggest that the participant’s attributions did shift after attending the group as presented here. Furthermore observational evidence from the group adds to these findings. For example PA5 had a very strong belief at the beginning of the group that she was to blame for her experience of sexual abuse. With some thought challenging from the facilitators and through the process of the group, PA5’s beliefs changed and she no longer reported feeling she was to blame. Conceivably this is what led PA5 to feeling comfortable enough to report her experience to the police.

ACS

There appears to be a trend towards a reduction in the use of non productive coping across the testing phases for four of the five participants. This suggests that participants were using strategies such as worry, avoidance, wishing for miracles and self blame less
frequently following attendance at the program. It is noted that two of the participants were using this strategy very infrequently at baseline anyhow, and only one participant indicated that they used these types of coping mechanisms frequently. For PA3 the infrequent use of non-productive coping strategies from baseline coupled with her lack of symptomology on other measures could suggest denial and avoidance. Or alternatively she did not complete the assessment in a valid way. The overall results for PA3 tend to favour the former explanation (i.e. she had no need to use non productive coping as she does not perceive herself to be symptomatic or having any problems).

It may have been expected that the participants would have all been using maladaptive coping strategies more frequently prior to the program given their ongoing distress and the impact of their experience on their lives. If they were not using maladaptive coping strategies one would expect that they were using more adaptive strategies and this could suggest that they would be performing better. Thus in some ways the finding is interesting and could reflect a flaw in the scale used. That is, perhaps the scale did not adequately measure the types of maladaptive coping that the participants were using. One concrete example of this would be avoidance. Many of the girls used avoidance as a coping strategy and this concept was not well measured using the adolescent coping scale.

One coping strategy, reference to others, is variable across the participants. It is noted that PA1’s use of this strategy is much less frequent than the other participants and reflective of her tendency not to share her problems or feelings with others. Her ratings of this strategy showed a slight increase from baseline to post test but this was not maintained at follow-up. Two participant’s scores remain largely unchanged on the scale whilst one increased her use of the strategy and one decreased her use of it. At follow-up the use of this strategy
ranged from ‘very little’ to ‘sometimes’ and overall does not appear problematic in the context of the girls lives and other available evidence (e.g. observation and self report).

The use of problem solving methods of coping at follow-up was rated as ‘sometimes’ for all participants. For two of the participants this is an improvement, whilst for two it is a decline from baseline levels. For the remaining participant, her use of problem solving increased at post test, which suggests that at the time she used the strategy a ‘great deal’ but she did not maintain its use at follow-up. These ratings were expected to increase much more following the program.

In examining this measure more closely, it is felt that this instrument may not have been entirely appropriate to achieve the set aims. Whilst the instrument has the benefit of asking participants to specifically rate the coping methods they use in relation to dealing with CSA, the items themselves may not necessarily reflect the coping mechanisms used by CSA survivors (e.g. avoidance as discussed above).

My Goals

This measure is less easy to summarise than the others in the battery given that each participant had their own personal goals which they identified and were working towards in the program. Table 7.25 gives an overview of the degree to which each participant rated their achievement of their goals at three month follow-up. As always, these scores are meaningless without being understood in the context of other information. In particular PA3’s ratings are inconsistent with other data and do not suggest she achieved her goals. Most notably her first goal which was to ‘deal with her experience’ and in the view of the facilitators was only marginally achieved. PA5’s results must also be interpreted in the context of her life circumstances at the time (i.e. moving overseas to avoid harassment).
Overall the results show that each girl felt that they had made gains towards the goals they wished to achieve by attending the program (with the exception of PA5, goal 1) and in many instances they fully achieved their goals.

Table 7.25. *Participants Ratings of Achievement of Personal Goals at 3 Month Follow-up*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Goal 1 % achieved</th>
<th>Goal 2 % achieved</th>
<th>Goal 3 % achieved</th>
<th>Goal 4 % achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA1</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>85</td>
</tr>
<tr>
<td>PA2</td>
<td>100</td>
<td>100</td>
<td>70</td>
<td>100</td>
</tr>
<tr>
<td>PA3</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>PA4</td>
<td>50</td>
<td>50</td>
<td>47</td>
<td>50</td>
</tr>
<tr>
<td>PA5</td>
<td>0</td>
<td>40</td>
<td>60</td>
<td>80</td>
</tr>
</tbody>
</table>

The main aim of introducing the My Goals assessment was to help focus the intervention so that it would be meaningful for participants and also to increase participant's responsibility for, and generalisation of, skills learned in sessions. Participants 1, 2 and 5 demonstrated good generalisation of skills and frequently noted that they practiced skills outside of session. PA4 reported this to a lesser extent and PA3 reported no evidence of generalising skills. PA1 and PA4 always completed homework. PA2 and PA5 mostly completed homework and PA3 infrequently completed homework. Thus the tool appears to have worked well in achieving its aims and provides some good information about how participants feel they have changed after attending the program.

*SDQ*

Both the subscales of the SDQ and the total difficulties scale suggest some considerable improvements in participant's emotional distress and behaviour problems as rated by their parents (see Table 7.26).
Table 7.26  SDQ Subscale Scores across the Testing Phases

<table>
<thead>
<tr>
<th>Scale</th>
<th>PA1</th>
<th>PA2</th>
<th>PA3</th>
<th>PA4</th>
<th>PA5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional distress</td>
<td>Range</td>
<td>Abnormal</td>
<td>Abnormal to Normal</td>
<td>Abnormal to Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td></td>
<td>Magnitude</td>
<td>-1</td>
<td>-3</td>
<td>0</td>
<td>-5</td>
</tr>
<tr>
<td>Conduct</td>
<td>Range</td>
<td>Abnormal</td>
<td>Abnormal to Normal</td>
<td>Abnormal to Borderline</td>
<td>Abnormal to Borderline</td>
</tr>
<tr>
<td></td>
<td>Magnitude</td>
<td>0</td>
<td>-4</td>
<td>0</td>
<td>-1</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>Range</td>
<td>Normal</td>
<td>Abnormal to Normal</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Magnitude</td>
<td>-4</td>
<td>-2</td>
<td>+1</td>
<td>-2</td>
</tr>
<tr>
<td>Peer problems</td>
<td>Range</td>
<td>Abnormal to Borderline</td>
<td>Normal</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td></td>
<td>Magnitude</td>
<td>-5</td>
<td>-1</td>
<td>+2</td>
<td>0</td>
</tr>
<tr>
<td>Prosocial</td>
<td>Range</td>
<td>Abnormal to Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Magnitude</td>
<td>+3</td>
<td>-1</td>
<td>+1</td>
<td>+1</td>
</tr>
<tr>
<td>Total Difficulties</td>
<td>Range</td>
<td>Abnormal to Normal</td>
<td>Abnormal to Normal</td>
<td>Abnormal to Borderline</td>
<td>Abnormal</td>
</tr>
<tr>
<td></td>
<td>Magnitude</td>
<td>-8</td>
<td>-10</td>
<td>+3</td>
<td>-8</td>
</tr>
</tbody>
</table>

For the total difficulties scale, only one participant (PA5) remained in the abnormal range at follow-up as opposed to four at baseline. Three of the participants reported clinically significant shifts on the conduct scale. Two of these participants also made clinically significant shifts on the emotional distress scale. This is consistent with participant’s ratings on the TSCC. Only one participant remained outside the normal range on the hyperactivity scale at follow-up as opposed to three on the peer problems scale. The failure to make considerable shifts on the peer scale is perhaps unsurprising given participants reports of the difficulties they have had with ‘so called’ friends (i.e. friends being disbelieving of the sexual abuse). Ratings of prosocial behaviour appear appropriate and consistent with observations of the girls in group. Whilst PA4 has moved into the borderline range on this scale at follow-up it does not appear problematic when taken into context of her family and her conflict with her younger brother.
**Self Reported Change**

A subjective measure of self reported change was also taken at follow-up. Participants were asked to rate how they felt about themselves prior to the group beginning, after the group finished and right now (i.e. at follow-up) on a scale from 0 (very poor) to 100 (very good). The results of this measure are presented in Figure 7.16. Consistent with other data (particularly facilitator observation) the figure clearly demonstrates that prior to attendance at the program PA1, 2 and 4 had very poor self concept and identified themselves as victims of abuse. All three of these participants reported a substantial positive impact on the way they felt about themselves after attending the program. This finding may suggest that these girls no longer saw themselves as victims of CSA but rather survivors. This would be consistent with other evidence (e.g. creative expression, observation, self report instruments) available which suggests that these girls made considerable shifts and rewrote their narratives associated with their experience.

![Participant's subjective ratings of how they felt about themselves prior to the group began and after it finished.](image)

*Figure 7.16. Participant's subjective ratings of how they felt about themselves prior to the group began and after it finished.*
PA5’s data is also consistent with other data which showed that following the group she was coping less well than before attending. As previously noted this was due to extenuating circumstances associated with her case. Her rating at follow-up however suggests that she is moving towards achieving her goals and that removing herself from the distressing situation (i.e. being harassed by her perpetrators) by moving overseas was important. PA3’s data is also consistent with other self report evidence suggesting that PA3 did not identify herself as having any problems and is concerning as this is in contrast to the observations of both facilitators which suggested that PA3 had some significant issues which she needed to deal with.

7.2.3 Facilitator Ratings of Outcome

The Facilitator questionnaire was designed to assess the extent to which facilitators believed each participant met the objectives of the group program. Facilitators completed this measure following the final session of the program. Overall these ratings by facilitators suggest that each of the objectives of the group were adequately attained by each participant (see Table 7.27). The lowest attainment was for self esteem and peer and relationship skills. Highest attainment ratings were in the reduction of self blame and shame, avoidance and isolation and an increase in personal safety skills. According to these ratings PA5 received the most benefit from attending the group and PA3 the least. Whilst PA5 did not show a great deal of positive change on her self report data, as presented in her portfolio, in comparison to some of the other participants, consistent observations from the facilitators which were noted in most sessions were that she gained the most from attending. If not for the mitigating circumstances involved with her case, perhaps her self report data would have been more convergent with these ratings. In regards to PA3, the facilitators ratings are in line with her outcome data but perhaps represent more change than was drawn from the outcome data given her asymptotic
presentation and tendency to minimalisation and avoidance. That is, as previously mentioned, PA3 seemed to benefit from being in the program and developed some skills, but this was inadequately captured in the self report data.

Table 7.27  Facilitator Ratings of each Objective of the Program at Post test

<table>
<thead>
<tr>
<th>Objective</th>
<th>PA1</th>
<th>PA2</th>
<th>PA3</th>
<th>PA4</th>
<th>PA5</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>↑ emotional expression skills and knowledge</td>
<td>FA1</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>8</td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>5</td>
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</tr>
<tr>
<td>↑ relaxation skills and knowledge</td>
<td>FA1</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>8</td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>4.2</td>
</tr>
<tr>
<td>↑ cognitive coping skills and knowledge</td>
<td>FA1</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>6</td>
<td>6.0</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
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<td>7</td>
<td>5</td>
<td>7</td>
<td>6.6</td>
</tr>
<tr>
<td>↑ personal safety knowledge and skills</td>
<td>FA1</td>
<td>7</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>6.6</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>9</td>
<td>8</td>
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<td>8</td>
<td>8.4</td>
</tr>
<tr>
<td>↑ understanding and knowledge and provide education regarding CSA</td>
<td>FA1</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>6.8</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>10</td>
<td>7</td>
<td>6</td>
<td>8</td>
<td>7.6</td>
</tr>
<tr>
<td>↑ self esteem</td>
<td>FA1</td>
<td>5</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>6.4</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>4.5</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>5.3</td>
</tr>
<tr>
<td>↑ assertiveness</td>
<td>FA1</td>
<td>7</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>6.2</td>
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<tr>
<td></td>
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<td>7</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>5.6</td>
</tr>
<tr>
<td>↑ peer and family relation skills</td>
<td>FA1</td>
<td>5</td>
<td>9</td>
<td>7</td>
<td>6</td>
<td>6.8</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>4.5</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>4.9</td>
</tr>
<tr>
<td>↓ emotional and behavioural difficulties</td>
<td>FA1</td>
<td>5</td>
<td>7</td>
<td>3</td>
<td>6</td>
<td>5.8</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>6</td>
<td>7</td>
<td>3</td>
<td>5</td>
<td>6.0</td>
</tr>
<tr>
<td>↓ avoidance and social isolation</td>
<td>FA1</td>
<td>6</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>7.6</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>6</td>
<td>8</td>
<td>9</td>
<td>9</td>
<td>8.2</td>
</tr>
<tr>
<td>↓ feelings of self blame and shame</td>
<td>FA1</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>7</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>FA2</td>
<td>8</td>
<td>8</td>
<td>9</td>
<td>6</td>
<td>7.8</td>
</tr>
<tr>
<td>Objective</td>
<td>PA1</td>
<td>PA2</td>
<td>PA3</td>
<td>PA4</td>
<td>PA5</td>
<td>Mean</td>
</tr>
<tr>
<td>-----------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>Mean Rating (SD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FA1</td>
<td>6.72</td>
<td>7.09</td>
<td>6</td>
<td>7</td>
<td>7.27</td>
<td>6.81</td>
</tr>
<tr>
<td>(1.27)</td>
<td>(0.94)</td>
<td>(1.41)</td>
<td>(1.00)</td>
<td>(0.46)</td>
<td>(0.50)</td>
<td></td>
</tr>
<tr>
<td>FA2</td>
<td>7.09</td>
<td>6.82</td>
<td>4.54</td>
<td>5.45</td>
<td>7.9</td>
<td>6.36</td>
</tr>
<tr>
<td>(1.74)</td>
<td>(1.40)</td>
<td>(3.01)</td>
<td>(2.34)</td>
<td>(1.22)</td>
<td>(1.35)</td>
<td></td>
</tr>
</tbody>
</table>

Note. Objectives are rated out of 10; Study 2 was only rated out of 5.

It is noted that on a number of occasions there is a discrepancy of greater than two points between the facilitator’s ratings. On most occasions it is noted that FA2 has rated the participants lower than I (FA1). This is more than likely because FA2 could only rate the participants on the basis of observations in session, where as I had a greater base of information on which to base my ratings in that I conducted the intake interviews, liaised with each of the participants out of session and had reviewed all of the session evaluations as the group progressed. This may be a confound of the ratings but was unavoidable.

Most significantly these discrepancies appear to have occurred for ratings of PA3, with 7 ratings being discordant by more than 2 points. In the case of PA3 I rated her according to the change I saw in her from the beginning to the end of the program. For example over the course of the program PA3 became much more expressive about her emotions and so I gave her a rating of 7. This does not mean that she was as expressive as other group members whom I also gave a rating of 7 (PA2 and 5) but that I identified changes in this objective which I attributed to attendance at the group. In reviewing FA2’s ratings I do not think that she approached the rating in this way. In addition FA2 did not have as much information on which to base her ratings on PA3. In reflecting on my ratings with the knowledge of all PA3’s data presented in her portfolio, I think my ratings may be slightly overestimated. Nevertheless this does not change the outcome that PA3 received the least benefit from the program.
The facilitator’s ratings of PA1 and PA2 are consistent with their self report data and show that these girls made a number of gains from their attendance at the program. In contrast the ratings given by the facilitators for PA4 appear to underrate the extent to which this participant changed. PA4 made the most clinically significant gains on the self report measures presented in her portfolio, however the facilitators (particularly FA2) do not appear to have captured this as much in their ratings. A large discrepancy in three ratings (emotion, relaxation and peer and family relations) given by the facilitators is also apparent. Again as I indicated with PA3 I have rated these objectives based on the shifts PA4 made during the group, not on how well she was doing in comparison to other group members on these objectives, which it seems FA2 may have done.

It is noted that the facilitator’s ratings were completed immediately following the closure of the group program. At 3 month follow-up, three of the five girls (PA 1, 2 & 4) attended the booster session/group reunion. It was observed at this time that these three participants had made further gains on most of the objectives presented. This is in keeping with the results of Study 2 which suggested that the participants of the program continued to process their experience of CSA and reflect on what they learned at the group program and made further gains after the program finished. This is consistent with the intervention sleeper effect proposed by Hawe et al. (1990) that was hypothesised for this program (i.e. the real world impact of the intervention would not be evident immediately following its implementation but would be evident after participants had time to reflect on it further). Unfortunately little can be concluded about the ongoing gains for the remaining two participants as they were unable to attend the group reunion and thus only parent and self report can be relied upon.
Table 7.28 Facilitators Ratings of Estimated Attainment of Group Aims Pre and Post Group on a Scale of 1 to 7

<table>
<thead>
<tr>
<th>Facilitator</th>
<th>Expected Pre Group</th>
<th>Actual Post Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decreasing Risk Factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FA1</td>
<td>5.5</td>
<td>5</td>
</tr>
<tr>
<td>FA2</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>Increasing Protective Factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FA1</td>
<td>5.5</td>
<td>5.5</td>
</tr>
<tr>
<td>FA2</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td><strong>Decreasing Effects of CSA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FA1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>FA2</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

*Note.* Higher scores indicate greater attainment of aims.

