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EFFICACY OF A GROUP THERAPY FOR SEXUALLY ABUSED ADOLESCENT GIRLS

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Abstract

Objective: The effects of a group therapy for teenage girls reporting sexual child abuse were evaluated by means of a pre-test/post-test design with a control group.

Method: A total of 27 teenage girls participated in the group therapy sessions and were compared to a group of 15 sexually abused girls not receiving therapeutic services. Participants completed a host of measures evaluating post-traumatic stress symptoms, behavior problems, coping strategies, empowerment, quality of the parent/teenager relationship and attributions following the abuse. The psycho-educational intervention consisted of an average of 20 weekly two-hour meetings.

Results: Results indicated that girls participating in the therapy sessions showed greater gains compared to control girls. Repeated ANOVAS revealed significant gains in terms of post-traumatic stress symptoms, internalizing and externalizing behavior problems, coping strategies, relationship with the mother and empowerment.

Conclusion: The findings suggest that the group therapy offered by the CIASF for teenagers reporting sexual abuse was effective in reducing a number of symptoms.

Keywords : Sexual abuse, adolescents, group therapy.

EFFICACY OF A GROUP THERAPY FOR SEXUALLY ABUSED ADOLESCENT GIRLS

Introduction

Child sexual abuse represents an important social problem. A recent study with a representative sample of 1000 Quebec adults shows that close to 1 out of 10 males and 1 out of 5 females declares having experienced sexual abuse before reaching the age of 18 (Tourigny et al., in preparation). Since the coming into force of the Child and Youth Protection Law in 1979 and until the beginning of the 1990s, Youth Protection Centers have been confronted by a considerable rise in the number of children taken under their responsibility for sexual abuse (Tourigny, 1991). In the last ten years, the number of children taken under their responsibility seem to be on the decrease while not necessarily representing a real decline in the number of sexually abused children (Wright et al., 2000). Estimates suggest that about 1 child from Quebec (0-17 years old) out of 1000 is sexually abused and reported to Youth Protection Centers, representing close to 1500 children each year (Tourigny et al., 2002). Adolescents (13-17 years old) are an important proportion of the reported cases, representing close to 40% of children (0-17 years old) for which allegations of sexual abuse were confirmed (Tourigny et al., 2003). Moreover, a recent study suggest that 30% of adolescents females taken in charge under different paragraphs (neglect, physical abuse, behavior problems) of the Youth Protection Law report having experienced sexual abuse (Pauzé et al., 2000). In this context, the development of specialized services that can respond to the needs of these adolescents reporting sexual abuse, becomes an important challenge.

Empirical data provides evidence that sexual abuse is associated with devastating effects. Victims of child sexual abuse suffer several consequences at a physical, cognitive and socio-affective level (Kendall-Tackett et al., 1993). Several studies have investigated associated

outcomes in teenagers disclosing sexual abuse and have reported a variety of negative correlates in a number of areas of functioning. Indeed, specific disorders such as depression, anxiety, post-traumatic stress, dissociation, low self-esteem, somatic problems, behavioral problems such as self-destructive, delinquency, substance abuse, sexual promiscuity, prostitution, as well as aggressivity and relational problems have been noted in adolescents victims of child sexual abuse (Beitchman et al., 1991; Forbey et al., 2000; Green et al., 1999; Grilo et al., 1999; Kendall-Tackett et al., 1993; Mennen & Meadow, 1993; Silverman et al., 1996).

Although the adolescence of sexually abused children seems to be more particularly characterized by the presence of self-destructive and delinquency behaviours, some adolescents demonstrate few or no symptoms (Kendall-Tackett et al., 1993). In their review of the literature, Kendall-Tackett et al. (1993) underline that a number of constellation of symptoms exists but that nearly 30% of victims display no clinical symptoms. The data suggest, however, that those children who are asymptomatic at the first evaluation are the most susceptible to develop symptoms subsequently (Putnam, 2003). In addition, several studies suggest that some symptoms can present complex trajectories and may persist during several years well into adolescence and even into adulthood (Briere & Elliott, 1994; Dembo et al., 1992; Rorty & Yager, 1996; van der Kolk et al., 1991) hence, the necessity of implementing efficient early interventions in order to counter such sequels.

Research development on the consequences of child sexual abuse and the questioning of so called “traditional” approaches of intervention have paved the way to the development of innovative approaches in the area of the treatment of sexually abused children, presenting a variety of objectives, program content and therapeutic modalities (Glaser, 1991; Keller et al., 1989; Marois et al., 1982; Putnam, 2003). Group therapy represents one of the therapeutic modalities particularly popular and frequently used (Kruczek & Vitanza, 1999; Tourigny, 1997).

Kruczek and Vitanza (1999) underscore that in the actual social context where demands for services are high and resources limited, group therapy presents important economic advantages relative to other forms of therapy. Furthermore, group intervention is particularly recommended in order to reduce social withdrawal and stigmatization so often suffered by victims of sexual abuse (Friedrich, 1997; Glasser & Frosh, 1988; Silovsky & Hambree-Kigin, 1994). Finally, group intervention may prove to be particularly suitable for adolescents who are at the stage of development where the presence of peers is very important and valuable (Kruczek & Vitanza, 1999).

Despite the proliferation of programs and the widespread use of group intervention, few evaluative studies have been conducted in this area (Finkelhor & Berliner, 1995; Putman, 2003 : Saunders, Berliner, & Hanson, 2003; Tourigny, 1997). The review of evaluative studies on the efficacy of group interventions offered to children and adolescent victims of sexual abuse generally conclude that group intervention seem to be a promising mode of intervention while highlighting that several methodological limits render difficult definitive conclusions (Darveau-Fournier et al., 1993; Finkelhor & Berliner, 1995; Saunders et al., 2003; Tourigny, 1997). The major limits identified refer to: 1) small sample sizes; 2) use of non-standardized measures or measures not covering a sufficient spectrum of symptoms or not sufficiently specific to sexual abuse; 3) use of designs not permitting the attribution of observed changes to various modalities of the treatment; 4) the amount of participation to group meetings that is rarely mentioned; and, 5) to the fact that in the majority of studies, the effects of group intervention are not distinguished in regards to the different age groups targeted by the therapy, the majority of studies confounding results concerning the effects of treatment for children (6-12 years old) to that of adolescents (13-17 years old).

