Introductory research into the efficacy of groups for survivors of childhood sexual assault

Prepared for the
NSW Health, Education Centre Against Violence (ECAV)

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Education Centre
AGAINST VIOLENCE

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Overview of Research Process

The following document was prepared following searches of a number of books from the ECAV library and 5 databases; Web of Science, ProQuest, Sydney University Library, Humanities & Social Sciences Collection and Families and Society Collection. Search terms included “group sexual assault”, “group childhood sexual assault”, “group women abuse”, “group work” survivor” and “group work survivor disability”.

Introductory findings based on a review of 26 articles have been prepared under the sub-headings listed in the Contents.

The majority of articles sourced are from the USA and UK, with the remainder coming from Western countries including Australia, Sweden and Canada. The sample groups from most studies are not very diverse in the cultural background of participants. Studies in this area, particularly many pre-2003 studies- have been critiqued for their methodological flaws (Dahl & Peleikis, 2005).

Areas for further research include modality of delivery- no studies were found exploring this theme. Studies from non-western countries. An in-depth search of the ‘Group Analysis’ Journal. Further searching of databases using a broader range of terms. Searching of further databases such as Health and Society, Medline, apais, LGBT Life, Oxford Journals online, Sage Research and Social Services abstracts. Thorough search of printed materials. Findings from studies about effective groups for other groups with complex trauma.

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1. Efficacy of Groups

The vast majority of studies show significant improvements for participants of CSA groups. Some pre-2000 studies described in Fritch and Lynch's (2008) review of the literature do not show discernable differences between group and individual therapy, however the methodology of these studies is not comprehensive.

Kessler, White, and Nelson's (2003) well cited meta-analytic review of group treatments for women sexually abused as children provides a critique of the outcome research of 13 studies conducted between 1984-1999. Although many of the studies contain methodological limitations, Kessler et al. have found group treatment to be effective in the recovery of female CSA survivors. The results indicate that group treatment helps reduce symptomatology in the short-term and at longer term follow-up.

Group work has been found to greatly improve symptoms of PTSD (Wolfsdorf & Zlotnick, 2001; Kreidler, 2005; Lundqvist, Svedin, Hansson, Broman, Sektion IV, Socialhögskolan, . . . Institutionen för kliniska vetenskaper, 2006) reduce depression (Wolfsdorf et al., 2001, Lundqvist et al., 2006), reduce dissociation (Classen, Koopman, Nevill-Manning & Spiegel, 2001; Wolfsdorf et al., 2001), reduce anxiety (Lundqvist et al., 2006), increase SOC (Sense of Coherence) (Lundqvist et al., 2006), improve negative self-perceptions such as feelings of shame, guilt, isolation and hopelessness (Gorey, Richter & Snider, 2001; Valerio & Lepper, 2010) and improve self-esteem (Classen et al., 2001; Valerio & Lepper, 2010).

Svedin, Hansson and Lundqvist,'s (2009) research again shows the efficacy of a CSA group for women, and presents the argument that offering groups for women who have experienced CSA offers an economic advantage as these groups have been shown to have higher health care costs than women without these experiences (Walker et. al., 1999 as cited in Svedin et al., 2009, p.172).

Edwards, Haynes, et al. (2017) suggest the data of their research "provide compelling preliminary evidence that trauma-informed SLHs [sober living homes] may promote a SOC [sense of community] among women with histories of DSV [domestic and/or sexual violence] and that SUDS [substance use disorder] and that SOC may promotes positive mental health symptoms."

Walker-Williams' (2017) analysis elaborated "Participants reported finding the group setting a healing space, a vehicle for recovery. After hearing the stories of the other participants throughout the group sessions (witnessing), they felt they could reveal their own pain and suffering. This could be indicative of a supportive, structured, contained, and accepting environment created by the unique common identity held in the S2T group."

Karlsson (2015) illuminates "participants reported statistically significant reductions in posttraumatic stress disorder, depression, and generalized anxiety disorder symptoms from pretreatment to posttreatment (large effect sizes; all η2 >.20). Among participants with

pretreatment and posttreatment data (n ¼ 36), approximately 70% showed clinical significant reductions and/or were considered recovered (e.g., no longer above the clinical cutoff) on at least one of the three diagnostic measures."