Post test ratings of the attainment of overall group aims also concur with the objectives presented above, suggesting that after the completion of the group program there was a decrease in risk factors, increase in protective factors and alleviation of the effects of CSA across the participants (see Table 7.28). Based on the estimated ratings of attainment of aims at pre test from facilitators, it is noted that full alleviation of the effects of CSA or attainment of group content was not expected to occur as a result of the 12 week program. The post test ratings of facilitator’s estimates of actual attainment are slightly lower than what was predicted at pre test but overall are suggestive of a good outcome.

### 7.2.4 Summary & Triangulation of Summative Findings

Overall the data presents a variable picture of the impact of the adolescent girl’s group program on the participants. The program was certainly beneficial for each participant but in different ways that are not always easy to capture in individual paper and pencil tests and highlights the need for mixed methods and multiple assessment points. The effect of the program depended upon the concerns with which participants initially presented. As evidenced by the variability presented in the measures, each participant had different concerns and different levels of symptomology. Nevertheless the results obtained appear to suggest that each participant developed a new narrative about what it means to have been
sexually abused following their attendance at the program (although PA3’s was in the very early stages of change). The most powerful evidence for this claim comes from the girl’s poetry and other creative pieces (including PA3’s). It was also evident in observations made in session and suggests that the negative self defeating stories these girls held have been challenged, thereby allowing them to develop new stories about themselves and the courage and strength which they possess.

Clinically significant changes on outcome measures occurred for three of the five participants (PA1, 2 & 4). Of the two without clinically significant change, one participant (PA3) was asymptomatic at the beginning of the program and the other participant (PA5) experienced extenuating factors which may have interfered with her ability to achieve significant change on the main outcome measures presented in the portfolios. Despite this, clinically significant changes in participant presentation were apparent for all participants as evidenced by participant and parental report and facilitator observation as summarised in Table 7.29.

Table 7.29  Summary of Changes in each Participant Following Attendance at the Program According to Triangulation of Data Sources

<table>
<thead>
<tr>
<th>Participant</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA1</td>
<td>• More expressive; more able to talk about CSA; more confident and assertive; less angry and aggressive; less anxious; good coping skills</td>
</tr>
<tr>
<td>PA2</td>
<td>• Increased personal safety skills; more confident and assertive; more relaxed; less angry and ashamed; less symptoms of anxiety, depression and PTSD; better relationship with father; identity of a survivor</td>
</tr>
<tr>
<td>PA3</td>
<td>• More ‘confident and open’ (according to PA3 &amp; Mother); beginning to unfold her experience and develop feelings about it</td>
</tr>
<tr>
<td>PA4</td>
<td>• More expressive and able to talk about CSA; more confident; less symptoms of anger, depression, anxiety, PTSD, dissociation and sexual concern</td>
</tr>
<tr>
<td>PA5</td>
<td>• More able to contain emotions; more confident; more open and expressive; less blame and shame associated with CSA</td>
</tr>
</tbody>
</table>
Whilst the changes for PA3 appeared minimal, I suspect that the processing and learning she undertook in the group have placed her in a good position to make further gains in the future when she is emotionally ready to do so. Prevention and preparation for future problems associated with CSA was one of PA3’s reasons for attending the group and so it is hoped that the vicarious experiences she had in group will assist her in the future.

As with Study 2, one of the most beneficial aspects of the group program appeared to be in its ability to allow survivors of CSA to meet one another, have their experiences validated and understand that what they are going through is normal. This was observed by the facilitators in every participant and was noted by participants and parents. For instance PA4 reported that prior to attending the program she felt no one could ever understand what she was going through but after the program she experienced a sense of validation and normalisation from her experiences in group. Overall this finding is consistent with Yalom’s (1995) concept of universality. He notes that the “disconfirmation of a patients uniqueness is a powerful source of relief” (p.6) which facilitates other aspects of group process (e.g. trust, self disclosure, cohesion) and allows the group to move into a working phase. Further evidence of this finding is noted in the formative data to follow.

Before attendance at the group program many of the girls expressed feelings of guilt, shame and differentness. After the group program they were more likely to express feelings of strength, courage and resilience. This was evidenced throughout their self report measures, creative pieces (e.g. poems) and discussions within group sessions. In drawing the data together from parents, participants and facilitators the evidence suggests that following the group program the girls were more able to talk and write about their experience of CSA without becoming distressed and instigate or proceed with legal matters (PA2, 4 & 5). Furthermore the girls were less likely to express blame or shame, or report
feeling different or ‘abnormal’ and most importantly felt believed and supported. This suggested that the girls have had an opportunity to create a new understanding of their experiences of CSA and a new sense of self.

Despite the gains each participant made, it should be noted that it was recommended that all five girls receive further individual or family counselling for difficulties that could not be targeted in group. For example it was recommended that PA4 receive family therapy as the entire family had been affected by her experience and their distress was impacting on PA4’s ability to move forward. This therapy could help all family members to come to terms with CSA and move through it. Furthermore this type of therapy may help PA4 repair her relationship with her father.

The outcome from the program may have been mediated by a number of factors. Whilst the coping measure used does not appear to have shown coping as a mediator of outcome or the program as proficient at improving participants coping skills, this is in contrast to other evidence. Firstly, three participants (PA1, 3, 4) presented with a high degree of avoidance in relation to CSA and their emotions in general. Two of these participants were observed to become increasingly more comfortable when discussing CSA and increasingly more open and expressive with their feelings through the course of the program. Furthermore both participants reported increasing use of adaptive coping skills through the course of the program (e.g. relaxation, singing, problem solving). In contrast PA3 remained more avoidant than these two girls and did not report the use of adaptive coping strategies very frequently.

One other significant mediator of outcome was perhaps family environment and social support. Whilst all parents were supportive of their daughters and wanted them to receive
help, other indicators of support were less obvious for some participants. As previously discussed, PA3’s mother tended to minimalise PA3’s experience, the relationship between PA1 and her mother was not close, and PA4 and her father also did not have a close relationship. Furthermore all of PA4’s family were considerably affected by PA4’s experience and appeared to be struggling to cope. Some changes in these relationships were noted over the course of the program but they still appeared to be significant mediating factors. PA2 and PA5 also appeared to avoid discussion with their parents around difficult topics including CSA prior to the program but both participants and parents reported that this changed after completing the group.

Attributions about CSA (e.g. self blame) did not appear to have been operating as a mediating factor with these five participants. Overall attributions about CSA appeared to be particularly low and therefore appropriate. Nevertheless the results did show declines on these scales and suggest that the group may have had an impact on decreasing participant’s ratings of self blame and guilt and increasing the belief that they are in control and can protect themselves from future sexual abuse. These factors may have been holding them back in the past.

Perhaps one final issue to consider, which is specific to PA4, is her limited amount of individual therapy prior to attendance at the group. It is recognised that her lack of prior trauma processing may have inflated the results she achieved in this group relative to other girls who had more extensive prior counselling, and therefore inflated the overall results of this study and the impact of the group. However, the rationale for not including girls in the program prior to undertaking individual therapy is largely one of ethical responsibility. In the case of PA4 I consulted with her parents and with her individual counsellor to ensure that she would cope with the demands of group prior to making a decision about her inclusion.
and felt confident that she would cope with the group. This was indeed the case. Thus while the results should be considered with PA4’s context in mind, it does not suggest that PA4 should not have been included in the program. Furthermore it indicates that adjunctive therapy is important but that in the future, participants for the group should be considered on a case by case basis.

It is recognised that in the absence of a control group, hypotheses about causality must be cautious, however by using quantitative and qualitative data and triangulating data from participants, parents and facilitators, a much clearer picture of the impact of the group was presented. Each of the girls in the group had been dealing with the effects of CSA for at least one year with little amelioration (and despite attendance at individual therapy) and as such it seems unlikely that the trajectory of these girls’ symptoms would have changed without the implementation of the program.

In drawing all of the summative data together, it is my conclusion that the participants attendance at the group program is likely to have facilitated many of the changes presented. The formative evaluation presented below attempts to describe the ways in which the group program and process may have helped to achieve these benefits for these participants.

**FORMATIVE EVALUATION**

The formative evaluation which follows was based primarily on the findings of the consumer satisfaction questionnaire and weekly session evaluations completed by participants, and the weekly facilitator questionnaires and observations made by facilitators. These measures were designed to assess the acceptability and integrity of the program as well as the impact of session content, group process and common factors of therapy. The aim of the formative
evaluation was to identify areas of improvement and assess contributors of program effectiveness. The results of the formative analysis are presented below.

### 7.2.5 Program Evaluation and Component Analysis of the Girls Group

#### Acceptability

The overall acceptability ratings as measured by the consumer satisfaction questionnaires indicate that the group was highly valued. Mean ratings of acceptability were 92.5% (range 82-100%) for girls and 81.3% (range 56-92%) for parents suggesting that the participants were very satisfied with the service they received (with the exception of MO3 as detailed below). Table 7.30 outlines some of the items of CSQ in finer detail.

<table>
<thead>
<tr>
<th>Item</th>
<th>Girls</th>
<th>Parents</th>
</tr>
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<tbody>
<tr>
<td>Quality of Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>fair</td>
<td>1 4</td>
<td>1 4</td>
</tr>
<tr>
<td>good</td>
<td>1 5</td>
<td>2 6</td>
</tr>
<tr>
<td>very good</td>
<td>1 6</td>
<td>2 7</td>
</tr>
<tr>
<td>excellent</td>
<td>2 7</td>
<td></td>
</tr>
<tr>
<td>Utility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>very useful</td>
<td>5 7</td>
<td>1 4</td>
</tr>
<tr>
<td>neither useful or useless</td>
<td></td>
<td>1 5</td>
</tr>
<tr>
<td>somewhat useful</td>
<td></td>
<td>2 6</td>
</tr>
<tr>
<td>useful</td>
<td></td>
<td>1 7</td>
</tr>
<tr>
<td>Satisfaction with amount of help received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>very satisfied</td>
<td>5 7</td>
<td>1 4</td>
</tr>
<tr>
<td>neither satisfied or dissatisfied</td>
<td></td>
<td>1 6</td>
</tr>
<tr>
<td>satisfied</td>
<td></td>
<td>3 7</td>
</tr>
<tr>
<td>Satisfaction with type of help received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>generally satisfied</td>
<td>2 5</td>
<td>1 4</td>
</tr>
<tr>
<td>mostly satisfied</td>
<td>2 6</td>
<td>4 7</td>
</tr>
<tr>
<td>definitely satisfied</td>
<td>1 7</td>
<td></td>
</tr>
<tr>
<td>Extent program met needs</td>
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<td></td>
</tr>
<tr>
<td>N Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>most needs met</td>
<td>1 6</td>
<td>1 3</td>
</tr>
<tr>
<td>almost all needs met</td>
<td>4 7</td>
<td>2 6</td>
</tr>
<tr>
<td>few needs met</td>
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<td>2 7</td>
</tr>
<tr>
<td>Enjoyment of Attending</td>
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<td></td>
</tr>
<tr>
<td>N Score</td>
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</tr>
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<td>enjoyed a lot</td>
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<td>1 4</td>
</tr>
<tr>
<td>enjoyed a little</td>
<td></td>
<td>1 6</td>
</tr>
<tr>
<td>enjoyed quite a bit</td>
<td></td>
<td>3 7</td>
</tr>
<tr>
<td>Overall satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mostly satisfied</td>
<td>1 5</td>
<td>1 4</td>
</tr>
<tr>
<td>satisfied</td>
<td>1 6</td>
<td>4 7</td>
</tr>
<tr>
<td>very satisfied</td>
<td>3 7</td>
<td></td>
</tr>
</tbody>
</table>

Table 7.30: CSQ Item Scores as Rated by Parents and Girls
The girls ratings presented in Table 7.30 suggest high satisfaction with the program. Only one rating below 5/7 is indicated, this was given by PA2 in relation to the quality of the service which she received which she indicated was poor. PA2 is noted to have given lower scores in general when compared to the other participants (but overall is still satisfied with the program as the remainder of her ratings are 5 or above). Perhaps one explanation for these ratings is related to other factors which occurred during the program. For example the therapeutic alliance was broken with PA2 when the facilitators needed to disclose confidential information to her parents that she reported in session which they were unaware of and placed her at risk. Notably all girls reported that the program was enjoyable, provided them with the amount of help they required and was mostly satisfying.

The girls also report that the group was effective in: helping them to deal effectively with their lives (1 helped a lot [6/7]; 4 helped a great deal to achieve this aim [7/7]); deal with problems in their family (1 sort of [4/7]; 1 somewhat [5/7]; 3 a great deal [7/7]); improving relationships (1 generally [5/7]; 4 definitely [7/7]) and; developing skills that can be used in life (1 generally [5/7]; 1 mostly [6/7]; 3 definitely[7/7]).

In comparison to the girl’s ratings, the parent’s ratings are more discordant, largely due to the ratings of one parent. PA3’s mother’s ratings are in contrast to all of the other parents which were rated 5 or greater for every item and indicate high satisfaction with the program overall. With the exception of question 3 which related to the extent to which the program met her daughter’s needs, MO3 rated all 4’s indicating she neither agreed or disagreed with each of the items. PA3’s mother reported that she felt the program did not met her daughters needs because her daughter’s experience was different to that of the other group members in that she had been abused by her sibling. This distinction was not of
significance to the facilitators as PA3’s experience was similar to the other girls. Perhaps a more likely explanation as discussed in the portfolio for PA3 was related to her age and maturity. It is interesting to note that in response to the question on the CSQ that asks participants if they feel that their parent believes the program was effective, PA3 reports that she does not think her parent thought the group was helpful. But in the second part of the question PA3 disagrees with her parent believing that the program was effective and noting “they weren’t there” (i.e. did not experience the process of the group).

When asked if the program was effective parents reported:

“I think her knowing that she isn’t the only one that this happened to has helped her cope better.” (MO2)

“She now feels not so alone and has been happier.” (MO4)

“[The group] gave her the opportunity to meet other peers who have experienced similar situations. She realises that it happens to a lot of people. It gave her other people to talk to who experienced similar situations and skills to deal with the experience.” (MO5)

All five girls reported that they would recommend the program to other girls who have experienced sexual abuse, noting “it helps”, “it’s useful”, and “it’s very good.” All parents also reported that they would recommend the program to others, although PA3’s mother indicated that this would only be if she perceived the survivor of CSA to be appropriate for the group (i.e. not abused by a sibling). One parent noted “the facilitators are the best – great with the girls and great follow-up after very tough sessions.”

Session Evaluation (Content & Process)

A session evaluation questionnaire was administered to the participants at the end of each group session and aimed to assess participant’s opinions about the session, the impact of session content and group process, and the extent to which the session achieved its
objectives. The results are intended to be used to identify areas of improvement within the program when triangulated with facilitator ratings and observation. It included the completion of the SEQ which provided ratings of session depth, smoothness, arousal and positivity; and a series of Likert scales and open ended questions which assessed usefulness of session content, understanding of session content, likes and dislikes, mood and an overall rating of the session. The results of the session evaluation are presented below.

**Session Depth, Smoothness, Arousal and Positivity:** The purpose of the depth scale is to measure how powerful and valuable versus weak and worthless a session was. Smoothness is a measure of how relaxed and comfortable (as opposed to how tense and distressing) a session was. Ratings of session depth and smoothness as evaluated by participants and facilitators suggest that in an overall sense the sessions were considered powerful, valuable, relaxed and comfortable (i.e. deep and smooth) (see Figure 7.17/7.18 and 7.19/7.20).