Studies that have specifically considered the effects of group interventions for adolescents victims are thus few in numbers. We have identified nine such studies (Ashby et al., 1987; Baker, 1987; Kruczek & Vitanza, 1999; Larzelere et al., 1995; Lindon & Nourse, 1994; Mackey et al., 1987; Picard, 1991; Sinclair et al., 1995; Verleur et al., 1986). In general, these studies present some positive effects (namely statistically significant) linked to group therapy concerning the following aspects: 1) behavioral problems (McGain & McKinzey, 1995; Sinclair et al., 1995), 2) self-esteem (Ashby et al., 1987; Baker, 1987; Kruczek & Vitanza, 1999; Sinclair et al., 1995; Verleur et al., 1986), 3) depression (Baker, 1987; Sinclair et al., 1995), 4) anxiety (Baker, 1987), 5) post-traumatic stress (Sinclair et al., 1995), 6) symptoms linked to sexuality (Verleur et al., 1986), and 7) positive coping strategies (Kruczek & Vitanza, 1999). The results of these studies show however that not all group therapies are effective, and that not all adolescent girls can take advantage from this type of therapy since some studies were unable to identify significant statistical effects for some variables and two studies report negative results for a minor proportion of adolescent girls (Ashby et al., 1987; Verleur et al., 1986).

The present study evaluates the effectiveness of a closed intervention group for adolescent girls¹ who have experienced sexual abuse. The study attempts to consider some of the methodological limits identified by: 1) including a comparison group, 2) relying on a large spectrum of measures of which some are specific to sexual abuse, 3) using a number of participants higher than the majority of past studies, and 4) documenting the level of participation of teenagers to therapeutic sessions.

Method

¹ The group intervention is also designed for male adolescents although in fact, few adolescent males participated. In the context of the present study, only one adolescent has participated in a

Design

The study used a quasi-experimental design with two waves of measurement (pre-test and post-test). The experimental group consists of 27 teenage girls who have participated in a closed therapy group and received weekly two-hour sessions for 20 weeks. The control group consists of 15 adolescent girls who have requested services from the center but did not receive treatment for the following reasons: the teenagers finally decided not to participate in the group intervention, has abandoned treatment in the first few weeks or the practitioners evaluated that the group therapy format was not suitable for them (for instance because of excessive timidity or of difficulties expressing emotions in a group setting).

Participants

All participants were recruited between September 1999 and May 2000 following a request for services at the Intervention Center for Sexual Abuse and the Family (*Centre d'Intervention en Abus Sexuels pour la Famille* - CIASF). In this first contact, the practitioner gave details about the study and solicited their participation. For participants younger than 14 years of age, the teenager's consent and that of her parents were requested. Only 4.5% of the 44 adolescents solicited refused, the 42 other participants signed a written consent form. The interviews lasted about 90 minutes and were performed by a trained research assistant at the Center or at the participant's home.

All adolescents are French Canadian except for one teenager of Russian ethnic background. Mean age of the participants was 14.6 years at pre-test evaluation. One out of three teenagers (33%) was living in a foster family or in a foster care center while 31% were living with both parents and 26% with their mother only.

group. For this reason, we will refer to group intervention involving females knowing that it also includes adolescent males.

Abuse-related variables indicated that the sexual abuse experiences were severe and characterized by penetration (oral, anal or vaginal) in 62% of the cases, frequent (at least once a week) for 69% of the cases and involved used of physical force in 31% of the cases. A total of 15% of the teenagers were abused by more than one perpetrator and 13% were also victims of physical abuse. Regarding the identity of the perpetrator, all were known to the victim except for one (97%), the perpetrator was an adult in 82% of the cases, 39% were members of the immediate family and 36% were members of the extended family. With the exception of the proportion of teenagers experiencing a sexual abuse episode involving penetration (for which the percentage is higher in the control group than in the experimental group ($\chi^2 = 4.39$, $df = 1$, $p < 0.05$)), the two groups did not present any statistically significant differences regarding socio-demographic characteristics or other abuse-related variables (see Table 1).

Insert Table 1

Measures

Socio-demographic characteristics and abuse-related variables

All questionnaires were completed by the teenagers except for the **Sexual Abuse Rating Scale** (*SARS* – Friedrich, 1992) which was completed by the CIASF practitioner. The two following questionnaires were administered only at pre-test evaluation. First a **socio-demographic questionnaire** evaluating the family composition (number of siblings, number of siblings living with her, rank in the family), the teenagers' and parents' education level, the teenagers' age and living arrangements (living with mother, father, foster family, foster care, etc.) was completed by the teenager. The French version of the *SARS* (Friedrich, 1992) consists of 21 yes/no items and three items coded in number of months that describes abuse-related variables (severity, frequency, identity of the perpetrator, age at first episode, etc.).

Outcome measures

The French version (Sabourin & Wright, 1996) of the **Trauma Symptoms Checklist for Children** (*TSC-C*; Briere, 1996) is used with youths aged from 8 to 17 years and evaluates different post-traumatic stress outcomes following trauma. The TSC-C produces six clinical subscales scores and measures the teenager's level of anxiety, depression, post-traumatic stress (PTSD), sexual concerns, dissociation and anger. In addition the TSC-C includes two validity scales; one evaluating the tendency to deny symptoms and a fake bad scale (tendency to show more symptoms than the norms). Cutoff scores are provided to identify invalid profiles on the two validity scales as well as clinical scores on the symptom scales. Internal reliabilities are adequate (ranging from .77 to .89) (Briere, 1996) and convergent and discriminant validity indices are reported to be satisfactory (Briere, 1996). Higher scores indicate a greater frequency of symptoms.

