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Lundqvist, Gunilla

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*Total number of authors:*

1

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PO Box 117  
221 00 Lund  
+46 46-222 00 00

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Running head: group therapy sexual abuse mental health

## **Group therapy for women sexually abused as children**

### **Mental health before and after group therapy**

Lundqvist Gunilla, Ph.D., lic psychotherapist<sup>1)</sup>

Svedin Carl Göran, Professor<sup>1)</sup>

Hansson Kjell, Professor<sup>2)</sup>

Broman Inger, Social worker/lic psychotherapist<sup>3)</sup>

<sup>1)</sup> Department of Child and Adolescent Psychiatry, Lund University

<sup>2)</sup> School of Social Work, Lund University

<sup>3)</sup> Department of Psychiatry, Östersund Hospital

## **Abstract**

Forty-five female outpatients sexually abused in childhood were offered a 2-year long phase-divided group therapy. Before and after treatment and at 12 months follow-up, they answered questionnaires designed to elicit responses concerning psychological symptoms (Symptom Checklist; SCL-90) and sense of coherence (SOC). Symptoms for posttraumatic stress disorder (PTSD) were assessed before and after treatment. Inpatient days and sick listing days were assessed during 2 years before and during 2 years after treatment. The psychological and PTSD symptoms were significantly reduced after treatment, and the SOC was increased as well. Inpatient days were decreased, and sick listing days increased but not significantly. Compared to a similar short-term focused therapy group and a waiting-list group there were no significant differences between the groups. Trauma-focused group therapy for women who were sexually abused in childhood seems to have promising effects on mental health, both concerning long-term and short-term approaches.

Key words:

group therapy; sexually abused as children; mental health

## **Introduction**

From studies about childhood sexual abuse among adult women, Fergusson and Mullen (1999) estimated the prevalence to be in the interval 15 % to 30 %. As adults, the women who had been sexually abused in childhood often show symptoms of increased mental suffering. One consequence of this is the reported high prevalence rates of childhood sexual abuse among female psychiatric patients ranging from 25 % to 77 %, with a mean value of 45 % (Lundqvist, Svedin & Hansson, 2004). An analysis of the odds ratio between sexual abuse cases and nonsexual abuse cases showed about 2 to 4 times increased risk for different psychiatric disorders such as depression, anxiety, phobias, eating disorders, and substance abuse among individuals exposed to sexual abuse during childhood. Suicidal behaviour and posttraumatic stress disorder (PTSD) showed the highest association with childhood sexual abuse (Fergusson & Mullen, 1999). One effective treatment for adult women, sexually abused in childhood, seems to be trauma-focused group therapy.

Evaluated trauma focused group therapies are mostly reported from the United States. The studies usually comprise treatment periods of 10 to 15 sessions and are evaluated in pretest/posttest designs. The studies show statistically significant improvements concerning depression, psychological symptoms, fears, anxiety and trauma and/or PTSD symptoms. Comparisons to waiting-list groups have shown statistically significant improvements for the therapy groups. The results from posttest have remained at follow-up (Alexander Neimeyer, Follette, Moore, & Harter, 1989; Chard, Weaver, & Resick, 1997; Cloitre & Koenen, 2001; Longstreth, Mason, Schreiber, & Tsao-Wei, 1989; Roberts & Lie, 1989; Talbot et al, 1999; Zlotnick et al, 1997). One evaluated trauma-focused group therapy study from Europe has been found, with similar results (Hall, Mullee, & Thompson, 1995).

## **Aim**

The aim of the current study was to follow up and evaluate psychological symptoms, symptoms for PTSD, and the sense of coherence (SOC) after a 2-year long trauma-focused group therapy for adult females who were sexually abused in childhood.

## **Material and methods**

### **Group Therapy Model**

The group therapy model for women who had been sexually abused in childhood was based on psychodynamical theory with emphasis on the object relation theory. The frame for the group therapy derived from Yalom's model (1985), and an inner structure was based on the sexual abuse model from Kreidler and Burns England (1990) and Kreidler and Carlson (1991). The group therapy was time limited to 46 sessions with a phase-divided structure. Phase 1 comprised 22 sessions during 5 months and mostly twice a week, designed to help the women to tell their childhood sexual abuse narratives and to discuss the relationships in the family of origin. Phase 2 comprised 15 weekly sessions during 4 months, designed to work through the effects on the present life. Phase 3 comprised 9 monthly sessions during one year, designed to work with the separation and get used to a new state of autonomy.

