GROUP THERAPY AS PRIMARY TREATMENT FOR ADOLESCENT VICTIMS OF INTRAFAMILIAL SEXUAL ABUSE

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ABSTRACT: This article describes the therapeutic needs of adolescent victims of sexual abuse and presents the case that group therapy more effectively addresses these needs than individual or family therapies.

Reported incidents of intrafamilial child sexual abuse have increased rapidly during the past two years. In several communities, namely San Joaquin, Sacramento, and Santa Clara Counties in California, the increase has been as high as 300%. The indicators of sexual abuse, the dynamics of sexually abusive families, and the negative impact upon the child victims have been described in the literature (Cormier, 1962; DeFrancis, 1969; Kaufman, 1954; Miselman, 1978; Sergroi, 1975). However, research and case descriptions of treatment methods and principles have not, as yet, gone beyond general statements that treatment is needed and that there are a variety of approaches being used (Giaretto, 1976; Segroi, 1975). The response of therapists coping with burgeoning caseloads of child victims has been to use triage and eclectic approaches to treatment. While waiting for empirical research findings, it is useful for those of us on the front lines to share what has been learned thus far.

The authors have worked intensively with forty-eight sexually abusive families during the past three years as social workers with Child Protective Services. Our experience has been that group therapy has some uniquely positive characteristics that more effectively address the needs of adolescent victims of intrafamilial sexual abuse than individual or family therapies. The purpose of this paper is to describe the therapeutic needs of these adolescent victims, which include the following: minimizing self-destructive behavior, resolving emotional conflicts, changing negative self-images, and promoting the normal developmental tasks of adolescence. This description is followed by an explanation of how therapeutic attention and corrective experiences are best provided by homogeneous group therapy.

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IMPACT OF INTRAFAMILIAL SEXUAL ABUSE UPON CHILD VICTIMS

One of the main themes in the literature is that the victims of intrafamilial sexual abuse feel isolated and different because they have been molested and that they are not aware that anyone has had the same experiences (Lustig, 1966; Miselman, 1978). Several researchers have found that child victims feel guilty for having had sexual contact with an adult in the family (DeFrancis, 1969; Lustig, 1966; Miselman, 1978). The parent-child role reversal described in the literature prevents these children from seeking help because they often feel it is their role to protect the family (Eist, 1968; Masters, 1976).

These children are in a double bind: If they make any attempt to stop the abuse, they are betraying their families; if the abuse continues, their feelings of self-revulsion and rage increase. They are helpless, and the anger turns inward. Researchers have documented a high incidence of self-destructive and antisocial behavior among victims of sexual abuse, for example, suicide, drug abuse, and prostitution (Benward & Densen-Gerber, 1975; James & Meyerding, 1977; Weber, 1977).

The childrens' belief that they are responsible for the sexual abuse is further strengthened when, as frequently happens with disclosure, the parents, in blatant or subtle manners, blame the children. The victims' feelings of responsibility extend to consequences experienced by their families such as loss of employement, incarceration, separation, and so on. Furthermore, all negative feelings expressed toward the offenders by family members or those in contact with the families are experienced by the child victims as meant for them. These children translate these messages as follows: "I'm a pervert . . . should be locked up . . .castrated." It is not surprising that a common clinical finding in these children is depression (Baker, 1976; DeFrancis, 1969; Lustig, 1966). The following is a list of therapeutic needs frequently seen in this population and the special response to those needs by group therapy.

Isolation and Alienation from Peers

Most adolescents do not believe that their conflicts regarding the sexual molestation could ever be fully understood by others. They believe that no one else has ever had similar feelings. They are certain that no one would want to associate with them if the details of the sexual contact were known. The presence of others in the group who have survived sexual abuse, who may attend the same school or live in the same community, is reassuring and diminishes these feelings of isolation.

