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AN EVALUATION OF A SUPPORT
GROUP FOR PARENTS WHO HAVE
A SEXUALLY ABUSED CHILD

BY

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THESIS

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ABSTRACT

This study investigates the effectiveness of a Parent Support Group for parents who have a child who has been sexually abused. Twenty-seven parents completed pre- and post-evaluation packages to assess the effectiveness of the group. The Louisville Behavior Checklist, the Mother-Child Relationship Evaluation, the Parenting Stress Index, an educational assessment form and a subjective evaluation using content analysis were used to test several hypotheses. The results indicated that there were significant decreases in the children's dysfunctional behaviors and an increase of the number of correct answers on the educational assessment. The subjective evaluation appeared to indicate that the parents found the group helpful, rated it highly, learned parenting and coping skills and felt more confident as parents. Recommendations for changing the Parent Support Group are discussed.

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INTRODUCTION

The problem of child sexual abuse has been widely discussed. Many believe that one out of every four female children will experience some type of sexual abuse before adulthood. There has been an increase in the reports of sexual abuse for both male and female children which has led to an increase in treatment programs and research.

The purpose of this study is to describe and evaluate a Parent Support Group for parents who have a sexually abused child by utilizing objective and subjective data in a one group before-after design.

REVIEW OF THE LITERATURE

The problem of child sexual abuse may be approached from numerous perspectives. One strategy is the use of the systems approach. The family may be viewed as a system (i.e., the family is assumed to be in equilibrium) and when a child is sexually abused in the family system, disruption and disequilibrium occurs.

The family system is altered by the sexual abuse and the changes in the family system are partially dependent on the relationship of the abuser to the child and family. Issues of trust, security, boundaries, roles and developmental tasks are disrupted by the sexual abuse and any intervention must deal with these issues.

The family as the focal system is used in family therapy. The issues cited above are then dealt with in the therapeutic intervention of family therapy. The Parent Support Group may also be viewed as a system. Its goal is to help the parents deal with the sexual abuse through educative, therapeutic and supportive intervention. The system is made up of the group members and the therapists, and this system may facilitate changes in the family system by teaching the parents how to help themselves and their children cope with the sexual abuse. Therefore, a major premise of the Parent-Support Group is that if the parent can change in positive ways, the parent-child relationship within the family

system will change as well in a positive manner. This is accomplished through the skills taught to the parents.

In this study, the Parent Support Group system is evaluated and other systems, e.g., the social service and legal systems which impact the family system are not assessed.

A review of the literature in the child abuse and neglect field reveals only a few articles which specifically discuss a therapeutic group for parents who have a child who has been sexually abused. While books and articles may be found discussing treatment for the child victim and the offender, the non-abusive parent's treatment needs are often neglected. In fact, research focusing on group treatment for incestuous families is scarce (Zimpfer, 1987).

The following discussion reviews the various types of interventions used with parents in both sexual and physical abuse situations. The systems perspective is included in this review. The Parent Support Group focuses on treating intra- and extra-familial sexual abuse cases in which the offender does not participate in any way in the Parent-Support Group. More than one member from a family may participate in the group. A description of the Parent-Support Group may be found in Appendix A. A support group through the school system for parents of sexually abused children in which the cases were of non-violent and non-incestuous sexual abuse is described by Devoss and Newlon (1986). Some of the therapeutic strategies that they utilize with the parents are:

ventilation of feelings, talking about sex and sexual abuse with their children, supporting the parents, providing information about child development, dealing with the social service system and preventing sexual abuse from occurring.

Another group for mothers is described from a family systems approach of a larger treatment program (Hildebrand & Forbes, 1987). These authors believe that use of a male therapist would be counterproductive. A self-esteem questionnaire was used to assess change in self-perception in which improvements were found.

A systems approach to group therapy with abusive or neglectful mothers allows the mothers to gain support from others, learn new behaviors and parenting skills, be confronted in a supportive environment and learn communication skills (Tuszynski, 1985). For example, a parallel group treatment mode in which a mothers group met to discuss issues while their children met in play therapy focused on similar issues for both groups including assertiveness skills, anger management, disclosing sexual abuse, feelings about the perpetrator, feelings of responsibility and guilt, and sex education (Damon & Waterman, 1986).

In one study, multisystemic therapy was compared to parent training for parents referred for child abuse and neglect (Brunk, Henggeler, & Whelan, 1987) in which self-report and observational measures were used to compare the two types of treatment controlling for physical abusive and neglectful parents. Both

approaches resulted in positive findings, although the effects of each type of treatment method differed.

A videotape parent education group program for abusive parents, in which the parents viewed different parenting problems depicted with alternative solutions presented for group discussion, demonstrated on post-test that parents generated more cooperative responses and less punitive responses in response to a videotaped child problem situation (Golub, Espinosa, Damon, & Card, 1987).

Lindley and Timmons-Mitchell (1986) presented a published structured program to black, single mothers from violent families. The use of multiple measures at the beginning and end of the group with a two-month follow-up demonstrated improvements in the parental perceptions of their children with increased family cohesion.

The Structured Learning method applied in a group context to abusive parents focused on teaching the parents through modeling, role playing, performance feedback and transfer training (Goldstein, Keller, & Erne, 1985).

Another program provides treatment for abusive parents and their children and included a preschool program and parent group and focused on parenting skills and anger management (Parish, Myers, Brandner, & Templin, 1985). An evaluation of the program found that the children's developmental skills increased.

A cognitive-behavioral group for abusive parents in which modeling, role playing, feedback, reinforcement, homework assignments, stress management and communication skills training were used, showed parental improvements (Barth, Blythe, Schinke, & Schilling, 1983).

Two methods of parent education, lecture-discussion and participatory drama, were compared in which both methods showed positive results in expectations of child behaviors and use of discipline (Wint & Brown, 1987).

One limitation of the above studies is the lack of a control group. Ethical reasons preclude the withholding of treatment from subjects in the above situations. Culp, Heide, and Richardson (1987) used a matched group of children on a waiting list for a group program as a control group to conduct a research project on correcting developmental delays of abused children. A similar approach could be used in conducting and evaluating a parenting group although various problems of matching might occur as well a time factor for groups that are open-ended.

Lewis (1986) described a behavioral model with a group of mothers in which family perceptions and child behaviors were assessed. A control group was utilized and the results indicated that the experimental group who attended the program showed greater family adjustment, with a decrease in their children's behavior problems, when compared to the control group.

A traditional parent education model was compared to a parent program which included their children and both programs were evaluated by the pre-test-post-test, control paradigm indicating that the parent group which included children was more effective than the parents only group (Coufal & Brock, 1984).

