Group psychotherapy in women with a history of sexual abuse: what did they find helpful?

Ashihan Sayın, Selçuk Candansayar and Leyla Welkin

Aims and objectives. To define the effects of group psychotherapy in women with a history of sexual abuse, to find possible predictors for dropout and treatment outcome rates and to find which therapeutic factors of group psychotherapy are perceived by group members to be most helpful.

Background. Sexual abuse of women is a global concern and causes many psychiatric and psychological sequelae. Group psychotherapy is one of the preferred treatment modalities.

Design. Prospective cohort study.

Methods. Forty-seven women with a history of childhood and/or adulthood sexual abuse were recruited for weekly 12-session group psychotherapy. Subjects were given the Hamilton Depression Rating Scale, the Hamilton Anxiety Rating Scale, the Clinician Administered Post-traumatic Stress Disorder Scale, the Dissociative Experiences Scale, the Childhood Trauma Questionnaire and the Group Therapeutic Factors Questionnaire. Re-evaluations were made after the 6th and 12th session and also at a six-month follow-up session.

Results. Group psychotherapy significantly reduced participants’ levels of depression (screening/12th session mean scores, 22.45/11.10), anxiety (15.45/4.32) and symptoms of post-traumatic stress disorder (42.27/9.32), and this decline became statistically significant at the 6th session and tended to persist at the six-month follow-up. Higher levels of dissociative symptoms at baseline were associated with less response to treatment, but higher levels of attendance at group sessions. Group members rated existential factors (41.40 ± 12.39), cohesiveness (37.42 ± 8.32) and universalism (37.56 ± 7.11) as the most helpful therapeutic factors.

Conclusion. Group psychotherapy was significantly effective in reducing levels of depression, anxiety and posttraumatic stress disorder symptoms in this sample of women. Dissociation had a significant effect on both treatment outcome and treatment adherence. For this sample of women, group psychotherapy was most helpful for reducing feelings of stigma, isolation and shame.

Relevance to clinical practice. Group psychotherapy can be used as a preferred treatment method for women from different cultural backgrounds with a history of sexual abuse.

Key words: dissociation, group psychotherapy, post-traumatic stress disorder, sexual abuse, therapeutic factors, women

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Introduction

Sexual abuse is a universal problem, and victims are most often women. A meta-analysis of prevalence of child sexual abuse in adults using 65 articles from 22 countries reported that 7.9% of men and 19.7% of women had experienced sexual abuse prior to the age of 18 (Pereda et al. 2009). In a random sample of the general population in USA, sexual assault during adulthood was reported by 22% of women and 3.8% of men, and risk factors for adult sexual assault

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include younger age, being female, having been divorced, sexual abuse in childhood and physical assault during adulthood (Elliott et al. 2004). In Turkey, sexual abuse, especially intrafamilial sexual abuse, continues to be vastly under-reported to authorities due to social taboos (Agirtan et al. 2009). The few published studies report a sexual abuse prevalence of 11–37% in the adolescent population (Aras et al. 1996, Alakasifoglu et al. 2006).

