Group Treatment of Adult Incest Survivors

Mary Ann Donaldson
Susan Cordes-Green

IVPS
Interpersonal Violence:
The Practice Series

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Group Treatment of Adult Incest Survivors

Interpersonal Violence:
The Practice Series

Jon R. Conte, Series Editor

Interpersonal Violence: The Practice Series is devoted to mental health, social service, and allied professionals who confront daily the problem of interpersonal violence. It is hoped that the knowledge, professional experience, and high standards of practice offered by the authors of these volumes may lead to the end of interpersonal violence.

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Preface

❑ Overview of the Village Family Service Center's Incest Treatment Program

History. During the late 1970s and early 1980s, Mary Ann Donaldson began treating adult incest survivors (many referred from a local rape crisis center) who were experiencing symptoms that included anxiety, depression, flashbacks, and nightmares. She consulted with an area psychiatrist who had been working with post-traumatic stress disorder (PTSD); the results of their research (Donaldson & Gardner, 1985) suggested that the PTSD diagnosis is appropriate for many survivors of incest who are troubled enough to seek a treatment program.

At first, all clients were seen on an individual basis, but as the numbers grew, groups were formed and more therapists were recruited to become part of a treatment team. The earliest groups, which were semistructured and topic centered, lasted about 12 weeks. As the

literature and therapists' practical understanding regarding the consequences of incest grew, they began to see a need for longer group experiences. Clients and therapists alike felt that short-term group was, in many cases, insufficient to deal with family systems issues, individual developmental processes, grief, assertion, and the like. The current program is the result of attempts to meet a wide range of needs while allowing individual choices.

Current program. The goal of the Village's incest treatment program is to provide change-oriented therapy in a supportive context. We believe that our clients benefit most when they are able to understand their victimization as an abuse of power and a denial of personal rights on the cultural as well as the familial level. Therefore, we view our clients as active partners in their treatment process.

Our program serves 50 to 70 adult female survivors at a given time. On the average, clients participate in our program for about one year. Over the years, we have worked with nearly 500 incest clients. According to a study of 104 of our clients (Edwards & Donaldson, 1989), survivors ranged in age from 17 to 54, with an average age of 28. Nearly 30% of the subjects were married and 30% were separated or divorced; the rest had never married. Nearly 80% had a high school education and 15% had attended college. Sixty percent reported middle to low incomes and 34% received some sort of financial assistance.

Our present treatment team consists of five therapists, all of whom work with the program part time. Therapists who conduct our groups have a minimum of masters' level training in programs such as clinical social work, psychology, counseling, family therapy, and psychiatric nursing.

Following is an overview of the components in our current treatment package. All components are discussed in greater detail in this book.

- Individual therapy and assessment: Individual therapy is provided for an average of 5 sessions before a client is referred to the group component.
- Education groups: Education groups precede the therapy groups and are conducted over 4 sessions.

- Pretherapy groups: Those clients who complete the education groups and want to enter a therapy group must first complete 3 to 4 pregroup orientation sessions.
- Therapy groups: Clients who enter group therapy commit for 6-month segments. The groups consist of six to eight members who meet for 1 ½ hours in weekly sessions.

Referrals or supplemental in-house services are provided for additional diagnoses, marital and sex therapy, and parenting. Spouses of our clients may participate in a partners group that is led by a member of the treatment team and a male staff cotherapist. Clients may also be referred to a local self-help support group, usually when they are "advanced" or their program is completed.

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Overview— Incest Survivors and Group Treatment

Group therapy is a widely used and accepted form of intervention that has been applied to a variety of problems and populations. Proponents of the group process list numerous benefits for clients and practitioners alike. Groups tend to be cost-effective, and they allow more people access to programs, provide greater support for members, facilitate the practice of new skills and behaviors, and provide a social milieu in which individuals can work through problems that occurred in social settings (Corey, 1985). Yalom (1985) lists 11 therapeutic factors that result from participation in the group process: instillation of hope, universality, imparting of information, altruism, the corrective recapitulation of primary family group, development of socializing techniques, imitative behavior, catharsis, interpersonal learning, group cohesiveness, and existential factors.

These therapeutic factors may be of particular benefit in ameliorating symptoms experienced by adult survivors of childhood incest (Courtois, 1988; Forward & Buck, 1978). To discuss the application of group therapy to this population, we must first review the available research literature that addresses the possible sequelae of this type of abuse.

❑ Long-Term Effects of Childhood Sexual Abuse

Surveys of women in general population samples estimate overall prevalence rates of childhood sexual abuse (CSA) at around 20-40% (Finkelhor, 1979; Finkelhor, Hotaling, Lewis, & Smith, 1990; Russell, 1986). However, rates vary from 6.8% (Stein, Golding, Siegel, Burnam, & Sorenson, 1988) to 60% (Peters, 1988). Variations in results may be attributed to differences in definitions of abuse, sampling, sample size, or methods of obtaining retrospective data.

