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Groupwork with female adult survivors of childhood abuse: A small study with statistical evaluation of outcome

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Abstract: *A programme of time-limited therapeutic groupwork with female adult survivors of childhood abuse within the United Kingdom is described and a statistical evaluation of its outcomes reported. The programme involved two separate groups, with a total of eight group members completing the test materials on the first and final group sessions and subsequently at a two-month post-treatment follow-up. Although a relatively small sample, the test results show a significant reduction in clinical symptoms and demonstrate the utility of this approach.*

Keywords*: survivors, childhood, abuse, women, improvement, semi-quantitative.*

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Introduction

Research in the area of childhood abuse indicates clear links between this experience and significant problems in adult life (Draucker, 1992). The legacy of abuse can permeate the following areas of functioning: emotional, interpersonal, behavioural, cognitive/perceptual, physical and sexual. Symptoms commonly presented to health professionals include depression, anger, low self-esteem, guilt, relationship difficulties, and self-harm including alcohol and substance misuse.

Groupwork in this field is a recognised form of therapy, which addresses the root cause of the effects listed above. A number of studies have demonstrated positive outcomes resulting from group therapy for adult survivors of childhood abuse (Alexander et al, 1989; Carver et al, 1989; Hazzard et al, 1993; Hughes, 1992; Richter et al, 1997; Roberts & Lie, 1989; Sultan & Long, 1988; Threadcraft & Wilcoxon, 1993). However, while individual work in this area is perhaps more usual and available, there appears to be a dearth of time-limited therapeutic groups that are offered regularly within the community. Groupwork for Adult Survivors of Childhood Abuse (GASCA) is an established groupwork programme, which has been run within the United Kingdom for six years for women within Surrey Social Services, Surrey Oaklands Health Trust, a women's prison, and more recently, in a men's prison. Originally the programme was modelled on a group run by social workers within the Health Service exclusively for survivors of sexual abuse. The programme has been significantly adapted and revised by the co-leaders and extended to address other forms of childhood abuse. Both co-leaders were employed as social workers within a local authority family centre setting and the first five GASCA groups operated within this venue, taking referrals from Social Services and the Community Mental Health Service. The co-leaders ran subsequent groups on a freelance basis in a number of settings. GASCA obtained funding from a Health Gain Grant (funding for innovative community based projects promoting mental or physical health) to run two Groupwork programmes for women who had been referred to the Community Health Care Teams in Surrey, UK. They were all adult survivors of childhood abuse. The funding also covered the costs

of psychological testing materials. The majority of group members have suffered sexual abuse but on occasions individuals who have experienced severe physical abuse have been included successfully. The group is 'client-centred' (Rogers, 1965) and uses group analytic techniques to enable the group as a whole to work both consciously and subconsciously (Yalom, 1985; Bion, 1961). GASCA aims to empower individuals and assist them to take control of their lives to better equip them to deal with the legacy of their abusive childhood experiences. The co-leaders place great emphasis on accepting the members, validating their feelings and experiences and responding to their needs regarding the focus of group sessions (Foulkes, 1964). Thereby the principles of congruence, empathy and unconditional positive regard underpin all their work. The group is semi-structured and a variety of techniques and exercises are employed in addition to free discussion to assist individuals to connect to the emotional pain of their past abuse. Much of the work is facilitative in this way, but also educative in making links for the participants between their past experiences and current functioning (Foulkes & Anthony, 1957).

The group is never portrayed to individuals, or their professional referrers, as a panacea, but rather as a 'step on their journey of healing' or a treatment component. With the recognition that the damage of childhood is often immense, and successful treatment possibly a lengthy process, the group is best viewed as ameliorating the effects rather than curing individuals forever.

Experiences with these groups and a statistical evaluation of the outcomes are presented and discussed in this paper.

Methods

Selection of group members

GASCA is a closed group running for 15 weekly sessions of one and a half hour's duration, followed by a reunion after an interval of two months. Selection for the two groups was as follows. Applicants were invited to come for an individual interview of between 30 and 45 minutes duration where the co-leaders and prospective group member mutually discussed and decided the suitability of this treatment method for them. While recognising

and acknowledging that the interview process could be a stressful experience for each applicant, it was important that the relevant issues were explored in full.