Childhood sexual abuse has been associated with long-term psychiatric problems in adult life, including dissociative and post-traumatic stress disorders, depression, anxiety, phobia, substance abuse, eating disorders, suicidal ideation and behaviours, self-harm behaviours, problems in interpersonal and intimate relationships, impaired self-esteem, and impaired identity formation (for a review, see Heim et al. 2010). Although these psychiatric problems are universal among sexual abuse victims from all over the world, women’s coping styles and the treatment for these problems by mental health providers vary greatly between different countries and cultures. For example, both legal and traditional approaches to sexual abuse victims in Turkey may consider the marriage of an abuser and the victim as a ‘solution’. In some Middle Eastern countries and most commonly among Muslim groups like Turkey, family honour is closely tied to the sexuality of its female members. According to these traditional values, young women are expected to be virgins when they marry to assure their purity and moral propriety. In this traditional system, women are not primarily considered as individuals, and one of their most important roles is to embody the family’s good reputation and honour (Arin 2001, Sever & Yurdakul 2001). These beliefs can be so strong that some families are prepared to sacrifice the lives of female members in order to restore family honour. After a rape, society perceives the violated woman not as a victim who needs protection, but as someone whose impurity has debased the family honour. Her relatives may opt to undo the shame of this violation by taking her life. But murder is not the only possible remedy. An alternative to murdering her is to arrange a marriage for her, preferably with the person who violated her honour through rape. This procedure of imposing a ‘reparative’ marriage on a violated woman is believed to remedy her perceived offence against her family. Based on this set of beliefs, the practice was until very recently legally sanctioned by the Turkish state and was considered to ‘protect the girl from social stigma’. After such a forced marriage, the criminal investigation was dropped, although a rapist could still face criminal charges if he divorced his wife within five years ‘without a legitimate reason’ (Fledner 2000). Despite changes in the laws, some courts continue to follow these principles. These local/cultural approaches may encourage more abuses of victims and may also have an influence on mental health approaches.

Given that sexual abuse of women is common and has lifelong psychological effects, efforts have been made to find effective treatment methods for these women. Group psychotherapy has been one of the most widely studied approaches (for reviews see Taylor & Harvey 2010, Trask et al. 2011). There are many reasons why a group setting may be a better way of healing sexual trauma. Treatment groups create a safe and structured environment where each woman can experience being heard and believed in a supportive community of her peers. Group members may choose themes that they consider relevant, often including dealing with anger, self-esteem, sexuality, family-of-origin issues, assertiveness, relationships, spirituality, perpetrators and confrontation (Westbury & Tuttly 1999). A group format lessens the feelings of stigma, isolation and shame that frequently follow sexual victimisation (Feiring et al. 1996, Talbot 1996). In addition, a group setting provides participants with greater opportunities to observe and learn from one another, especially for the acquisition of new skills.

In this study, we report the results of a group psychotherapy experience conducted with Turkish women with a history of sexual abuse. We had two aims before conducting this work. The first aim was to treat the psychiatric symptoms and psychological difficulties of survivors of sexual trauma using group psychotherapy and also to find possible predictors for dropout and treatment outcome rates. Second, we aimed to find which therapeutic factors of group psychotherapy would most help the group members. In addition to these aims, our exploratory goal in this study was to observe similarities and differences with regard to responses to sexual trauma-related issues and the group therapy setting between Turkish women and women from other countries reported in the literature, because culture may have an important impact on ways of responding to and coping with trauma (Bryant-Davis et al. 2009).

Methods

Subjects

Group members \(n = 47\) were selected from among women with history of a sexual abuse who applied for psychiatric outpatient or inpatient treatment at the Psychiatry Department of Gazi University Hospital or were staying at one of the domestic violence shelter houses in Ankara and/or were private practice patients of two of the authors. Some participants learned of the groups by word of mouth. All of the
women were interviewed before inclusion in this study by one of the authors (A.S.). During this screening interview, detailed oral information about the purpose and process of this study was given, and a written informed consent form was signed by all participants. Then, information about their socio-demographic characteristics, previous psychiatric treatment and sexual abuse history was obtained through a semi-structured interview. The exclusion criteria included being younger than 16 years of age, having a psychotic disorder, active alcohol or substance dependence, mental retardation, severe suicidal thoughts and not signing the written informed consent form.

The mean age of the participants was 31.74 (minimum 20, maximum 50, standard deviation 7.32). The majority of them were single (n = 21, 44.7%), had an education level above 12 years (n = 27, 57.4%), had a job (n = 23, 48.9%), were born in a big city (n = 25, 53.2%), had lived mostly in a big city during their lives (n = 32, 68.1%) and were living with family at the time of therapy (n = 33, 70.2%).