This also includes the follow-up study (Karlsson, 2020) that tried to replicate the original results in a separate centre. It found "Pre- to posttreatment symptom reductions in PTSD, depression, and GAD were statistically significant with large effect sizes. Moreover, 21-37% of treatment completers evidenced reliable change in their symptom reduction during the course of treatment. Most women who did not evidence reliable change were already below the clinical cutoff on the corresponding symptom measure at pre-treatment and remained below by post-treatment" and results consistent with prior studies of Survivors Healing from Abuse: Recovery through Exposure (SHARE).

2. Length of Groups

Only two studies were found examining the length of groups, with no clear outcome as to superiority. Valerio and Lepper's (2010) study into the Short and Long-term Groups for Survivors of Sexual Abuse in the UK provides some insight into ideal group length, however the methodology has some limitations. The sample size was small (16 people) and there was no follow-up from short-term group participants at one year. Results of this study suggest that the long-term therapy demonstrates more effectiveness on nearly all measures, however participants from the short term group were not followed up at 1 year. The two groups were no different in their progress at 14 weeks on 6 measurement scales. Short term group participants showed an increase in self-esteem (ISS) and a reduction in dissociative symptoms, 2 out of 6 measures. For the long-term group there was a significant improvement from pre- to post-therapy in scores on five of the six measures a reduction in dissociative experiences (as measured by the DESII), a reduction in feelings of shame and an increase in self-esteem (as measured by the ISS sub-scales) and a reduction in total reported symptoms (as measured by the two BSI indices). The change in the group's reported self-esteem as measured by the CFSE approached, but did not reach statistical significance.

The first Swedish study into the outcomes of CSA groups for women (Lundqvist et al., 2006) ccompared a 2 year group with a similar short-term group of 20 weeks and a waiting-list group. Improvements in anxiety and depression, PTSD and SOC (Sense of Coherence) were seen in clients of both groups compared to the wait-list group. Differences between the 2 year and 20 week groups were not statistically significant.

Walker-Williams (2017) et al. employed a "quasi-experimental, one group, pretest, posttest, time-delay design (Leedy & Ormrod, 2005) was employed to evaluate the benefits of the S2T strengths-based intervention for this group of women. Due to the secrecy surrounding CSA,

it was impossible to randomly select women and also difficult to recruit enough women to constitute a comparison group, thus a quasi-experimental design was most suited (Yegidis, Weinbach, & Myers, 2012). The S2T program spanned 3 months, in which six group-facilitated sessions took place. These sessions typically lasted between 2 and 3 hours and were conducted at 2-week intervals. Three months after the last session, a delayed follow-up session was conducted."

Ha (2019) explored a program where "South Korean participants who had experienced sexual abuse were randomly assigned to two groups (M = 22.3 years, SD = 1.60; n = 16 per group): the forgiveness writing therapy (FT) group and the control group. The FT group participated in four writing sessions in which they wrote about self-forgiveness, situational forgiveness for 30 min; the control group did not participate in any particular treatment program."

3. Curative Factors of Group Therapy

Yalom (1975, p.82 as cited in Valerio & Lepper, 2010, p.33) identified the following curative factors in group therapy:

- Discovering and accepting previously unknown or unacceptable parts of the self,
- Being able to say what was bothering me instead of holding it in,
- Other members honestly telling me what they think of me,
- Learning how to express my feelings,
- The group's teaching me about the type of impression I make on others,
- Expressing negative and/or positive feelings toward another member,
- Existential—taking responsibility for self,
- Learning how I come across to others,
- Seeing that others could reveal embarrassing things, and take other risks and benefit from it, helped me to do the same.

Tschuschke and Dies (1994, as cited in Valerio & Lepper, 2010, p.33) studied five therapeutic factors: group cohesiveness, interpersonal learning, self-disclosure, feedback and family re-enactment.

Valerio and Lepper (2010, p.34) propose that "changes in the 'group as a whole' can also be used as indicators of change in the functioning of the individual 'within the group'. This approach also allows for a proper evaluation of the effect of group psychotherapy rather than simply analysing individuals who happen to be in a group".

