

Development, Evaluation, and Dissemination of

ESCAPE

**AN EFFECTIVE STRATEGY-BASED CURRICULUM FOR
ABUSE PREVENTION AND EMPOWERMENT**

**Center for Opportunities and Outcomes for People with Disabilities
Teachers College, Columbia University**

**Linda Hickson, Principal Investigator
Gillian Will, Project Coordinator
Ishita Khemka, Consultant to the Project**

FINAL REPORT

**Submitted to
The Joseph P. Kennedy, Jr. Foundation
August 31, 2002**

Introduction

Project Overview

As a result of recent policies and laws emphasizing independence and inclusion, individuals with mental retardation (intellectual disability) are facing an increasing range of opportunities in their lives in the community. All too often, however, these new opportunities have been associated with increased vulnerability to exploitation and abuse. Efforts to expand decision-making opportunities for people with mental retardation are often frustrated by the limited ability of these individuals to make effective, self-protective decisions. The present project was designed to address the problem of the heightened vulnerability of women with mental retardation to domestic violence and abuse by known individuals.

This three-year project focused on the development, evaluation and dissemination of a systematic educational curriculum – *ESCAPE: An Effective Strategy-Based Curriculum for Abuse Prevention and Empowerment*. The purpose of this curriculum was to empower women with mental retardation to become more effective decision-makers so that they can protect themselves against violence and abuse and benefit more fully from increased opportunities for independence and community inclusion. The project's focus was on situations of violence and abuse in the home and community, particularly those involving individuals who were known to the participants, including partners, family members, friends and acquaintances.

The *ESCAPE* curriculum consists of 12 curriculum lessons and 6 support group sessions covering three broad units: *Unit I – Knowledge of Abuse and Empowerment*; *Unit II – Decision-Making Strategy Training*; *Unit III – Women's Support Groups*. Detailed trainer scripts and visuals are provided for each lesson. *ESCAPE* was developed for use with small groups of adult women with moderate to mild mental retardation. The curriculum model was based on Hickson and Khemka's earlier research and theory on decision-making processes (Hickson, Golden, Khemka, Urv, & Yamusah, 1998; Hickson & Khemka, 1999; 2001; Khemka & Hickson, 2000). In particular, the curriculum draws heavily upon the decision-making training model developed by Khemka (2000) to teach independent decision-making skills in simulated situations of abuse.

The present three-year project represented a collaboration between the Center for Opportunities and Outcomes for People with Disabilities at Teachers College, Columbia University and AHRC New York City, an agency that provides a comprehensive continuum of services for people with mental retardation. The initial phase of the project focused on identifying and recruiting project participants from agency sites and on developing, implementing and evaluating Units I and II of the *ESCAPE* curriculum. Participants completed an extensive pretest battery and were then randomly assigned to receive one of two programs: *ESCAPE* (the new curriculum-based intervention program developed as part of this project) or the existing AHRC abuse prevention program (an eclectic approach that incorporates the current best practices for addressing domestic violence and abuse prevention issues with adults with mental retardation). Participants who received the *ESCAPE* curriculum constituted the project's treatment group and those who

received the AHRC abuse prevention program constituted the project's alternative treatment control group. Because the focus of the project was on prevention, all women who participated in the project (both treatment and control conditions) continued to receive any needed services for the treatment of abuse-related problems. A pretest-posttest control group research design was utilized to measure differential effects of the treatment and comparison programs on participant performance on a battery of posttest instruments.

The second phase of the project focused on the development, implementation and evaluation of a support group system (Unit III of the curriculum) for the women who had already received Units I and II of the curriculum as part of the treatment group. These women participated in semi-structured support groups comprised of the same small groups who had met together for the Unit I and Unit II activities. These support groups met over six sessions and were co-led by a member from the Teachers College project team and by a social worker from the AHRC staff. A battery of selected post-posttests was utilized to measure treatment effects of these support groups.

The final phase of the project consisted of providing the women in the control group with access to the project interventions. Members of the Teachers College project team trained several AHRC staff members and worked collaboratively with them to implement the ESCAPE curriculum with the control group women. These staff members, who now have the necessary training and experience, will continue to offer the curriculum to new groups of women and provide ongoing support group experiences to all women who have already received the curriculum. A domestic violence and abuse prevention center is in the initial stages of being established at AHRC as an outgrowth of this collaborative project. The project team is currently seeking opportunities for additional funding to continue the collaborative pursuit of project-related initiatives.

Dissemination

Dissemination was a major focus of the project's final year. Dissemination efforts have targeted local, national, and international audiences including families, professionals, and policy makers. Dissemination activities have included:

- ESCAPE Curriculum Package. The project has yielded the *ESCAPE* curriculum, a validated, field-tested abuse prevention curriculum package including an instructor's manual, a booklet of vignettes and visuals, a booklet of masters for reproducible activity sheets and stickers, and an easel/portfolio to present vignettes and store activity sheets and stickers. A training video, based on the instructor's manual and ongoing staff training activities at AHRC, is currently under development and will be added to the package to facilitate the wide dissemination of the curriculum.
- Workshops. Throughout the course of the project, workshops have been offered to familiarize service providers at the various AHRC facilities with the goals and strategies of the project. Workshops featuring the project intervention were also presented at AHRC Family Day and at a mini-conference of the New York State Association of Day Service Providers, an inter-agency organization for day habilitation programs.
- Preservice Module. A module featuring the *ESCAPE* curriculum has been incorporated into

the graduate course on the Nature and Needs of People with Mental Retardation (HBSE 4010) taught by Professor Linda Hickson at Teachers College, Columbia University. This course, required for students enrolled in the MA programs in Mental Retardation/Intellectual Disability and Guidance and Habilitation, is also selected as an elective by many students in other Teachers College programs.

- Internship Opportunities. Numerous students in the MA and doctoral programs in the education of students with mental retardation/intellectual disability and guidance and habilitation have been actively involved in all aspects of this project as interns, assistants, and research fellows.
- Conference Presentations. Throughout the three years of the project, symposia and poster presentations have been presented at the annual conference of the Center for Opportunities and Outcomes for People with Disabilities at Teachers College, Columbia University (2000, 2001, and 2002), at the annual convention of the American Association on Mental Retardation (2000 and 2002), at a conference sponsored by the President's Committee on Mental Retardation (2000), and at the conference of the International Association on the Scientific Study of Intellectual Disability (2000).
- Publications. Upon completion of this final report, the project team will continue to work collaboratively to prepare manuscripts for submission to peer-reviewed journals, including *Mental Retardation, Disability and Sexuality*, and the *Journal of Clinical Psychology and Psychotherapy* (invited submission for a special issue of the journal).
- World Wide Web and Newsletters. Throughout the three-year project, descriptions and updates have been provided in the newsletters and on the websites of AHRC and the Center for Opportunities and Outcomes for People with Disabilities. Up-to-date information about project outcomes and the availability of project workshops, materials, and publications will be maintained on the website of the Center for Opportunities and Outcomes at Teachers College (www.tc.columbia.edu/oopd).

Method

Project Participants

Recruitment

A group of 49 women with mild and moderate mental retardation from four program sites of AHRC New York City, an adult services agency, were recruited based on pre-set selection criteria: gender (female), intellectual functioning (IQ 45-70), chronological age (CA) (22-50 years) and residential placement (not living in an agency supervised residence). Participant recruitment was conducted by ARHC staff members, who referred all eligible participants based on the pre-set selection criteria. Informed consent procedures were then followed. In total, 49 women were recruited and consented from four AHRC sites, including a clinic and three day program sites located in three boroughs of New York City. A Participant Screening Form was developed for this referral process. The overall means of the initial 49 women's chronological age and IQ are 35.8 years and 56.21 respectively. The participants' ethnicities represented the

following groups: African-American (50%), White (29%), Hispanic (19%), and other (2%). The participant recruitment details for each participating AHRC site are provided below.

Fifteen women (15) with a mean age of 33.00 years and a mean IQ of 58.40 were recruited from AHRC Site 1, an AHRC clinical services site. AHRC Site 1 is an outpatient offering a full range of clinical services, ensuring that people with mental retardation and developmental disabilities receive needed diagnostic services and appropriate treatment. Services that are provided at the clinic include medical, psychological, physical therapy, social work, and speech therapy.