A minority 19.1% (n = 9) of the participants had never received any kind of psychiatric or psychological treatment before. Among those who had received treatment before, 40.4% (n = 19) had been treated with psychotropic medication, 38.3% (n = 18) had been treated with both medication and psychotherapy, and 1 had received only psychotherapy. A total of 65.9% (n = 31) were still using psychotropic medicine, 17.0% (n = 8) had been hospitalised once in their lives in a psychiatric inpatient clinic, and 6.4% (n = 3) had been hospitalised more than once. A total of 51.1% (n = 24) had attempted suicide in the past. After the screening interview, it was concluded that 23.4% (n = 11) did not have any current psychiatric diagnosis. The most common diagnosis was major depression (n = 20, 42.5%), followed by borderline personality disorder (n = 11, 23.4%) and post-traumatic stress disorder (n = 6, 12.7%). Other psychiatric diagnoses were panic disorder, eating disorders, vaginismus, social phobia, obsessive-compulsive disorder and conduct disorder.

According to their sexual abuse history, the majority of these women were children when their sexual trauma occurred (n = 19, 40.4%), the most common perpetrators were first-degree family members (n = 14, 29.8%) and husbands/lovers (n = 14, 29.8%), most of these women were raped (n = 28, 80.9%), and most of them were traumatized more than once by the same perpetrator (n = 30, 63.8%). Revictimisation had occurred for 40.4% (n = 19) of the women (‘re-victimisation’ was defined as at least one additional incident of sexual abuse in both childhood and adulthood, refer Wyatt et al. 1992). A total of 25.5% of them (n = 12) had never talked about their sexual assault to anyone before this therapy and had not received professional help after the assault (n = 37, 78.7%).

**Instruments**

After obtaining the information discussed above, the Hamilton Depression Rating Scale (HAM-D), Hamilton Anxiety Rating Scale (HAM-A), Clinician Administered Post-traumatic Stress Disorder Scale (CAPS), Dissociative Experiences Scale (DES) and Childhood Trauma Questionnaire (CTQ-28) were administered. All of the instruments throughout the study were administered by one of the authors (A.S.), who has 10 years of experience in clinical psychiatry and is familiar with the scales. Some of the scales are self-report scales.

**The Hamilton Depression Rating Scale**

This is a clinician-applied scale with 17 questions, developed by Max Hamilton (Hamilton 1960). Scores from 8–15 show mild, from 16–28 points show moderate, and above 29 show severe depression. The Turkish form’s validity and reliability had been previously established (Akdemir et al. 1996), with a test–retest reliability coefficient of 0.85 and Cronbach’s coefficient of 0.75.

**The Hamilton Anxiety Rating Scale**

This is a clinician-applied five-point Likert-type scale with 14 questions (Hamilton 1959). It includes both psychological and bodily symptoms of anxiety. The Turkish form’s validity and reliability had been previously established (Yazıcı et al. 1998), with a test–retest coefficient of 0.72 and Cronbach’s coefficient of 0.94.

**The Clinician Administered Post-traumatic Stress Disorder Scale**

This is a 17-item scale for the assessment of current and lifetime PTSD symptoms (Blake et al. 1995). The 17 symptoms cluster into three subscales: CAPS-R for re-experiencing, CAPS-A for avoidance/numbing and CAPS-H for hyperarousal. A subject is considered ‘positive’ for lifetime symptoms if he/she endorses the symptoms within a certain amount of time after the traumatic event. A subject is considered ‘positive’ for current symptoms if he/she still has these symptoms. The Turkish version of CAPS has a Cronbach’s alpha of 0.91 for the whole scale, 0.78 for re-experiencing symptoms, 0.78 for avoidance/numbing symptoms and 0.82 for hyperarousal symptoms (Aker et al. 1999).
The Dissociative Experiences Scale
This is a 28-question self-report scale. For each question, participants are asked to rate a sentence related to dissociative symptoms on a scale between 0–100 (Bernstein & Putman 1986). The Turkish version has a Cronbach’s alpha of 0.97 and a test–retest correlation of 0.77, and the cut-off point for a Turkish population is 30 (Yargıcı et al. 1995). This scale was used only at screening in this study, because it evaluates dissociative symptoms experienced within a lifetime.