Adult women who report a history of CSA, including incestuous abuse, share a variety of problems and characteristics that are assumed to be linked to their earlier abusive experiences (Briere, 1992a; Browne & Finkelhor, 1986; Courtois, 1988; Herman, 1981; Tsai & Wagner, 1978). Finkelhor and Browne (1985) theorize that the deleterious effects of CSA are the result of traumagenic factors that were manifested within the abusive relationship. These include traumatic sexualization, betrayal, powerlessness, and stigmatization. Other researchers attribute the negative effects of CSA to cognitive distortions (Celano, 1992; Gold, 1986; Harter, Alexander, & Neimeyer, 1988; Jehu, 1988), psychological defenses (Blake-White & Kline, 1985; Courtois, 1988; Summit, 1983), learning history (Jehu, 1988), altered or truncated development (Alexander, 1992a; Meiselman 1978), factors in the family environment (Alexander, 1985; Conte & Schuerman, 1987; Edwards & Alexander, 1992; Madonna, Van Scoyk, & Jones, 1991), emotional abuse integral to the sexual abuse (Briere, 1992a), and socio-cultural factors (Brickman, 1984; Finkelhor, 1984, Yassen & Glass, 1984).

For the purpose of a brief review of the research literature addressing the sequelae of incest and other CSA, we will consider the following categories of problems, symptoms, and characteristics: emotional and cognitive effects, social and interpersonal functioning, physical and sexual functioning, compulsive behaviors and behaviors of excess, and psychiatric diagnoses.

EMOTIONAL AND COGNITIVE EFFECTS

Anxiety and Tension

Various features of anxiety, such as tension, hyper-alertness, fears and worries, a sense of powerlessness in the face of perceived or impending danger, and related autonomic arousal, seem to be connected with early sexual abuse experiences (Briere, 1989). In both clinical and nonclinical samples, women reporting CSA, as compared to those reporting none, have been found to have greater levels of anxiety or tension (Briere & Runtz, 1988a, 1988b; Bryer, Nelson, Miller, & Krol, 1987; Bushnell, Wells, & Oakley-Browne, 1992; Courtois, 1988; Gelinas, 1983; Lundberg-Love, Marmion, Ford, Geffner, & Peacock, 1992; Murphy et al., 1988; Sedney & Brooks, 1984; Stein et al., 1988). Studies have also found that abuse survivors experience higher levels of other emotions that may be linked to anxiety, including anger control problems (Briere & Runtz, 1988b; Murphy et al., 1988), mania (Bushnell et al., 1992), fear of being alone (Stein et al., 1988), sleep disturbances (Sedney & Brooks, 1984), flashbacks and nightmares (Donaldson & Gardner, 1985), and recurrent thoughts and images related to abuse (Gelinas, 1983). Victims of parental incest, those abused for a longer duration, and those abused by an older offender tend to report the greatest levels of anxiety (Briere & Runtz, 1988a).

Depression

Depression is a frequently noted, often chronic symptom that may be evidenced in suicidal or self-destructive behaviors (Courtois, 1988). Studies assessing depressive symptomatology in nonclinical samples suggest that women sexually abused as children experience greater levels of depression and other mood disturbances than do

nonabused subjects (Briere & Runtz, 1988a; Bushnell et al., 1992; Gold, 1986; Lundberg-Love et al., 1992; Sedney & Brooks, 1984; Stein et al., 1988). Studies that involve clinical samples also note elevated levels of depression in women sexually abused as children (Bryer et al., 1987; Jackson, Calhoun, Amick, Maddever, & Habif, 1990; Jehu, 1988; Kinzl & Biebl, 1991). Browne and Finkelhor (1986), however, note that such findings are inconsistent, especially in studies involving clinical comparison samples (e.g., Herman, 1981; Meiselman, 1978). This inconsistency may be explained by the fact that clinical subjects, in general, are likely to experience high levels of depression (Lehman, 1985; Millon & Kotik, 1985). For incest survivors, depressive symptoms may be related to powerlessness (Finkelhor & Browne, 1985), to negative thoughts and beliefs (Jehu, 1988), or to grief resulting from a loss of normalcy or safety (Courtois & Watts, 1982; Hays, 1985).

Guilt and Shame

Descriptions of incest survivors consistently note that they report feeling guilt and shame regarding their abuse experiences (Browne & Finkelhor, 1986; Courtois, 1988; Tsai & Wagner, 1978). Guilt and shame may be mediated by internal attributions of responsibility that lead to self-blame (Celano, 1992). Jehu's (1988) assessment of women presenting for treatment for CSA indicated that 88% felt guilty about the abuse. Several prevalent beliefs were associated with guilt: distorted beliefs about compliance with the perpetrator, participation in the maintenance of secrecy, seductive behaviors, curiosity about sex, experience of physical and emotional pleasure in the abusive situation, and material rewards gained through the abuse. Similar results, also with clinical samples, are reported by Kinzl and Biebl (1991). Stein et al. (1988), using a nonclinical sample, likewise note that abused women, as compared to nonabused women, reported significantly higher levels of guilt and shame.