With regard to session depth, sessions 5 (what is CSA?), 6 (Secrets, Shame & Guilt 1), and 7 (Secrets, Shame & Guilt 2) were rated deepest by facilitators. There is a slight elevation in participant ratings of depth for these sessions (5, 6 & 7) also, but overall there appears to be variability between participants with regard to this dimension. No sessions were rated below a three indicating no session was considered weak or worthless. In contrast two sessions received ratings of three or below for session smoothness by participants, namely sessions 6 (PA1) and 7 (PA1 & PA2). None of these ratings appear of concern and relate more to extraneous factors that occurred in the session than the session itself (e.g. girls needing individual attention; general anxiety). The fact that not all group members rated these sessions below a 3 indicates this. All other sessions appear to have been rated highly
(above 4/7). Facilitator’s smoothness ratings for sessions 1 and 7 were lower than other sessions. The low rating of session 1 is related to the difficulty that the facilitators had containing one of the participant’s emotions in this session and perhaps just because it was the first session in general. The lower rating of Session 7 is related to the fact that PA2 and PA5 needed individual attention outside of the group during this session which disrupted its flow and cohesiveness.

Figure 7.17. Ratings of session depth by participants.

Figure 7.18. Ratings of session depth by facilitators.
Ratings of post session mood as measured by the arousal and positivity scales were also very high across the sessions indicating that the sessions had a positive impact on group members (see Figures 7.21 and 7.22). Consistent with the information presented above PA2’s ratings are somewhat lower in session 7. It is also noted that PA1’s ratings of arousal are somewhat lower than other participants but are perhaps consistent with her general presentation (i.e. somewhat reserved and flat affect).
Overall the findings from the SEQ indicate that the group process involved was viewed and rated by both participants and facilitators as being positive. This is important as both the therapist and client perspective are represented and are convergent. In addition the findings suggest that if the sessions were suitably, deep, smooth, positive and aroused that the group process was functioning well. If so it is conceivable that this process may translate into emotional and behavioural change.
Overall Rating of the Sessions: Each session was given an overall rating by participants ranging from 1 (very good) to 5 (poor). The overall mean rating across participants and sessions was 1.91 (SD = 0.81) indicating that the sessions were considered ‘good.’ Only one rating of ‘not so good’ and one rating of ‘poor’ were received across the 12 sessions. Both ratings were given by PA2 in sessions 6 (‘What is CSA?’) and 7 (‘Secrets, shame and guilt I’). Such ratings are likely to be mood related given the content of these two sessions. That is, the participant was potentially uncomfortable with the session content. Excluding these two ratings, 17 ratings of ‘very good’, 31 ratings of ‘good’ and 7 ratings of ‘ok’ were received.

The mean good/bad rating was 6.02/7 (SD = 1.45) for participants and 6.17 (SD = 0.83) and 5.75 (SD = 0.86) for facilitators respectively, indicating that all sessions were considered ‘good.’ Two participants rated sessions 6 (‘What is CSA?’) and 7 (‘Secrets, shame and guilt I’) with 1’s and 2’s indicating they felt the session was bad. As previously discussed the good/bad rating for participants on the SEQ loads on the smoothness indices rather than the depth indices as it does for facilitators. Thus these low ratings would suggest that these participants did not feel relaxed or comfortable in the session and this is why they rated the session as ‘bad.’ Discussions with group members following difficult sessions were congruent with this assertion. Participants frequently noted that they felt that the content of the program was appropriate and that it was important for them to undertake it, nevertheless it was very difficult for them to manage and their ratings of the sessions reflect this. Thus these ‘bad’ ratings are not of concern and do not indicate that the session is in need of change. No sessions were rated below a four by facilitators indicating they considered all sessions beneficial.
**Usefulness of sessions:** The mean usefulness rating across core program content was 2.15 (SD = 0.20) (rated out of 5 where 1 = very useful) and suggests that the content was considered useful by participants. However sessions 8, 9 and 10 received ratings of ‘not useful’ by PA3. She indicated that she had already learned the concepts of these sessions (e.g. protective behaviours, assertiveness, feelings, communication, and conflict resolution) in a depression prevention program undertaken at her school. PA2 rated session 7 ‘not useful’ which is consistent with her SEQ ratings above and again possibly related to extraneous factors beyond the session. It is noted that PA2 was absent for much of this session and spent time talking to FA2 about other concerns. Arguably her rating could also relate to session content (‘Secrets, shame and guilt’) but is in contrast to the other participants who all rated the session ‘useful’ or ‘very useful.’

**Understanding of session content:** Four instances of difficulty understanding session content were reported by participants. PA1 indicated difficulty in session 4 (‘Cognitive coping’) and 5 (‘What is CSA?’). Difficulty understanding session 4 is perhaps not unexpected as the cognitive triad and the link between thoughts, feelings and behaviours can be a difficult concept to grasp in one session. However this participant was the only one to score 100% on the sessional knowledge test for this session. All other participants failed this test indicating that PA1 was the only one to understand the session content. It was observed by the facilitators that PA1 took some time to grasp the concepts of this session and perhaps felt uncomfortable trying to apply new skills, however by the end of the session she was doing well with these new tasks but perhaps felt she required further information. Given the other participants scores on the knowledge assessment it is perhaps of concern that they did not report any difficulty in understanding this concept. These findings may also bring into question the impact of the cognitive components of the treatment program.
PA3 indicated difficulty understanding sessions 9 and 10. This is curious given that she indicated in the usefulness section above that she already understood the concepts of these two sessions from a program she learned at school. Throughout the program the facilitators recorded constant concerns about the degree to which PA3 was able to comprehend and apply the material learned in sessions. This is perhaps another illustration of these concerns.

These two instances (i.e. lack of reporting for cognitive session & contradictory reporting of PA3) raise some concern about how well the participants answered this question. The question was largely included to crudely measure whether the way in which session content was implemented needed to be changed. That is, if participants indicated they had trouble understanding the content, this may indicate that the facilitators need to change the way the concept is taught. The question can also be compared to the sessional knowledge assessment. If participants indicate they had no trouble understanding the content of the session, then they should also score highly for knowledge. Overall, the facilitators felt that the session content was mostly understood based upon observations of participants in session and the way they engaged with the material.

Helpful for Future: Fifteen reports of session content being unhelpful were received in Study 3. Four of these ratings were received in sessions 6 and 7 (i.e. the sessions that are most relevant to CSA). Consistent with the overall rating of the session presented earlier it is hypothesised that these ratings are again associated with the emotionality of the session and the difficulty the girls had in discussing CSA rather than the session content. Particularly given that all of the girls indicated on a number of occasions that they understood it was important for them to discuss their experience of CSA.
Sessions 1, 3, 4, 8, 10, 11 and 12 were also rated as ‘unhelpful’ by at least one participant and perhaps suggests that the rating of helpfulness depends upon what is the most salient presenting issues for the individual participants. For example PA4 and PA5 rated session 8 as being helpful because they learned techniques to help them manage nightmares. This issue was not relevant to PA1 or PA3 (i.e. they did not report experiencing nightmares) and PA2 had already learned these techniques in individual therapy. Thus these ratings were likely to be mediated by need. By triangulating ratings of unhelpfulness with other evidence available for each session (e.g. SEQ, observation), it is concluded that the majority of session content was considered helpful to participants and does not suggest that any session content should necessarily be removed.

**Mood pre and post session**: Mean ratings of mood prior to and following each session (see figure 7.23) indicate that participant mood worsened following three sessions (6, 7 & 10). The impact of sessions 6 and 7 on mood are expected given the content of these sessions (i.e. explicitly related to CSA and the girl’s personal experiences). Session 10 (communication & assertiveness) is less easy to explain but it is noted that only one participants mood changed and this was from a rating of ‘very good’ to ‘good’ which is not of major concern. In looking at the mood ratings of individual participants, it is surprising to note that PA3’s mood remained ‘very good’ in session 7 (secrets, shame & guilt 2), perhaps suggesting that she was not emotionally connected to the telling of her story of sexual abuse as one may expect that doing so may impact on her mood as it did with the other participants. This would then suggest that the telling of her story had little impact in terms of processing her experience. As Briere (2002) suggests, in order for survivors to adequately process their experience of abuse, a significant level of emotion which he calls the ‘therapeutic window’ must be present. This is in keeping with many of the observations of PA3 and her interaction with the group program as presented in her portfolio earlier.
Qualitative feedback: With regard to the most helpful aspect of each session, a wide array of answers were given and again may depend on the individual needs of the participants. Creative activities (craft, poetry, art) appeared to be highly valued. In session 1 the participants indicated that the most helpful aspects of the session were: “being a part of the group”, “knowing I am not the only one”, “knowing what others have gone through” and “talking about what happened.”

Very few responses were given to the question pertaining to the least helpful aspect of the sessions. The responses received do not appear to discriminate helpfulness from comfort. For example two participants indicated that in session one they found it unhelpful to talk about their experience or hear others experiences. However in talking to these girls in session 2, they stated that it was simply that this was a difficult process not that they felt this activity should be excluded and that they should have not been asked to do it. The only relevant response to the least helpful aspect of the session question was received by PA5.
and pertains to session 2. PA5 reports that she found relaxation particularly unhelpful. In combining this report with an observation from the session that PA5 began crying and had to leave the room during relaxation this feedback was taken very seriously. This is a particularly salient point and one in which the facilitators and the treatment manual need to make much more clear. That is, prior to beginning this activity facilitators should inform participants that they may find relaxation uncomfortable and that they may not be able to do it. Alternate strategies could then be offered.

Taken as a whole the participant’s session evaluations suggest that each session was well received, useful and helpful, for the most part understood and helped to improve mood. Strengths and weaknesses of each session were identified and as such some changes to the treatment program were apparent. For the most part these changes were recognised as the treatment program progressed. The results presented here are encouraging in the sense that very little further refinement of the program appears to be needed.

Knowledge of core program concepts

Similar to the summative knowledge measure, problems with sessions 4, 9 and 11 are highlighted with this measure as the criterion of 80% correct on the sessional measure was not met (see Table 7.31). As already discussed, this may relate to the phrasing of the questions which were designed to assess the core concepts of these sessions. Nevertheless it may be worthwhile reviewing these sessions in the context of other data to determine if other things can be done to improve the ease with which the core concepts of these sessions are attained by participants. As previously mentioned it may indeed also be worthwhile fully considering the role of such skills in the treatment approach. This would of course warrant adequate deconstructive studies with and without such components (see ch9. for further discussion of this point).
Table 7.31  Overview of Sessional Knowledge Test Scores

<table>
<thead>
<tr>
<th>Session</th>
<th>Topic(s)</th>
<th>PA1</th>
<th>PA2</th>
<th>PA3</th>
<th>PA4</th>
<th>PA5</th>
<th>Mean score for session (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Confidentiality, Self care</td>
<td>100</td>
<td>75</td>
<td>75</td>
<td>100</td>
<td>100</td>
<td>90 (13.69)</td>
</tr>
<tr>
<td>2</td>
<td>Mood Management</td>
<td>100</td>
<td>*</td>
<td>80</td>
<td>60</td>
<td>100</td>
<td>85 (19.1)</td>
</tr>
<tr>
<td>3</td>
<td>Emotions, Self esteem</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>*</td>
<td></td>
<td>100 (0)</td>
</tr>
<tr>
<td>4</td>
<td>Cognitive coping</td>
<td>100</td>
<td>33</td>
<td>50</td>
<td>67</td>
<td>33</td>
<td>56.60 (28.06)</td>
</tr>
<tr>
<td>5</td>
<td>What is CSA</td>
<td>100</td>
<td>86</td>
<td>86</td>
<td>71</td>
<td>100</td>
<td>88.6 (12.67)</td>
</tr>
<tr>
<td>6/7</td>
<td>Secrets, Shame &amp; Guilt</td>
<td>100</td>
<td>80</td>
<td>60</td>
<td>100</td>
<td>100</td>
<td>88.0 (17.88)</td>
</tr>
<tr>
<td>8</td>
<td>Memories, Protective behaviours</td>
<td>75</td>
<td>69</td>
<td>88</td>
<td>94</td>
<td>88</td>
<td>82.8 (10.38)</td>
</tr>
<tr>
<td>9</td>
<td>Stuck feelings</td>
<td>83</td>
<td>67</td>
<td>33</td>
<td>50</td>
<td>33</td>
<td>53.2 (21.8)</td>
</tr>
<tr>
<td>10</td>
<td>Communication, Assertion, Relationships</td>
<td>*</td>
<td>100</td>
<td>100</td>
<td>75</td>
<td>100</td>
<td>93.75 (12.50)</td>
</tr>
<tr>
<td>11</td>
<td>Goal setting, Relapse prevention</td>
<td>67</td>
<td>33</td>
<td>67</td>
<td>67</td>
<td>67</td>
<td>60.2 (15.20)</td>
</tr>
<tr>
<td>Mean</td>
<td></td>
<td>91.67</td>
<td>71.44</td>
<td>73.90</td>
<td>78.40</td>
<td>80.11</td>
<td>79.81 (16.72)</td>
</tr>
</tbody>
</table>

* denotes absence from session

The validity of the knowledge data is strengthened by observations made during sessions and at the three month follow-up. At the three month booster/reunion session, the participants were asked as a group to write down everything they could remember about the program. Overall the participants could remember most topics discussed. It was noted however that they often did not remember the names of concepts, for example early warning signs, but could recall the activity which was used to teach the concept and could provide examples of ways they had used the concept in their lives. It was noted at this session that the girls could recall very little of the cognitive aspects of the program, particularly the cognitive triad and ABC model and its applications.
As indicated with the summative knowledge measure, whilst improvements were made with the sessional knowledge measure compared to Study 2, it was still noted to be very long and an arduous task for participants to complete. Thus its utility needs to be considered in the context of whether or not it is useful to continue applying it outside of a research context.

Facilitator Evaluation

In terms of treatment integrity and fidelity, the facilitators reported that all to most of the session content was delivered in each session and session plans were relatively closely adhered to. The facilitators reported that all session objectives were covered however some adaptation to session content and the way it is administered was necessary. This is in keeping with the idea of natural adaptation (Natasi & Schensul, 2005) and the ethical requirements of dealing with the problems participants present with. A number of changes were made to the sessions prior to the session beginning. These decisions were made on the basis of formative data gathered from previous weeks. A full outline of these changes may be found in Appendix Q. Perhaps the biggest change as previously mentioned is the in-depth focus which was placed on the review of previous sessions at the beginning of the following session.

Ratings of group atmosphere across the sessions suggest that the sessions were suitably open, co-operative, friendly, interested and cohesive. A balance between formality and informality was also obtained. As such the group provided a very conducive environment for participants to approach their experience of CSA. This is consistent with the girls SEQ ratings and other self report data about the process of the group.
Facilitator’s satisfaction with the program was also high. Ratings were made on a scale of 1 to 7 and indicate that the program met the needs of clients ($FA1=5; FA2=7$); was beneficial to clients ($FA1 & FA2 = 7$); provided clients with an appropriate amount of help ($FA1=4.5; FA2=5$); allowed clients to attain relevant skills ($FA1=5; FA2=4.5$); was effective in helping clients deal more effectively in their lives ($FA1 & FA2 = 5$); and was enjoyable for clients ($FA1 & FA2 = 7$). The overall rating of satisfaction was 5 for FA1 and 6 for FA2 out of a total of 7.

Strengths and weaknesses of each session were identified by the facilitators based on their observations of the sessions. These are documented in Appendix Q. Suggested improvements are apparent from these observations. A consistent strength noted in each session of the program was related to the process of the group and the way in which the participants interacted and supported one another. In particular the degree of group cohesiveness and the importance of ‘universality’ for these girls. All of the girls had had experiences of being disbelieved by peers or family members and so to be in a supportive environment with peers who had similar experiences appeared to be very important and validating. This was also reflected in parent’s observations as indicated on their consumer satisfaction questionnaires. Parents noted that one of the most important aspects of the group was their daughter learning that they were not “the only one” and that they were “not alone”. These sentiments manifested in the group in that each member was very trusting of the others and willing to self disclose (perhaps with the exception of PA3). As such it also seemed to place the girls in a better position to process their experience of CSA and make considerable gains from their attendance at the group. These observations also indicate that the group achieved its aim of decreasing isolation among survivors. Collectively this evidence appears to suggest that the process of the group was a highly important factor associated with the outcomes of the program.
A further observation made by the facilitators was that many activities appeared to strike a chord with participants and appeared particularly relevant in terms of achieving the intended objectives of the session (e.g. problem solving activity, Aunt Agatha activity, poetry). The use of playdough and pipe cleaners was also observed to work very well in session 7 as a means of channelling anxiety. Overall the observations in regard to session content suggest that the activities were very appropriate and achieved their intended aims. The structured approach to the opening and closing of sessions was also observed to work very well in that they facilitated a very strong, connected group and allowed each girl to provide individual updates, for the previous session to be reviewed and for containment of the session.