Two female group leaders did all the group sessions in all 10 groups together. One group leader is the first author of this article.

### **Participants**

*Study group.* Between 1993 and 2001 at an outpatient treatment unit of the Department of Psychiatry at Lund University Hospital, 45 women were treated in 10 different 2-year therapy groups, including four to five women in each group, with focus on childhood sexual abuse. The first six groups were started twice a year respectively; however, the last four groups started once a year, respectively. The inclusion criteria were to have a memory of the childhood sexual abuse and to know who the perpetrator was. Exclusion criteria were diagnoses of psychosis or ongoing substance abuse. *Sexual abuse* was defined as all physical contact and visual or verbal interaction between a child and/or teenager age 18 years or younger, 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 and/or teenager is used to sexually stimulate the perpetrator or someone else (Allender, 1993; Courtois, 1988). The 45 women in the study group are described in Table 1.

*Comparison groups.* The waiting-list group comprised 10 women, who were interviewed in the same way as the women in the study group. They also answered the same questionnaires at admission and 5 to 13 months later, median 11.5 months, when offered to participate in a therapy group. The 10 women in the waiting-list group are described in Table 1.

A short-term focused therapy group, at a department of psychiatry at another hospital, comprised 22 women. The group therapy model was similar to the one for the study group but time limited to 20 weekly sessions and including six topics. Of the 22 women the last 14 women were also treated with 15 minutes of body-awareness therapy according to Mattsson (1998). No statistically significant differences were found concerning psychological symptoms according to the Symptom Checklist (SCL-90; Derogatis, 1979) between the group having and not having body-awareness therapy. Inclusion and exclusion criteria were the same as for the study group. The 22 women in the short-term group are described in Table 1.

### **Scientific Method**

A 2-hour admission interview with each woman was done by the group leaders about the present life, the sexual-abuse history, and the family of origin. At the end of the interview a questionnaire was filled in about these data. The woman got verbal and written information and gave her written consent. The 23 last-treated women were interviewed about the PTSD

symptoms (DSM-IV; American Psychiatric Association, 1994) before and after the group therapy.

Before and after group therapy, questionnaires were answered, and also at a follow-up 12 months after termination of the group therapy. In this article, three instruments are presented.

The SCL-90 is a self-rating scale with 90 questions measuring present psychological symptoms and reflecting nine dimensions of psychological symptoms and Global Severity Index (GSI), the total score (Derogatis, 1979). A low score shows good psychological health. The validity is high and in the Swedish standardization the instrument has shown Cronbach's alpha 0.97 for the GSI (Fridell, Cesarec, Johansson, & Malling Andersen, 2002). In the current study, Cronbach's alpha was 0.97 for the GSI.

SOC is a self-rating 29-item scale measuring life attitude in relation to stress resistance (Antonovsky, 1993). A high value seems to show salutogenic properties. The validity is tested, and the reliability including the Swedish translation has shown Cronbach's alpha 0.88 (Hansson & Olsson, 2001). In the current study, Cronbach's alpha was 0.89.

Life Events is a self-rating questionnaire with 31 questions, measuring if life events have happened or have not happened during a defined time period. The instrument has been tested in a Swedish twin study (Reiss et al, 2001).

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 the Lund University Hospital (LU 274-92 and LU 398-97).

### **Statistics**

The statistic program SPSS (Version 12.0.1 for Windows) was used. Group comparisons within groups were made with Wilcoxon signed-rank test and McNemar test. The Pearson chi-square test and Kruskal-Wallis test were used for comparisons between groups. For calculating the effect size the Cohen's *d* test was used.

**Table 1.****Sociodemographic and Abuse Variables for the Women in the Study Group, the Waiting-List group and the Short-Term Group**

Variables	Study group (n=45)	Waiting-List Group (n=10)	Short-Term Group (n=22)	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 and/or college	18 (40)	6 (60)	11 ((50)	n.s.
Work and/or studies	30 (67)	7 (70)	14 (64)	n.s.
Unemployed	12 (27)	1 (10)	1 (5%)	n.s.
Perpetrator - biological father	20 (44)	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)	*

Comparisons between study group, waiting-list group, and short-term group were made through Kruskal-Wallis test.