Referrals for the group were invited from professionals of women of 21 years and over, with no upper age limit. Each individual should have disclosed childhood abuse, and this was confirmed at interview. GASCA is not an exploratory group for women who are experiencing confusion regarding the validity of their childhood experiences and such referrals were directed sensitively towards more appropriate professional intervention and support. Additionally, individuals must have suffered a period of abuse rather than an isolated incident. This is not to minimise the trauma of, for example, a rape, but rather recognises that the dynamics of family relationships explored within the group are not usually common to an isolated experience.

At the interview each individual was asked to describe briefly her childhood abuse. Although painful, this was necessary to establish whether she would be able to participate within a groupwork setting. Each woman was also asked the likely impact on them of hearing the experiences of other group members, which at times could be traumatic and distressing.

A significant aspect of the interview was the exploration of whether an individual had the time, commitment and emotional energy to pursue fully the rigours of this therapeutic work. It is the experience of the group co-leaders that those who are undergoing current crises, such as compulsory removal of their children, drug or alcohol detoxification, domestic violence or acute mental health problems would not be able to engage fully in the treatment programme. For such individuals, re-referrals to a future GASCA group at a time of greater personal stability are accepted. Cole & Barney (1987) state the importance of a screening interview.

The interview was also an opportunity for prospective group members to gain information regarding any aspect of the group, in particular expressing any personal concerns they may have. The time was therefore spent in laying the foundations of trust and safety, the pre-conditions essential before any therapeutic survivor work can commence.

Confidentiality is of paramount importance (Draucker, 1992).

Where women share the most intimate details of their lives, it is essential that they do so in a place of complete safety, and consequently any breach of confidentiality results in loss of group membership. At interview this was stressed to each individual, and the exceptions of self-harm and child protection issues were explained. Where these are suspected disclosure to the relevant agencies might be necessary to ensure the safety of individuals. Such action was rare and had only been necessary on two occasions.

Groupwork programme

There are many themes that can be covered in therapeutic survivor work, but not all are relevant to each individual. Consequently, each groupwork programme reflects the needs of its particular members. Over time, the co-leaders have found that a number of themes appear common to all groups and specific exercises to address these are incorporated into each programme. The first session for each group commences with a 'brainstorm' exercise that helps the women recognise their legacy of abuse. In this way the commonality of symptoms, once articulated, has the effect of breaking down their sense of isolation and uniting them as a group. Such isolation is invariably experienced by survivors of abuse and is often linked to the abusers' use of secrecy and shame as a way of silencing their victims. A self-rating questionnaire (Buckingham & Parsons, unpublished), rating from zero to 10 certain perceptions commonly held by survivors about themselves, is completed by individuals and sealed in an envelope. It is re-issued in the final session when the exercise is repeated and a comparison of the two scorings highlights the amount of progress made in specific areas. This method of self-evaluation has been used in every group and is separate from the psychological evaluation discussed in this paper.

In the second session group members create individual button sculpts by choosing particular buttons to represent significant people in their lives. The arrangement then depicts relationships within their lives. This visual tool has proved extremely effective in eliciting the feelings associated with their abuse and damaged family and personal relationships.

Subsequent sessions often incorporate an exercise designed

to respond to issues relevant to the particular group. Guided fantasies, therapeutic stories and poems have been used. There is an emphasis on 'inner child' work (Bradshaw, 1990) and letter writing and artwork as vehicles for the expression of feelings. Gestalt (Perls, 1974) has always been used as a particularly powerful technique, enabling survivors to direct their anger in a personal way towards a significant person in their absence. In this way it is possible to address a perpetrator who is deceased.

The nature of the work is inevitably a painful process for the women, especially as it is not confined to the duration of each session. Feelings that have been triggered during a session continue to emerge during the following days and each group member is encouraged to share these at the beginning of the next group meeting. In this way their experiences are validated as the other women witness them. Time is always allowed for group interactions and the support given and received can be very powerful. Some sessions are used for free discussion and to consolidate progress by reflection on the process to date; this is particularly important following exploration of very painful experiences.

Group one commenced with seven women and Group two with six; all were survivors of sexual abuse. In the first group one member left following a car accident and her testings were not completed. Another group member attended intermittently and also did not complete the testings. A third member was absent for the first session and failed to complete a testing sent to her. She therefore could not be included in the results. In the second group a member was asked to leave due to a breach in confidentiality. Additionally one member failed to complete her final testings, and had moved from her known address. Consequently, a total of eight group members, four in each group, completed full testings.