The **Youth Self-Report and Profile** (*YSRP* - Achenbach, 1991) is the adolescent (11 to 18 years) version of the Child Behavior Checklist (*CBCL*) and evaluates the teenager's perception of behaviors problems such as withdrawal, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behavior and aggressive behavior. The YSRP consists of 112 items evaluated on a 3-point scale the frequency of the behavior in the last six months. Two dimensions regroup Internalizing behavior problems and Externalizing behavior problems. Stability coefficients vary from .67 to .91 for a delay of one week for the different subscales. A higher score reflects greater behavior problems.

A French brief version of the **Ways of Coping Questionnaire** (Bouchard et al., 1995; Folkam & Lazarus, 1988; Knussen et al., 1992) evaluates the coping strategies of adolescents and adults. The scale consists of 21 items measuring the frequency of a given strategy (never used, sometimes used, often used, always used). Scores are regrouped into three coping subscales:

seeking social support, planful problem solving and escape-avoidance. A higher score reflects a greater frequency of use of the given coping strategy.

A 23-items scale of **Empowerment** was also used (Rogers et al., 1997; Wowra & McCarter, 1999). This instrument consists of five dimensions: control, optimism, self-efficacy, helplessness and justified anger. In the present study, the four latter dimensions are used. For each item, the teenager responds whether she agrees or not with the statement on a 4-point Likert scale. A higher score is associated with a higher sense of empowerment. This scale has been validated with an adult population. The global score demonstrates high reliability (.85) while subscales scores show alpha coefficients ranging from .55 to .91 (Wowra, 1999).

The French version (Daignault et al., 1998) of the **Children's Attributions and Perception Scale** (CAPS, Mannarino et al., 1994) has been elaborated to evaluate attributions and perceptions following sexual abuse. The questionnaire consists of 18 items evaluated on a 5-point frequency Likert scale ranging from never to always. The measure provides a global score as well as four subscale scores: Feeling different from peers, Interpersonal trust, Personal attributions for negative events and Perceived credibility. For the global score, higher scores indicates that the teenager present negative attributions and perceptions. The internal consistencies of the subcales vary from .64 and .73 and the test-retest stability indexes vary from .60 and .82.

Self-harming behaviors specific to the adolescence period were evaluated by the **Self-Injurious Behaviors Questionnaire** (Sadowsky, 1995; unpublished manuscript). The scale measures the presence of 21 self-harming behaviors in the last three months, such as the self-harm behaviors (cutting veins, burning skin, pulling out hair, etc.), suicidal behaviors (taking poisonous substances, suffocating, etc.), eating-related disorders (refuse to eat and bingeing, self-

induced vomiting, etc.), and dangerous behaviors that can provoke injuries. A total score of self-harming behaviors is used in the present study.

The **Child's Attitude toward the Mother (CAM)** et le **Child's Attitude toward the Father (CAF)** evaluates the teenager's perception of the quality of her relationship with each of her parents. The scale consists of 25 items and the total score can evaluate the presence or absence of conflicts in the teenagers/parents relationship. A score between 30 and 69 reveals the presence of a problematic relationship in the clinical range with the parent while a score greater than 70 indicates the teenager is sustaining severe stress and that it is likely he/she might or is thinking of using violence to face the problems (Giuli & Hudson, 1977). Guili and Hudson (1977) report internal consistencies of 0.94 and 0.95 and stability of 0.89 and 0.96 for a one-week interval and a good factorial validity and adequate discriminant validity.

Independent variable - The group intervention

The CIASF is a community agency located in the Outaouais region of the province of Quebec. The Center has been offering group treatment for adolescents disclosing sexual abuse since 1993. The closed-group treatment evaluated in the present study has been offered since September 1999. A closed group does not accept new participants once the intervention has started. The services are offered to teenagers (13 to 17 years of age) whom have disclosed intra-familial or extra-familial sexual abuse. Participants may have been oriented to the CIASF by different agencies such as the Child Protection and Welfare Agency of the region or other community groups designed to offer counseling services to victims of sexual abuse.

The group intervention involves six to eight participants. The intervention comprises about 20 weekly meetings each lasting two hours. The psychoeducational approach used involves different therapeutic activities such as group discussions, personal testimonies and stories,

individual and collective exercises and lectures. Each session has a similar format and centers on a specific theme.

The main topics discussed relate to the disclosure of the abuse, the cycle of the abuse, the consequences of the abuse, the relationship to the perpetrator, different issues related to sexuality, the prevention of revictimization and, intimate and romantic relationships. The weekly sessions are lead by two practitioners (generally one woman and one man) supervised if needed by the director of the Center. While specific group dynamics are taken into account, the homogeneity of the interventions is insured by means of a treatment manual (Please contact the first author for information regarding the treatment manual).

The objectives of the intervention are : a) to reduce the negative and traumatic consequences of the sexual abuse (anxiety, depression, low self-esteem, behavior problems, difficulties linked to sexuality, agressivity, post-traumatic stress, academic and school-related difficulties) to insure survivors may attain normal development; b) to reduce social isolation by enabling exchanges and supportive relationships with other teenagers also victims of sexual abuse; c) to reduce shame and culpability from the sexual abuse and d) to help teenagers to rely and use their personal resources and develop skills to manage the repercussions of the sexual abuse.

In the present study, the 30 teenagers were distributed into four different intervention groups. Three adolescents (10%) have abandoned treatment. Excluding those abandoning treatment, the level of participation to the weekly meetings varied from 64 to 100%. On the average adolescents participated to 90% of the proposed meetings, representing a mean of 17.3 meetings.

Results

First a series of two-tailed t-test analyses were performed to evaluate the equivalence of the two groups at pre-test on the outcomes measures presented in Table 2. Results showed that, with the exception of five variables, both groups presented similar profiles. The differences found were associated with scores for eating-related disorders, attributions linked to interpersonal trust, empowerment and two coping strategies (seeking social support and planful problem solving). In all cases, differences revealed that teenagers in the control group showed greater difficulties compared to adolescents in the experimental group.