Due to the introduction of some activities and the length of time for review, time appeared to be a consistent weakness across the program thus suggesting that at present there is still possibly too much content in the sessions for the session duration. Thus ways of decreasing session content may need to be sought. Often in session facilitators had to help participants manage ‘other’ life issues which consumed a significant amount of time. The post testing in session 12 detracted from a proper closing down process and it is suggested that this occurs in a separate individual session in the future.

Facilitator Performance

The facilitators had a good working relationship in this group. There appeared to be less of a need for the facilitators to have defined roles within each session, yet an equal balance in terms of the leadership role was maintained. Issues between facilitators were monitored throughout the session, however none appeared apparent. The facilitators shared a clear idea about the purpose of the group and this led to a strong sense of co-operation and collaboration between the facilitators. Both facilitators reported feeling confident in their
delivery of the program and satisfied with the way the sessions were implemented. The facilitators obtained a good balance of formality and informality in the sessions. Post session debriefs were considered important to both facilitators. A strong need to seek supervision was only reported by both facilitators following session 1. In this session, containment of one participant was particularly difficult and threatened to impede the process of the program. Supervision allowed the facilitators to think about different ways to support this participant so that she would not be so uncontained in the future and would not potentially harm (in an emotional sense) other group members in the process.

As with Study 2 the common factors of therapy (i.e. therapist attributes, facilitative conditions and the therapeutic alliance) appeared to be instrumental to the success of the program. The facilitators appeared to serve the function of role models to the group participants and were observed to have a good trusting relationship with each group member. Observations from the sessions suggest that the therapeutic alliance was developed with each participant by creating a safe and supportive environment, being genuine, empathic and warm with each of the girls. In general it seemed to be the facilitator’s ability to relate to adolescent girls and to be believing of their stories which were important factors. The facilitators were also very skilled at repairing fractures in the relationship when they occurred. For example the facilitators needed to break confidence of PA2 and inform her parents of something that she had reported in group. PA2 understandably felt betrayed by the facilitators for doing this. To repair this, the facilitators had PA2 inform the group of what the facilitators had done and the rationale for the breach in confidence was explained. The fracture in the relationship with PA2 was repaired very well and did not affect the remainder of the program as evidenced by PA2’s continued trust with the facilitators (i.e. she continued to divulge personal information in the sessions and allowed confidentiality to be breached again later in the program following an incident at
school). This is positive given that PA2 was one of the more open, vocal members of the group.

The role of the facilitators was also important in assisting the participants to overcome avoidance and reluctance associated with attending a group for CSA survivors. It was important that the facilitators had the skills to engage the girls, gently support them through the sessions, challenge them when necessary to help shift maladaptive beliefs, help them to manage anxiety and feel comfortable to self disclose. Evidence that the facilitators achieved this comes from many sources including: the high attendance rate of the group (cf. Study 2 and with reports in the literature that attendance is often low at these types of groups); the degree of involvement observed by facilitators in session; the high satisfaction ratings given by both parents and participants; parents observations and appreciation given to the facilitators e.g. “facilitators are the best”; the high SEQ ratings; and facilitators general observations of the sessions which identified the shifts participants were making. If the facilitators could not get the participants to engage in the group and overcome any avoidance, then the participants would not have been in a position to make the emotional and behavioural changes that many of them made. Thus the role of the facilitators as change agents seems highly important to the outcomes of this program.

The role of the facilitators within this group is nicely encapsulated by the 4M model of Donaldson & Cordes-Green (1994). This model suggests that facilitators of sexual abuse programs serve the roles of Messenger (modelling & teaching), Monitor (observing & analysing), Mediator (acting & activating) and Member (participating & learning). Each of these roles interact and help to facilitate the process of the group and the therapeutic alliance. The Messenger role is both verbal and nonverbal, intentional and unintentional. It consists of the way facilitator’s model appropriate behaviour in the group (i.e. active
listening, empathic and respectful responding, problem solving, emotional expression, healthy boundaries, empowerment, and respect) and the way facilitators teach appropriate skills without being too controlling of the group process. The Monitor role is an internal process which facilitators use to observe the group in terms of content, process, emotional level and interactions between group members. Once observed the facilitator creates hypotheses about what is occurring. In the Mediator role the facilitator may then act on these hypotheses that have been developed and activate some level of change within the group. For example the facilitator may have observed that one participant was being particularly quiet in session. This observation may be acted upon in a number of ways for example by highlighting the participant’s silence to the group or by simply inviting the participant to offer their thoughts or opinions. Finally the Member role acknowledges that facilitators are members of the group and that they must actively participate whilst maintaining professional boundaries. Furthermore this role recognises that each group is different and that facilitators are constantly developing knowledge and skills with every program they facilitate. This model appears highly pertinent to the current program and consistent with the way in which the facilitators of the current group went about facilitating the group. Thus it is recommended that this model be incorporated into the treatment manual as a means of capturing what the facilitators of this program were able to achieve by harnessing the group process and common factors of therapy.

Overall the evaluation by facilitators appears to highlight the importance of having facilitators (and supervisors) who understand CSA, have had experience working in groups, have had experience working with adolescents and are able to connect with them. The therapeutic relationship appears fundamental to the success of the girl’s group program as does the relationship between the group members. In this sense it is recognised that the girls group is much more than a TFCBT group and indeed some of the findings of this study
may bring into question the degree to which the results can be argued from a strictly CBT theoretical model.

7.2.6 Evaluation of the Parent Sessions

Two sessions were provided to parents. These sessions were designed to assist parents in supporting their daughters through the group process. Six parents attended session 1 (both parents attended for PA2 and PA4; no parent attended for PA3). Seven parents attended session 2 (both parents for PA2 & PA4; PA1, PA3 and PA5’s mothers). PA4’s father did not complete an evaluation of the sessions but PA2’s father did.

Parents reported that the sessions met their expectations (10 parents - definitely met expectations [7/7]; 1 parent - generally met expectations [5/7]) and covered the topics that they expected it to. The overall mean satisfaction with sessions was 26.27/28 (range 13-28). With the one outlier removed (i.e. MO3’s rating of 13) the mean is 27.6/28 (range 26-28) indicating a high degree of satisfaction with the service received. Session 2 was however rated lower than session 1. It is noted that PA3’s mother was absent from session 1 and in session 2 this mother’s ratings are much lower than the other parents which has impacted on the overall rating. This mother was the only one to report that session 2 was unhelpful. There is also the suggestion that this mother felt isolated within the group. The other parents appear to have expressed a lot of anger towards the perpetrators of their daughter’s abuse, however for PA3’s mother the perpetrator was also her son. This parent perhaps did not also understand that the purpose of the session was to support her daughter. Perhaps if she had attended both sessions this may have been clearer to her.

The most helpful aspects of the session reported by the parents included: not feeling alone, being in a relaxed environment, hearing the girl’s thoughts and ‘everything’. The only
suggested improvement for the sessions was a unanimous indication that more sessions should be provided as parents had found them highly beneficial as indicated by all parents rating the benefit they received from sessions at 7/7 (with the exception of MO3 who rated 3/7 for the benefit she received). On average parental mood also increased after the sessions. This was rated on a scale from 1 (very good) to 5 (very poor). Before session 1 parents average mood was ‘ok’ ($M = 3/5$; range 2-4), after the session it was ‘good’ ($M = 1.4/5$; range 1-2). Before session 2 parents mood was also on average ‘ok’ ($M = 2.83/5$; range 2-3) and after it was also ‘ok’ ($M = 2.33/5$; range 1-4) but showed improvement with the exception of MO3, whose mood declined from ‘good’ (2/5) to ‘not good’ (4/5) in session 2 and is consistent with the facilitators report that this mother felt isolated within the group.

Parents also completed the first dimension of the SEQ. As with the satisfaction and mood ratings presented above, MO3’s ratings are considerably discordant with the other parent’s ratings and consequently affect the mean ratings presented. Overall average session depth and smoothness were rated quite highly (5.6/7 [range 2.8-7] and 5.82/7 [range 3.6-7] respectively) indicating that they felt the sessions were valuable, relaxed and comfortable. The facilitator ratings of depth and smoothness concur with this (depth was 5.8 & 5.6 and smoothness was 3.6 & 3.4 for the two sessions, respectively). Both parents and the facilitator also agree that overall the sessions were very ‘good’ as rated on the good/bad scale of the SEQ (parents $M = 6.62/7$ [1 rating of 3; 1 rating of 6 and 11 ratings of 7]; facilitator 7 & 6 respectively). MO3 provided the rating of 3 indicating she felt the session she attended was more ‘bad’ than ‘good’ which is again consistent with the facilitators observations.

The facilitator of the parent sessions also completed a facilitator evaluation. This evaluation showed that all session content was covered and that the session plan was followed
closely. Most of the session content was reported to be understood. Both sessions were rated by the facilitator as being suitably open, cooperative, friendly, interesting and cohesive with the exception of PA3’s mother in session 2. Weaknesses of the sessions were time, lack of sessions, and an inability to engage PA3’s mother in session 2. Strengths of the parent sessions included the commitment of parents, the level of participation and the parents focused attention on what their daughters were going through. Recommended improvements which stem from this include increased length of sessions to two hours, more frequent parent sessions and an improved facilitators manual which includes very practical suggestions for parents on how to best support their daughters.

Other salient issues observed by the facilitator included: the need to gently manage parents and allow them to tell their story but also keep the session on track, the benefit of refreshments, the benefit of having mothers and fathers for some participants, the difficulty in having parents in the session who themselves were at different stages in coping with their daughters experience and the need for a strong experienced facilitator to be able to manage the needs of parents whilst also achieving the aims of the session. Overall this data suggests that the parent sessions are important and that parents themselves are likely to need assistance in coping with the experiences of their daughters.

7.2.7 Program Observations

Throughout the course of the program many observations were made about the program and how it was progressing. These observations were not necessarily captured in formalised measures presented to this point and so are outlined here.

Duty of care remained the most salient issue in running the group program. The participants presented in sessions with a number of problems which were not necessarily related to the
content of the program. Problems included disclosures of instances of sexual abuse not previously disclosed, problems with family, friends and the school environment, and suicidal ideation. These issues did not require that the order of session be altered however they did require changes to the structure of individual sessions in which they occurred and created some time pressures to complete the tasks of the session. Nevertheless as already mentioned all objectives of the program were achieved.

It was observed that a significant case management role was required within the administration of the program. Most participants required follow-up after sessions and liaison with referrers/individual therapists was frequently required to ensure ongoing care. This process was considered important however, and most likely contributed to both the high rates of attendance (cf. Study 2 where absenteeism was high) and the group process. That is, by providing such a level of care, participants and their families were sent a message that they were respected and valued. It is thought that this most likely translated into cohesiveness within the group environment.

It was noted that running the program consumed a significant amount of time for the facilitators beyond the two hours in which participants attended and beyond what it would perhaps be expected to take to run a group program. It is important to discuss this as it is another example of information clinicians need to know if thinking of implementing such a program. Whilst the exact time taken each week was not collected, a rudimentary estimate of time would be six hours for the primary facilitator and three hours for the second facilitator. This time takes into account preparation for each session, facilitation of the session, debriefing and packing up, progress notes, reflections and case management. The time estimate for the primary facilitator is perhaps two hours more than would be expected to run a group of this size.
Observations concerning the content of the program indicates that for the most part the content was appropriate and relevant for achieving the aims of the program. As discussed Appendix Q highlights the recommended changes to the program. Some of the more significant changes and issues are discussed here. Observations of session 3 (self esteem) suggest that this session is irrelevant in the context of the program. Whilst the individual activities worked well and had the benefit of improving group cohesiveness, they added very little in terms of helping girls to process their experience of sexual abuse as the material is not closely related to the topic. Thus it is recommended that this session be removed from the program. It is suggested that the ‘warm fuzzy’ activity from this session is retained as it works very well at building rapport between group members and in helping girls to feel as if they are a significant member of the group. Whilst this session will be removed it is argued that the main objectives of session 3 can be achieved through the process of the entire group anyhow, particularly the objective of improving participants self esteem. That is, it can be achieved through the process of the group by facilitators and participants providing positive feedback to other members of the group and on the basis of acknowledging the participants achievements in the group.

It was recommended by one of the expert evaluators that sessions 4, 10 and 11 also be removed from the program. Whilst the problems with session 4 (cognitive coping) are recognised (e.g. participants find it hard to grasp the ABC model in the time frame available), this is a TFCBT program. Helping participants to establish the link between their attributions about sexual abuse and their emotions and behaviours seems paramount and so this session will be retained but modified significantly. Whilst it could be argued that session 4 is not required because the objectives of session 4 could (and are) achieved through the course of the entire program (i.e. the program is designed to constantly
challenge participants attributions and thoughts about CSA), it has also been observed within the group that many survivors of CSA do not see the link between their experience of CSA and their emotions/thoughts. This was particularly true for PA1 in the current study. Over the course of the group the facilitators were slowly able to help PA1 see that the anger which she presented with and felt most of the time was likely to be related to her thoughts and feelings about being sexually abused. Thus it seems most important to retain a session which explicitly highlights the CBT model to participants. Nevertheless session 4 still does need to undergo further modification to allow participants to more easily grasp these concepts. These changes may include adding different pictorial representations of the cognitive triad to the one currently used and working through examples that are more specifically related to CSA. More importantly however it is essential that the tenets of the CBT approach (e.g. thought challenging) are carried out through each session as this was important in the current group. In stating that the cognitive elements of the treatment approach will remain, it would be remiss not to further elucidate my affinity with CBT and my belief in this theoretical model. It is acknowledged that other alternate theoretical models (e.g. Solution focused, narrative) may well be able to explain the results of this research (see section 7.4 for further discussion of this point). Nevertheless this research did set out to develop a TFCBT program and in keeping with the developmental intervention research paradigm it would be unwise to completely remove the cognitive components at this point, given that there is some observational evidence for its utility and the treatment program as a whole demonstrates positive outcome for participants. As acknowledged earlier these findings do suggest that further deconstructive studies and comparisons of the treatment approach with other approaches is required in the future.

Changes to session 10 (communication and relationships) are recommended as noted in Appendix Q. However I do not agree that this session should be disbanded. All of the
participants in the current group reported significant difficulties getting along with parents and managing relationships within their lives. Thus the changes to this session aim to increase the relevance of the session to CSA, highlight the impact that CSA has on relationships and decrease the focus on communication related material. In terms of session 11 (planning for the future) the activities in this session worked particularly well and no weaknesses were recorded by either the participants or facilitators in the post session evaluations. The major aim of this session was relapse prevention and preparation for group closure. These are particularly important objectives and as such session 11 will remain in the program. Less focus could perhaps be placed upon goal setting in terms of the teaching of the 6 stage model of goal setting, however discussion of goals and how to achieve them is empowering for participants as it sends a message that if they apply themselves they can achieve their goals. In this sense the task is also building self esteem.

One problem noted in the previous study was the need for the program to be more focused on CSA. This was largely achieved in the current program however it is still felt that more focus and more examples could be included in the program to keep the focus on CSA. For example in the coping skills session girls could be specifically asked to identify a time/situation associated with their memories of CSA that is difficult for them to cope with. Each girl could then identify the most appropriate coping skill of those learnt to apply to that situation when it next arises. Many of the skills that are taught in the program could be applied to coping with any life problem (e.g. a relationship break up) as such it is important that the participants recognise that whilst the skills they are taught can be used in different ways they are being taught to specifically help them manage CSA related sequelae.

The addition of structured opening and closing circles to the sessions appeared to have a major impact on the functioning of the group in this study relative to Study 2. In particular
the introduction of in-depth reviews of previous sessions had considerable benefit particularly in identifying areas of deficit from the previous session and closely tracking behavioural shifts that participants were making. Participants were initially asked to say what they could recall from the previous session and what was of particular relevance to them. For the most part it was observed that participants had good delayed recall of the previous session and had attained the ‘take home message’ of the session. This process allowed the facilitators to correct any misunderstandings that may have occurred or provide any missed information. The use of the sessional knowledge tests assisted in this regard and helped facilitators to focus on particular topics and participants who may not have attained the knowledge related to the previous session.

