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Effectiveness of Solution-Focused Brief Group Counseling for Psychological Problems of Sexually Abused Children: The Case of Godanaw Rehabilitation Integrated Project

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Abstract:

This study examined whether Solution-Focused Brief Group Counseling (SFBGC) is effective in addressing the psychological problems of sexually abused children in Godanaw Rehabilitation Integrated Project. The research design was a non-equivalent control group pretest-posttest quasi-experimental design. Fifty participants aged 12–18 years were selected purposefully based on inclusion criteria. They were randomly assigned to control and treatment groups each with 25 participants. Three standardized scales, namely, the Children Depression Inventory, the Child Posttraumatic Stress Symptoms Scale, and the Rosenberg Self-Esteem Scale, were used to measure the dependent variables on two occasions: pretest and posttest. Participants in the treatment group received SFBGC for three weeks, three days per week, 1:00-1:20 hours per session for eight sessions. Results of the dependent t-test indicated that, after treatment, participants in the treatment group showed a statistically significant reduction in the level of depression ($df = 24$, $t = 2.186$, $p<0.05$) and significant improvement in self-esteem ($df = 24$, $t = -2.623$, $p<0.05$) compared to the control group. An independent t-test indicated that there was no statistically significant difference between the treatment and control groups in posttraumatic stress symptoms during the pre-test ($df = 48$, $t = 0.183$, $p>.05$) and during the post-test ($df = 48$, $t = 0.199$, $p>.05$). From these results, it was suggested that the application of SFBGC has to be expanded to address psychological problems of sexually abused children in more organizations or settings.

Key Words: *Effectiveness, Counseling, psychological problems, Sexual abuse*

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Introduction

The issue of child sexual abuse, exploitation and neglect, especially the plight of the girl child, has recently become a major area of concern in Ethiopia. Traditional Ethiopia value and belief systems coupled with poverty and ignorance, in most cases, have facilitated the violations of the rights of children. Early marriages and the associated sexual abuse are not considered as abuse in most traditional communities of Ethiopia (Belay, 2001). The efforts of governmental and non-governmental bodies in raising the awareness of the public and preventing the abuse and neglect of children in Ethiopia is a good start although a lot remains to be done to protect children from all forms of abuse and neglect and promote their wellbeing (Belay, 2001).

There is no universally accepted definition of what constitutes childhood sexual abuse because of the historical time, between cultures and among professional disciplines (Baker, 2002). Sanderson (2006) defined childhood sexual abuse as the involvement of dependent children and adolescents in sexual activities with an adult, or any person older or bigger, where there is a difference in age, size or power, in which the child is used as a sexual object for the gratification of the older person's needs or desires. It is also considered sexual abuse when a child cannot give informed consent given the unequal power in the relationship. Activities can range from simple culturally unacceptable touching and fondling to forceful, penetrative sexual intercourse. This definition excludes consensual activity between peers (Sanderson, 2006).

According to the World Health Organization, (WHO, 2002), fewer than 1% of parents admit to have their children sexually abused. In the international literature, the WHO determined a mean rate of 20% for females and 5–10% for males as having reported child sexual abuse (WHO, 2002). Globally, 40 million children aged 0–14 years suffer from some form of abuse and neglect, requiring health and social care, among which the most devastating is child sexual abuse (WHO, 2004).

There are three primary forms of abuse: sexual, physical, and emotional. Sexual abuse includes sexual contact or attempted sexual contact with a child under the age of 18 by an adult for the purposes of the adult's sexual gratification or financial gain (Cicchetti & Toth, 2005). Physical abuse describes physical injuries to a child caused by punches or kicks, shakes or smacks, burns or scalds, drowning or suffocating, bites or poisons. Bruises may appear. Bones may be broken. Cuts are caused and illnesses arise. Even before they are born, some children are exposed to damaging levels of alcohol or drugs (Howe, 2005).

Iwaniec (1995) defines emotional abuse as the 'hostile or indifferent behavior which damages a child's self-esteem, degrades a sense of achievement, diminishes a sense of belonging, prevents healthy and vigorous development, and takes away a child's wellbeing.'

Females can and do sexually abuse children, however most abuse is carried out by males, including fathers, stepfathers, mothers' partners, brothers, grandfathers, uncles, as well as friends of the family including neighbors. Caregivers who are emotionally detached, violent or who abuse alcohol or drugs increase the risk of leaving their children prey to sexual abuse (Berliner &Elliot, 1996).

In relation to the impact of sexual abuse Howe (2005) found that many children who suffer sexual abuse experience pain, shame, fear, guilty, depression, low-self-esteem and confusion. Children aged 12 to 17 years who reported experiencing child sexual abuse (CSA) at home were included in a national report produced by Kilpatrick, Saunders, andSmith (2003, as cited in Cromer, 2006) for the U.S. Department of Justice. They were at an increased risk of experiencing posttraumatic stress symptoms, abusing substances, and engaging in delinquent behavior compared to children who were not sexually abused.

Similarly, sexual abuse impairs children's ability to understand emotions and regulate their arousal. Severe physical and sexual abuse can traumatize children. Victims are, therefore, at an increased risk of posttraumatic stress symptoms, which include intrusive thoughts, sleep

problems, nightmares, and feelings of helplessness, avoidance, numbing, and flashbacks of the abuse experience (Kendall-Tackett, 2002, as cited in Howe, 2005). Some sexually abused children become so deregulated and suffer from depression, internalizing and externalizing behavioral problems, and peer relationship difficulties. They tend to deny feeling emotionally needy, and yet they display a high level of emotional liability, inappropriate emotional outbursts, low levels of emotional awareness, and little emotional empathy. In challenging social situations, they often seem to be psychologically disengaged and emotionally switched off (Berliner & Elliott, 1996; Widom & Kuhns, 1996; Jones, 2002).

In a further refinement, sexually abused children are at risk of experiencing a range of psychopathologies and problem behaviors including low self-esteem, major depression, anxiety, substance abuse, self-harming behavior, suicide, sudden feelings of anger and fear, obsessive-compulsive disorders, and eating disorders (Berliner & Elliott, 1996; Widom & Kuhns, 1996; Jones, 2002).

