Efficacy of Group Therapy on Learned Helplessness, Locus of Control and Current Functioning with Adult Survivors of Childhood Sexual Abuse

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Running Head: GROUP THERAPY WITH SURVIVORS OF SEXUAL ABUSE

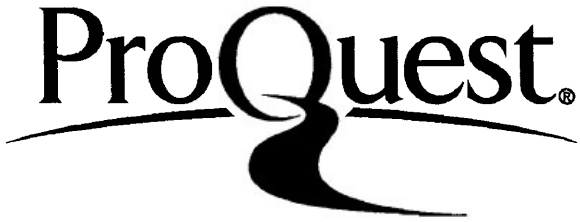

Table of Contents

List of Tables. 3

Acknowledgements. 4

Abstract 5

Introduction 6

Method 22
- Subjects 22
- Materials 23
- Procedure 28

Results 31

Discussion 47

References 55

Appendices
- A. Multimodal Life History Inventory. 64
- B. Modality Analysis of Current Problems. 65
- C. Attributional Style Questionnaire. 66
- D. Social Reaction Inventory. 67
- E. Satisfaction Questionnaire 68
- F. Catholic Family Development Centre Cover Letter. 69
- G. Introductory Statement 70
- H. Crisis Telephone Listing 71
- I. Consent Form 72

List of Tables

Table 1
Modality Analysis of Frequently Endorsed Behavior Descriptors 33

Table 2
Modality Analysis of Frequently Endorsed Affect Descriptors 34

Table 3
Modality Analysis of Frequently Endorsed Physical Sensation Descriptors 35

Table 4
Modality Analysis of Frequently Endorsed Image Descriptors 36

Table 5
Modality Analysis of Frequently Endorsed Cognitive Descriptors 37

Table 6
Modality Analysis of Daily Drug/Biological Descriptors 38

Table 7
Modality Analysis of Behavior/Affect Descriptor Change Scores 40

Table 8
Modality Analysis of Physical Sensation/Image/Cognition Descriptor Change Scores 41

Table 9
Modality Analysis of Current Problems Table of Means by Session 43

Table 10
ASQ and SRI Table of Means by Session . . 46

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Abstract

Increasing numbers of adult survivors of childhood sexual abuse are coming forth to seek aid for problems stemming from their abuse experiences. Long-term consequences for survivors are believed to affect every facet of human functioning. The efficacy of one therapeutic group on learned helplessness, locus of control and current levels of functioning with female survivors of childhood sexual abuse was investigated. Subjects were comprised of female volunteers, recruited from the Catholic Family Development Centre in Thunder Bay, Ontario. The Multimodal Life History Inventory (Lazarus & Lazarus, 1991), the Modality Analysis of Current Problems (adapted from the Multimodal Life History Inventory), the Attributional Style Questionnaire (Seligman, 1990), the Social Reaction Inventory (Rotter, 1966) and a Satisfaction Questionnaire designed for use in this investigation served as psychometric tools. The results indicated significant change between first and last testings on behavior descriptors, personal belief statement scores (cognition modality) and level of helplessness scores. The remaining modalities and the locus of control scores were statistically non-significant. Subjects were generally satisfied with the therapeutic group. The major criticism reported by subjects concerned the relatively brief duration of the therapy group. Several proposals for future areas of investigation were recommended.

Introduction

From the beginning of this century, women have reported instances of sexual victimization in childhood. Freud's early writings appear to have contributed to the long-standing disbelief concerning the occurrence of sexual abuse (Briere & Runtz, 1987; Courtois, 1988; Lerman, 1988). Childhood sexual abuse issues were initially brought to the attention of the psychoanalytic community by Freud in the late 1800's as the magnitude of the abuse experiences relayed to him by his female patient's emerged in significant proportions. Freud's (1896) initial belief concerning the incidence of sexual abuse was clearly illustrated in Lerman's (1988) documentation of Freud's writings: "it is expected that increased attention to the subject will very soon confirm the great frequency of sexual experiences and sexual activity in childhood" (p. 39).

Nonetheless, because the notion of sexual abuse of children was emphatically discounted by members of the health profession and due to Freud's own personal dream analysis regarding his daughter, Freud retreated from his earlier standpoint (Briere & Runtz, 1987; Lerman, 1988). The reasons underlying Freud's reversal may be found in Masson's (1985, as cited by Lerman, 1988) illustration referencing Freud's correspondence to Wilheim Fliess:

> ... in all cases, the <u>father</u>, not excluding my own, had to be accused of being perverse - the realization of the unexpected frequency of

> hysteria, with precisely the same conditions prevailing in each, whereas surely such widespread perversions against children are not very probable. (emphasis in original, p. 40)

Subsequently, Freud changed his earlier viewpoint and relabelled childhood sexual abuse as the product of imagination and "the expression of the typical Oedipal complex in women" (Briere & Runtz, 1987, p. 368). Armstrong (1982, as reported by Courtois, 1988), marked the ensuing 70 year time-frame as the "Age of Denial" (p. 7).

The 1970's saw a reemergence of interest in the area of sexual abuse (Courtois, 1988; Finkelhor, 1986). Although long overdue, the subject has inspired countless research since that time. Clinical and empirical investigations supplemented by increased media coverage have assisted in enlightening both professionals and non-professionals alike. Consequently, more survivors of sexual abuse are coming forward to seek aid for problems stemming from their abuse experiences. The prevalence of reported cases of sexual abuse has correspondingly increased. Although it could be perceived as an indication that sexual abuse is more rampant than in previous years, it is more likely due to the upsurge of extensive inquiry investigating the topic.

Despite our past reluctance in admitting to the realities encompassing sexual abuse, it is of vital importance to continue such investigations. Courtois (1988) in citing

Herman and Shatzow's (1987) comments regarding the necessity for further inquiry into the issues of sexual abuse demonstrates her agreement in this regard: "...it would seem warranted to return to the insights offered by Freud's original statement of the etiology of hysteria and to resume a line of investigation that the mental health professions abandoned 90 years ago" (p. 9).

Statistics documenting the prevalence of childhood sexual abuse vary due to differing definitions of sexual abuse, sample sizes, subject characteristics and investigative methods (Peters, Wyatt & Finkelhor, 1986). Walker (1983), in her investigation of battered women, found that 48% of the women in her survey reported attempted or actual sexual abuse during childhood. Peters, Wyatt and Finkelhor's (1986) extensive literature review in the area of child sexual abuse discovered estimates ranging "from 6% to 62% for females and from 3% to 31% for males" (p. 19). Briere and Runtz (1987) found that among 152 consecutive walk-in female clients requesting counselling services, 44% reported a history of childhood sexual abuse. Despite the rate variance, the numbers are of astounding proportions and clearly indicate a need for further research.

The reported effects manifesting from childhood sexual abuse are numerous. Long-term effects have been found to influence functioning in a wide variety of areas including behavior, affect, sensation, imagery, cognition, interpersonal

relations, and biological factors (Neland, 1987). Among the most frequently cited long-term behavioral effects are sleep disturbance, self-destructive behavior, suicidal tendencies, sexual disturbance (i.e., avoidance or promiscuity), substance abuse, eating disorders and obsessive or compulsive behaviors. Affective disturbances often manifest in fear, anger, anxiety, shame, depression, feelings of isolation and loneliness, low self-esteem, helplessness and powerlessness. Dissociation, aversion to touch, flashbacks, tension, and hypervigilance are typical sensation reactions. Imagery disturbance may consist of nightmares, intrusive images and distorted body-image. Intrusive and/or self-defeating beliefs, thoughts, and values are listed among the long-term cognitive effects. Interpersonally, survivors may experience boundary problems, difficulty trusting others, withdrawal, isolation and revictimization tendencies. Frequently cited as affecting biological functioning are somatization complaints (i.e., headaches, nausea, various aches and pains), gastrointestinal disturbance, respiratory disturbance, and psychoactive medication usage (Bass & Davis, 1992; Briere & Runtz, 1987; Browne & Finkelhor, 1986; Butler, 1985; Courtois, 1988; Finkelhor & Browne, 1985, 1988; German, Habenicht & Futcher, 1990; Gold, 1986; Kunzman, 1989; Mayer, 1983; McCann, Pearlman, Sakheim & Abrahamson, 1988; Rew, Esparza & Sands, 1991; Sgroi & Bunk, 1988; Spear, 1992; Summit, 1983; Tsai & Wagner, 1978).

The literature has revealed mixed consensus concerning the factors believed to increase the severity of effects. Duration, frequency, relationship to the abuser and type of abuse experience have been associated with effect severity. Effects were found to be more severe in survivors whose sexual abuse experience involved penetration by a father-figure and whose abuse experience was frequent and of long-term duration. While there appeared to be agreement between violent abuse episodes resulting in increased symptomology, there were mixed reviews concerning age at onset affecting the severity of effects (Asher, 1988; Browne & Finkelhor, 1986; Courtois, 1988).

Although a minority of research has documented beneficial outcomes resulting from childhood sexual abuse (i.e., positive coping skills, Rew et al., 1991), the vast majority of research has clearly illustrated the negative impact of sexual abuse experiences during childhood. As Courtois (1988) summarized, "childhood sexual abuse has been found to affect the victim's personality development and every major life sphere, either at the time of the incest and/or later in life" (p. 117). The long-term consequences endured by survivors encourages further investigation concerning this issue in order to gain understanding and lend aid to those afflicted by their abuse experiences.

Repeated themes of powerlessness (i.e., Finkelhor & Browne, 1985, 1988; Courtois, 1988) and helplessness (i.e.,

Summit, 1983) appear to manifest long-term consequences for survivors of sexual abuse. As children, survivors of sexual abuse were powerless to stop their abuse experience. Consequently, survivors learned that their world was unsafe. They may have attributed responsibility for the abuse experience to themselves rather than to the abuser. Because childhood experiences may become ingrained, it is conceivable to expect that future situations may result in similar outcomes. Thus, survivors who feel powerless to stop the abuse and those who accept responsibility for it, may tend to generalize their feelings of powerlessness and helplessness to include many or all other situations (Ettinger, 1987).

The theory of learned helplessness has been extensively investigated. Hiroto (1974) studied the effects of uncontrollable events on college students. Students were assigned to one of three conditions, a controllable noise group, an uncontrollable noise group or a control group. The results demonstrated that students who had been assigned to the uncontrollable condition failed to emit avoidant behavior in future controllable situations. However, students who had been assigned to the controllable noise group and the control group were able to successfully emit escape behaviors when in the same condition.

The original theory of learned helplessness in humans (Maier & Seligman, 1976) hypothesized that when faced with uncontrollable situations (outcome independent of behavior),

humans display motivational, cognitive and emotional deficits that may be generalized across different situations. The reformulated model (Abramson, Seligman & Teasdale, 1978) elaborated on the initial proposal to include causal factors. Specifically, uncontrollable situations may be attributed to "stable or unstable, global or specific and internal or external" causes (p. 49). The assignment of causal attributions to events has implications for future expectancies. Attributions may be considered as enduring or intermittent, likely to occur in a wide-range of situations or be situation-specific, and finally, due to a deficiency within oneself or to outside forces.

Studies investigating the learned helplessness model have demonstrated that internals tend to exhibit greater depression and performance deficits than externals (Pittman & Pittman, 1979). Performance deficits have also been noted for subjects whose attribution style was global and internal (Mikulincer, 1986). However, further studies have found increased affect (frustration and hostility), but improved performance by internal attributors (Mikulincer, 1988).