Further to the observations made about group process in the facilitator evaluation section, the group was observed to move into a working phase very quickly (by session 3 or 4). Key signs that a group has moved into a working phase include trust, cohesion and self disclosure (Corey & Corey, 2006). It is also evidenced by the development of group norms and group members understanding of, and using of the process of the group. As identified previously the participants of the group identified with one another very quickly and the concept of ‘universality’ was central in the formation of this group. In addition the facilitator’s session observations note that trust and cohesion developed rapidly within the group. This was mostly evidenced by the fact that girls became increasingly willing to disclose information about themselves in the sessions. There were also many times throughout the program that the girls worked together and supported one another through a difficult process (e.g. helping one another solve problems they were having in their lives, for instance conflict with parents or issues at school). Strong bonds were established between the girls as is evidenced by the fact that four of the five girls continued to remain in contact with one another after the group finished.
Aside from the role the facilitators played in facilitating the process of a working group, the structure of the program (i.e. gradual exposure) also appears important. The way in which the program is designed to build in intensity of CSA related material and allow for coping skills and group cohesiveness to be built prior to discussing CSA in great detail (i.e. the girls own stories) is essential. It appeared important to speak about CSA in each session and focus the sessions on CSA in general and the girls experiences in particular, however at the same time it was important to contain the girls emotions and try not to allow them to become overwhelmed. Again this is consistent with the concept of the ‘therapeutic window’ (Briere, 1995). This was first noted by the facilitators in session 1 where it was observed that allowing the girls to provide a brief disclosure about their experience of CSA (i.e. just providing details of who and when) lowered anxiety levels, allowed the girls to connect more to the process and to one another. Given that many of the girls were very anxious and avoidant about their experiences, the gradual exposure approach seemed to allow them to slowly build more strength and courage in each session as the program built up to the disclosure sessions. This is confirmed by three of the girls reporting at the follow-up session that not having the sessions solely focused on CSA was particularly important to them and helped them to better manage their anxiety about attending the group. Whilst there is no evidence from the current study to disconfirm alternate approaches to gradual exposure, the facilitator's clinical judgement and experiences during this group suggested that gradual exposure was a safe and supportive way to allow adolescent girls to explore and process their experiences of CSA. The facilitator's observations also suggest that this approach was an important one in allowing the participants to engage with the group without being overwhelmed. Conceivably this may also help to explain why attendance was so high in this group. It is felt that if this process did not occur then the group may not have been as
successful. Thus the gradual exposure approach of TFCBT seems very important in terms of actively helping participants to confront CSA in a contained way.

### 7.2.8 Barriers Encountered

Very few barriers to the successful implementation of this treatment program were encountered. The main one was recruitment of participants to the program in a timely manner. It is noted that the recruitment for the group in Study 3 occurred within 10 weeks of the program being advertised, as opposed to 8 months for Study 2. Although the current program began within 10 weeks, a substantial amount of effort was applied by the researcher to gain the five appropriate referrals that were received, thus still not making the program a viable enterprise in the long term if there is not an ongoing need for it.

The reduction in time for recruitment of participants may be due to a number of factors including: running the program in the Southern suburbs of Perth as opposed to the Northern suburbs where Study 2 was conducted, as no services of this kind have been offered in the South previously; making the program independent from PACTS; using local newspapers as a means of advertising the program; and actively contacting as many referral sources as possible and discussing the benefits of the program. In future if the program is to run, a significant amount of effort will need to be made by the facilitator of the program to establish strong links with potential referral agencies. School psychologists may be the most appropriate source of accessing potential participants. In both Studies 2 and 3 school psychologists were only sent a brochure about the program. In future it is recommended that the facilitators of the program try to meet school psychologists personally, perhaps by attending staff meetings and the like. As argued in Study 2 there are likely to be many adolescent girls in the community who would benefit from the program who are not engaged in statutory or mental health agencies. Such is the situation in the current study.
where only two of the five participants were involved with the Department for Community Development and only one of the girls was referred by this agency.

In addition to making the program well known within the professional community, the issues associated with survivor’s anxiety about attending a group must also be overcome. As previously indicated, Nelson-Gardell (2001) and Kambouridis and Jevtic (2002) have reported that participants of adolescent CSA groups are initially very reluctant to attend. A similar observation was found in the current study. The three girls who attended the 3 month follow-up session all reported that they initially did not want to attend and found it difficult to overcome their anxieties about the group. Two of the girls reported that they thought the group would only be about CSA and that is all that would be talked about. One of the girls noted that it was useful to have the brochure about the program as it explained in more detail what the group was about. One suggestion which may help to overcome this problem is ensuring that professionals who are referring potential group members provide accurate information about the program and its expected benefits. It may also be worthwhile to hear what previous members of the group have had to say about it. The three girls who attended the reunion session were asked to write down what they would say to other girls who were thinking of attending the program. Their answers were as follows:

“There are other girls out there who understand and you can express yourself without feeling stupid. It will help.”

“You need to get worse before you can get better, so go and do this group, it helps you get better.”

“If you follow through it will be better because the strategies [you learn in group] will work and you might not realise it but the things you think don’t effect you have an effect, so get help for them.”
This issue about participant’s reluctance is an important one and must be given significant attention when attempting to recruit participants for future groups.

A final point about recruitment relates to the issue of substantiation of abuse. It was a requirement of the program that participant’s abuse be substantiated either by police or Department for Community Development. In attempting to garner referrals to the program, many professionals noted that this criteria was problematic as many girls that may be appropriate were unwilling to disclose their experience to either of these authorities. It may be worthwhile adapting the program to capture the group of non disclosing adolescents who are likely to be in need. In a legal sense the program may not be able to undertake trauma processing specifically as it may be seen that the approach taints any evidence which participants may wish to give in the future. Nevertheless it may be worthwhile looking into the utility of such an approach given that the statistics suggest that up to 50% of abuse survivors do not report their abuse to authorities.

Few other barriers to the successful implementation of the program were observed. However as previously discussed the outcome of the program was mediated by a number of factors, most notably family environment and the level of social support available to participants.

7.2.9 Summary of Formative Findings

The aim of the formative evaluation was to identify factors which may have mediated the impact of the treatment program whilst also identifying areas in which the treatment program could be improved. This was achieved by triangulating data from participants, parents and the facilitators of the group. Few factors were identified as mediators of
treatment outcome. Family environment was the main one identified in this study and yet this only appeared to mediate outcome to some extent.

The treatment was found to be acceptable to both participants, parents and the facilitators, indicating that they received benefit and it met their needs. Parent sessions were also valued although more were wanted. The treatment was implemented with integrity and as such this does not appear to have mediated outcome. The evidence presented from the observations of facilitators and from participants and parents indicates that role of the facilitators is likely to be central to the outcome of the program. These observations are consistent with research suggesting that group facilitators supportive relationship with group members is a requisite for client change (Dies, 1994) and that it is the therapists genuineness, empathy and warmth (i.e. common factors of therapy) that lead to successful outcomes (Corey & Corey, 2006). Conceivably the role of the facilitators will be an important mediator of outcome in future groups and it is suggested that facilitators have adequate knowledge of CSA, the treatment program and experience in facilitating groups.

Evaluation of session content and process indicated that for the most part these were appropriate and contributed to outcome. The majority of sessions appeared to be valued, enjoyed, understood and rated as useful. Sessional knowledge tests indicated that the core concepts of most sessions were understood by the participants. Lower scores for sessions 4, 9 and 11 indicate that some changes to these sessions may be warranted to ensure that the concepts are understood. For session 4 (cognitive coping) in particular this is consistent with other data indicating changes need to be made to this session. Minor changes to a number of session activities are also indicated. The findings also suggest that session 3 is unnecessary. The results also suggest that the program needs to ensure that it has a continual focus on CSA in all sessions. In terms of what is working well with the program,
the gradual exposure approach to CSA seems to be a particularly important contributor to the success of the program.

Other salient factors identified in the formative evaluation included the importance of duty of care, the role of case management and recruitment of participants for the program. These are important factors for clinicians to consider when thinking of implementing this program.

7.3 RECOMMENDATIONS FOR THE FUTURE UTILISATION OF THE PROGRAM

As a result of both the formative and summative evaluations, a number of recommendations can be made on ways in which the treatment program can be further refined to ensure that it is as effective and appropriate for adolescent survivors of CSA as possible. The majority of these recommendations relate to session content. The recommendations are outlined below:

**Content**

- Make changes to the manual as specified in Appendix Q. For example it is important to change the instructions for the disclosure activity in session 1 to ensure containment of participants;
- Incorporate changes into the manual that were made prior to session commencement as outlined in Appendix Q;
- Remove session 3 (self esteem). The program should continue being 12 sessions in length. As such the remaining content will need to be redispersed through the sessions, this should overcome time issues noted;
- Further changes are required to session 4 (cognitive coping) to aid participants understanding of this content. Ensuring the objectives of this session are also applied
throughout the program is required so that the underlying concepts of CBT are grasped fully;

- Preparation for disclosures in session 7 should occur in session 6 perhaps by way of homework asking participants to think about what they do and do not want to disclose in session;

- A more powerful and meaningful rationale for disclosure and discussion of CSA related material should be given across the program so that participants fully understand why it is important to process CSA;

- Incorporate the 4M model of facilitation into the treatment manual as an effective way for facilitators to remember their role in facilitating group process;

- More focus on CSA across all sessions;

- More focus on generalisation of skills to ensure the impact of the group is long lasting;

Other

- Improve recruitment strategies perhaps by targeting school psychologists. Also find ways to better inform potential participants about what to expect from the program to alleviate reluctance and anxiety;

- Phone calls to families between sessions to foster engagement with the program and provide additional support;

- If resources permit, a collateral parent program should be provided given the success of, and the desire for parent sessions in the current study;

- Consider developing a program for unsubstantiated cases.

Overall the program simply needs to be maintained as the evidence available suggests that it is working well, providing benefit to participants and achieving its stated aims.
7.4 **Summary & Conclusions**

The current study provides further evidence for the effectiveness and utility of this trauma focused Adolescent Girls Group treatment program. Clinically significant changes were evident for four of the five participants and this was confirmed by both parents and facilitators. Some changes were also evident for PA3 but not in the sense of outcome data, since as previously discussed these changes were more subtle and were largely observed by the facilitators in session. As with Study 2, the variability across participants made it very difficult to evaluate the program collectively and it is recognised that the changes which occurred for each participant are very different and are likely to be dependant on initial presenting concerns. One of the major benefits of the program appears to be its capacity to reduce isolation and sense of being different. In this sense the secrecy that surrounds CSA is challenged and removed as a constraining factor to engaging in the treatment approach. The participants also demonstrated the ability to develop and apply coping skills, increase their awareness of personal strengths, become more emotionally expressive, learn personal safety skills and develop their relationships with others. Overall each participant appears to have constructed (or begun to construct in the case of PA3) a new narrative about what it means to have experienced sexual abuse. In this way a new sense of self has begun to be developed. It was clearly evident that following the program the participants continued to process their experience of CSA and in the words of one participant “move on with their lives.” These findings highlight the importance of not simply looking for broad generalisations (i.e. nomothetically) but also looking at the individual and how the program works for them (i.e. idiographically). The findings also support the advantages and benefits of mixed methods assessment in that much of what has been captured would not have been identifiable if only one method was used.
The formative findings of the study support its utility. Few changes to the program were identified as being required at its completion, although some were made ‘in situ’ and need to also be incorporated. The program appeared to work well and was acceptable to participants, parents and facilitators. In addition to the reductions in isolation and feelings of being different (i.e. group process), the gradual exposure approach to CSA and the coping skills taught appear to be particularly important in the outcome of the program. The role of the facilitators can also not be underestimated. The results of this research also highlight the need for treatment flexibility and individualisation when working with CSA survivors given the myriad of presenting problems and endless challenges that present throughout the program. It is noted that the results of Study 3 may have been bolstered by: i) having at least one more participant to strengthen the validity of the findings; ii) providing more parent sessions so that parents could better support their daughters; and iii) improving assessment measures and techniques to better capture group process and the change in participants trauma narratives over time. These are important considerations for future research.

Finally, the results of Study 3 have raised some concerns about some aspects of the TFCBT model and the degree to which this theoretical model can explain the results better that other theoretical models, particularly given the results relating to the cognitive components. Most of the treatments reviewed in Chapter 1 targeted similar goals and it was acknowledged that there was a large degree of commonality of content between treatments irrespective of theoretical orientation. For instance most treatments acknowledged the following treatment goals: 1) discussion of abuse related feelings (e.g. shame, guilt, isolation); 2) disclosure and discussion about the abusive experience; 3) alleviation of CSA related symptoms; and 4) abuse prevention skills. These were also the goals of the current treatment program. Given some of the poor results associated with CBT components of the current program (e.g. participants rating them as unhelpful; poor
knowledge attainment of these skills) alternate theoretical explanations for the positive outcome should perhaps be considered. It is acknowledged that it may not be the CBT components of the treatment that account for outcome. Indeed some of the techniques used in the treatment may not be considered to be strictly coming from a CBT perspective. For instance, elements of narrative therapy were drawn upon, in addition to gradual exposure and cognitive/affective processing during times when the girls discussed their experiences of CSA and developed their trauma narratives. The overlap between the current treatments goals and objectives and those of other treatments from alternate theoretical perspectives (e.g. Solution Focused Ericksonian) certainly allows for the possibility of the results being explained using these perspectives. What seems to be required is for future research to undertake both deconstructive studies and comparisons with treatments from alternate theoretical perspectives to better assess the impact of treatment content.

Perhaps more saliently than treatment content or theoretical orientation, the results strongly point to the impact of group process and common factors of therapy as significant contributors to treatment outcome. Specifically it can be argued from the findings that the sense of ‘universality’, cohesion, trust and the working relationships developed within the group contributed to a sense of safety and security which in turn impacted on the girls desire to attend and the positive outcomes achieved. Conceivably, these factors may more potently account for the variance in results obtained and help to explain why some of the CBT components of the treatment did not necessarily contribute to treatment outcome. These findings suggest that future research into the role of group process and common factors for this treatment program is warranted. Specifically methodological attention should be paid to measuring the impact of the therapist-client relationship and the client-client relationship as contributors to treatment outcome as has been suggested here. Such
research will be important in better understanding the specific contributing factors which make this treatment 'work'.

Ultimately, the results of this study do provide evidence that the treatment program is effective and beneficial.
CHAPTER 8
COMPARING AND CONTRASTING THE FINDINGS
OF STUDIES 2 & 3
The purpose of this chapter is to assess whether the implementation of the recommendations made in Study 2 and changes made to the treatment program as outlined in Chapter 6, made a substantial contribution to the effectiveness of the program. Whilst the results of Study 3 presented in the previous chapter indicate that the program achieved its stated aims, it is useful to determine whether the developmental intervention process undertaken in the current series of studies was worthwhile. This chapter briefly compares and contrasts the results of studies 2 and 3, to assess whether the changes made to the program did in fact improve it and make it a more valuable and successful program. The findings of the two studies are compared along the following lines: Effectiveness, Acceptability, Content, Knowledge, Integrity, Facilitation (i.e. common factors) and Group Process, Program observations and Barriers to success.

Prior to comparing and contrasting the findings of the two studies, one significant moderating factor must be noted as this may affect the ability to compare the two studies on the dimensions mentioned above. This factor relates to some notable differences between the two sets of participants. Most importantly, the experience of sexual abuse for the girls in Study 3 was somewhat different from, and perhaps slightly less severe than, the girls in Study 2. All girls in Study 2 had experienced intrafamilial sexual abuse as opposed to only one girl in Study 3. The sexual abuse experienced by the girls in Study 2 was more protracted and the nature of the abuse more acute (i.e. numerous sexual acts, all penetrative experiences, more severe threats made about disclosure) than those in Study 3. In addition 3 of the girls in Study 2 versus only one in Study 3 experienced other forms of abuse (i.e. emotional, physical and/or neglect). The girls in Study 3 also had less familial troubles, were less chaotic and had higher socio economic status than Study 2 participants. Given these competing demands that were present for Study 2 participants, it may be expected that they would have had more difficulty engaging with the process of the group
and as a consequence may not have been in the best position to change. This possibility will be considered throughout this chapter as the two studies are compared.

Nevertheless, whilst these differences between the two samples are apparent, the similarities between the girls, in that they are all survivors of sexual abuse who have experienced significant negative sequelae, are central. Indeed as has been highlighted throughout this research, the mere act of bringing survivors of CSA together and allowing them to understand that there are others out there who understand what they have gone through and have felt how similar emotions such as shame is potentially beneficial.