Johnson (2004) found that some long-term effects of CSA include mental, physical, and emotional problems such as depression, anxiety, sexual disturbances, eating disorders, and substance abuse. Johnson also noted that victims of CSA have reported guilt, feelings of worthlessness and powerlessness, inability to distinguish sexual from affectionate behavior, difficulty in maintaining appropriate personal boundaries and the inability to refuse unwanted sexual advances. Similarly, Davis and Petretic-Jackson (2000) reported that experiencing problems with intimacy and feelings of guilt and shame are also long-term effects of CSA. Generally, several studies have found that the more physical force and violence used by the perpetrator, the more likely survivors will experience negative outcomes and the more intense the effects will be (Finkelhor, 1979; Friedrich, Beilke&Urquiza, 1986; Fromuth, 1983; Russell, 1986; Tufts New England Medical Center, 1984, as cited in Sanderson, 2006).

Childhood sexual abuse (CSA) is often a significant trauma that may have a lifelong impact on survivors. When survivors of childhood sexual abuse seek counseling for any reason,

counselors must be prepared to explore with them the impact the abuse has had on their development and the effect it might be having on their present concerns. Due to the prevalence of childhood sexual abuse in the histories of individuals who seek counseling and its possible pervasive and long-term effects, it is important that all counselors become practiced at addressing the unique and complex needs of survivors.

Brief counseling is a descriptor of time-limited counseling which utilizes strengths, sees problems in context, and concentrates on the future (McLeod, 2003, as cited in Lines, 2006). It is an intervention provided for sexually abused children that focuses on the client's resources and strengths. Solution-focused brief group counseling (SFBGC) is one part of brief counseling. It is a non-pathological approach that emphasizes competencies rather than deficits and strengths rather than weaknesses (Metcalf, 2001). This approach differs from traditional counseling by focusing on the present and the future instead of evaluating and exploring past problems (Corey, 2009).

Reviews of SFBC generally found an average number of sessions ranging between three and five (McKeel, 1996; Miller, 1994). Dewan, Steenbargerand Greenberg (2004) also asserted that solution-focused counseling was able to address the concerns of clients in a brief fashion, generally in fewer than 10 sessions.

Therefore, the researcher has an interest in studying the effects of SFBGC on sexually abused children's problems to help abused children realize their own potential, solve their own problems, and develop the psychological resilience and behavioral buoyancy to protect their lives in the future. The result also will be a guide for counseling service providers, especially counselors and social workers that work with sexually abused children, with regard to the use and effectiveness of need-based solution-focused brief group counseling services.

Based on the above discussion, an attempt was made to answer the following research questions:

- Is there a statistically significant difference in depression from pre-to-post treatment measures between the treatment and control groups (child survivors treated with solution-focused brief group counseling)?
- Is there a statistically significant difference in posttraumatic stress symptoms from pre-to-post treatment measures between the treatment and control groups (child survivors treated with solution-focused brief group counseling)?
- Is there a statistically significant difference in self-esteem from pre-to-post treatment measures between the treatment and control groups (child survivors treated with solution-focused brief group counseling)?

Objectives

The general objective of this research is to examine the effectiveness of solution-focused brief group counseling in addressing psychological problems of sexually abused children in Godanaw Rehabilitation Integrated Project. More specifically, the study examines whether there is or is not a significant statistical difference in the most common psychological problems, namely depression, post-traumatic stress symptoms, and self-esteem, from pre-to post-treatment measures between treatment and control groups.

Operational Definition of Terms

Solution-Focused Brief Group Counseling (SFBGC): is defined as a practical, step-by-step group approach which promotes the utility of the clients' own strengths and resources in a collaborative process of goal setting to work toward the desired change.

A child: for the purpose of this study, a child is defined as a sexually abused girl child between the ages of 12 and 18.

Child Sexual Abuse: for the purpose of this study, child sexual abuse is defined as sexual activity involving a person 18 years of age or younger. Most often perpetrated by an adult,

such activities include rape and molestation, sexual harassment, and the exposure of children to the sexual acts of others.

Depression: is defined as acute, but time-limited, episodes of depressive symptoms including disturbances in mood, pleasure capacity, self-evaluation, interpersonal behavior, eating and sleeping behaviors as measured by the Children's Depression Inventory.

Posttraumatic stress symptoms: in the present study, posttraumatic stress symptoms are a debilitating psychological condition caused by sexual abuse. The symptoms include, but are not limited to: nightmares, flashbacks about the incident, low startle threshold, difficulty sleeping, thoughts or obsessions about death and dying, difficulty concentrating, loss of desire to do things the individual formerly enjoyed, isolating, and avoidance of reminders of the trauma.

Self-esteem: is defined as global feelings of self-acceptance and self-worth as measured by the Rosenberg Self-Esteem Scale (RSES).

Methods

The Research Design and Methods

The study was a non-equivalent control group pretest-post-test with a quasi-experimental design (Cohen et al., 2000).

	Pre-test		**Post-test**
Treatment group	0_1	X	0_2
Control group	0_3		0_4

FIGURE: DESIGN OF A QUASI-EXPERIMENTAL DESIGN

Where:

1. The **Treatment group** was sexually abused children who received both usual care provided by the institution and Solution focused Brief Group Counseling delivered by the researcher.
2. The **Control group** was sexually abused children who only received usual care provided by the institution.
3. $\mathbf{0_1}$ and $\mathbf{0_3}$ refer to mean scores of dependent variables (Depression, Posttraumatic stress symptoms and Self-esteem) **before** the treatment for both the treatment group and control group.
4. **X** refers to Solution-focused Brief Group Counseling delivered by the researcher.
5. $\mathbf{0_2}$ and $\mathbf{0_4}$ refer to mean scores of dependent variables (Depression, Posttraumatic stress symptoms and Self-esteem) **after** the treatment for both the treatment group and control group.

Research Site

The study was conducted at the Godanaw Rehabilitation Integrated Project Center (GRIP). The aim of GRIP is to provide protection and assistance to girls (age 20 and below) who suffer from various types of social problems, such as domestic violence, abuse, victims of trafficking, etc. GRIP can accommodate up to 120 girls enrolling in rehabilitation services. The length of stay of the girls in this organization is approximately 8 to 14 months. GRIP, as a local non-governmental organization, provides social services free of charge. The girls receive accommodation, medical care, and education, vocational training (e.g., beauty treatment; hairdressing; dress-sewing; candle and soap-making; hand crafts; etc.); recreational services; and social activities, such as entertainment programs and religious activities.