Eight women (8) from AHRC Site 2 were recruited. At this day habilitation program site, men and women with mental retardation are helped to become more independent through training in basic daily living skills, basic pre-vocational skills, and experience in community-based settings. The mean age and IQ of the recruited participants from this site are 27.38 years and 54.57 respectively.

From AHRC Site 3, seven women (7) were recruited to participate in the project. At Site 3, a day habilitation and pre-vocational waiver program, men and women with mental retardation learn social, communication, and independent living skills and receive pre-vocational training in simulated work areas. The mean age of the women recruited from this site is 38.86 years, with a mean IQ of 54.29.

AHRC Site 4 is a day habilitation and pre-vocational waiver program similar to Site 3, providing men and women with mental retardation with opportunities to acquire social, communication, independent living, and pre-vocational skills. Nineteen women (19) with a mean of age of 37.33 years and a mean IQ of 55.79 were recruited.

Attrition

During the course of the three-year study, 12 women were unable to continue their participation due to scheduling constraints, unavailability due to work placements, withdrawal or transfer from their initial program sites, or the unavailability of accurate contact information. This attrition occurred at various points in time after initial referral, recruitment, informed consent, and pretesting, but before random assignment of the women to treatment conditions. Most of the attrition (9 women) occurred at the clinic site, where there was high turnover of the women who came to receive outpatient services. No more than 1-2 women were lost from each of the three day program sites.

Thirty-seven women were available for random assignment into the treatment and control conditions. By the end of the project, 36 women had participated in either the treatment or control groups and had completed the posttest battery and the post-posttest battery, comprising the final sample for the project evaluation. One woman in the control group was lost to the sample because she was unavailable for posttesting due to illness and hospitalization.

Final Sample

The final sample of 36 women consisted of a treatment group of 18 women (mean CA = 35.41 years, mean IQ = 57.22) and a control group of 18 women (mean CA = 35.39 years, mean IQ = 54.24). Preliminary analyses verified that the women in the treatment and control groups, across the four sites, did not differ significantly in intellectual functioning and age.

Instruments

The pre-intervention/pretest battery consisted of 13 instruments that included screening measures, surveys designed to gather comprehensive background information on the women, and pretest measures assessing key variables targeted by the intervention. The post-intervention/posttest battery included only the 6 pretest measures. The post-support group/post-posttest battery consisted of a subset of 3 measures from the posttest battery, selected for their relevance to the support group intervention.

Several of the test instruments were developed for this project, taking into consideration the specific needs of the project participants. Pilot testing and adaptation of some existing evaluation instruments were also done to accommodate the special needs of the population. Based on information gathered during pilot testing, the instruments were modified to ensure that all items could be readily understood by the participants (e.g. the wording of items and instructions was simplified). Reliability studies consisting of test-retest and internal consistency analyses were conducted to establish the reliability of the measures.

The instruments that constituted the final pretest, posttest, and post-posttest batteries are summarized with brief descriptions in Table 1. Copies of the instruments may be found in the Appendix.

Table 1. List of Project Instruments

* = pre-test battery

† = post-test battery

□ = post-post test battery

INSTRUMENTS	SOURCE	DESCRIPTION
* Participant Screening Form (PSF) (completed by client coordinator or social worker)	Developed for project	Records demographic information pertaining to participants' level of mental retardation, independent functioning and residential placement.
* Risk Indicator Survey (RIS) (completed by client coordinator or social worker)	Developed for project	Documents history of abuse and individual clinical services.
* Participant Information Questionnaire (PIQ)	Developed for project	Records demographic information pertaining to participant's current residential placement, independent functioning and extent of friends network
* Sexual Knowledge Assessment (SKA) (completed by AHRC staff)	<i>Sexuality Knowledge Assessment</i> , Developed by AHRC New York City	Measures social/sexual knowledge, feelings related to social relationships, sexual behavior and abuse.
* Index of Abuse (IA)	Adapted from <i>Index of Spouse Abuse</i> , Hudson & McIntosh, 1981; <i>The Conflict Tactics Scale</i> , Straus, 1979; <i>Ease-Pi</i> , Nicholas, Beiber, 1997	Assesses the incidence/frequency of domestic violence and abuse. internal consistency (r_u) = 0.83
* Support Systems Scale (SSS)	Adapted from <i>The Interpersonal Support Evaluation List</i> , Cohen, Mermelstein, Kamarack, & Hoberman, 1985	Measures areas of social support: tangible, appraisal, and belonging. test re-test (rtt) = 0.91
* † □ Empowerment Scale (ES)	Developed for project	Measures personal agency beliefs, expectancies of control, self-efficacy, and feelings of empowerment against abuse. internal consistency (r_u) = 0.61
* Motivational Goals Inventory (MGI)	Developed for project	Assesses individual motivational goals and priorities. internal consistency (r_u) = 0.74
* † Stress Management Survey (SMS): Life Stressors & Ways of Coping	Developed for project	Measures individual life satisfaction and coping with stressful life events. test re-test (rtt) = 0.59
* † □ Knowledge of Abuse Concepts (KAC)	Developed for project	Measures awareness and knowledge of physical, verbal and sexual abuse concepts and terminology. Interrater reliability = 0.81 internal consistency (r_u) = 0.85
* † Decision-Making Video Scale (DMVS)	<i>Khemka (1997 & 2000)</i> (Modified)	Measures independent, self-protective decision-making in response to video-taped simulated situations of general interpersonal conflict, sexual, physical and verbal abuse Internal consistency (r_u) = 0.90
* † Decision-Making Interview (DMI)	Developed for project	Measures risk perception, consequence evaluation, and prevention skills in interpersonal situations of abuse. Interrater reliability = 0.96
* † □ Self Decision-Making Scale (SDMS)	<i>Khemka (1997 & 2000)</i> (Modified)	Measures identification of emotions and self-protective decision-making and coping skill in situations of abuse. Interrater reliability = 0.84 internal consistency (r_u) = 0.74

Participant Screening Form (PSF). The screening form was prepared for completion by AHRC client coordinators or social workers of potential participants. The screening form requested demographic information pertaining to participants' level of mental retardation, age, independent functioning, residential placement and primary language spoken. The form was used to identify participants that met the project's initial screening criteria and qualified for recruitment for this project.

Risk Indicator Survey (RIS). The *RIS* recorded background information pertaining to participants' documented history of abuse, independent functioning, and individual/group clinical services. A client coordinator or social worker completed the survey for each participant once informed consent was received.

Participant Information Questionnaire (PIQ). The *PIQ* allowed the examiner and the participant to become acquainted through a general interview at the start of the pre-test battery. The 7-item survey asked questions regarding the participant's current residential living arrangement, modes of transportation used in the city, work placement, level of community involvement, and extent of friends network.

The Sexual Knowledge Assessment (SKA). This 125 item instrument, developed by AHRC New York City, measured and evaluated sexual knowledge in areas of human growth and development, sexual feelings and behavior, reproductive health, and relationships. This measure is used by the agency to assess clients' sexual knowledge and their ability to be in consenting sexual relationships. It was administered by AHRC trained staff. In order to assess participants' prior sexual knowledge, project staff reviewed the project participants' protocols.

Index of Abuse (IA). The *IA* is a 44-item scale that assesses the incidence/frequency of domestic violence and abuse in the participants' lives. The scale included 7 items in each of the four domains of psychological/emotional, verbal, physical and sexual abuse. Sixteen (16) positive items delineating prevention or support features were written to serve as filler items and counter balanced the negative abuse items on the scale. Each item consisted of a question (e.g. "Is there someone you know who makes you do sexual things you do not want do?") followed by three response options, "no", "yes, once in a while" or "yes, often". The Index of Abuse was developed for this project, with items drawn and adapted from several existing scales: *Index of Spouse Abuse (ISA)* (Hudson & McIntosh, 1981), *The Conflict Tactics Scale* (Strauss, 1979) and *The Exposure to Abusive and Supportive Environments Parenting Inventory (EASE-PI)* (Nicholas & Beiber, 1997). Many new items were created for this scale in order to measure the unique issues of abuse for the target population. These items were written and validated by a team of professionals at the participating agency, AHRC. Frequencies are reported as percentages for each item and category of abuse.