8.1 Effectiveness

The results showed positive outcomes for the participants in Study 3 just as they did in Study 2. All participants from both studies had at least one positive outcome and for the most part these positive outcomes continued three months following the treatment program, providing convincing evidence that the program is effective. However, the results of Study 3 appear to be much less ambiguous than those of Study 2 as there were fewer divergent findings (e.g. comparisons of attainment of program knowledge between the two studies; less missing data leading to stronger inferences). At this point, it is perhaps unwise to make judgements about whether the program was more effective in Study 3 than Study 2 as outcome may be dependant upon the level of distress and symptomology of the participants to begin with, as well as other contextual factors which may have been operating at the time of the group. As mentioned above, the participants of Study 2 had more difficult life circumstances which may have affected their outcome from the program, thus a judgement on whether the program used in Study 3 was more effective in reducing symptomology is reserved. Just as it was difficult to compare across the participants within a study, the same difficulties apply across studies. However other measures of treatment effectiveness (e.g.
acceptability) may shed more light on this as the chapter progresses. It is also noteworthy that these positive outcomes were not always captured in paper and pencil tests of outcome (e.g. PA3 and PA5 in Study 3) but often were noted in observations from the participant, facilitators and parents. This highlights the importance of capturing outcome from a treatment program in multiple ways and from multiple perspectives.

8.2 Knowledge

The degree to which participants gain knowledge of the core concepts of the program is also an indicator of program success and the ease with which the program relays these concepts to the participants. It can also be considered a precursor to behavioural and emotional change. In Study 2 none of the participant’s knowledge scores were above 80% correct, nor did they show much evidence of increasing over time. In Study 3, three of the girls met the 80% criterion at post test which was maintained at follow-up. It was observed in both studies from other data (e.g. answers to questions in session) that participants gained much more knowledge of session content than this test reflected. This may suggest that there are either problems with the testing instrument or that the style of test as indicated in Study 2 particularly, seemed to the participants too much like a school based test and as such they had little interest in completing it. Overall these results suggest that it is important to monitor and observe the participants application of knowledge in structured activities and through their self report, not just on a paper and pencil test to truly capture the degree to which the core components of the program are learnt.

In an overall sense there was a much more successful application of the sessional knowledge tests in Study 3. This suggests that the changes made to this measure following Study 2 were successful (e.g. applying Blooms taxonomy (1956); removing many open ended questions). In particular it was noted that there is very little missing data in Study 3’s
data set: participants were observed to try and apply knowledge and were less eager to leave at the conclusion of sessions. Furthermore it is noted that Study 3’s participants had better literacy than those in Study 2 and so an interaction between literacy and changes made to the measure may have resulted in the improved outcome on this measure. Furthermore the tests were reviewed following each session and problems were discussed in the next session. This was observed to have significant benefits for the group and for group process in that it allowed the core messages of the program to be disseminated.

8.3 ACCEPTABILITY

Overall, the evidence collected from both studies demonstrated that the program was providing an unmet need to the participants and that they valued the program. The mean participant acceptability rating for Study 3 was 92.5% (range 82-100%) as opposed to 75% (range 60-87%) in Study 2. This finding suggests that the participants in Study 3 were more satisfied with the revised program and found that it had greater benefits for them than participants in Study 2. Although, given that the participants from Study 3 were better able to engage with the program and had fewer competing demands inhibiting change, this finding may reflect the greater outcomes from the program that Study 3 participants received. As previously reported acceptability can often have a large degree of influence over the effectiveness of a program. It is likely however that this finding of greater acceptability and satisfaction with the Study 3 program also reflects elements of stronger group process in that the Study 3 group was much more cohesive and more willing to self disclose than participants from Study 2 (this is discussed in greater detail in section 8.6). This is reflected in the findings from the facilitator’s ratings of satisfaction which also indicate that Study 3 was a more acceptable program (4.5 & 5.0/7 for Study 2 v. 5.0 & 6.0/7 for Study 3).
8.4 Content

The impact of session content was measured primarily through the session evaluation and facilitator observation of sessions in both Study 2 and 3. The impact of session content was measured to ensure that it was: useful and helpful to participants, targeted, met the objectives of the session and facilitated ways for the participants to process their experience of CSA. In this section it is important to consider whether the changes made the session content between Study 2 and 3 made an impact (positively or negatively) and that both groups of participants agree that the content that remained is important.

Ratings of the usefulness of core program content were consistent between Study 2 and 3 and suggestive that all core content was useful to participants. Few instances of participants having difficulty understanding session content were noted in either study and were suggestive that for the most part session content was delivered in a way that was appropriate to the participants.

More instances of session content being unhelpful to participants were noted in Study 3 in comparison to Study 2 (15 v. 3 instances). This may have been a result of the participants in Study 3 taking more time to complete the questionnaire, providing more considered answers and some participants of Study 3 having undertaken CBT based therapy before. Sessions related to the girl’s disclosure of CSA received ratings of unhelpfulness in both studies, but as previously discussed seem indicative of the emotional content of the session, not that it is not helpful for the girls to discuss their experience of CSA. Overall the ratings of session content being unhelpful remained low in both studies and indicates that the session content is considered helpful to participants. Nevertheless it may be worthy to consider the extent of CBT therapy that participants have had prior to entering the group program as this problem may continue to re-surface.
In both programs the facilitators noted the importance of the gradual exposure approach to CSA related material and the need to develop participants coping skills prior to discussing participant’s experiences of CSA in great detail. Throughout each session of both programs facilitators noted the activities which worked well with participants. Consistently, adolescent girls appeared to enjoy and benefit from activities which had a creative element to them (e.g. craft, poetry). In both studies facilitators reported that most to all objectives of the session were achieved and that the activities undertaken in the session helped achieve these objectives (with the exception of the recommendations and changes made at the completion of the studies).

The changes to the program used in Study 3 appeared to be beneficial. There was no evidence to suggest that the content that was removed (e.g. healthy sexuality session) was required and the changes made (e.g. implementation of opening and closing circles) led to the program running more smoothly and with greater impact. The findings presented for Study 3 indicated that the content of all sessions were well received by the participants (as indicated by the session evaluations & CSQ). Whilst some changes to session content were still recommended in Study 3, the refinement of the program from Study 2 appears to have had a considerable positive effect.

8.5 Group Process

The most objective measure of group process factors comes from the SEQ. The results from this measure suggest considerable improvements in the program used for Study 3 over the previous one used in Study 2. Ratings of session depth and smoothness as rated by participants and facilitators are higher in Study 3 than in Study 2 (see Table 8.1 & 8.2).
Table 8.1  
**Comparison of Session Depth and Smoothness Between Study 2 and 3 for Participants**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Study 2 Mean (Range) n = 48&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Study 3 Mean (Range) n=57&lt;sup&gt;b&lt;/sup&gt;</th>
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<tbody>
<tr>
<td>Depth</td>
<td>4.24 (4.01-4.90)</td>
<td>4.37 (3.00-5.60)</td>
</tr>
<tr>
<td>Smoothness</td>
<td>4.47 (4.00-5.20)</td>
<td>5.11 (1.00-7.00)</td>
</tr>
</tbody>
</table>

*Note.* Ratings were made on a Likert scale ranging 1-7. Higher scores indicate greater depth and smoothness of sessions.  
<sup>a</sup> number of ratings available (i.e. number of sessions attended in total by the 4 participants).  
<sup>b</sup> number of ratings available (i.e. number of sessions attended in total by the 5 participants).

Table 8.2  
**Comparison of Session Depth and Smoothness Between Study 2 and 3 for Facilitators**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Study 2 Mean (Range) n=16 sessions</th>
<th>Study 3 Mean (Range) n=12 sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FA1</td>
<td>4.20 (2.9-5.7)</td>
<td>5.37 (4.40-6.20)</td>
</tr>
<tr>
<td>FA2</td>
<td>4.45(3.2-6.2)</td>
<td>5.23 (3.00-6.60)</td>
</tr>
<tr>
<td><strong>Smoothness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FA1</td>
<td>4.64 (3.60-5.80)</td>
<td>5.40 (3.10-6.80)</td>
</tr>
<tr>
<td>FA2</td>
<td>4.90 (3.60-6.20)</td>
<td>5.5 (2.00-7.00)</td>
</tr>
</tbody>
</table>

*Note.* Ratings were made on a Likert scale ranging 1-7. Higher scores indicate greater depth and smoothness of sessions.

It is noted however that there was considerably more variability in scores in Study 3 as compared to Study 2. As indicated previously these extreme scores (e.g. a rating of 1 for session smoothness for PA2 in session 7) were not necessarily related to group process or session content, rather they were likely to be related to participants mood states or extraneous factors occurring at the same time as the group. From the perspective of a facilitator of both Study 2 and 3’s groups I also observed that the participants of Study 3 took much more time to consider their responses to this scale and as such they are perhaps more reflective of the experience of the sessions. Thus if the extreme scores were removed.
for Study 3 then the mean ratings of depth and smoothness would be even higher and further indicate the positive impact of the sessions.

In addition to the SEQ, the proportion of ‘good’ and ‘very good’ ratings for each session was also much higher in Study 3 than in Study 2. Furthermore, ratings of how good/bad the session was, were also much higher than in Study 2 for both participants (4.86 /7 v. 6.02 /7) and facilitators (5.0 & 4.7 /7 v. 6.17 & 5.75 /7) across the sessions. Thus these higher scores for Study 3 suggest that the content of the session was more favourable but also that there were more stronger group process factors evident in Study 3 in comparison to Study 2.

In terms of comparing and contrasting the process of the groups for studies 2 and 3, a number of differences are apparent. These differences are based on facilitator observation, particularly my observations as the facilitator of both groups and are consistent with the results of the SEQ presented above. The participants in Study 3 were, as a group, much more cohesive, trusting and open in their ability to discuss CSA than the participants of Study 2. They were less influenced by any one member (cf. Study 2 where PA5 was the group leader) and they were more able to learn vicariously from one another. These participants also appeared to show greater concern for one another (e.g. checking in with one another, buying one another small gifts) and became closer friends (e.g. messaging or telephoning each other during the week). Many of the Study 3 participants also continued to maintain the friendships they developed in the group after it finished. This did not occur in Study 2. The Study 2 group was significantly hampered by its size and the fact that there were two sisters in the group. This affected the dynamics of the group. As previously stated six group members is likely to be a good number.
Whilst there are many differences between the groups in terms of group process, there are however some salient similarities. These are of note as they are likely to have influenced group dynamics and the ability of the group to facilitate change in the participants in both programs. As argued previously, allowing the girls to meet and identify with one another as survivors of CSA is primary. This is consistent with some of the girl’s quotes from the first session when they were asked what the most helpful aspect of the session was:

“being a part of the group”, “knowing I am not the only one”, “knowing what others have gone through” and “talking about what happened.”

Session 1 appears fundamental in the process of these groups in terms of setting up a safe place, normalising experiences and beginning to remove secrecy as a constraining factor. This is further carried through the program by taking a gradual exposure approach to discussions of CSA.

Given these findings, group process factors may well be a critical reason why the program in Study 3 is seemingly more effective than the program in Study 2.

8.6 Facilitation & Common Factors

The role of the facilitators appeared central in both Study 2 and Study 3. In both studies the program was facilitated by two female psychologists aged in their mid to late twenties who had experience working with sexual abuse survivors. In both studies the facilitators developed good relationships with the participants and were easily able to relate to them. It is noted that the changes implemented on the basis of the recommendations of Study 2 in terms of facilitation also had considerable impact. That is, the facilitators were able to take more of a leadership role and act as role models for the group which seems to have led to the sessions running more smoothly and the participants being more actively engaged. In addition this seemed to be reflected in higher attendance rates, greater compliance within
the sessions, more open discussion and as a result less requirement for the sessions to be structured.

The findings of both studies highlight the importance of the facilitators as change agents, the therapeutic relationship and the skill of the facilitators as key factors which more than likely mediated treatment outcome. This was evidenced primarily by the observations of the facilitators who found that it was important to gently support the girls in session so as to help them manage their anxiety and/or avoidance associated with CSA whilst challenging them to make shifts with maladaptive beliefs and other constraining factors which were maintaining their presenting problems. The facilitators found that by doing this and by being genuine with the girls, greater trust was developed and as a consequence the girls were more likely to engage with the group and disclose about their experiences. The importance of the facilitators as change agents is also reflected in other indicators such as high attendance rates, participant engagement, satisfaction ratings, SEQ ratings and verbalisations from participants and parents. It is noted that facilitation was much stronger and perhaps more involved in Study 3 in comparison to Study 2, and conceivably greater outcomes for these participants reflect this.

8.7 Integrity

Both programs were implemented with a high degree of integrity. In both studies the facilitators consistently reported that the objectives of each session of the program were achieved. The findings of both studies also highlighted the need and importance of treatment flexibility and individuation as has been previously discussed.

8.8 Program Observations

Duty of care remained the single most important factor in terms of implementing the program in both studies, and it is expected that this factor will remain the single most
relevant factor throughout the life of this treatment program. That is, it is to be expected that future clients will continue to present with many crises and problems that will in turn take precedence over the treatment session and the extent to which the session can be implemented as planned. Treatment flexibility and individuation are therefore key components of this treatment and therefore comprehensive, contextualised, mixed method assessment of cases is crucial.

The shorter, 12 week program in Study 3 appeared to be much more functional than the 16 week program in Study 2. Whilst the girls were still willing to attend at the end of the program in Study 3, and expressed a great deal of sadness about its closure, the group had ‘run its course’. Running the program through the school holidays rather than stopping as occurred in Study 2 also had benefits in that the momentum of the group was not lost. Furthermore attendance was exceptionally high for this type of program and is an indicator of success in itself.

Having five members in Study 3 also appeared to have benefits over four members in Study 2. The former group was observed to be much more open and engaged in the process. Of course this may simply have related to the personality of the group members in Study 3 and their willingness to engage in conversation. Also as previously indicated having sisters in the Study 2 group also created considerable difficulty. Six group members seems ideal for future groups as it would allow enough time in session for the individual needs of each member to be met and the objectives of each session to be adequately achieved.

The general structuring of the program for Study 3 also had benefits over the program run in Study 2. For example, from the start of the program used in Study 3 the room was set up so that the girls sat in comfortable chairs around a coffee table. The facilitators were placed
such that they were on opposite sides of the room and could have direct eye contact with one another. This allowed the facilitators to remain in contact with one another and signal each other if required and for them to better engage with the group. Refreshments were provided at the beginning of the session. This allowed the girl’s time to socialise with one another and build relationships before the sessions started. Group norms and rules were set up within the first session and these norms allowed the group to function in a very efficient way. This is in contrast to Study 2 where the group norms were not set up as well and the participants, particularly PA5 kept testing the boundaries which led to the group being less cohesive and disjointed.

The introduction of parent sessions in Study 3 also appears to have had a considerable impact and led to parent’s better understanding the process their daughters were going through and parents providing better support to their daughters. All but one parent in Study 3 were observed to be very engaged in the parent sessions and eager to find ways to support their daughters. The parent’s acceptability ratings and feedback about the sessions also reflect this sentiment. In many cases the parent sessions also seemed to have a role in terms of fostering better parent-child relationships (e.g. PA2, PA4 & PA5). In contrast the parents in Study 2 were literally absent and not involved in the process at all and as speculated in Chapter 5 the family environment is likely to have considerably hindered these participants’ progress and ability to process their experience of CSA. At an observational level, the involvement of parents in Study 3 appears to have many benefits for the participants which did not occur in Study 2. The research evidence emerging demonstrates that the way parents support their child and manage their own reactions to the abuse is an important moderating factor (Deblinger et al., 1999; Everson et al., 1989; Heriot, 1996). As indicated it is hoped that more parent sessions will be provided in the
future, given the success of this pilot, to better allow parents to manage their own feelings about the abuse and be available to support their daughters.

A final observation associated with differences between the two groups is related to literacy and participant's ability to generalise the core concepts of the program. The group in Study 3 were much more literate than those in Study 2. This had enormous benefits in terms of the girl's ability to complete worksheets in session and also complete homework. This is not to say however that the program is not appropriate for girls with literacy problems. As discussed in Chapter 5 the program simply needs to be modified ‘in situ’ in the way it is presented to suit girl’s individual needs. But given that participants in Study 3 completed homework and practiced skills they learned in the group at home/in the community, they were much more likely to generalise their skills beyond the group environment leading to greater overall changes. At follow-up 4 of the 5 girls in Study 3 reported that they still used the techniques learned in group and 3 of the 5 indicated they had referred to their workbooks or reflected upon them (as opposed to 1 girl reporting she still used her workbook in Study 2). This does not imply that generalisation could not be further improved within the program, but taken as a whole these findings suggest that participants in Study 3 were in a better position to make changes to their lives following attendance at the program.