Population and Sampling

The population in this study was sexually abused female children who lived in Godanaw Rehabilitation Integrated Project. The inclusion criteria were children who:

1. Are aged between 12 and 18
2. Have been sexually abused prior to the study; will stay in the institution for at least six months
3. Were willing to participate in the study

Accordingly, 50 sexually abused children who met the above criteria were selected and included as the samples of the study.

Randomization

The main purpose of the study is to examine the effectiveness of solution-focused brief group counseling in addressing the psychological problems of sexually abused children who are found in GRIP. Based on the stated criteria, 50 eligible participants were purposefully selected. The participants ranged in age from 12 to 18. All participants were sexually abused female children. Before the administration of the pre-test, the researcher assigned code numbers to the questionnaire from 01 to 050. During the completion of the pre-test, the researcher requested the participants to write and use their first name and assigned code numbers on the front of the questionnaire, which remained strictly confidential between the participants and the researcher. After the participants completed the questionnaire, the researcher changed all first names into code numbers. These code numbers were also erased immediately after all the data was gathered. The main reason behind assigning code numbers was to randomly allocate participants into the treatment or the control group. Accordingly, using a coin toss (head means even and tail means odd number) beginning from 01 as a starting point, the researcher selected the first 25 odd numbers from the list of 50 participants. The participants who had previously been assigned these numbers were assigned to the control group. Thus, the remaining 25 participants who were assigned even numbers were assigned to the treatment group.

Variables

Independent Variables

The two independent variables for the research design were treatment and time. The treatment variable included solution-focused brief group counseling for the treatment group and no solution-focused brief group counseling for the control group. The time variables were before (pre) and after (post), and included those that received treatment and those that did not receive treatment programs.

Dependent Variables

The dependent variables were: (i) depression; (ii) posttraumatic stress symptoms; and (iii) self-esteem. The dependent variables were measured by pre and post-test self-reported measures: Children's Depression Inventory (Kovacs, 1981); Child Posttraumatic Stress Symptom Scale (Foa et al., 2001); and Rosenberg Self-Esteem Scale (Rosenberg, 1965). The detailed psychometric properties of each self-reported measure are reviewed below.

Research Instrument

In this study, the questionnaire was comprised of two parts: a demographic data sheet and standardized scales to measure the pre-and post-treatment effects of solution-focused brief group counseling on sexually abused children's problems.

Standardized Scales

Children's Depression Inventory (CDI)

The Children's Depression Inventory (CDI; Kovacs, 1981) is a 27-item scale designed to quantify a wide range of depression symptoms, including disturbances in mood, pleasure capacity, self-evaluation, interpersonal behavior, and eating and sleeping behaviors. It is designed for children 7 through 18 years of age.

The CDI is a downward extension of the Beck Depression Inventory (Beck, 1967), one of the most widely used adult measures of depression. Some items were removed and reworded to decrease the reading level of the scale, and a few items were rewritten. Berndt, Schwartz, and Kaiser (1983) evaluated the reading level of the CDI and nine other depression scales. They found that the CDI was written at a third-grade reading level and had the lowest reading level of all the measures assessed.

Each item of the CDI consists of three statements from which the respondent chooses the one that describes his or her feelings best. Half the items are reversed so that the choice indicating more depression comes first; this helps control for the acquiescent response set. About 15 minutes are required to administer and 5 minutes to score the questionnaire.

Cronbach's alphas ranged from 0.59 to 0.68 for the subscales of the CDI, and the alpha was 0.86 for the total score in the normative sample. Test-retest correlations ranged from 0.66 to 0.83 over 2-to-4-week intervals and 0.54 to 0.56 over 4-to-6-month intervals (Kovacs, 1985). The total score of the CDI has a sensitivity of 80% and a specificity of 84% in distinguishing children with depression from children without depression (Kovacs, 2003).

Items are scored from 0 (absence of symptom) through to 2 (definite symptom), in the direction of the severity of symptoms. A total score ranges from 0-54, where higher scores indicate greater depression severity, which is calculated by summing all items. Kovacs (1981) suggested a cutoff score of 11 if the CDI is used as a screening device and false negatives are to be kept to a minimum (children who score below 11 but are later found to be depressed). A cutoff of 13 is suggested if the CDI is to be used to assess the presence of depression in a sample of problem-behaving children. Thus, taking 11 as a cutoff score of CDI, the following ranges were adapted for the purpose of this study:

- Scores between 0 and10 are indicative of minimum levels of depression symptoms
- Scores between 11 and 25 are indicative of mild levels of depression symptoms

- Scores between 26 and 40 are indicative of moderate levels of depression symptoms
- Scores between 41 and 54 are indicative of severe levels of depression symptoms.

The Child Posttraumatic Stress Symptoms Scale

The Child Posttraumatic Stress Symptom Scale (CPSS) is a new instrument that was developed to assess the severity of Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 1994) posttraumatic stress symptoms in children exposed to trauma. The CPSS is a children's version of the Posttraumatic Diagnostic Scale (Foa et al., 1997), a well-validated measure for assessment of posttraumatic stress symptoms severity and diagnosis in adult victims of a variety of traumas. The language of the PTDS was modified to incorporate developmentally appropriate language to maximize children's understanding of the items. The CPSS was developed to assess the diagnosis and severity of posttraumatic stress symptoms in children aged 8 to 18 who had witnessed a traumatic event. It contains one question for each of the 17 DSM–IV PTSD symptoms to ascertain their frequency in the past month.

The psychometric properties of the CPSS show high internal consistency and test–retest reliability for both the total score and the three subscales. The coefficient alpha was 0.89 for the total score. Item analysis did not reveal any items whose exclusion would increase the internal consistency. The test–retest reliability coefficient of the total scale score was 0.84 (Foa, Johnson, Feeny, & Treadwellet, 2001).

The convergent validity of the total scale score was assessed by comparing it with the severity rating obtained from the Child Post-Traumatic Stress Disorder Reaction Index (CPTSD–RI). The Pearson Product–moment correlation coefficient was 0.80 (Foa et al., 2001).The correlations of the CPSS with depression and anxiety measures were lower than those with the CPTSD–RI, providing some support for discriminant validity of the CPSS (Foa et al., 2001). These results suggest that the CPSS is a useful tool for the assessment of posttraumatic

stress disorder (PTSD) severity and for the screening of PTSD diagnosis among traumatized children.