Repeated analyses of variance were computed to explore whether teenagers in the experimental group showed significant gains over time relative to participants in the control group. Results displayed in Table 2 indicate that the teenagers participating in the group intervention showed greater improvement relative to the control group teenagers for several variables. Participation in the group intervention is associated with a significant reduction of post-traumatic stress symptoms for all subscales of the TSC-C except for sexual preoccupations which did not show a greater change in the experimental group relative to the control group. A reduction of negative attributions is evident especially regarding the interpersonal trust and responsibility subscales. The teenager's perception of the quality of mother/teenager relationship also showed greater improvements for the group receiving therapy. Similar results are found for coping strategies as adolescents involved in therapy rely more on seeking social support and planful problem solving strategies. No significant differences are found for the frequency of use of avoidant strategies.

The results also show that the global score of the empowerment scale increased significantly for those teenagers participating in therapy, even though no significant gains are evident on the subscales scores. Regarding behavior problems, adolescents involved in treatment reported significantly less behavior problems relative to control group teenagers. The reduction in

behavior problems is evident for the attention problems and social problems subscales of the Externalizing type problems and are noted for the social withdrawal and anxiety subscales of the Internalizing type problems. Finally no significant difference are found between the experimental and control group regarding eating-related disorders, self-harming behaviors, delinquent behaviors and the adolescent/father relationship at the end of the treatment.

Insert Table 2

Discussion

Level of implementation of the group intervention

Before undertaking the question of the effects of the group intervention, it is important to point out the observed level of participation to the proposed treatment. Only 10% of adolescent girls have abandoned treatment during the course of the intervention and adolescent girls participated in 90% of their group sessions. These results indicate a high level of treatment implementation and clearly demonstrate that adolescent girls have indeed received the intended treatment, an aspect that is rarely demonstrated in evaluative studies in the area. Several authors have previously identified the inherent difficulties of implementing services offered to sexually abused children and taken under the responsibility of the Youth Protection Services and this, in Canada (David, 1987; Messier, 1986; Messier & De Champlain, 1984; Picard, 1991; Vancouver Incest and Sexual Abuse Center, 1989) as well as in the United-States or in Europe (Ashby et al., 1987; Bander et al., 1982; Bentovim et al., 1988; Carozza & Heirsteiner, 1982; Friedrich et al., 1992; Gomes-Schwartz et al., 1990; Oates et al., 1994). Depending on the modalities of the therapy, the percentage of participation to therapeutic meetings can vary from 0% to 100%, the majority being inferior to 80%. In a review of studies on the effectiveness of interventions for sexually abused children, Tourigny (1997) underscores that one of the most important factors

explaining the difficulty of detecting positive effects linked to treatment is the possibility that an important proportion of the clientele does not in fact receive or receive only a part of the scheduled treatment. Tourigny (1997) reports that the majority of the reviewed studies ($n = 42$) do not report on the proportion of dropout nor the proportion of participation to treatments for children and adolescents. In the specific case of evaluations of group therapy, only four studies out of 21 indicate the level of participation to the group therapy or the proportion of dropout in the course of treatment. For these studies, the proportion of dropout varies from 14% to 28% (Carozza & Heirsteiner, 1983; Hack, Osachuk, & De Luca, 1994; Picard, 1991; Ashby et al., 1987). Not only does the description of the level of participation of adolescent girls to the treatment facilitates the demonstration that the treatment has effectively been well implemented but this description can also represent a pertinent indicator of the treatment's capacity to respond to the needs of adolescent girls.

Effects of the group intervention

Results show significant improvements in the group of adolescent girls that participated in the group intervention mainly at the level of post-traumatic stress symptoms, attributions, coping strategies, internalizing and externalizing behavioral problems, and feelings of empowerment. The majority of these aspects are directly treated during the course of the group intervention. For example, one of the workshops focuses specifically on the question of "intrusive thoughts or flashbacks", and how to manage them. Several workshops discuss the attributions following the sexual abuse often seen in survivors in concrete ways through exercises on the understanding of the cycles of sexual abuse which helps participants overcome the guilt and to place back to the aggressors the responsibility for the sexual abuse. Three meetings specifically focus on the identification of personal consequences of sexual abuse in adolescent girls and the identification

of adequate means to face such consequences (positive coping strategies). The group intervention appears to increase the use of seeking social support coping strategies and the use of reevaluation or problem-solving. These 'approach' strategies are generally associated to more positive outcomes than escape-avoidance coping strategies. The generalization of these approach coping strategies by the teenagers may help them to better manage other stressful events faced in other life contexts.

Significant gains are also noted regarding the adolescent's perception of her relationship with her mother while no change is observed regarding the relationship with the father. A detailed examination of the scores on the two scales shows that at pre-test, adolescent girls participating in the group intervention present a mean score of 43 which corresponds to the presence of a clinically problematic relationship with the mother which is not the case for the adolescent girls from the control group (Giuli & Hudson, 1977). These girls seem therefore to present particular difficulties in their relationship with their mother that may be linked at least in part to the fact that adolescent girls could bear resentment and negative feelings towards their mother for not having protected them from the aggressor. Furthermore, examination of the results concerning the relationship with the father shows that adolescent girls from both groups do not seem to perceive their relationship with their father as conflictual, the mean score at pre-test being under the threshold indicating the presence of clinically problematic relationships (less than 30). Although in the majority of cases, the father is not the sexual aggressor, it seems that the adolescent girls from the treatment group present more conflicts with their mother than with their father.

Some aspects of the lives of adolescent girls do not seem, however, to change following the therapy. For example, we do not note any significant decline in the eating-related behavior problems, self-destructive behaviors or delinquent behaviors. These results might be linked to a

low frequency of these behaviors at the beginning of therapy. On average, adolescent girls from the two groups present very few eating or delinquent behavior problems (table 2). In the case of self-destructive behaviors, a mean reduction of close to three behaviors in the adolescent treatment group is however noted while this difference does not reach significance level.

Limitations and Clinical Implications

This study suggests that group intervention might be an efficient intervention modality in helping in the reduction of the consequences of sexual abuse and enhances the psychological health of adolescent girls that have been sexually abused. In the present study, the use of a comparison group, reliance on a variety of measures directly linked to consequences of sexual abuse, an acceptable number of participants, and the documentation of the level of participation of adolescent girls to group intervention represents methodological strengths.