The Childhood Trauma Questionnaire
This is a five-point Likert-type self-report questionnaire developed by Bernstein et al. (1994). It evaluates childhood trauma history according to five dimensions: physical neglect, physical abuse, emotional neglect, emotional abuse and sexual abuse. The Turkish version has a Cronbach’s alpha of 0.96 (Aslan & Alparslan 1999).

The Group Therapeutic Factors Questionnaire
For this study, Yalom’s 60-item therapeutic factor questionnaire was used (Yalom 1975). The questionnaire contains 60 items, 5 describing each of the 12 factors (a brief description of each therapeutic factor can be found in Table 3). Patients are asked to consider each of the 12 items (presented on five separate pages) and rank each item from the least helpful (1) to the most helpful (12). This questionnaire had previously been translated into Turkish (transl Tangör & Karaçam 1999).

The HAM-D, HAM-A and CAPS were given four times during the study: at entry (baseline), after the sixth session, after the final (12th) session and at a follow-up session (six months after the therapy ended). The DES and CTQ-28 were given at entry. The Group Therapeutic Factors Questionnaire was given after the final therapy session.

Group psychotherapy method
An eclectic method of group psychotherapy was applied that had been developed by one of the authors (L.W.) and used by her for 20 years. This method uses a combination of well-validated psychotherapy methods (such as cognitive behavioural therapy, interpersonal therapy, narrative therapy, psychoeducation, expressive techniques) for trauma-focused therapies (for a review, see Taylor & Harvey 2010). It includes 12 90-minute sessions, and each session has an agenda. Some of the topics from the first three sessions include group rules, safety issues and effects of sexual trauma on psychological and interpersonal well-being. A psychotherapeutic approach for common psychiatric and psychological responses to trauma was applied, and some relaxation techniques were introduced. In sessions 4–7, participants were asked to tell their sexual abuse stories, in an order determined by themselves. In sessions 8–10, some common themes raised in the members’ stories were discussed more deeply in the group. Examples of some of these themes include issues about self-respect, self-esteem, sexuality, relationships with men, with family, anger, etc. The 11th and 12th sessions were closure sessions during which members summarised their group process, gave feedback to each other and talked about their future plans. An additional follow-up session was provided six months after finishing the 12th session. All of the sessions were conducted by all of the authors (one therapist and two co-therapists), who have 10–20 years of group psychotherapy experience as therapists and co-therapists.

Statistical analysis
All data were statistically analysed using the spss, version 15.0 package (SPSS Inc., Chicago, IL, USA) programme. For statistical analysis of the differences between the mean scores of the HAM-A, HAM-D and CAPS during the entire group process and on follow-up, the general linear model for repeated measures, chi–square test, and Friedman’s and Wilcoxon’s analysis with Bonferroni correction were used. The Mann–Whitney U-test, chi–square test, and Pearson’s correlation and linear regression analyses were used to find the variables that had a significant effect on the therapeutic factors, treatment efficacy and dropout rates. A p-value < 0.05 was considered statistically significant.

Results

Treatment adherence
A total of five groups were completed, each consisting of 8–10 members. There were no statistically significant differences between these five cohorts with regard to sociodemographic variables, sexual trauma history, scores from whole scales, and dropout and efficacy rates. Among the 47 women who applied for this study, 32 (68.1%) finished the whole group process. Seven (14.9%) never attended group after being screened, and these subjects were excluded from further statistical analysis. The remaining eight (17.0%) subjects will be referred as ‘dropouts’, because these women attended at least one session but did not finish the whole process. To determine the predictors...
for these dropouts, chi-square and linear regression analyses were conducted, and we found that being younger than
33 years of age (median) [odds ratio (OR) = −0.459; 95% confidence interval (CI) −0.571 to −0.140, p = 0.002] and a DES score lower than 30 (no dissociation) (OR = −0.405; 95% CI −0.547 to −0.101, p = 0.006) predicted a higher dropout rate (Table 1).