Differences have also been documented between attributions of personal and universal helplessness. Abramson et al. (1978) describe personal helplessness as the belief that while one is unable to achieve the desired outcome, others would be capable of such an achievement. Universal helplessness, on the other hand, is defined as the belief

that while one is unable to achieve the desired outcome, others would be equally unsuccessful. Murphey and Galbraith (1990), in an investigation assessing the impact of personal and universal helplessness on self-esteem, found that females suffered a greater loss of self-esteem than males in all conditions. As well, subjects in the 10% helpless condition (personal helplessness) did not exhibit self-esteem deficits to the degree experienced by subjects in the 50% or 100% (universal helplessness) helpless conditions.

The learned helplessness model has been applied to various types of abuse experiences. Follingstad (1980) reported a case study in which a physically abused woman displayed characteristics similar to those cited in learned helplessness theory. Measurements obtained from the Minnesota Multiphasic Personality Inventory (MMPI) depicted a woman characterized by "extreme passivity, dependency and helplessness" (p. 296). Gellen, Hoffman, Jones and Stone (1984) reported significant differences between physically abused and non-abused women on eight MMPI scales. The results were discussed in terms of the learned helplessness syndrome.

Walker (1983) investigated battered women's psychological perspectives. The results revealed that childhood and adult abuse experiences appeared to influence the formation of learned helplessness. Learned helplessness also seemed to interfere with women's ability to successfully stop the battering. Further research investigating gender and

victimization (Walker & Browne, 1985) isolated various childhood factors believed to contribute toward the development of a learned helplessness response. Among these factors were children who had witnessed or experienced physical or sexual abuse.

Launius and Lindquist (1988) reported a significant difference between battered and non-battered women on problem-solving skills and passivity with partners. Both these findings were considered to be consistent with the learned helplessness model. Strube (1988), in his review of the literature assessing the decision to leave an abusive relationship, suggested that a "risk factor" may contribute toward learned helplessness. According to Strube (1988), "some people are more predisposed to making the internal, stable, and global attributions for negative outcomes which enhances the likelihood of chronic and general learned helplessness with self-esteem deficits" (p. 244). Childhood sexual abuse could be such a "risk factor".

Kelley (1986) discussed learned helplessness as it pertained to the sexually abused child. Specifically applying the reformulated learned helplessness model to childhood abuse survivors, she hypothesized that internal, stable, and global factors would be a typical attributional style for these children resulting in a learned helplessness effect. Further discussion supported childhood abuse experiences and learned helplessness as contributing toward revictimization. German

et al. (1990) also suggested that adolescent incest survivors may be oriented toward developing learned helplessness as a result of their abuse experience.

Finally, Gold (1986) examined the effects of childhood sexual abuse on adult functioning. Using the Attributional Style Questionnaire as one measure of adult functioning, the results demonstrated that the abuse group tended to attribute internal, stable, and global factors to bad events and to attribute external factors to good events significantly more often than the control group.

In addition to developing learned helplessness, survivors of childhood sexual abuse may also become externally focused or shift their developing sense of focus from internal to external standards. The powerlessness they experienced as children was beyond their personal control. Consequently, an external locus of control may signify the expectation that their lives will continue to be controlled by external forces.

Rotter (1966) defined the notion of control expectancies as the belief people hold regarding whether an event is contingent upon behavior. If people believe that an event is contingent upon their behavior or personal characteristics then they are considered to be internally focused or have an internal locus of control. Conversely, if people believe that an event is not contingent upon their behavior or personal characteristics then they are considered to be externally focused or have an external locus of control. Externally

focused people tend to attribute events to God, luck, chance, fate or external authorities.

People's tendencies to attribute events as either being within or beyond their control affects their behavior. As Rotter (1966) illustrates, "if a person perceives a reinforcement as contingent upon his [or her] own behavior, then the occurrence of either a positive or negative reinforcement will strengthen or weaken potential for that behavior to recur in the same or similar situation" (p. 5). If a person perceives a reinforcement to be due to external factors (beyond one's control), "the preceding behavior is less likely to be strengthened or weakened" (p. 5).

Rotter (1966) cautioned against viewing locus of control as entirely internal or external. Rather, he proposed viewing locus of control along a hypothetical continuum on which people would tend to lean toward either an internal orientation or an external orientation. Whereas people at either extreme have been considered maladjusted, positive attributes have typically been assigned to those with an internal locus of control (independent, motivated and resistant to external influence). Negative attributes such as passiveness, powerlessness, and susceptibility toward outside influence have been assigned to those with an external locus of control. Nonetheless, Rotter (1966) suggested that "externality may act as an adequate defense against failure" (p.10).

Investigations have been conducted utilizing Rotter's Internal-External control scale. Hiroto (1974), investigating locus of control and learned helplessness, found that subjects with an external locus of control tended to exhibit greater learned helplessness than subjects with an internal locus of control.

Other studies researching abusive experiences on locus of control have reported locus of control differences between abused and non-abused children (Allen & Tarnowski, 1989; Barahal, Waterman & Martin, 1981) and youth (Simmons & Weinman, 1991). Abused subjects were more externally oriented than non-abused subjects. Launius and Lindquist (1988), however, did not observe any differences between locus of control orientation and general assertiveness among battered and non-battered women. Despite their findings, they conceded that the results could be biased due to the battered sample residing at a shelter at the time of their investigation.

Galambos and Dixon (1984) speculated that short-term abuse experiences (beginning in adolescence) may not affect locus of control to the degree that long-term abuse (beginning in childhood) experiences would. Based on their review of the literature, the authors hypothesized that long-term abuse experiences would likely result in children adopting a more external orientation than either their non-abused counterparts or those whose abuse experience initiated during adolescence.

Effective and efficient therapeutic methods are rapidly gaining popularity due to the overwhelming numbers of people seeking aid for a myriad of problems. Group therapy is considered to be the treatment of choice in a variety of areas including, but not limited to, marital, alcohol and medical related, obesity, assertiveness, and behavioral (Lazarus, 1989; Yalom, 1985). Inherent within the therapeutic group procedure is cost-effectiveness and volume-efficiency. Its flexible format also affords therapists the leeway to modify their group program to better meet the needs of their clients, while at the same time, preserving effective and efficient therapy.

Research studies have supported the use of group therapy on alleviating psychological distress with cancer patients (Telch & Telch, 1986) and on treating depression (Hoberman, Lewinsohn & Tilson, 1988; Marshall & Mazie, 1987). Wierzbicki and Bartlett (1987), nevertheless, found individual cognitive therapy to be more effective than either group cognitive therapy or no therapy on the treatment of mild depression.

Increasing numbers of adult survivors have come forth to seek treatment for problems stemming either directly or indirectly from their abuse experience. The expedience, effectiveness, and cohesiveness resulting from a group therapy format has proven beneficial in treating adult survivors. Reported benefits include decreased feelings of isolation, anxiety, guilt and depression; increased feelings

of trust, acceptance, empowerment, and self-esteem; and enhanced interpersonal relationships (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Apolinsky & Wilcoxon, 1991; Axelroth, 1991; Carver, Stalker, Stewart & Abraham, 1989; Gold, 1986; Sultan & Long, 1988; Tsai & Wagner, 1978).

Courtois (1988) reported that a wide-range of therapeutic techniques may be employed in the treatment of adult survivors. She suggested that therapists adopt a "flexible, eclectic, multimodal therapy utilizing a broad range of techniques" (p. 184). The overall goals that appear to govern group therapy for survivors typically include releasing verbal and affective expressions of the abuse experience, assigning responsibility for the abuse to the perpetrator, cognitive restructuring, and behavior modification within a safe, validating, and supporting atmosphere (Agosta & Loring, 1988; Courtois, 1988; Courtois & Sprei, 1988; Mayer, 1983; McCann et al. 1988; Sgroi, 1988a, 1988b; Sgroi & Bunk, 1988).

Partially to aid in group experience processing, several researchers have advocated individual or marital therapy as adjuncts to group therapy for adult survivors (Amaranto & Bender, 1990; Courtois, 1988; Follette, Alexander & Follette, 1991; Sgroi & Bunk, 1988). Lazarus (1989), however, generally discourages conjoint individual and group therapy. In his opinion, participants may "save sensitive material for their individual sessions" (p. 224) and disclose selectively which is believed to hinder the group experience.

While learned helplessness and locus of control may be considered as comprising both state and trait characteristics, Wallston, Wallston, Smith and Dobbins (1987) have documented that "beliefs and systems of belief are amenable to change, given differing experiences in a given situation" (p. 11). Aasen (1987) also believes that despite the stability associated with learned helplessness and locus of control characteristics, the potential for their modification exists.

Seligman (1990) supports the aptitude for changing attributional style from a pessimistic stance to an optimistic one. Forsterling (1985) researched attributional training studies and found them to be generally successful in modifying maladaptive cognitions and behaviors. Gellen et al. (1984) reported that assertiveness training and rational-emotive techniques were effective in overcoming learned helplessness effects.

Locus of control orientation has also been successfully modified. Sultan and Long (1988), in their study of female inmates, reported a shift in locus of control orientation from an external focus to an internal focus. While the change failed to reach significance, factors beyond the inmates control during their prison confinement were cited as inhibiting the radical locus of control change. Other researchers have also documented the advantages of becoming more internally focused. Barahal et al. (1981) in their discussion of treatment implications recommended therapeutic

training to help children "overcome the detrimental effects of an external locus of control" (p. 514). Strickland (1989) linked an internal locus of control orientation to improved health, mindfulness and creativity; factors associated with a positive life experience.

The aim of the present study was to assess the efficacy of group therapy on learned helplessness, locus of control and current levels of functioning with female survivors of childhood sexual abuse. For the purpose of this study, childhood sexual abuse was defined as any type of inappropriate gesture, touch, visual stimuli, voyeurism, or coercion aimed at a person under the age of 18 and perpetrated by an older sibling, parent, relative or any other authority figure (i.e., babysitter) with the intent on achieving sexual gratification. Women who suspected childhood sexual abuse, but who did not have specific memories of the abuse experience, were included in the investigation. The effects of abuse may be exhibited without benefit of concrete memories. Suspected sexual victimization during childhood with manifestations of abuse symptomology were the key factors.

In terms of clinical implications for therapy, the study may be useful in prioritizing treatment goals and objectives for both individual and group therapy. Degree of learned helplessness may serve to focus the course of therapy toward alleviating the helpless effects and instilling a sense of

personal agency. Concurrently, determination of locus of control may aid therapists in recognizing internal versus external orientation which could further structure the therapeutic sessions. Attainment of a more internal locus of control could aid survivors in establishing a sense of empowerment and responsibility for their destiny.

Method

Subjects

Subjects were female volunteers from the Thunder Bay community, recruited from the Catholic Family Development Centre. A total of nine subjects participated in this investigation. Although 15 subjects were registered to participate, four subjects dropped out, one subject declined to participate at the outset and one subject failed to complete all test requirements.

Of the remaining nine subjects, six were married or equivalent to married, one was separated and two were single. The mean age of the subjects was 35 years (SD = 7.5 with a range of 22 to 46 years). The mean number of years of education was 12.5 (SD = 1.7 with a range of 10 to 16 years). In regards to employment status, two subjects were employed outside the home, three subjects were unemployed, two subjects were homemakers, one subject was a student and one subject failed to respond to the question. All subjects had received prior therapy, four had experienced hospitalization for psychological/psychiatric problems and four had attempted

suicide (M = 2 attempts). Three subjects acknowledged a family member as suffering from an "emotional" or "mental" disorder. One subject admitted that a family member had attempted or completed suicide.