However, certain methodological limits remain. The use of a quasi experimental design, although representing a clear advantage comparing to the pre and post treatment design frequently used in the evaluation of group intervention, is still a design that present some threats to internal validity. Though adolescent girls from both groups do not distinguishes themselves in terms of their psychological status at pre-test, it is possible that adolescent girls from the treatment group present some characteristics that could explain, in part or in totality, the changes observed following group intervention. For instance, it is possible that individual factors such as the motivation of participating in the group therapy, or a more active participation in services outside the CIASF may partially explain the noted gains. A second limit concerns the fact that all the measures used in this study are self-administered. The use of several sources of data (parents, teacher, other significant adult) could eventually give a more complete and valid portrayal of possible outcomes following therapy.

Our study therefore confirms what several studies have showed, that group therapy can attenuate a number of symptoms associated to sexual abuse (see reviews of Finkelhor & Berliner (1995) and Tourigny (1997)). For example, from rigorous scientific designs (quasi experimental or experimental), Baker (1985), Burke (1988), McGain & McKinzey (1995), Perez (1988) and Verleur et al. (1986) have stated statistical significant differences linked to the efficiency of group therapy. However, several challenges remain and subsequent evaluative studies should attempt to further explore: 1) if the effects of treatment are maintained over time; 2) what are the characteristics of the intervention that are linked to a greater effectiveness of the treatment; 3) who are the children/adolescent girls that can benefit most from the intervention; 4) what are the characteristics of the children/adolescent girls that abandon treatment. Answers to these questions should help us better understand the needs of the children/adolescent girls that have been sexually abused and thus enhance therapeutic services offered to this clientele. This in turn, would help ensure that survivors of child sexual abuse engage on a pathway leading to optimal development.

References

- Achenbach, T. M. (1991). Manual for the Youth Self-Report and 1991 Profile. Burlington, VT: University of Vermont Department of Psychiatry.
- Ashby, M. R., Gilchrist, L. D., & Miramontez A. (1987). A group treatment for sexually abused American Indian adolescents. Social Work with Groups, *10* (4), 21-32.
- Baker, C. R. (1987). A comparison of individual and group therapy as treatment of sexually abused adolescent females". Dissertation Abstracts International, *47* (10-B), 4319-4320.
- Bander, K. W., Fein, E., & Bishop, G. (1986). Évaluation des programmes contre l'exploitation sexuelle des enfants. In Sgroi, S. M. (Ed.) L'agression sexuelle et l'enfant: Approche et thérapies, (pp. 377-410). St-Laurent (Qué.): Éditions du Trécarré.
- Bédard, C., & Berteau, G. (1995a). Controverse actuelle sur l'intervention de groupe auprès des enfants abusés sexuellement: Un regard positif. Intervention, *101*, 18-25.
- Bédard, C., & Berteau, G. (1995b). Intervention de groupe auprès des enfants abusés sexuellement: Mises en garde et lignes directrices pour la pratique. Intervention, *101*, 26-33.
- Beitcham, J. H., Zucker, K. J., Hood, J. E., DaCosta, G. A., & Akman, D. (1991). A review of the short-term effects of child sexual abuse. Child Abuse & Neglect, *15* (4), 537-556.
- Bentovim, A., van Elburg, A., & Boston, P. (1988). The results of treatment. In Bentovim, A., Elton, A., Hilderbrand, J. Tranter, M., & Vizard, E. (Eds.). Child sexual abuse within the family: Assessment and treatment, (pp. 252-268). Londres: Wright.
- Beutler, L. E. (1993). Designing outcome studies: treatment of adult victims of childhood sexual abuse. Journal of Interpersonal Violence, *8* (3), 402-414.

Bouchard, G., Sabourin, S., Lussier, Y., Richer, C., & Wright, J. (1995). Nature des stratégies d'adaptation au sein des relations conjugales: présentation d'une version abrégée du Ways of Coping Questionnaire. Revue canadienne des sciences du comportement, 27 (3), 371-377.

Briere, J. (1996). Trauma Symptom Checklist for Children (TSCC): Professional Manual. Odessa: Psychological Resources, Inc.

Briere, J. N., & Elliott, D. M. (1994). Immediate and long-term impacts of child sexual abuse. The Future of Children, 4, 54-69.

Carozza, P. M., & Heirsteiner, C. L. (1983). Young female incest victims in treatment: Stages of growth seen with a group art therapy model. Clinical Social Work Journal, 10 (3), 165-175.

Conte, J. R. (1986). Sexual abuse and the family: A critical analysis. Journal of Psychotherapy and the Family, 2 (2), 113-126.

Daigneault, I., Tourigny, M., & Cyr, M. (1999). Rapport d'évaluation de l'implantation et de l'efficacité d'une thérapie de groupe pour adolescentes victimes d'agressions sexuelles et d'une intervention post-dévoilement. Montréal: Institut de recherche pour le développement social des jeunes.

Darveau-Fournier, L., Lindsay, J., Tessier, L., & Beaudoin, G. (1993). Abus sexuels envers les enfants: intervention de groupe et évaluation. Ste-Foy: Université Laval, École de service social.

David, G. (1987). Nécessité et efficacité d'une approche intégrée dans le traitement de l'inceste. Service Social, 36 (2/3), 350-368.

Dembo, R., Williams, L., Schmeidler, J., Berry, E., Wothke, W., Getreu, A., Wish, E. D., & Christensen, C. (1992). A structural model examining the relationship between physical child abuse, sexual victimization, and marijuana/hashish use in delinquent youth: A longitudinal study. Violence and Victims, 7, 41-61.

Elie, C., & Hould, R. (1992). Relation parents-adolescent(e)s: impact de l'âge et du sexe. Revue québécoise de psychologie, 13 (2), 51-65.

Finkelhor, D. (1986). Sexual abuse: Beyond the family systems approach. Journal of Psychotherapy and the Family, 2 (2), 53-65.