The instructions for answering the questions are as follows: "Circle the number that describes how often that problem has bothered you in the past two weeks." Answers are on a 4-point Liker type scale, ranging from 0 (not at all), 1 (once a week or less), 2 (2 to 4 times a week), and 3 (5 or more times a week). Seven additional items that inquire about daily functioning (e.g., relationships with friends, schoolwork) were inserted after the 17 posttraumatic stress symptoms. The 17 symptom items yield a total symptom severity scale score ranging from 0 to 51. Add the scores for the 24 items. Scores range from 0 to 58. Scores for children who have been diagnosed with posttraumatic stress symptoms are interpreted as follows:

- Scores between 0 and 15 are indicative of minimum levels of posttraumatic stress symptoms.-
- Scores between 16 and 24 are indicative of mild levels of posttraumatic stress symptoms.
- Scores between 25 and 39 are indicative of moderate levels of posttraumatic stress symptoms.
- Scores between 40 and 58 are indicative of severe levels of posttraumatic stress symptoms.

The Rosenberg Self-Esteem Scale

The Rosenberg Self-Esteem Scale (RSES) (Rosenberg, 1965) was originally designed to measure children and adolescents' global feelings of self-acceptance and self-worth. It consists of 10 items with Likert scaling represented by four points (ranging from strongly agree to strongly disagree) used to assess global self-esteem. Respondents are requested to read the statements and rate the degree to which each one can be self-applied. The 10 statements are related to overall feelings of self-acceptance and self-worth. Five statements were worded positively and five statements were worded negatively. The original sample for

which the scale was developed consisted of 5024 juniors and seniors from 10 randomly selected schools in New York State (Rosenberg, 1965).

The reliability of this scale has been extensively reported in the literature. McCarthy and Hoge (1982) reported internal consistency coefficients (Cronbach's alpha) of between 0.74 and 0.77. McCarthy and Hoge also found test-retest reliability of 0.63 (with a 7-month interval) and 0.85 (2-week interval). Silbre and Tippett (1965) reported a test-retest correlation of 0.85 for 28 subjects after a 2-week interval. Rosenberg (1989) found test-retest correlations typically in the range of 0.77 to 0.88.

The RSES is associated with self-esteem-related constructs. For example, Reynolds (1988) found a correlation of 0.38 between RSES scores and overall academic self-concept, with correlations between RSES scores and specific facets of academic self-concept ranging from 0.18 to 0.40. The Rosenberg measure correlated 0.60 with the Coopersmith Self-Esteem Inventory (Coopersmith, 1967). The correlation between the Single-Item Self-Esteem scale (SISE) and the RSE scale ranged from 0.74 to 0.80 (Robins et al., 2001).

Respondents indicate their level of agreement using a 4-point Likert-type scale (Strongly Agree = 4, Agree = 3, Disagree = 2, and Strongly Disagree = 1). Items worded negatively are reverse scored, that is, Strongly Agree=1, Agree=2, Disagree=3, and Strongly Disagree=4. Add the scores for the 10 items. Scores range from 10–40, with lower scores representing lower reported levels of self-esteem, feelings of rejection, and self-dissatisfaction. Some researchers (Strange et al., 2005) considered scores of 17–25 to be average, and the same ranges were adapted for the purpose of this study as follows:

- Scores between 0 and 16 are indicative of low levels of self-esteem.
- Scores between 17 and 25 are indicative of average levels of self-esteem.
- Scores between 26 and 40 are indicative of high levels of self-esteem.

Translation of the Scales

The English version of the Children Depression Inventory, the Child Posttraumatic Stress Symptoms Scale, and the Rosenberg Self-Esteem Scale were first translated into Amharic by the researcher in this study. Then, its accuracy and readability were revised by two graduate students in the literature department. Finally, it was verified again by two former graduates of counseling psychology.

Pilot Testing

Pilot testing was conducted on 20 participants for the main purpose of determining the reliability of the Children's Depression Inventory, Child Posttraumatic Stress Symptoms Scale, and Rosenberg Self-Esteem Scale. Accordingly, after administering the instrument for the pilot samples, the responses were scored and assessed for its reliability by using Cronbach's alpha. The computation yielded a reliability coefficient of 0.883, 0.754, 0.80, and 0.728 for Children Depression Inventory, Child Posttraumatic Stress Symptoms Scale Part One and Part Two, and self-esteem scale, respectively. The above coefficients of reliability clearly show that the instruments seem to be highly reliable. Moreover, following pilot testing, minor modifications were made to the scales, like changing formats, adding some words in the sentences (e.g., after you have been sexually abused...) and so on.

Ethical Issues Considered

The success of any study counts upon unconditional and enthusiastic cooperation from the participants. If the participants were not willing to participate in the study voluntarily, they might have provided careless responses, which could have misled the overall findings of the study. To ensure the quality of data and also for ethical purposes, the following ethical issues were taken into account while contacting and collecting data from the participants. The objectives of the study were briefed to all the study participants, and their informed consent was obtained. The date and time of the data collection and group counseling were decided as per the convenience of the study participants. Participants were assured of the confidentiality

of the communicated information. Participants were informed of their choice to withdraw at any point during the study period, if they wished so.

Data Collection Procedures

To conduct and accomplish the research, the following steps were followed in the study:

1. The researcher requested a letter of introduction from the Department of Psychology, Addis Ababa University, to the Director of Godanaw Rehabilitation Integrated Project to ask for permission to collect the data.
2. After receiving permission to collect data at Godanaw Rehabilitation Integrated Project, the researcher met with "home mothers" at Godanaw Rehabilitation Integrated Project to ask for their collaboration by presenting the objectives of the study and the research process.
3. The 'home mothers' at Godanaw Rehabilitation Integrated Project selected the samples according to the inclusion criteria of the study. A total of 50 participants were selected. The participants were approached by the researcher to inform them of the research objectives, the research process, and confidentiality of the information. The confidentiality of participants was maintained through the assignment of a code, which was used throughout the data collection, analysis, and reporting process to reduce the anxiety of participants.
4. Then, the participants were asked to complete a pre-test questionnaire. They were encouraged to answer the questions honestly and ask if they had any problems understanding the questions. After completing the questionnaire, all selected participants were randomly assigned to treatment and control groups, with 25 participants per group.
5. The participants in the treatment group were asked to participate in the program of solution-focused brief group counseling for a total of eight sessions, three sessions per week. Each session lasted approximately 1:00–1:20 hours. These sessions are the maximum average of all sessions in SFBC. Generally, several researchers have found an

average number of SFBC sessions ranging between three and eight (Dewan et al., 2004; de Shazer, 1988; Iveson , 2002; McKeel, 1996; Miller, 1994).

