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## Childhood sexual abuse. Women's Mental and Social Health Before and After Group Therapy

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**Childhood Sexual Abuse**  
**Women's Mental and Social Health**  
**Before and After Group Therapy**

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**2005**

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## Abstract

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Aim: The aim of the study was to evaluate changes in psychological and social variables before and after group therapy for adult women who were sexually abused in childhood. Other aims were to describe and evaluate the trauma-focused group therapy by consumer satisfaction, to describe the women's health before group therapy start and to evaluate the impact of single childhood sexual abuse variables on mental and social health.

Material and Methods: 45 female psychiatric outpatients were treated in 10 different two-year long trauma-focused therapy groups. Each woman was interviewed on admission. Before and after treatment the women answered questionnaires regarding psychological symptoms, social variables and sense of coherence. A 12-months follow-up was done. Inpatient days and sick-listing days were assessed. After treatment termination the consumer satisfaction was evaluated.

Results: The women had mostly been abused at an early age, by a close perpetrator, through serious sexual abuse and over several years. It was common not to have revealed the sexual abuse when it happened, mostly owing to fear of not being believed.

Before treatment, nearly half of the group reported a suicide attempt in their life history. In present life, most of the women had problems with their relationships to men and to women, sexual problems, low self-esteem and somatic pain. Compared to general female groups, the women suffered more from psychological symptoms, were less satisfied with their network, had a poorer social adjustment and poorer values regarding family climate and expressed emotion to their partner.

Improvements after group therapy were found regarding psychological and PTSD-symptoms, sense of coherence, social interaction and social adjustment. Expressed emotion was improved regarding perceived criticism. Family climate, the inpatient days and the sick-listing days showed no improvements. Consumer satisfaction was high. Comparisons were made with a short-term therapy group which also showed satisfying treatment effects. A waiting-list group showed no changes except for improvement of the total social interaction. No differences were found between the groups.

Conclusions: Time-limited and trauma-focused group therapy seems to have positive effects on psychological and PTSD-symptoms, sense of coherence, social interaction, overall social adjustment and perceived criticism from the partner.

## Svensk sammanfattning

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Att barn utsätts för sexuella övergrepp är vanligt, liksom att barnen inte berättar om övergreppen. Bland kvinnor i normalbefolkningen är förekomsten av sexuella övergrepp i barndomen 15% - 30%. Ett sexuellt övergrepp av ett barn eller en tonåring kan definieras som alla handlingar eller situationer med sexuell innebörd, där en vuxen utnyttjar en underårig. Om man utsätts för sexuella övergrepp som barn är risken stor att som vuxen drabbas av psykiska svårigheter såsom t.ex. depression, ångest, fobi, ätstörningar eller missbruk. Också självmordsförsök och posttraumatiskt stressyndrom har ett starkt samband med sexuella övergrepp som barn. Relationssvårigheter till både män och kvinnor är vanligt liksom sexuella problem och smärtproblem. Undersökningar bland kvinnliga psykiatriska patienter har visat att mellan 25% och 77% har varit utsatta för sexuella övergrepp som barn.

En i USA ofta använd behandlingsmetod för kvinnor som utsätts för sexuella barndomsövergrepp är tidsbegränsad och traumafokuserad gruppterapi. Trots att gruppterapimetoderna har olika behandlingstid och använder olika tekniker visar resultaten generellt att psykiska symtom och sociala problem minskar.

Vid en psykiatrisk öppenvårdsmottagning i Lund har sedan 1993 bedrivits gruppterapi för vuxna kvinnor som utsätts för sexuella övergrepp som barn. Behandlingsmetoden är 2-årig och indelad i tre faser. I fas ett får kvinnorna möjlighet att berätta om de sexuella övergreppen och om relationer i ursprungsfamiljen. Under fas två diskuteras och bearbetas svårigheter i kvinnornas aktuella vardagsliv, med hänsyn tagen till det ursprungliga traumat. I fas tre bearbetas separationen från gruppen vilket bidrar till att kvinnornas begynnande autonomi stärks. Kvinnorna har i utvärdering av gruppterapin visat sig vara mycket nöjda med upplägget och bearbetningen av både traumat och nuvarande svårigheter. Att tala om den relation man som barn hade dels till mamman, dels till förövaren, var två av de teman som värderades högst i gruppterapin.

Studien omfattar 45 kvinnor som behandlades i gruppterapin. Före och efter behandling besvarade kvinnorna enkäter gällande psykiska symtom, sociala variabler och egna hälsoresurser (livets meningsfullhet, begriplighet och hanterbarhet). En uppföljning efter 12 månader gjordes också.

I stor utsträckning befann sig kvinnorna i förskoleålder när övergreppen startade. De utsattes för fleråriga och grova övergrepp och förövaren fanns inom familjen eller släkten. Att ha varit utsatt i tidig ålder medförde större psykisk belastning som vuxen. De flesta av kvinnorna hade som barn inte berättat för någon annan om de sexuella övergreppen, framför allt beroende på rädsla för att inte bli trodd.

Före behandlingsstart var relationsproblem till både män och kvinnor vanligt liksom sexuella problem, smärtproblem och lågt självförtroende. Hälften av kvinnorna hade gjort ett självmordsförsök. De allra flesta hade tidigare behandlats i olika former av psykoterapi och knappt hälften använde psykofarmaka.

Jämfört med både en normalgrupp och en patientgrupp omfattande olika diagnoser, hade kvinnorna avsevärt mer psykiska symtom. I förhållande till normalgruppen upplevde kvinnorna sämre stöd från sitt nätverk, hade sämre social anpassning samt uppvisade sämre familjeklimat i både ursprungsfamiljen och den nuvarande familjen. De som hade en partner redovisade ett sämre känslomässigt förhållande än normalgruppen. Också hälsoresurserna var sämre än för normalgruppen.

Efter gruppterapin reducerades de psykiska symtomen, med störst effekt vad gäller depression. Resultaten hade dessutom förbättrats något vid uppföljningen ett år senare. Också de symtom som ingår i posttraumatiskt stressyndrom minskade. Hälsoresurserna förbättrades och hade förstärkts vid uppföljningen. En jämförande gruppterapi med kortare behandlingstid och liknande målgrupp förbättrades likartat men med något lägre värden. Slutenvårdsdagar och sjukskrivningsdagar minskade inte.

Efter gruppterapin förbättrades också upplevelsen av stödet från det sociala nätverket, framför allt vad gäller tillfredsställelsen med antal sociala kontakter. Värdena för den sociala anpassningen förbättrades totalt och speciellt för arbete/studier. Kritik känsligheten i förhållande till partnern minskade, medan ingen förändring noterades i familjeklimatet varken avseende ursprungsfamilj eller egen familj. Gruppen kvinnor som väntade på behandling visade oväntat förbättrad upplevelse av det totala stödet från det sociala nätverket.

Resultatet av studien pekar på att tidsbegränsad och traumafokuserad gruppterapi för kvinnor som utsatts för sexuella övergrepp som barn har god effekt vad gäller psykiska och sociala variabler. Sjukvårdskostnader och sjukvårdsanvändning har visat sig vara högre för kvinnor med denna bakgrund än för kvinnor utan sådana upplevelser. Att utveckla olika traumafokuserade behandlingsprogram för kvinnor som utsatts för sexuella övergrepp som barn torde därför vara kostnadseffektivt och en uppgift för den psykiatriska sjukvården.



## List of Original Papers

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- I      Lundqvist G, Hansson K, Svedin CG, Ekström I.  
Group therapy for women who were sexually abused as children. Description, symptoms and consumer satisfaction. In F. Columbus (Ed), Issues in Domestic Violence. New York: Nova Science publishers Inc.  
Accepted 2005
- II     Lundqvist G, Svedin CG, Hansson K.  
Childhood sexual abuse. Women's health when starting in group therapy.  
Nordic Journal of Psychiatry 2004;58:25-32
- III    Lundqvist G, Hansson K, Svedin CG.  
The influence of childhood sexual abuse factors on women's health.  
Nordic Journal of Psychiatry 2004;58:395-401
- IV    Lundqvist G, Svedin CG, Hansson K, Broman I.  
Group therapy for women sexually abused as children. Mental health before and after group therapy.  
Submitted 2004
- V     Lundqvist G, Hansson K, Svedin CG.  
Group therapy for women sexually abused as children. Social interaction, adjustment and relationships before and after group therapy.  
Submitted 2004

## Introduction

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A child should never be the victim of sexual abuse. If it happens, the child should be taken care of by its parents and be given professional treatment. If this is not the case, the adult person who was sexually abused as a child and suffers from psychological and psychiatric long-term effects, should expect adequate treatment from the psychiatric health-care. In Sweden however, little is known within psychiatric health-care about the prevalence and long-term consequences of childhood sexual abuse. There is, on the other hand, rather a lot of research about adults who have been sexually abused as children and the treatment needed. Most studies come from the USA, New Zealand, England and Canada.

As childhood sexual abuse often gives rise to severe symptoms, there is a need for adequate treatment. The aim of this thesis is to evaluate one form of treatment for adult women who were sexually abused in childhood and who have sought psychiatric help. The focus is on mental and social health. In 1948 WHO defined health as “a state of complete physical, mental and social well-being ...”, but then, in 1986 and in 1991, developed the definition: “Health itself should be seen as a resource and an essential prerequisite of human life and social development rather than the ultimate aim of life. It is not a fixed end-point, a product we can acquire, but rather something ever changing, always in the process of becoming” (Medin & Alexanderson, 2000). This definition has its focus on health as a resource. In the present thesis, mental health and social health are defined through the instruments involved in measuring changes before and after group therapy. Because the thesis focuses on treatment of childhood sexual abuse in adult women, other areas, such as e.g. legal aspects or aspects of how the sexuality has been regarded or developed through the years, will not be discussed.

# Childhood sexual abuse

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## Definition

Exactly which experiences should be denoted as childhood sexual abuse (in the following designated as CSA) are not always clear. There are several definitions. A possible general definition is that sexual abuse of a child or a teenager comprises all acts or situations with a sexual meaning, where an adult interacts with a child/teenager (Svedin, 2001). A child reaches adulthood at the age of 18 years, according to the United Nation's Convention on the Rights of the Child. In studies of childhood sexual abuse however, a child may be defined as an adult already at the age of 14 years. The forms of sexual abuse are often categorised into three groups which are penetration, sexual physical contact and sexual non-physical contact e.g. exposure. The perpetrator is defined as a person either within the family, a relative, an acquaintance or a stranger (Fergusson & Mullen, 1999). Each study of childhood sexual abuse must decide on its own definition.

## History

Sigmund Freud (1856-1939) had a large influence on the development of the historical approach to CSA. He considered (Freud, 1896) that patients with hysterical features had been sexually abused as children by their caregivers, often by their fathers. This was his aetiology of hysteria, based on the stories of sexual abuse from the patients whom he labelled as hysterical. Later he changed his mind (Freud, 1905) and meant that most, but not all, of the reported assaults had not occurred but were incestuous fantasies. The effects (Bolen, 2001) of Freud's renunciation were that most of the reported CSA was perceived as fantasies. If it was proved to be a reality, the young girl was blamed for seducing her father in order to fulfil her incestuous fantasies. This resulted in silencing the victims.

Bolen (2001) continues that during the years 1900 – 1970 the general opinion was that CSA was uncommon. There was also difficulty in understanding why a child should be disturbed as a result of sexual experiences together with adults. But in the 1970s and 1980s the society began to admit the reality of CSA. Studies of incidence and prevalence of child abuse and neglect were made and institutes for treatment were opened.

According to Bolen (2001) there has been a backlash in the 1990s. It has, to a great extent, been related to discussions of whether females are under-identified as offenders and whether fathers are falsely charged for sexually abusing their children. There have also been accusations against clinicians for leading their clients to falsely recall histories of childhood sexual abuse.

## **Prevalence**

### ***Female general studies***

The prevalence of CSA among adult women is estimated to be 15% - 30% (Fergusson & Mullen, 1999). A review of North American studies has shown figures of 30% - 40% (Bolen, 2001). When only physical contact forms of sexual abuse are included Gorey & Leslie (1997) have found that at least 12% of the women have been sexually abused during childhood.