Davidson (2007, p.10) synthesises the therapeutic factors named in Yalom's later work (2005) to be:

- installation of hope,
- universality,
- imparting information,
- altruism,
- corrective recapitulation of the primary family group,
- development of socialising techniques,
- imitative behaviour,
- interpersonal learning,
- group cohesiveness,
- catharsis,
- Existential factors.

Walker-Williams (2017) identified the following curative factors:

- "encouraged heightened emotional awareness that resulted in all participants displaying deep cathartic reactions, and this led to higher levels of introspection pertaining to the impact of the CSA trauma on their emotional and overall functioning"
- "experimenting with new adaptive coping behaviors that enabled a posttrauma identity and an internal locus of control"
- "Participants reported a shift from a survivor to a thriver identity"

Ha (2019): "the [forgiveness writing therapy] group demonstrated a significant reduction in shame and depression, and an increase in post-traumatic growth."

4. Re-Victimisation

Classen, Koopman, Nevill-Manning, and Spiegel's (2001) study of 52 female CSA survivors with PTSD offers some evidence that group participation can reduce re-victimisation. Women who received group therapy were less likely to be re-victimised compared to those on a wait-list 24 months later. When those individuals in the study with a history of having been sexually re-victimized in the previous six months were isolated, at post-treatment only 38% of the women who were in the treatment group were re-victimized compared to 67% of women in the wait-list condition. Given the small sample size, these differences were not statistically significant, however, a 50% reduction in re- victimization is clinically significant. Re-traumatisation was measured using the Sexual Experiences Survey (Koss & Gidycz, 1985; Koss & Oros, 1982 as cited in Classen, et al., 2001, p.276), a 13-item scale designed to assess hidden sexual trauma, trauma that might not be identified by the victim as sexual aggression or violation. At post-treatment, 24 months later, participants were asked to indicate how

often a particular item was experienced in the previous six months. Re-victimized participants were those individuals who endorsed any items that indicated sexual coercion (items 3- 7), attempted rape (items 8 and 9) or rape (items 10-12).

5. Disability

There is a paucity of literature describing the needs of survivors of CSA living with a disability (Mikton, Maguire, & Shakespeare, 2014). In a review of the peer-reviewed literature from 1995 to 2010 on violence-related service, prevention, and intervention programs for people with disabilities, Lund (2011) noted that most of the intervention and prevention articles focused exclusively on abuse prevention for adults with intellectual disabilities, generally had small samples and lacked controlled conditions. Lund (2011) found that very few methods of abuse treatment for people with disabilities were empirically evaluated.

There have been only four published group interventions with intellectually disabled survivors (Cruz et al. 1988; Corbett et al. 1996; Chaplin 1997; Barber et al. 2000 as cited in Peckham, Howlett & Corbett, 2007, p.308). Mikton, Maguire, & Shakespeare, (2014) searched 736 titles in a systematic review of the effectiveness of interventions to prevent and respond to violence against persons with disabilities finding only 10 articles that met criteria for quality and suitability. A number of studies which were not selected detail studies which found some success utilising groups to work with CSA survivors with a disability, however they were not included in the Mikton review due to small sample size or lack of a control group. Of the 10 articles, only two discussed group treatments for women- one for women with an intellectual disability who had experienced CSA (Peckham et al., 2007) and a group to teach women with intellectual disabilities “protective behaviors”(Mazzucchelli, 2001). The Mazzucchelli study evaluated the success of a pilot program in Perth with 10 people, compared to 10 in a wait-list control group. The study aims to show that by attending the program participants increase their use of protective behaviour skills however participants did not perceive themselves as being safer or more satisfied with how safe they felt following the program. Peckham, Howlett and Corbett’s (2007) UK study shows more positive results. In a study of 7 white people with intellectual disabilities, results showed improvements in sexual knowledge, trauma and depression. Qualitative interviews show that participants felt less isolated following the group and a reduction in feelings of self-blame. Neither self-esteem nor anger improved for most of the group and challenging behaviour worsened before improving. The group ran for 20 sessions over 5 months. A concurrent group was held for carers in a separate room of the same building. Carer knowledge of sexual issues also increased.