6. The control group didn't receive solution-focused brief group counseling; they received the usual care that is provided by the institution.
7. The post-test was conducted after 8 sessions of solution-focused brief group counseling for the treatment group to check whether there had been any significant changes in the scores compared with the pre-test. The control group also completed the post-test, and it was compared with the treatment group to detect any statistically significant difference in the counseling effectiveness.

Method of Data Analysis

The data collected was analyzed using the Statistical Package for Social Science (SPSS) version 17.0. Descriptive statistics, frequency distributions, and percentages were used to describe the participants' demographic characteristics and the prevalence of problems. A dependent and independent t-test were used to compare the mean difference between the treatment and control group on pre-test and post-test measures. The mean difference was tested for statistical significance at .05 level.

Results

The major purpose of the present study was to examine the effectiveness of solution-focused brief group counseling for sexually abused children's problems (depression, posttraumatic stress symptoms, and self-esteem) in the Godanaw Rehabilitation Integrated Project.

To properly meet the above objectives, the collected data on both the pre-test and post-test were presented based on the specific research questions raised in chapter one.

Participants' Demographic Characteristics

Demographic characteristics of the participants in the control and treatment groups are provided in Table 1. The average age for the control group was 16.80 years (SD = 1.32; range = 13-18) and 16.40 years (SD = 1.60; range = 12-18) for the treatment group. In terms of educational background, it was found that in the control group, 68% had an elementary school level and 32% had a secondary school level, while 76% of the treatment group had an elementary school level and 24% had a secondary school level. As to the period the participants stayed in the institution, data show that all 50participants (100%) of the control and treatment groups have stayed for less than a month in the institution.

Table 1: Demographic Characteristics of Treatment and Control Group

Characteristics		**Control group (N=25)**		**Treatment group(N=25)**	
		Mean	**SD**	**Mean**	**SD**
Age	12-18	**16.80**	**1.32**	**16.40**	**1.60**
		Frequency	Percentage	Frequency	Percentage
Educational level	Elementary	17	68	19	76
	Secondary	8	32	6	24
	Total	**25**	**100**	**25**	**100**
Time stayed in the institution	One week	3	12	5	20
	Two weeks	6	24	7	28
	Three weeks	5	20	4	16
	Four weeks	11	44	9	36
	Total	**25**	**100**	**25**	**100**
Time since abused	< 1 year ago	25	25	25	25
	1-2 years ago	-	-	-	-
	Total	**25**	**100**	**25**	**100**
Counseling received	Yes	-	-	-	-
	No	25	100	25	100
	Total	**25**	**100**	**25**	100
Received SFBGC before	Yes	-	-	-	-
	No	25	100	25	100
	Total	**25**	**100**	**25**	**100**

In terms of the timing, all of the participants (n = 50, 100%) in the control and treatment groups were abused less than a year ago. When participants were asked if they had ever received counseling from the institution, all of the participants (100%) in the control and treatment groups responded "No.", all of the participants (n =50, 100%) in the control and treatment groups were abused less than a year ago. When participants were asked if they had ever received counseling from the institution, all of the participants (100%) in the control and treatment groups responded “No”. Similarly, when subjects were asked if they had ever received solution focused brief counseling before, all of the participants (100%) in the control and treatment groups responded “No”. In addition to the above findings, the researcher also observed that all social workers called ‘home mothers’, who are found in GRIP, are working with sexually abused children without any training on how to recognize, understand, identify physical and psychological needs and rights of abused children and then how care for and handle them properly. Therefore, in general, the descriptive and percentage analyses of participants both in the treatment and control groups indicated that the groups were equal in terms of demographic characteristics. This implies that the participants were comparatively and equally distributed between the treatment and the control groups with little to no discrepancies.

Psychological Problems of Sexually Abused Children

Depression

Table 2: Depression Level of Treatment Group before and after Treatment (N=25)

Level of Depression	Before Treatment (Pre-test)		After Treatment (Post-test)	
	Frequency	Percentage	Frequency	Percentage
0-10 (Minimum)	-	-	1	4
11-25 (Mild)	8	32	13	52
26-40 (Moderate)	12	48	9	36
41-54 (Severe)	5	20	2	8
Total	25	100	25	100

As shown in Table 2, before the treatment the participants in the treatment group showed moderate (48%), mild (32%) and severe (20%) level of depression. Whereas, after the treatment majority of the participants showed mild or minimum(56%) and relatively fewer number of participants displayed moderate(36%) and severe (8%) levels of depression.

Table 3: Depression Level of Control Group before and after Treatment (N=25)

Level of Depression	Before Treatment (Pre-test)		After Treatment (Post-test)	
	Frequency	Percentage	Frequency	Percentage
0-10 (Minimum)	2	8	1	4
11-25 (Mild)	9	36	7	28
26-40 (Moderate)	12	48	15	60
41-54 (Severe)	2	8	2	8
Total	**25**	**100**	**25**	**100**

Table 3 indicates that, before the treatment, 48% of the control group participants showed moderate, while 36%, 8%, and 8% of participants respectively experienced mild, minimum, and severe levels of depression. Whereas, after the treatment, 60% of the participants showed moderate while 28%, 8%, and 4% of the participants showed mild, severe and minimum level of depression, respectively.

Posttraumatic Stress Symptoms

Table 4: Posttraumatic Stress Symptoms Level of Treatment Group before and after Treatment

Levels of posttraumatic stress symptoms	Before Treatment (Pre-test)		After Treatment (Post-test)	
	Frequency	Percentage	Frequency	Percentage
0-15 (Minimum)	-	-	-	-
16-24 (Mild)	7	28	5	20
25-39 (Moderate)	15	60	18	72
40-58 (Severe)	3	12	2	8
Total	**25**	**100**	**25**	**100**

As shown in Table 4, before the treatment, the participants in the treatment group showed moderate (60%), mild (28%) and severe (12%) level of posttraumatic stress symptoms. After the treatment, they experienced moderate (72%), mild (20%) and 8% participants showed severe level of posttraumatic stress symptoms.