In Scandinavian studies, female prevalence figures have ranged from 8% to 31% (Helweg-Larsen & Larsen, 2002; Sariola & Uutela, 1994; Spak et al, 1998; Tambs, 1994). In a recent investigation among 18 year-old teenagers in Sweden 13.5 % of 2300 females reported having been sexually abused in childhood through penetration (Svedin & Priebe, 2004).

Notable is, that there is a considerable difference between officially reported cases and the prevalence in the whole community (Svedin, 2001). Fergusson & Mullen (1999) report that in approximately 10% of all sexual abuse cases (6% - 32%) the perpetrator is a family member, i.e. a parent, a stepparent or a sibling, and about 18% is a relative. For female victims about 97% (92% - 99%) of the perpetrators are males. The risk is 2 to 3 times higher for females than for males to be sexually abused as children.

### ***Female psychiatric studies***

Studies of CSA among female psychiatric patients, published during the last 15 years, show a prevalence of CSA ranging between 25% and 77%, table 1. Among inpatients the figures were 25% - 77% and among outpatients 25% - 55%.

The studies included a variety of diagnoses, e.g. psychoses, depressions, personality disorders and substance-abuse disorders. Two groups having the same diagnosis could show a different prevalence. Concerning prevalence in different countries, the USA showed the highest prevalence figures, 36% - 77%. Studies from England also showed high figures, 50% - 52%, but other countries such as Denmark and France showed lower scores, 25% and 33% respectively.

In a recent Swedish survey of abuse among psychiatric patients in the same catchment area as the study group, 1382 women participated during one specific week, and 27 % reported having been sexually abused in childhood (Bengtsson-Tops, 2004).

Table 1. Prevalence of CSA among adult female psychiatric patients

Study (reference)	n	Prevalence	Sample	Country
<u>Inpatients</u>				
Chu & Dill (1990)	98	36 %	Mixed diagnoses	USA
Shearer et al (1990)	40	40 %	Borderline	USA
Bryer et al. (1987)	66	44 %	Mixed diagnoses	USA
Beck & van der Kolk (1987)	26	46 %	Active psychosis	USA
Wurr & Partridge (1996)	63	52 %	Mixed diagnoses	England
Margo & Mclees (1991)	38	58 %	Mixed diagnoses	USA
Figuroa et al (1997)	47	77 %	Borderline and/or major depr	USA
<u>Outpatients</u>				
Grilo & Masheb (2001)	111	34 %	Binge eating	USA
Jacobson (1989)	26	42 %	Mixed diagnoses excl schizofrenic	USA
Muenzenmaier et al (1993)	78	45 %	Mixed diagnoses	USA
Lipschitz et al (1996)	86	55 %	Mixed diagnoses	USA
<u>Inpatients/Outpatients</u>				
Glyngdal et al (1989)	92	25 %	Mixed diagnoses	Denmark
Darves-Bornoz et al (1995)	90	33 %	Schizofrenic, bipolar	France
Palmer et al (1992)	115	50 %	Mixed diagnoses	England
Mueser et al (1998)	153	52 %	Severe psychiatric illness	USA

## Symptoms

### *Symptoms of adult women*

Adult CSA women have been found to suffer from many different symptoms. In their meta-analysis of 12 community based studies published since 1990, Fergusson & Mullen (1999) described linkages between CSA and psychiatric or psychological problems in adult life. There was about a two to four times increased risk for a great variety of psychiatric disorders such as depression, anxiety, phobias, eating disorders and substance abuse. Suicidal behaviour and post-traumatic stress disorder showed the highest association with CSA. Concerning sexual adjustment, five community based studies were analysed finding, that when CSA was reported, there were greater difficulties in establishing satisfactory sexual relationships in later life.

Other symptoms reported are somatization, interpersonal relationship problems (Polusny & Follette, 1995) and low self-esteem (Hazzard et al, 1993). Elliot (1994) has found interpersonal discomfort, maladaptive interpersonal patterns and interpersonal hypersensitivity among professional women with CSA compared to non-abused women. Furthermore, Finkelhor et al (1986) has reported of discomfort in responding to own children and difficulties in trusting other people, and DiLillo (2001) of problems with confiding in and communicating to a male partner.

***The impact of different CSA variables***

Different factors are connected with reported symptoms in adulthood. Usually five variables are mentioned - the child's age at onset of abuse, the relationship between the child and the perpetrator, number of perpetrators, the forms of abuse and the duration of abuse (Fergusson & Mullen, 1999). How each sexual abuse variable can affect the adult woman's health probably depends on the actual abuse situation, e.g. if the perpetrator was a family member or a stranger, if the child was a pre-school child or a teenager, if the abuse was penetration or not, if the sexual abuse happened once or over a long period. When assessing the long-term effects of CSA, the abuse variables are usually treated together. Some studies concerning statistically significant relations to separate sexual abuse variables were however found, table 2.

Table 2. Relations between separate CSA variables and severity of symptoms

Symptom	Early age of onset	Long duration	Serious abuse	Close perpetrator	More than one perpetrator
Psychological symptoms		X <sup>5</sup>	X <sup>3, 5)</sup>		X <sup>5)</sup>
Depression			X <sup>9)</sup>		
Phobia			X <sup>9)</sup>		
Obsessive-compulsive			X <sup>9)</sup>		
Chronic depression		X <sup>1)</sup>			X <sup>1)</sup>
Chronic anxiety		X <sup>1)</sup>		X <sup>1)</sup>	X <sup>1)</sup>
Chronic somatisation		X <sup>1)</sup>		X <sup>1)</sup>	
PTSD	X <sup>4)</sup>	X <sup>7)</sup>	X <sup>9)</sup>		
Sexual disturbances			X <sup>3, 9)</sup>		X <sup>2)</sup>
Suicide attempt			X <sup>2, 9)</sup>		
Self-harm or suicide attempt/ideation		X <sup>8)</sup>	X <sup>8)</sup>		
Repeated deliberate self-harm	X <sup>6)</sup>	X <sup>6)</sup>	X <sup>6)</sup>		X <sup>6)</sup>
Personality disorder			X <sup>2)</sup>		X <sup>2)</sup>
Borderline diagnosis	X <sup>4)</sup>				X <sup>2)</sup>
Drug use		X <sup>2)</sup>	X <sup>2)</sup>		
Overdose		X <sup>6)</sup>	X <sup>6)</sup>		X <sup>6)</sup>

(1=Briere & Runtz, 1988; 2=Briere & Zaidi, 1989; 3=Fleming et al, 1999; 4=Heffernan & Cloitre, 2000; 5=Lange et al, 1999; 6=Pettigrew & Burcham, 1997; 7=Rodriguez et al, 1997; 8=Santa Mina & Gallop, 1998; 9=Saunders et al, 1992).

From table 2 it can be seen that it is more traumatic for a child to be sexually abused at an early age, over a long period, through penetration, by a close perpetrator and by more than one perpetrator. Fergusson et al (1996) made an odds ratio analysis of relations between different sexual abuse forms and psychiatric symptoms. Penetration was found to have a high odds ratio ranging from 3.3 for alcohol abuse to 11.8 for suicide attempt. Beitchman et al (1992) concluded in their review that there is a high prevalence of sexual disturbances when the abuse form is penetration or when the perpetrator is a father.

## **The attachment of the child related to CSA**

During the early years, a child develops emotionally as well as physically. To be sexually abused during childhood is presumed to emotionally damage the child. Knowledge about normal psychological development helps us to better understand the nature and extent of the psychological damage.

Bowlby (1997; 1998a; 1998b) presented an attachment theory which was a further development of object relations theory and concerns how parental behaviour affects the child. He suggested that a child, just like any other infant mammal, is born with a biological instinct to adapt actively to the environment in order to survive. It therefore acts with attachment behaviour towards an attachment figure. The attachment behaviour is motivated from the child's primary need to cling to a human being and is independent of the need of food and warmth. The attachment figure, usually the mother, is also biologically adapted to answer the signals of her child and to give protection, safety and proximity. The child's attachment behaviour arouses the mother's care-giving behaviour, which furthermore results in a social interaction between mother and child. Even if the child's primary attachment is usually the mother, other subsidiary attachment figures will gradually be included, e.g. the father and the siblings, arranged in hierarchical order.

The parents develop the ability to be a 'secure base' for the child. The child will make sorties to investigate the environment but it can always return to the base if threatened. If the base is secure, the child will develop a secure attachment comprising the conviction that the mother and the father are there to help when needed. But if the base is insecure or bad, the child will grow up with an anxiety for, or avoidance of, close relationships.

The child who has developed an insecure avoidant attachment is convinced that the mother will not help, and child with an insecure ambivalent attachment does not know whether the mother is there or not, because help is sometimes forthcoming and sometimes not. The child also constructs inner working models, which are its own perceptions of the self, the mother and the nature of the relationship between them. The inner working models develop throughout life as the child grows older and makes new experiences, but its relationship to the first attachment figure is the base for its ability later in life to relate to other people and to separate from them.

The younger the child is at the time of sexual abuse, the more incomplete the psychological personality structure. Finkelhor & Browne (1985) have organized a model of traumagenic dynamics in order to understand how sexually abused children can become psychologically damaged. The model comprises *traumatic sexualization, betrayal, powerlessness and stigmatization*, and states that "a child's sexuality is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion". If the sexual abuse is committed by an adult with whom the child has a deep and trusting relationship, the child feels betrayed. This can result in an experience of all-embracing powerlessness, and also communicate to the child negative feelings such as shame, guilt and badness. The child will incorporate all this stigmatization into a negative self image. These experiences can lead a child to mistrust not only the perpetrator, but all adults and to use sexual behaviours for developmental needs. Later in life, and as an adult there may be difficulties in developing deeper relationships, and

the identity of a victim can become a fact. A greater tendency to become exposed and revictimized may develop as well as low self-esteem, which in turn may lead to self-destructive behaviour.

A similar “self-trauma model” is presented by Briere et al (1996). He describes how sexual abuse can injure a child’s psychological development regarding *identity, personal boundaries and affect regulation*, including affect modulation and affect tolerance. The aversive events affect the child’s development of the ‘sense of internal stability’ necessary for interacting with the environment. The parent-child attachment will be disturbed and the child will protect itself by avoiding close relationships with others.

### **Revealing CSA**

Many children dare not reveal the sexual abuse trauma to an adult (Albach & Everaerd, 1992; Anderson et al, 1993; Boudewyn & Liem, 1995), but keep it secret until they have grown up. According to Summit (1983) this can be understood with the help of the model of “child sexual abuse accommodation syndrome”. Sexual abuse happens in *secrecy* and the child is threatened or persuaded to keep quiet. This brings an experience of *helplessness* to the child, who feels *entrapped* in a dependent relationship to a perpetrator, who again and again abuses the child. The child has to *accommodate* to the abuse situation. The longer the child is quiet, the more difficult it will be to *reveal* what is happening. When the child at last tries to say something, it will be met with *distrust*, because the adult has difficulties in understanding why the child has not said anything before. The adult, often the mother, accuses the child of wanting to send the perpetrator, maybe the father or stepfather, to prison and disrupting the family. In the end there is a high risk that the child will *retract* the story.

### **Individual psychotherapy**

Traumas like CSA have to be treated psychologically. Individual psychotherapy is probably the most common form of psychotherapy. Three studies have been found, describing and assessing individual psychotherapy exclusively for CSA women.

Jehu et al (1986) offered an approximately 24 sessions cognitive-behavioural therapy to 11 women. Improvements pre-test/post-test were found regarding depression but there was no comparison group.

Clarke & Llewelyn (1994) offered seven women 16 sessions of cognitive analytic therapy, especially identifying patterns of interpersonal relationships. Improvements pre-test/post-test were found regarding depression, psychological symptoms, distorted beliefs, and self-esteem. There was no comparison group.

Edmond et al (1999) randomised 59 women to 6 sessions of EMDR treatment (eye movement desensitization and reprocessing), 6 sessions of routine individual treatment



or approximately 6 weeks of delayed treatment. Improvements post-test were found for the EMDR-group compared to delayed treatment regarding anxiety, PTSD-stress, depression and negative beliefs and these results remained stable at 18 months follow-up (Edmond & Rubin, 2004).