In regards to the nature of the groups for survivors, there is even less literature available. Anecdotally, it is interesting to note that most articles describe shorter programmes than those offered for CSA survivors without a disability (2-10 week with disabilities vs 10-50 weeks no disability). Peckham et al. (2007, p.317) note that by definition, learning is a difficult process for clients with intellectual disabilities and this may account for the lack of any significant improvements for participants in their group. Certainly, Barber et al. (2000, as cited in Peckham et al., 2007, p.317) criticise their own 10-week survivors group as it was unable to effect long-term changes in their client participants' self-esteem, depression, assertiveness or anxiety. To build upon critiques of earlier groups, Peckham et al. (2007) incorporated more visually based tasks into their group design. Peckham et al. (2007) also built upon Barber et al.'s design by making the initial stages of this SG educational, preparing client participants for the later stage when they would reprocess their sexual abuse. The support group for carers was designed to increase the chances of reinforcement outside the group.

6. Sleep

Davis and Wright's (2007 as cited in Courtois, C. A., & Ford, J. D. (Eds.), 2009). *Treating complex post- traumatic stress disorders: An evidence-based guide.* New York: The Guildford Press. Group Therapy, Ford, Fallot and Harris, p.419)) study into EERT groups (Exposure work, Rescripting of nightmares and Relaxation) found that after a 3 session group intervention, survivors reported reduced PTSD symptoms, depression symptoms, fear of sleep and improved sleep compared to a control group who reported no changes. At 6 month follow up, 84% of completers reported no nightmares in the past week.

7. What Survivors Want

Unfortunately only two articles were located identifying the needs of survivors, articulated by survivors. Parker, Classen, Dalton, Langmuir and Fourt (2007) conducted a qualitative study of 7 participants the 8 week Women Recovering from Abuse Program (WRAP) in Toronto, Canada. To their knowledge this was the first qualitative study conducted of this nature. The findings of this study show that a relational focus and empowerment-based model is most important to participants. Within the findings, participants describe changes in beliefs, changes in behavioural patterns, changes in connectedness, learning about group processes and learning helpful strategies and techniques. A positive aspect identified by the women was that they felt empowered to continue to seek help through more therapy or self-help activities, however this may challenge workers in the field as one of the outcomes for determining efficacy of services is decreased use of services post-intervention (Parker et

al., 2007, p.74). Due to the small sample size, and the fact that only program completers were interviewed, the study is not entirely representational, however it is the only study of its' kind.

Martsolf, Draucker, Cook, Ross, Stidham, and Mweemba (2010) conducted a meta-summary of qualitative findings about professional services for survivors of sexual violence, which includes a section about what survivors have identified that they want. This study is not specific to groups, covering many types of service provision, however some findings are relevant. Regardless of service type, survivors wanted to be believed and validated about the abuse and the expectation that they might not be believed prevented some participants from seeking or using professional services (Martsolf et al., 2010, p. 494). When professionals were present and available, took time, were sensitive, listened, and followed the survivor's lead, they were perceived positively by participants (Martsolf et al., 2010, p. 494). The findings of incompetence in some professionals were concerning, and lead to a finding that survivors value professional competence in service providers (Martsolf et al., 2010, p.496). Survivors noted that some professionals seemed unable or unwilling to use their specialized training to effectively help the survivors deal with or recover from the sexual violence and in some cases, participants indicated that the professionals lacked sufficient or current knowledge and training to adequately perform their jobs. Sexual boundary violations were described by participants in several studies. Some professionals did not provide information in a competent, clear manner; instead, they overwhelmed the survivor with information. Professionals who were unaware of, or lacked knowledge about, gender issues were problematic for survivors (Martsolf et al., 2010, p.496).

8. Concurrent Groups

Due to the direct relationship between childhood sexual abuse and poor relational outcomes in adulthood (DiLillo and Long 1999; Godbout et al. 2009; Holman 2001; Walker et al. 2011, as cited in Sims and Garrison, 2014, p.17.), one would expect a number of studies into the success of groups for partners and carers of CSA survivors. Two studies suggest that there may be some use in running concurrent groups for partners or carers of survivors of CSA. Sims and Garrison (2014) ran a small study of 5 men and 5 women in Canada who completed a 10 week Partner Support Group conducted concurrently with and Incest Resolution Group. The study suggests that there may be clinical benefits to running a group for partners concurrently with a group for CSA survivors. The study did not name criteria for determining effectiveness of the groups, however it describes a number of benefits including that partners were ill informed about CSA prior to the group and were able to learn more about it and that the men were able to acknowledge their own difficulties and how they contributed to relational distress. For the couple, the benefits included decreased levels of secrecy around the abuse

issues; an increase in supportive communication between the couple; and an increase in the level of intimacy experienced by the couple. Sims and Garrison cite an earlier study by Barcus (1997) which found in his work with male partners that the men became more supportive and had more empathy for their partners.