Regarding the abuse experience, seven subjects reported age at onset of abuse. The mean age at onset was 4.1 years (SD = 2.6 with a range of 2 to 9 years). Two subjects were unsure of their age at the time of abuse. Of the six subjects who reported duration of abuse, the mean length of time was 7.8 years (SD = 3.6 with a range of 5 to 15 years). Two subjects did not know the duration of their abuse and one subject reported the abuse as an isolated incident. One subject named her mother as the abuser, two subjects named their father, two subjects named their sibling(s), two subjects named other family member(s) and three subjects reported other(s) as their abuser. One subject reported the abuse as occurring from two different sources. Eight subjects reported other abuse experiences in addition to their childhood sexual abuse. Parents, spouses, and/or boyfriends were cited as having been verbally, emotionally, physically, and/or sexually abusive both during and beyond childhood. One subject neglected to answer this query.

Materials

Several materials were used in this study. These include modified versions of the Multimodal Life History Inventory (Lazarus & Lazarus, 1991), the Attributional Style

Questionnaire (ASQ) (Seligman, 1984), the Social Reaction Inventory (SRI) (Rotter, 1966) and a Satisfaction Questionnaire.

The Multimodal Life History Inventory (Lazarus & Lazarus, 1991) is a 15-page self-report. Demographic information, personal and social history, presenting problems, and a modality section assessing current problems in relation to **B**ehavior, **A**ffect, **S**ensation, **I**magery, **C**ognition, **I**nterpersonal relationships, and **D**rug/Biological factors (BASIC I.D.) are explored in this inventory. As a qualitative instrument, the Multimodal Life History Inventory queries a wide-range of historical, sociological, and psychological factors. As a quantitative instrument, it provides a measurement of description assessing the degree of improvement or regression across the seven modalities comprising the BASIC I.D.

For the purpose of this investigation, a modified version of the Multimodal Life History Inventory which incorporated several additional inquiries was used (See Appendix A). Areas of further inquiry included the number of times subjects attempted suicide; sexual abuse age of onset, frequency, duration, and abuser; self-mutilating behavior; and past involvement in any physical, emotional, or verbal abusive relationships.

Portions of the Multimodal Life History Inventory were also employed as post-measurements. Specifically, the behavior, affect, sensation, imagery, cognition and

drug/biological checklist components were combined to comprise the Modality Analysis of Current Problems (See Appendix B). Scores were generated based on the number of descriptors checked off within each modality. An additional cognitive measurement derived from the cognition modality was also included as a post-measurement. The 15 statements rated along a 5-point Likert scale which reflect personal beliefs provided further pre-post data. The interpersonal relationship modality was not included as a post-measurement due to the absence of a checklist component within this domain.

Clinically, the advantages of utilizing the Multimodal Life History Inventory affords a thorough and comprehensive assessment of subjects' history and functioning. Consequently, the Multimodal Life History Inventory provides a meticulous examination of historical information and contemporary functioning while presenting a framework on which to base therapeutic intervention strategies.

The Attributional Style Questionnaire (Seligman, 1984) is a self-report method of measuring explanatory style for good and bad events (See Appendix C). Causal explanations for these events are attributed to three out of a possible six causes (internal/external, stable/unstable, and global/specific). Internal, stable, and global attributions indicate a predisposition toward learned helplessness.

The questionnaire consisted of 48 open-ended questions. Subjects responded to the questions based on 12 situational

propositions (six good events and six bad events) by first citing a cause for the situation and then answering three questions about the event along a 7-point scale ranging from 1 "Totally due to other people or circumstances" to 7 "Totally due to me".

Although scores could be generated based on the degree of internality, stability and globality for positive and negative events, composite scores were used to determine the level of helplessness. Composite scores were computed by summing all positive and negative scores for a total range of scores from 3 to 21. Composite negative scores were then subtracted from composite positive scores to reveal the degree of helplessness. Scores ranged from minus 18 to plus 18 with lower scores indicating greater helplessness. As a pre-post measurement, scores obtained from the ASQ measured the degree of helplessness over time.

Investigations assessing the reliability and validity of the ASQ have reported acceptable validity and modest reliability for individual scores. Nevertheless, utilizing overall composite scores for good and bad events was found to increase reliability to acceptable alphas of .75 for good events and .72 for bad events (Peterson, Semmel, von Baeyer, Abramson, Metalsky & Seligman, 1982; Peterson & Seligman, 1984). Tenen and Herzberger (1986) have also supported the use of composite scores. As a result, composite scores were the primary foci in determining degree of learned

The Social Reaction Inventory (Rotter, 1966) is a self-report measure determining the degree to which persons attribute events as being controlled by internal or external causes (See Appendix D). The scale consists of 29 forced-choice questions including six filler questions. Scores were generated based on the number of external responses. The proclivity toward an external focus indicates the tendency of subjects to view forces beyond their control as influential life factors.

The Satisfaction Questionnaire is a 4-page self-report measure designed for use in this investigation (See Appendix E). As a follow-up measure, the Questionnaire was designed to reflect functioning across Lazarus' BASIC I.D., assess degree of satisfaction with the group experience, recommend improvements for the program and state personal areas of improvement.

To aid in assessing improvement or regression of functioning across modalities, three statements were listed within each of the behavior, affect, sensation, imagery, cognition, and drug/biological domains. The interpersonal relationship modality contained nine statements. The rationale underlying the greater number of statements listed within this domain stemmed from the exclusion of this modality from the Modality Analysis of Current Problems. Subjects responded to each of the statements based on a Likert scale ranging from 1 "Strongly Disagree" to 7 "Strongly Agree".

In order to rate degree of satisfaction related to the therapeutic program, 17 group experience statements were rated following the 7-point Likert scale. Three of the 17 statements requested explanations concerning the cause of any disagreement ratings. Causal explanations served as determinants for internal or external dissatisfaction. Statements within this section of the Questionnaire reflected several of the long-term effects experienced by survivors, the agency's goals and subjective information regarding the group experience.

The final portion of the Satisfaction Questionnaire requested comments on recommended improvements for group therapy and personal areas of improvement resulting from the group experience. Satisfaction with the therapeutic program and suggested areas of improvement could serve to structure or modify the agency's group therapy format. Personal areas of improvement could function as feedback to the agency assessing the efficacy of their program.

Procedure

A cover letter was presented to the Catholic Family Development Centre requesting their cooperation in assessing learned helplessness, locus of control and current functioning as a function of participation in the agency's 16-week sexual abuse therapeutic group (See Appendix F). Permission was granted to proceed with the research project.

Subjects were assigned to one of two therapeutic groups

based on their scheduling preference. The first group was conducted on Monday evenings from 7:00 p.m. to 9:00 p.m. Group 1, originally comprised of eight participants, was subsequently reduced to five subjects. Three members failed to see the program through to completion. The second group ran on Wednesday afternoons from 1:15 p.m. to 3:15 p.m. Of the seven members originating in Group 2, one subject dropped out of the program, one subject declined to participate in the study and one subject failed to complete all test sessions. A total of four subjects comprised the second group.

Both groups functioned according to the same format. Predominately, the therapy group followed a feminist perspective. A "Bioenergetics" stance adhering to the premise that action precedes emotion was also fundamental to the group procedure. This type of expressive therapy was believed to benefit survivors by aiding in the release of emotions associated with past trauma. Specific exercises were employed to encourage insight, bodily-awareness and emotional expression. A variety of therapeutic techniques were utilized including the empty chair, psychodrama, emotional expression (hitting, kicking, pounding, verbalizing) art, sentence completion, visualization and inner child work. The group format was semi-structured in design. Input from participants was encouraged especially as it pertained to individual performance. Therapeutic methods employed by participants were based on the facilitators' recommendation. Two

experienced therapists (one counsellor on staff and one on contract with the agency) and 2 therapist trainees served as facilitators for the groups. Facilitators adopted a relatively didactic, validating and supportive role.

A counsellor at the Catholic Family Development Centre contacted all the women who intended to participate in group therapy prior to the advent of the 16-week program. The voluntary emphasis of subjects participation as well as the nature, purpose and testing requirements of the study were explained at that time. The agency's policy to accept women into the therapeutic group after having completed a 12-week sexual abuse educational group ensured that the women who participated in the study had prior exposure to group work and were cognizant of the risks and benefits they could expect from such an undertaking.

The purpose and requirements of the investigation were thoroughly explained during the initial meeting of Group 1. Introductory statements, crisis telephone listings and consent forms were provided to all subjects who agreed to participate in this investigation. Informed consent was obtained and the measures ensuring and limiting confidentiality were discussed. Subjects were advised that their participation was entirely voluntary and that they could choose to terminate their participation at any time. Copies of the introductory statement, crisis listing, and consent form may be found in Appendices G, H, and I respectively.

The introduction and testing for this phase of the project required one hour. Subjects completed the ASQ and the SRI during the first group meeting. Upon completion of the tests, the Multimodal Life History Inventory was distributed to subjects with instructions for its completion and return at the time of the next group meeting. Completion of the Inventory was expected to require one and one-half hours. Nonetheless, subjects had one week to accomplish this task. Total testing time for this phase of the project required approximately two and one-half to three hours.

Further testing was required mid-way through the program (Session 8) and upon its completion (Session 16). The ASQ, SRI, and the Modality Analysis of Current Problems were re-administered at these times. The Satisfaction Questionnaire was administered exclusively at the final group meeting. Testing time for each of these sessions required approximately one hour. The Wednesday afternoon group (Group 2) was approached according to the same procedure as outlined for Group 1.

For the purpose of ensuring confidentiality, all data derived as a result of this investigation were coded. Names were not revealed and identifying information was not disclosed. All identifying data were securely stored at the agency.

Results

The results of this study must be viewed with

circumspection. While recognizing the methodological shortcomings inherent in the design, namely the non-random sample, scanty number of subjects and lack of a control group, the results appear to be noteworthy and are presented with this cautionary statement in mind.

Scores derived from the Modality Analysis of Current Problems revealed qualitative information common to adult abuse survivors. Tables 1 to 6 illustrate the behavioral, affect, physical sensation, imagery, cognition and drug/biological modality descriptors that were frequently endorsed by the sample subjects. Descriptor inclusion was based on agreement between five or more subjects at Session 1. An exception to this rule was allowed for the drug/biological modality (Table 6) which notes daily usage based on one-third (N=3) agreement between subjects.

Table 1 illustrates the most frequently endorsed behavior descriptors including unassertiveness, procrastination, withdrawal, concentration difficulties and sleep disturbance.

Table 1

Modality Analysis of Frequently Endorsed Behavior Descriptors (N=9)

Descriptor	Session 1	Session 8	Session 16
Overeat	5	4	5
Unassertive	8	6	7
Procrastination	8	8	6
Impulsive reactions	6	6	3
Crying	6	4	4
Compulsions	5	3	2
Withdrawal	8	8	7
Concentration difficulties	8	8	7
Sleep disturbance	8	7	7
Spend too much money	6	5	3
Insomnia	6	6	3
Lazy	5	4	5
Outbursts of temper	5	1	4

Table 2 illustrates anxiety, loneliness and tension as the most common affective descriptors endorsed by 100% of the subjects during Session 1. Feelings of depression, fear, guilt, conflict and panic were also reported by eight of the nine subjects.