### Table 1 Regression analysis for treatment adherence

<table>
<thead>
<tr>
<th>Age</th>
<th>Finished n (%)</th>
<th>Dropped out</th>
<th>χ²</th>
<th>p</th>
<th>OR</th>
<th>Sig (reg)</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 33 years</td>
<td>15 (65.2)</td>
<td>8 (34.8)</td>
<td>7.391</td>
<td>0.007</td>
<td>−0.459</td>
<td>0.002</td>
<td>−0.571 to −0.140</td>
</tr>
<tr>
<td>&gt;33 years</td>
<td>17 (100)</td>
<td>0</td>
<td>0</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 27</td>
<td>18 (72)</td>
<td>7 (28)</td>
<td>4.778</td>
<td>0.036</td>
<td>−0.405</td>
<td>0.006</td>
<td>−0.547 to −0.101</td>
</tr>
<tr>
<td>&gt;27</td>
<td>14 (100)</td>
<td>0</td>
<td>0</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DES, Dissociative Experiences Scale.

### Table 2 Mean scores of Hamilton Depression Rating scale (HAM-D), Hamilton Anxiety Rating Scale (HAM-A), Clinician Administered Post-traumatic Stress Disorder Scale-Total (CAPS-T) (subtitles re-experiencing symptoms CAPS-R, avoidance symptoms CAPS-A, hyperarousal symptoms CAPS-H), Dissociative Experiences Scale (DES) and Childhood Trauma Questionnaire (CTQ-28) at screening (1), after 6th session (2), after 12th session (3) and six-month follow-up (4)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Mean</th>
<th>SD</th>
<th>χ²</th>
<th>p</th>
<th>Z</th>
<th>p¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAM-D1</td>
<td>22.45</td>
<td>11.1</td>
<td>48.363</td>
<td>0</td>
<td>HAM-D1/2</td>
<td>−4.889</td>
</tr>
<tr>
<td>HAM-D2</td>
<td>14.64</td>
<td>9.89</td>
<td>HAM-D2/3</td>
<td>−4.725</td>
<td>0</td>
<td></td>
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<tr>
<td>HAM-D3</td>
<td>8.55</td>
<td>8.13</td>
<td>HAM-D3/4</td>
<td>−2.445</td>
<td>0.002</td>
<td></td>
</tr>
<tr>
<td>HAM-D4</td>
<td>5.55</td>
<td>4.95</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HAM-A1</td>
<td>15.45</td>
<td>8.9</td>
<td>41.533</td>
<td>0</td>
<td>HAM-A1/2</td>
<td>−4.62</td>
</tr>
<tr>
<td>HAM-A2</td>
<td>9.82</td>
<td>9.17</td>
<td>HAM-A2/3</td>
<td>−4.173</td>
<td>0</td>
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<tr>
<td>HAM-A3</td>
<td>5.09</td>
<td>6.61</td>
<td>HAM-A3/4</td>
<td>−0.683</td>
<td>0.082</td>
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<tr>
<td>HAM-A4</td>
<td>4.32</td>
<td>2.44</td>
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<tr>
<td>CAPS-T1</td>
<td>42.27</td>
<td>19.68</td>
<td>42.823</td>
<td>0</td>
<td>CAPS-T1/2</td>
<td>−4.42</td>
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<td>26.64</td>
<td>25.95</td>
<td>CAPS-T2/3</td>
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<tr>
<td>CAPS-T3</td>
<td>13.77</td>
<td>24.21</td>
<td>CAPS-T3/4</td>
<td>−0.669</td>
<td>0.167</td>
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<tr>
<td>CAPS-T4</td>
<td>9.32</td>
<td>11.84</td>
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<tr>