Peckham, Howlett and Corbett's (2007) UK study of 7 white people with intellectual disabilities, results showed improvements in sexual knowledge, trauma and depression for the survivors and an increased carer knowledge of sexual issues.

9. Exposure Therapy

"Research on the treatment of PTSD has shown strong empirical support for two cognitive-behavioral methods, both of which may change inaccurate trauma-related beliefs: cognitive restructuring (i.e., identifying and correcting inaccurate thoughts that lead to negative feelings) and exposure therapy (i.e., facilitating exposure to feared but safe trauma-related memories and situations, leading to habituation of anxiety) (Mueser 2007, Bolton, Carty, Bradley, Ahlgren, DiStaso, . . . Liddell, p.285). Mueser et al., note that studies comparing these methods have failed to find significant differences between the approaches however financial reasons suggest that one method is preferable to both. This study chose not to use exposure therapy with the rationale that "clients with SMI (Severe Mental Illness) are highly sensitive to the effects of stress, and it is crucial that treatment for PTSD in this population minimize unnecessary exposure to stress (Mueser et al., 2007, p.285). Since exposure therapy has often been reported to be stressful for persons with PTSD (Tarrier et al., 1999), Mueser opted to use cognitive restructuring instead" (Mueser 2007, p.285). In addition, there is some evidence that exposure therapy is less effective in treating primary PTSD when the dominant emotions are guilt and shame rather than anxiety (Smucker, Grunert, & Weis, 2003, as cited in Mueser 2007, p.285).

Tarrier and Sommerfield's (2004) research into the treatment of chronic PTSD by cognitive therapy and imaginal exposure therapy offers some very substantial evidence to suggest that exposure therapy does not have as successful long term results as CBT. The sample included did not include CSA survivors, however is worth consideration as the sample included rape survivors and is the only substantial study of its' nature which was located. A 5-year follow-up was conducted. Of 54 available participants, 5 years following treatment, 32 provided data. Although there had been no difference between the two treatment groups up to 12 months post-treatment, at 5-year follow-up a clear superiority of cognitive therapy over imaginal exposure emerged. The cognitive therapy group showed significant differences on the primary outcome measures: total PTSD symptoms on the CAPS and percentage of PTSD cases. At 5 years no patients who received cognitive therapy were diagnosed with full PTSD compared to 29% of those who received imaginal exposure therapy.

10. Type of Therapy

Several methods of therapy have shown effectiveness with no clear evidence favouring any type of therapy (Ford, Fallot & Harris, in Courtois & Ford J. D., (Eds.), 2009). Kessler, White, and Nelson's (2003) meta-analytic review of studies conducted between 1984-1999 found a lack of evidence as to what type of therapeutic interventions where successful. As of 2008, no studies had directly compared the effectiveness of two types of group therapy for interpersonal trauma victims (e.g., cognitive- behavioural therapy vs. IPT) (Fritch & Lynch, 2008). A few studies (i.e., Alexander et al., 1989; Resick et al., 1988 as cited in Fritch & Lynch, 2008) have compared treatments within a particular modality (e.g., IPT, behavioural groups). No studies were found from the period 2008-2015 that compared the effectiveness of a particular type of therapy. Classen, Koopman, Nevill-Manning, and Spiegel's (2001) study comparing trauma-focused (exploring historical events in depth) and present-focused group therapy for survivors of CSA was inconclusive.

Chard's (2005) evaluation of cognitive processing therapy for survivors of CA with PTSD showed very positive results suggesting the efficacy of individual and group therapy in combination.

11. Retaining Attendance

Only one article was located although there were some methodological issues. Martinez and Wong's (2009) research into using prompts to increase attendance at groups for survivors of domestic violence suggest that prompts to attend meetings increased group attendance by more than double, including prompts in first language. It is important to note that the sample size was small (15) and specific to clients in a long-term residential facility for survivors of domestic violence. Improvements were only tracked over a short time period, and not utilising substantiated tools.