The above studies focused on parent groups for parents involved in physical, sexual and neglectful abuse situations. Focusing on sexual abuse, the characteristics of mothers of sexually abused children have been described in the literature. For example, in describing a mothers group for mothers of incest victims, Mayer (1985) points out that the mothers feel guilty, angry toward self, victim and offender, confused and have low self-esteem. From a group treatment program for mothers of incest victims, the following treatment issues were identified: need for emotional support, need to deal with their own childhood sexual abuse, developing problem-solving skills, gaining confidence and need for parenting skills (Koch & Jarvis, 1987).

Some professionals believe that the mother of an incest victim must participate in individual therapy before employing other treatment modalities (Sgroi & Dana, 1982). These authors describe the treatment issues for the group of mothers as establishing trust, sharing past history of sexual abuse, dealing with denial, identifying unreasonable expectations, practicing limit setting, dealing with anger, improving communication, assertiveness training, improving social skills, assisting with

concrete services, improving body awareness, and support through legal justice system involvement.

The mother is often viewed from different perspectives within the incestuous family. Four personality types identified by James and Nasjleti (1983) are the passive child-woman mother, the intelligent, competent, distant mother, the rejecting, vindictive mother, and the psychotic or severely retarded mother. While empirical evidence for the above categories is not present from the authors' observations, Ayoub and Jacewitz (1982) describe families at risk for child abuse and neglect utilizing factor analysis to delineate five types of families: abusive, neglectful or antisocial, emotionally unstable, culturally and intellectually limited, and families with child rearing difficulties. By classifying mothers by types, treatment modalities for the specific situation might be implemented.

The need for outcome research on the effectiveness of parenting and therapy groups for parents of sexually abused children is apparent. The current literature indicates that a variety of group treatment programs focusing on parenting skills have been used with positive results for parents who physically abuse their children. Few studies have been conducted which evaluate the effectiveness of a parent group for parents who have a child who has been sexually abused. This study attempts to describe and evaluate a group for these parents. The various measures used were chosen in order to measure a variety of

outcomes based on both the therapeutic and educational components of the Parent Support Group.

METHODOLOGY

Hypotheses

The following conceptual hypotheses have been developed based on the literature review and clinical experience of the author.

1. The group participants will indicate significant decreases in their children's dysfunctional behaviors.

2. The participants will indicate a significant decrease in their stress levels.

3. The participants will show a significant increase in an accepting attitude and conversely a significant decrease in a rejecting attitude toward their children.

4. The participants will show an increase in educational knowledge of child development and parenting skills.

5. The participants will rate the Parent Support Group as a positive and helpful experience.

Data Sources

In this research, the population consists of approximately 50 parents who participated in the Parent Support Group to some extent, including those who did not complete the program or complete the pre- or post-tests.

The sample is composed of 27 parents/caretakers who have participated in the Parent Support Group and completed both the

pre-group and post-group evaluation package. The sample is a non-probability convenience sample. This type of sample does not allow for control of variability (see Data Analysis for details).

Data Collection Techniques

To test the above hypotheses, the following techniques were used. The pre- and post-evaluation packages were administered to the members of the four groups. These pre-group and post-group evaluation packages consist of the Louisville Behavior Checklist (Miller, 1984), the Mother-Child Relationship Evaluation (Roth, 1980), the Parenting Stress Index (Abidin, 1983), and an education assessment form. The post-group evaluation package also consists of the Subjective Evaluation Form. The pre-group evaluation package was administered during the first session of the group and parents/caretakers made up any missed evaluations by the beginning of the third session. The post-group evaluation package was administered during the second to last session. Some group members continued into the next group and completed their evaluation package after they completed the sessions they missed.

Operational Definitions of Variables

The dysfunctional behaviors exhibited by the children were assessed using the Louisville Behavioral Checklist (Miller, 1984). This instrument is a self-administered inventory which consists of 164 true/false questions which form a profile based on twenty

scales. The Louisville Behavioral Checklist measures pathological behaviors on the following twenty scales:

1. Infantile Aggression
2. Hyperactivity
3. Antisocial Behavior
4. Aggression
5. Social Withdrawal
6. Sensitivity
7. Fear
8. Inhibition
9. Intellectual Deficit (form E1 ages 4-6)
Academic Disability (form E2 ages 7-12)
10. Immaturity
11. Cognitive Disability (form E1 ages 4-6)
Learning Disability (form E2 ages 7-12)
12. Normal Irritability
13. Severity Level
14. Prosocial Deficit
15. Rare Deviance
16. Neurotic Behavior
17. Psychotic Behavior
18. Somatic Behavior
19. Sexual Behavior
20. School Disturbance Predictor (form E1 ages 4-6)

Norms are given for both the general and clinical population ($R = .60 - .97$). The clinical norms were used in this study.

The attitudes of the parents/caretakers toward their children were evaluated using the Mother-Child Relationship Evaluation (Roth, 1980). This self-administered exploratory and experimental evaluation instrument measures the attitudes of the parent/caretaker in four domains: acceptance, overprotection, overindulgence and rejection ($R = .41 - .57$).

The parental/caretaker level of stress was assessed with the Parenting Stress Index (Abidin, 1983). This self-administered instrument presents questions answered in a Likert type scale

form. Three domains of stressors are measured: child characteristics (Child Domain Score), mother characteristics (Parent Domain Score) and situational/demographic life stress ($R = .55 - .95$).

The Child and Parent Domain Score are divided into the following subscales:

Child Domain Score:

1. Adaptability
2. Acceptability
3. Demandingness
4. Mood
5. Distraction/Hyperactivity
6. Reinforces Parent

Parent Domain Score:

1. Depression
2. Attachment
3. Restriction of Role
4. Sense of Competence
5. Social Isolation
6. Relationship with Spouse
7. Parent Health

The amount of knowledge gained from the Parent Support Group was measured by an educational assessment form designed by the Parent Group therapists. This form is a self-administered multiple-choice and true/false questionnaire which consists of twelve questions regarding specific material taught in the Parent Support Group (see Appendix B). This result should be interpreted with caution since no reliability or validity tests have been performed.

The group members subjective rating of the Parent Support Group was assessed with a subjective evaluation form designed by one of the group therapists. The self-administered evaluation asks the participants to rate the group therapists and various topics covered in the group. Open-ended questions about what the participant liked, disliked, would like to change and what they have learned are included on this evaluation form (see Appendix C).

Data Analysis

The evaluation package data were analyzed using the paired samples t-test and the Wilcoxon Matched-Pairs Signed-Ranks Test to compare the group means of the evaluation measures. This consists of a comparison of the pre- and post-means of the Louisville Behavioral Checklist, Mother-Child Relationship Evaluation, Parenting Stress Index and Educational Assessment. The post-group subjective evaluation form was analyzed using percentages and content analysis.