Another three studies regarding individual psychotherapy have been found. Chard et al (1997) combined 17 group therapy sessions and 9 individual sessions. Saxe & Johnson (1999) combined group sessions and individual sessions and compared with a waiting-list group having individual sessions. Stalker & Fry (1999) compared 10 group therapy sessions with 10 individual sessions. These three studies are reported in the part of group-therapy.

## **Group therapy**

Group therapy generally is defined (Nationalencyklopedin, 1992) as psychotherapy with several persons at the same time who are unknown to each other. Nearly all theoretical schools of psychotherapy engage in therapy in groups. According to a more extensive definition of Corsini (1957) “group psychotherapy consists of processes occurring in formally organized, protected groups and calculated to attain rapid ameliorations in personality and behavior of individual members through specified and controlled group interactions.”

### ***CSA group treatment models***

CSA therapy is often described as a trauma-focused therapy because of its focus on relating the sexual abuse. Many treatment studies report of this focus in their group therapy models, offered to female outpatients who have been sexually abused in childhood (Apolinsky & Wilcoxon, 1991; Carver et al, 1989; Goodman & Nowak-Scibelli, 1985; McBride & Emerson, 1989; Morgan & Cummings, 1999; Paddison et al, 1993; Zlotnick et al, 1997). Most of the groups are closed and have about 6 members. The treatment is mostly time-limited, and the most common treatment duration is between 10 weeks and 6 months. The treatments are usually structured regarding stages, themes or complementary techniques such as homework, role-playing, empty chair, and writing letters. The most common practice is for a group to have two female group leaders. Simultaneous individual therapies for the patients as well as meetings between the group sessions are often encouraged.

### ***Evaluation of group therapy effects on psychological and psychiatric variables***

Trauma-focused group therapy has been shown to reduce psychological and psychiatric symptoms among CSA women. Group therapy evaluation studies published during the latter 15 years are presented in table 3.

The studies in table 3 show the reduction of different psychological and psychiatric symptoms totally and regarding sub-scales e.g. depression and anxiety, as an effect of trauma-focused group therapies for CSA women. A number of the studies in the table compared to waiting-list groups, showing improvements for the therapy groups, and with results that remained constant from post-test to follow-up. One study (Stalker &

Fry, 1999) compared group therapy with individual therapy and found improvements for both groups. Chard et al (1997) showed results when combining group sessions and individual sessions. Saxe & Johnson (1999) combined group sessions and individual sessions and compared with a waiting-list group having individual therapy. There were improvements for the group therapy group.

Table 3. Reduction of psychological/psychiatric symptoms related to group therapy

Symptoms	Reference
Psychological symptoms	1, 3,4, 5, 7, 8, 9, 15, 16, 17
Depression	1, 2, 4, 6, 8, 10, 11, 12, 13, 14, 15, 18, 19
Anxiety	5, 11, 13
PTSD symptoms	4, 5, 10, 15, 16, 20
Trauma symptoms	7, 16, 20
Fears	1

(1=Alexander et al, 1989; 2=Apolinsky & Wilcoxon, 1991; 3=Carver et al, 1989; 4=Chard et al, 1997; 5=Cloitre & Koenen, 2001; 6=Hall et al, 1995; 7=Hazzard et al, 1993; 8=Kreidler et al, 1999; 9=Longstreth et al, 1998; 10=Morgan & Cummings, 1999; 11=Paddison et al, 1993; 12=Richter et al, 1997; 13=Rieckert & Möller, 2000; 14=Robets & Lie, 1989; 15=Saxe & Johnson, 1999; 16=Stalker & Fry, 1999; 17=Talbot et al, 1999; 18=Threadcraft & Wilcoxon, 1993; 19=Westbury & Tutty, 1999; 20=Zlotnick et al, 1997)

#### ***Evaluation of group therapy effects on social variables***

Trauma-focused group therapy has been shown to have positive effects on social variables in CSA women. Group therapy evaluation studies published during the latter 15 years are presented in table 4.

Table 4. Positive impact on social variables related to group therapy

Symptoms	Reference
Social adjustment	1, 7
Psychosocial functioning	10, 12,
Self-esteem/self-worth/self-concept	2, 5, 6, 8, 9, 11, 13
Assertiveness	3
Intrusion	11
Avoidance	11
Social support from friends and family	11
Sexual functioning	10
Isolation	4

(1=Alexander et al, 1989; 2=Apolinsky & Wilcoxon, 1991; 3=Cloitre & Koenen, 2001; 1995; 4=Gorey et al, 2001; 5=Hazzard et al, 1993; 6=Kreidler et al, 1999; 7=Morgan & Cummings, 1999; 8=Richter et al, 1997; 9=Rieckert & Möller, 2000; 10=Robets & Lie, 1989; 11=Saxe & Johnson, 1999; 12=Stalker & Fry, 1999; 13=Threadcraft & Wilcoxon, 1993)

The studies in table 4 show improvements concerning social variables e.g. adjustment, psychosocial functioning, interpersonal problems and self-esteem/self-worth/self-concept as effects of trauma-focused group therapies for CSA women. A number of the studies in the table were compared to waiting-list groups, showing improvements for the therapy groups, with results that remained constant from post-test to follow-up. One study (Stalker & Fry, 1999) compared group therapy with individual therapy and found improvements for both groups. Saxe & Johnson (1999) combined group sessions and individual sessions and compared with a waiting-list group having individual therapy. There were improvements for the group therapy group.

## **Aim**

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The aim of the study was

- to describe a trauma-focused group therapy method
- to evaluate the level of consumer satisfaction
- to describe the women's health when starting in group therapy
- to describe the impact of CSA variables on the adult women's health when starting in group therapy
- to evaluate changes in psychological and social variables, measured by different self-questionnaires, before and after group therapy, and at a 12 months follow-up

## Material and Methods

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### Background

The research project started as a clinical project with support from the Swedish National Board of Health and Welfare. This start led to few considerations of the research aspects. Evaluation material was collected and if this material was to be used in the research project, the design had to be acceptable. There was however, a possibility of adding some more questionnaires for the 23 last treated women and to carry out a 12 months follow-up for these women.

### Group therapy model

The group therapy model for women who had been sexually abused in childhood was a trauma-focused therapy. It was based on psychodynamic theory with emphasis on object relations theory (Balint, 1968; Segal, 1976; Winnicott, 1983, 1993). The frame for the group therapy was derived from Yalom's model (1985), and an inner structure was based on the sexual abuse model from Kreidler & Burns England (1990) and Kreidler & Carlson (1991). The group therapy was time-limited to 46 sessions with a phase-divided structure.

- Phase one comprised 22 sessions during 5 months and mostly twice a week. These sessions were designed to allow the women to relate their CSA narratives and to provide for discussion of the climate and the relationships in the family of origin.
- Phase two comprised 15 weekly sessions during 4 months, and these sessions were designed to provide for working through the trauma and its effects on present life.
- Phase three comprised 9 monthly sessions during 9 months that were intended to provide women a chance to work with the separation and to get used to a new state of autonomy.

The group therapy emphasised the therapists actively questioning about the CSA story (Herman, 1998). It also comprised the opportunity of physical contact (Smith Lawry, 1998) in order to work through the women's conviction of having to pay for enjoying being touched and feelings of being sullied and thereby contaminating others.

A description of the process was documented after each session and used to give feedback to the women after each phase. There were two female group leaders who led all the group sessions in all 10 groups. One of the group leaders is the author of this thesis.

## Subjects

### **Study group**

Between 1993 and 2001 at an outpatient treatment unit of the Department of Psychiatry at Lund University Hospital, 45 female outpatients were treated in 10 different two-year long therapy groups focused on CSA. The inclusion criteria were that the women had a memory of the CSA and knew who the perpetrator was. Exclusion criteria were diagnoses of psychosis or ongoing substance abuse. *Sexual abuse in childhood* was defined as

*all physical contact and visual or verbal interaction between a child/teenager up to 18 years old, and a family member, a relative or a person who, in the place of a relative, has a position of trust in the family, in which the child/teenager is used to sexually stimulate the perpetrator or someone else (Allender, 1993; Courtois, 1988).*

The reason for the definition was that all kinds of sexual abuse are harmful to the child.

The women were accepted for group therapy consecutively after having been interviewed. The 45 women in the study group are described concerning socio-demographic and abuse variables in table 5. Of the 45 women, 38% were workers, 27% were lower-level employees, 15% were higher-level employees, 9% were studying at upper secondary school and 11% were studying at university/college (SCB, 1995).

### **Reference groups**

The study group was assessed before the start of group therapy regarding

- health (paper 2) and compared with three general groups and three clinical groups
- impact of separate CSA factors on health (paper 3) and compared with one general group and one clinical group.

- 1) The *general group* concerning *psychological symptoms (SCL-90)* comprised a population of 707 women with mixed ages (Fridell et al, 2002). The age range was from 18 to 63 years and the women were mostly studying at university/college or working within health-care.
- 2) The *first clinical group* comprised 955 female inpatients and outpatients with mixed diagnoses and ages (Fridell et al, 2002). The age range was from 17 to 77 years. The diagnoses included borderline personality disorder, neurosis, schizophrenia, eating disorder, suicide attempt, somatic pain, panic disorder, alcoholic and narcotic abuse, and there were also patients in psychotherapy.
- 3) The *second clinical group* comprised 162 female outpatients with mixed ages who had all been sexually abused as children. The mean age was 33 years (Gold et al, 1999).
- 4) The *general group* concerning *social interaction (ISSI)* comprised 180 mothers (Samuelsson, 1995).
- 5) The *clinical group* comprised 42 female inpatients that had all made a suicide attempt (Magne Ingvar, 1999). The age range was from 19 to 81 years.

- 6) The *general group concerning social adjustment (SAS-SR)* comprised 277 women of mixed ages (Weissman et al, 1978). The age range was from 25 to 65 years and more.
- 7) The *clinical group* comprised 155 female patients with acute depression (Weissman et al, 1978). The age range was from 18 to 64 years.

### ***Comparison groups***

The study group was assessed before and after treatment (paper 4 and 5) as well as at 12 months follow-up (paper 4). Comparison groups were the waiting-list group and a short-term focused therapy group.

- 1) *The waiting-list group* was used as a comparison group for measuring psychological symptoms, sense of coherence, social interaction, social adjustment, family climate and questions about family members at admission and 5-13 months later, median 11.5 months, when offered participation in a therapy group. The 10 women in the group were interviewed in the same way as the women in the study group. They also answered the same questionnaires on admission and later. The 10 women in the waiting-list group are described concerning socio-demographic and abuse variables in table 5.
- 2) *A short-term focused therapy group*, conducted at the department of psychiatry at Östersund Hospital and comprising 22 women, was used as another comparison group for measuring psychological symptoms (SCL-90) and sense of coherence (SOC) before and after group therapy and at a 12 months follow-up. The group therapy was time-limited to 20 weekly sessions including 6 topics with focus on CSA and its effects. Inclusion criteria were that the women had a memory of CSA, knew who the perpetrator was, had a symptom level of specialised psychiatry and a wish to work in a group. Exclusion criteria were diagnosis of ongoing psychotic symptoms or ongoing substance abuse, and the patients were not to be acting out.

The group therapy model was based on group theory according to Foulkes (1979) and Bion (1974) together with psychodynamic theory according to Dewald (1973) and trauma theory according to Herman (1998). Furthermore, gender theory according to Åsberg (1998), Lazerson (1992), and Rossiter et al (1998) was very prominent.

Of the 22 women, the last 14 women were also treated with 15 minutes of body-awareness therapy according to Roxendahl (1985), Mattsson (1998), and Lundvik Gyllensten (2001). There were no statistically significant differences concerning psychological symptoms (SCL-90) either before or after treatment, between the group having and the group not having body-awareness therapy. The short-term group is described regarding socio-demographic and abuse variables in table 5.