Mueser et al.'s (2007) study found that treatment completers had beneficial responses to the program and therefore advises clinicians to maximize retention in Trauma Recovery Groups to avoid any negative effects of premature dropout. Most clients who dropped out of the group showed modest increases in symptoms from baseline to post-treatment of depression and PTSD symptoms. Mueser et al. note that the negative results of clients who dropped out of the program raise the question of whether some participation in the program, followed by dropping out, may have ''stirred up memories,'' leading to a temporary increase in PTSD symptoms and depression. Mueser et al. advise clinicians to use any means to support clients remaining in the group.

12. Phases of Therapy

Saxe and Johnson (1999, as cited in Fritch & Lynch, 2008, p.158-9) describe effectively utilising a structure following the four phases of recovery described by Courtois (1988): establishing a safe place, breaking the silence, working through, and integration. Consequently, the first phase includes several structured exercises aimed at establishing safety, whereas the second phase is devoted to retelling each member's story. During the third phase, members develop personal goals and participate in experiential exercises designed to help participants work through their trauma, whereas the final phase emphasizes the progress that each member has made, future goals, and termination.

A number of studies noted that groups were based on the stage approach to trauma of Judith Herman (1992; Fritch et al., 2008; Mendelsohn, Harney, & Zachary, 2007). Herman's stage approach to trauma treatment proposes that "recovery occurs in phases, first stabilization of symptoms, then meaning making via a review of traumatic events, and finally focusing on re-establishing meaningful and safe connections with others" (Herman, 1992, as cited in Fritch, 2008, p.151).

13. Assessment and Group Make-up

Research suggests that types of abuse may not contribute to clients' successful participation in CSA groups. In a randomised control trial (Chard, 2005) with seventy-one women participating in a 17 week group for CSA survivors, no differences of treatment outcome were found related to the age at onset of abuse, chronicity of abuse, time between last abuse and treatment, and relationship to the perpetrator. "This is significant information in that these variables are often used by therapists to judge the type of therapy and readiness for therapy on behalf of the client. Instead, therapists may want to consider severity of PTSD or other variables reported in the literature, such as peri-traumatic dissociation, when making treatment decisions" (Chard, 2005, p.969). Kreidler (2005)'s study of 189 women on group therapy for survivors of CSA showed that completion of the group was not found to be related to any demographic of historical variables (p.181).

Some research suggest some participants may find CSA groups more beneficial, suggesting that CSA treatment programs should run specialised groups, or provide additional support for those clients who's needs are noted during assessment. Harper, Richter and Gorey's (2009) thorough research into group work with female survivors of CSA with eating disorders shows evidence of poorer outcomes among those with eating disorders. Study of 50 survivors who completed a 15-week CSA group treatment program. Survivors with reported histories of anorexia nervosa or bulimia nervosa were significantly more depressed and tended to have significantly less self-esteem at discharge and six-month

follow-up than those without an eating disorder. Follette et al. (1991, as cited in Dahl & Peleikis, 2005, p.308) found that less education was associated with poorer therapeutic outcomes, as was married women compared with those with non-partner relationships and women with more severe types of CSA. Follette's results suggest that women with less education, women with non- partner relationships and more severe types of CSA may require additional support. Fisher et al. (1993) and Mo¨ ller and Steel (2002, as cited in Dahl & Peleikis, 2005, p.308) confirmed the negative predictive influence of interfamilial abuse. Thompson (2009) uses the example of sibling abuse to argue groups may be more successful if they are specifically designed for survivors of a particular type of abuse, however this is not backed up with a clinical study. Hazzard, Rogers and Angert (1993, as cited in Fritch & Lynch, 2008, p. 155) noted that participants who reported greater change were more likely to be Caucasian, had no substance abuse history, had received prior treatment, and participated in a more homogeneous group with others' reporting similar abuse histories.

Northen and Kurland (2001, as cited in Thompson, 2009, p.535) argue that the smaller the group, the more demand on members to be fully involved in the group and the more pressure for intimacy of relationships between participants. O'Hare and Taylor (1983, as cited in Thompson, 2009, p.536) note that diversity is a point that should not be ignored, however facilitators should take into consideration that the composition of the group as a whole does not make anyone stand out or feel uncomfortable e.g. one African American woman, one lesbian woman.