Group profiles

The mean age of the eight group members completing questionnaires was thirty-eight years, the range being from 28 to 47 years. Seven women were White British and one woman was Black African. Regarding the history of abuse, the age at onset was between two and twelve years and, for half the group members, the abuse started

in middle childhood, when six to eight years old. No individual was abused for less than two years and five were abused throughout their childhoods and into late adolescence, in one case continuing into adulthood. Of the eight women six were abused by family members. All perpetrators were male and two women reported multiple abusers.

Six women had experience of individual therapy, this being current for four women at the time of referral. The treatment for two women had ended three and six years ago prior to group entry. The remaining two group members had had no previous therapeutic experience. No individuals were engaged in any other form of therapy whilst attending the group. Consequently clinical improvements measured were attributed to the groupwork treatment and not any concurrent therapy.

Quantitative evaluation tools

The Trauma Symptom Inventory (TSI) and the Symptom Checklist Revised (SCL90-R) were used in order to evaluate the outcome of the treatment. These are standard tests in this field, which are known to have very good reliability and validity. These were administered to each person at the very beginning of the groups, on the last sessions of the groups and two months after the groups had ended at the post-treatment follow-up session. The Consultant Clinical Psychologist specialising in trauma work within the Health Trust chose the evaluative tools and her assistant psychologist scored the questionnaires of the group members.

The TSI, (Briere, 1995), is a 100-item self-report test of post-traumatic stress and psychological distress following traumatic events. This was developed to provide a comprehensive quantitative system for assessing psychological trauma. It was designed to measure the effects of rape, spouse abuse, physical assault, combat, major accidents, natural disasters, as well as childhood abuse and other early traumatic events. The scales of the TSI assess a wide range of psychological impacts. These include not only symptoms typically associated with post-traumatic stress disorder (PTSD) and Acute Stress Disorder (ASD) but also interpersonal difficulties often associated with more chronic psychological trauma.

The inventory asks the subject to read each item, then to indicate

how often it has happened to them within the last six months. Subjects are asked to rate this on a scale ranging from zero to 3. Rating zero indicates that it has not occurred at all, whilst 3 would indicate that it has happened often in the last six months.

The SCL90-R (Derogatis, 1983) is a 90-item self-report symptom inventory designed to reflect the psychological symptom patterns of psychiatric and medical patients and it was routinely employed within the Community Mental Health Service. Choosing this tool for the evaluation of GASCA was based on its successful use over a period of time. Subjects were asked to read through a list of problems or complaints that people sometimes have and rate how much discomfort this had caused them personally within the last week. Each item of the SCL-90 is rated on a five-point scale of distress (0-4) ranging from not at all distressing with a rating of 0 to extremely distressing with a rating of 4. This is then scored and interpreted in terms of nine primary symptom dimensions.

Both of the questionnaires measure the extent to which a person reports certain trauma- related symptoms. They measured the following areas: anxious arousal, depression, anger/irritability, intrusive experiences, defensive avoidance, dissociation, sexual concerns, tension reducing behaviours, impaired self-reference, and dysfunctional sexual behaviour. In the areas of depression and anxiety the SCL-90 and the TSI both have scales that measure these. To avoid reporting the same findings twice it was decided to only report the results from the TSI, it being the more specialised test, although the results from the SCL-90 were consistent with these. Although both tests involved answering many questions, a spontaneous rather than a considered response was demanded. The questions were simply worded and sentences brief. Consequently it was possible to complete the initial questionnaires thirty minutes before the first groupwork session commenced and incorporate the first re-testing in the final session. All group members were literate.

Post-treatment follow-up

Two months after the groupwork programme finished, a review session for all members took place. At this session, each group member completed TSI and SCL-90 questionnaires and progress was discussed.

Results

In order to examine whether there was a lessening in symptomatology it was necessary to investigate whether there was a statistically significant difference in scores as the programme progressed. A Wilcoxon Signed Ranks Test was chosen to analyse whether there was any significant difference between the pre-treatment and post-treatment scores. A significant difference was found between the pre-treatment and post-treatment scores in the statistical analysis using a one tailed test. (T = 3, df= 7 p<O.O5).

As may be seen from the graphs (Figures 1 and 2 overleaf) the results show that there was a significant difference in scores as the treatment progressed. All the scales on both tests show a lessening in symptomatology. Two months after the treatment had ended scores on the scales of interpersonal sensitivity, defensive avoidance, dissociation, sexual concerns, dysfunctional sexual behaviour and impaired self-reference had risen slightly but had not reached the clinical elevations that they were at before the start of treatment.