Finkelhor, D., & Berliner, L. (1995). Research on the treatment of sexually abused children: A review and recommendations. Journal of the American Academy of Child and Adolescent Psychiatry, 34 (11), 1408-1423.

Folkman, S., & Lazarus, R. S. (1988). Ways of Coping Questionnaire: Research edition. Palo Alto, CA: Consulting Psychologists Press.

Forbey, J. D., Ben-Porath, Y. S., & Davis, D. L. (2000). A comparison of sexually abused and non-sexually abused adolescents in a clinical treatment facility using the MMPI-A. Child Abuse & Neglect, 24, 557-568.

Frenken, J., & Van Stolk, B. (1990). Incest victims: Inadequate help by professionals. Child Abuse & Neglect, 14 (2), 253-263.

Friedrich, W. N. (1992). Self-Destruction Behaviors Inventory. Document inédit. Rochester: Department of Pedopsychiatry, Clinique Mayo.

Friedrich, W. (1997). Psychotherapy with sexually abused boys. In Wolfe, D. A., McMahon, R. J., & Peters, R. D. (Eds). Child abuse, new directions in prevention and treatment

across lifespan. Banff International Behavioral Science Series. Thousand Oaks, CA: Sage Publications.

Friedrich, W. N., Luecke, W. J., Beilke R. L., & Place, V. (1992). Psychotherapy outcome of sexually abused boys: An agency study. Journal of Interpersonal Violence, 7 (3), 396-409.

Giard, M., Paiement, H., Paquet-Lavallée, L., Alexandre, H., David, G., Audette, J., & Rondeau, G. (1985). Programme de traitement de l'inceste selon Giarretto: bilan d'une expérience d'un an au B.S.S. Laval. Intervention, 72, 41-55.

Glaser, D. 1991. Treatment issues in child sexual abuse. British Journal of Psychiatry, 159, 769-782.

Glaser, D., & Stephen Frosh, S. (1988). Child sexual abuse. Chicago : Dorsy Press

Gomes-Schwartz, B., Horowitz, J. M., Cardarelli, A. P., & Sauzier, M. (1990). The aftermath of child sexual abuse: 18 months later. In Gomes-Schwartz, B., Horowitz, J. M et Cardarelli, A. P. (Eds). Child sexual abuse: The initial effects, (pp. 132-152). Newbury Park, CA: Sage.

Green, S. M., Russo, M. F., Navratil, J. L., & Loeber, R. (1999). Sexual and physical abuse among adolescent girls with disruptive behavior problems. Journal of Child and Family Studies, 8, 151-168.

Giuli, C. A., & Hudson, W. W. (1977). Assessing parent-child relationship disorders in clinical practice: The child point of view. Journal of Social Service Research, 1 (1), 77-92.

Grilo, C. M., Sanislow, C., Fehon, D. C., Martino, S., & McGlashan, T. H. (1999). Psychological and behavioral functioning in adolescent psychiatric inpatients who report histories of childhood abuse. American Journal of Psychiatry, 156, 538-543.

Hack, T. F., Osachuk, T. A. G., & De Luca, R. V. (1994). Group treatment for sexually abused preadolescent boys. Families in Society: The Journal of Contemporary Human Services, 75, 217-228.

Keller, R. A., Cicchinelli, L. F., & Gardner, D. M. (1989). Characteristics of child sexual abuse treatment programs. Child Abuse & Neglect, 13 (3), 361-368.

Kendall-Tackett, K. A., Meyer-Williams, L., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. Psychological Bulletin, 113 (1), 164-180.

Knussen, C., Sloper, P., Cunningham, C. C., & Turner, S. (1992). The use of the Ways of Coping (revised) questionnaire with parents of children with Down's syndrome. Psychological Medicine, 22, 775-786.

Kruczek, T., & Vitanza, S. (1999). Treatment effects with an adolescent abuse survivor's group. Child Abuse & Neglect, 23 (5), 477-485.

Lanktree, C. B., & Briere, J. (1995). Outcome of therapy for sexually abused children: A repeated measures study. Child Abuse & Neglect, 19 (9), 1387-1399.

Larzelere, R. E., Smith, G. L., Collins, L. E., Collins, R. A., Sinclair, J. J., Osgood, D. W., & Daly, D. L. (1995). Relating treatment process to outcomes of group therapy for sexually abused adolescent females. Presented at the 4th International Family Violence Research Conference, Durham (NH), University of New Hampshire.

Lebeau, T., & Benoît, D. (1984). Rapport sur le programme de traitement des enfants abusés sexuellement. Repentigny, Québec: Centre des Services sociaux de Laurentides-Lanaudière.

Lindon, J., & Nourse, C. A. (1994). A multi-dimensional model of groupwork for adolescent girls who have been sexually abused. Child Abuse and Neglect, 18 (4), 341-348.

Mackey, B., Gold, M., & Gold, E. (1987). A pilot study in drama therapy with adolescents girls who have been sexually abused. The Arts in Psychotherapy, 14 (1), 77-84.

Mannarino, A. P., Cohen, J. A., et Berman, S. R. (1994). The Children's Attributions and Perceptions Scale: A new measure of sexual abuse-related factors. Journal of Clinical Child Psychology, 23 (2), 204-211.

Marois, M. R., Messier, C., & Perreault, L. A. (1982). L'inceste: une histoire à trois ou plus... apprendre à les aider. Québec: Ministère de la justice, Comité de la protection de la jeunesse.

McGain, B., & McKinzey, R. K. (1995). The efficacy of group treatment in sexually abused girls". Child Abuse and Neglect, 19 (9), 1387-1399.

Mennen, F. E., & Meadow, D. (1993). The relationship of sexual abuse to symptom levels in emotionally disturbed girls. Child and Adolescent Social Work Journal, 10, 319-328.

Messier, C. (1986). Le traitement des cas d'inceste père-fille: Une pratique difficile. Québec: Ministère de la justice, Comité de la protection de la jeunesse.