Table 2

Modality Analysis of Frequently Endorsed Affect Descriptors

(N=9)

Descriptor	Session 1	Session 8	Session 16
Angry	7	9	5
Annoyed	6	7	4
Depressed	8	9	8
Fearful	8	9	8
Guilty	8	7	6
Conflicted	8	8	8
Regretful	5	3	6
Unhappy	5	5	4
Restless	5	6	7
Sad	7	8	8
Anxious	9	8	7
Panicky	8	5	4
Shameful	7	7	4
Hopeless	7	5	2
Helpless	6	4	3
Lonely	9	7	7
Tense	9	8	7

Table 3

Modality Analysis of Frequently Endorsed Physical Sensation Descriptors (N=9)

Descriptor	Session 1	Session 8	Session 16
Dizziness	7	6	5
Sexual disturbance	5	5	5
Bowel disturbance	5	7	5
Numbness	7	7	6
Headaches	7	7	7
Tension	9	9	7
Unable to relax	8	7	7
Stomach trouble	6	7	4
Fatigue	9	9	7
Don't like to be touched	6	7	6

The overall trend observed from Table 3 reveals a decline in physical sensation symptoms across sessions. All subjects reported tension and fatigue as normative descriptors during Session 1 and Session 8 testings.

Table 4

Modality Analysis of Frequently Endorsed Image Descriptors

(N=9)

Descriptor	Session 1	Session 8	Session 16
Not coping	9	6	5
Losing control	8	8	5
Being talked about	7	6	6
Being helpless	7	4	3
Being trapped	7	6	3
Failing	8	3	4
Being laughed at	6	4	4
Negative body image	8	8	9
Lonely images	6	6	7
Unpleasant childhood images	7	6	7
Unpleasant sexual images	6	6	7

As illustrated in Table 4, an image of not coping was cited by 100% of the subjects during Session 1. Losing control, failing and negative body images were also endorsed by eight of the nine subjects. Negative body and unpleasant sexual images were endorsed more frequently at Session 16 than at Session 1 or Session 8.

Table 5

Modality Analysis of Frequently Endorsed Cognitive Descriptors (N=9)

Descriptor	Session 1	Session 8	Session 16
Intelligent	6	5	7
Sensitive	7	7	8
Trustworthy	6	5	6
Considerate	5	5	6
Unattractive	6	6	5
Inadequate	6	5	4
Naive	7	5	3
Conflicted	9	7	8
Memory problems	7	6	6
Can't make decisions	7	6	6
Lazy	5	4	2
Loyal	5	5	3
Confused	8	6	7
Honest	5	4	5
Concentration difficulties	7	8	7
Suicidal ideas	5	3	2

Table 5 illustrates the most frequently endorsed cognitive descriptors. All subjects reported thoughts of conflict and eight of the nine subjects reported thoughts of

confusion at Session 1. An increase across sessions was noted for several "positive" descriptors. Cognitions concerning intellect, sensitivity and consideration were checked off more frequently at Session 16 than at Session 1.

Table 6 depicts the daily drug/biological descriptors. Due to the rating classification within this modality (never, rarely, occasionally, frequently or daily), criterion for inclusion in Table 6 was based on one-third (N=3) subject agreement for any daily descriptor across testings. Only four daily descriptors were endorsed by three or more subjects at any testing time. Daily cigarette usage, fatigue and weight problems were reported more frequently during latter sessions than during Session 1. Daily coffee consumption was noted to increase at Session 8 then decrease at Session 16.

Table 6

Modality Analysis of Daily Drug/Biological Descriptors (N=9)

Descriptor	Session 1	Session 8	Session 16
Cigarettes	3	4	4
Coffee	3	5	3
Fatigue	3	3	4
Weight problems	2	1	3

Change scores were calculated from Session 1 to Session 16 on the Modality Analysis of Current Problem scores. A difference score of one-third (N=3) was established as being indicative of change. Table 7 illustrates the behavior and affect change scores. Of the total 28 behavior descriptors, seven descriptors decreased in endorsement frequency from Session 1 to Session 16. Impulsive reactions, compulsions, over-spending and insomnia, originally endorsed by five or more subjects, were reduced to three or fewer reportings at Session 16. Five of the 28 affect descriptors changed across sessions by a frequency of three. Shameful and helpless feelings decreased from Session 1 to Session 16 by three reportings and feelings of panic and hopelessness decreased by four and five reportings respectively. Anger was endorsed more frequently at Session 8 than at Session 1 and was endorsed less frequently at Session 16 than at Session 8. 'Other' affect descriptors reported by subjects included "numbness", "rootless" and "distrustful".

Table 7

Modality Analysis of Behavior/Affect Descriptor Change Scores

Descriptor	Session 1	Session 8	Session 16	Chg
Behaviors				
Work too hard	3	1	0	3
Impulsive reactions	6	6	3	3
Compulsions	5	3	2	3
Nervous tics	3	2	0	3
Spend too much money	6	5	3	3
Insomnia	6	6	3	3
Aggressive behavior	3	2	0	3
Affect				
Angry	7	9	5	4[1]
Panicky	8	5	4	4
Shameful	7	7	4	3
Hopeless	7	5	2	5
Helpless	6	4	3	3

[1] Change score from Session 8 to Session 16

Table 8

Modality Analysis of Physical Sensation/Image/Cognition Descriptor Change Scores

Descriptor	Session 1	Session 8	Session 16	Chg
Physical Sensations				
Muscle spasms	4	2	1	3
Rapid heart beat	3	6	6	3
Blackouts	3	6	0	3
Images				
Being happy	1	3	4	3
Not coping	9	6	5	4
Losing control	8	8	5	3
Being helpless	7	4	3	4
Being trapped	7	6	3	4
Being followed	4	2	1	3
Failing	8	3	4	4
Cognitions				
Useless	4	3	1	3
Naive	7	5	3	4
Lazy	5	4	2	3
Dishonest	3	1	0	3
Suicidal ideas	5	3	2	3

Table 8 illustrates the physical sensation, image and cognition change scores from Session 1 to Session 16. Of the 35 physical sensation descriptors, three met the one-third change criterion. While muscle spasm and blackout descriptors were reported less frequently at Session 16 than at Session 1, sensations of rapid heart beat increased. Seven of the 24 image descriptors are included in Table 8. Not coping, helpless, trapped and failing images decreased by a frequency of four from first to last testing. The remaining descriptors also decreased, with the exception of the "being happy" image descriptor which increased by a frequency of three. 'Other' descriptors reported by subjects included images of death, staying stuck, surviving and overcoming difficulties. Of the total 40 cognition descriptors, five met the established criteria. While all five descriptors decreased by a minimum of three reportings, the descriptor "naive" decreased by a frequency of four reportings from first to last testing. 'Other' cognitive descriptors included "warped sense of humor", "conceited" and "too serious". None of the 47 drug/biological descriptors met the criterion for inclusion in Table 8.

A multivariate analysis of variance revealed a non-significant interaction between modalities and sessions on the number of descriptors reported, $\underline{F}(8,64)=0.58$, n.s. Although a significant main effect was found between modalities on the number of descriptors reported, $\underline{F}(4,32)=3.82$, $p=.012$, follow-

up analyses were not performed. The number and type of descriptor variables assigned to each modality was predetermined by Lazarus. Because the modalities were designed to reflect unique areas of functioning, the differences between them were anticipated and are believed to account for this effect. A non-significant effect of session on the number of descriptors reported was also determined, $F(2,16)=2.30$, n.s. Nonetheless, as Table 9 illustrates the overall trend indicated a modality mean decrease across sessions. Further analyses were conducted in the form of t-tests to determine statistical significance.

Table 9

Modality Analysis of Current Problems Table of Means by Session

Modality	Session 1	Session 8	Session 16
Behaviors	13.00	11.00	9.44
Affect	16.11	14.33	13.00
Physical Sensations	15.11	15.22	14.11
Images	11.67	10.00	10.00
Cognitions	16.44	14.44	14.22

Prior to combining the data, independent t-tests were performed on the Modality Analysis of Current Problem scores comparing means between the Monday and Wednesday groups. Non-

significant differences between groups across sessions were determined for behavior $\underline{t}(7)=-0.76$, n.s., affect $\underline{t}(7)=0.06$, n.s., physical sensation $\underline{t}(7)=1.78$, n.s., image $\underline{t}(7)=-0.02$ n.s. and cognition $\underline{t}(7)=-0.11$, n.s., modalities.

Non-independent t-tests were conducted on the mean Modality Analysis of Current Problem scores. A significant difference was determined between means at Session 1 (M = 13.0) and Session 16 (M = 9.44) on the behavior modality, $\underline{t}(8)=2.77$, $p=.024$. The number of behavior descriptors reported was significantly less at the end of the therapeutic group than at its conception. Affect, physical sensation, image and cognition modalities were all non-significant, $\underline{t}(8)=1.70$, n.s., $\underline{t}(8)=0.68$, n.s., $\underline{t}(8)=1.10$, n.s. and $\underline{t}(8)=0.82$, n.s., respectively.

An independent t-test comparing groups was performed on the 15 personal belief statements derived from the cognition modality. The results showed a non-significant difference between groups $\underline{t}(7)=2.16$, n.s. Non-independent t-tests on the combined personal belief scores revealed a significantly lower mean score at Session 16 (M = 38.33) than at Session 1 (M = 50.44), $\underline{t}(8)=5.24$, $p<.01$. The decline in personal belief statement scores indicated a decrease in cognitive distortion ratings from first to last testing. Scores ranged from 15 to 75 per testing. Total combined scores across testings ranged from 90 to 181 (SD = 26.83).

Independent t-tests comparing groups were performed on

the ASQ and SRI scores. A non-significant difference was determined between groups on level of helplessness $\underline{t}(7)=2.29$, n.s., and locus of control $\underline{t}(7)=-0.50$, n.s. Non-independent t-tests were then conducted on the combined data. A significant difference between Session 1 and Session 16 means on level of helplessness was determined, $\underline{t}(8)=-3.47$, $p=.008$. Total ASQ scores across testings ranged from -26.8 to +3.5 with a standard deviation of 10.27.

Locus of control means were not significantly different from Session 1 to Session 16, $\underline{t}(8)=1.40$, n.s. Six of the nine subjects were classified as having an external locus of control at Session 1. A SRI score greater than or equal to 11.5 was the midpoint between internal and external orientation. Total SRI scores ranged from 25 to 51 (SD = 9.43).

As Table 10 illustrates, learned helplessness scores improved significantly across sessions. Locus of control scores, although exhibiting a general movement toward internality, failed to reach significant levels.

Table 10

ASQ and SRI Table of Means by Session

Variable	Session 1	Session 8	Session 16
Learned Helplessness	-4.16	-1.36	-0.12
Locus of Control	13.56	12.33	11.78

Pearson correlation coefficients were calculated on the ASQ and SRI scores. A non-significant correlation between level of helplessness and locus of control was determined, $r(7)=-0.43$, n.s.

Prior to combining the data derived from the Satisfaction Questionnaire, an independent t-test was conducted comparing group means. A non-significant difference was established between groups on level of satisfaction, $t(7)=1.99$, n.s. Subjects were generally satisfied with the therapeutic group. An overall mean satisfaction score of 4.65 was determined with scores ranging from one to seven. Subjects appeared to be the most satisfied with the change noted from the group experience (M = 5.8) followed by affect (M = 5.4) and behavior (M = 4.7) modifications. Physical sensation and imagery modalities received identical mean scores (M = 4.4) as did cognition and drug/biological modalities (M = 4.1). The interpersonal relationship modality received a mean rating of 4.3.

Consensus among subjects commenting on recommended

improvements for group therapy revealed dissatisfaction with the 16-weeks allotted for the therapeutic group. A longer time frame was strongly advocated by subjects. Additional comments included endorsement for a support or aftercare group and restricting therapeutic group participation to a maximum of six members. Comments regarding personal areas of improvement included greater feelings of trust, optimism, strength, support and hope. Improved communication, interpersonal relations and boundary setting were also cited by subjects. Further comments included decreased feelings of helplessness, rage, shame, fear and isolation.