14. Fritch and Lynch

Fritch and Lynch (2008) offer a good quality summary of early empirical literature (pre 2002) including long and short term groups, CBT, structured vs semi-structured and groups for males.

Noteworthy studies (in year order) that time permitted a summary of:

Carver, Stalker, Steward, and Abraham (1989) (p.156)

This study found a 15-week of women survivors of CSA to be effective in treating global psychiatric symptoms. Twenty-nine women participated in interpersonal groups with the goal of enhancing affect regulation and tolerance, understanding of difficult memories, and examining interpersonal relationship functioning. Although clinically significant improvements were observed in global psychiatric symptoms, no improvements were observed on measures of depression or self-esteem.

Tutty, Bidgood, and Rothery (1993) (p.148)

A pre-test–post-test quasi-experimental design examining the effectiveness of a support group for battered women. Found significant improvements in self-esteem, belonging, support, locus of control, perceived stress, and marital functioning in 76 battered women. Twelve support groups at three agencies met weekly for 2 to 3 hours for 10 to 12 weeks and focused primarily on psychoeducation, building self-esteem, and planning. Although the content varied across groups and agencies, all groups aimed to reduce violence via education. Sixty women completed the support group program and post-treatment assessment, whereas only 32 women completed 6-month follow-up assessments. Follow-up data from these 32 women suggested that the gains made by clients during the program on a number of standardized scales (i.e., perceived stress, marital relations) were maintained.

Bagley and Young (1998) (p.154)

Random control trial involving 34 participants of a 15 week group for female survivors of CSA who were also mothers. Initial results yielded statistically significant reductions in depression and gains in self-esteem and social support in treatment completers versus waitlist controls. At 5-year follow-up, authors located and reassessed 29 of the participants. Results revealed that the psychosocial gains reported by group members at 6-month follow-up were maintained at 5-year follow-up. In contrast, no significant gains were observed for the women referred for psychiatric services, none of whom received any form of group treatment since initial referral to psychiatry. Notably, at intake these women were more depressed than group therapy participants, which may account for their continued poor mental health.

Najavits, Weiss, Shaw, and Muenz (1998) (p.152)

Study examining the effectiveness of a group based cognitive-behavioural psychotherapy, for 27 women with PTSD and substance use disorder. The majority of the participants reported histories of childhood sexual abuse (94%) and physical abuse (88%). Exposure is specifically discouraged. Participants reported significant improvements in substance abstinence, trauma-related symptoms, suicidal thoughts, social adjustment, family functioning, problem solving, depression, cognitions about substance use, and didactic knowledge related to the treatment. Although these results are encouraging, it is important to note that the final sample size was extremely small (n = 17 group treatment completers) and there was no comparison or control group. Analyses compared the pre- treatment assessments of the 17 treatment completers to the 10 dropouts and found completers were significantly more impaired than dropouts and were more engaged in the treatment.

Saxe and Johnson (1999) (p.158-9)

In their assessment of the Victim to Survivor 20 Session Group for adult female survivors of CSA. Employed a quasi-experimental design to compare treatment group participants (n = 32) to wait- listed individuals (n = 31). The treatment group demonstrated significant improvement on scores of intrapersonal difficulty (i.e., depression, PTSD symptoms, and general distress), whereas the waitlist group scores worsened at post-treatment.

Zlotnick, Najavits, Rohsenow, & Johnson (2003) (p.152)

Afore-mentioned treatment was adapted for incarcerated women and revealed some promising results, however there were some methodological issues with the study including a small sample size (17) and no comparison group. At post-treatment, 9 (53%) of 17 no longer met criteria for PTSD, and at the 3-month follow-up, 7 (46%) still no longer met criteria. However recidivism rates were high (33%) at the 3-month follow-up and there was no comparison group. Nonetheless, authors suggest that Seeking Safety appears to be useful for incarcerated women, a population with high rates of IPV, and has the potential to be beneficial, particularly with regards to reducing PTSD symptomology and substance use disorder, as many substance abusing individuals are excluded from other groups.

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