Messier, C., & De Champlain, J. (1984). La protection sociale des enfants victimes d'abus sexuels: Où en sommes-nous au Québec ? Québec: Ministère de la justice, Comité de la protection de la jeunesse.

O'Donohue, W. T., & Elliott, A. N. (1992). Treatment of the sexually abused child: A review. Journal of Clinical Child Psychology, 21 (3), 218-228.

Oates, R. K., O'Toole, B. I., Lynch, D. L., Stern, A. E., & Cooney, G. (1994). Stability and change in outcomes for sexually abused children. Journal of American Academy for Children and Adolescent Psychiatry, 33 (7), 945-953.

Perez, C. L. (1988). A comparison of a group play therapy and individual therapy for sexually abused children. Dissertation Abstracts International, 48, 3079.

Picard, D. (1991). Rapport d'évaluation de l'activité de groupe pour les adolescentes victimes d'abus sexuel. Québec: Direction des services professionnels, Centre de services sociaux du Québec.

Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. Journal of the American Academy of Child and Adolescent Psychiatry, 42, 269-278.

Rogers, S. E., Chamberlin, J., Langer Ellison, M., & Crean, T. (1997). A Consumer-Constructed Scale to Measure Empowerment Among Users of Mental Health Services. Psychiatric Services, 48 (8), 1042-1047

Rorty, M., & Yager, J. (1996). Histories of childhood trauma and complex post-traumatic sequelae in women with eating disorders. Psychiatric Clinics of North America, 19, 773-791.

Saunders B. E., Berliner, L., & Hanson, R. F. (2003). Guidelines for psychosocial treatment of intrafamilial child physical and sexual abuse (Final Report). Charleston, SC: Authors.

Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: A longitudinal community study. Child Abuse & Neglect, 20, 709-723.

Silvosky, J. F., & Hambree-Kigin, T. L. (1994). Family and group treatment for sexually abused children : A review. Journal of Child Sexual Abuse, 3 (3), 1-20.

Sinclair, J. J., Larzelere, R. E., Paine, M., Jones, P., Graham K., & Jones, M. (1995). Outcome of group treatment for sexually abused adolescent females living in a group home setting. Journal of Interpersonal Violence, 10 (4), 533-542.

Tourigny, M. (1997). Efficacité des interventions pour enfants abusés sexuellement: une recension des écrits. Revue canadienne de psycho-éducation, 26 (1), 39-69.

Tourigny, M. (1991). Incidence, facteurs de risque et programmes de prévention des abus sexuels envers les enfants. Recueil des études commandées par le Groupe de travail pour les jeunes. Québec: Ministère de la Santé et des Services sociaux.

Tourigny, M., Péladeau, N., Bouchard, C., & Doyon, M. (1998). Efficacité d'un programme de traitement des enfants abusés sexuellement. Child Abuse & Neglect, 22 (1), 25-43.

Tourigny, M., Hébert, M., Daigneault, I., & Wright, J. (2003). Portrait québécois des signalements pour abus sexuels faits à la Direction de la protection de la jeunesse. Rapport de recherche. Sherbrooke : Université de Sherbrooke.

Tourigny, M., Mayer, M., Wright, J., Lavergne, C., Trocmé, N., Hélie, S., Bouchard, C., Chamberland, C., Cloutier, R., Jacob, M., Boucher, J., & Larrivée, M.-C. (2002). Étude sur l'incidence et les caractéristiques des situations d'abus, de négligence, d'abandon et de troubles de comportement sérieux signalées à la direction de la protection de la jeunesse au Québec (ÉIQ). Montréal: Centre de Liaison sur l'Intervention et la Prévention Psychosociales.

Tourigny, M., Mayer, M., Wright, J., Lavergne, C., Trocmé, N., Hélie, S., Bouchard, C., Chamberland, C., Cloutier, R., Jacob, M., Boucher, J., & Larrivée, M.-C. (2003). Québec Incidence Study of reported child abuse, neglect, abandonment and serious behaviour problems (QIS). Montréal: Centre de Liaison sur l'Intervention et la Prévention Psychosociales.

Vancouver Incest and Sexual Abuse Centre (VISAC) (1989). The integrated treatment model ITM: For sexually abused children and their mothers. Vancouver: Family Services of Greater Vancouver.

van der Kolk, B. A., Perry, J. C., & Herman, J. L. (1991). Childhood origins of self-destructive behavior. American Journal of Psychiatry, *148*, 1665-1671.

Verleur, D., Hughes, R. E., & de Rios, M. D. (1986). Enhancement of self-esteem among female adolescent incest victims: A controlled comparison. Adolescence, *21*, 843-854.

Vitaliano, P. P., Maiuro, R. D., Russo, J., & Becker, J. (1987). Raw versus relative scores in the assessment of coping strategies. Journal of Behavioral Medicine, *10*, 1-18.

Wowra, S. A. & McCarter, R. (1999). Validation of the Empowerment With an Outpatient Mental Health Population. Psychiatric Services, *50* (7), 959-961.

Wright, J., Tourigny, M., Trocmé, N., & Mayer, M. (2000). Decline of incidence of sexual abuse in Québec: An exploration of possible causes. Office of Juvenile Justice and Delinquency Prevention, November 3rd, Rockville, Maryland US.

Table 1

Socio-demographic characteristics and abuse-related variables

Variables	Total sample %	Experimental group %	Control group %	Statistical tests Chi ²
Mean age (years) of the victim	14.6	14.8	14.3	F=1,21
Living situation ¹	n = 42	n = 27	n = 15	
Parents	30.9	29.6	33.3	
Mother	26.1	22.2	33.3	
Foster family	23.8	29.6	13.3	
Foster care	9.5	11.1	6.7	
Other	9.5	7.4	13.3	
Characteristics of the perpetrator	n = 39	n = 26	n = 13	
Known	89.7	92.3	84.6	0.56
Adult (18 years and over)	82.1	80.8	84.6	0.09
Immediate family	38.5	34.6	46.2	0.49
Extended family	35.9	34.6	38.5	0.06
Stranger	2.6	0	7.7	2.05
More than one perpetrator		15.4	11.5	23.1 0.89

(1) The Chi square test is invalid considering the number of cells with $n < 5$.