Several analytical limitations need to be mentioned. First, there is no control group to compare with the Parent Support Group. Second, the structure and content of each of the four groups were different. This decreases the reliability of the evaluation. Third, the sample is an available sample and may not be representative of all parents who have a child who was sexually abused, therefore generalizability of the data to a larger

population is limited. While some parents were in the group on a voluntary basis, others were court-ordered to participate. Finally the data are non-random and do not meet the assumptions required for the t-test, but are provided. The Wilcoxon Matched-Pairs Signed-Rank Test will therefore be used with the t-test to provide a non-parametric statistical comparison. The Wilcoxon Matched-Pairs Signed-Rank Test is more appropriate for this non-probability sample and will strengthen any inferences to be made.

FINDINGS

Description of the Groups

Four groups were held and the differences in the format are explained below. Married and non-married couples made up part of the sample. These parents and caretakers are caring for a child who has been sexually abused. None of the parents/caretakers had allegations against them as sexually abusing children. Table 1 describes the demographic characteristics of the groups.

The Parent Support Group is an educational/therapeutic group for parents who have a child who has been sexually abused. The group is one of the treatment components of the Child Protection Team, Orlando Regional Medical Center.

The Parent Support Group meets once a week for two hours for thirteen weeks. The group is open-ended and those who begin after the first few sessions of the group make up the missed sessions when the next thirteen week group cycle begins. There are between five to eighteen members in the group at one time. The maximum number of group members is eighteen. The group is run by two therapists, a male and a female. The Parent Support Group was started as a group for parents who had a child in a treatment program for sexually abused preschool children. The need for a parenting program was based on the following observations:

TABLE 1
DEMOGRAPHIC CHARACTERISTICS OF THE GROUPS

CHARACTERISTICS		
<u>Race:</u>		
	White	85% (23)
	Black	15% (4)
<u>Sex of Parent:</u>		
	Male	22% (6)
	Female	78% (21)
<u>Marital Status:</u>		
	Married	70% (19)
	Divorced	11% (3)
	Single/Not Married	19% (5)
<u>Years Married:</u>		
	Mean = 6.70	S.D. = 8.83
<u>Relationship to Child:</u>		
	Mother	70% (19)
	Father	11% (3)
	Stepmother	4% (1)
	Stepfather	4% (1)
	Grandmother	4% (1)
	Grandfather	7% (2)
<u>Sex of Child:</u>		
	Male	19% (5)
	Female	82% (22)
<u>Number of Children:</u>		
	Mean = 2.11	S.D. = 1.19
<u>Age of Child:</u>		
	Mean = 4.63	S.D. = 2.37

1. The parents demonstrated ineffective means of dealing with their children's inappropriate behaviors.

2. The parents sexualized normal sexual development. (The parents attributed normal sexual behaviors to the sexual abuse).

3. The parents had unrealistic expectations of their children.

4. Some parents appeared to be trying to sabotage the child's treatment.

5. There was a lack of parental involvement in the children's treatment.

6. There was a lack of parental treatment.

7. Some parents were inappropriately using the social service system.

8. There was a lack of support systems for the parent.

9. Individual parent meetings were ineffective.

While the group structure has changed somewhat since the first group was run, the objectives of the group remain the same. The overall goal is to help the parents help themselves in order that they may support and help their children. The following are the objectives of the Parent Support Group:

1. To assist the parent in recognizing his/her responsibility to protect the child from abuse.

2. To assist the parent in dealing with feelings of guilt, anger and shame about the sexual abuse of their child.

3. To assist the parent in supporting his/her child during the acute period, following the disclosure of the sexual abuse.

4. To assist the parent in supporting the child to resume normal development following resolution of the trauma of the sexual abuse.

5. To teach the parent to discriminate between normal developmental issues versus issues arising from the sexual abuse.

6. To assist the parent in establishing boundaries in the parent/child relationship.

7. To ensure continuity between the child's treatment and the parents.

Parents are referred to the Parent Support Group by the Child Protection Team, Department of Health and Rehabilitative Services, courts, and private practitioners. A few self-referrals have also been received.

The Parent Support group is based on an educative and therapeutic model which makes it both a parent education and training group as well as a therapeutic support group. The educative component of the group is based on three main approaches to parenting education and training. First, material from the Systematic Training for Effective Parenting (Dinkmeyer & McKay, 1973, 1976, 1982; Dinkmeyer, McKay, Dinkmeyer, Dinkmeyer, & McKay, 1987) which is based on the Individual Psychology perspective of Alfred Adler (Dreikurs, 1964; Sweeney, 1981; Mosak, 1984) is utilized throughout the parent education and training component of

the group. Second, material from Parent Effectiveness Training (Gordon, 1975) is used. Third, behavioral approaches based on the behavior modification techniques of parent training (Patterson, 1975; Cautela, Cautela, & Esonis, 1983) are presented to the parents.

The therapeutic component of the Parent Support Group is based on a blend of counseling theories and techniques. This may be described as an eclectic approach to group therapy. Corey (1985) describes the stages of a group as well as theoretical approaches to group counseling. The major theoretical approaches which are apparent in the Parent Support Group are the Individual Psychology approach of Alfred Adler, the Person-Centered perspective of Carl Rogers (Corey, 1985; Meador & Rogers, 1984; Rogers, 1970), the Behavioral approach (Corey, 1985; Martin & Pear, 1983; Skinner, 1953, 1973; Bandura, 1969; Wolpe & Lazarus, 1966) and the Rational Emotive Therapy approach of Albert Ellis (Ellis, 1984).

The structure and content of the Parent Support Group may be viewed as evolving because the structure and content of the sessions have changed since the first group was implemented. The therapeutic and educational components of the sessions have remained the same throughout the history of the group. The major changes are the length of the sessions and the deletion of the child lab component.

The first format involved the parents and the children in part of five sessions which were composed of parent-child activities. The parents and their children participated in a massage exercise, toy making session, art activity, relaxation exercises and a graduation party. The length of each group was 90 minutes and there were 14 actual group sessions.

The second format consisted of two sessions with children present. It was during this time that the group therapists decided that the parent-child sessions would be deleted from the group program. Apparently, the parents were feeling anxious about having their children present and expressed that they felt they were being evaluated by the therapists. It was determined through observations that the needs of the parents could be addressed in a more effective manner without their children present. The length of the sessions were 90 minutes and there were 13 actual sessions.

The third and fourth formats consisted of 13 actual sessions which lasted 2 hours each. The children of the parents did not attend any of the sessions. The name of the group was changed from the Parent-Child Lab to the Parent Support Group.

Hypothesis 1

In testing the first hypothesis, the t-tests for the Louisville Behavior Checklist revealed significant decreases in pathological behaviors in the areas of fear, inhibition, intellectual deficit/academic disability, cognitive disability/

learning disability, severity level, normal irritability, neurotic behavior ($p < .01$), psychotic behavior, rare deviance and sexual behavior ($p < .05$). The results are presented in Table 2. Similar significant differences using the Wilcoxon test were found for these same behaviors, except for rare deviance. No significant differences were found for the variables infantile aggression, hyperactivity, antisocial behavior, aggression, social withdrawal, sensitivity, immaturity, prosocial deficit, somatic behavior and school disturbance predictor.