\*p<.05, \*\*p<.01

## Results

Comparisons were made within the groups pretest/posttest, pretest/follow-up, and posttest/follow-up for the study and short-term treatment groups. Comparisons between the groups were based on treatment and/or waiting 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 (Table 1).

There were three dropouts; however, these women were not different from the women in the study group concerning the variables noted in Table 1. In the pretest/posttest analyses the data was dropped for these three cases. The 20 women who took part in the follow-up were used in paired data sets for pretest/follow-up analyses.

### Psychological Symptoms

In the pretest/posttest assessment of psychological symptoms according to SCL-90 there were statistically significant reductions for the study group in the total score GSI and in eight of the nine subscales (Table 2). The most evident reductions were seen for GSI, obsessive-compulsive, depression, paranoid ideation, and psychoticism ( $p < .001$ ). The effect size for the total score GSI was .59 which is in the medium range according to Cohen (1992).

In the short-term group, there were statistically significant reductions for four of the nine subscales ( $p < .05$ ), and the effect size for the total score GSI was .54. In the waiting-list group there were no statistically significant differences.

In the pretest/follow-up assessment there were statistically significant reductions for the study group in the total score GSI and in eight of the nine subscales. The effect size for the total score GSI was large, 1.06. In the short-term group there were statistically significant reductions for the total GSI and for five of the nine subscales. The effect size of the total GSI reduction was .74.

No statistically significant differences were found between the groups concerning treatment differences or at pretest, posttest, and follow-up, using Kruskal-Wallis Test with only paired data sets.

### Posttraumatic Stress Disorder

In the pretest/posttest assessment of posttraumatic stress disorder according to the *DSM-IV* system there was a statistically significant reduction for the study group, from 87% to 40%, ( $p < .01$ ) but not for the waiting-list group. There was no statistically significant difference between the groups.

### SOC

In the pretest/posttest assessment of SOC there was a statistically significant increase for the study group, from 106 to 116 points, and for the short-term group, from 106 to 113 points, ( $p < .05$ ). The points for the waiting-list group decreased. There were no statistically significant differences between the groups, using Kruskal-Wallis test. In the pretest/follow-up assessment for the study group there was a statistically significant increase and in the posttest/follow-up assessment. These assessments were not performed for the short-term group.





**Table 2.**  
**Psychological Symptoms (Symptom Checklist; SCL-90)**

	Study Group (n=45)			Waiting-List Group (n=10)		Short-Term Group (n=22)		
	Pretest Treatment	Posttest	Follow-up, 1 year later (n=23)	Pretest Admission	Posttest, 5-13 months later	Pretest Treatment	Posttest	Follow-up, 1 year later
	n=45 M(SD)	n=42 M(SD)	n=20 M(SD)	n=10 M(SD)	n=10 M(SD)	n=22 M(SD)	n=18 M(SD)	n=15 M(SD)
Global Severity Index (Total)	1.58±0.73	1.10±0.86***	1.11±0.68**	1.35±0.94	1.19±0.77n.s.	1.74±0.48	1.46±0.66n.s.	1.28±0.82*
Somatization	1.62±0.80	1.17±0.98**	1.07±0.75**	1.44±1.08	1.15±0.95n.s.	1.82±0.83	1.64±0.80n.s.	1.38±0.85*
Obsessive-compulsive	1.62±0.80	1.10±0.94***	1.07±0.83**	1.54±1.32	1.30±0.93n.s.	1.78±0.67	1.52±0.82n.s.	1.29±0.87*
Interpersonal sensitivity	1.77±0.92	1.26±1.02**	1.26±0.90**	1.49±1.00	1.42±1.16n.s.	1.89±0.70	1.64±0.82n.s.	1.50±0.88n.s.
Depression	2.15±0.86	1.45±1.06***	1.46±0.90**	1.89±1.19	1.78±1.09n.s.	2.31±0.48	1.89±0.90*	1.52±1.05*
Anxiety	1.68±0.89	1.15±0.99**	1.11±0.79**	1.38±0.81	1.30±0.80n.s.	1.86±0.61	1.42±0.74*	1.29±0.95*
Hostility	1.16±0.81	0.79±0.92**	0.92±0.80n.s.	0.93±1.14	0.62±0.60n.s.	1.01±0.85	0.79±0.61*	0.86±0.98n.s.
Phobic anxiety	1.05±1.04	0.70±0.86n.s.	0.72±0.75*	0.50±0.78	0.59±0.83n.s.	1.22±1.04	1.32±1.14n.s.	1.06±0.99n.s.
Paranoid ideation	1.53±0.87	1.11±0.95***	1.13±0.82*	1.20±1.30	1.00±0.73n.s.	1.52±0.78	1.38±0.74n.s.	1.22±0.82*
Psychoticism	1.20±0.78	0.66±0.69***	0.81±0.71**	0.94±0.90	0.77±0.75n.s.	1.26±0.59	0.91±0.68*	0.93±0.93n.s.