Table 1 (cont'd)

Socio-demographic characteristics and abuse-related variables

	Total sample	Experimental group	Control group	Statistical tests
Variables	%	%	%	Chi ²
Abuse-related variables	n = 39	n = 26	n = 13	
With penetration	61,5	50.0	84.6	4.39*
Use of force	30.8	30.8	30.8	0.00
Presence of physical abuse	12.8	15.4	7.7	0.46
More than once a week	69.2	73.1	61.5	0.54

* p < 0.05

Table 2

Efficacy of the group intervention for sexually abused teenagers

Outcomes	Intervention group				Control group				Effect					
	T0		T1		T0		T1		Time	Group		Time x Group		
	M	SD	M	SD	M	SD	M	SD	F (1,40)	F (1,40)	F (1,40)	F (1,40)		
<i>Post-traumatic stress symptoms (TSC- C; Briere, 1989)¹</i>														
Total score	69.7	26.0	46.3	18.3	60.9	26.1	62.3	20.7	20.9	***	0.3	n.s.	26.3	***
Anxiety	13.0	5.6	7.9	3.8	11.4	5.2	12.4	3.8	13.8	***	1.0	n.s.	32.6	***
Depression	13.9	5.5	9.0	3.9	14.1	7.1	13.2	4.6	22.1	***	2.0	n.s.	10.3	***
Dissociation	11.7	5.2	8.4	4.0	10.1	5.2	9.4	4.4	10.7	**	0.1	n.s.	4.4	*
Post-traumatic stress	16.7	5.0	10.9	4.0	15.0	4.7	16.6	3.7	10.3	***	2.4	n.s.	33.0	***
Anger	10.8	5.8	7.2	4.4	9.8	4.2	9.4	4.5	9.4	**	0.2	n.s.	5.8	*
Sexual preoccupations	7.3	4.4	5.3	2.9	7.1	3.6	7.3	3.3	2.8	n.s.	0.7	n.s.	3.8	n.s.
<i>Cognitive distortions following sexual abuse (CAPS, Mannarino, Cohen & Berman, 1994)</i>														
Total score	52.9	9.6	47.6	8.1	53.4	13.5	55.7	9.9	2.3	n.s.	2.0	n.s.	14.1	***
Feeling different	12.9	3.6	13.3	3.3	12.0	4.4	12.8	3.0	1.6	n.s.	0.4	n.s.	0.3	n.s.

Interpersonal trust	15.9	4.0	13.6	3.4	16.3	4.7	18.2	3.3	0.2	n.s.	4.8	n.s.	19.7	***
Responsibility	10.8	2.4	8.4	1.9	10.8	3.6	11.2	3.2	14.1	***	2.9	n.s.	27.6	***
Perceived credibility	13.3	2.7	12.1	2.7	14.2	3.0	13.5	2.3	9.6	**	2.0	n.s.	0.5	n.s.
<i>Mother/teenager relationship</i>	42.8	29.3	31.3	26.6	37.1	24.3	41.0	24.6	1.6	n.s.	0.1	n.s.	6.5	*
<i>Father/teenager relationship</i>	27.3	24.4	22.0	24.5	39.3	24.9	42.0	24.2	0.4	n.s.	3.1	n.s.	3.3	n.s.
<i>Coping strategies</i>														
Social support	8.0	4.0	11.6	3.3	5.8	4.2	4.5	3.1	2.9	n.s.	22.1	***	13.9	***
Problem-solving	9.9	6.3	15.1	5.8	7.3	4.2	5.9	3.0	3.4	n.s.	18.7	***	10.4	**
Avoidance	9.9	3.0	10.3	3.6	11.2	3.3	11.9	2.6	1.1	n.s.	2.6	n.s.	0.1	n.s.
Empowerment	2.7	0.3	2.9	0.4	2.6	0.3	2.6	0.3	2.6	n.s.	5.1	*	4.3	*
<i>Youth self-report and profile (Achenbach, 1991)</i>														
Total score	98.1	30.1	76.7	24.6	87.5	27.6	91.6	20.5	10.4	**	0.1	n.s.	22.5	***
Internalizing behaviors	29.4	12.2	18.3	9.0	27.4	12.0	31.6	9.8	9.9	**	2.9	n.s.	49.0	***
Social withdrawal	7.4	2.9	4.8	2.3	6.5	3.5	8.6	3.2	0.5	n.s.	2.7	n.s.	44.8	***
Somatization	6.5	3.8	3.8	2.9	7.7	3.7	5.6	2.6	15.9	***	2.8	n.s.	0.2	n.s.
Anxiety	17.2	7.3	10.1	5.9	14.2	7.6	18.9	6.5	2.1	n.s.	2.1	n.s.	52.7	***

Thought problems	3.7	3.3	2.1	2.1	4.1	2.8	1.9	1.6	18.1	***	0.0	n.s.	0.5	n.s.
Externalizing behaviors	17.8	8.4	15.0	7.8	14.4	6.8	15.8	8.0	0.5	n.s.	0.3	n.s.	4.2	*
Social problems	4.2	3.5	3.0	2.2	3.6	2.3	4.1	2.8	0.9	n.s.	0.1	n.s.	6.0	*
Attention problems	8.3	4.1	6.3	3.3	6.1	2.9	7.3	2.7	1.0	n.s.	0.3	n.s.	19.0	***
Delinquency	5.7	3.3	4.7	3.2	5.2	2.6	5.3	2.8	1.1	n.s.	0.0	n.s.	2.0	n.s.
Agressivity	12.2	6.1	10.3	5.7	9.2	4.7	10.4	5.7	0.1	n.s.	0.78	n.s.	3.3	n.s.

(1) Exceptionally analyses on the TSC-C were performed with 41 participants, one participant being excluded on the basis on her score on the validity scale, displaying a tendency to deny symptoms.

* $p < 0.05$, ** $p < 0.01$ et *** $p < 0.001$