The data support the hypothesis that the participants would report a decrease in their children's dysfunctional behaviors. One confounding variable which may account for the decrease in the children's dysfunctional behaviors is that many of the children of the Parent Support Group participants were in one of the Child Protection Team's children's treatment programs.

While lack of a control group precludes clear determination of the effects of the children's treatment, parents' treatment or children's and parents' treatment, at this time, it seems logical that the Parent Support Group helps to reinforce the child's progress in treatment. The Parent Support Group participants were taught parenting and coping skills, and they indicated that these skills helped them to feel more confident as a parent. If the parents transferred this learning from the group to their homes, it would be expected that their children's dysfunctional behaviors would decrease.

TABLE 2
PRE- AND POST-MEAN SCORES FOR THE
LOUISVILLE BEHAVIOR CHECKLIST (MILLER, 1984)

SCALE	PRE-	POST-	<u>t</u>
Infantile Aggression	42.63 (11.25)	41.70 (11.73)	.78
Hyperactivity	42.93 (12.77)	40.37 (12.57)	1.47
Antisocial Behavior	43.26 (10.05)	42.07 (10.18)	1.22
Aggression	42.22 (11.30)	40.15 (11.50)	1.67
Social Withdrawal	46.30 (12.90)	43.93 (11.35)	1.91
Sensitivity	44.26 (13.75)	41.85 (12.61)	1.66
Fear	48.11 (14.75)	42.22 (13.13)	3.36 ** +++
Inhibition	46.00 (14.40)	41.15 (12.80)	2.87 ** ++
Intellectual Deficit/ Academic Disability	46.74 (13.34)	43.19 (12.67)	2.78 ** ++
Immaturity	42.45 (12.11)	40.45 (9.97)	1.73
Cognitive Disability/ Learning Disability	44.33 (12.43)	40.96 (11.26)	2.84 ** ++
Severity Level	42.30 (12.69)	39.22 (12.19)	3.08 ** ++
Normal Irritability	44.85 (12.70)	41.48 (12.35)	2.64 ** ++
Prosocial Deficit	42.59 (11.46)	40.89 (11.46)	1.60
Rare Deviance	46.19 (13.78)	42.48 (11.14)	2.29 *
Neurotic Behavior	47.11 (14.63)	42.59 (12.77)	3.10 ** ++
Psychotic Behavior	45.67 (13.76)	42.63 (11.07)	2.30 * +
Somatic Behavior	46.78 (13.66)	44.26 (11.70)	1.78
Sexual Behavior	52.44 (14.94)	48.52 (12.89)	2.29 * +
School Disturbance Predictor	35.48 (17.37)	35.25 (18.50)	.22
<u>t</u> -test		Wilcoxon	
<u>p</u> < .05 *		<u>p</u> < .05 +	
<u>p</u> < .01 **		<u>p</u> < .01 ++	
<u>p</u> < .001 ***		<u>p</u> < .001 +++	

Note: The top number is the mean score while the number in parentheses is the standard deviation (N = 27).

Overall it appears that the parents did not consider their children to have severe pathological behaviors as indicated by their ratings. If the children were thought by their parents to have few problems, then it would be expected that there would not be much change in problem behaviors.

No significant differences were found for aggressive behaviors. This might be due to the children's exhibiting dysfunctional behaviors in other ways, e.g., sexual, neurotic, psychotic and fearful behaviors which were all shown to have decreased significantly on the post-test. The sexual behavior scale was elevated on the pre-test compared to the other variables which might be a result of the child learning and acting out sexual behaviors or the parent attributing a higher level of sexual behaviors due to the knowledge that sexual abuse occurred.

Hypothesis 2

The second hypothesis, that the participants' stress levels would decrease was not supported by the Parenting Stress Index (see Table 3). The Wilcoxon test indicated a significant decrease in two scales, the Child Domain Score and the Adaptability scale ($p < .05$), while the t -test results indicated no significant differences. This result would be consistent with the decrease found in the children's dysfunctional behaviors found on the Louisville Behavior Checklist. The parents, on the other hand, showed little change in their stress levels and maintained high

TABLE 3
PRE- AND POST-MEAN SCORES FOR THE
PARENTING INDEX (Abidin, 1983)

SCALE	PRE-	POST-	<u>t</u>
Total Stress Score	244.41 (58.22)	237.67 (62.31)	1.19
Child Domain Score	115.59 (27.64)	109.85 (30.96)	1.82 +
Adaptability	27.96 (9.46)	26.15 (7.21)	1.18 +
Acceptability	15.04 (4.57)	14.07 (4.84)	1.43
Demandingness	22.07 (6.73)	22.59 (7.45)	-.54
Mood	12.33 (3.89)	11.37 (4.19)	1.69
Distractibility/ Hyperactivity	26.44 (5.67)	25.74 (7.25)	.87
Reinforces Parent	11.74 (3.32)	10.81 (3.62)	1.39
Parent Domain Score	129.56 (33.98)	127.81 (35.18)	.48
Depression	20.15 (7.51)	19.89 (6.82)	.32
Attachment	13.74 (4.18)	14.59 (4.99)	-.96
Restriction of Role	20.41 (5.93)	19.15 (7.03)	1.40
Sense of Competence	32.44 (8.59)	30.67 (7.76)	1.59
Isolation	14.18 (5.55)	13.89 (5.00)	.37
Relationship With Spouse	16.70 (5.87)	17.26 (6.58)	-.60
Parent Health	11.93 (3.96)	12.37 (3.70)	-.72
Life Stress	11.44 (8.24)	12.37 (8.78)	-.68

<u>t</u> -test	Wilcoxon
$\underline{p} < .05$ *	$\underline{p} < .05$ +
$\underline{p} < .01$ **	$\underline{p} < .01$ ++
$\underline{p} < .001$ ***	$\underline{p} < .001$ +++

Note: The top number is the mean while the number in parentheses is the standard deviation (N = 27).

levels of stress. The parents indicated that they felt much internal and external stress.

Hypothesis 3

The third hypothesis, that the Parent Support Group participants would show an increase in an accepting attitude and a decrease in a rejecting attitude was not supported based on the t-test and Wilcoxon test of the Mother-Child Relationship Evaluation, which indicated no significant changes except for a significant decrease in overprotection ($p < .001$). The results are presented in Table 4.