Interpersonal and sexual issues appear to be the main areas that had increased since the group finished.

Both tests have an operational rule for caseness. If the scores on any scale are above a certain value the individual shall be considered a positive diagnosis or a case. This score is 65 or over on the TSI, and 63 or over on the SCL-90. Both authors of the tests acknowledge that this is not sufficient in itself for diagnosis, but has more use as a screening tool in providing a useful diagnostic profile, that can be used in conjunction with other methods to aid diagnosis. This is useful to consider when examining the graphs as all mean scores on all the scales have reduced to significantly below these baselines.

Fig 1
Mean SCL-90 score at the beginning and end of treatment and 2 months later

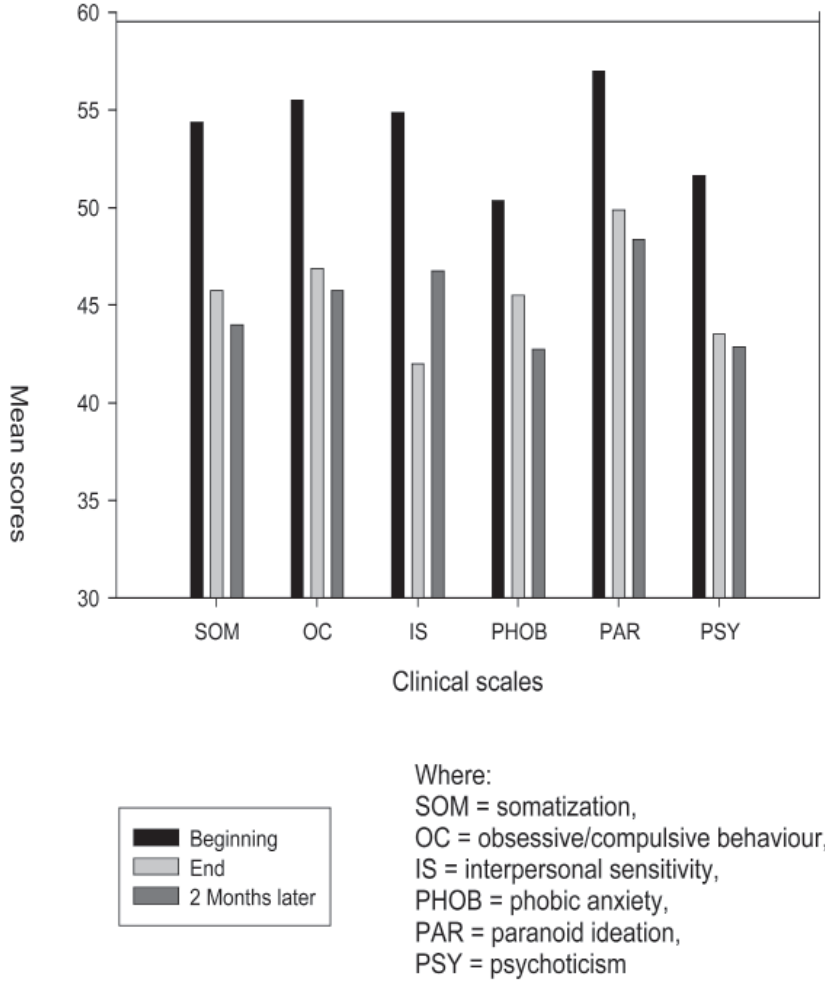
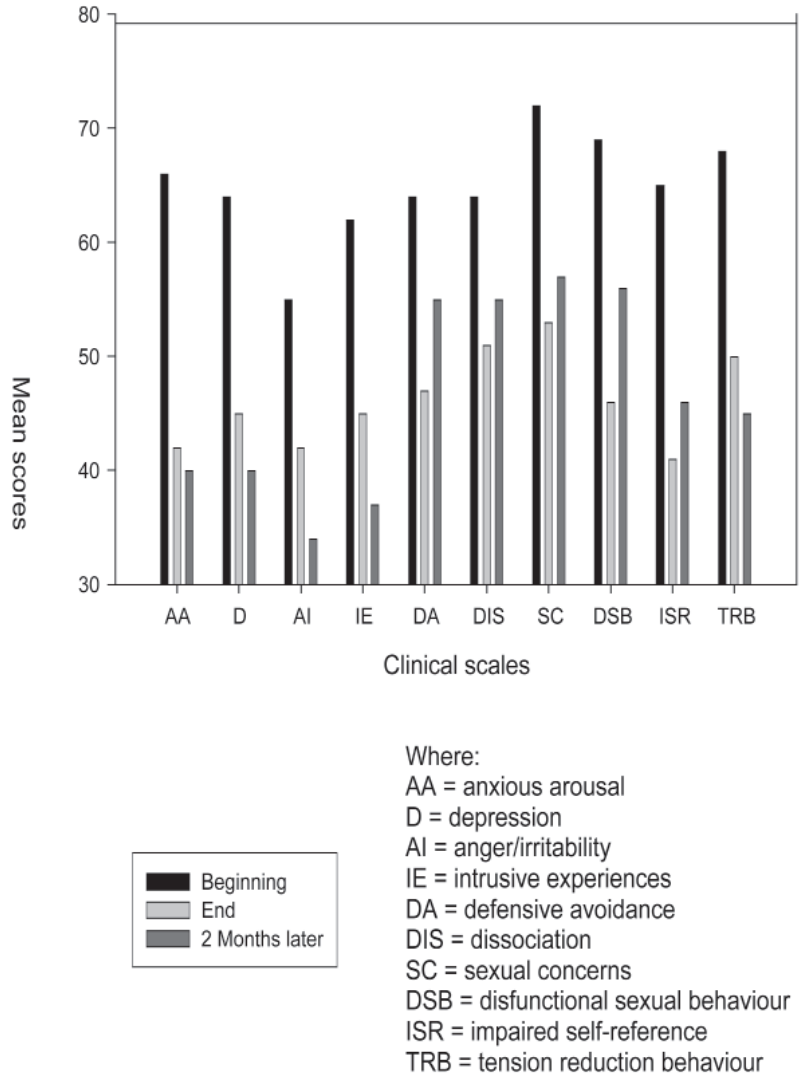