Discussion

The results of this study may be of limited value due to the methodological shortcomings inherent in the design. Nonetheless, its contribution to future investigations may be beneficial under the auspices of a pilot study. Consequently, the interpretation of the results and the following discussion are presented according to this dictate.

Overall, the results of the study appear to be consistent with previous research documenting long-term effects of survivors of childhood sexual abuse. Symptoms common to the sample subjects were noted from the Modality Analysis of Current Problems. Within the behavior, affect, sensation, interpersonal relationship and cognition modalities, several descriptors were endorsed more frequently than others supporting Neland's (1987) inquiry.

Although no more than four subjects were in agreement concerning daily drug/biological descriptors, an overall pattern was observed that was consistent with the remaining modalities. For example, negative effects in areas governing sleep (fatigue, insomnia) sexuality (negative body image, aversion to touch, unpleasant sexual images) and self-image (unassertive, procrastination, impulsive reactions, compulsions, withdrawal, lazy, depression, fear, guilt, conflict, regret, unhappy, sadness, anxious, panic, helplessness, hopelessness, not coping, being trapped, suicidal ideation) were not specific to any one particular modality. Rather, the effects appeared to be widespread and interrelated suggesting the absence of modality boundaries. The aftermath of childhood sexual abuse may manifest a reciprocal interaction between and amongst modalities. Functioning across all aspects of life may consequently be susceptible to childhood influence which supports Curtois's (1988) belief that the entire life sphere is affected by the abuse experience.

Change scores assessing current functioning partially support the efficacy of the therapeutic group. Successful modification of maladaptive behaviors was noted to occur during the 16-week program. Although descriptors within the behavior modality were the only ones to significantly decrease in endorsment frequency between first and last testings, the remaining modalities also decreased across testings. The

presence of both positive and negative descriptors were noted in all modalities except the behavior modality which contained only negative descriptors. This inconsistency between modality descriptors may have inaccurately confounded the results. Conversely, behaviors may be more amenable to change than other areas of functioning. Nonetheless, the significant decrease in personal belief statement scores revealed successful modification of cognitive distortions. Thus, Wallston et al.'s (1987) proposition that maintains "beliefs and systems of belief" (p. 11) being responsive to change was supported.

Learned helplessness appeared to be a common phenomenon among group members. Whether the helpless effect stemmed from childhood sexual abuse was unable to be determined. While acknowledging that other factors may have contributed to the development of learned helplessness, the finding was consistent with Walker's (1983) study linking child or adult abuse experiences to the development of a learned helpless response. All survivors displayed a marked level of helplessness at the time of the initial testing. The possible range of helplessness scores between minus 18 to plus 18, offered objective measurements toward determining the sample subjects level of helplessness. While scores consistently remained on a negative scale across testings, a significant improvement was noted between first and last testings. Thus, the study lends support to Aasen's (1987), Forsterling's

(1985) and Seligman's (1990) investigation examining successful modification of helplessness characteristics.

Eight of the nine subjects reported other abuse experiences in addition to childhood sexual abuse. This finding tentatively supports Kelly's (1986) and German et al.'s (1990) proposal that helplessness, a learned response resulting from childhood abuse, may lead to revictimization.

Although specific attributional styles were not determined in this study, Strube's (1988) proposition connecting childhood "risk factors" to the development of learned helplessness with negative self-perceptions was partially supported. Repeated themes of helplessness and powerlessness were documented from the Modality Analysis of Current Problems. Behavioral (unassertive), emotive (depression, fear, guilt, conflict, sadness, anxiety, panic, shame, hopelessness, helplessness), image (not coping, being helpless, being trapped, failing) and cognitive (inadequate, conflicted, lazy, inability to make decisions, confusion, concentration difficulties, suicidal ideation) deficits, all reinforcing helplessness and powerlessness paradigms, were reported by subjects.

An external locus of control was noted to be the primary orientation among participants. While the study was unable to corroborate childhood abuse experiences as manifesting an external focus, the results lend tentative support to Allen and Tarnowski's (1989), Barahal et al.'s (1981) and Simmons

and Weinman's (1991) study. The majority of subjects in the sample displayed an external locus of control which corresponds to the above-mentioned investigations studying locus of control among abused and non-abused children and youth. Although scores shifted toward an internal focus which tentatively lends credence to Sultan and Long's (1988) investigation on locus of control modification, mean scores across testings remained in the external domain.

Specific details regarding the type of abuse experience were omitted from this investigation. While other variables related to the abuse were queried, correlation coefficients were not calculated. Subject attrition, small sample size and failure to respond to particular questions deemed it impractical to calculate data other than basic demographic information. Among the subjects who responded to age at onset (M = 4.1 years) and duration (M = 7.8 years) of abuse, all were abused prior to 10 years of age. Consequently, Galambos and Dixon's (1984) speculation regarding short-term (beginning in adolescence) and long-term (beginning in childhood) abuse experiences affecting locus of control orientation was unable to be supported.

Correlation coefficients between ASQ and SRI scores revealed a non-significant relationship between level of helplessness and locus of control. Despite the study's inability to support Hiroto's (1974) investigation establishing greater learned helplessness to those with an

external locus of control, further research may warrant validity in this regard.

All subjects had received therapy prior to participating in the therapeutic group. Additionally, the group leaders advised subjects to seek individual counselling as an adjunct to group therapy. For these reasons, the study was unable to confirm or dispute investigations regarding the efficacy of individual therapy in conjunction with group therapy (Amaranto & Bender, 1990; Follette et al., 1991; Lazarus, 1989; Sgroi & Bunk, 1988).

Overall, subjects were satisfied with the therapeutic group. Although the interpersonal relationship modality was rated second to last in terms of level of satisfaction, the nature of the statements appeared to encourage ambiguity. For example, dissatisfaction in response to a statement within this domain may indicate positive or healthy change. Insight regarding relationship issues may have promoted discord which in turn could encourage interpersonal modifications.

Subjects were overwhelmingly satisfied with the group experience. The singular statement indicating malcontent concerned the duration of the group. Recommendations to extend the group's time frame provided further evidence of subjects dissatisfaction in this area.

Future research investigating the efficacy of group therapy on childhood sexual abuse survivors continues to be an area worthy of inquiry. The present study could serve as a

framework in which the methodological shortcomings inherent in this design may be rectified. Several avenues of investigation appear to be of noteworthy concern. Long-term effects experienced by survivors could be distinguished from control group subjects and the results could be correlated to level of helplessness, attributional style and locus of control. Modification of maladaptive attributional styles contributing to greater levels of helplessness and extreme internal or external orientations could serve to focus therapeutic sessions.

A comparison of different types of therapy would be of benefit to professionals in this field. Specific techniques may be more conducive to alleviating learned helplessness and modifying locus of control than others. Survivors may be more or less amenable to therapy distinct from that utilized at the Catholic Family Development Centre. A 'Bioenergetic' focus may not be the best treatment for survivors. The 16-week duration of the therapeutic group may not be of adequate length to address the specific needs of survivors. A much longer time-frame may be required. Further research comparing strategies and techniques could enhance the efficacy of group therapy with survivors of sexual abuse.

The debate concerning individual versus group therapy as well as individual and/or marital therapy in conjunction with group therapy has both cost-effective and volume-efficient implications. Therapeutic analyses could serve as a frame of

reference in the selection of a particular mode of therapy according to predetermined criteria. Whether long-term benefits are maintained subsequent to therapy termination is another potentially critical area of investigation. Information derived as a result of inquiry into these areas may enhance the resources and services available to survivors.

Details particular to the abuse experience (frequency, severity, duration, relation to perpetrator and type of abuse experience) as well as characteristics of subjects lost to attrition may also serve to focus therapeutic intervention strategies in terms of assessment, diagnosis and treatment. The limitations of the present study served as barriers toward establishing conclusive results. Nonetheless, its value may be established through its relatively pioneer status in the field of restorative functioning for survivors of childhood sexual abuse.

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APPENDIX A

MULTIMODAL LIFE HISTORY INVENTORY

The purpose of this inventory is to obtain a comprehensive picture of your background. In psychotherapy records are necessary since they permit a more thorough dealing with one's problems. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program. You are requested to answer these routine questions in your own time instead of using up your actual consulting time (please feel free to use extra sheets if you need additional answer space).

It is understandable that you might be concerned about what happens to the information about you because much or all of this information is highly personal. Case records are strictly confidential.

Second edition, 1991
First edition, 1980, published as the Multimodal Life History Questionnaire

Research Press
2612 North Mattis Avenue
Champaign, Illinois 61821

GENERAL INFORMATION

Date: _____

Name: _____

Address: _____

Telephone numbers: Day _____ Evening _____

Age: _____ Occupation: _____ Sex: ___ M ___ F

Date of birth: _____ Place of birth: _____ Religion: _____

Height: _____ Weight: _____ Does your weight fluctuate? ___ Yes ___ No If yes, by how much? _____

Do you have a family physician? ___ Yes ___ No

Name of family physician: _____ Telephone number: _____

By whom were you referred? _____

Marital status (check one): ___ Single ___ Engaged ___ Married ___ Separated ___ Divorced

___ Widowed ___ Living with someone ___ Remarried: How many times? _____

Do you live in: ___ House ___ Room ___ Apartment ___ Other: _____

With whom do you live? (check all that apply): ___ Self ___ Parents ___ Spouse ___ Roommate

___ Children ___ Friend(s) ___ Others (specify): _____

What sort of work are you doing now? _____

Does your present work satisfy you? ___ Yes ___ No

If no, please explain: _____

_____

What kind of jobs have you held in the past? _____

_____

Have you been in therapy before or received any professional assistance for your problems? ___ Yes ___ No

Have you ever been hospitalized for psychological/psychiatric problems? ___ Yes ___ No

If yes, when and where? _____

_____

Have you ever attempted suicide? ___ Yes ___ No If yes, how many times? _____

Does any member of your family suffer from an "emotional" or "mental disorder"? ___ Yes ___ No

Has any relative attempted or committed suicide? ___ Yes ___ No

PERSONAL AND SOCIAL HISTORY

Father: Name: _____ Age: _____

Occupation: _____ Health: _____

If deceased, give his age at time of death: _____ How old were you at the time? _____

Cause of death: _____

Mother: Name: _____ Age: _____

Occupation: _____ Health: _____

If deceased, give her age at time of death: _____ How old were you at the time? _____

Cause of death: _____

Siblings: Age(s) of brother(s): _____ Age(s) of sister(s): _____

Any significant details about siblings: _____

_____

_____

If you were not brought up by your parents, who raised you and between what years?

_____

_____

Give a description of your father's (or father substitute's) personality and his attitude toward you (past and present):

_____

_____

_____

_____

_____

Give a description of your mother's (or mother substitute's) personality and her attitude toward you (past and present):

_____

_____

_____

_____

_____

In what ways were you disciplined or punished by your parents?

Give an impression of your home atmosphere (i.e., the home in which you grew up). Mention state of compatibility between parents and between children.