Table 5. Socio-demographic and CSA variables for the women in the study group, the waiting-list group and the short-term group

Variables	<u>Study group</u> n=45 n (%)	<u>Waiting-list group</u> n=10 n (%)	<u>Short-term group</u> n=22 n (%)	<u>Kruskal-Wallis Test</u> p-value
Cohabits/married/living separately	25 (56 %)	4 (40 %)	13 (59 %)	n.s.
Children	24 (53 %)	6 (60 %)	17 (77 %)	n.s.
Compulsory school	7 (16 %)	1 (10 %)	4 (18 %)	n.s.
Upper secondary school	20 (44 %)	3 (30 %)	7 (32 %)	n.s.
University/college	18 (40 %)	6 (60 %)	11 (50 %)	n.s.
Work/studies	30 (67 %)	7 (70 %)	14 (64 %)	n.s.
Unemployed	12 (27 %)	1 (10 %)	1 (5 %)	n.s.
Perpetrator - bio father	20 (45 %)	6 (60 %)	6 (27 %)	n.s.
Penetration (oral, anal, genital)	24 (53 %)	5 (50 %)	20 (91 %)	**
Age at onset ≤ 6 years	23 (51 %)	5 (50 %)	12 (55 %)	n.s.
More than one perpetrator	15 (33 %)	3 (30 %)	9 (41 %)	n.s.
Duration > 5 years	30 (67 %)	6 (60 %)	14 (64 %)	n.s.
Mean age (years)	34 (20 - 54)	41 (28 - 55)	39 (25 - 54)	*

Statistical significant difference between the three groups:

n.s.=no statistical significance, \*=p<.05, \*\*=p<.01

## Procedure

A 2 hour admission interview with each woman was conducted by the group leaders regarding the present life, the sexual abuse history and the family of origin. At the end of the interview a questionnaire was filled in to provide socio-demographic data, and to answer questions about health, relationships, earlier psychiatric contacts, and history of sexual abuse. After receiving both verbal and written information about the treatment model and the research project, the woman gave her written consent to participate in the research project. Forty-four of the 45 women were given a diagnosis of posttraumatic stress disorder (PTSD) according to the DSM-IV system (1994). The 23 last treated

women were interviewed about the PTSD symptoms according to the DSM-IV system (1994) after group therapy. In certain cases there could also be other diagnoses.

The 45 women, who took part in the group therapy, were asked to answer a questionnaire about psychological symptoms (SCL-90), a questionnaire about social interaction (ISSI) and a questionnaire about social adjustment (SAS-SR).

The 23 last treated women were also asked to answer a questionnaire about sense of coherence (SOC), a questionnaire about family climate, a questionnaire concerning questions about family members and a questionnaire about life events. These 23 women also participated in the 12 months follow-up.

Concerning the evaluation of the group therapy, all the 45 women after termination of the group therapy were asked to answer a questionnaire about their satisfaction with the therapy, and an independent evaluator conducted a structured interview (paper 1).

## **Instruments**

After the termination of the group therapy a questionnaire was answered and a structured interview conducted.

*The Client Satisfaction Questionnaire (CSQ)* consists of six questions with four possible answers, ranging from 4 points to 1 point (Larsen et al, 1979). A high score shows high satisfaction (for more information see paper 1).

*The structured interview* followed a questionnaire specially designed for this study. The questionnaire comprises both questions with answer alternatives and questions without specific alternatives. The questionnaire has a seven-point scale (Good for 7-6-5, No importance for 4, Bad for 3-2-1) and comprises 32 questions (for more information see paper 1).

Before and after group therapy or waiting period respectively, questionnaires were answered. At a 12 months follow-up two questionnaires were answered (SCL-90 and SOC).

*The Symptom Check List (SCL-90)* is a self-rating scale with 90 questions measuring present psychological symptoms (Derogatis, 1979). The questionnaire reflects 9 dimensions of psychological symptoms and a total score, Global Severity Index (GSI). The answer alternatives range from 'not at all' (0 points) to 'very much' (4 points). A low score shows good psychological health (for more information see paper 4).

*Sense of coherence (SOC)* is a self-rating 29-items scale measuring a life-attitude in relation to stress-resistance (Antonovsky, 1993). The answer alternatives range from 'never' (1 point) to 'very often' (7 points), and the total score can be 29 – 203 points. A high value seems to show salutogenic properties (for more information see paper 4).

*Life events* is a self-rating questionnaire with 31 questions, measuring if life events have happened or not happened during a defined time period. The total score can be 31



points, and there is no selection between positive and negative values of the life events. The instrument has been tested in a Swedish twin study (Reiss et al, 2001a; Reiss et al, 2001b). In the present study the instrument was used for measuring if the life events had any effects on the SCL-90 and SOC values (for more information see paper 4).

*The Interview Schedule of Social Interaction (ISSI)* is a self-rating scale (Henderson et al, 1981) which in its abbreviated and Swedish version (Undén & Orth-Gomér, 1989) has 30 items measuring social integration and attachment both totally and in 4 sub-scales. A high score shows good social integration and attachment (for more information see paper 5).

*The Social Adjustment Scale (SAS-SR)* is a self-rating scale with 54 variables (Weissman & Bothwell, 1976) measuring social adjustment both overall and within 7 sub-scales. The questionnaire was used in its Swedish version (Hansson et al, 1992). The answer alternatives range from about 'manage very well' (1 point) to 'manage very badly' (5 points). A low score shows good social adjustment (for more information see paper 5).

*The Family Climate Test* is a family diagnostic questionnaire in checklist form with 85 adjectives, representing the family's emotional state. At least 15 adjectives are chosen and underlined (Hansson, 1989a). The test is homogenised into 4 factors (for more information see paper 5).

*Questions of family members* is a self-rating scale with 30 items measuring expressed emotion in relation to one person in the family (Hansson & Jarbin, 1997). The answer alternatives range from 'almost never' (1 point) to 'nearly always' (5 points). The scale is subdivided into 4 sub-scales (for more information see paper 5).

An overview of instruments, groups and measuring occasions in the study is presented in table 6.

Table 6. Overview of instruments, groups and measuring occasions in the study

Instrument	Before treatment	After treatment	Follow-up	Comparison group	Paper
CSQ		X		-	1
Structured interview		X		-	1
SCL-90	X			General 1/Clinical 1	2
	X			General 1/Clinical 2	3
	X	X	X	Waiting/Short-term	4
SOC	X	X	X	Waiting/Short-term	4
Life events	X	X	X	Waiting-list group	4
ISSI	X			General 2/Clinical 3	2
	X	X		Waiting-list group	5
SAS-SR	X			General 3/Clinical 4	2
	X	X		Waiting-list group	5
Family climate	X	X		Waiting-list group	5
Questions of family members, partner	X	X		Waiting-list group	5

*Inpatient days* were assessed during 2 years before and during 2 years after the group therapy, through the register of the National Board of Health and Welfare.

*Sick-listing days* were assessed during 2 years before and during 2 years after the group therapy, through the register of the Swedish regional social insurance office.

### **Ethics**

The study was approved by the Ethics committee of Lund University Hospital (LU 274-92 and LU 398-97).

### **Statistics**

Non-parametric methods for statistical calculations were chosen owing to the somewhat uncertain normal distribution and small groups. The statistic programme SPSS version 11.5 and 12.0 was used. Group comparisons were made with Wilcoxon Signed Ranks Test, Mann-Whitney Test, Kruskal-Wallis Test, McNemar Test and Pearson Chi-Square Test. To calculate the effect size the Cohen's d-test was used. When comparing data with previously presented studies the method used was t-test, resulting in a significant analysis of mean values with standard deviation, based on a formula recommended by Fergusson (1959).

## Results

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There were 4 dropouts. Two women left the treatment shortly after start. A third woman stayed through the treatment and answered the questionnaires, but did not come to the final evaluation interview. A fourth woman stayed throughout the treatment but skipped the whole evaluation. The women who dropped out were not different from the women in the study group concerning socio-demographic data and sexual abuse variables.

Pre-test comparisons were made (Kruskal-Wallis Test) between the study group, the waiting-list group and the short-term group concerning the socio-demographic and sexual abuse variables, table 5. There were two significant differences. The women in the waiting-list group and the short-term group were slightly older and the women in the short-term group were more abused through penetration.

Comparisons were also made between the study group and the group of evaluation studies (see table 3) concerning socio-demographic data and CSA variables. The groups were similar, but the evaluation studies did not have the inclusion criteria of perpetrators among family and relatives. The exclusion criteria were the same, but some evaluation studies also had a criterion of not being suicidal.

### **Paper I – Group therapy for women who were sexually abused as children. Description, symptoms and consumer satisfaction**

The group therapy method was presented and consumer satisfaction assessed. Owing to the fact that the number of group sessions was increased in the middle of the study period, the first therapy groups, 1 – 5, were compared with the later therapy groups, 6 – 10, regarding consumer satisfaction. Six questions were answered according to the Client Satisfaction Questionnaire (CSQ). The therapy groups 6 – 10 evaluated four of six questions higher than the earlier therapy groups, 1 – 5, and the question ‘Meeting needs’ was statistically significant. For the total group the highest score was on ‘Recommendation’.

Comparisons were also made between sub-groups comprising group therapy with or without different combinations of simultaneous therapy. The sub-group including physiotherapy had the highest scores in all questions, but there were no statistically significant differences. The second best sub-group had only group therapy.

In the evaluation interview, after having finished the group therapy, 80% - 100% of the women were satisfied and rated as good: the treatment as a whole, the information given, the length of the therapy (2 years), the phase division (3 phases) and the feedback received from and given to the group leaders. The women also evaluated the importance of 29 themes discussed in the group therapy. All themes were rated high and important. The themes with the highest scores were: being abandoned as a child, relationship to mother as an adult, relationship to perpetrator as a child, guilt, how to

handle feelings in the group, relationship to mother as a child, shame, sadness and being able to receive.

In the evaluation interview 93% of the women expressed having acquired a more intensive emotional life and 83% were more satisfied with their relationships to other people. Of the women who had a partner, 81% reported an improved relationship to their male partner, and of the women who were parents, 90% reported better relationships with their children.

The women's health when starting in group therapy is reported in paper II. The influence of childhood sexual abuse factors on women's health is reported in paper III.

## **Paper II – Childhood sexual abuse. Women's health when starting in group therapy**

In the admission interviews the women answered questions about their health. In their life history, 87% had had suicidal thoughts and 47% had made at least one suicide attempt. There were relationship problems in their present life to men for 82%, and to women for 64%. In their present life, 80% had sexual problems and 80% had low self-confidence. Somatic pain was a present problem for 64% of the women.

Among the women 91% had previously tried individual psychotherapy, 22% had tried group psychotherapy and 7% family psychotherapy. At the admission interview, 42% were using psycho-pharmaceuticals.

According to the DSM-IV system (1994), 44 of 45 women were given a first diagnosis 'post-traumatic stress disorder' (309.81) and one woman a diagnosis of 'problem related to alleged sexual abuse of child by person outside primary support group' (995.5). Twenty-four women were given a second diagnosis, and of these 24, six were given a third diagnosis, all diagnoses comprising depression (296.23, 296.24, 300.4, 311), personality disorder (301.81, 301.83, 301.9), anxiety (300.01, 300.02, 300.23) and bulimia nervosa (307.51).

The women were suffering a high level of psychological symptoms (SCL-90), statistically significant higher in relation to both a general female group and a clinical female group. The sub-scales with the highest scores were depression, interpersonal sensitivity and anxiety.

Concerning social interaction / support (ISSI) the women were significantly less satisfied with their networks than a general group of mothers, but there was no statistical significance in relation to the clinical female group. The sub-scale with the lowest score was availability for social interaction.

Social adjustment (SAS-SR) was significantly poorer in relation to a general female group but there was no statistical significance in relation to the clinical female group. The poorest sub-scale was social and leisure.

### **Paper III – The influence of childhood sexual abuse factors on women's health**

Of the 45 women in the study group, 51% were abused when they were  $\leq 6$  years, and, for 67%, the duration of the sexual abuse was more than 5 years. Penetration was the form of abuse for 53%, and 40% were abused through other sexual physical contact. For 45%, the perpetrator was the biological father, for 28% the stepfather/foster-father and for 27%, a male relative. In 33% of the cases there was more than one perpetrator.

In the study group the different sexual abuse variables - age of onset, relationship to the perpetrator, number of perpetrators, abuse forms, and duration - were related to psychological symptoms (SCL-90), to social interaction (ISSI) and to social adjustment (SAS-SR). Regarding age of onset, comparisons were made to a general female group and a clinical female group.

