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Therapy Groups for Women Sexually Molested as Children

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A neglected class of sexual assault victims consists of women who were molested as children. In response to their unmet needs, therapy groups composed solely of women who were sexually abused in their childhood have been established. The goals of these groups are twofold: (1) the alleviation of sexual guilt and shame and (2) the clarification of emotional and behavioral consequences of molestation. Ten groups have been conducted, each containing four to six members, comprising an overall total of 50 women. In 97% of the cases, a prior relationship had existed between perpetrator and victim. Treatment consisted of a four-session format. During session I, each group participant described her molestation experiences in detail. Sessions II and III focused on how these experiences have affected the women. Session IV dealt with individual stages of recovery and further treatment plans. Clinical findings included feelings of guilt and depression, negative self-image, and problems in interpersonal relationships associated with an underlying mistrust of men, inadequate social skills, and difficulties in sexual functioning. Evaluations of the therapy groups by the participants indicated that the primary curative component was the sense of identification and emotional closeness instilled by a warm and supportive environment where a common bond was shared.

KEY WORDS: victim; childhood sexual molestation; group therapy; sexual guilt; sexual problems; incest.

INTRODUCTION

Sexual molestation of children is part of a spectrum of injustices constituting child abuse. A conservative estimate places the annual occurrence of reported child sexual abuse at 100,000 cases (DeFrancis, 1971). Since approximately 80%

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of sex crimes against children occur within affinity systems (immediate family, relatives, close friends, neighbors) (Chaneles, 1967), this phenomenon is largely unreported. As a result, the hidden incidence may be anywhere from 5 to 10 times greater than what is reported.

Child molestation usually involves coercive secrecy and the abuse of power by a trusted adult. In our culture such behavior is heavily laden with taboos, and therefore victims are exposed to serious stresses which often have long-range effects on their psychosexual development. Yet society's concern with prosecuting the offender, combined with a general reluctance to acknowledge the phenomenon, contributes to the neglect of the victim. One indication of this is the paucity of treatment literature on this topic. Existing reports concern the child victims of sexual abuse (Burgess and Holstrom, 1975; Eist and Mandel, 1968; Machotka *et al.,* 1967; Sgroi, 1975), but with the exception of a few case studies (Katan, 1973; Sloan and Karpinski, 1942) the adult population of women who have lived with their molestations over the years has not been subject to therapeutic attention.

In response to the unmet needs of these victims, therapy groups composed solely of women who were molested in their childhood have been established in the Department of Psychology at the University of Washington. The goals of these groups are twofold: (1) the alleviation of sexual guilt and shame and (2) the clarification of the emotional and behavioral consequences of molestation.

GROUP PARTICIPANTS

Participants for the groups were reached through the Seattle-Tacoma media – newspapers, radio, and television – via press releases describing the purpose and format of the therapy groups. Interested parties were encouraged to call the Psychological Services Center at the University for more information. Media response was enthusiastic, and there were no negatives associated with this direct public request. Applicants for the groups were contacted by telephone by the female cotherapist. Other than a brief discussion of the nature of their molestation experience, no formal screening was undertaken. A fee of $20 was charged each participant for the four group meetings.

In the past year, ten groups have been conducted, each containing four to six members, comprising an overall total of 50 women. The group members were predominantly white and middle class (45 Anglo, three black, 1 American Indian, 1 Spanish surname). Twenty-nine were married, 13 single, and eight divorced. They ranged in age from 19 to 53 years, with a mean of 30.7. The severity of the molestation varied from one incident of vaginal fondling by a stranger to repeated subjugation to intercourse by two uncles and a stepfather. The mean age for first sexual contact with an adult was 6.5 years, and the duration of molestation ranged from one incident to 12 years of continual oc-

Table I. Relationship of Molestor to Victim

	Frequency	Percent
Father	20	31.7
Mother	1	1.6
Stepfather	11	17.5
Grandfather	7	11.1
Uncle	7	11.1
Brother	4	6.3
Other relative	1	1.6
Family friend	2	3.2
Neighbor or acquaintance	8	12.7
Stranger	2	3.2
	$N = 63$	100.00

currences, with a mean duration of 4.6 years. Almost all of the perpetrators (97%) had a prior relationship with the victim (see Table I). Fathers composed 31.7% of the molestors, while stepfathers accounted for 17.5%. Of the 63 molestors, only one was a female; in this case, she was mother of the victim.