Distrust of Adults and Authority Figures

Therapists working individually with sexually victimized adolescents have noted the long period of time needed to build a trusting

relationship. There is frequently distrust of adults and authority figures as well as the expectation of being hurt or exploited. Immediate help and support is essential because the lives of these teenagers are often in turmoil. They face court appearances, foster care, and so on. Knowing that other group members have had similar experiences facilitates the building of trust and self-disclosure, which leads to the exploration and expression of feelings. Adam: "I mean it happened to him (other group member) too, and he can understand. I thought my dad was a faggot or something. I couldn't tell anyone. . . well, I could tell you (the therapist) but, you know, you are *supposed* to understand. . . John, well, he's been there."

Guilt and Shame

Abused children often endure guilt and shame related to feelings of responsibility for the sexual contact and for having caused subsequent family problems. One of the survival techniques learned and used by abused children is to assess how others want them to respond. These adolescents have learned to relate to people by taking care of others' feelings at the expense of their own. This can be utilized in the group setting, for example, when an adolescent hears another group member describe an abusive incident and becomes enraged when that person speaking assumes full responsibility. Adolescents will express feelings for others that they cannot express regarding their own situations. These feelings can then be mobilized and related to an adolescent's own situation. The group support is powerful and confrontation of self-destructive assumptions is effective.

In individual therapy, defenses are strong and the adolescent often shrugs off the therapist's interventions with, "You just don't understand." A trap for the therapist inexperienced in working with sexual abuse or the therapist who is hesitant to work at deep emotional levels is to believe the pseudo-maturity and the pseudo-togetherness they see put on display by these teenagers (for the therapist's benefit).

Fear of Intimacy with the Therapist/Other Adults

Adolescents in group therapy have told of their fears of becoming close to therapists in individual therapy and the stress they experienced in that setting. Angela: "I had counseling with Dr. X for a year. I wanted to tell him, but we were alone in that room. . . and the door was shut. . . and, well, I just never could." The child feels pressure to "do something" in a one-to-one setting.

A therapist working individually is in a bind if the sexual abuse is known. If the abuse is not openly discussed, then the therapist is reinforcing the shame and introducing the same dynamic of "family secret" into therapy. But if the therapist does bring up the molestation

and elicits feelings of pain and sadness from the child, efforts to be supportive will often be met with extreme fear since kind words and touching are associated with sexual assault. And, if the molestation incidents are addressed at an intellectual level, the child's defense of suppressing feelings is further strengthened.

Group therapy provides a setting in which the child is not constantly the focus of attention and feeling pressured to work. Therapeutic gains can be made at a tolerable pace. With two therapists and other group members present, physical contact and emotional support is not threatening to the adolescent. It has been the writers' experience that this kind of contact in group settings is eagerly sought out by members of the group. Also, therapists are provided with an opportunity to model appropriate limit-setting relating to personal preferences for intimate contact. The group becomes a place where members can learn to give and receive affection and practice setting limits for themselves.

Anger Turned Inward: Depression, Suicide and Self-Mutilation

The feelings of anger and betrayal experienced by these adolescents are intense and usually unexpressed because the sexual abuse was by someone they loved and looked to for guidance. They experience loss and know, at some level, that they missed out on a normal parent-child relationship that cannot be regained. Once the adolescent internalizes that one can love a person and hate specific behaviors, anger can be expressed outwardly. The angry feelings toward the nonexploitive parent are often intense and more difficult for the adolescents to acknowledge, even to themselves. They believe that this parent should have known what was going on, should have protected them, and should have been a sufficient sex partner so that they would not have had to fill that role. Often the abusive parent is out of the home and the child believes that acknowledging these feelings toward the other parent might somehow lead to total abandonment. In some instances, this is true.

Body therapy and Gestalt techniques have been effectively used in group settings with these adolescents. It is the writers' impression, based upon victims' self-reports, that suicide attempts and self-mutilation were greatly reduced when anger could be safely expressed.