The *early age of onset* ( $\leq 6$  years of age) showed statistically significant higher values compared to later onset (7-18 years of age) for psychological symptoms (SCL-90) total score GSI ( $p < .01$ ) and also for 8 of the 9 sub-scales (all  $p < .05$ ). The early age of onset group was compared with the general female group and had significantly higher values for both the total score and all sub-scales ( $p < .001$ ), but there was no statistical significance in comparison with the clinical female group. For social interaction (ISSI) and social adjustment (SAS-SR) there were no differences between the two groups of age of onset.

When the male relative was the *perpetrator*, compared to the other perpetrator groups, there was a statistically significant higher value for the psychological sub-scale (SCL-90) interpersonal sensitivity ( $p < .05$ ). Being sexually abused by *more than one perpetrator* compared to a single perpetrator showed a significantly higher value on the psychological sub-scale (SCL-90) anxiety ( $p < .05$ ). No differences were found between the perpetrator groups when measuring social interaction (ISSI) and social adjustment (SAS-SR).

The *abuse form penetration* compared to non-penetrative sexual abuse showed a statistically significant difference regarding a poorer social interaction (ISSI) in the sub-scale availability for attachment ( $p < .05$ ). No other differences were found between the abuse forms.

There were no differences between the *duration* groups on the three instruments SCL-90, ISSI and SAS-SR.

In a regression analysis, 15.5 % of the variation in the psychological symptoms according to SCL-90 could be explained by *age of onset, relationship to the perpetrator, abuse forms and duration together*, but only early age of onset was significantly related to SCL-90 ( $p < .01$ ).

Thirty-five women had *not revealed* the sexual abuse when it took place. Thirty-four of the thirty-five women reported several reasons for keeping quiet. The most common reasons were fear of not being believed (71 %), fear of being accused of being willing participant in the sexual abuse (46 %) and fear of being physically punished by the

perpetrator (46%). For 29% the loyalty to the perpetrator was the reason for not revealing the sexual abuse.

The reasons for not revealing were related to the different measuring instruments. Having fear of being accused of being a willing participant in the sexual abuse compared to those without this fear had a higher degree of psychological symptoms (SCL-90) total score GSI ( $p < .05$ ) and higher scores on the 4 sub-scales depression, anxiety, paranoid ideation and psychoticism ( $p < .05$  for all four sub-scales). The group fear of being physically punished by the perpetrator compared with those without this fear showed a higher score on psychological symptoms (SCL-90) sub-scale hostility ( $p < .05$ ) and the social adjustment (SAS-SR) overall scale ( $p < .01$ ).

#### **Paper IV – Group therapy for women sexually abused as children. Mental health before and after group therapy**

The study group, the waiting-list group and the short-term therapy group were compared both within and between the groups. The comparisons within groups were made before and after the treatment/waiting respectively, before treatment and one year after the termination of the study and short-term therapy groups, and after termination and one year later for the study and the short-term therapy groups. The comparisons between the groups were based on the differences before and after the treatment/waiting, before and one year after termination and, finally, after termination and one year after termination.

In *pre-test/post-test* for the study group the *psychological symptoms* (SCL-90) were statistically significantly reduced in total (GSI) and in 8 of the 9 sub-scales. The most evident reductions were seen for GSI, obsessive-compulsive, depression, paranoid ideation and psychoticism (all  $p < .001$ ). The results were maintained at the one year *follow-up* with the exception of the sub-scale hostility. The sub-scale phobic anxiety was not reduced at termination but at follow-up.

For the short-term group there were statistically significant reductions for 4 of the 9 sub-scales (all  $p < .05$ ). At follow-up the results from 2 of the sub-scales were maintained and another 3 sub-scales together with the total score (GSI) were added to the results. In the waiting-list group there were no statistically significant reductions.

In *post-test/follow-up* there was a statistically significant reduction for the study group in the sub-scale somatization, but none for the short-term group.

No statistically significant differences were found between the groups concerning treatment differences or at pre-test, post-test and follow-up, according to the Kruskal-Wallis Test.

Effect size (Cohen, 1992) measures the clinically observable change, where values of .20 or less are considered as small, .50 as medium and .80 or more as large.

Table 7. Effect sizes for SCL-90 and SOC for the study group, the waiting-list group and the short-term group

Variable	Study group		Waiting list group	Short-term group	
	<u>Pre-test/</u> <u>Post-test</u> (n=42)	<u>Pre-test/</u> <u>Follow-up</u> (n=20)	<u>Pre-test/</u> <u>Post-test</u> (n=10)	<u>Pre-test/</u> <u>Post-test</u> (n=18)	<u>Pre-test/</u> <u>Follow-up</u> (n=15)
SCL-90 – Symptom Check List					
GSI (Total)	.59	1.06	.18	.54	.74
Somatization	.52	1.15	.29	.28	.57
Obs.-compuls.	.62	1.07	.21	.33	.57
Int.pers. sens.	.50	.88	.06	.34	.60
Depression	.72	1.29	.09	.56	.89
Anxiety	.56	.93	.10	.71	.69
Hostility	.41	.09	.35	.38	.41
Phobic anxiety	.36	.63	-.11	.12	.22
Paranoid ideat.	.44	.56	.19	.24	.81
Psychoticism	.71	.78	.20	.51	.51
SOC – Sense of coherence					
Total	.39	.76	-.08	.39	-

Cohen's d-test (1988)

Measured in *effect size for psychological symptoms pre-test/post-test* (table 7) the study group showed the highest values for the sub-scales depression, psychoticism and obsession-compulsion, level over medium. The short-term group showed the highest effect size values for the sub-scales anxiety, depression and psychoticism, level medium. The values for the total score GSI were similar for the study group and for the short-term group, level medium.

At *one year follow-up* the effect size in the study group was at level large for GSI as well as for the five sub-scales depression, somatization, obsession-compulsion, anxiety and interpersonal sensitivity. For the short-term group, the effect size for GSI was over medium and at level large for the two sub-scales depression and paranoid ideation. The waiting-list group had at pre-test/post-test a small effect size level.

In *pre-test/post-test of sense of coherence (SOC)*, there was a statistically significant increase in both the study group and the short-term group ( $p < .05$ ), but not in the waiting-list group. There were no differences between the groups. At *one year follow-up* the result for the study group had further increased and there was also a statistically significant increase in the *post-test/follow-up* assessment. These assessments were not performed for the short-term group.

Measured in *effect size of sense of coherence pre-test/post-test* (table 7) the level for the study group was low but had at *follow-up* increased to nearly large. The short-term group had in *pre-test/post-test* the same low level as the study group and the waiting-list group had a negative value.

In *pre-test/post-test* of *posttraumatic stress disorder* according to the symptoms in the DSM-IV system, there was a statistically significant reduction for the study group ( $p < .01$ ), but not for the waiting-list group, and there was no difference between the groups.

The number of *life events* was measured for the study group between termination and follow-up, and for the waiting-list group before and after waiting. The mean value for the study group was 4.0 points of a possible 31 points (range 0-12 points) and for the waiting-list group 3.4 points (range 1-8 points). The comparison within the study group and within the waiting-list group for differences of SCL-90 and SOC showed no statistically significant differences in relation to low or high life events points, based on the median value for the total of the two groups (median 3). The comparison between the two groups showed no difference.

The comparison of *inpatient days* during 2 years before and during 2 years after treatment in the study group revealed a large reduction, from a total of 986 days before treatment to a total of 86 days after treatment. One patient accounted for 78 % of the inpatient days before treatment. A comparison between high and low values, based on the median (0 days), showed no statistically significant difference.

The comparison between *sick-listing days* during 2 years before and during 2 years after treatment in the study group, revealed a large increase of pension days and a moderate increase of rehabilitation days. There was a total increase in sick-listing days, from 8 962 days before treatment to 11 030 days after treatment. A comparison between high and low values, based on the median (77/78 days) showed no statistically significant difference.

## **Paper V – Group therapy for women sexually abused as children. Social interaction, adjustment and relationships before and after group therapy**

The study group and the waiting-list group were compared both within and between groups. The study group was compared before and after treatment, and the waiting-list group on admission and later. Comparisons between the groups were based on differences before and after treatment or waiting respectively, and based on the pre-test and post-test values for the two groups.

In *pre-test/post-test* in the study group for *social interaction / support* (ISSI) there were statistically significant improvements totally and in 3 of the 4 sub-scales. The most marked improvements were seen for the total score and the sub-scale ADSI, adequacy of social integration ( $p < .001$ ). The effect size (Cohen, 1992) level totally and for the sub-scale ADSI (table 8) were medium and over medium, respectively.



Table 8. Effect sizes for ISSI, SAS, Family climate and Questions about family members - partner for the study group and the waiting-list group

Variable	<u>Study group</u> Pre-test/Post-test (n=42)	<u>Waiting-list group</u> Pre-test/Post-test (n=10)
<b>ISSI – Interview Schedule of Social Interaction</b>		
Total	.55	.47
AVSI - Availability of social integration	.45	.22
<u>ADSI</u> – Adequacy of social integration	.64	.29
<u>AVAT</u> – Availability of attachment	.26	.56
<u>ADAT</u> – Adequacy of attachment	.30	.48
<b>SAS-SR – Social Adjustment Scale</b>		
Overall	.53	.18
Work/Studies/Homework	.56	-.16
Social and leisure	.35	.20
Extended family	.29	.38
Marital	.42	-.04
Parental	.25	-.19
Family unit	.16	.16
<b>Family climate, family of origin</b>		
Closeness	.08	-.16
Distance	.25	-.07
Spontaneity	-.02	-.22
Chaos	-.14	-.35
<b>Family climate, current family</b>		
Closeness	.33	.05
Distance	.19	.03
Spontaneity	-.14	.23
Chaos	.26	-.27
<b>Questions of family members - partner</b>		
Perceived criticism	.89	-.32
Perceived emotional involvement	.10	.00
Critical remarks	.41	1.08
Emotional over-involvement	.15	.25

Cohen's d-test (1988)

In the waiting-list group the total score was statistically significantly improved ( $p < .05$ ) and the effect size was nearly medium. The highest effect size level, medium, was for the sub-scale availability of attachment (AVAT).

No differences were found between the groups when comparing differences before and after treatment/waiting respectively, nor when comparing pre-test values or post-test values, according to the Mann-Whitney Test.

In *pre-test/post-test* in the study group for *social adjustment* (SAS-SR), there were statistically significant improvements in the overall score and in 2 of the 7 sub-scales, most evident for the overall score and the sub-scale work/studies/homework ( $p < .001$ ) with effect size level medium for both (table 8). In the waiting-list group there were no statistically significant improvements.

No differences were found between the groups when comparing differences before and after treatment/waiting respectively or for pre-test values, according to the Mann-Whitney Test. Comparison between the post-test values for the two groups showed a statistically significant better value ( $p < .05$ ) in the sub-scale work/studies/homework for the study group.

In *pre-test/post-test* of *family climate in the family of origin* there were no statistically significant improvements for either the study group or the waiting-list group, and no differences between the groups. Effect size values are reported in table 8. Comparing the pre-test values for the two groups, there was a significantly higher value ( $p < .05$ ) in the sub-scale chaos for the study group.

In *pre-test/post-test* of *family climate in the current family* there were no statistically significant improvements for either the study group or the waiting-list group, and no differences between the groups. Effect size values are reported in table 8.

In *pre-test/post-test* of *expressed emotion concerning the partner* there was a statistically significant reduction for the study group in the sub-scale perceived criticism ( $p < .05$ ). Effect size was large (table 8). The waiting-list group only comprised 4 women.

## Comparisons with reference groups

The study group, the waiting-list group and the short-term group were all compared with reference groups within respective instruments (table 9).