Low Self-Esteem/
Distorted Self-Perceptions

Descriptions of CSA survivors indicate that they tend to experience low or unstable self-esteem (Browne & Finkelhor, 1986; Courtois,

1988; Gold, 1986; Herman, 1981; Jackson et al., 1990; Jehu, 1988; Kinzl & Biebl, 1991; Tsai & Wagner, 1978; Van Buskirk & Cole, 1983). Adult survivors frequently describe themselves as "different" from other people (Harter et al., 1988; Jehu, 1988) or as feeling stigmatized by their early experiences (Browne & Finkelhor, 1986). Low self-esteem may also relate to reported distortions in body image (Jackson et al., 1990; Sullivan, 1988).

Low self-esteem and negative self-evaluation may be induced or exacerbated by the victim's assumptions of guilt and responsibility (Briere, 1989). Gold (1986) reports that women in a nonclinical sample who were sexually abused in childhood and who displayed both psychological distress and low self-esteem characteristically made stable internal and global attributions regarding negative events. It is not clear whether the abuse alone causes negative self-perceptions or this type of attributional style, or whether it serves to intensify them.

SOCIAL AND INTERPERSONAL FUNCTIONING

Interpersonal Difficulties

Women with a CSA history may also have difficulties with interpersonal relationships and social adjustment, and they may report heightened interpersonal sensitivity (Alter-Reid, Gibbs, Lachenmeyer, Sigal, & Masseth, 1986; Browne & Finkelhor, 1986; Harter et al., 1988; Murphy et al., 1988; Van Buskirk & Cole, 1983). Jehu (1988) organizes various interpersonal problems into four common themes: isolation, insecurity, discord, and inadequacy.

Increased social isolation (or perception of social isolation) is an effect discussed both in descriptions of CSA victims and in comparisons of abused with nonabused subjects (Briere & Runtz, 1988b; Harter et al., 1988; Jehu, 1988; Tsai & Wagner, 1978). Insecurity may stem from experiences of betrayal and powerlessness that result in fear or mistrust in relationships (Briere, 1989, 1992b; Browne & Finkelhor, 1986; Gelinas, 1983; Herman, 1981; Jehu, 1988; Tsai & Wagner, 1978). Jehu (1988) determined that 88% of his clinical sample reported feeling insecure in relationships. Adult abuse survivors also report a high rate of discord or disruption in intimate relationships. In Jehu's

(1988) clinical sample, every subject in a committed relationship reported that it was troubled. High levels of marital problems have also been reported by Herman (1981) and Meiselman (1978). Partnership discord may be related to issues such as mistrust or betrayal (Courtois, 1988), to abuse survivors' tendency to be adversarial and manipulative in relationships (Briere, 1989), to insecure attachments (Alexander, 1992), and to the presence of sexual dysfunctions (Briere, 1989, 1992a). Finally, social difficulties may derive from inadequacy in social skills, particularly a lack of assertion (Jehu, 1988; Tsai & Wagner, 1978; Van Buskirk & Cole, 1983).

Although many types of social functioning problems are reported, few have been the subject of controlled, nonclinical studies. One exception (Harter et al., 1988) found in a college student sample that abused students had lower ratings than nonabused students on social adjustment measures, but did not report evidence of generalized social fragmentation in their lives.

Revictimization

Numerous studies note that CSA victims are vulnerable to subsequent victimizations including rape, physical assault, domestic violence, and emotional abuse (Briere & Runtz, 1986; Browne & Finkelhor, 1986; Goodwin, Cheeves, & Connell, 1990; Jackson et al., 1990; Miller, Moeller, Kaufman, DiVasto, Pathak, & Christy, 1978; Wyatt, Guthrie, & Notgrass, 1992). Wyatt et al. (1992) observe that there is considerable variation in the methodologies involved in these studies and that few studies have examined the differential effects of type of abuse, age of first abuse, or type of revictimization.

In a study that did address differential effects, Wyatt et al. (1992) found that women sexually abused in childhood are 2.4 times more likely to be revictimized than nonabused women. Women with two or more childhood victimizations reported the highest rate of unwanted pregnancies and a higher rate of sexual involvements. Briere and Runtz (1986) found similar rates of adult rapes in their sample and a significantly higher incidence of battery in adult relationships.

Several studies suggest that incestuous abuse may have a more profound effect on revictimization than nonincestuous abuse. Miller