<td>CAPS-R1</td>
<td>10</td>
<td>9.25</td>
<td>6.596</td>
<td>0.086</td>
<td>CAPS-R1/2</td>
<td>−1.255</td>
</tr>
<tr>
<td>CAPS-R2</td>
<td>9.55</td>
<td>11.32</td>
<td>CAPS-R2/3</td>
<td>−1.725</td>
<td>0.028</td>
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<tr>
<td>CAPS-R3</td>
<td>6.36</td>
<td>10.48</td>
<td>CAPS-R3/4</td>
<td>−1.074</td>
<td>0.094</td>
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<tr>
<td>CAPS-R4</td>
<td>3.95</td>
<td>7</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>CAPS-A1</td>
<td>20.55</td>
<td>10.25</td>
<td>40.026</td>
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<td>CAPS-A1/2</td>
<td>−4.341</td>
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<tr>
<td>CAPS-A2</td>
<td>10.18</td>
<td>11.57</td>
<td>CAPS-A2/3</td>
<td>−3.481</td>
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</tr>
<tr>
<td>CAPS-A3</td>
<td>3.82</td>
<td>10.63</td>
<td>CAPS-A3/4</td>
<td>−1.153</td>
<td>0.083</td>
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<tr>
<td>CAPS-A4</td>
<td>0.91</td>
<td>2.52</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>CAPS-H1</td>
<td>11.73</td>
<td>9.42</td>
<td>17.112</td>
<td>0.001</td>
<td>CAPS-H1/2</td>
<td>−3.23</td>
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<tr>
<td>CAPS-H2</td>
<td>6.91</td>
<td>8.22</td>
<td>CAPS-H2/3</td>
<td>−3.126</td>
<td>0</td>
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<tr>
<td>CAPS-H3</td>
<td>3.59</td>
<td>6.26</td>
<td>CAPS-H3/4</td>
<td>−0.306</td>
<td>0.253</td>
<td></td>
</tr>
<tr>
<td>CAPS-H4</td>
<td>4.45</td>
<td>7.75</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Friedman’s test.
†Wilcoxon’s test with Bonferroni correction.
in two steps. First, a nonparametric analysis for K-repeated samples (Friedman) was performed to analyse the changes in scores from baseline to follow-up. Second, to find exactly when a significant decrease in scores had occurred, nonparametric analysis for 2-Related Samples (Wilcoxon’s test with Bonferroni correction) was performed. According to these results, the significant decline in HAM-D (mean = 22.45 versus 14.64, p < 0.001), HAM-A (15.45/9.82, p < 0.001), CAPS-total (CAPS-T) (42.27/26.64, p < 0.001), CAPS-A (20.55/10.18, p < 0.001) and CAPS-H (11.73/6.91, p < 0.001) began during the first six sessions. This tendency to decline continued through the follow-up session, and the statistical significance was lost between 12th session and the six-month follow-up, except for the HAM-D (8.55/5.55, p = 0.002). CAPS-H scores increased between the 12th session and the six-month follow-up session without a statistically significant difference. For the CAPS-R scores, a significant decline began between the 6th and the 12th sessions (9.55/6.36, p = 0.028), and this significance was lost between the 12th session and the six-month follow-up session.