Were you able to confide in your parents? ___Yes ___ No

Basically, did you feel loved and respected by your parents? ___Yes ___ No

If you have a stepparent, give your age when your parent remarried: _____

Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc.? ___Yes ___ No

If yes, please describe briefly: _____

Scholastic strengths: _____

Scholastic weaknesses: _____

What was the last grade completed (or highest degree)? _____

Check any of the following that applied during your childhood/adolescence:

___ Happy childhood
___ Unhappy childhood
___ Emotional/behavior problems
___ Legal trouble
___ Death in family
___ Medical problems
___ Ignored
___ Severely bullied or teased
___ Not enough friends
___ School problems
___ Financial problems
___ Strong religious convictions
___ Drug use
___ Used alcohol
___ Severely punished
___ Eating disorder

Sexual abuse ___Yes ___ No

If yes, Age of onset _____
Isolated incident _____
Repeated incident _____
Abuse lasted ___months. _____ years

ABUSER: _____ Father
_____ Mother
_____ Sibling(s)
_____ Other Family Member(s)
_____ Other(s)

State in your own words the nature of your main problems: _____

_____

_____

_____

_____

_____

On the scale below, please estimate the severity of your problem(s):

____ Mildly upsetting ____ Moderately upsetting ____ Very severe ____ Extremely severe ____ Totally incapacitating

When did your problems begin? _____

_____

What seems to worsen your problems? _____

_____

What have you tried that has been helpful? _____

_____

How satisfied are you with your life as a whole these days?

Not at all satisfied 1 2 3 4 5 6 Very satisfied

How would you rate your overall level of tension during the past month?

Relaxed 1 2 3 4 5 6 Tense

EXPECTATIONS REGARDING THERAPY

In a few words, what do you think therapy is all about? _____

_____

_____

How long do you think your therapy should last? _____

_____

_____

What personal qualities do you think the ideal therapist should possess? _____

_____

_____

MODALITY ANALYSIS OF CURRENT PROBLEMS

The following section is designed to help you describe your current problems in greater detail and to identify problems that might otherwise go unnoticed. This will enable us to design a comprehensive treatment program and tailor it to your specific needs. The following section is organized according to the seven modalities of Behaviors, Feelings, Physical Sensations, Images, Thoughts, Interpersonal Relationships, and Biological Factors.

BEHAVIORS

Check any of the following behaviors that often apply to you:

___ Overeat	___ Loss of control	___ Phobic avoidance	___ Crying
___ Take drugs	___ Suicidal attempts	___ Spend too much money	___ Outbursts of temper
___ Unassertive	___ Compulsions	___ Can't keep a job	___ Others: _____
___ Odd behavior	___ Smoke	___ Insomnia	_____
___ Drink too much	___ Withdrawal	___ Take too many risks	_____
___ Work too hard	___ Nervous tics	___ Lazy	___ Self-mutilation
___ Procrastination	___ Concentration difficulties	___ Eating problems	
___ Impulsive reactions	___ Sleep disturbance	___ Aggressive behavior	

What are some special talents or skills that you feel proud of? _____

_____

What would you like to start doing? _____

_____

What would you like to stop doing? _____

_____

How is your free time spent? _____

_____

What kind of hobbies or leisure activities do you enjoy or find relaxing? _____

_____

Do you have trouble relaxing or enjoying weekends and vacations? ___Yes ___ No

If yes, please explain: _____

_____

_____

If you could have any two wishes, what would they be? _____

_____

_____

Check any of the following feelings that often apply to you:

___ Angry	___ Fearful	___ Happy	___ Hopeful	___ Bored	___ Optimistic
___ Annoyed	___ Panicky	___ Conflicted	___ Helpless	___ Restless	___ Tense
___ Sad	___ Energetic	___ Shameful	___ Relaxed	___ Lonely	___ Others: _____
___ Depressed	___ Envious	___ Regretful	___ Jealous	___ Contented	_____
___ Anxious	___ Guilty	___ Hopeless	___ Unhappy	___ Excited	_____

List your five main fears:

1. _____

2. _____

3. _____

4. _____

5. _____

What are some positive feelings you have experienced recently? _____

_____

_____

When are you most likely to lose control of your feelings? _____

_____

_____

Describe any situations that make you feel calm or relaxed: _____

_____

_____

PHYSICAL SENSATIONS

Check any of the following physical sensations that often apply to you:

___ Abdominal pain	___ Bowel disturbances	___ Hear things	___ Blackouts
___ Pain or burning with urination	___ Tingling	___ Watery eyes	___ Excessive sweating
___ Menstrual difficulties	___ Numbness	___ Flushes	___ Visual disturbances
___ Headaches	___ Stomach trouble	___ Nausea	___ Hearing problems
___ Dizziness	___ Tics	___ Skin problems	___ Others: _____
___ Palpitations	___ Fatigue	___ Dry mouth	_____
___ Muscle spasms	___ Twitches	___ Burning or itching skin	_____
___ Tension	___ Back pain	___ Chest pains	
___ Sexual disturbances	___ Tremors	___ Rapid heart beat	
___ Unable to relax	___ Fainting spells	___ Don't like to be touched	

what sensations are:

Pleasant for you? _____

Unpleasant for you? _____

IMAGES

Check any of the following that apply to you:

I picture myself:

___ Being happy
___ Being hurt
___ Not coping
___ Succeeding
___ Losing control
___ Being followed
___ Being talked about
___ Being aggressive
___ Being helpless
___ Hurting others
___ Being in charge
___ Failing
___ Being trapped
___ Being laughed at
___ Being promiscuous
___ Others: _____
_____
_____

I have:

___ Pleasant sexual images
___ Unpleasant childhood images
___ Negative body image
___ Unpleasant sexual images
___ Lonely images
___ Seduction images
___ Images of being loved
___ Others: _____
_____
_____

Describe a very pleasant image, mental picture, or fantasy: _____

_____

_____

Describe a very unpleasant image, mental picture, or fantasy: _____

_____

_____

Describe your image of a completely "safe place": _____

_____

_____

Describe any persistent or disturbing images that interfere with your daily functioning: _____

_____

_____

How often do you have nightmares? _____

Check each of the following that you might use to describe yourself:

___ Intelligent	___ A nobody	___ Inadequate	___ Concentration difficulties	___ Lazy
___ Confident	___ Useless	___ Confused	___ Memory problems	___ Untrustworthy
___ Worthwhile	___ Evil	___ Ugly	___ Attractive	___ Dishonest
___ Ambitious	___ Crazy	___ Stupid	___ Can't make decisions	___ Others: _____
___ Sensitive	___ Morally degenerate	___ Naive	___ Suicidal ideas	_____
___ Loyal	___ Considerate	___ Honest	___ Persevering	_____
___ Trustworthy	___ Deviant	___ Incompetent	___ Good sense of humor	
___ Full of regrets	___ Unattractive	___ Horrible thoughts	___ Hard working	
___ Worthless	___ Unlovable	___ Conflicted	___ Undesirable	

What do you consider to be your craziest thought or idea? _____

_____

Are you bothered by thoughts that occur over and over again? ___Yes ___ No

If yes, what are these thoughts? _____

_____

What worries do you have that may negatively affect your mood or behavior? _____

_____

On each of the following items, please circle the number that most accurately reflects your opinions:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I should not make mistakes.	1	2	3	4	5
I should be good at everything I do.	1	2	3	4	5
When I do not know something, I should pretend that I do.	1	2	3	4	5
I should not disclose personal information.	1	2	3	4	5
I am a victim of circumstances.	1	2	3	4	5
My life is controlled by outside forces.	1	2	3	4	5
Other people are happier than I am.	1	2	3	4	5
It is very important to please other people.	1	2	3	4	5
Play it safe; don't take any risks.	1	2	3	4	5
I don't deserve to be happy.	1	2	3	4	5
If I ignore my problems, they will disappear.	1	2	3	4	5
It is my responsibility to make other people happy.	1	2	3	4	5
I should strive for perfection.	1	2	3	4	5
Basically, there are two ways of doing things—the right way and the wrong way.	1	2	3	4	5
I should never be upset.	1	2	3	4	5

INTERPERSONAL RELATIONSHIPS

Friendships

Do you make friends easily? ___Yes ___ No Do you keep them? ___ Yes ___ No

Did you date much during high school? ___Yes ___ No College? ___ Yes ___ No

Were you ever bullied or severely teased? ___Yes ___ No

Describe any relationship that gives you:

Joy: _____

_____

Grief: _____

_____

Rate the degree to which you generally feel relaxed and comfortable in social situations:

Very relaxed 1 2 3 4 5 6 7 Very anxious

Do you have one or more friends with whom you feel comfortable sharing your most private thoughts? ___Yes ___ No

Marriage (or a committed relationship)

How long did you know your spouse before your engagement? _____

How long were you engaged before you got married? _____

How long have you been married? _____

What is your spouse's age? _____ His/her occupation? _____

Describe your spouse's personality: _____

_____

_____

What do you like most about your spouse? _____

_____

_____

What do you like least about your spouse? _____

_____

_____

What factors detract from your marital satisfaction? _____

_____

_____

On the scale below, please indicate how satisfied you are with your marriage:

Very dissatisfied 1 2 3 4 5 6 7 Very satisfied

How do you get along with your partner's friends and family?

Very poorly 1 2 3 4 5 6 Very well

How many children do you have? _____

Please give their names and ages: _____

_____

_____

Do any of your children present special problems? ___Yes ___ No

If yes, please describe: _____

_____

Any significant details about a previous marriage(s)? _____

_____

_____

Sexual Relationships

Describe your parents' attitude toward sex. Was sex discussed in your home? _____

_____

When and how did you derive your first knowledge of sex? _____

_____

_____

When did you first become aware of your own sexual impulses? _____

_____

_____

Have you ever experienced any anxiety or guilt arising out of sex or masturbation? ___Yes ___ No

If yes, please explain: _____

_____

Any relevant details regarding your first or subsequent sexual experiences? _____

_____

_____

Is your present sex life satisfactory? ___Yes ___ No

If no, please explain: _____

_____

_____

Provide information about any significant homosexual reactions or relationships: _____

_____

_____

Please note any sexual concerns not discussed above: _____

_____

_____

Other Relationships

Are there any problems in your relationships with people at work? ___Yes ___ No

If yes, please describe: _____

_____

Please complete the following:

One of the ways people hurt me is: _____

_____

I could shock you by: _____

_____

My spouse (or boyfriend/girlfriend) would describe me as: _____

_____

My best friend thinks I am: _____

_____

People who dislike me: _____

_____

Are you currently troubled by any past rejections or loss of a love relationship? ___Yes ___ No

If yes, please explain: _____

Have you ever been involved in a physically, emotionally, or verbally abusive relationship

If yes, please explain: _____

_____

Do you have any current concerns about your physical health? ___Yes ___ No

If yes, please specify: _____

_____

_____

_____

Please list any medications you are currently taking: _____

_____

_____

Do you eat three well-balanced meals each day? ___Yes ___ No

Do you get regular physical exercise? ___Yes ___ No

If yes, what type and how often? _____

_____

_____

Please list any significant medical problems that apply to you or to members of your family: _____

_____

_____

_____

Please describe any surgery you have had (give dates): _____

_____

_____

_____

Please describe any physical handicap(s) you have: _____

_____

_____

Menstrual History

Age at first period: _____ Were you informed? ___ Yes ___ No Did it come as a shock? ___Yes ___ No

Are you regular? ___Yes ___ No Duration: _____ Do you have pain? ___ Yes ___ No

Do your periods affect your moods? ___Yes ___ No Date of last period: _____

Check any of the following that apply to you:

	Never	Rarely	Occasionally	Frequently	Daily
Muscle weakness					
Tranquilizers					
Diuretics					
Diet pills					
Marijuana					
Hormones					
Sleeping pills					
Aspirin					
Cocaine					
Pain killers					
Narcotics					
Stimulants					
Hallucinogens (e.g., LSD)					
Laxatives					
Cigarettes					
Tobacco (specify)					
Coffee					
Alcohol					
Birth control pills					
Vitamins					
Undereat					
Overeat					
Eat junk foods					
Diarrhea					
Constipation					
Gas					
Indigestion					
Nausea					
Vomiting					
Heartburn					
Dizziness					
Palpitations					
Fatigue					
Allergies					
High blood pressure					
Chest pain					
Shortness of breath					
Insomnia					
Sleep too much					
Fitful sleep					
Early morning awakening					
Earaches					
Headaches					
Backaches					
Bruise or bleed easily					
Weight problems					
Others:					

Directions: Rate yourself on the following dimensions on a seven-point scale with "1" being the lowest and "7" being the highest.