Support Systems Scale (SSS). The *SSS* consisted of 12 items that measured participants' perceptions of their social support systems. Four "yes" and "no" questions were asked for each of the following three areas of social support: tangible (e.g. "If you were in trouble, is there someone you can call for help?"), appraisal (e.g. "Do you go out with friends and family?") and

belonging (e.g., “Is there someone you can ask to help you with your problems?”). If participants answered “yes”, they were further probed to identify the person who provided social support. The SSS was adapted from the *Interpersonal Support Evaluation list (ISEL)* (Cohen & et. al, 1985) by modifying the scale’s administration format from a self-report measure into an interview form, by reducing the number of items, simplifying the language, and deleting the domain of self-esteem. Test-retest reliability for the *SSS Scale* after a four-week interval was 0.91.

Empowerment Scale (ES). Items drawn and adapted from *Adult Nowicki-Strickland Internal-External Locus of Control Scale- ANS-IE*, Nowicki & Duke, 1974; *Arc’s Self-Determination Scale*, Wehmeyer & Kelchner, 1995; *Self-efficacy scale*, CSAP. The Empowerment Scale measures individual self-efficacy and generalized beliefs of control and yields two scores: Final Empowerment and Experience of Abuse. Items that made up the Final Empowerment score were presented in two different formats. Fifteen paired empowerment versus non-empowerment statements were presented and participants were asked to choose the statement from each pair that best described themselves (e.g. “Do you make your own decisions?” or “Do other people make decisions for you?”). Once participants chose which statement best described them, they stated whether the statement was true for them “once in a while” or “most of the time”. The remaining eight items were presented as a question (e.g. “Do you think you can change the way people treat you?”) probing for participants feelings about self empowerment and rights, followed by three response options, “no”, “yes, once in a while” or “yes, often.” The Experience of Abuse subscale consists of 4 items. Each item consists of a question (e.g. “Do you feel you can stop people from hurting you?”) probing for participants feelings about abuse prevention and control, followed by three response options, “no”, “yes, once in a while” or “yes, often”. The scores on this scale range from 0-2 for each item, with a maximum total score of 46 for Final Empowerment and 8 for Experience of Abuse. Overall Cronbrach alpha reliability for *Final Empowerment* is 0.61.

Motivational Goals Inventory (MGI). This 23 item instrument measured participants’ personal motivational goal preferences and priorities. Participants responded to various motivational goals linked to personal gain preferences (e.g. “How important is it for you to speak up for your rights?”) or social preferences (e.g. How important is it for you to have people treat you nicely) on a 3 point Likert scale (“no”, “yes, once in a while” and “yes, often”). The overall Cronbach alpha reliability coefficient for this scale is 0.74.

Stress Management Survey (SMS). This instrument measures individual life stressors and knowledge of coping strategies in response to stressful situations. A stress level score and a ways of coping score were obtained. The *SMS-Life Stressors* subtest, yielding the stress level score, consisted of 8 items measuring participants’ feelings about different things in their lives (e.g., “Do you feel worried?”) on a Likert scale (“no”, “yes, once in a while”, or “yes, always”). The *SMS-Coping* subtest yields the ways of coping score consisting of 8 multiple-choice items, and probes for the participants’ coping strategies to deal with difficult situations in their lives. Test-retest reliability for *SMS-Coping* was 0.59.

Knowledge of Abuse Concepts (KAC). The *KAC* measures knowledge of concepts of abuse. The scale consisted of two parts: Definitions of Abuse and Identification of Abuse. The *KAC-Definitions of Abuse* subtest consisted of 12 open ended items which required the participants to

explain abusive terms, such as “physical abuse,” “rape,” and “consent”. The *KAC-Identification of Abuse* subscale consisted of 12 items that described different scenarios and required the participant to identify whether the scenario represented abuse. Scores were derived for each part separately based on correct recognition and statement of type of abuse. Interrater reliability correlations between two raters’ scores for *KAC-Definitions of Abuse* was 0.81. Cronbrach alpha reliability for the 12 items of the *KAC-Identification of Abuse* subscale was 0.85.

The Decision-Making Video Scale (DMVS). The *DMVS* is a revised version of the *Social Interpersonal Decision-Making Video Scale* (Khemka, 1997 & 2000). This scale measured independent, self-protective decision-making in response to simulated situations of general interpersonal conflict and sexual, physical, or verbal abuse. The *DMVS* included 16 hypothetical social interpersonal decision-making situations presented in the form of short video vignettes. The 16 vignettes were divided into 12 target items representing abuse and comprising an abuse subscale and 4 filler items representing situations of general interpersonal conflict. The vignettes were short video clips, less than a minute in length, and included a visual scene overlaid with a verbal narrative. The visual scene shows a problematic real life social interpersonal situation that requires decision-making on the part of a key decision-maker faced with the situation. Immediately after the presentation of each vignette, a structured interview was conducted to assess comprehension of the problem and to assess the ability of the participant to suggest an independent, prevention-focused decision-making for the key decision-maker. Scores are derived to measure independent prevention-focused decision-making ability of participants in situations of abuse in response to two key questions: What is the best choice for ___ in this situation (decision response) and why is this the best choice? (statement of rationale for proposed choice). Two independent raters scored the protocols using a defined scoring system based on previously validated scoring methods for this scale. Inter-rater reliability for this scale is 0.96. Overall Cronbach alpha reliability for *DMVS* Independent Prevention-Focused Decision-Making Scores is .90.

The Decision-Making Interview (DMI). The *DMI* measures risk perception, consequence evaluation and prevention skills in response to 6 verbally presented vignettes depicting hypothetical interpersonal situations of abuse. Each vignette presented scenarios in which a female decision-maker made a decision in response to an interpersonal situation of sexual, physical or verbal abuse involving someone known to her. After each vignette was presented orally, a structured interview was conducted to assess participants’ reactions to the scenario and the decision made by the key decision-maker. Specific questions measured participants’ abilities in identification of problems and emotions; evaluation of choices; alternative choice generation; self-decision making; rationale for reporting/not reporting abuse; efficacy and abuse prevention. Prevention-focused decision-making scores were derived separately for each question based on accurate understanding and application of decision-making skills. Interrater reliability for the *DMI* is .96.

Self Decision-Making Scale (SDMS). The *SDMS* is a modified version of the *Independent Self Decision-Making Scale* (Khemka, 1997 & 2000). The scale measured the identification of emotions and self-protective decision-making and coping skills. Six hypothetical situations of abuse (2 sexual, 2 physical, and 2 verbal abusive situations) were verbally presented and the participants were asked how they would deal with such difficult situations if they were to

encounter them in their own lives. At the end of each vignette, the participant was asked, “what would you do if you were ever in this situation?” The format varied from open-ended questions to multiple choice items. Two primary decision-making scores were computed for this scale: one measuring the ability to self generate an independent prevention-focused decision when presented with an open-ended decision question, and the other measuring the ability to choose an independent prevention focused decision among multiple choice options. The maximum score in each case was 6, with a higher score representing greater ability for independent prevention focused decision making for self. Interrater reliability between two trained raters for the open-ended decision question is 0.84. Overall Cronbach Alpha for *SDMS* Independent Prevention-Focused Decision-Making Scores (multiple-choice) is 0.74.

The *ESCAPE* Curriculum

ESCAPE Curriculum -- Units I and II: Knowledge of Abuse/Empowerment and Decision Making

The participants in the treatment condition received an intervention based on *ESCAPE*, an abuse prevention and empowerment training curriculum which was developed for this project. The twelve lessons in Units I and II of the *ESCAPE* curriculum and the six support group sessions in Unit III were designed to empower women with mental retardation to become more effective decision-makers so that they can protect themselves against violence and abuse in the home and community by known individuals, including their partners, family members, friends and acquaintances. The training portion of the curriculum was comprised of two broad units: Unit I -- Knowledge of Abuse and Empowerment and Unit II -- Decision-Making. Each unit includes specific learning objectives and detailed lesson plans with teacher scripts and visuals. The curriculum is intended for a small group presentation/discussion format delivered over a six to twelve-week period. Most information was covered in the context of simulated or hypothetical situations, from a gender-specific perspective. The first unit consisted of five lessons and focused on abuse concepts, personal safety and empowerment and self-awareness. The second unit consisted of seven lessons and focused on decision-making skills and a final lesson that summarized the content of the curriculum and included an informal interview, which served as a criterion measure.