GROUP FORMAT

The groups were limited to four weekly or biweekly sessions, each lasting 1½ hr, and were led by a male and a female cotherapist. The sessions were structured in the following manner:

Session I

The therapists begin by introducing themselves and their professional backgrounds. Next the confidential nature of all disclosed information is stressed. The women are then asked to give a short introduction of their name, age, marital status, number of children, type of work. Following a brief discussion of the prevalence of child abuse and the rationale of the groups, the women are requested to describe their molestation experiences in detail. The therapists acknowledge that this is a most difficult task and that they are acutely aware of the high level of apprehension and anxiety. Specifically, it is stated in each group, "Unless we all know exactly what happened, we can't begin to deal with the problem!" Invariably, the woman who can least stand silence will speak first. Rarely does the silence last for more than 10 or 15 sec, although it always seems much longer.

The following information is solicited from each woman: relationship to molestor, age at which molestation began, frequency, duration, exactly what was done, why it ended. The women are not allowed to speak in generalities. To facilitate explicit detail, the therapists ask such questions as "Did he put his

fingers in your vagina?" or "Do you mean he performed oral sex or cunnilingus on you?" Group participants are encouraged to ask each other questions, to make comments, and to share the similarities and differences in their feelings.

After all the women have had a chance to speak, the effects of talking and listening to others' experiences are discussed. For some, it was the first time they had revealed their molestations. For most, it was the first time they had related the specifics. This initial session is an emotional one marked by poignancy and emotion, and the inception of a special chemistry and cohesiveness among the group members.

Sessions II and III

Topics discussed in sessions II and II usually focus on emotional and behavioral repercussions of their molestations, their interpersonal relationships, and sexual functioning. Prior to dealing with these matters, the feelings of the women since the previous session are discussed. Although they generally feel better after the first session, it is not unusual for them to become more depressed as a consequence of dealing with such traumatic material. Most of the women report having been increasingly preoccupied with their childhood molestations and find more detailed memories coming back.

Session IV

The final session deals with any remaining unresolved issues as time permits. Topics of discussion usually include precautions which can be taken to prevent their own children from being molested, and individual stages of recovery, further treatment plans, and alternatives. Feedback is also requested concerning the group experience as a whole, how it helped, and if it could have been more beneficial. Frequently the sense of group identification is so strong the women are reluctant to part. When this occurs, they are encouraged to meet without the therapists. In an additional attempt to ease this termination anxiety, a follow-up session is scheduled for 2 or 3 months in the future.

This is the basic format of the four sessions; however, it is flexible depending on the specific needs of each group. Each group has developed its unique characteristics and consequent emphasis.

COMMON CLINICAL FINDINGS

For these women, childhood molestation had long-range effects on the quality of personal adjustments and interpersonal relationships. The following issues were repeatedly raised by women in almost every group:

Guilt

Guilt was universally experienced by the group participants and was related to the interaction of three factors. First, since in almost every case the relationship was one of propinquity between perpetrator and victim, she was pressured to keep the acts secret. Second, sometimes physically pleasurable sensations, incongruent with the child's intellectual repugnance of the acts, were elicited. This served to evoke much conflict, as exemplified by the following statements: "I liked it, but I hated myself and my father for it" and "I felt guilty since I didn't fight as hard sometimes because it felt good to me." A third element is the length of the molestation, which, as noted earlier, was an average of 4.6 years. One or more of the following reasons, or a combination of all of them, may prevent the victim from seeking help: pressure of secrecy, sense of complicity, fear that people won't believe her, reluctance to create turmoil in the family unit. Whatever the reason for the protracted duration, the victim frequently attributes the blame to herself – "I must have been responsible 'cause it went on for so long . . . I must have been seductive in some way." One group member with a humorous style remarked, "There must have been something I could've done to stop it . . . what if I had laughed hysterically the first time I saw his penis?"

In attempting to absolve the women of guilt, the therapists point out that the acts done to them are often carried out in sex play among children of similar ages and that it is natural to derive pleasurable sensations from them. In their cases, however, the unequal power element, characterized by the disparity in age and often augmented by the consanguinity of the relationship between perpetrator and victim and the resultant constraints of secrecy, serves to generate the negative emotional consequences. Related to the discordant relationship is the fact that children are taught to obey and respect their elders, and not to question the propriety of their actions.

Furthermore, it is stressed that at the preadolescent stage at which they were molested, they were too young to have an adult concept of sexuality or seductiveness; rather, they were seeking to satisfy a childish and instinctive hunger for love and affection. Unfortunately, it was reciprocated with a callous theft of their childhood innocence.

Lastly, it is stipulated that "unless you can look at everyone else in this room and feel their guilt is warranted, your own guilt cannot be justified." This is clearly the most powerful guilt reducer.

Negative Self-Image and Depression

The statement "I really feel inferior to other people . . . it's hard to feel good about yourself when you're constantly carrying something with you that can't be talked about" typifies the feelings of worthlessness and depression of

many of the group members. These feelings are highly correlated with guilt and are lessened as the guilt is reduced and eliminated.