Table 5: Posttraumatic Stress Symptoms Level of Control Group Before and After Treatment

Level of posttraumatic stress symptoms	Before Treatment (Pre-test)		After Treatment (Post-test)	
	Frequency	Percentage	Frequency	Percentage
0-15 (Minimum)	-	-	1	4
16-24 (Mild)	8	32	7	28
25-39 (Moderate)	13	52	14	56
40-58 (Severe)	4	16	3	12
Total	**25**	**100**	**25**	**100**

Table 5 indicates that, before the treatment, 52% of the control group participants showed moderate, while 32% and 16% of participants respectively showed mild and severe level of posttraumatic stress symptoms. Whereas, after the treatment, 56% of participants showed moderate while 28%, 12%, and 4% participants showed mild, severe and minimum level of posttraumatic stress symptoms respectively.

Self-Esteem

Table 6: Self-Esteem Level of Treatment Group Before and After Treatment

Level of Self-esteem	Before Treatment (Pre-test)		After Treatment (Post-test)	
	Frequency	Percentage	Frequency	Percentage
0-16 (Low)	7	28	2	8
17-25 (Average)	15	60	13	52
26-40 (High)	3	12	10	40
Total	**25**	**100**	**25**	**100**

Table 6 indicates that, before the treatment, of the participants in the treatment group had low (28%), average (60%) and high (12%) level of self-esteem. Whereas, after the treatment, majority of participants in the treatment group had average or high (92%), while only 8% of the participants had low level of self-esteem.

Table 7: Self-Esteem Level of Control Group Before and After Treatment

Level of Self-esteem	Before Treatment (Pre-test)		After Treatment (Post-test)	
	Frequency	Percentage	Frequency	Percentage
0-16 (Low)	9	36	6	24
17-25 (Average)	15	60	17	68
26-40 (High)	1	4	2	8
Total	25	100	25	100

As can be seen in Table 7, before the treatment, 60% of the control group participants had average while 36% and 4% of participants had low and high level of self-esteem respectively. Whereas, after the treatment, 68% of participants had average, 24% had low and 8% had high level of self-esteem.

Analysis of Dependent and Independent ttest

Table 8: Dependent t Test of the Mean Depression Scores of the Treatment Group before and after the Treatment (N=25).

Treatment Group	Depression Score			
	Mean	SD	t	p
Before treatment(pre-test)	28.36	9.16		
After treatment(post-test)	23.56	7.62	2.186	.039
Paired Differences	**4.80**	**10.98**		

As Table 8 indicates, in the treatment group, it was found that the pre-test mean depression scores was 28.36 (SD=9.16), whereas the post-test mean depression score decreases to 23.56 (SD=7.62). The mean difference in depression scores was 4.80. A 2-tailed t-test for statistically significant difference between the means indicated that the difference between the pre-test and post-test scores was significant at 0.05 level (*df*=24, t=2.186). The implication of this finding is that Solution-focused Brief Group Counseling had impact on the improvement of treatment group depression from pre-test to post-test.

Table 9: Dependent t Test of the Mean Depression Scores of the Control Group Before and After the Treatment (N=25).

Control Group	**Depression Score**			
	Mean	**SD**	**t**	**p**
Before treatment(pre-test)	26.64	8.73		
After treatment(post-test)	28.92	7.93	-.913	.371
Paired Differences	**-2.28**	**12.49**		

Table 9 indicates that the mean depression scores in the pre-test was 26.64 (with standard deviation of 8.73) while in the post-test the mean depression scores was 28.92 (with standard deviation of 7.93). The mean difference in depression scores was -2.28. The dependent ttest was used for a comparison of the mean depression scores of the control group before and after the treatment. The result revealed that there was no statistically significant difference between pre-test and post-test mean of depression scores (*df* = 24, t = -.913). This implies that though there is a seemingly worsening situation in the control group, the variation from pretest to post-test is attributable to probability or chance.

Table 10. Independent t Test of the Mean Depression Scores of the Treatment and Control Group

Depression Scores	Groups		Mean Difference	t	p
	Control	Treatment			
Pre-test	26.64	28.36	1.72	.679	.500
Post-test	28.92	23.56	-5.36	-2.437	.019
Mean Difference	**-2.28**	**4.80**			

As can be seen in Table 10, the provision of Solution-focused Brief Group Counseling for treatment group has brought a significant improvement in depression scores over the control group. That is, the depression score for the treatment group decreased by a mean of 4.80 against -2.28 for control group after eight sessions of group counseling. The mean difference in depression scores on thepre-test between groups was 1.72 whereas on thepost-test the mean difference was -5.36. A 2-tailed test for the equality of means indicated that there was statistically significant difference between control group and treatment group during the post-test at 0.05 level (*df* = 48, t=-2.437) and no statistically significant difference during the pre-test at 0.05 level (sig.2-taild = 0.421, t=.679, *df* = 48). This finding indicated that participants in the treatment group had a high advantage of improving depression level as measured by Children Depression Inventory from per-test to post-test.

Table 11: Dependent t Test of the Mean Posttraumatic Stress Symptoms Scores of the Treatment Group Before and After the Treatment (N=25).

Treatment Group	Posttraumatic Stress Symptoms Scores			
	Mean	SD	t	p
Before treatment(pre-test)	29.44	7.64		
After treatment(post-test)	28.24	5.39	.628	.536
Paired Differences	**1.20**	**9.56**		

Table 11 indicates that the mean posttraumatic stress symptoms scores in the pre-test was 29.44 (with a standard deviation of 7.64) while in the post-test the mean posttraumatic stress

symptoms scores was 28.24 (with a standard deviation of 5.39). The mean difference in posttraumatic stress symptoms scores was 1.20. The dependent t-test was used for comparison of the mean posttraumatic stress symptoms scores of the treatment group before and after the treatment. The result revealed that there was no statistically significant difference between pre-test and post-test mean of posttraumatic stress symptoms Scores (*df* = 24, t = .628). This implies that the treatment group showed no improvement in posttraumatic stress symptoms from pre-test to post-test.

Table 12: Dependent t Test of the Mean Posttraumatic Stress Symptoms Scores of the Control Group Before and After the Treatment (N=25).

	Posttraumatic Stress Symptoms Scores			
Control Group	**Mean**	**SD**	**t**	**p**
Before treatment(pre-test)	29.08	7.35		
After treatment(post-test)	27.88	7.24	.527	.603
Paired Differences	**1.20**	**11.39**		

It was found in Table 12 that the mean posttraumatic stress symptoms scores for the pre-test was 29.08 (SD = 7.35) while for the post-test the mean posttraumatic stress symptoms scores was 27.88(SD = 7.24). The mean difference in posttraumatic stress symptoms scores was 1.20. A 2-tailed test for the equality of means indicated that there was no statistically significant difference between post-test and pre-test scores at 0.05 level (*df* = 24, t = .527).