The curriculum was initially pilot-tested with a small group of participants and reviewed by several staff members of AHRC New York City for validity and appropriateness of content. Revisions to the curriculum were based on these reviews and feedback received during pilot-testing. The visuals prepared for the curriculum were also validated for content (e.g. type of abuse) by a group of ten graduate students from the programs in special education at Teachers College, Columbia University.

ESCAPE Curriculum – Unit III: Women’s Support Groups

Unit III of the *ESCAPE* curriculum consisted of a six-session support group intervention designed to allow for review and repetition of the knowledge and decision-making concepts discussed in the training curriculum and to help participants apply some of the acquired concepts to their own life situations. The information shared in the support group sessions was part of the

process of further educating and empowering participants to take control of their own lives. The group-sessions provided the participants with an opportunity to talk about their individual life experiences, communicate their feelings, and apply the decision-making skills to develop greater insight about prevention strategies in their own lives.

Each of the six support group sessions, included structured group activities for which materials were developed. The activities were intended to provide concrete examples of how to utilize decision-making strategies to identify prevention-focused alternatives in real life situations of abuse. Open-ended discussions followed the activities led by support group leaders.

The ESCAPE Curriculum -- Final Package

Subsequent to the *ESCAPE* curriculum's use in the treatment phase of the project, the curriculum was further revised and refined (primarily for format and ease of delivery) based on input and feedback from the project team who administered the training. In addition, feedback and input from AHRC staff members provided during inservice training workshops was also incorporated. A final version of the curriculum package has been completed and is being submitted with this report (see *ESCAPE* curriculum package).

Procedure

Pre-Intervention Data Collection: Pretesting

The pre-intervention/pretest battery consisted of 13 measures and was administered individually to participants over five 25 to 40 minute sessions. Pretesting took place at the participants' agency sites and was conducted by trained members of the Teachers College project team, which included professorial and professional staff members as well as MA and doctoral students in special education. After each session, participants were given food or two dollars as a token for their participation. Participants who were required to travel by subway to complete the testing were also reimbursed for travel expenses.

Intervention: ESCAPE Curriculum Training Units I and II

Upon completion of the pretest battery, project participants from each site were ranked according to pretest scores on the subset of abuse items from the *Decision-Making Video Scale (DMVS)* and were then randomly assigned from matched pairs to treatment and control groups. Preliminary analyses were conducted to verify that the treatment and control group participants from each site did not differ. t-tests for independent samples on IQ, age, *Empowerment Scale (ES)* scores, and independent prevention-focused decision-making scores measured on the *DMVS* were performed to identify any pre-intervention differences between the treatment and control groups. Preliminary t-tests failed to reveal significant initial differences between groups on any variable. Table 2 presents the pretest means and SDs for each of the variables separately for the treatment and control groups.

Table 2
Means and standard deviations (SDs) for age, IQ, and pretest *Decision-Making Video Scale (DMVS)* independent prevention-focused decision-making scores

Group	Age		IQ		<i>DMVS</i> Independent prevention-focused decision-making	
	Mean	SD	Mean	SD	Mean	SD
	Treatment	34.24	8.61	57.11	11.85	11.25
Control	33.85	7.64	54.89	9.36	13.38	7.12

Participants assigned to the treatment condition were then assigned to small training groups of three women based on the AHRC site they attended. In total, there were 6 different curriculum training groups of 3 women each, resulting in 18 women who received curriculum training. Each of sites 1, 2 and 3 had one curriculum training group, while Site 4 had three separate curriculum training groups. A curriculum trainer from the Teachers College project team led each curriculum group. The curriculum was delivered in training sessions of forty to fifty minutes, once or twice a week, over a period of six to twelve weeks. All trainers were briefed during weekly project meetings. The meetings involved training in the use of the curriculum materials, including a review and discussion of each of the twelve curriculum lessons. To ensure treatment fidelity most sessions were either observed by a co-trainer, who recorded and transcribed trainer and participant responses and comments, or taped with an audio recorder. As a token for the women's participation in the curriculum sessions, food and beverages, or two dollars were given to the women. If participants were absent for a training session, individual make-up sessions were completed before further training sessions were conducted.

During this time participants in the control group continued to receive existing AHRC abuse treatment and prevention services, which typically included counseling services with a social worker and sex education activities.

Post-Curriculum Training (Units I and II) Data Collection: Posttesting

The post-curriculum training/posttest battery included 6 instruments from the pretest battery (*Empowerment Scale (ES)*, *Knowledge of Abuse Concepts (KAC)*, *Self Decision-Making Scale (SDMS)*, *Decision-Making Interview (DMI)*, *Decision-Making Video Scale (DMVS)*, and *Stress Management Survey (SMS)*). Blind post testing at each site by a member of the project team unknown to the women in a particular curriculum group was conducted approximately two weeks following the completion of the curriculum delivery. The posttest battery was completed over three sessions of approximately 30 to 45 minutes each.

Intervention: ESCAPE Curriculum Support Groups Unit III

Subsequent to receiving the 12 *ESCAPE* curriculum lessons and completing the posttest battery, the 18 women in the treatment condition met in their training groups for Unit III of the study, the six-session support group intervention. This phase consisted of six semi-structured support group sessions, with each session lasting approximately 45 minutes. Participants attended weekly or biweekly support group sessions and individual makeup sessions. The group sessions were co-facilitated by the same trainer from the Teachers College project staff who had led the participating women in the curriculum training sessions and a designated social worker from AHRC. The trainer led the activities and the social worker assisted the participants to interpret and apply information presented in each session to their own life context.

During the support group sessions, participants were encouraged to apply the information learned during the curriculum training to their own experiences and needs. In the support groups, participants talked about their own life experiences and learned how to utilize the learned information from the curriculum. During each session, with the aid of the co-leaders, the women filled out a weekly goal sheet.

Post-Support Group Intervention (Unit III) Data Collection: Post-Posttesting

The post-support group/post-posttest battery was completed approximately one week following the completion of the support group sequence. This battery consisted of three measures selected from the post-curriculum training/posttest battery: *Empowerment Scale (ES)*, *Self Decision-Making Scale (SDMS)*, and *Knowledge of Abuse Concepts Scale (KAC)*. Blind post testing by a member of the project team unknown to the women in a particular curriculum group was conducted with all project participants.

Results

Participant Background Information

In addition to the participants' demographic information already reported (age, IQ, and ethnicity), additional background information pertaining to participants' independent functioning, reported incidents of abuse, and prior sexuality knowledge was gathered at the start of the project. The following data are based on the final sample of 36 women who participated in all phases of the project.

Independent Functioning

Information pertaining to independent living skills was collected using two instruments completed by AHRC staff members, the *Participant Screening Form (PSF)* and the *Risk Indicator Survey (RIS)*, and through a semi-structured interview conducted individually with the participants themselves, the *Participant Information Questionnaire (PIQ)*. Of the final sample, 60% of the women reported living with a member of their family, 11.4% of the women lived

with a partner (husband or boyfriend), 20% of the women lived on their own, while 8.6% of women reported other living situations.

When interviewed with the *PIQ*, approximately 65% of the women reported that they travel independently, and 35% reported that they travel accompanied by someone else or on the agency bus. When asked whether they participate in community activities independently (e.g. Do you go shopping, to the supermarket, to parties, or movies by yourself?), 31% of the women replied “never,” 50% replied “once in a while” and 19% replied “a lot.”