8.9 Barriers

In contrast to Study 2 where significant barriers to the successful implementation of the program presented themselves (e.g. referrals to the program, attendance, transportation, completion of homework, family environment) Study 3 was only constrained by referrals to the program, and to some extent family environment. As indicated above, the removal of many of these barriers may be the result of differences between the client groups in each study. It is noted that the families who took part in the program for Study 3 were much less
chaotic and more supportive of the therapeutic process than the participants of Study 2. As such, participants attended regularly, arrived on time, completed homework and actively engaged in the process of change, thereby overcoming the most significant barriers of Study 2. This perhaps led to the Study 3 participants being in a position to learn more from the program. In reflecting on these results and on the information presented in previous sections, the engagement of parents in this process seems paramount in ensuring that participants can be in a position to utilise the program to its full capacity. This will be of primary importance in future programs.

8.10 Conclusions

In comparing the results of Study 2 with Study 3, considerable improvements are evident. Study 3’s program appears to have run more smoothly, the activities were more effective and overall the program seems to have had a greater impact on the participants. Furthermore the benefits of having parents as both research and treatment participants is apparent in that the validity of the data is strengthened and the adolescent participants were supported through a difficult process. These findings highlight the importance of both the developmental intervention research approach and the use of both formative and summative evaluation to critically reflect upon the data, refine the treatment program and implement it. Given that the program had effective results in changing the level of distress of participants in Study 2 (although with some level of ambiguity which may have been rationalised as occurring due to the participants life circumstances), if the formative evaluation was not present, one may have continued to provide the program as it was, assuming that the program was working. Alternatively, had the results of Study 2 been based only on individual paper and pencil tests and carried out using a standard experimental design, the treatment may have been discontinued on the basis that change did not occur. However, by implementing the recommendations of the evaluation in Study 2,
a more refined and well targeted program has been produced. The formative evaluation of Study 3 is still suggestive of improvements that may be made to the program but these changes are relatively minor. Nevertheless as previously mentioned it is recommended that formative evaluation continues through the life of a program as a means of quality assurance and reflective practice.
CHAPTER 9

GENERAL DISCUSSION
When I started group, I wondered why he did this; Why did he lie?
I felt like running, Just like hiding my face. What he did made me feel loads of
disgrace.
Was it my fault? I’d think to myself. Did I deserve it?
I learned quite a lot, Learned to control my anger. Learned it wasn’t my fault, and
that I should not hide my face because I did no wrong.
I learned to be brave and to stand strong, I can speak for myself and I do belong.
I met lots of people, They’re all full of consistent support,
But most of all I found that all along,
I've got courage
And no one, Not even a perp,
Can take that away.

(Poem written by a Girls Group participant, 2005).

The current study set out to develop an effective evidence based group treatment for
adolescent CSA survivors. Adolescents were identified as a relevant sample on account of
the lack of evidence based treatments available for this population and the premise that
adolescence may be a time at which survivors of CSA truly begin to process their
experience of abuse. A group treatment modality was used because it fits with the
developmental tasks of adolescence and has other associated benefits such as decreasing
isolation, providing support, and being cost effective. In order to achieve both treatment
evaluation and development in this endeavour, the strengths of developmental intervention
research, action research and mixed methods program evaluation were drawn upon. These
paradigms allowed for in-depth evaluation of an existing treatment program, and the
subsequent development and evaluation of a new treatment program for adolescent
survivors of CSA. In adopting these approaches I was able to identify in greater detail
whether the treatments worked, as well as the underlying mechanisms which contributed to
its outcome. In an overall sense the results of the current study provide support for the
benefits of the Adolescent Girls Group program developed here.

A sequentially phased approach to treatment evaluation and development has not
previously been employed within the CSA literature. However within the current study it has
proven to be a uniquely effective method. As summarised in the developmental intervention research model presented in Figure 9.1, this series of studies has involved problem analysis, information gathering and synthesis which led to the considered design and evaluation of an evidence based treatment program for CSA. The overall results of phases one (problem analysis) and two (information gathering and synthesis) determined that it was necessary to develop a more clinically responsive treatment for adolescent girls who had experienced sexual abuse. Whilst the overall body of evidence suggested that group treatment was a viable treatment for CSA survivors, few empirical studies were identified which had evaluated the effectiveness of group treatment for adolescent girls. Furthermore there was little replication of studies using a particular treatment approach nor any evidence that the treatments had undergone reflective improvement.

Figure 9.1. Summary of the phases of the current research project.

The PACTS girls’ group program was identified as a natural example of a treatment program for adolescent CSA survivors. By studying this program, Study 1 demonstrated that the PACTS program, as rated by facilitators of the program, parents and a past participant, was unlikely to be effective at alleviating distress associated with CSA. However consistent with the research evidence, ratings by parents and the past participant suggested that group treatment for this population is considered necessary and important to both adolescent girls and their parents. A review of the treatment programs in the CSA research literature suggested that many elements were amiss in the PACTS program in terms of a comparison with best practice in the literature. These elements included the lack
of structure and theoretical background, lack of focus on CSA, lack of consideration of coping skills and failure to target CSA related attributions. This may explain why the PACTS hybrid program was found not to be effective (although this may relate to other factors such as the rating scale used by the agency as discussed in Chapter 3 and the constraints on assessing group and common factors in a retrospective analysis). Thus in drawing phase one and two together, it was recommended that a new evidence based treatment program be developed. It was also recommended that the findings of Study 1 serve as the foundation upon which to develop the treatment program. This was achieved in phase three (design).

Phases four and five of this approach then set about evaluating the pilot program to determine both whether it was effective at alleviating distress and what components made the treatment successful. This occurred in studies 2 and 3. As highlighted in Chapter 1, to investigate whether or not the treatment worked, it was evaluated according to: the extent to which participants changed following attendance at the program (i.e. whether the program achieved its stated aims); and the degree to which it was mediated by treatment integrity, acceptability and the lived experience of participants. These outcomes are highlighted below.

The poem presented at the beginning of this chapter, written by a participant of the treatment group in Study 3, is indicative of the impact that the Adolescent Girls Group had on the majority of girls that attended it. As this young woman indicates, after attending the group she was able to overcome feelings of self blame, guilt, shame and anger and shift to a more healthy sense of self which included feelings of strength, courage, resilience and empowerment. In this way the insidious and stifling effects of CSA began to be overcome.
Positive and in most cases clinically significant changes were evident for every participant across the two studies, however some participants received more benefit than others and in some instances signs of maladjustment remained following attendance at the program. As Ramchandani and Jones (2003) suggest, this is perhaps not surprising given the context in which CSA occurs and the wide ranging symptoms and behavioural presentations of survivors. This was certainly true in the current sample. It was challenging to examine the impact of the program in a summative fashion across the studies as the changes which occurred in each participant depended upon many factors including the severity of abuse, presenting problems and the level of support outside of group and resources available. In an overall sense there is evidence to support the fact that subjective distress and emotional, cognitive and behavioural effects associated with CSA decreased in each participant, however this was less evident for the Study 2 participants and PA3 in Study 3. Whilst the Study 2 participants all made positive gains, some problematic and concerning signs of emotional and behavioural disturbance remained for each participant following the treatment program indicating that further trauma processing was required. For PA3 in Study 3, her asymptomatic presentation and associated mediating factors meant that she made fewer gains than other participants, nevertheless there was evidence that this participant did make some gains in developing a new narrative about her experience and exploring associated emotions (e.g. the letter to her perpetrator expressing her anger towards him).

On the whole the findings of Study 2 and 3 provide support for the use of group treatments with adolescent CSA survivors. These findings are in keeping with other studies which have also found group treatment to be effective in the alleviation of negative sequelae associated with CSA (e.g. Kambouridis & Jevtic, 2002; Kruczek & Vitanza, 1999; Sinclair et al., 1995; Thun et al., 2002). The findings also showed that the number of risk factors participants presented with declined and they learned a number of protective skills to assist them in the future.
On the basis of the gains made by each participant, it could be argued that the group was not equally effective for each participant. Each girl appeared to take different things from the group and this was perhaps dependent on their initial presenting concerns. What can be said is that the group was effective in providing support and decreasing isolation which are important factors for this population. This is in keeping with the premise of group therapy in general (Yalom, 1995) and research in the CSA literature (Furniss et al., 1988; Hiebert-Murphy et al., 1992; Kambouridis & Jevtic, 2002; Knittle & Tuana, 1980; Kruzeck & Vitanza, 1999; Trolley, 1995).

The research design used in this study overcame many of the problems highlighted with experimental research when a heterogenous sample is present. The importance of a contextual within case analysis is highlighted by this approach. As was demonstrated in the cross case analyses of studies 2 and 3, the overall impact of the program could not be interpreted meaningfully without contextual data. That is, the variability across cases did not give an accurate reflection of how effective the program was for each participant. For if the effectiveness of the study was measured only on how participants scored on outcome measures and only on means of combined cases, the conclusions drawn would be less favourable, but more importantly, erroneous. These studies highlighted the importance of placing participant’s results within the context of their lives and meaningfully interpreting them in this way. This finding potentially raises concerns about the findings of other research with this population. If the participants in the current study were so variable and had so many contextual factors which mediated their ability to engage with the treatment program, conceivably so do many adolescent survivors of CSA including those in other research studies presented in Chapter 1. This conjecture raises some doubt about the meaningfulness of data presented in past research that has used only experimental research designs and statistical significance as the indicator of treatment effectiveness.
The ability of this research to capture functionally relevant data which was multi focused was also an advantage. If studies 2 and 3 had only used standardised measures of change then it may have been concluded that the treatment program was not very successful. As an example, if quantitative and qualitative non standardised data were not collected for PA5 in Study 3, then it would have been concluded that the treatment was ineffective for this participant and actually made her worse (according to summative outcome measures e.g. TSCC). However the extenuating factors which were present for this participant seem to have hindered changes on the TSCC and other measures. Nevertheless PA5, her mother and the facilitators reported a great many changes that they attributed to attendance at the group (e.g. more contained, more expressive, “stronger”). This finding highlights the importance of establishing efficacy using the metric of clinically significant change as well as using multiple informants to triangulate data and bolster the reliability and validity of findings. The methodology used in the study was crucial as it highlighted discrepancies between outcomes drawn from standardised assessment methods and qualitative/formative methods. The sheer number of data points on which the conclusions of the studies are drawn (11,000+ for Study 2 and 15,000+ for Study 3) also strengthens the validity of the conclusions. Most importantly the contrast between results on these measures indicated that researchers should not rely on single outcome measures.

In order to preserve the integrity of the treatment program as much as possible and thereby ensure that the program was uniformly applied, the studies presented here used treatment manuals, ensured training of therapists and completed an evaluation of each session noting the degree to which session objectives were achieved. In keeping with the only two studies to have done this in the CSA group treatment literature (i.e. Berliner & Saunders, 1996; Deblinger et al., 2001), the current study found that all treatment objectives were covered and the program was administered with integrity. Having said this, unlike these two studies
and as hypothesised in Chapter 1, deviations from the treatment manual and treatment flexibility and individualisation were important in the current study. This process has not been discussed by any other study in the child and adolescent CSA literature to my knowledge and yet it seems to be one of the most important factors. Study 2 in particular deviated from the treatment manual in a number of ways including the need to change the order of sessions. The level of deviation may be dependant upon the presenting issues, the level of chronicity and other contextual factors of clients. This was evident in that Study 3 did not deviate anywhere near the extent of Study 2. Overall however these deviations show that a feature of the program is that it is adaptable to the needs of the participants. Sessions can be re-ordered and adapted relatively easily to fit with the presenting needs of the clients. In as much, the program is participant responsive. This is consistent with the child physical and sexual abuse treatment guidelines (Saunders et al., 2004) which highlight the need for interventions to be matched to the problems, disorders and conditions identified in clients.

Had the current research used a randomised control trial design, the changes that were required in the implementation of the treatment program in both Study 2 and 3 arguably would have violated the assumptions of this approach because the treatment was not uniformly applied. It is difficult to understand how a treatment with this population could ever be uniformly applied (which is, of course, one of the critiques of reporting randomised controlled trials). A great many CSA survivors and their families appear to lead chaotic lives. They frequently present in crisis and as psychologists, ethically we must respond to these crises. For example in Study 2, two of the girls were grieving about friends who died in a motor vehicle accident, one girl attempted suicide, another was experiencing conflict with her carer. All of these situations needed to be attended to but none can be found in the treatment manual. It is argued that all treatment research in this area should report on ways
in which they depart from the specified treatment. This highlights the importance of Natasi and Schensul’s (2005) natural adaptation approach to treatment implementation. This approach argues that treatment integrity should be obtained by maintaining critical elements of a program while allowing flexibility of non critical elements. By doing so, this approach also has the benefit of improving treatment acceptability and satisfaction. Furthermore this approach to treatment integrity appears to be the most ethically responsive as ignoring these competing demands would be unethical. These findings emphasise the importance of having both a research design and treatment program which can accommodate such deviations whilst still being able to demonstrate effectiveness.

If a program is going to be effective, it must be acceptable to consumers. Acceptability proved to be an important concept to measure across these three studies. The findings of Study 1 showed that mothers of past PACTS clients felt that even though the PACTS treatment program was not effective, it served an unmet need and an important function in the lives of their daughters thereby providing evidence for the need of an improved program. The findings of both Study 2 and 3 indicate that the new treatment program was very acceptable to consumers. This is similar to other studies which also found that group treatment was an acceptable treatment modality for CSA survivors (Deblinger et al., 2001; Trowell et al., 2002; Kambouridis & Jevtic, 2002). The findings from the satisfaction ratings suggest that both programs, but in particular the program used in Study 3, were considered valuable and beneficial to participants. In particular, participants indicated that they enjoyed attending, felt the program met their needs, were provided with appropriate skills and felt the program had an impact on the way in which they dealt with their lives and relationships. Most importantly all participants and parents (in Study 3) indicated they would recommend the program to other adolescent survivors of CSA.
The acceptability rating of the program rose between studies 2 and 3 (from 75% to 92.5% for participants) suggesting that the refinements which occurred between the two studies made the program more targeted to consumer need. This finding also highlights the importance of the formative approach which allowed these refinements to be made (i.e. without the formative evaluation, improvements would not necessarily have been identified and as such the program may not have met the needs of participants as well as it is reported to have in Study 3). Perhaps one of the key factors which separated the treatment programs in studies 2 and 3 was the level of involvement facilitators had with clients outside of sessions (i.e. contacting parents and girls to check that they were coping, keeping parents informed and making them feel supported). This did not occur in Study 2 and perhaps would have made a considerable impact if it had. This difference between the programs could perhaps help to explain why the participants in Study 3 were more satisfied with the program they received. That is, they were likely to feel more connected to the program. Thus the findings suggest that it is important to measure treatment acceptability as a measure of treatment effectiveness.

It was suggested in Chapter 1 that to provide effective treatments to adolescents that will work, we must have personal accounts from survivors about what helps them to cope and what they feel are the most important aspects of therapy (Nelson-Gardell, 2001). Whilst a focus group methodology was not used in the current study (as in Nelson-Gardell’s) the data collected from participants are very much in keeping with the findings of Nelson-Gardell. The major finding of Study 1 was that the provision of group treatment programs is important to adolescent girls and their mothers. This finding was further supported by the participants of Study 2 and 3 who all noted that attending the group was a positive and valuable experience which they would recommend to other girls in their position. This is in keeping with Nelson-Gardell’s theme “group helps (but no one wanted to go).” The
participants in Study 3 agreed with the participants of Nelson-Gardell’s study that it is difficult to summon the courage to attend a group program. However on attending it was noted by the participants of both studies 2 & 3, that meeting others and understanding that they are not alone nor the only ones who have experienced CSA is important. The participants of Study 3 further acknowledged that the group is hard and difficult to take part in at times, but overall they recognised the importance of undertaking such a process. That is, the girls understood that “talking about what happened helps” and “talking about feelings help”. These findings suggest that adolescent girls think that group treatment programs are important, they want to be helped and they want the chance to talk about what happened to them while being in a supportive environment. The treatment program developed for this study provides an opportunity for this to occur and is thus in an advantageous position to be effective as it has been accepted by, and is relevant to, its intended audience.