Problems in Interpersonal Relationships

"I don't even know what a normal relationship between a man and a woman is like . . ." Many of the women report problems in interpersonal relationships stemming from one or more of the following factors:

Mistrust of Men

The sense of betrayal often generalized mistrust to all males. Although a few of the group participants distrusted women as well as men, the majority distrusted only men. This feeling is aptly summarized by one young woman: "I don't trust any men – they have to earn my trust; I initially trust women, they have to destroy that trust." The bulwark which is erected against men precludes the formation of intimate, loving relationships – "When loving you has been used against you when you're small, you make the association that people who love you mistreat you and you set up barriers . . . ." An extreme form of this mistrust is manifested in the fear that any man, including her own husband, may molest her children.

The presence of a male therapist in each group helped in facilitating a more differentiated response to men. As the male therapist reflected a compassionate individual who participated in the general discussion, women were required to face their feelings directly and not to simply engage in antimale sentiments.

Inadequate Social Skills – Feelings of Isolation

Many of the women felt that because of their molestation experiences they were emotionally and experientially cheated out of a normal childhood and the usual opportunities to develop exploratory relationships with the opposite sex. Often social ineptness developed – "Socially and sexually I still feel like a little girl" – and consequent feelings of isolation.

Repetition Compulsion

A number of women reported a compulsion in getting involved with unworthy men. Not infrequently, these men bore personal characteristics similar to those of the molestor. As one woman candidly stated, "I have a pattern of getting attracted to assholes – my current lover is a xerox copy of my stepfather."

Other reasons for this self-destructive behavior included: "My self-esteem is so low I always picked men beneath me, men who I didn't have to measure up to" and "I picked unaffectionate men 'cause I didn't want to get involved in a loving, trusting relationship due to what happened with my father."

Sexual Dysfunction

Difficulties in sexual functioning played a major role in the gestation and continuation of relationship problems. A small percentage of the women declared that they had satisfactory sexual relations. The majority reported sexual response falling into one of three maladaptive patterns:

1. Nonresponse. The women in this category were unable to achieve arousal with their partners; a small subset were even nonresponsive during masturbation. Common descriptions included: "sexually dead," "I hear other people talk about how great it is but I've never been there," and "He asked me once what I enjoyed and I couldn't answer 'cause there's nothing that I enjoy." Some women in this classification not only were unresponsive but also reacted to sex with abhorrence and "casual terror" and developed an active avoidance of sexual situations – "I can't get out of a public place fast enough when men look at me" and "I can't stand for men to touch me or even come near me; I get numb and nauseated."
2. Orgasmic but not enjoyable. Some women reported the ability to become aroused and reach orgasm but did not find the experience to be satisfying and could "take it or leave it." "I can get aroused but I just want to get it over with." In years of sex therapy, the second author has encountered this pattern only in molested women. They have learned to be sexually responsive at an early age, but the unpleasant associations they experience with arousal inhibits a pleasurable response.
3. Arousal contingent on control. "I was so badly controlled before, I don't want it to happen anymore." As their initial sexual experiences were marked by subjugation and passivity, some women could achieve arousal only if they were in control. "I tried to make my father go away by lying there and being stiff; therefore, my sex is much better when I initiate it, am active and on top."

Although their sexual responsivity varied widely, certain experiences and feelings were common. "Flashbacks" to their molestations, which detracted from sexual pleasure, were often experienced during sex play and intercourse. While some women were able to ignore the distraction and continue, others lost all desire when flashbacks occurred – "When sexual experiences bring back

associations with my dad, there's always this feeling of guilt, humiliation, anger, resentment, and bitterness."

The women were also in agreement that they craved affection apart from sex, something which was denied them in their childhood – "Any physical interaction between us was just sexual – I just wish I had a father who'd hug me and tell me he loved me." They had a particular need to be affirmed as individuals independent of their sexuality.

Since the number of sessions is limited, the therapists generally focus the discussion on the most salient aspect of relationship problems – sexual dysfunction. The common misconception that a form of dysfunction is inability to achieve orgasm through coitus is corrected. It is pointed out that while most women find it preferable to achieve "Look, Ma – no hands" orgasm, there is evidence that a majority of women actually cannot do so (Barbach, 1975; Hite, 1976), and fulfillment by any other means whether oral, manual, or mechanical should be equally desirable. Openness in communicating to the sex partner what she finds pleasurable is encouraged, and suggestions are made for concomitant manual stimulation of the clitoris by herself or her partner during intercourse.

In dealing with the phenomenon of flashbacks, the women are advised that "it is important to let your partner know when you're flashing – that your response is not due to him or what he's doing at the moment." This helps to differentiate the current partner from the traumatic past experience.

Women with more pervasive sexual and/or relationship problems are referred to the form of treatment most appropriate to their needs – either preorgasmic, sexual enhancement, social skills, or assertiveness training groups, or to individual therapy.