BEHAVIORS:	Some people may be described as "doers"—they are action oriented, they like to busy themselves, get things done, take on various projects. How much of a doer are you?	1	2	3	4	5	6	7
FEELINGS:	Some people are very emotional and may or may not express it. How emotional are you? How deeply do you feel things? How passionate are you?	1	2	3	4	5	6	7
PHYSICAL SENSATIONS:	Some people attach a lot of value to sensory experiences, such as sex, food, music, art, and other "sensory delights." Others are very much aware of minor aches, pains, and discomforts. How "tuned into" your sensations are you?	1	2	3	4	5	6	7
MENTAL IMAGES:	How much fantasy or daydreaming do you engage in? This is separate from thinking or planning. This is "thinking in pictures," visualizing real or imagined experiences, letting your mind roam. How much are you into imagery?	1	2	3	4	5	6	7
THOUGHTS:	Some people are very analytical and like to plan things. They like to reason things through. How much of a "thinker" and "planner" are you?	1	2	3	4	5	6	7
INTERPERSONAL RELATIONSHIPS:	How important are other people to you? This is your self-rating as a social being. How important are close friendships to you, the tendency to gravitate toward people, the desire for intimacy? The opposite of this is being a "loner."	1	2	3	4	5	6	7
BIOLOGICAL FACTORS:	Are you healthy and health conscious? Do you avoid bad habits like smoking, too much alcohol, drinking a lot of coffee, overeating, etc.? Do you exercise regularly, get enough sleep, avoid junk foods, and generally take care of your body?	1	2	3	4	5	6	7

Please describe any significant childhood (or other) memories and experiences you think your therapist should be aware of:

APPENDIX B

MODALITY ANALYSIS OF CURRENT PROBLEMS

Behaviors

Check any of the following behaviors that often apply to you:

___ Overeat
___ Take drugs
___ Unassertive
___ Odd behavior
___ Drink too much
___ Work too hard
___ Procrastination
___ Impulsive reactions
___ Phobic avoidance
___ Can't keep a job
___ Take too many risks
___ Eating problems
___ Crying
___ Self-mutilation
___ Loss of control
___ Suicidal attempts
___ Compulsions
___ Smoke
___ Withdrawal
___ Nervous tics
___ Concentration difficulties
___ Sleep disturbance
___ Spend too much money
___ Insomnia
___ Lazy
___ Aggressive behavior
___ Outbursts of temper
___ Others: _____
_____
_____

Feelings

Check any of the following feelings that often apply to you:

___ Angry
___ Annoyed
___ Depressed
___ Fearful
___ Energetic
___ Guilty
___ Conflicted
___ Regretful
___ Hopeful
___ Relaxed
___ Unhappy
___ Restless
___ Contented
___ Optimistic
___ Others: _____
_____
_____
___ Fearful
___ Sad
___ Anxious
___ Panicky
___ Envious
___ Happy
___ Shameful
___ Hopeless
___ Helpless
___ Jealous
___ Bored
___ Lonely
___ Excited
___ Tense

Physical Sensations

Check any of the following physical sensations that often apply to you:

___ Abdominal pain
___ Menstrual difficulties
___ Dizziness
___ Muscle spasms
___ Sexual disturbances
___ Bowel disturbances
___ Numbness
___ Tics
___ Twitches
___ Tremors
___ Hear things
___ Flushes
___ Skin problems
___ Burning or itching skin
___ Rapid heart beat
___ Blackouts
___ Visual disturbances
___ Others: _____
_____
_____

___ Pain or burning with urination
___ Headaches
___ Palpitations
___ Tension
___ Unable to relax
___ Tingling
___ Stomach trouble
___ Fatigue
___ Back pain
___ Fainting spells
___ Watery eyes
___ Nausea
___ Dry mouth
___ Chest pains
___ Don't like to be touched
___ Excessive sweating
___ Hearing problems

Images

Check any of the following that apply to you:

I picture myself:

___ Being happy
___ Not coping
___ Losing control
___ Being talked about
___ Being helpless
___ Being in charge
___ Being trapped
___ Being promiscuous

___ Being hurt
___ Succeeding
___ Being followed
___ Being aggressive
___ Hurting others
___ Failing
___ Being laughed at
___ Others: _____
_____
_____

I have:

___ Pleasant sexual images
___ Negative body image
___ Lonely images
___ Images of being loved

___ Unpleasant childhood images
___ Unpleasant sexual images
___ Seduction images
___ Others: _____
_____
_____

Thoughts

Check each of the following that you might use to describe yourself:

___ Intelligent
___ Worthwhile
___ Sensitive
___ Trustworthy
___ Worthless
___ Useless
___ Crazy
___ Considerate
___ Unattractive
___ Inadequate
___ Ugly
___ Naive
___ Incompetent
___ Conflicted
___ Memory problems
___ Can't make decisions
___ Persevering
___ Hard working
___ Lazy
___ Dishonest
___ Confident
___ Ambitious
___ Loyal
___ Full of regrets
___ A nobody
___ Evil
___ Morally degenerate
___ Deviant
___ Unlovable
___ Confused
___ Stupid
___ Honest
___ Horrible thoughts
___ Concentration difficulties
___ Attractive
___ Suicidal ideas
___ Good sense of humor
___ Undesirable
___ Untrustworthy
___ Others: _____
_____
_____

On each of the following items, please circle the number that most accurately reflects your opinion.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
. I should not make mistakes.	1	2	3	4	5
. I should be good at everything I do.	1	2	3	4	5
. When I do not know something, I should pretend that I do.	1	2	3	4	5
. I should not disclose personal information.	1	2	3	4	5
. I am a victim of circumstances.	1	2	3	4	5
. My life is controlled by outside forces.	1	2	3	4	5
. Other people are happier than I am.	1	2	3	4	5
. It is very important to please other people.	1	2	3	4	5
. Play it safe; don't take risks.	1	2	3	4	5
. I don't deserve to be happy.	1	2	3	4	5
. If I ignore my problems, they will go away.	1	2	3	4	5
. It is my responsibility to make other people happy.	1	2	3	4	5
. I should strive for perfection.	1	2	3	4	5
. Basically, there are two ways of doing things - the right way and the wrong way.	1	2	3	4	5
. I should never be upset.	1	2	3	4	5

APPENDIX C

ATTRIBUTIONAL STYLE QUESTIONNAIRE

PSYCHOLOGY DEPARTMENT
LAKEHEAD UNIVERSITY

DIRECTIONS

1) Read each situation and vividly imagine it happening to you.
2) Decide what you believe would be the one major cause of the situation if it happened to you.
3) Write this cause in the blank provided.
4) Answer three questions about the cause by circling one number per question. Do not circle the words.
5) Go on to the next situation.

SITUATIONS

YOU MEET A FRIEND WHO COMPLIMENTS YOU ON YOUR APPEARANCE.

1) Write down the one major cause: _____

_____

2) Is the cause of your friend's compliment due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

3) In the future when you are with your friend, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

4) Is the cause something that just affects interacting with friends, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

YOU HAVE BEEN LOOKING FOR A JOB UNSUCCESSFULLY FOR SOME TIME.

5) Write down the one major cause: _____

_____

6) Is the cause of your unsuccessful job search due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

7) In the future when you look for a job, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

8) Is the cause something that just influences looking for a job, or does it also influence other areas of your life?

Influences just this 1 2 3 4 5 6 7 Influences all

YOU BECOME VERY RICH.

9) Write down the one major cause: _____

_____

10) Is the cause of your becoming rich due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

11) In your financial future, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

12) Is the cause something that just affects obtaining money, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

A FRIEND COMES TO YOU WITH A PROBLEM AND YOU DON'T TRY TO HELP HIM/HER.

13) Write down the one major cause: _____

_____

14) Is the cause of your not helping your friend due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

15) In the future when a friend comes to you with a problem, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

16) Is the cause something that just affects what happens when a friend comes to you with a problem, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

YOU GIVE AN IMPORTANT TALK IN FRONT OF A GROUP AND THE AUDIENCE REACTS NEGATIVELY.

17) Write down the <u>one</u> major cause: _____

_____

18) Is the cause of the audience's negative reaction due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

19) In the future when you give talks, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

20) Is the cause something that just influences giving talks, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situtations in my life

YOU DO A PROJECT WHICH IS HIGHLY PRAISED.

21) Write down the <u>one</u> major cause: _____

_____

22) Is the cause of your being praised due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

23) In the future when you do a project, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

24) Is the cause something that just affects doing projects, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

YOU MEET A FRIEND WHO ACTS HOSTILELY TOWARDS YOU.

25) Write down the one major cause: _____

---

26) Is the cause of your friend acting hostile due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

27) In the future when interacting with friends, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

28) Is the cause something that just influences interacting with friends, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

YOU CAN'T GET ALL THE WORK DONE THAT OTHERS EXPECT OF YOU.

29) Write down the one major cause: _____

---

30) Is the cause of your not getting the work done due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

31) In the future when doing work that others expect, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

32) Is the cause something that just affects doing work that others expect of you, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

YOUR SPOUSE (BOYFRIEND/GIRLFRIEND) HAS BEEN TREATING YOU MORE LOVINGLY.

33) Write down the one major cause:_____

_____

34) Is the cause of your spouse (boyfriend/girlfriend) treating you more lovingly due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

35) In future interactions with your spouse (boyfriend/girlfriend), will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

36) Is the cause something that just affects how your spouse (boyfriend/girlfriend) treats you, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

YOU APPLY FOR A POSITION THAT YOU WANT VERY BADLY (E.G., IMPORTANT JOB, GRADUATE SCHOOL ADMISSION, ETC.) AND YOU GET IT.

37) Write down the one major cause: _____

_____

38) Is the cause of your getting the position due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

39) In the future when you apply for a position, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

40) Is the cause something that just influences applying for a position, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

YOU GO OUT ON A DATE AND IT GOES BADLY.

41) Write down the one major cause: _____

_____

42) Is the cause of the date going badly due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

43) In the future when you are dating, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

44) Is the cause something that just influences dating, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

YOU GET A RAISE.

45) Write down the one major cause: _____

_____

46) Is the cause of your getting a raise due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

47) In the future on your job, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

48) Is this cause something that just affects getting a raise, or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

APPENDIX D

SOCIAL REACTION INVENTORY

Instructions:

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of alternatives lettered A or B. Please select the one statement of each pair (and only one) which you more strongly believe to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief; obviously there are no right or wrong answers.

Your answer, either A or B to each question on this inventory, is to be recorded on the answer sheet.

Please answer these items carefully but do not spend too much time on any one item. Be sure to find an answer for every choice. For each numbered question place the appropriate letter in the corresponding blank on the answer sheet, either the A or B, whichever you choose as the statement most true.

In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case as far as you're concerned. Also try to respond to each item independently when making you choice; do not be influenced by your previous choice.

REMEMBER

Select the alternative which you personally believe to be more true.

I more strongly believe that:

1. A. Children get into trouble because their parents punish them too much.

   B. The trouble with most children nowadays is that their parents are too easy with them.

2. A. Many of the unhappy things in people's lives are partly due to bad luck.

   B. People's misfortunes result from the mistakes they make.

3. A. One of the major reasons why we have wars is because people don't have enough interest in politics.

   B. There will always be wars, no matter how hard people try to prevent them.

4. A. In the long run people get the respect they deserve in this world.

   B. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. A. The idea that teachers are unfair to students is nonsense.