Table 9. Comparisons between reference groups and the study group, the waiting-list group and the short-term group concerning SCL-90, SOC, ISSI and SAS-SR

Variable	Reference General group M(SD)	Study group		Waiting Post-test (n=10) M(SD)	Short-term group	
		Post-test (n=42) M(SD)	Follow-up (n=20) M(SD)		Post-test (n=18) M(SD)	Follow-up (n=15) M(SD)
SCL-90 (n=707) <sup>1)</sup>	0.49(0.44)	1.10(0.86)	1.11(0.68)	1.19(0.77)	1.46(0.66)	1.28(0.82)
SOC (n=83) <sup>2)</sup>	151(24.5)	116(27.7)	125(26.3)	113(28.6)	113(18.5)	-
ISSI (n=180) <sup>3)</sup>	23.9(5.2)	18.4(8.1)	-	15.7(6.9)	-	-
SAS-SR (n=277) <sup>4)</sup>	1.61(0.34)	2.12(0.53)	-	2.22(0.54)	-	-

<sup>1)</sup> Women with mixed ages (Fridell et al, 2002)

<sup>2)</sup> Women (Hansson & Cederblad, 1995)

<sup>3)</sup> Mothers (Samuelsson, 1995)

<sup>4)</sup> Women with mixed ages (Weissman et al, 1978)

The table shows that all values for the study group, the waiting-list group and the short-term group are poorer than the reference groups, and all comparisons resulted in a statistically significant difference in favour for the reference groups ( $p < .001$ ). This means that in spite of good effects of the trauma focused group therapy, the CSA women after treatment still had not reached the level for the reference groups.

## Discussion

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The main findings of this thesis were the reduction of various psychological symptoms and symptoms of posttraumatic stress disorder, the increase of sense of coherence and the improvements of social support, social adjustment and perceived criticism related to the partner after the time-limited and trauma-focused group therapy for CSA women.

Other findings were that women with this background seeking help within psychiatric health-care often have been abused in pre-school age, by a family member or a relative, through serious physical sexual abuse and over a long period of time. The women often have suicidal thoughts and make suicide attempts. They have sexual problems, somatic pain, low self-esteem, and have relationship problems regarding both men and women.

Another finding was the high level of consumer satisfaction among the women, after the 2-year long trauma-focused group therapy.

## Limitations

This study had a number of limitations, which makes generalisation somewhat uncertain.

The first limitation was that the study group ran the risk of becoming a selected group of highly motivated women. This may result in an overestimation of the positive outcome and thereby difficult to generalise to all CSA women within psychiatric health-care. Time-limited trauma-focused group therapy was not included among the basic treatments on offer in psychiatric health-care. The women had to ask for it specially and thereby had to reveal their difficult background. Not all CSA women manage to do that. On the other hand, all psychotherapy is based on motivation. The study group was however, compared to the evaluation studies mentioned in the introduction, not different concerning socio-demographic and CSA variables and this increases the value of possible comparisons.

A second limitation was the women's involvement in various other therapies parallel to the group therapy. This may have blurred the more explicit effects of the given therapy, but must perhaps be accepted as the true baseline, when therapy is given patients with complex problems.

A third limitation was that the group therapy started as a clinically based study with no available treatment to compare with. A randomised design was therefore not possible to perform which could have increased the possibilities to draw general conclusions from the study to other CSA women within the psychiatric health-care. There are results indicating a larger effect size at single group studies compared to randomised (Wilson & Lipsey, 2001). The waiting-list group could have been used in a randomised cross-over design, but being on the waiting-list for two years was not considered as an ethical

alternative. Possible comparable groups were a small waiting-list group and another treatment group in another city in the country.

A fourth limitation was the fact that the same person both gave the treatment and collected the self-questionnaires which may generate a risk for “good answering”. The risk was considered greater at the evaluation interview compared to answering the self-questionnaires, whereby an independent evaluator conducted those interviews. Two women dropped out of the group treatment which may be interpreted that the treatment did not suit everyone. Two other women completed the group therapy but did not come to the evaluation interview. Perhaps these women represented more negative opinions.

A fifth limitation was the changed design, where half of the study group answered all the questionnaires and half only some of the questionnaires. Regrettably, this limited the sub-group analyses but, on the other hand, associations were found in spite of the small group sizes. Also, the waiting-list group was small with the risk that differences between groups were difficult to demonstrate, even if they were present.

A sixth limitation was that all the instruments except for post-traumatic stress disorder were self-questionnaires. Clinical interviews about mental and social health would have confirmed the data gathered from the self-questionnaires and thereby validated the information by a two-source strategy.

### **The study group**

At the admission interview, two thirds of the 45 women in the study group were working or studying, and half the group were married/living together/living separately, a frequency which other studies also have reported (Elliot, 1992; Finkelhor, 1986; Polusny & Follette, 1995). Fewer women in the study group had been to college or university than reported in other studies about CSA women (Elliot, 1992; Rodriguez et al, 1997; Rowan et al, 1994; Saunders et al, 1992). Compared with the general population in Sweden however, the percentage of college/university education in the study group was higher, 40 % in the study group vs. 27 % in the general population (SCB, 2003). This higher percentage of college/university-educated women could perhaps be explained by the fact that many studies as this one in Lund, are performed around a university town. In addition, it is likely that those who are better educated make a greater effort in searching for help to find a programme offering special group therapy. Reports of higher level of education in studies are confirmed by other researchers (Rathsman, 2000; Svahnberg, 2003).

The study group was compared with community studies on CSA (Fergusson & Mullen, 1999). Half of the women were abused for the first time when they were younger than seven years of age, compared to community studies with peak ages of risk occurring between 10 and 12 years. The most common CSA forms in the study group were penetration (53 %) and sexual physical contact (40 %). Community studies report considerably less penetration than sexual physical contact (relation 10.1% to 19.2 % in weighted average rates). Close relationship between perpetrator and victim is considered to bring about more disastrous psychosocial consequences (Beithchman et al, 1992). All the perpetrators in the study group were close to the children, even if they

were not exclusively biological fathers (45 %) and stepfathers including foster-fathers (28 %) but also other relatives (27 %). The assumption was that all the women were abused by a perpetrator in a position of trust. In community studies these groups of perpetrators represent about 29 % of all perpetrators (Fergusson & Mullen, 1999). McClellan et al (1996) found associations between an early onset of sexual abuse and abuse by a parent/step-parent. The mean length of duration was 9 years in the study group, which could be compared to the mean length of 6 years in a study of 404 CSA women (Lange et al, 1999).

At the admission interview, most of the women in the study group reported earlier psychiatric contacts and earlier psychotherapy, and nearly half of the group were on psycho-pharmaceutical medication. Yet they continued to seek health-care. Earlier psychiatric contacts such as hospitalisation has been reported to a degree of 18% - 50% (Paddison et al, 1993; Zlotnick et al, 1997). Previous psychotherapy, both individual and in group, has been reported to a degree of 63% - 88% (Carver et al, 1989; Morgan & Cummings, 1999). Hall et al (1995) reported in a group therapy study that the improvements in depression were independent of antidepressant medication. Some of the women in the study group used medication either from the beginning of the group therapy or later on, which indicates that in certain cases there is a need to combine psychotherapy and medication.

### **Group therapy and consumer satisfaction**

The group therapy model was evaluated by the women and the consumer satisfaction was high, even when compared with other studies evaluating an outpatient sample with long-term mental illness (Warner et al, 2000) and outpatient samples within psychiatry in Sweden (Hansson, 1989b; Sandlund & Hansson, 1999). The positive evaluation could partly be explained by the group therapy in itself. CSA women often bear the trauma as a secret within themselves, and “it is only within a group that the secret becomes public knowledge” (Bautz, 1997) and thereby possible to emotionally work with. The trauma isolates but the group recreates a sense of coherence and belonging (Herman, 1998). The length of the group therapy model could be another explanation and thus a risk for positive over-evaluation. Most of the women in the study group would have liked longer group therapy and none wanted shorter treatment.

When comparing other treatment studies of CSA women, there seem to be satisfactory results in spite of different length, different techniques and different approaches to simultaneous therapy (Carver et al, 1989; Morgan & Cummings, 1999; Zlotnick et al, 1997). Most studies however, report that time-limited group therapy seems to make a good contrast to the lack of structure in the family of origin (Goodman & Nowak-Scibelli, 1985; Herman, 1998). The present time-limited group therapy is longer than the American traditional length, i.e. 10 - 24 weeks (Morgan & Cummings, 1999; Talbot et al, 1999), probably influenced by different social security systems.

When the women in the study group also had some form of simultaneous therapy, they considered the group therapy to be the core therapy. The subgroup with simultaneous physiotherapy had the highest evaluation score, but this group included only five women. Feelings of CSA women regarding being “shut off” from bodily sensations and

perceiving their bodies as disgusting have been described both by Sgroi (1982) and by Rathsmann (2000). Perhaps these feelings could be affected by some form of physiotherapy (Horton, 1998; Smith Lawry, 1998). Matsson et al (1998) reported development of health conditions after a body awareness therapy group for CSA women. The evaluation in the study group confirmed the appreciation of being touched.

The subgroups with additional individual therapy and individual therapy combined with physiotherapy respectively, had the lowest scores. It seems that individual therapy does not strengthen the treatment effects (Morgan & Cummings, 1999), and that three simultaneous therapies weaken the ability to focus in therapy. Most of the women however, wanted simultaneous individual therapy, and in many treatment studies women often are required or encouraged to participate in a parallel program of individual therapy (Goodman and Nowak-Scibelli, 1985; Zlotnick et al, 1997).

In the evaluation interview, the different discussion themes in the group therapy were assessed. Two of the most important, and perhaps most painful, themes to discuss were the relationship to the mother as a child, the often non-caring mother, and the relationship to the perpetrator as a child, focusing on his reason for abusing. The theme of the relationship to the father as a child had lower score, even when being abused by a male relative and not by the father. The relationship to the mother as an adult was central and often still characterised by disappointment. Other important themes were concerned with identifying feelings and trying to handle feelings in the group. The working through of feelings of guilt and shame is often pointed out as a special effect in group therapy for CSA women (Apolinsky & Wilcoson, 1991; Goodman & Nowak-Scibelli, 1985; Gorey et al, 2001; Rieckert & Möller, 2000) and these two themes were also highly rated in the study group. The theme concerning being able to receive could be seen as a result of working with themes concerning feelings. The themes associated with the attraction between a man and a woman were less highly rated and seemed to be less interesting for the women at this stage.

The women reported a more intensive emotional life after terminating the treatment, a life characterised by better relationships to others. The group therapy seemed to positively influence the affect dysregulation, which is a common symptom for people with early onset of interpersonal trauma as well as dissociation, somatization, and post-traumatic stress disorder (van der Kolk et al, 1996).

The phases in the present group therapy include a task for the women to relate their CSA narrative. The women are challenged to reveal the secret and thereby must perceive the therapists and the group as a secure base. The telling is perceived as both frightening and positive by the women: "Good to be forced. No possibility of running away." Perris (1996) refers to Bowlby and describe how the sexually abused children perceive the perpetrator as one person in the night and another in the day. This leads to unbearable situations and the children decide to remove these experiences from the consciousness. At the same time the children remove thoughts, feelings and impulses related to the sexual experiences and no conscious working through will be done. By working with the CSA in the present group therapy, these hidden feelings and thoughts are released and the women begin to come into contact with their feelings.

Bowlby perceived depression as an adult symptom stemming from severe disturbances in attachment (Perris, 1996). The evaluation results from the study group show high

rates of depression at the start of therapy and a considerable reduction after group therapy. Having stopped protecting and idealising their mother, the women have the possibility to start mourning her (Bowlby, 1963). Through this, the internal working model can start changing. The therapists show care and the women can begin to perceive their selves as worthy. In turn, this changed internal working model can be transmitted to the children (Bretherton & Munholland, 1999), and provide a better base for development of attachment.

There are trauma theories suggesting that the trauma should not be worked through. Instead the patients learn how to deal with the effects of the trauma in the present (Ehlers & Clark, 2003). The experiences from the study group indicate, counter to the above theory, that women who relate and work through their entire frightening experiences gain a psychological benefit (Herman, 1998).

## Symptoms

### *Before treatment*

On admission the 45 CSA women in the study group were suffering from more psychological symptoms than both a general and a clinical group. Compared to general groups, the study group showed deteriorated social interaction / support, poorer social adjustment, lower level of sense of coherence (Hanson & Cederblad, 1995), poorer scores for family climate both in the family of origin and in the current family (Hansson, 1989a) and for expressed emotion in relation to the partner (Hansson & Jarbin, 1997). These poorer scores are confirmed for CSA women concerning psychological symptoms by Fergusson & Mullen (1999), concerning social support by Gibson & Hartshorne (1996), concerning social adjustment by Jackson et al (1990) and concerning sense of coherence by Renck & Rahm (in press).