In combining each of these outcomes, there appears to be cumulative evidence to suggest that the Adolescent Girls Group program is effective. This is consistent with previous findings (e.g. Kambouridis & Jevtic, 2002) that group therapy is a useful and beneficial treatment for adolescent girls who have experienced sexual abuse. However as has been argued throughout this thesis, it is not enough to understand that a treatment works, we must also understand what makes it work. This was achieved in the current study by formatively evaluating the treatment program as it progressed. In the current study this occurred by examining the impact of the treatment content, the barriers to success and most importantly common factors and group process. These are discussed below.

Whilst one deconstructive study of group TFCBT has been conducted to assess the differential utility of component aspects of the treatment (Berliner & Saunders, 1996), no studies in the CSA literature to my knowledge have undertaken formative evaluation of their
The formative evaluations across studies 2 and 3 indicated that both group members and facilitators felt that the sessions of the intervention were useful, relevant and presented in such a way that facilitated understanding in the recipients. Furthermore at a process level the sessions consistently met the expectations of participants and facilitators. At the same time, use of the formative evaluations allowed us to identify weaknesses in the treatment program (e.g. the need for in depth reviews at the beginning of each session to aid generalisation). Using the action research framework, these issues could be addressed as they arose from the data, something which would not be possible if a purely experimental design had been taken. In terms of providing an intervention for adolescent girls, the formative data indicated that it is important to take literacy into account, use modes of dissemination that are interactive (e.g. craft activities, butchers paper rather than overheads), keep an adequate focus on CSA and maintain adequate structure and guidance. Most importantly the formative approach ensured that the duty of care of participants was the number one priority. Formative data also identified the barriers to the successful implementation of the program. These included recruitment of adolescents, impact of the family environment, absenteeism and a lack of generalisation of skills. This is important information for clinicians in the field who may consider using the intervention. The formative evaluation demonstrated that participants and facilitators found most of the content of the program to be useful in achieving the main aims of the program. Some content was identified as unhelpful (e.g. healthy sexuality, self esteem) and subsequently was deleted or modified.

Other findings raise some concern about the tenets upon which the program is based (i.e. TFCBT). In both Study 2 and 3 the participants had difficulty grasping the ABC model and the link between thoughts, feelings and behaviour. This was seen on both their knowledge test scores for this session and observation in this session. This finding leads me to critically
ask the question: “Did TFCBT contribute to treatment outcome in this program given the participants did not understand the basic tenets of the CBT approach?” A further question which could be posed given this finding is: “Was it the TFCBT/treatment content or the common factors and group process that lead to treatment outcome?” Whilst there is evidence that the participants did not understand the underlying tenets of the CBT model, the merits of TFCBT and its involvement in producing change should not be completely dismissed. This may depend on what we label as TFCBT. As reported in Chapter 3 and 4 TFCBT has four main therapeutic components:

- Coping skills
- Gradual exposure & direct discussion of the abusive experience (i.e. a trauma focus)
- Education
- Cognitive and affective processing – expressing abuse related feelings, clarifying erroneous beliefs that might lead to negative attributions about self or others (e.g. self blame)

In examining each of these components independently, there is evidence to suggest their importance. The results suggest that most of the girls developed more adaptive coping mechanisms following attendance at the group and applied these skills to help them cope with sequelae associated with CSA. For example in Study 3, PA4 and PA5 successfully applied grounding techniques to manage their flashbacks. The coping skill components of the program were also rated well in the session evaluations. Thus coping skills are an important part of this treatment approach. Similarly, there is evidence to suggest that gradual exposure to CSA is also important. The participants from Study 3 actively stated that one of their main concerns in attending the program was that it would be wholly focused on CSA and their own stories. By not doing this, the participants were given the opportunity to build relationships with one another, to develop their coping skills and to incrementally approach CSA in a way that was palpable but not overwhelming. Whilst we
do not have evidence for an alternative treatment approach (e.g. exposure based flooding), this approach seems to be ethical and supported by participants. It is also consistent with the approach of other treatment models. The gradual exposure approach was facilitated by the educative components of the program. Observations of the girls and examination of their knowledge tests (in Study 3) demonstrated that the girls understood CSA (e.g. definition, effects, grooming). This was important in terms of normalising and dispelling common myths. Factual knowledge also assisted in the disputation process. Many of the girls held erroneous beliefs about the experience of sexual abuse which it was important to dispute (e.g. it was my fault I was sexually abused). Factual information assisted in dispelling these myths and assisting the participants to hold more helpful beliefs about their experience. This was further assisted by cognitive and affective processing which was used throughout the program. Expression of abuse related feelings was used a great deal in the program, particularly by way of creative pieces. These were very important to the program and worked well with the participants. In terms of cognitive processing, the evidence presented earlier suggested that this part of the program did not work. However, there was evidence that thought challenging and cognitive disputation were used successfully within the program. For example the facilitators frequently used these techniques when the participants expressed negative and/or erroneous beliefs about their experience of CSA. Observation of the participants showed that over time they did begin to understand the link between their experience and their emotions/symptoms. The participants were also observed to use cognitive disputation techniques. For example in Study 3 the girls were observed to challenge and dispute with PA5 when she stated she was to blame for her abuse. There is some concern that these skills did not generalise and therefore the participants may not have them to draw on later. Conceivably, specific thought challenging and use of the ABC model may be best left to individual therapy where more time is available to undertake this process. This then suggests that the way cognitive processing is
undertaken in the group program may need to be reconceptualised. That is, a specific session on the ABC model may not be worthwhile but it will still be important for the facilitators and participants to challenge negative thoughts through the process of the group and for the participants to express abuse related emotions and to understand the link between their emotions, behaviour and experience of CSA. Thus to answer the first question posed, the majority of the TFCBT techniques seem important to the outcome of the program.

In presenting the information above about how the components of the program worked, it seems that the components would not have worked without having skilful facilitators and without the dynamic of the groups being cohesive and open to undertaking this process. The findings of both Study 2 and 3 suggest that the therapeutic alliance and the skill of the facilitators were of upmost importance in assisting the girls to process their experiences of abuse and gain the most from their attendance at the group. The facilitators observed that it was important in the groups to validate participants experiences and provide them with a sense of what they were experiencing was normal. In both treatment programs the facilitators developed a good working relationship with one another and with most group members. Findings from each group suggested that these relationships, particularly in Study 3, had a large role to play in helping these girls to work through their experiences as evidenced by observation from the facilitators, high satisfaction ratings, high SEQ ratings, high attendance and engagement, and positive feedback from parents. The findings of Study 1 add further support to this notion in that the working relationship between the past participant who contributed to this study and the facilitator of the semester 1 2003 group was more important than the group content. These findings fit with those of Nelson-Gardell’s (2001) in that “believing defines help and support.” That is, participant’s perceived experience that the group facilitators understand them and believe their story assists them
in further exploring and processing their experience of sexual abuse. This also holds for the other participants of the group. As previously discussed, interacting with other survivors and being believed by them is also important, particularly if they have had past experiences of not being believed by peers (e.g. PA4 & PA5 in Study 3 both had experiences of peers disbelieving them and disclosing the information to other students leading to negative consequences of the disclosure). Thus the concept of ‘universality’ (Yalom, 1995) is central to this treatment program and is important in allowing the group to be cohesive and move into a working phase and thus further processing their experience of CSA.

In addition to the role of the facilitators, the process of the group is also an important factor which contributed to treatment outcome in these studies. As discussed in Chapter 8, stronger group dynamics appeared to contribute to Study 3 being more successful than Study 2. The Study 3 group was more cohesive, trusting and it seems that as a consequence more willing to explore their experience of CSA. Important factors in facilitating this were setting up a safe environment, normalising experiences and beginning to remove secrecy as a constraining factor. The role of parents in the Study 3 group also appeared to be an important mediating factor leading to successful outcome. Parents attended two sessions to assist them in understanding the aims and objectives of the program and the ways they could facilitate these outside of group. Parents were also actively informed of their daughter’s progress via weekly phone calls. This led to the participants feeling more supported and as a consequence were more likely to continue their processing outside of the program. In a number of cases it also led to closer parent-child relationships (PA2, 4 & 5). This is very much in contrast to Study 2 where, arguably, the family environment acted as a constraint to change occurring.
In triangulating all of the available evidence, it seems that common factors, group process and TFCBT techniques were all important factors that appeared to influence participant outcome in these studies. According to Lambert & Barley (2002) we might expect that around 30% of the variance in participant outcome following attendance at the group program is accounted for by common factors and only 15% by the TFCBT techniques. This was not measured in the current study and so it is not possible to argue what accounted for the greatest proportion of variance in participant outcome. But very clearly, as a facilitator of these programs I would argue that the treatment techniques used in this program could not have been applied successfully without the therapeutic alliances and the group dynamics which were developed. That is, without making the girls feel safe and supported in group, it would be unlikely that they would be willing to disclose their experience of CSA or work towards processing their experience in any meaningful way. So, in answering the second question posed, I have argued that both technique, common factors and process factors were important to the outcome of the treatment program.

This finding related to the importance of group process and common factors raises some concern about the findings of other research in this area. It is concluded in many of the research articles presented in Chapter 1 (e.g. Berliner & Saunders, 1996; Deblinger et al. 2001) that it is the treatment model and technique that led to the successful outcomes for participants. But, as has been shown here, group process and common factors of therapy are likely to have had a great deal to do with outcome. The same may be true for those studies with unsuccessful findings which have remained unpublished. These factors need to be considered quite explicitly and in greater detail in future research.

On account of the formative data produced and in triangulating it with what was already known, much more is now known about what does and does not work with adolescents who
have experienced CSA. In summarising the above argument, the following factors seem to be the most important in terms of making the intervention work:

- Group process (in particular universality/group cohesion)
- Common factors (specifically the role of the group facilitators)
- Gradual exposure of material related to sexual abuse culminating in a disclosure of the abuse (i.e. a trauma focused approach)
- Skill building capacity (development of coping skills) and containment model
- Educative components
- Parental support and involvement

Furthermore the formative approach highlights the importance of applying the standards of evidence based practice to this treatment. That is, the treatment itself, the clients, the facilitators, the therapeutic relationship and the group process are all contributors to the success of the program. The findings in general also highlight the importance of both summative and formative evaluation when a treatment is in its pilot stages. If a purely summative approach had been taken many of these problems with the intervention may not have been recognised and most certainly would not have had the data to support the changes made. Using this approach, the factors that are helping and hindering the outcome/impact of the intervention could be demonstrated. This understanding that now exists in relation to treatment programs for adolescent CSA survivors could not have developed without both formative and summative data, nor without a focus on nomothetic and idiographic knowledge.

The current research is not without its limitations. A major limitation which plagued each of the three studies was sample size. In terms of Study 1, the findings were limited by an insufficient sample of past participants of the PACTS girls group to comment on the group. The data which these girls could have provided about the past groups would have been very valuable and may have changed the direction of the construction of the new
intervention. Nevertheless the inability to attract these participants to comment on the program is informative in itself as previously discussed. The generalisability of studies 2 and 3 are also limited by the number of participants. As Kinard (2001) points out, recruitment of participants in child abuse research poses fundamental challenges and is often an arduous task. Nevertheless Study 2 and 3 were more than simply a research project. The participants were receiving a free service and as such one would have expected greater interest in the service given that no such treatment exists in the Perth metropolitan area. Whilst the sample size to a large degree can be outweighed by the research design (i.e. A-B-A single case mixed method accountability design), it would have been advantageous to have up to 10 participants in each study to further strengthen the reliability and validity of the findings although this must be balanced against therapeutic needs and as such six is recommended as a maximum for each group.

Following on from the issue of sample size, it is noted that the cross case analyses in Study 2 and 3 did not make use of inferential statistics. This decision was made on account of the variability in the data, the size of the sample and the resultant lack of statistical power to detect statistically significant changes. It may be argued that it would have been advantageous to demonstrate both clinical and statistically significant change however as indicated from the results of participant portfolios, the degree of variability in initial presentation and therefore outcome of each participant may have also prevented statistically significant change from being demonstrated and would have thus lead to faulty conclusions about the program. Thus it was determined that the most effective way to analyse the program across cases was by qualitatively summarising the outcomes and focusing on the number of cases with clinically significant change.
A limitation specific to Study 2 that weakens the validity of findings is the extent of missing data. Predominately this is due to the fact that parents did not take part in this research. By not having these data, the process of triangulation was weaker than in Study 3 and therefore the conclusions drawn are more tentative. The data relies most heavily on the self report of the adolescent girls. Limitations of this are recognised in that it is based on individual internal working models and may not accurately reflect the change that did occur.

The fact that parents in Study 2 did not take part in the research is informative and speaks of the family environment in which the group participants were living. In addition it is noted that process factors occurring in the group were not given as much attention in Study 2. This again highlights the importance of contextual analysis in examining the outcomes of this type of research. Missing data was also evident for group participants in Study 2, particularly in open ended questions. These data would have been useful in better understanding the participant’s thoughts and feelings about the program and what they had learned from it. The missing data however is also perhaps reflective of the participant’s being more engaged with the treatment than the research process (as should be expected) and perhaps not fully understanding the need for, and importance of, the research component. Nevertheless, the finding has implications for the types of measures to be used with this population. For example limiting the amount of open ended questions and being cognizant of literacy. This limitation was largely overcome in Study 3 by implementing recommendations from Study 2 such as making some changes to the measures, following up on data immediately after it was collected and striving to ensure parents were involved as research participants which strengthened the conclusions drawn. The addition of parental data in Study 3 allowed for stronger inferences to be made and the quality of these inferences to be legitimised.
Finally, despite the research design of studies 2 and 3 which allowed for each component of the intervention to be assessed, this research is unable to categorically conclude which elements of the treatment package are responsible for change in the participants. Nevertheless, the data presented does provide some strong indicators of what these elements may be (i.e. group process and common factors, gradual exposure, coping skills, education). In addition, as discussed above it may be expected that a large proportion of the resultant change in participants is due to attendance at the group itself and the process which occurs within the group as opposed to the treatment content. Furthermore the data did provide some evidence about elements that are not useful in such a program. These included sessions specifically focused on healthy sexuality, friendships, self esteem and emotions. As previously discussed there are also some concerns about specifically teaching the ABC model and cognitive triad in session.

Future research must in the first instance aim to replicate and extend the findings of the current study. This is in keeping with the phase five of Rothman and Thomas’ (1994) intervention research approach. It would be beneficial to compare the finalised treatment which resulted from Study 3 to alternate treatments or to a waitlist control group. A more traditional quasi or true experimental design may also be of benefit to further establish causality associated with the treatment program. However it is recognised that this may not be possible due to the limitations previously discussed. The formative findings of Study 3 provide specific recommendations on the required changes to the treatment program which must occur prior to further evaluation. In addition, it is recommended that formative evaluation continue throughout the life of this treatment program as a means of quality assurance. Future research may also be directed at specific deconstructive studies which aim to investigate the elements of the treatment program which make it work and the proportion of variance accounted for by technique, group process and common factors. Specifically a more in depth analysis of group process issues should be undertaken and
may for instance necessitate the use of videotapes of each session which can be analysed by independent raters. Finally, future research may also consider investigating the utility of a treatment program for ‘at risk’ and non substantiated cases as suggested in Study 3.

In conclusion, the overarching aim of the current research was to further extend best practice group treatment for adolescent CSA survivors and to produce an effective evidence based treatment that met the needs of a vulnerable population. This was achieved in the current study by evaluating past research and the current series of studies iteratively, incrementally and developmentally; and overcoming past methodological challenges by using a research methodology which focused on both nomothetic and idiographic outcomes. In doing so, a 12 week trauma focused CBT program was produced which has been demonstrated to be effective and meets the needs of adolescent girls. Best practice recommendations which have stemmed from this research include placing considerable focus on both treatment technique (i.e. TFCBT), group process and common factors, involving parents in the treatment process and having the treatment as an adjunct to prior or concurrent individual therapy, thereby allowing greater trauma processing to be undertaken. In addition, given the diversity of the effects of CSA, no single type of intervention is likely to be effective for all survivors of CSA and as such treatment flexibility and responsiveness are crucial components of any treatment for this population. Overall, the treatment program developed here assisted adolescent survivors of CSA to minimise the powerful impact of their memories and equip them with coping skills to move through this stage of development.

*It [the group] made me stronger than ever. I met others who had gone through the same pain. We went through some more pain together. My memories have begun to fade from my mind. Now I am stronger. I have control of my life. My life is now going to be longer* (Girls Group Participant, 2005).
References


Family Planning Association of Western Australia (FPWA). (2000). *Promoting Adolescent Sexual Health (PASH) program*. Perth, Australia: FPWA.


Appendices

All appendices may be found on the attached compact disc.