Unmet Dependency Needs

These adolescents are often striving to have dependency needs met. This is particularly noticed after disclosure of the sexual abuse, when they are under stress and there is a tendency to regress. Their relationships with their mothers are frequently unaffectionate and emotionally distant, but they have hope that this will somehow change. In the group, these dependency needs are met, in part, by strong peer approval. In learning to care for one another, the group members gradually learn to care for themselves.

Helpless Victim Mentality

In most families that are reported for sexual abuse, the sexual contacts occur frequently (two to three times a week) for a number of years. Initially, the child victims were helpless because of ignorance, fear, or because they needed to please their parents. Often, the non-abusing parents are themselves victims and have role modeled that stance in life to the child. Because of their experienced helplessness, a lack of assertive modeling, and, in most cases, few successful life experiences, these adolescents have little confidence that they can succeed at anything.

Another factor reinforcing the victim role is that these adolescents look back at themselves as children and perceive themselves as having had the same cognitive, emotional, and physical abilities they have in the present. They make statements such as: "I should have known it would keep happening and put a lock on the door. . . I should have thrown him out of my room. . . I could have called the police. . . I never should have watched T.V. wearing that shorty nightgown. . . " and they are talking about themselves as children less than nine-years old!

The group support and extensive use of psychodrama techniques help these young people to view what happened to them realistically: They see that they were helpless but that they are no longer. For example, a group member would select others in the group to play the roles of significant family members and set up a family scene. The therapist would assist the child in recalling a specific sexual assault incident, putting emphasis upon the victim's feelings and encouraging expression of those feelings. The same incident would then be reenacted, only this time the victim would stop the assault by means of verbalizations, physically overpowering the offender, obtaining assistance from the other parent, or some other method. The group members develop a sense of mastery over situations in which they were once helpless. They use the group to practice assertiveness skills, and they warmly support each other in the process.

Development of Social Skills

Family restrictions, self-imposed isolation from peers, and low self-esteem have led to most of these teenagers feeling painfully awkward in social situations. The group setting is a safe place to learn and practice social skills. The members can rely on encouragement for their efforts, celebration for their gains, and support when they are awkward in their new attempts. The group is also a place where a member can learn to have fun, to be a kid. Many groups for sexually abused children include as part of the treatment plan activities such as roller skating and camping.

The group is also a forum for teaching. The writers' experience has been that these young people have little knowledge and are grossly misinformed about human sexuality and birth planning.

Developmental Tasks of Adolescence

Keeping in mind the psychological and emotional difficulties experienced by sexually abused adolescents, let us look at the rather awesome developmental tasks that they are also attempting to master. They must

-separate and individuate from parents;
-develop satisfying peer attachments, with the ability to love and appreciate the worth of others as well as themselves;
-develop a sense of identity in familial, social, sexual, and work areas; and
-develop a flexible set of life goals for the future.

This is a time when young people are most interested in their sexuality; there are secondary sex characteristics appearing, growth spurts, and important metabolic changes. There is an excitement and a fear about the changes that are occuring. There is a push to move away from the family and a pull to return to safety. Many sexually abused adolescents are pushed out of the home before they are ready, and regressing emotionally does not bring them to a safe place, but rather a place of fear and confusion. Friendships are most important during this transitional identity time of adolescence, but most sexually abused teenagers do not have friends nor do they know how to make friends.

The corrective experiences provided by the group therapy process described in this paper also support and assist these adolescents in coping with their maturational conflicts. This population of adolescents needs to find others who care. They do find this among their peers in the group.

CONCLUSION

The reported number of children sexually abused within their families has drastically increased in the United States. Research and professional writings related to this problem have focused upon behavioral indicators and family dynamics; however, specific treatment techniques for child victims have not been presented.

It has been the writers' experience that homogeneous group therapy most effectively addresses the needs of adolescent victims of intrafamilial sexual abuse. We believe that during the middle phase of group treatment, individual therapy as an adjunct to group therapy can be useful. Only after a sufficient time to openly explore the adolescents' feelings toward self and family would we recommend child/parent therapy or family therapy as an adjunct to group therapy.

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