Comparisons within each group were made through Wilcoxon signed-rank test. Comparisons between groups were made through the Kruskal-Wallis test. Then the values were put together in a group value.

\*p<.05, \*\*p<.01, \*\*\*=p<.001

## **Life Events**

The comparisons of the number of life events within the study group, within the waiting-list group, and between the groups for SCL-90 and SOC showed no statistically significant differences. The comparisons were based on the median value for the total of the study group and the waiting-list group (median 3).

## **Inpatient and Sick Listing Days**

The comparison of inpatient days during 2 years before and during 2 years after treatment in the study group revealed a reduction, from 256 days to 79 days. One extreme case with 730 inpatient days before and 7 days after treatment was excluded in this comparison. When comparing high and low values, based on the median (0 days), there was no statistically significant difference before and after treatment.

The comparison between sick listing days during 2 years before and during 2 years after the treatment in the study group revealed a totally increase of sick listing days, from 8 563 days to 10 300 days. The same extreme case as for the inpatient days showed 399 sick-listing days before and 730 after treatment. The total pension days increased from 365 to 1615, and the rehabilitation days from 1021 to 1676. Comparison between high and low values, based on the median (77/78 days), showed no statistically significant difference before and after treatment.

## **Discussion**

The trauma-focused group therapy used in the current study showed significant improvements concerning psychological symptoms, PTSD symptoms and SOC. There were, however, some limitations. The lack of a randomised control group makes it difficult to draw more far-reaching conclusions. Another limitation was that the women in the study group could be perceived as a distinct and different group. Because the trauma-focused group therapy was not provided as an alternative on a regular basis, but generally known only to professionals within the health care and social welfare system, the women had to ask for this special therapy. Therefore, they had to reveal their abuse secret. Consequently, these women seemed to be highly motivated, and perhaps the effects of the group therapy therefore were somewhat higher.

In summary, the short-term group had highest scores whereas the waiting-list group had lowest scores on psychiatric and somatic symptoms at the pretest occasion. Symptoms decreased for all groups, and lack of pretest/posttest analysis significance may be the product of the small samples, especially the waiting-list group. Despite the lack of statistical significance the study group showed the greatest pretest/posttest effect. In more detail the best effects were seen in depression in the study group and the short-term group. This is supported by the studies referred to in the introduction, where depression was the most common condition for which therapeutic improvement was reported. Even anxiety showed improvement in the study group and the short-term group, which is confirmed in a study by Cloitre and Koenen (2001). Phobic anxiety was not statistically significantly reduced in neither the study group, nor the short-term group; however, at 1-year follow-up the study group had improved to a statistically significant level.

The follow-up 1 year after termination showed that the symptom effects from termination mostly remained, for the study group and for the short-term treatment group. The healthy process that started in the group therapy seemed to continue after ending it. This is confirmed

in evaluation studies with follow-up assessments (Alexander et al, 1989; Hall et al, 1995; Longstreth et al, 1989; Roberts & Lie, 1989; Talbot et al, 1999).

In the waiting-list group, no significant reduction of symptom scores was seen pretest/posttest, supporting the idea that the given therapeutic interventions made a difference. This finding is confirmed in other evaluation studies (Alexander et al, 1989; Zlotnick et al, 1997) and is also in accordance with a study comparing one group having group counselling and another group having psychiatric referral. After 6 years, the counselling group showed maintained improvement as concerned depression and suicidal ideas and behaviour, but not the psychiatric group (Bagley & Young, 1998).