Data collected from the *RIS*, which was completed by AHRC staff members, reported similar percentages for independent travel. According to AHRC staff members, 73% of the women travel independently, and 27% travel accompanied by someone else or on the agency bus. However, agency staff reported somewhat higher frequencies of participants’ independent participation in the community. It was reported by staff that only 13% of the participants did not participate in community activities independently, 17% of the women participated once in a while independently, and 70% of the women often participate in community activities independently. The discrepancy in the frequency of independent community participation reported by participants and the agency staff could be a result of either underestimates by participants who may have desired even greater levels of independence than presently afforded or overestimates by staff members who may not have been fully aware of all of the restrictions experienced by participants.

Reported Incidents of Abuse

Information regarding the incidence of abuse in participants’ lives was collected through two different sources: the *Risk Indicator Survey (RIS)* and the *Index of Abuse Scale (IAS)*. AHRC staff members known to the participants completed questions on the *RIS* pertaining to participants’ documented (validated) and reported history of abuse. Staff members were asked to indicate whether the individual had a reported history of any type of abuse (neglect, physical, verbal/psychological, or sexual), the time period when the individual experienced this abuse (within the last 6 months, 6 months to 1 year, 1 to 5 years, and beyond 5 years) and whether the reported incident was documented. Table 3 shows percentages of participants for whom reported and documented incidents of abuse are recorded by type and frequency.

Table 3
Percents of participants who have experienced abuse as reported by agency staff members on the *Risk Indicator Survey (RIS)*

Type of Abuse	Within Past 12 Months	Within Past 1-5 Years	Beyond 5 Years	Docu- mented	No
Physical Abuse	6.3	15.6	15.6	21.2	62.5
Sexual Abuse	10.0	10.0	13.3	16.1	66.7
Verbal Abuse	28.1	15.6	9.4	15.2	46.9
Neglect	10.3	6.9	6.9	10.0	75.9

Participants completed the *IAS* as part of the pretest battery. This measure was administered after a few initial pre-testing sessions by which time the participants had become comfortable with the examiners. Participants were asked whether they had ever experienced specific situations of abuse (e.g. Do you know someone who hits you?) followed by three response options, “no”, “yes, once in a while” or “yes, most of the time”. Items covering different types of abuse (physical, verbal, sexual and emotional/psychological) were included. Frequencies for each item under each type of abuse are recorded as percentage of participants reporting each item by frequency level. For example, 14.7% of the participants reported that someone known to them tells them that they are ugly most of the time, whereas 33.3% of the participants reported that they experienced this type of abuse only once in a while.

Table 4
Percents of participants reporting various frequencies of abuse for items from the *Index of Abuse Scale (IAS)*

Item	Percent		
	Yes, Most of Time	Yes, Once in a while	No
Verbal Abuse			
Tells you that you are ugly.	14.8	33.4	51.6
Calls you names.	18.2	30.3	51.5
Makes fun of you.	15.2	45.5	39.4
Yells at you.	24.2	48.5	27.3
Tells you that you are stupid.	18.2	18.2	63.6
Says that they want to kill you.	0.0	6.1	93.9
Physical Abuse			
Pulls your hair.	12.1	15.2	72.7
Throws things at you.	15.2	15.2	69.7
Breaks or smashes your things when angry.	6.3	34.4	56.3
Chokes you	3.0	9.1	87.9
Beats you up.	6.1	9.1	84.8
Punches you.	6.1	15.2	78.8
Pushes to hurt you.	12.1	18.2	69.7
Sexual Abuse			
Hugs you when you don't want them to	27.3	21.2	51.5
Touches your private parts when you do not want them to	6.1	6.1	87.9
Touches you after you say stop	12.1	21.2	66.7
Says sexual things that you do not like	12.1	27.3	60.6
Makes you do sexual things that you do not want to do	9.1	6.1	84.8
Forces you to have sex	3.0	12.1	84.8
Makes you look at private parts when you do not want to	3.0	3.0	93.9
Psychological/Emotional Abuse			
Gets angry when you do things slowly	45.5	27.3	27.3
Speaks for you	21.2	30.3	48.5
Treats you like you are stupid	15.2	21.2	63.7
Makes you feel like you are a bad person	8.7	42.1	48.4
Ignores you when you are talking to them	21.2	39.4	39.4
Stops you from spending time with your friends	12.1	24.2	63.6
Forces you to do things	12.1	21.2	66.7

Evaluation of Curriculum Training (Units I and II)

Quantitative Posttest Analyses

Pretest and posttest comparisons between treatment and control group participants were performed using t-tests for independent samples for instruments that were administered both before and after the 12-session curriculum training phase of the study (see Table 1). Means and SDs for these measures are presented in Tables 5 and 6. While the analyses revealed no significant differences between the two groups on any of the pretest comparisons, significant differences were found for several of the measures at the time of posttest. Although the 36 women who participated in all phases of the study were included in the final sample, there is some variation in the number of cases included in the analyses for the different posttest measures. This variation reflects the fact that scores on some of the measures were not available for all of the women due to either the woman's unavailability for testing with a particular measure or missing item response data.

The analyses reported below are intended to provide information on key variables to permit an overall assessment of the effectiveness of the *ESCAPE* curriculum. However, they do not represent a final, comprehensive analysis of the project data. Because very large amounts of data were generated over the three-year period and because the final cohort of women did not complete the study until a few weeks ago, data analyses are still ongoing. As we continue to examine both the quantitative and qualitative data from the study, we plan to look carefully at individual differences among the women, especially patterns that may be associated with differential responsiveness to the intervention.

Empowerment Scale (ES)

Treatment and control group means and SDs for pretest and posttest scores on the *ES* are presented in Table 5. Pretest scores on the *ES* did not differ significantly for the two groups. However, posttest scores were statistically significantly higher for the treatment group (Mean = 31.44) than for the control group (Mean = 27.78), $t(34) = -2.30, p < .05$.

Self Decision-Making Scale (SDMS)

Means and SDs for the *SDMS* are presented in Table 5. No significant pretest differences between groups were obtained on either the open-ended or the multiple-choice scores of the *SDMS*. At the time of posttest, significant differences between groups were found for both sets of scores. Independent prevention focused decision-making scores on the open-ended decision questions of the *SDMS* (*What would you do if you were in this situation?*) were statistically significantly higher for the treatment group (Mean = 3.44) than for the control group (Mean = 1.94) $t(34) = 2.87, p < .01$. Further, when participants were presented with a multiple-choice task requiring selection of the most independent prevention focused decision in a situation of abuse, the participants in the treatment group obtained significantly higher mean scores (Mean = 3.78) than the participants in the control group (Mean = 2.33), $t(34) = 2.44, p < .05$.

Knowledge of Abuse Concepts (KAC)

Means and SDs for the *KAC* are presented in Table 5. No significant pretest differences were obtained on either the *Definitions of Abuse* subtest or the *Identification of Abuse* subtest. Posttest scores on the on the *Definitions of Abuse* subtest were statistically significantly higher for the treatment group (Mean = 11.11) than for the control group (Mean = 7.56), $t(34) = -2.11$, $p < .05$. No significant differences were found on the *Identification of Abuse* posttest between the treatment (Mean = 9.50) and control (Mean = 8.06) groups.

Stress Management Scale (SMS)

Means and SDs for the *SMS* are presented in Table 6. No significant differences between the treatment and control groups were found for either the *Life Stressors* score or the *Ways of Coping* score on the *SMS* at the time of either pretest or posttest.

Decision-Making Interview (DMI)

Means and SDs for two of the interview questions from the *DMI* are presented in Table 6. No significant pretest differences between groups were obtained for either question. Posttest scores for the problem identification question (*What is the problem here?*) were significantly higher for the treatment group (Mean = 5.58) than for the control group (Mean = 4.06), $t(27) = 3.04$, $p < .01$. Posttest scores for the two groups did not differ for the decision question (*Do you think _____ did the right thing in the situation and why?*).

Decision-Making Video Scale (DMVS)

Means and SDs for overall effective decision making on the *DMVS* are presented in Table 6. No significant pretest or posttest differences were found on this overall measure of decision making.