Fig. 2
Mean TSI scores at the beginning and at 2 months after treatment



Discussion

Research into the area has pinpointed several factors that are associated with the severity of the impact of the abuse. Such factors include age at onset of abuse, degree of violence/penetration, number of abusers, frequency and duration, closeness of the perpetrator in relationship to the victim, lack of support figures and the reaction of the non-abusing parent to attempts to disclose the abuse. (Ross 1997).

There appeared little difference between the two groups in terms of the factors listed above. Within both groups there was a victim of multiple abusers. Additionally, early onset of abuse and long duration featured in each group profile. Women from both groups seemed equally motivated and attendance levels were consistently high. We were therefore led to consider other possible factors of relevance to the outcomes.

Group Two's scores were not as clinically elevated as Group One's, even at the beginning of treatment. Also, Group Two had a higher statistically significant outcome than Group One. Not only did Group Two's scores drop to much lower levels than Group One, but they did not rise so much in the two months after treatment, or on as many clinical scales. One reason why the women in Group Two had better outcomes may be partially linked to the fact that all who completed testings were 'professionals', being established in careers and/or having undertaken further education. Research has suggested that people who have more experience of success in controlling their environment have a greater sense of controlling their lives. These people would be more likely to expect success and therefore accomplish more at things they try in the future. (Rotter, 1996, cited in Yule, 1999)).

People often need a degree of stability in their lives to benefit fully from therapeutic intervention and those who have chaotic lifestyles may find it more difficult to concentrate on the treatment programme. In particular, when the healing process becomes very painful and demanding, as is inevitably the case, those individuals can more easily retreat into the familiar chaos of their lives. Within the first group there was some evidence of this when a number of members became preoccupied at times with current relationship

difficulties. This had a direct impact on their ability to focus on the issues directly related to their past abuse. Although within the second group a number of women did have external issues of a similar nature, they exhibited a determination to be free of the past that appeared to keep them more motivated and focused.

Although some women within both groups had disclosed to family members in adulthood, the response to the disclosures appeared not to be the most significant factor relating to subsequent functioning. Non-abusing parents in particular often attempted to minimize the abuse or place some of the responsibility for the events on the women themselves. Of far greater importance was the women's reaction to the response. In Group One women were most likely to attach more importance to maintaining the family status quo, sacrificing their individual well-being for the sake of the family unit. In this way they remained enmeshed in continuing family dynamics, which they experienced as paralysing. Their resultant position differed very little from those who had felt unable to attempt disclosure. The feelings and experiences of childhood were largely unacknowledged and remained unvalidated. For those in Group Two who disclosed, even where there was not a positive response, individuals were not deterred from pursuing openness. Having taken the step they were then determined to have their experiences acknowledged, in particular to dispel the guilt and to lay the responsibility for the abuse firmly at the abuser's door. This may well be associated with their generally higher self esteem linked to the point made above regarding the expectation of success in other areas of their lives.