TABLE 4
PRE- AND POST-MEAN SCORES FOR THE MOTHER-CHILD
RELATIONSHIP EVALUATION (ROTH, 1980)

SCALE	PRE-	POST-	<u>t</u>
Acceptance	41.81 (4.47)	41.74 (3.72)	.12
Overprotection	35.74 (5.74)	33.26 (5.63)	3.98 *** +++
Overindulgence	32.37 (3.88)	32.33 (4.07)	.07
Rejection	33.11 (4.84)	33.63 (3.75)	-.75
<div> <div> <u>t</u>-test <div> $\underline{p} < .05$ * $\underline{p} < .01$ ** $\underline{p} < .001$ *** </div> </div> <div> Wilcoxon <div> $\underline{p} < .05$ + $\underline{p} < .01$ ++ $\underline{p} < .001$ +++ </div> </div> </div>			

Note: The top number is the mean score while the number in the parentheses is the standard deviation (N = 27).

Hypothesis 4

The fourth hypothesis, that there would be an increase in the educational knowledge of parents, was supported by the educational assessment. The t-test and Wilcoxon test indicated a significant difference ($p < .001$) between the pre-and post-test means, wherein the parents provided a greater number of correct responses on the post-test. The results are presented in Table 5.

TABLE 5
PRE- AND POST-MEAN SCORES FOR THE EDUCATIONAL ASSESSMENT

PRE-	POST-	<u>t</u>
8.26 (1.56)	9.52 (1.09)	-.4.27 *** +++
<u>t</u> -test		Wilcoxon
$\underline{p} < .05$ *		$\underline{p} < .05$ +
$\underline{p} < .01$ **		$\underline{p} < .01$ ++
$\underline{p} < .001$ ***		$\underline{p} < .001$ +++

Note: The top number is the mean score while the number in parentheses is the standard deviation (N = 27).

Hypothesis 5

The fifth hypothesis was supported as a majority of the parents indicated on the subjective evaluation that they strongly agreed or agreed that the information was easy to understand and useful, the setting was comfortable, the lab/group leaders were

knowledgeable and supportive, the other parents were supportive, bringing their child was helpful, and the handouts were understandable and helpful. The results are presented in Table 6.

A majority of the parents rated as excellent or good the sessions on the goals of behavior, child development, group therapy, parent resource center visitor, child protection team visitor, behavioral charting, stress management, sexual development, disciplining your child and activities with your child. The results are presented in Table 7.

Content Analysis of Written Responses

These subjective evaluations support the hypothesis that the Parent Support Group is helpful and were consistent with previously cited findings. The use of qualitative data was very important in evaluating the Parent Support Group. The content analysis identified themes in the evaluation written by the participants. A summary of responses are in Appendix D.

For the question, "what did you like about the group," the group participants described the educational material on parenting skills, the opportunity to express their feelings regarding the sexual abuse, the support of the therapists and other parents, learning coping skills, and the fact that they were not alone in the situation.

The participants indicated for the question of "what you disliked about the group," that some parents failed to participate

TABLE 6
SUBJECTIVE EVALUATION OF THE PARENT SUPPORT GROUP

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE	N
1. The information was easy to understand	52%(15)	48%(14)	0%	0%	0%	29
2. The information was useful	59%(17)	41%(12)	0%	0%	0%	29
3. The setting was comfortable	52%(15)	38%(11)	7%(2)	3%(1)	0%	29
4. The group leaders were knowledgeable	62%(18)	38%(11)	0%	0%	0%	29
5. The group leaders were supportive	59%(17)	41%(12)	0%	0%	0%	29
6. The group leaders were boring	0%	3%(1)	7%(2)	45%(13)	45%(13)	29
7. The other parents were supportive	48%(14)	31%(9)	7%(2)	0%	14%(4)	29
8. The group program was too short	7%(2)	21%(6)	24%(7)	31%(9)	17%(5)	29
9. The group program was too long	3%(1)	3%(1)	17%(5)	45%(13)	31%(9)	29
10. The group sessions were too long	3%(1)	0%	14%(4)	59%(17)	24%(7)	29
11. The group sessions were too short	0%	7%(2)	28%(8)	52%(15)	14%(4)	29
12. Bringing your child was helpful*	42%(5)	42%(5)	0%	17%(2)	0%	12
13. The handouts were understandable	48%(14)	45%(13)	0%	7%(2)	0%	29
14. The handouts were helpful	55%(16)	41%(12)	0%	0%	3%(1)	29

* This question was deleted after the second group format

TABLE 7
SUBJECTIVE EVALUATION OF THE PARENT SUPPORT GROUP

	EXCELLENT	GOOD	AVERAGE	FAIR	POOR	N
1. Goals of behavior						
	38%(11)	59%(17)	0%	3%(1)	0%	29
2. Child development						
	38%(11)	52%(15)	10%(3)	0%	0%	29
3. Group therapy sessions						
	61%(17)	36%(10)	4%(1)	0%	0%	28
4. Parent resource center visitor*						
	27%(3)	36%(4)	9%(1)	9%(1)	18%(2)	11
5. Guest speaker*						
	40%(8)	40%(8)	5%(1)	0%	15%(3)	20
6. Behavioral charting						
	43%(12)	54%(15)	4%(1)	0%	0%	28
7. Stress management						
	38%(11)	45%(13)	3%(1)	10%(3)	3%(1)	29
8. Sexual development						
	41%(12)	52%(15)	0%	7%(2)	0%	29
9. Disciplining your child						
	45%(13)	48%(14)	7%(2)	0%	0%	29
10. Activities with your child*						
	36%(4)	45%(5)	9%(1)	9%(1)	0%	11

* These questions were deleted after the second group format

in the group. When the participants were asked "what you would add to the group," they described wanting more group therapy sessions and guest speakers. One parent mentioned that a listing of parenting books might be provided. As to the question of "what would you leave out from the group," few suggestions were noted.

In response to the question of "what have you learned," the participants indicated that they learned how to deal with their children better and finally, in response to the question "how have you grown," the participants indicated that they were more patient and calm with their children, they learned coping and parenting skills and they felt more confident.

The parents also indicated that the group was not long enough in duration and that there needed to be more therapy sessions. It appears that the Parent Support Group helped the parents increase their confidence as parents by teaching them parenting skills.

SUMMARY AND CONCLUSIONS

The original question of this research had to do with whether the Parent Support Group was providing aid and assistance to parents of children who had been sexually abused. In the process of this research, several evaluative measures were examined with regard to their adequacy in determining the outcomes of the therapy and education sessions. The results of this research are that the group is effective, as evidenced by the decrease in the children's dysfunctional behaviors and the group participants ratings and comments of the Parent Support Group.

The results of the Louisville Behavior Checklist indicated that the parents report their children showing less dysfunctional behaviors on the post-test. While the mean of the scores did not indicate severe pathology, changes were noted in several variables. It appears that the parents felt that their children's behaviors improved in some areas. Since most of the children were in a treatment program during the time that the parents were in the Parent Support Group, the improvement in the children's behavior could be attributed to the child's treatment, the Parent Support Group treatment, a combination of these two variables or extraneous variables. It is possible to then conclude that a combination of parent and child treatment leads to a decrease in the children's dysfunctional behaviors.