Table 5

Means and standard deviations (SDs) for pretest and posttest scores by experimental condition for the *Empowerment Scale (ES)*, the *Self Decision-Making Scale (SDMS) – Open-Ended*, the *SDMS – Multiple Choice*, the *Knowledge of Abuse Concepts (KAC) – Definitions*, and the *KAC -- Identification*

Group	ES (Total)		SDMS Independent prevention- focused decision-making (open-ended)		SDMS Independent prevention- focused decision-making (multiple-choice)		KACS Definition of abuse		KACS Identification of abuse	
	Pre Mean (SD)	Post Mean (SD)	Pre Mean (SD)	Post Mean (SD)	Pre Mean (SD)	Post Mean (SD)	Pre Mean (SD)	Post Mean (SD)	Pre Mean (SD)	Post Mean (SD)
	n = 16	n = 18	n = 18	n = 18	n = 18	n = 18	n = 16	n = 18	n = 18	n = 18
Treatment	28.00 (6.71) n = 16	31.44 (4.64) n = 18	2.33 (1.61) n = 18	3.44 (1.62) n = 18	2.39 (1.58) n = 18	3.78 (1.70) n = 18	6.76 (3.72) n = 16	11.11 (3.92) n = 18	8.67 (2.30) n = 18	9.50 (2.15) n = 18
Control	26.27 (5.02) n = 15	27.78 (4.90) n = 18	2.39 (1.61) n = 18	1.94 (1.51) n = 18	1.67 (1.41) n = 18	2.33 (1.85) n = 18	5.75 (4.85) n = 16	7.56 (5.98) n = 18	7.64 (3.00) n = 14	8.06 (3.52) n = 18

Table 6

Means and standard deviations (SDs) for pretest and posttest scores by experimental condition for the *Stress Management Scale (SMS) – Life Stressors* and the *SMS – Ways of Coping*, and the *Decision-Making Interview (DMI) – Problem Question* and the *DMI -- Decision Question*, and the *Decision-Making Video Scale (DMVS) – Overall Effective Decision-Making Score*

Group	SMS (Life Stressors)		SMS (Ways of Coping)		DMI (Problem)		DMI (Decision)		DMVS (Overall Score)	
	Pre Mean (SD) n =	Post Mean (SD) n =	Pre Mean (SD) n =	Post Mean (SD) n =	Pre Mean (SD) n =	Post Mean (SD) n =	Pre Mean (SD) n =	Post Mean (SD) n =	Pre Mean (SD) n =	Post Mean (SD) n =
Treatment	7.61 (2.40) n = 18	7.50 (1.79) n = 18	4.44 (1.68) n = 18	5.33 (1.91) n = 18	4.92 (0.90) n = 12	5.58 (0.67) n = 12	5.33 (2.74) n = 12	6.17 (2.92) n = 12	3.71 (2.44) n=17	6.53 (3.41) n=17
Control	7.22 (1.80) n = 18	6.94 (1.79) n = 18	4.89 (2.61) n = 18	5.17 (2.33) n = 18	4.71 (1.40) n = 17	4.06 (1.64) n = 17	5.71 (2.82) n = 17	5.12 (2.23) n = 17	2.94 (3.51) n=17	5.65 (4.23) n=17

Qualitative Exit Interview Analyses: Treatment Group Only

Analyses for only the eighteen women who received the curriculum training intervention are presented below. A brief exit interview including two open-ended questions was conducted at the end of the twelfth curriculum session for participants in the treatment group to record their qualitative experiences and reflections about the usefulness of the curriculum delivered. Participants were also probed for their overall gist understanding of the decision-making process and their awareness of some of the important things to consider when making effective decisions. Illustrative responses from a few of the interviews are summarized in Table 7.

Table 7
Summary of illustrative responses from the *Posttest Exit Interview*

What are some important things you need to think about when you make decisions?	Has this group helped you? How?
<i>How to handle it. How to about making decisions. How to handle it. How to solve it. What you need to do. What is the best way to deal with it.</i>	<i>Yeah, because I know that if I have a problem and I have to solve it, not by hiding. Using verbal word, which is what I do. Ah, basically has taught me a lot of things. You know, I am a person like this. I'm very short temper. My short temper, it's like the slightest thing just aggravate me and I would just blow off. I don't do that anymore...</i>
<i>Yourself. Your friends and your co-workers.</i>	<i>... We can stand up for ourself, walk away, call the cops</i>
<i>I don't want to do things that I don't like. I don't want to get hurt. I am going to be different.</i>	<i>Yes. Talking a lot.</i>
<i>Your love life, your friendships, your family and your parents.</i>	<i>Yes a lot. How to make good decisions. It's been helpful.</i>
<i>Think about before we go out. Think about... thinking more in my mind.</i>	<i>Yes. It help me 'cause every time some people be joking about me, like Anthony. He goes home joking to me about me. He comes here trying to bother me.</i>
<i>That choices you're making, make them the right choices. Make sure it is not a bad choice but a good choice.</i>	<i>Yes a lot. Well, we went over how to speak out by ourselves, to tell people how we feel if we don't want them to touch us.</i>
<i>Not to let people touch you, not to fight people, and tell them you don't want to if they want to fight. I learned to say no to my friend here. I have a friend here and my mom and social worker told me that I shouldn't buy things for them. I need to save my money. He always asks me to buy him things. So the other day, I told him I cannot buy things for him. And I hope we can still be friends.</i>	<i>B/c if someone does something I can tell them to leave me alone. It has helped me a whole lot. If I get angry, I use to hold it in and curse. Now it helps me because if I have a problem I can talk about it.</i>
<i>Make good decisions. Think about it.</i>	<i>Yes. Helped me with decisions when I have a bad relationship or a good relationship.</i>
<i>Have a healthy relationship. Respect yourself and others. Be safe, speak up, tell someone. Think before you talk -- have to listen and think about it. Tell your family or relatives.</i>	<i>Yes. Things changed. It helped me a lot to help myself. It gave me advice; it changed my life around a little. [Thinking about your decisions] Yes.</i>

Evaluation of Support Group Intervention (Unit III)

Quantitative Post-Posttest Analyses

Post-Support Group/ Post-Posttest Analyses

Post-support group/post-posttest comparisons were made between the treatment and control groups using t-tests for independent samples on the three post-posttest measures. Significant differences were found between the two groups on various scores from the post-posttest battery. These results indicate that the knowledge and training of the women who received curriculum training was maintained by the women's participation in the support groups.

Empowerment Scale (ES)

Total post-posttest scores on the *ES* were statistically significantly higher for the treatment group participants (Mean = 32.62) than for the control group participants (Mean = 27.50), $t(34) = 2.08, p < .05$.

Self Decision-Making Scale (SDMS)

When the participants were presented with a multiple-choice task requiring selection of the most independent prevention focused decision in a situation of abuse, the participants in the treatment group obtained significantly higher mean scores (Mean = 3.83) than the participants in the control group (Mean = 2.27), $t(34) = 2.46, p < .05$.

Although independent prevention focused decision-making scores for self on the open-ended decision question of *SDMS* were somewhat higher for the treatment group (Mean = 2.72) than for the control group (Mean = 1.83), comparisons failed to reveal statistically significant differences, $t(34) = 1.64, p < .11$.

Knowledge of Abuse Concepts (KAC)

Post-posttest definitions and knowledge of abuse scores on the *KAC* were higher for the treatment group (Mean = 10.29) than for the control group (Mean = 7.62), $t(34) = 2.17, p < .05$.

Similar to posttest results, no significant differences were found between the treatment (Mean = 9.55) and control (Mean = 8.87) groups on the post-posttest identification score on the *KAC*.

Qualitative Analyses of Support Group Sessions: Treatment Group Only

Participant-oriented approaches (e.g. observations, interviews) were the main qualitative sources of data utilized to provide an understanding of the nature of the interactions and responses of the participants during the support group intervention. Two observers independently examined the

information collected during the support group intervention, including direct interviews of participants and anecdotal records of group meetings, to establish the reliability of the reported outcomes of the support group. A third independent observer summarized the information and outcomes to write a qualitative, descriptive summary of the support group process and its findings. The evaluation includes a delineation of the proposed objectives for each of the six support group sessions and a descriptive analysis of the extent to which the objectives were met based on participants' responses from two randomly selected three-person cohort treatment groups (Group A and B). Participants' satisfaction with the support groups was also documented through their qualitative descriptions and appraisal of ways in which the intervention was beneficial to them.