According to the symptoms of the DSM-IV system, most of the assessed women in the study group fulfilled the criteria for the diagnosis of post-traumatic stress disorder (PTSD), which has been found in other studies of CSA women seeking outpatient therapy (Johnson et al, 2003; Rodriguez et al, 1997).

Most of the 45 women in the study group reported suicidal thoughts in their life history, and nearly half of the group had made at least one suicide attempt during their lives. Associations between sexual assault and attempted suicide have been reported (Davidson et al, 1996) and between childhood sexual and/or physical abuse and self-harm or suicidal behaviour (Santa Mina & Gallop, 1998). Suicide attempts are indications of possible future suicide, and women are described as having made suicide attempts both in younger ages and inbetween the ages of 50 – 60 years (Brådvik, 2000). Two studies have been found pointing out an association between CSA and repeated suicide attempts (Söderberg et al, 2004; Ystgaard et al, 2004).

Sexual problems and difficulties in relationships with men and women proved to be a major problem in the study group as well as in other studies (Finkelhor et al, 1986; Mullen et al, 1994). Many of the women had somatic pain, which is in accordance with other studies (Finestone et al, 2000; Walker et al, 1999a).



### ***Impact of CSA variables***

The influence of the five CSA variables – *age of onset, relationship to the perpetrator, number of perpetrators, abuse forms, and duration of abuse* – were assessed.

*Age of onset* prior to seven years of age was the factor most consistently related to psychological symptoms (SCL-90), both totally and for eight of nine sub-scales. The link between early onset and symptoms has been confirmed regarding post-traumatic stress disorder and self-harm (Heffernan & Cloitre, 2000; Pettigrew & Burcham, 1997). The risks for life-time alcohol dependence/abuse and for life-time anxiety are found to increase when being sexually abused before the age of 13 years (Spak et al, 1998). In a study of gender mixed, seriously mentally ill adolescents (McClellan et al, 1996) a significant relation was found between onset of sexual abuse prior to seven years of age and inappropriate sexual behaviours.

When a male relative was the *perpetrator*, in comparison to other perpetrator sub-groups, a higher value of interpersonal sensitivity (SCL-90) was found. No other studies have been found describing the impact of a perpetrator outside the family. There was no sub-group difference when the perpetrator was a biological father, which may be a result of the very homogenous sample of clinical cases.

Being sexually abused by *more than one perpetrator* gave rise to more anxiety (SCL-90), which other studies have also confirmed (Briere & Elliot, 2003; Briere & Runtz, 1988).

Different *abuse forms* and different *durations* were not significantly related to psychological symptoms, which may also be explained by the very homogenous sample of clinical cases.

*The abuse form penetration* had a greater influence on social interaction/support (ISSI), the sub-scale available attachment (AVAT) than sexual physical contact. This means that the women sexually abused as children through penetration, as adults find one attachment person but long for more. The attachment person was primarily a female relative or friend, secondly the partner or the psychotherapist. No other study of CSA women measuring social interaction has been found, but higher degree of loneliness and a lower level of network orientation among CSA women has been reported by Gibson & Hartshorne (1996). Furthermore several studies underline the existence of social isolation in incestuous families (Dadds et al, 1991; Flemming et al, 1997; Svedin et al, 2002).

No single abuse variable seemed to influence the social adjustment (SAS-SR). Jackson et al (1990) reported a relation between poorer overall social adjustment and CSA, but no single abuse variable was reported.

### ***Disclosure of CSA***

During childhood, as many as 35 of the 45 women in the study group had not told anyone of the sexual abuse, owing to different fears. They were most afraid of not being believed. This is in accordance with the accommodation syndrome (Summit,

1983), where the child feels entrapped in a dependent relationship to the perpetrator and, as a consequence, keeps quiet. When at last revealing the abuse, the child will often be met with distrust owing to the delayed disclosure.

The two next reasons were fear of being accused of being a willing participant in the sexual abuse and fear of physical punishment. Anderson et al (1993) reports of 252 CSA women where 28% had never told anyone of the abuse and 34% had delayed the disclosure with 1 year or more after the abuse, owing primarily to fear of being blamed and embarrassment. In an American national survey of 3220 women (Smith et al, 2000) with 288 women reporting child rape, 28% had never told anyone. Disclosure latencies longer than one month were associated with younger age at the time of rape, family relationship with the perpetrator and repeated rapes. Another study (Sas & Cunningham, 1995) measuring disclosure as a process rather than as an event, examined 524 prosecuted CSA cases and found that the most common reason for children to postpone their disclosures by more than one year was fear of harm to self or others.

In the study group links were found between more psychological symptoms (SCL-90) and fear, as opposed to no fear, of being accused of being willing participant in the sexual abuse. Fear of being physically punished, compared to no fear, was related to higher values for hostility (SCL-90) and poorer overall social adjustment (SAS-SR). Ruggiero et al (2004) report of higher past-year prevalence of PTSD and major depressive episodes among CSA women who waited longer than 1 month with disclosure, relative to no disclosure and disclosure within 1 month.

### **Group therapy and mental health**

After treatment, the psychological symptom scores (SCL-90) in the study group, were reduced both totally and in all sub-scales with the exception of phobic anxiety, and the results were mostly stable one year later. In the short-term group, the scores were reduced in 4 sub-scales of which 2 were maintained one year later and another 3 sub-scales together with the total score GSI were added to the results. According to the same instrument, reduction in eight of nine sub-scales is reported in one of the evaluation studies (Carver et al, 1989) and in another study there is a reduction in 5 sub-scales (Talbot et al, 1999).

Effect size (Cohen, 1992) after treatment concerning the psychological symptoms for the study group mostly showed values over medium and for the short-term group small to medium. In general, the treatment effects were somewhat higher for the study group compared to the short-term group after completed therapy. This may be related to the longer treatment period.

Structured treatment programs seem to initiate a healthy process that continues even after the end of the therapy. This is confirmed in the evaluation studies with follow-up assessments (Alexander et al, 1989; Hall et al, 1995; Longstreth et al, 1989; Morgan & Cummings, 1999; Richter et al, 1997; Rieckert & Möller, 2000; Roberts & Lie, 1989; Saxe & Johnson, 1999; Stalker & Fry, 1999; Talbot et al, 1999). Another aspect of this

continued effect is that the effect size in the short-term group at the one-year follow-up is as good as the post-test result in the study group. The effect size at one-year follow-up in the study group shows continued improvements, with an effect size of over medium to high. The sub-scale hostility, with a low effect size, was the only exception.

In the waiting-list group, no significant reduction of symptom scores was seen between the pre-test and post-test assessments, which is confirmed in other evaluation studies (Alexander et al, 1989; Rieckert & Möller, 2000; Zlotnick et al, 1997). A study comparing group counselling with psychiatric referral, showed maintained improvement for the counselling group regarding depression and suicidal ideas/behaviour at 6 years follow-up, in contrast to the psychiatric group (Bagley & Young, 1998).

One of the strongest effects in both the study group and in the short-term group was seen in the reduction of depression. In the evaluation studies referred to in the introduction, depression was also the condition most often reported to show improvement after therapy (Chard et al, 1997; Rieckert & Möller, 2000; Westbury & Tutty, 1999). According to a review of Kendall-Tackett (2002) CSA persons, both men and women, are reported to run a greater risk of developing depression, compared to non-abused persons, and this in its turn, has a severe negative influence on general health. Negative effects on the immune system and the sleep are mentioned. There are also reports of increased risk for heart disease related to depression. Reducing depression therefore seems to have far-reaching gains. Depression is often treated with antidepressant medication which was the case for 36% of the women in the study group when starting in group therapy. Some of these women stopped using this medication during the group therapy and some others started during the treatment. After termination of group therapy 45% had antidepressant medication. The conclusion may be that antidepressant medication is supposed to be effective on reducing depressive symptoms of CSA women, but that other interventions are needed to dispel the depression. It seems difficult to get a permanent effect of the medication without its continuous use. Perhaps a combined treatment of medication and psychotherapy is the best offer for these women.

Even anxiety was a condition that showed improvement with a moderate to high effect size in both the study group and the short-term group. High effect size has been shown by Cloitre & Koenen (2001) concerning group therapy in relation to anxiety.

Both the study group and the short-term group reduced their scores on the sub-scale psychoticism, a finding which was corroborated in one of the earlier mentioned evaluation studies, Carver et al (1989). This result may be explained by the fact that the women remained in a group where such experiences were worked through and normalised (Carver et al, 1989).

The sub-scale paranoid ideation was reduced in the study group. In the short-term group it was not reduced at termination but at one year follow-up. The evaluation group, Carver et al (1989), showed no reduction. Items included in this sub-scale concern trust, and trust probably takes time to develop, whereby longer treatment seems to be necessary (Carver et al, 1989).

The study group and the short-term group did not reduce their scores on the sub-scale phobic anxiety, while that was reported in two evaluation studies, Carver et al (1989) and Talbot et al (1999). Worth noting is however, that at one year follow-up the study group had improved to a statistically significant level.

The ratings of life events were not associated with any difference in psychological symptoms between termination and follow-up for the study group, or when compared to before and after the waiting period for the waiting-list group. This may support the observation that it was the given treatment that explained most of the changes and not other life events.

The numbers of symptoms for meeting the criteria for post-traumatic stress disorder in the DSM-IV system were significantly reduced in the study group, but not in the waiting-list group. This result indicates that the given treatment positively affects these symptoms and is confirmed in other studies (Chard et al, 1997; Cloitre & Koenen, 2001; Zlotnick et al, 1997).

Concerning sense of coherence (SOC), the results after treatment showed an increase of the resilience resources in both the study group and the short-term group, with a further increase in the study group at one year follow-up. Treatment effect according to effect size was only small for both the study group and the short-term group directly after treatment, but was over medium for the study group one year later. Thus, there seems to be a delayed outcome effect. The results indicate that treatment may positively affect the sense of coherence, which is confirmed in other treatment studies (Hansson, 2001). Sense of coherence measures salutogenetic factors that can protect human beings in stress situations. People with a strong sense of coherence tend to manage the stressors of life better than people with a weak sense of coherence, and this is associated with health status (Antonovsky, 1987). Maybe the results can be interpreted as showing that group therapy for the CSA women strengthens their health status and thereby prevents further symptom development e.g. the earlier mentioned repeated suicide attempts.

The reduction of self-reported symptoms according to SCL-90 and the strengthening of sense of coherence according to SOC among the women in the study group were not accompanied by a reduction in inpatient days or sick-listing days. Another psychotherapy project in Sweden has shown similar preliminary results regarding sick-listing days (Lazar, 2004). The women in the study group benefited from the group therapy, but compared to general groups they still showed a greater frequency of psychological symptoms (Fridell et al, 2002) and a lower sense of coherence (Hansson & Olsson, 2001). This together with a difficult labour market with high unemployment rates during the years of assessment could contribute to the fact that so many still were on sick-list, or had been transferred to sickness pension, 2 years after therapy, common solutions to unemployment used by the Swedish government during the late 1990s.

### **Group therapy and social health**

Social support according to ISSI measures both availability and satisfaction with relationships that can give reassurance of personal worth, shared interests and

instrumental support. It also measures availability and satisfaction with deep emotional relationships. Concerning effect size (Cohen, 1992) the study group after treatment rated the social support level higher (effect size medium). The women perceived a better availability of social relations and they were much more satisfied with the situation (effect sizes nearly medium and over medium, respectively). The group treatment encourages interaction and support, which may create possibilities for using the current network better and eventually engaging in new social contacts. Other treatment studies confirm improved assertiveness (Cloitre & Koennen, 2001), reduced isolation (Gorey et al, 2001) and improved social support from friends and family (Saxe & Johnson, 1999). Concerning attachment, the effect size was small for the two sub-scales, and the women were not satisfied. They wished more availability, but on the other hand they reported the attachment as more satisfying than before therapy. The women seemed to long for deeper relationships but at the same time hesitated for getting too close to other people. Perhaps there was a fear of not being able to keep limits for the integrity. Saxe & Johnson (1999) mean that treatment enables the women to defend themselves against perceived intrusion and teaches them to meet difficulties directly, rather than simply trying to avoid them.