It would be helpful to determine whether the parents over- or under-report their children's dysfunctional behaviors by correlating the parent report with reports of others who are familiar with the child, such as therapists and other family members. A study of the factors surrounding the onset, duration and type of abuse would be helpful to understand the effects on the parent-child relationship. One must view the Louisville Behavior Checklist results with caution when making inferences about the effects of sexual abuse on children due to the fact that the onset of the abuse, disclosure, extent, duration and when the child's therapy started, were not obtained in this study. What is important for this study is that the Louisville Behavior Checklist indicated that the children did show improvement per parent report over a thirteen week period. Future research might focus on evaluating children's treatment with and without parent treatment. This could be done by using a matched group of parents as a control group who are waiting to begin treatment while their child is in treatment. Time series data would add to the understanding of the effects of treatment for both child and parent.

The results of the Parenting Stress Index did not support the hypothesis that there would be a decrease in the overall level of parental stress. While a small difference was found for the Child Domain and Adaptability Score (Wilcoxon test), this was not supported by the t-test. The Parent Support Group may have helped the parents feel more confident and cope better as indicated by

the subjective evaluation but overall the parental stress levels remained the same. Perhaps thirteen group sessions is not long enough to make an impact in the parental stress level as measured by the Parenting Stress Index. Follow-up with this assessment tool would be useful to determine stress levels following the group experience. An extended time for the group might be used to assess how length of treatment is related to stress levels, and environmental factors could be factored into this research allowing for multivariate analysis. The major implication here is that thirteen sessions may not be enough to help parents adequately cope with the sexual abuse of their children.

The results of the Mother-Child Relationship Evaluation indicated a decrease in the variable of overprotection. This can be viewed as both positive and negative, depending on whether the parent was overprotecting the child to a pathological degree or whether the parent lacked the basic protective skills necessary for the child. Since the pre- and post-overprotection score fell within the normal range, the change may not be clinically significant. Of concern is that the rejection level did not change significantly and approached the 60th percentile on the post-test. This may mean that the parents are rejecting their children to some degree, and might be confused as evidenced by a normal range acceptance score. The program may want to directly address this issue and help the parents work through their rejection feelings and confusion.

Future research might focus on the parental attitudes of parents who have a sexually abused child using cross-sectional data and asking them to describe attitudes before and after the sexual abuse. Addressing the issue of parental attitudes following child sexual abuse will help us understand the meaning that the sexual abuse has for the parent. This may also be assessed by using qualitative research such as clinical interviews.

The educational assessment showed that the parents answered more questions correctly on the post-test. This must be interpreted with caution since this assessment form has not been shown to be valid or reliable. It would seem likely that the parents would learn the skills and be able to answer questions regarding those skills, but the real test would be if the parent actually applied the parenting skills in the parent-child system.

The subjective evaluation showed that the parents rated the group as positive in areas of content and group leader skills. Categorization of the open-ended questions revealed that the parents learned coping and parenting skills and felt more confident as parents. They also indicated that they wanted more group therapy sessions, which again suggests that the thirteen session program is not long enough to address the therapeutic issues.

Parenting skills training has been shown to be effective in helping the parent-child relationship and thus the child. From a

systems perspective it would be expected that attitudinal and perceptual changes in the parent would lead to changes in the child. In cases of incest, the child suffers not only the trauma of the sexual abuse incident, but other traumas such as separation from the family. If a parent was taught parenting skills while the child was removed from the home, the parenting skills and the effect of these new skills on the child could not be accurately assessed. Follow-up assessments when the child is returned is necessary to obtain a useful determination of the utility of the parenting skills on the child.

Research has demonstrated that short-term therapy for individuals involved in incest has not been shown to be effective, while parenting skills training for the non-offending parents has been effective. This is supported by this study.

While the research on this topic is in its early stages, this study provides suggestions for further research, e.g., duration of treatment, type of treatment, and whether parent education and therapy should be combined or separated for parents of sexually abused children.

This study demonstrates that the parents of sexually abused children are victimized and need treatment to deal with issues of sexual abuse and to help their children overcome the effects of sexual victimization.

RECOMMENDATIONS

Beyond the suggestions for further research and the results of this evaluation, the following recommendations are being made for the Parent Support Group:

1. That the content and structure of the educational sessions of the group remain the same. The parent's scores indicated that they increased their knowledge of parenting skills and felt more confident as parents. The educational part of the Parent Support Group uses materials from various well established parenting programs. This combination gives the parents an opportunity to choose from a variety of parenting techniques. Additional educational material regarding childhood sexuality and sexual abuse has been introduced and appears to be relevant to the group population.

2. That the number of therapy sessions be increased by changing the structure to an open-ended group allowing the participants to stay as long as needed, or if this cannot be done, that the parents be referred to a group therapy program or individual counseling at the end of Parent Support Group participation. The parents indicated that they would like more therapy sessions, and previous research has demonstrated that short-term therapy is not effective with cases of incest. This

would allow the parents to deal with the therapeutic issues surrounding the sexual abuse. The open-ended group has the advantages of allowing each parent to progress at his or her own rate and to allow parents having problems dealing with certain issues to receive feedback and support from those parents who have successfully dealt with those issues.

3. That a parenting skills/confidence inventory be added to the group. The addition of such an inventory which assesses actual transfer of parenting skills in the home would be most useful in assessing the effectiveness of the educational part. This could be accomplished by home observation, self reports, or interviews with significant others.

4. That the subjective evaluation format be refined by changing the structure of the first part to a semantic differential scale and that the open-ended questions deal with more specific issues related the participants feelings about sexual abuse. By using a semantic differential scale which consists of ratings between polar adjectives, a summary score could be derived thus allowing for easier interpretation. Open-ended questions relating to the parent's change in feelings and perceptions of having a child who had been sexually abused would be of clinical interest and would also provide data on the impact of the Parent Support Group on parental feelings about sexual abuse. While a survey is the current format, adding

clinical interviews conducted by a skilled interviewer not associated with the group program might glean additional information.

APPENDICES

APPENDIX A

DESCRIPTION OF THE PARENT SUPPORT GROUP SESSIONS

Session 1

During this session the purpose of the group is explained and the group schedule is passed out. Each group opens with an open-ended question which serves the purpose of encouraging participation and openness. It is explained to the group that each group session will start with the opening question by going around the group circle. The topic of discipline is discussed and the goals of behavior from the STEP program (Dinkmeyer & McKay, 1982) are explained. The group members are asked to share examples of goals of behavior that they have observed with their own children. A short break takes place halfway into the session and refreshments are available. Each group session ends with each member having the opportunity to express their feelings about the group or something they would like to discuss at the next group session.