Support Group Session 1

Objective. The first session was designed to provide a quick review of information covered in *ESCAPE* curriculum Units I and II. The session included a broad overview of healthy and abusive personal relationships and definitions of different types of abuse (sexual, physical, and verbal). Participants listed rights or goals most desired in their personal relationships (e.g. the right to be safe; the right to say no to things that you do not want) and practiced the use of the decision-making strategy outlined in the curriculum to explore prevention-focused choices in response to a hypothetical situation of interpersonal abuse.

Participation Summary. Participants successfully recognized and distinguished between healthy and abusive relationships, and among different types of abusive situations. The participants sorted vignettes (visuals) representing different interpersonal situations into categories of healthy and abusive relationships, and among abusive situations, into different types of abuse (sexual, physical, verbal). This demonstrated participants' increased knowledge regarding abuse and self-protection in social relationships. Participants knowledge about what builds positive, healthy relationships can in the future, help prevent relationship violence and break the cycle of abuse. [Group A labeled healthy relationships as "healthy boyfriend-girlfriend love" or "where you can be friends". To illustrate, M mentioned having healthy relationships with her husband and D her foster family].

Participants were able to recall and apply the different steps of the decision-making strategy to solve a hypothetical situation of abuse with minimal prompting. They were able to spontaneously generate many choices (e.g. speak up, tell someone, call social worker, call police) aimed at stopping and preventing abuse, agreeing most often that the best choice is to always speak up to the abuser and then tell someone else.

Support Group Sessions 2 and 3

Objective. The second and third sessions provided the participants with space that allowed them to reflect on their personal experiences and begin to explore the importance and applicability of information reviewed in the curriculum to their own lives. Each participant individually used an abuse indicator checklist to identify if she had ever been (or is) in an abusive relationship. Next, participants were asked to volunteer to share their personal experiences with the group. Using any one situation as an example, the group reflected on the problem and used the decision-

making strategy to identify alternative choices that could help stop abuse if the situation was to ever happen again.

Participation Summary. All participants indicated some incidence of abuse in their lives, with type and severity of abuse varying among the participants. [In Group A, M said that a male at the workshop had pushed her. H shared that one day when she was at the cafeteria eating her lunch, a guy told her in a mean way to move to another place, as he wanted to take her chair. She said that she moved and did not say anything to the person]. In general, participants reported more instances of physical and verbal abuse than sexual abuse. When recalling their personal experiences, most participants were not afraid to share their experiences, but felt sad and showed concern for what had happened to them. In most instances, the participant reflected upon past feelings of helplessness and their inability to resist or stop the problem of abuse. They were able to define the problem and identify what type of abuse they had faced (or are facing). Some participants reflected on instances of childhood abuse or having witnessed either a family member or friend in a situation of abuse. [In Group B, C recalled that her boyfriend in school used to get angry with her and twist her arm. She said she used to do nothing when he did it. Y informed the group that her father used to fight and hit her mother when she was younger. Now they did not live with him. She added that now her stepfather and mom fight verbally which scares her. Y also recalled that in school, a boy used to kick her everyday when he saw her. She said that she told the teacher when he hurt her, but nothing happened. Recently, a person from the program had been calling her really hurtful names. She said that she told him that she doesn't like it, but he continues to call her names].

Participants were able to generalize the use of the decision-making strategy, learned in the context of hypothetical interpersonal situations of abuse, to their own real life situations. Using the decision-making steps, participants generated various prevention choices that could have been used in the past or are available to stop abuse from happening in the future. The ability of participants to utilize decision-making skills to effectively assess prevention focused choices in the context of their own life experiences demonstrated their preparation to generalize effective decision-making skills acquired in a hypothetical context to actual self-protection choices in real life situations. [In Group A, D empathized strongly with M being pushed and physically hurt by a male at the workshop. D proposed to tell her supervisor but also to push the guy back. In response to H's situation, the group suggested that H should not stay silent but speak up to the coworker and tell someone else to protect her. H agreed with the group's recommendation and recognized that she should not go along with the abuse, which is what she usually does. She mentioned that she did not want problems and that she was afraid to get hurt. The group prompted her that it would turn worse if she remained silent because the guy would think that he could do it again. During the next group session, H told the group that she had made a mistake because she let the guy abuse her and she did not say anything. Next time, she was not going to move out of her seat and she was going to tell the guy to stop being mean to her. She also said that she would report it to her supervisor or parents.

Group B discussed C's encounters with her boyfriend and determined that the most effective choice would be to tell him to stop. Y informed the group that she told her stepfather that she would call the cops if he hits her mother. After evaluating several choices, the group agreed that

it is important to stand up for oneself and then get help. In assisting Y to think of her options with the guy on the bus who had been insulting her, the group discussed the importance of standing up for oneself, and then asking for help and support from other people. After the session, Y and a counselor talked to the guy on the bus].

Support Group Session 4

Objective. The fourth session probed participants to think about their support networks and identify individual people and/or places they could contact for help. They reviewed incident reporting procedures and how to access follow-up protective and therapeutic services should the need arise.

Participation Summary. The participants understood the importance of reporting abuse and seeking social support and help as a follow-up prevention strategy. They were able to label ‘safe places’ (staff members, family and friends) that they could go for help and some were able to give names of specific family members and counselors that they could trust to help them when they are in need. Participants felt assured of the available support networks and joining the support groups appears to have provided them with an expanded sense of safety and belonging. If connections with existing support networks were not established the participants developed an awareness of how to reach out and expand on their supports. [*Group B emphasized the importance of having friends to talk to and, in one case, a participant offered support to another participant by saying “you could call me anytime if you needed to talk”*]. In general, participants did not appear well informed about available prevention and support services in the community, specifically the availability of medical assistance if required. One of the participants remarked, “no one taught me before to get medical help”. Access to information and protective services, including support networks in the community need to be continued.

Support Group Session 5

Objective

During the fifth session the participants reviewed ways to maintain healthy interpersonal relationships and listed individual rights that they would want to have in their relationships. This helped summarize self-protective goals (e.g. being safe, speaking up for oneself) that provided a benchmark for evaluating decisions when faced with difficult/abusive interpersonal situations.

Participation Summary

The participants articulated their rights in relationships and charted a personal ‘bill of rights’ that included goals of safety, independence, and speaking up against abuse. Participants prioritized their rights or goals depending on their own situations and what they would like to pursue the most for themselves. *For example, H chose the right to stand up for herself as being the most important for her and D selected the right to say “don’t treat me badly”.* In Group B, *C declared “I have the right to be safe, have fun, and express my feelings” and Y said that she would like to “try to communicate with him (referring to her boyfriend) and ask him what he*

wants. *I have the right to say no, have fun, and be safe*". The participants' identification of a list of rights took them a step forward in recognizing and asserting a need for change in their lives in committing to the pursuit of greater freedom and choice.

Support Group Session 6

Objective

The sixth and final session of the support group intervention allowed the participants to elaborate on their understanding of issues relating to abuse and their ability to cope with situations of abuse. They responded to two questions [What are some important things you need to think about when you find yourself in a situation of abuse? and Has this group helped you?] that assessed their learning and growth as a result of their participation in the curriculum and support group process.

Participation Summary

What are some important things you need to think about when you find yourself in a situation of abuse? Participants showed adequate understanding of abuse concepts and suggested effective, prevention-focused coping options for themselves if they were ever to encounter a situation of abuse. In assessing prevention-focused ways to cope with situations of abuse, most of the participants recognized that it was important to speak up to the abuser and then report the abuse to someone else. [In Group B, A said *"Not to let someone abuse you. Not to touch you if you don't want to. Only let them if you want to. I gotta speak up by myself. To tell people that I think. Tell them how you think, if you don't like it"*. C summarized *"I need to think about what I should do. Tell them not to do it. Tell someone if you need help. Tell the police"* and Y alleged, *"No one should touch you. That's bad. Abuse is bad. Tell them to leave you alone. Tell someone else"*].