However, it must be remembered that both groups made positive progress. Within each the significance of support from other group members was observed. Accepting and valuing each other as individuals had the effect of increasing their self-esteem. Additionally this challenged their perception of their roles within family relationships and subsequently released them from much of the guilt and shame. They were then empowered to assert themselves and this greater confidence was evident in both personal relationships and in their working lives.

The slight increase in scores in the two months following the end of treatment may be due to the 'rebound effect'. (Yule 1999) This

suggests in the period immediately following the end of treatment symptomatology often rises as a consequence of no longer having that ongoing level of support, but gradually reduces again. It would have been useful to test the participants again after a few months to try to determine if this was the case; from experience this was not possible. Earlier work had included a review at six months but attendance was very poor. Anecdotally, the main reason given for such poor attendance was that group participants felt that they had moved on and did not want to revisit that phase of their lives

Meeting for a post-treatment review session is important. It is an opportunity for each member to share their experiences of progress and/or difficulties in a way they had become used to during the 15 week programme. The reviews were very well attended, with just one absentee. During the reviews for Group One and Group Two each woman was invited to take her turn to express her thoughts and feelings and then receive feedback from the others. There was, in both sessions, an acknowledgement of how painful a journey it had been for everyone and how, at times, it had seemed impossible to continue. The support and encouragement of group members towards each other, and a newfound trust in others, had made it possible for them to carry on. It was also commented on how the pacing of the work had contributed to the motivation to continue. It was often necessary to slow the pace of the work after particularly difficult sessions when much past trauma had been faced. A session for reflection and discussion always followed such times.

During the final groupwork session, each group member was asked to complete a second self-rating questionnaire. The original questionnaires, completed during the first groupwork session, were then taken from their sealed envelopes and returned to their owners. The scorings and the questionnaires were confidential to the women, who were at liberty to comment or not on the contents. All chose to share their progress and expressed how radically and positively some of their scorings had changed over the fifteen weeks. The women kept their questionnaires for their own use.

The impact of working with survivors of abuse is an issue that must be taken very seriously. Every two weeks throughout the duration of the programme, the facilitators of the work described in this paper received supervision from an experienced

groupwork psychotherapist who specialised in the field of abuse. This supervision allowed both personal and group process issues to be explored and discussed.

When considering the results as they have been presented in this paper, it is important to remember that the figures are mean scores and that some individuals made more progress than others. The group means conceal this variation between people, but it was noted that within Group One there was a greater range of individual scores for a number of the recorded symptoms.

In addition to the formal testing group members completed evaluation forms on the final session of each group, within which there was opportunity for personal comments. Feedback was unanimously positive with all members feeling they had benefited from the programme. The following quotes represent the voices of the women themselves:

It was invaluable to watch, support and share the pain and anguish with everyone at such a deep level.

I feel more at peace with myself and those around me. I have also got to know more about myself. My abusive past has diminished considerably due to the weeks of confronting it.

I feel totally free. I feel I can walk with my head held high. I no longer feel like a victim any more.

The group helped me change my life, change my way of thinking and helped to bring back me.

I have become more independent, less fearful and ready to face the world as me, the whole me.

New head, new heart, new stomach, new woman. Feel alive. The abuse doesn't matter so much, I can get on with my life.

I still can't believe the change in my life.

Conclusion

This is a small but nevertheless positive study. Numbers, although limited, were sufficient to warrant statistical evaluation and these demonstrated positive results. We acknowledge the absence of a control group, however, the primary purpose was not quantitative research but, as indicated in the title of this article, an independent evaluation of an established treatment programme. The group co-leaders, as part of this project, trained two therapists to co-run the groupwork programme. It continues to be offered, under another name, within the community, therefore increasing the availability of this treatment option. In this way it has been possible to replicate the specific method of intervention and to date six such groups have been completed. Further research in this area is needed to confirm the conclusions of this study. The GASCA programme was subsequently run by the co-leaders within a male prison, and the same psychological tests were completed. The authors intend to incorporate the results in a second paper.

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