Session 2

While the first session is educational in content and process, the group discussion in this session is therapeutic. In this group session the group members are led by the therapists to discuss their feelings about having a child who was sexually abused. As the parents discuss what happened to their child, anger, lack of trust, fear, anxiety, confusion and guilt are some of the common themes that emerge during this session. While some parents tearfully describe how their child was sexually abused and

how they feel about the abuse, child, themselves, abuser and the social service system, the other group members offer support by expressing an understanding of the situation and disclosing their own feelings. Other parents express rage at the abuser and their desire to never see the abuser. Some parents express a wish to fight or kill the abuser. The therapists reflect the feelings expressed and point out the commonalties that emerge. The feelings of isolation are addressed by allowing the group members to offer support to each other. This session is very intense and the parents appear to feel some relief after having been able to express themselves with others who they can identify with. The therapists allow the group members to express their range of feelings. Coping methods are discussed. When a parent wants to injure or kill the abuser, it is pointed out that this would be detrimental to the child because the parent would be in jail and unable to support their child. The therapists work with the group to instill hope and faith. It is during this session that the groups resistance breaks down as they feel closer with other group members.

Session 3

During this session the group discusses discipline techniques. Natural and logical consequences are explained to the group (Dreikurs, 1964; Sweeney, 1981). The time-out procedure is explained and actually demonstrated by the two therapists. The

group finds this somewhat humorous as one therapist role plays the parent and the other therapist role-plays the child. Different situations are demonstrated and the parents are encouraged to ask questions and make comments. The importance of limit setting is brought up. The therapists let the group members know that there are many techniques of discipline and there is no single best technique. The group is told that they will have to experiment with different techniques and use the one that works best for them and their child and which is the most comfortable for them to utilize. The parents are asked to try out the techniques and report back at the next group session what happened.

Session 4

This session is an educational session in which child sexuality is discussed. The sexualization of normal developmental issues is explained. Normal and problematic sexual behaviors that the group have observed their children involved in are addressed. Masturbation, sexual identity, sex play and sex questions are brought up for group discussion. Masturbation and sex play between same age children is explained as part of the normal development of children. Problematic sexual behaviors are explained as ones in which the child uses force or manipulation to engage other children in sex play, inappropriate sexual behaviors, and inappropriate sexual verbalizations. The therapists point out that many sexual behaviors, questions, or verbalizations are part

of normal childhood development and that we can learn to distinguish normal and problematic sexual behaviors.

Myths of sexual abuse are also discussed with the group. For example, the group is told that same-sex sexual abuse does not lead to homosexuality and that opposite-sex sexual abuse does not lead to promiscuity. The therapists point out that it is possible for the child to fully recover from sexual abuse and resume normal childhood development. The impact of the sexual abuse and the resulting issues which the children may deal with are described such as guilt, fear, anger, and lack of self-control.

A structured group exercise in which the group describes sexual behaviors that their children have done addresses differentiating developmental sexual issues from sexual abuse issues.

Session 5

During this session normal child development is discussed. The use of a chart listing the developmental milestones is utilized. The areas of physical, emotional, social, and cognitive are covered. The focus is on the preschool and preadolescent child although adolescence is discussed briefly. After the presentation of developmental milestones, the group members participate by discussing their children's development. It is emphasized that children reach the developmental milestones at different rates.

Session 6

This therapy session focuses on the issues of guilt and trust. The group discusses feelings of guilt over not being able to prevent the sexual abuse from occurring or not recognizing that the sexual abuse was happening. Some group members may deny the extent or their role in the sexual abuse. Denial is explained as a defense mechanism and examples of denial are presented. As feelings of guilt are expressed, the therapists and group members offer support and attempt to understand the individual's rationale for the guilty feelings. The use of guilt is discussed and positive and negative ways of using the guilty feelings are described by the group members with the therapists pointing out where successful coping has occurred. For example, one parent stated that she could never forgive herself for allowing the sexual abuse to occur. During this discussion the parent was able to use these feelings to plan protective measures so that re-abuse would not occur to her child.

The group expresses the breach of trust that they feel toward the abuser. This is especially apparent when the abuser was a spouse or boyfriend. The group discusses their reactions to trust in new relationships. Some of the group members disclose that they were sexually abused when they were children. The group offers support and allows the individual to discuss their feelings about the sexual abuse and how it affects them now and the relationship with their child.

Session 7

This session consists of stress management training. The group is taught a progressive relaxation exercise. To demonstrate the stress response, one of the therapists tells the group that he has some songs that he would like the group to sing. Most of the group members laugh at this and state that they will not sing in front of the other group members. At this point the therapist tells the group that they will not be asked to sing but asks them to note their response to the situation. The group discuss how their body changed. The therapists then explain that stress can be helpful and useful, as well as harmful and cite personal examples of useful and harmful stress. The therapists then model progressive relaxation by tensing and relaxing different body sections with the group. The therapists lead the group into a relaxed state and allow time for reflection of the experience.

The use of imagery to help relax is explained to the group and the members describe their own relaxing imagined scene. Adaptive thinking and reframing the situation are described. Activities which are relaxing are shared by the group.

Session 8

In this session behavior modification is explained. Learning and behavior is described using the concepts of modeling, reinforcement and punishment. The group describes how they can

use modeling and reinforcement with their children. Accidental reinforcement is also discussed.

Setting up behavioral contracts and charts (Patterson, 1975) is described by the therapists and the group actually sets up a chart and contract for one of the group member's child. Copies of the contracts and charts are distributed to the group.

The steps in the application of behavioral modification are described as defining the problem, observing the target behavior, establishing a baseline, defining a goal for change, setting up the behavioral contract or chart, explaining the contract or chart to the child, implementing the behavioral modification plan and evaluating if the plan worked.

Session 9

In this session problem solving is discussed. The therapists explain that the first step to problem solving is to determine who owns the problem (Gordon, 1975). The steps of the problem solving procedure are explained as defining the problem, determining factors related to the problem, listing of alternative solutions, evaluating the alternative solutions, choosing one or a combination of alternatives, implementing the alternative solution, evaluating the solution and revising the plan as necessary. The group chooses problems and goes through the steps of the problem solving process with the other members and therapists offering feedback.

Session 10

In this session a guest speaker visits the group to discuss a topic which the group has questions about. The topic for the fourth group was protecting your child from sexual abuse and the guest speaker for this session was a clinical psychologist in private practice who is an expert in the field of sexual abuse. The participants discussed techniques for protecting their children and asked the guest speaker questions about the sexual offender. The groups have expressed an interest in having other visitors such as a state attorney, who could explain how their case would be processed through the legal system.