Table 13: Independent t test of the Mean Posttraumatic Stress Symptoms Scores of the Control and Treatment Group Before and After the Treatment

Posttraumatic stress	**Groups**		**Mean**		
symptoms scores	**Control**	**Treatment**	**Difference**	**t**	**p**
Pre-test	29.08	29.44	.36	.170	.866
Post-test	27.88	28.24	.36	.199	.843
Mean Difference	**1.20**	**1.20**			

As can be seen in Table 13, before the treatment, the mean posttraumatic stress symptoms scores of the control group for the pre-test was 29.08 while the mean posttraumatic stress symptoms scores of the treatment group was 29.44. The mean difference in posttraumatic stress symptoms scores between groups for pre-test was .36. A 2-tailed test for the equality of means indicated that there was no statistically significant difference between control and treatment group during the pre-test at 0.05 level (*df* = 48, t = .170).

After the treatment, the mean posttraumatic stress symptoms scores of the control group for the post-test was 27.88 while the mean posttraumatic stress symptoms scores of the treatment group was 28.24. The mean difference in posttraumatic stress symptoms scores between groups for post-test was .36. A 2-tailed test for the equality of means indicated that there was no statistically significant difference between control and treatment group during the post-test at 0.05 level (*df* = 48, t = .199). These results indicated that both the control and treatment groupsdid not show any improvement in posttraumatic stress symptoms as measured by the Child Posttraumatic Stress Symptoms Scale from pre-test to post-test.

Table 14: Dependent t Test of the Mean Self-Esteem Scores of the Treatment Group Before and After the Treatment (N=25).

	Self-esteem Score			
Treatment Group	**Mean**	**SD**	**t**	**p**
Before treatment(pre-test)	20.64	5.49		
After treatment(post-test)	25.32	5.86	-2.623	.015
Paired Differences	**-4.68**	**8.92**		

The result in Table 14 indicates that the pre-test mean self-esteem scores forthe treatment group was 20.64 (SD=5.49), whereas the post-test mean self-esteem scores became 25.32 (SD=5.86). The mean difference in self-esteem scores was -4.68. Comparison by using

dependent ttest revealed that the mean score of self-esteem forthe treatment group were significantly higher after the treatment (*df* = 24, t = -2.623, p < .05).

Table 15: Dependent t Test of the Mean Self-Esteem Scores of the Control Group Before and After the Treatment (N=25).

	Self-esteem Score			
Control Group	**Mean**	**SD**	**t**	**p**
Before treatment(pre-test)	19.16	5.13		
After treatment(post-test)	20.28	5.91		
			-.715	.481
Paired Differences	-1.12	7.83		

As Table 15 indicates, in the control group, it was found that the pre-test mean self-esteem score in the control group was 19.16 (SD=5.13), whereas the post-test mean self-esteem score was 20.28 (SD=5.91). The dependent t-test was used for comparison of the mean self-esteem scores of the control group before and after the treatment. The result as presented in Table 15 shows that there was no statistically significant difference between pre-test and post-test mean of self-esteem scores (df=24, t=-.715).

Table 16: Independent t Test of the Mean Self-Esteem Scores of the Treatment Group and Control Group.

	Groups		Mean		
Self-esteem score	**Control**	**Treatment**	**Difference**	**t**	**p**
Pre-test	19.16	20.64	1.48	.984	.330
Post-test	20.28	25.32	5.04	3.030	.004
Mean Difference	**-1.12**	**-4.68**			

As can be seen in Table 16 above, before the treatment, the control group had mean self-esteem score of 19.16 while the treatment group had the mean self-esteem scores of 20.64. The mean difference in self-esteem scores for pre-test was 1.48. A 2-tailed test for the

equality of means indicated that the mean self-esteem scores between control group and treatment group during pre-test was not statistically significant at 0.05 level (df = 48, t =.984).

After the treatment, the control group had mean self-esteem score of 20.28 while the treatment group had the mean self-esteem score of 25.32. The mean difference in self-esteem scores for post-test was 5.04. When the dependent t-test was used to test the mean difference in self-esteem scores between the control and treatment groups, the mean self-esteem scores of the treatment group was significantly higher than that of the control group at 0.05 level (df = 48, t = 3.030). The result indicates that the provision of solution focused brief group counseling for the treatment group has brought a significant improvement in self-esteem scores over the control group as measured by Rosenberg Self-Esteem Scale from pre-test to post-test.

Discussion

This study was designed to examine the effectiveness of Solution-focused Brief Group Counseling in addressing psychological problems of sexually abused children. Thus, the results mentioned in the previous chapter are discussed in relation with the available related research findings.

Psychological Problems of Sexually Abused Children

Depression

The present study indicated that, before treatment, 48% of the treatment group participants showed moderate, 32% mild and 20% severe level of depression. Whereas 48% of the control group participants showed moderate, 36% mild, 8% severe and 8% of participants experienced minimum level of depression. It means that 68% of sexually abused children from treatment group and 56% of sexually abused children from control group show higher levels of depression and these findings areconsistent with many previous research findings.

For instance, Pribor and Dinwiddie (1992) reported highest rates of depression for sexually abused female survivors. Other researchers have also found that CSA survivors experience significantly higher depression than non-abused participants (Hunter, 1991; Roland et al., 1989), suggesting symptoms of hopelessness about the future, and general dissatisfaction with life (Graham, 1990). Polusny and Follette (1995) reported significantly higher rates of major depression in sexually abused children compared to non-abused ones, the prevalence rates ranged from 13% to 88% for CSA survivors and 4% to 66% for non-abused.

Following the provision of solution focused brief group counseling, the findings of the study revealed that the treatment group had low levels of the mean depression scores with statistical significance at $p<0.05$. In addition, the treatment group was compared to the control group and showed improvement on measures of depression. This finding was congruent with the study by Smock et al. (2008), who compared solution-focused group counseling (SFGC) with a traditional problem-focused treatment for level-one substance abusers. The clients who engaged in the solution-focused group counseling significantly improved on depression while clients in the comparison group did not improve significantly on either measure.