Bitterness Toward the Mother

For the 31 of 50 group participants who were molested by their fathers and stepfathers, resentment and bitterness toward the molestor were matched, if not superseded, by the intensity of similar emotions toward the mother for consciously or inadvertently perpetuating the pathological sexual relationships.

The role of the mother covered the gamut from active collusion ("My mother said I didn't have enough self-confidence and needed oral sex with my father . . . it was a mechanism for deflecting father's attention away from her") to either obliviousness or denial ("She didn't acknowledge it but I don't see how she could've not known – there were so many signs she could have cued in on") and included passive acceptance ("My mother told me, 'That's to be expected – put up with it' "). The majority of the women believe that their welfare was sacrificed in their mother's attempts to keep the family intact ("Mother went along with everything, she just wanted their marriage to work out").

Related to this bitter resentment against both parents is the wish to confront them on their behavior ("I want to know if they feel any remorse or if they're aware of how much it's affected me").

While not condoning the mothers' behavior, the therapists dissipated some of the expressed bitterness and hostility by exploring some of the reasons for their lack of supportiveness. Issues discussed included the emotional and financial dependence of wives on their husbands 15–20 years ago and the defense mechanism of denial. In terms of present parental confrontation, each situation was discussed individually. Generally, it was concluded that such action would not achieve a useful purpose.

SIX-MONTH FOLLOW-UP RESULTS

Six months after the termination of each group, participants were mailed group experience evaluation questionnaires. Thus far, the first six groups of women have been contacted and 23 of 29 questionnaires (79%) have been returned.

The helpfulness of the group experience received a mean rating of 6.0 on a 7-point scale (1 = not at all helpful, 7 = extremely helpful). In answer to the question "What was most helpful about the experience?" the consensus was "being able to share feelings with women who have gone through similar experiences and who could truly understand." Other comments included: "feeling of release," "learning what could be done about it," and "being able to talk about the details enabled me to deal with my feelings, and I was better able to put the experience behind me." Suggestions for improvement included: "more sessions needed," "more suggestions on how to cope," and "specific answers as to why people molest children, how to educate people to the problem."

Mean ratings of 6.1 and 5.8 were given in response to the questions "How have your feelings of guilt changed?" (1 = much more guilty, 7 = much less guilty) and "Do you feel more accepting of yourself as a person?" (1 = much less accepting, 7 = much more accepting).

A number of women reported no changes in feelings toward the molestor while other reactions varied from being "more understanding" to "much more angry."

Relationships with current partners were generally more positive, the changes given a mean rating of 5.2 (1 = very negative change, 7 = very positive change). Explanations were "don't take my fears to bed with me anymore, able to enjoy lovemaking more," "recognizing and working on our problems (sexual and otherwise) together," and "we're closer 'cause he can understand my problems with sex."

Answers to the question "What other changes have you experienced as a result of your participation in this group?" included: "I have a much stronger

sense of self and I don't feel fragile and unsafe anymore," "Most of the guilt is gone and I'm really making changes in my life," "Have been able to confide in several friends as a result and was amazed to find out two of them were also molested," and "Feel freer somehow, also feel less different."

DISCUSSION

As indicated by the participants' verbalizations and the initial follow-up results, the sense of group identification instilled by a common bond played a major role in dispelling feelings of unique misery. The primary therapeutic effect was the mitigation of guilt and a resultant increase in self-esteem. A concomitant behavioral manifestation was a newfound freedom in talking about their molestations – "I'm so excited that I'm comfortable with saying I was molested. It's a way of showing that I'm over my shame and guilt. I didn't do anything I should be ashamed of – it was done to me."

For most of the women, depression and hopelessness in dealing with their problems were replaced by the more mobilizing emotion of anger and a sense of optimism. A realization was reached that the incidents of molestation could not be eradicated from their past but need no longer remain a focal point in their lives.

As there was no screening for emotional disturbance, two women with psychotic histories (two and three hospitalizations) were included. In each instance, with some special support and redirection where the content was tangential, these women were productive group members and benefited from participation. It is our intention to continue to accept *all* women who report a molestation experience and wish to participate in a group.

A continual comment in response to suggestions for improving the groups has been that four sessions are too short. All ten groups have voiced this opinion. This is an issue that has received considerable thought, and, at present, groups lasting five sessions are being conducted. Although we may ultimately settle on more than four sessions, we are committed to a time-limited format. The realization of a specific number of sessions mobilizes the participants to face the issues which brought them to the group. Many women choose to become involved in other therapeutic experiences, group and individual, after the positive experience of sharing with other women their guilt, fears, and concerns related to their molestation.

In sum, preliminary evidence suggests that short-term group therapy is profoundly effective in the alleviation of guilt and the palliation of other long-range consequences of childhood molestation. It is hoped that this presentation will serve as a stimulus to other mental health professionals in the treatment of women sexually abused as children.

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