Session 11

During this session the group reflects on their feelings and ways of coping. The group discusses supporting, understanding and helping their children by helping and understanding themselves. Issues around sexual abuse are discussed with the therapists and other group members offering feedback, support and suggestions.

Session 12

This session consists of a review of the group experience and the group members describe how the group has helped them and how the other group members acted as a support system. The group reviews the educational components. The group also plans a graduation party during this session.

Session 13

This session is a graduation party for the group members. The group plans the party and take responsibility for providing the refreshments. The therapists present each group member with a certificate of completion and congratulate the group member for participating in the group. The group members and the therapists share goodbyes and some of the group members exchange phone numbers and make plans to get together with each other.

APPENDIX B
EDUCATIONAL ASSESSMENT

MULTIPLE CHOICE QUESTIONS

Instructions: Please CIRCLE the best answer

1. The purpose of disciplining a child is:
 - a. To make them obey immediately
 - b. To help the child learn self-control
 - c. To teach the child adults are always right
 - d. To scare the child into being good
2. Setting limits on your child's behavior:
 - a. Helps him/her feel secure
 - b. Is harmful
 - c. Does not work
 - d. Makes the behavior worse
3. A child's behavior:
 - a. Happens by chance
 - b. Is determined by his/her horoscope sign
 - c. Has a purpose
 - d. Can be totally controlled by his parents
4. Limits are best enforced by:
 - a. Threats
 - b. Bribes
 - c. Yelling and a spanking
 - d. Being firm, kind, and consistent

TRUE/FALSE QUESTIONS

Instructions: CIRCLE either true or false

5. Average three year olds have bad dreams.
 - a. True
 - b. False
6. Preschool children masturbate.
 - a. True
 - b. False
7. Preschool children are interested in differences between the sexes.
 - a. True
 - b. False
8. Preschool children may have difficulty telling the difference between fantasy and reality.
 - a. True
 - b. False
9. Sex play between same age children is harmful and abnormal.
 - a. True
 - b. False
10. A child always knows the purpose of his/her behavior.
 - a. True
 - b. False
11. Make-believe play is harmful for the child.
 - a. True
 - b. False

APPENDIX C
SUBJECTIVE EVALUATION

PARENT GROUP EVALUATION

Directions: Please write the number which corresponds to the word which best describes your feelings about the questions in space provided.

- (1) Strongly Agree (2) Agree (3) Undecided
(4) Disagree (5) Strongly Disagree

1. The information was easy to understand. _____
2. The information was useful. _____
3. The setting was comfortable. _____
4. The group leaders were knowledgeable. _____
5. The group leaders were supportive. _____
6. The group leaders were boring. _____
7. The other parents were supportive. _____
8. The group program was too short. _____
9. The group program was too long. _____
10. The group sessions were too long. _____
11. The group sessions were too short. _____
12. The handouts were understandable. _____
13. The handouts were helpful. _____

Please write the number which corresponds to the word that best describes the listed parts of the group.

- (1) Excellent (2) Good (3) Average (4) Fair (5) Poor

1. Goals of behavior _____	6. Stress Management _____
2. Child Development _____	7. Sexual Development _____
3. Group therapy sessions _____	8. Disciplining your child _____
4. Guest Speaker _____	

Please Write Your Comments to the Following Questions

1. What did you like about the Parent Group Program?
2. What did you dislike about the Parent Group Program?
3. What would you suggest we add to the Parent Group Program?
4. What would you suggest we leave out from the Parent Group Program?
5. What have you learned from the Parent Group Program?
6. How have you changed or grown as a result of the Parent Group Program?

(If additional space is needed, please write on the back of this page)

APPENDIX D

SUBJECTIVE EVALUATION RESPONSES
TO OPEN-ENDED QUESTIONS

The following quotes were selected and listed below from the open-ended questions of the subjective evaluation form as a means of summarizing parent's evaluations.

1. What did you like about the Parent Group program?

"It was educational and gave us an opportunity to express our feelings."

"I liked the thought of not being the only one with the same problem. I also liked getting to know you people (therapists) who work with the children."

"Had a chance to express feeling, got to see that we were not alone."

"Getting together with the people with the same situation as yours and learning how to deal with problems."

"Group sessions. Learning about child behaviors."

"Information on how to handle discipline and what is normal behavior was reassuring. Chance to voice anger and hurt with others."

"Opportunity to discuss the problems my child presents."

"Being with other parents who share the same problems as I do. The information about how to handle a child who has been abused was very helpful. The support from each other was very good. Learning why my child has some of the problems she does and how to help her."

"I could get help with how to help."

"Being able to release emotions during my very stressful last few months. Being able to express anger, fear, etc. Finally understanding my problem."

2. What did you dislike about the Parent Group program?

"Not enough participation with some parents."

"All the parents didn't participate regularly."

"Filling out forms."

"Initially feeling I should attend."

"There weren't enough meetings."

"Some people talking on and on."

3. What would you suggest we add to the Parent Group program?

"Put in 1 or 2 more sessions for the parents to let their own feelings out, to deal with their own stress."

"More therapy sessions."

"Allowing the parents to open their anger up more, even to sit on the floor and being informal to relax the mood to, show their hurt and anger."

"Add the abuser, then we can abuse him or her and let them see what it is like."

"One or two more guest speakers. More information on how to handle a child when the child gets out of hand! More information on where to go from here. Some help to find other groups to get involved with for abused kids."

"A library or books (good ones) that we could buy."

"More advice on how to handle individual problems that come up."

4. What would you suggest we leave out from the Parent Group program?

"Meeting with parents that have been through it and had extremely bad experience with HRS (Health and Rehabilitative Services)."

"Filling out forms."

"Let the parents tell you what they want to talk about."

5. What have you learned from being in the Parent Group program?

"I have learned that there are lots more things, emotions to deal with."

"How to cope better with the situation, that there are caring people."

"How to deal with what has happened."

"All parents and others are feeling the same stress and anger over this trauma."

"To better deal with our kids."

"I have learned the goals of my child's behavior and how to handle it with a greater sense of calm. Understanding the behavior decreased my anxiety and has allowed me to remain calmer in the midst of crisis."

"Not to feel so guilty; that I'm not alone in this situation; what changes could occur as a result of XXXXXX's being molested. What behavior to notice."

6. How have you changed or grown as a result of the Parent Group program?

"I am more patient and also more calm."

"I can handle a lot more pressure and deal with my child easier."

"Feel more confident in my role as the parent to guide and handle child's behavior."

"Feeling freer in admitting and discussing my child's difficulties."

"Realizing you can make it, once the problem is in the light there is good with the bad."

"I have learned that I am not the only one going through this difficult time and there are people who care and want to help you understand how to deal with the situation. I know now that you can get through it. I have confidence that my child will be O.K. as a result of the help she is receiving and from what I am able to give her from what I have learned here."

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