Social adjustment according to SAS-SR measures role performance in 6 major areas of social functioning. After group therapy the overall social adjustment improved (effect size medium), a finding reported in other studies (Alexander et al, 1989; Morgan & Cummings, 1999). Improved psychosocial functioning according to GAS and Self-Assessment Scale has also been reported (Stalker & Fry, 1999; Roberts & Lie, 1989). The two sub-scales work/studies/homework and social and leisure were also improved. The adjustment measured in SAS-SR comprises more close relationships inside family and with relatives, but also less close relationships at work and in spare time. The sub-scales work and leisure, including relationships partly outside the family, i.e. more formal contacts, were improved. But the four sub-scales concerning relationships to children, partner, relatives and earlier partners/adult children were not improved. Group treatment may have a greater impact on formal relationships and close relationships may be more resistant to change.

The family climate, comprising the four sub-scales closeness, distance, spontaneity and chaos, was measured in both the family of origin and the current family. No significant changes after treatment were found and the effect size values were small. It seems that the group therapy had little or no impact on the perceived family climate, either in the family of origin or in the current family. Perhaps this should be expected. Therapy does not change the reality of the family history, and the current family probably represents the only safe place for the woman and therefore cannot be questioned.

Questions about family members in the study measure expressed emotion between the woman and her partner, and comprise the four sub-scales perceived criticism, perceived emotional involvement, critical remarks and emotional over-involvement. A noticeable improvement was seen for the study group in the sub-scale perceived criticism, and the effect size value was large. This means that the group therapy had a good effect on the psychological sensitivity to criticism, but not for the other 3 sub-scales. Through sharing experiences in the therapy group the woman could be encouraged to talk to the partner and thereby meet and work through the perceived criticism. Notable however, is that only 11 women in the study group answered questions about their partner.

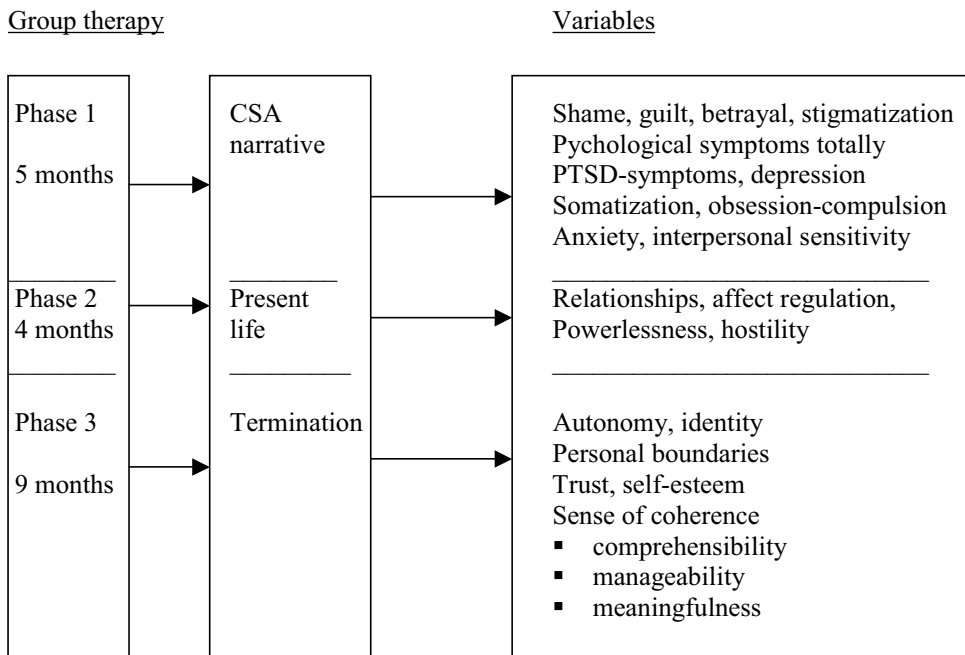
The waiting-list group showed no improvements in the sub-scales on social support but surprisingly in total support. The effect size was over medium in one sub-scale, the availability of attachment. Perhaps the women during the waiting period had to accept whatever was offered in the way of social contacts in the absence of a holding treatment group. Another reason is, of course, that there were too few participants in the group, which make the result uncertain. Concerning social adjustment and family climate there were no improvements and the effect size values were small.

Even if the women benefited from the group therapy as measured by the improvement of the total social support and the overall social adjustment, they still showed poorer values, compared to general groups, regarding support (Samuelsson, 1995) and adjustment (Weissman, 1978). Group therapy has good effects on some social variables (Gorey et al, 2001; Morgan & Cummings, 1999; Stalker & Fry, 1999). However, the effects seem to be better on intrapersonal symptomatology than on interpersonal difficulties (Saxe & Johnson, 1999). CSA women seem to need help to develop deeper relationships to significant others such as their partner and their own children, which probably can be accomplished better through direct psychological work.

### What works in this time-limited trauma-focused group therapy?

The affective ingredients in the group therapy can probably be related to the different phases (figure 1).

Figure 1. Group therapy phases and probable effects on different variables.



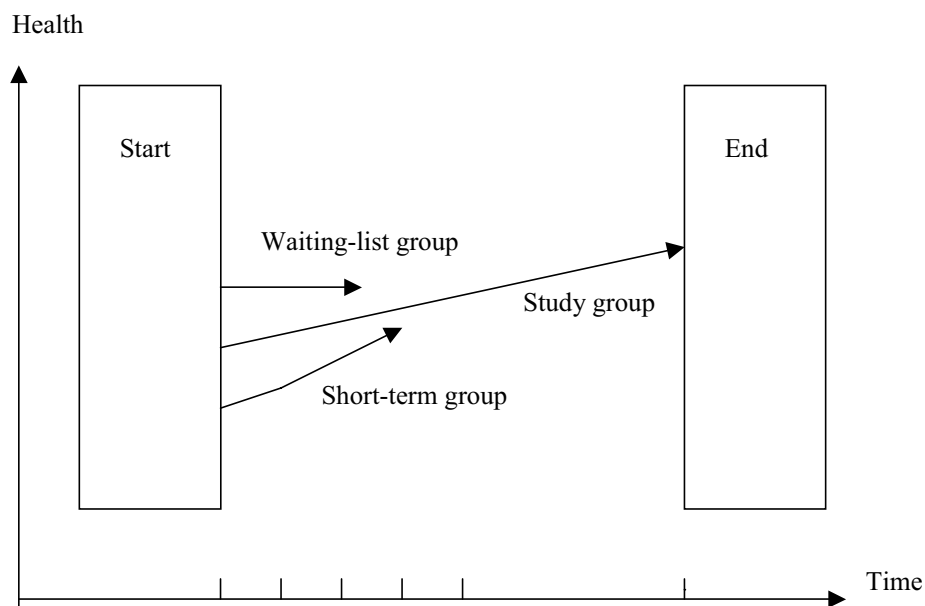
The overall advantages with this group therapy model are the trauma focus, the time-limited structure and the group cohesiveness. The probable core intervention of the group therapy model is the CSA narrative in phase one, related to the relationships in the family of origin. It affects the women's conception of themselves, the feelings of shame and guilt and thereby many of the psychological symptoms.

In phase two the women are less occupied with the trauma and may begin to work with the relationships in their present life. Shame and powerlessness may give way to pride.

Phase three strengthens the autonomy, identity and personal boundaries as well as trust and self-esteem. At this time a sense of coherence of life begins to emerge and to be perceived as comprehensible, manageable and meaningful.

In relation to the comparison groups, the development of the process can be illustrated as in figure 2.

Figure 2. The development of the process of the study group, the short-term group and the waiting-list group.



The study group and the short-term group showed improvements on psychological symptoms. The waiting-list did not change. The conclusion must be that waiting for treatment has no advantages. Group treatment however, shows improvements, and on a short-term basis, there are roughly the same improvements for the shorter and longer treatments.

## Conclusions

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Female CSA is common, both in community and among psychiatric patients. The CSA women who come for psychiatric health-care often suffer from many psychological symptoms, fulfil the diagnosis for post-traumatic stress disorder, have suicidal thoughts and make suicide attempts. They have sexual problems, somatic pains and relationship problems to both men and women. Compared to general groups these women have poorer social adjustment and diminished social support, poorer family climate both in the family of origin and the current family, as well as in expressed emotion to the partner, and the total health score according to sense of coherence is lower.

The women in the study were seriously sexually abused by a close perpetrator and over many years. Being sexually abused at an early onset was the abuse variable that separately was related to many psychological symptoms, and being abused by more than one perpetrator was related to higher anxiety. Having a male relative as the perpetrator resulted in greater interpersonal sensitivity.

CSA is kept secret by the children or has a delayed disclosure. The most common reasons in the study for not disclosing the abuse were fear of not being believed, fear of being accused of being a willing participant in the sexual abuse and fear of being physically punished. The conclusion of this must be that the support system around a child must be strengthened in order to facilitate for children to disclose experiences of CSA and to be helped. The United Nation's Convention on the Rights of the Child states that a child friendly society provides resources for protection and rehabilitation of children victimised by abuse.

The main findings of this study are that despite limitations, the 2-year long trauma-focused group therapy model presented promising results in the reduction of psychological symptoms and symptoms of post-traumatic stress disorder, an increased sense of coherence, improved social support and improved social adjustment. The majority of the women were very satisfied with the treatment.

The author's conclusion of 12 years' special treatment of CSA women together with research work is, that there is too little interest in the psychiatric health-care system in allocating resources and developing treatment models for adult women who have been sexually abused as children. This group usually has had traumatic experiences over many years, leading to a profound distrust of others. Together with the serious symptomatology of mental ill health and psychosocial problems this group need special treatment methods and health-care professionals with special training.

Nearly half of the female psychiatric patients have a history of CSA. The health-care costs and health-care utilisation for CSA women are higher than for women without these experiences (Farley & Patsalides, 2001; Hulme, 2000; Newman, 2000; Walker, 1999b). Utilisation seems to decrease after group therapy (Hall et al, 1995). To invest and develop trauma-focused treatment programmes for this group would therefore seem cost effective and an important task for psychiatric health-care.



## **Clinical implications**

The model of group therapy seems to suit CSA women. These women have greater feelings of loneliness and make less use of their social network, and therefore probably have a greater need of group cohesion. The present group therapy is a long model. Yet the treatment can only be seen as a start, and must be followed by rehabilitation and time for testing both close and formal relationships in social life. Probably the group therapy model also should include a more direct psychological work with significant others.

Therapists who ask questions are important in helping the women relate their CSA narrative. Hyman et al (2003) found that among CSA women self-esteem support from others and appraisal support including advice or guidance in coping with problems, decrease the severity of PTSD symptom development. One of their conclusions was that “psychology practitioners should be trained in these skills in order to respond effectively to an abuse disclosure in therapy”. Research about improvement in therapy suggests that as many as 30% depends on the relationship between the client and the therapist (Hubble et al, 1999).

There are reports of women experiencing abuse in the health-care system. Often these women also report events of emotional, physical and/or sexual abuse in childhood (Svahnberg, 2003). This indicates that women who have experienced abuse in childhood are more vulnerable and in need of support. Therefore a female psychiatric patient must be helped to disclose eventual CSA, whereby the psychiatric intake interview should include questions about all violence in the life history. There must also be an openness to believe the women when they relate their narrative and to see that they receive adequate treatment. By treating the original trauma, the women may abandon their perception of being a victim, and thereby perhaps diminish their health-care utilisation. The working through of CSA should be done parallel to treating other expressed psychological and/or psychiatric difficulties.

Today there is little specialist help offered to the group of CSA women in Sweden. This may partly be due to the great number of symptoms presented by those women and the subsequent difficulties in making a proper diagnosis. The treatment may therefore be fragmentary and not sufficient (Herman, 1998). In a study of patients, disclosing abuse to the psychiatric health-care (Agar & Read, 2002) only 22 % were offered abuse-focused therapy. Studies indicate that there will be little change in symptoms unless the underlying trauma is treated (South & Wallis, 2003).

## **Future research**

It is important to follow up the women in the study group and in the short-term group after a longer period in order to establish if a shorter treatment model can be recommended. It is also important to initiate a randomised study concerning treatment. Comparisons between group and individual therapy or between different group therapies concerning therapeutic approach would be valuable. Perhaps combinations of treatments should be evaluated e.g group therapy combined with physiotherapy or couple therapy. Further studies on the prevalence of CSA among the patients in the psychiatric health-care, both females and males, are needed.

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