Posttraumatic Stress Symptoms

As shown in the result section, before treatment, 60% of the treatment group participants showed moderate, 28% mild and 12% severe level of posttraumatic stress symptoms. Whereas 52% of the control group participants showed moderate, 36% mild, 16% of participants experienced severe level of posttraumatic stress symptoms. The findings indicated that majority of participants (72 %) from the treatment group and 68% of participants from control group experienced high level of posttraumatic stress symptoms.

These findings are similar with previous findings. For example, Saunders et al. (1992) found significantly higher rates of lifetime posttraumatic stress symptoms in participants reporting contact sexual abuse and child rape compared to participants reporting non-contact sexual

abuse experiences. Rodriguez et al. (1992) found that 72% of children from a clinical sample of sexual abuse survivors met criteria for current posttraumatic stress symptoms diagnosis.

After the Solution-focused brief group treatment, it was found that there were no differences between the treatment and control groups in posttraumatic stress symptoms as measured by the Child posttraumatic stress symptoms Scale from pretest to posttest. The finding was inconsistent with Cloitre and Koenen (2001) who recruited participants with posttraumatic stress symptoms related to child sexual abuse to participate in a study of a 12-week interpersonal process group. Participants in the groups in which there were no members diagnosed with borderline personality disorder showed significant improvement on measures of anger and posttraumatic stress symptoms.

Self-Esteem

It was found that before the treatment, the treatment group had low (28%), average (60%) and high (12%) level of self-esteem while of the control group participants had average (60%), low (36%) and high (4%) level of self-esteem. The result implied that more participants (88%) from the treatment group and 96% of participants from the control group had low or average level of self-esteem.

The result was congruent with previous research. Sexually abused children frequently have extremely low self-esteem (Wickham & West, 2004). Moreover, this statement was supported by numerous studies which repeatedly noted poor self-esteem in children as a result of being sexually abused (Kuyken and Brewin, 1999; Briere and Runtz, 1990; Russell, 1997).

After solution-focused brief group treatment, the participants in the treatment group showed significant improvement in levels of self-esteem. The result is the same with the finding of Springer et al. (2000, cited in Kim &Franklin, 2009), who examined six-session of specific solution-focused brief group therapy techniques such as scaling questions and the miracle

questions, including mutual aid and interactional approaches for children whose parents or other family members have been imprisoned. Children in the treatment group make significant pre-post improvements on self-esteem, whereas the control group's scores were unchanged.

Summary

This quasi-experimental study was conducted to examine the effectiveness of solution focused brief group counseling in addressing psychological problems of sexually abused children. Specifically, it aimed at examining whether there is significant difference in depression, posttraumatic stress symptoms and self-esteem from pre-to post treatment measures between treatment and control groups. The study was conducted on sexually abused children who are found in Godanaw Rehabilitation Integrated Project.

A total of 50 sexually abused children were purposefully selected based on the inclusion criteria. They were randomly assigned into two groups: the control and the treatment groups, with 25 participants in each group. The participants in the control group received usual care provided by the center, while the participants in the treatment group received usual care provided by the center followed by 8 sessions of Solution-focused Brief Group Counseling.

The findings regarding the level of psychological problems of sexually abused children found that before the treatment, participants (68%) in the treatment group and 56% in the control group showed high level of depression. After the treatment, majority of participants showed mild or minimum (56%) in the treatment group and 88% of participants in the control group showed moderate or mild level of depression.

According to the results, before the treatment, the posttraumatic stress symptoms level of participants (72%) in the treatment group and 68% in the control group were moderate or

severe. After the treatment, 79% of participants in the treatment group and 60% in the control group experienced moderate or severe level of posttraumatic stress symptoms.

It was found that majority of participants (88%) from the treatment group and 96% of participants from the control group had low or average level of self-esteem before the treatment while 92% of participants from the treatment group and 76% of participants from the control group had average or high level of self-esteem after the treatment.

Results from the analysis of dependent t-test indicated that there was statistically significant difference in the mean scores of depression and self-esteem for the treatment group; this indicates that participants in the treatment group showed improvement in depression and self-esteem compared to the control group. In contrast, independent ttest indicated that there was no statistically significant difference in the mean posttraumatic stress symptoms scores between the treatment and control groups.

Conclusions

Based on the findings, the following conclusions are drawn.

- The treatment group showed statistically significant reduction in the level of depression and significant improvement in the level of self-esteem from pretest to posttest after the completion of SFBGC while this was not the case for the control group.
- Following completion of SFBGC, no statistically significant change was observed in both the control and treatment groups' posttraumatic stress symptoms scores.

Overall, SFBGC was effective in significantly improving sexually abused children's depression and self-esteem scores but not their posttraumatic stress symptoms scores.

Recommendations

Based on the findings of the study, the following recommendations are forwarded.

- The results indicated that all of the participants did not receive any psychological counseling services from the organization. The researcher also observed that there was no counseling service center or a counselor who could provide psychological counseling to sexually abused children who were found in the organization. Consequently, it is suggested that the organization should hire counselors and establish and organize a counseling service center to provide psychological counseling services for the survivors.
- It was also found that the majority of sexually abused children experienced depression, posttraumatic stress symptoms and low self-esteem. It is thus recommended that counselors along with social workers assess sexually abused children's problems and determine their physical and psychological needs to plan appropriate intervention strategies to support their development, optimum growth, and function as capable individuals, family members and citizens of the nation.
- The researcher found that all social workers called 'home mothers', who are found in GRIP, are working with sexually abused children without any training on how to recognize, understand, identify physical and psychological needs and rights of abused children. They lack the skills to know how to care for and handle them properly. So, it is recommended that the organization should provide training on the capacity building of these home mothers on how to treat and handle sexually abused children properly.
- The results of the study indicate that Solution-focused Brief Group Counseling is effective for treating sexually abused children experiencing depression and low self-esteem as measured by Children Depression Inventory and Rosenberg Self-esteem Scale. This is a good beginning to helping sexually abused children. Thus, counselors or social workers in developing psychological treatment plan for sexually abused children use the findings of this study and the theory of SFBC as a guide.

- While the results of this study are encouraging and positive, more research is still needed. Counselor educators should encourage and promote continued research in various areas regarding the application of Solution-focused Brief Group Counseling in different settings or with other groups of children, such as imprisoned children, children with disabilities or drug addicts, because these children are at risk of suffering from psychological proble

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