Has this group helped you? If yes, how? The participants expressed their satisfaction and labeled specific benefits that they derived from the group, thus validating the usefulness and efficacy of the support groups. [In Group A, M mentioned, *"I learned to say No Pushing"*. D added *"I know that people cannot touch me or hit me, don't let them call me names. I learned to call my parents if I have a problem, call 911 or call people at the agency"*. She added that she found the groups very helpful especially because *"you tell your problems and people listen to you. We shared and talked about feelings"*. In Group B, A said *"The group helped a lot. I know I need to speak up for myself. We went over how to make good choices, right ones"*. C concurred saying *"I liked the group. It helped me to know what to do if someone touches you and how to make decisions"*. Y asserted *"Yes, it has helped tell (ex-boyfriend) to get away. He was always joking about me and I didn't like it. He always tries to bother me"*].

General Comments on Support Groups

Overall, the findings indicate the usefulness of support groups and provide support for greater utilization of this mode of intervention for women with mental retardation. The women who

completed the support groups expressed satisfaction with the service they received and showed interest in continuing to participate in on-going support groups. Additional formal research on the efficacy of support groups is needed to further validate the usefulness of the support group approach with women with mental retardation.

The outcomes of the support group sessions reveal that the participants are beginning to show increased understanding of abuse and ability to utilize a decision-making process to evaluate alternative choices and consequences in interpersonal situations, including identifying the choices that will be most effective in stopping abuse from happening [*In Group A, M who had initially reported abusive encounters with a male co-worker at the workshop mentioned at the end of the group sessions that she had one day told the man “do not push me” and he had stopped. The abusive behaviors had not been repeated again. In Group B, Y sought assistance from her social worker to help end a long term relationship with her boyfriend who had been insulting towards her*]. In sharing their personal experiences and listening to each other's personal stories, the participants had their feelings and experiences acknowledged as real and they received emotional support. In supporting each other emotionally they began a ‘healing’ process of breaking through their feelings of being isolated and unappreciated with regard to their own experiences. Together they grew in their understanding that they are not alone in their experience; abuse can happen to anyone and it is not their fault. This helped participants to lessen the emotional burden of feelings of shame and guilt and to enhance their self-esteem and confidence. The sharing of personal experiences also served a ‘therapeutic’ function in enabling participants to vent their anger about being victimized and to express their feelings of loss in a relationship. In collectively identifying various available options in any abusive situation, the group process allowed participants to explore choices concerning their own protection and prevention of abuse. This added to their sense of security and empowered them to gain more control over the decisions that affect their own lives.

In spite of the success of the support group intervention, a number of difficulties were encountered in the implementation of the support groups that deserve attention in interpreting the present findings and in planning future interventions. The format of the support group discussions depended largely on self-reports and verbal descriptions of individual experiences and therefore placed high verbal language demands on the participants. A number of participants were unable to fully and effectively communicate thoughts due to language or speech difficulties. The facilitators were required to assist participants in summarizing thoughts based on a few articulated words or expressions and to utilize picture cues or more direct questioning to elicit responses. Further, the discussion tasks in the support group sessions were challenging for the participants as they traditionally have had limited experience with reflection or insight-oriented processes of communication. However, as the support group meetings progressed, an increase in participants' engagement in the group discussions was reported suggesting an overall improvement in their ability to participate in an insight-oriented group process and benefit from such an opportunity. For future interventions, further adaptations involving greater use of pictorial prompts, role-playing or sign language is recommended to fully accommodate the needs of participants with differing verbal abilities.

Another area of concern related to the extent to which participants were emotionally prepared for

recalling serious and highly intense real experiences of abuse that could trigger varying emotional reactions or coping difficulties. Special care was taken to ensure that the group members were not left emotionally disturbed at the end of each session. They were assured of the confidentiality of their interactions and offered additional support or counseling services if desired. However, for future interventions it is recommended that individual counseling sessions be made available to the participants during the time period when they are attending the support groups so that they will have the opportunity on an individual basis to resolve any issues that were not fully attended to in the group sessions.

General Discussion and Conclusions

This three-year effort to develop, evaluate, and disseminate an abuse prevention curriculum for women with mental retardation has accomplished all three of its stated goals.

- *An Effective Strategy-Based Curriculum for Abuse Prevention and Empowerment (ESCAPE)* has been developed and it is now available in a complete, user-friendly package.
- An evaluation study has been completed, yielding clear evidence for the effectiveness of the *ESCAPE* curriculum on several outcome measures.
- A variety of dissemination activities have provided (and will continue to provide) information about the project to local, national, and international audiences.

In addition, the three-year project has provided detailed information about the impact of the *ESCAPE* curriculum. After receiving Unit I (Knowledge of Abuse/Empowerment) and Unit II (Decision Making) of the curriculum, the performance of the women in the treatment group was superior to that of the women in the control group on posttest measures of knowledge about different types of abuse, empowerment, and some aspects of independent, prevention focused decision making (self-situations and problem identification). Although significant group differences were not obtained on posttest measures of stress management and decision-making with videotaped simulations of problem situations, additional analyses are needed to completely assess the impact of the intervention on those measures. In the lesson-12 exit interview, the qualitative comments of participants in the treatment group also attested to the benefits of the curriculum. These preliminary findings reveal the positive effects of the *ESCAPE* curriculum.

After receiving Unit III (Women's Support Groups) of the *ESCAPE* curriculum, women in the treatment group continued to perform better than women in the control group on measures of knowledge about the types of abuse, empowerment, and self decision making. Qualitative analysis of the support group sessions indicated that many of the women felt that participation in the curriculum and support group activities was having a positive impact on their lives. The women's comments indicated an increase in their individual self-efficacy and generalized perceptions of control including their capabilities to control their environment and prevent abuse.

The impact of the curriculum on the participants' knowledge, empowerment and decision-making skills is a promising indicator that women with mental retardation can be better equipped

to effectively prevent and handle situations of abuse in their lives as well as experience increased perceptions of control over specific aspects of their lives. Further evaluation and interpretation of *ESCAPE* curriculum findings will result from the more comprehensive data analyses that are presently underway.

Our experiences with this three-year project have underscored the need to continue collaborative efforts in this area. Our collaborators at AHRC New York City have expressed considerable enthusiasm about the project, indicating that it addressed a pressing need and that it promised to yield an extremely valuable resource. Although the evaluation study has indicated that the curriculum intervention was effective, the members of our collaborative team agree that most of the participating women could benefit from an extended time period in which to master the content and become proficient at applying it to their own lives. We are committed to continuing our work together to obtain additional funding to continue this line of prevention research – through both longitudinal follow-up studies and the design and evaluation of needed interventions.

References

- Hickson, L., Golden, H., Khemka, I., Urv, T., & Yamusah, S. (1998). A closer look at interpersonal decision making in adults with and without mental retardation. *American Journal on Mental Retardation, 103*, 209-224.
- Hickson, L., & Khemka, I. (2001). The role of motivation in the interpersonal decision making of people with mental retardation. In H. N. Switzky (Ed.), *Personality and motivational differences in persons with mental retardation*. Mahwah, NJ: Erlbaum.
- Hickson, L., & Khemka, I. (1999). Decision making and mental retardation. In L. M. Glidden (Ed.), *International review of research in mental retardation, Vol. 22*. San Diego: Academic Press.
- Hudson, W. W., & McIntosh, S. R. (1981). The assessment of spouse abuse: Two quantifiable dimensions. *Journal of Marriage and the Family, 43*, 873-885.
- Khemka, I. (1997). *Increasing independent interpersonal decision-making skills of women with mental retardation in response to social-interpersonal situations involving abuse*. Unpublished doctoral dissertation, Teachers College, Columbia University, New York, NY.
- Khemka, I. (2000). Increasing independent interpersonal decision-making skills of women with mental retardation in simulated interpersonal situations of abuse. *American Journal of Mental Retardation, 105*, 387-401.
- Khemka, I., & Hickson, L. (2000). Decision making in adults with mental retardation in simulated situations of abuse. *Mental Retardation, 38*, 15-26.
- Nicholas, K. B., & Bieber, S. L. (1997). Assessment of perceived parenting behaviors: The exposure to abusive and supportive environments parenting inventory (EASE-PI). *Journal of Family Violence, 12*, 275-291.