   B. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. A. Without the right breaks one cannot be an effective leader.

   B. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. A. No matter how hard you try, some people just don't like you.

   B. People who can't get others to like them don't understand how to get along with others.

8. A. Heredity plays the major role in determining one's personality.

   B. It is one's experiences in life which determine what they're like.

9. A. I have often found that what is going to happen will happen.

   B. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. A. In the case of the well-prepared student, there is rarely if ever such a thing as an unfair test.

    B. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. A. Becoming a success is a matter of hard work; luck has little or nothing to do with it.

    B. Getting a good job depends mainly on being in the right place at the right time.

12. A. The average citizen can have an influence in government decisions.

    B. This world is run by the few people in power, and there is not much the little guy can do about it.

13. A. When I make plans, I am almost certain that I can make them work.

    B. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. A. There are certain people who are just not good.

    B. There is some good in everybody.

15. A. In my case getting what I want has little or nothing to do with luck.

    B. Many times we might as well decide what to do by flipping a coin.

16. A. Who gets to be the boss often depends on who was lucky enough to be in the first place first.

    B. Getting people to do the right thing depends upon ability; luck has little or nothing to do with it.

17. A. As far as world affairs are concerned, most of us are victims of forces we can neither understand nor control.

    B. By taking an active part in political and social affairs, the people can control world events.

18. A. Most people don't realize the extent to which their lives are controlled by accidental happenings.

    B. There really is no such thing as "luck".

19. A. One should always be willing to admit his mistakes.

    B. It is usually best to cover up one's mistakes.

20. A. It is hard to know whether or not a person really likes you.

    B. How many friends you have depends upon how nice a person you are.

21. A. In the long run the bad things that happen to us are balanced by the good ones.

    B. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. A. With enough effort we can wipe out political corruption.

    B. It is difficult for people to have much control over the things politicians do in office.

23. A. Sometimes I can't understand how teachers arrive at the grades they give.

    B. There is a direct connection between how hard I study and the grades I get.

24. A. A good leader expects people to decide for themselves what they should do.

    B. A good leader makes it clear to everybody what their jobs are.

25. A. Many times I feel that I have little influence over the things that happen to me.

    B. It is impossible for me to believe that chance or luck plays an important role in my life.

26. A. People are lonely because they don't try to be friendly.

    B. There's not much use in trying too hard to please people; if they like you, they like you.

27. A. There is too much emphasis on athletics in high school.

    B. Team sports are an excellent way to build character.

28. A. What happens to me is my own doing.

    B. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. A. Most of the time I can't understand why politicians behave the way they do

    B. In the long run the people are responsible for bad government on a national as well as on a local level.

APPENDIX E

SATISFACTION QUESTIONNAIRE

In looking back to your level of functioning prior to beginning group therapy, please answer the following statments based on how you would rate yourself now:

Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1	2	3	4	5	6	7

Behaviors

_____ I am spending more time on leisure/nurturing activities.

_____ I am starting new activities.

_____ I am more able to control unhealthy/maladaptive behaviors.

Feelings

_____ I generally feel more optimistic.

_____ I am more able to face my fears.

_____ I am more accepting of my emotional responses.

Sensations

_____ I am generally more in touch with my senses (sight, hearing, smell, taste and touch).

_____ I am more able to enjoy pleasant sensations.

_____ I am more able to control unpleasant sensations.

Imagery

_____ I am generally more able to view myself favourably.

_____ I am more able to imagine positive outcomes.

_____ I am more able to control negative images.

Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1	2	3	4	5	6	7

Thoughts

_____ I worry less now than I did before.

_____ I am more able to control intrusive thoughts.

_____ I am more able to replace negative thoughts with positive ones.

Interpersonal Relationships

_____ I generally feel more comfortable in social situations.

_____ I am more willing to share my private thoughts with friends.

_____ I am more willing to share my private thoughts with family.

_____ I am more satisfied with my committed relationship.

_____ I am more satisfied with the relationships I have with my family and friends.

_____ I am more satisfied with the relationships I have with my partner's family and friends.

_____ I am more satisfied with my sex life.

_____ I am more satisfied with my relationships at work.

_____ I am more sensitive to women's issues.

Biological Factors

_____ I am more concerned about my physical well-being.

_____ I am more satisfied with my eating habits.

_____ I am more satisfied with the amount of physical exercise that I am engaging in.

Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1	2	3	4	5	6	7

Group Experience

_____ I feel supported by the other group members.

_____ I am able to identify with the other group members.

_____ I feel less responsible for my abuse experience(s).

_____ I feel accepted by the group.

_____ I am able to trust the group members.

_____ I feel that the group is cohesive (close).

_____ I feel an inner strength.

_____ I feel less isolated.

_____ I feel less helpless.

_____ I feel more in control of my life.

_____ I have gained insight regarding how my childhood abuse experience(s) has affected my entire life.

_____ I am satisfied with the length of time that the group ran.

_____ I am satisfied with the type of therapy provided.

_____ I am satisfied with the number of new skills I learned as result of the group experience.

_____ I am satisfied with the amount of work that I did in the group.
If you disagree, is your dissatisfaction due to yourself or due to others? _____

_____ I am satisfied with the amount that I was able to share with others.
If you disagree, is your dissatisfaction due to yourself or due to others? _____

_____ I am satisfied with the amount of attention that I received from the therapists.
If you disagree, is your dissatisfaction due to yourself or due to others? _____

Recommended Improvements for Group Therapy

Please comment on how you think the therapy group could be improved.

Personal Areas of Improvement

Please comment on the specific areas of your life that have improved as a result of your group experience.

APPENDIX F

LAKEHEAD UNIVERSITY

5 Oliver Road, Thunder Bay, Ontario, Canada P7B 5E1

Department of Psychology
Telephone (807) 343-8441

Nancy Montgomery
1911 Mountdale Avenue
Thunder Bay, Ontario
P7E 3B2
Telephone: 473-8403

January 21, 1993

Ms. Judy Atherton, M.A.
Counsellor,
Catholic Family Development Centre
36 Banning Street
Thunder Bay, Ontario

Dear Ms. Atherton:

Re: Proposed Investigation Concerning the Efficacy of The Catholic Family Development Centre's Sexual Abuse Therapeutic Group

Further to our recent conversation, I am writing to reiterate my proposal to conduct a research project concerning the efficacy of The Catholic Family Development Centre's sexual abuse therapeutic group. As you are aware, I am a second year Master of Arts student at Lakehead University studying Clinical Psychology. I am undertaking an investigation as part of my program thesis requirement which may be of interest to the Catholic Family Development Centre.

I intend to focus my thesis on assessing the efficacy of group therapy on learned helplessness, locus of control and current levels of functioning with survivors of childhood sexual abuse. The Catholic Family Development Centre may benefit as a result of this investigation. By assisting me in my endeavour, the therapeutic value of your agency's sexual abuse therapeutic program could be evaluated. Specifically, the Catholic Family Development Centre has the opportunity to gain objective information regarding the program's efficacy in terms of aiding clients decrease their level of learned helplessness, become more internally focused, and generally, increase functioning.

Should your agency agree to help, I would request that you contact any survivors who intend to participate in your therapeutic program and ask if they would be willing to participate in my study. In the event of such agreement, I request permission to attend the initial group meeting in order to introduce my project, receive informed consent as well as to administer an Attributional Style Questionnaire and an Internal-External Locus of Control Scale. A Multimodal Life History Inventory would also be distributed to volunteers with instructions for its completion and return at the time of the next group meeting.

APPENDIX G

LAKEHEAD UNIVERSITY

ver Road, Thunder Bay, Ontario, Canada P7B 5E1

Department of Psychology
Telephone (807) 343-8441

INTRODUCTORY STATEMENT

Dear Participant:

Thank you for volunteering to participate in a study concerning the benefits of group therapy as it pertains to survivors of childhood sexual abuse. In order to provide the best possible service to survivors of sexual abuse, programs need to be evaluated on the basis of its therapeutic value. Because therapeutic programs are designed to aid members overcome certain difficulties, it is important to ensure that programs are adequately addressing the needs of its members.

In cooperation with the Catholic Family Development Centre, the purpose of this research project is to assess the effectiveness of group therapy on decreasing problem areas resulting from sexual abuse experiences. In order to accomplish this task, I require volunteers who intend to participate in the sexual abuse therapeutic group offered at the Catholic Family Development Centre. Your participation in this research project is entirely voluntary and will not affect your membership with the therapeutic group.

During the first group meeting, volunteers who agree to participate in this study will be asked to complete tests designed to assess your current levels of functioning. As well, a Multimodal Life History Inventory will be distributed with instructions for its completion and return at the time of the next group meeting. The testing during this phase of the project will likely require one and one half hours of your time. The Multimodal Life History Inventory will probably require an equal amount of time to complete. However, you will have a week to accomplish this task. Further testing will also be conducted mid-way through the program (8 weeks) and upon its completion. The additional tests will require approximately one hour to complete.

In order to evaluate current levels of functioning, the Multimodal Life History Inventory will focus on general information, personal and social history and current problem areas. As these questions may arouse feelings of discomfort, volunteers will be provided with a listing of crisis telephone numbers. The other tests will focus solely on your personal beliefs. All answers will be accepted. There are no right or wrong responses to any questions in this research project. You may withdraw from this study at any time.

APPENDIX H

Crisis Telephone Listing

Thunder Bay Physical & Sexual Assault	(24 Hours)	344-4502
	(If Busy)	345-0062
Faye Peterson Transition House	(24 Hours)	345-0450
		1-800-465-6971
Lakehead Psychiatric Hospital	(24 Hours)	343-4300
		1-800-461-6648
Suicide Prevention Hotline	(24 Hours)	344-1192
Telecare Crisis & Caring Hotline	(24 Hours)	344-1192
Family & Children's Services	(24 Hours)	343-6100
Beendigen Inc.	(Call Collect 24 Hours)	622-5101
Dilico Ojibway Child & Family Services	(24 hours)	345-1888
		1-800-465-3985
Thunder Bay Police Emergency	(24 Hours)	911
Ontario Provincial Police OPP	(24 Hours)	1-800-465-6777
TDD		1-800-465-6788
Ambulance	(24 Hours)	911

APPENDIX I

LAKEHEAD UNIVERSITY

ver Road, Thunder Bay, Ontario, Canada P7B 5E1

Department of Psychology
Telephone (807) 343-8441

CONSENT FORM

My signature on this form indicates that I agree to participate in a research project conducted by Nancy Montgomery, M.A. Candidate, Lakehead University, in cooperation with the Catholic Family Development Centre concerning the benefits of group therapy as it pertains to survivors of childhood sexual abuse.

I have received an introductory letter regarding this project and I understand its nature, purpose, and procedures. I understand that my participation in this research project will consist of completing various tests and a Multimodal Life History Inventory. Testing will be conducted at the time of the first group meeting, 8 weeks after the commencement of the therapeutic program, and upon the program's completion.

I realize that some of the questions are personal in nature and may arouse feelings of discomfort. A crisis telephone listing will be made available to me and I will use this listing to seek aid in the event of becoming overwhelmed.

I am aware that my participation in this project is entirely voluntary. I may withdraw from the study at any time and this will in no way affect my membership with the therapeutic group.

Any information that is collected about me will remain confidential and my anonymity will be assured in any written reports. I understand that I will receive a summary of the investigation, upon request, following completion of the project.

_____ _____

Signature of Participant Date