The result of Life Events showed no effects on the symptom difference posttest/follow-up for the study group and compared with the pretest/posttest period for the waiting-list group. This could support the observation that it was the given treatment that answered for most of the changes and not other life events.

The number of symptoms for fulfilling the diagnosis of posttraumatic disorder according to the *DSM-IV* system were significantly reduced in the study group but not in the waiting-list group. This indicates that the treatment can positively affect the symptoms that is confirmed in the introduction studies (Chard et al, 1997; Cloitre & Koenen, 2001; Zlotnick et al, 1997).

The SOC measures salutogenetic factors that can protect human beings in stress situations. The study group had significant lower pretest values ( $p < .001$ ) than a general female group (Hansson & Cederblad, 1995). The study group and the short-term group showed an increase in the resilience resources. This indicates that treatment can positively affect the SOC, which is confirmed in other treatment studies (Hansson, 2001). Also treatment effects pretest/follow-up for the study group was increased, and again there seems to be a delayed outcome effect.

In the current study the improvement in self-reported symptoms according to SCL-90 and the strengthening of resilience according to SOC among the women in the study group was not accompanied by reduction in inpatient days or sick listing days. Concerning the inpatient days most of the reduction was due to one single patient. Even if the women benefited from the group therapy, they still showed a greater frequency of psychological symptoms (Fridell et al, 2002) and lower SOC (Hansson & Olsson, 2001) than general groups. This together with a difficult labour market with high unemployment rates during the assessed years could contribute to the fact that so many still are on the sick list or have been transferred to sickness pension, common solutions to unemployment used by the Swedish government during the late 1990s.

This is the first Swedish evaluated treatment study for women who have been sexually abused in childhood. For the whole of Europe, only one study was found. In the current study, the trauma-focused group therapy model lasted for 2 years and is thereby longer than the common American ones with 10 to 15 sessions. The American group therapies are mostly structured with, for example, themes or home-works (e.g. writing letters to the perpetrator) whereas our model combines a psychodynamic approach with structure. This model is also unique in the sense that the group therapy starts with a high intensive phase, sessions twice a week, including a structure comprising three sessions for each woman to tell their narrative of the childhood sexual abuse with active help from the group leaders. This contrasts to an end with a low intensive consolidating Phase 3, where the experiences from the first year are integrated

and the coming separation is worked through. The women who were sexually abused as children are more likely to be lonely and less likely to use their social network (Gibson & Hartshorne, 1996) and therefore probably have a greater need for group cohesion. They often bear the childhood sexual abuse as a secret within themselves, and “it is only within a group that the secret becomes public knowledge” (Bautz, 1997, p. 16). The group therapy gives them the opportunity to work emotionally with this.

A comparison was made between the first five therapy groups and the last five therapy groups. The last groups had higher value for psychological symptoms pretest; however, concerning treatment effects there were no differences. The last groups were more satisfied with the therapy than the first ones, probably related to a model change comprising an increase of seven sessions in Phase 1. Even if one could presume that the group leaders became more skilled over time, the results, aside for consumer satisfaction, did not support this (Lundqvist, Hansson, Svedin, & Ekström, in press).

### **Conclusion**

Childhood histories of sexual abuse are prevalent among women seeking psychiatric care as adults. Trauma-focused group therapy seems to show reduction in psychological symptoms. Short-term and long-term treatment groups seem to show promising results. To establish if a short-term treatment group is to be recommended, a longer follow-up period is needed.

Gunilla Lundqvist is a licensed psychotherapist, received her master’s degree of social work and her philosophical degree of Faculty of medicine from Lund University. Her research interest is the effects of the trauma focused therapy on adult women, sexually abused as children.

Carl Göran Svedin, M.D., Ph.D., is a child psychiatrist and professor in Child and Adolescent Psychiatry at Lund University. His main scientific research concerns children at risk, especially child abuse and neglect. He is the former project leader of BUP-Elefanter, a specialised unit for abused children in Linköping.

Kjell Hansson is a psychologist and licensed psychotherapist and works as a professor of Social Work at Lund University. Research areas are mainly prevention and implementation of prevention for conduct disorder. He is also clinically active as a family therapist in a private practice.

Inger Broman is a licensed psychotherapist at Östersund Hospital

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