As shown in Table 2, the standard deviations were high, which suggests that there were some extreme cases that did not respond to therapy. To find predictors for treatment outcome, we divided the subjects into two groups with regard to treatment efficacy. For those subjects whose scores from all scales decreased more than 50% between baseline and the end of therapy (12th session), the treatment could be considered ‘efficacious’ (n = 25, 78.1%). Chi-square and linear regression analyses were performed to find the predictors for treatment outcome. The only significant result was for DES scores; for the majority of those who had a DES score of <30 (no dissociation), the treatment was efficacious (n = 17, 94.4%), while for the 42.9% (n = 6) of the women who had a DES score above 30, the treatment was not efficacious (OR = -0.448; 95% CI = -0.651 to -0.095, p = 0.010).

Understanding the therapeutic factors

Table 3 shows the results of the Group Therapeutic Factors Questionnaire. Existential factors (mean ± standard deviation, 41.40 ± 12.39), universality (37.56 ± 7.11) and cohesiveness (37.24 ± 8.32) were rated as the most helpful therapeutic factors in the group process, while identification (23.56 ± 7.90), interpersonal learning – input (24.64 ± 8.70) and interpersonal learning – output (25.80 ± 7.91) were rated as the least helpful factors.

Table 3 Mean scores of Group Therapeutic Factors Questionnaire

<table>
<thead>
<tr>
<th>Therapeutic factors</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altruism</td>
<td>29.24</td>
<td>10.12</td>
</tr>
<tr>
<td>Cohesiveness</td>
<td>37.24</td>
<td>8.32</td>
</tr>
<tr>
<td>Universality</td>
<td>37.56</td>
<td>7.11</td>
</tr>
<tr>
<td>Interpersonal learning – input</td>
<td>24.64</td>
<td>8.70</td>
</tr>
<tr>
<td>Interpersonal learning – output</td>
<td>25.80</td>
<td>7.91</td>
</tr>
<tr>
<td>Guidance</td>
<td>26.00</td>
<td>8.15</td>
</tr>
<tr>
<td>Catharsis</td>
<td>30.48</td>
<td>7.14</td>
</tr>
<tr>
<td>Identification</td>
<td>23.56</td>
<td>7.90</td>
</tr>
<tr>
<td>Family re-enactment</td>
<td>34.32</td>
<td>11.59</td>
</tr>
<tr>
<td>Self-understanding</td>
<td>42.32</td>
<td>11.35</td>
</tr>
<tr>
<td>Hope instillation</td>
<td>36.40</td>
<td>9.61</td>
</tr>
<tr>
<td>Existential factors</td>
<td>41.40</td>
<td>12.39</td>
</tr>
</tbody>
</table>

Discussion

We were able to fulfil the three aims we had for this study. The first aim was to help these women to heal from their trauma-related psychiatric and psychological difficulties. Most of these women had severe psychiatric symptoms at screening, including depression, anxiety, post-traumatic stress disorder and dissociation. Their symptom patterns were similar to those previously reported for comparable populations (for a review, see Barker-Collo & Read 2003). As shown in Table 2, most of the group members had significantly less depressive, anxious and post-traumatic stress disorder symptoms, both immediately after and six months after this therapy. These results show that group psychotherapy was effective for this sample, a result that is in accord with previous literature (for reviews see Taylor & Harvey 2010, Trask et al. 2011). A significant decline in symptoms began as early as the 6th session for depression and anxiety, along with their overall symptoms of PTSD, primarily avoidance and hyperarousal symptoms. The only exception was the re-experiencing of symptoms of PTSD, which showed a small decline at the 6th session evaluation, but this decline became significant at the 12th session evaluation. We think that the possible reason for this ‘late’ decline in re-experiencing symptoms is that from sessions 4–7, participants were asked to tell their sexual abuse stories. Telling their trauma stories in front of other members, as well as listening to the other members’ stories, may have caused a temporary increase in some participants’ re-experiencing symptoms. But as group members became ‘de-sensitised’ to the telling and hearing of stories, their symptoms begin to decline.

We found that this treatment was efficacious for 78.1% of these women. This rate is similar to the rates reported in the literature, because a large meta-analysis of 26 studies...
including 44 treatment conditions for psychotherapy of PTSD reports that, of patients who completed treatment, 67% no longer meet the criteria for PTSD (Bradley et al. 2005). What is interesting is that none of the variables had a significant effect on treatment efficacy. The only significant result was for dissociation at baseline; the treatment was significantly more effective for members who had a lower score for dissociation at baseline, as compared to those who had higher dissociation scores. This finding is in contradiction to results from previous studies which have shown that more severe dissociative symptoms at baseline are associated with the same or even better outcomes for psychological treatments for PTSD (Lynch et al. 2008, Hagenaars et al. 2010). Dropout rates were also similar to the rates reported in the literature (Bradley et al. 2005). A younger age and having lower levels of dissociation at baseline predicted a higher dropout rate. Dissociation is a complex symptom and may have a significant negative effect on individual’s daily life and functioning. This may have created a higher level of motivation for treatment, which is reflected in a lower dropout rate.

Our second aim was to find how different characteristics of group members affected their understanding of the group process, especially the therapeutic factors of group psychotherapy. In this sample, group members reported that existential factors, universality and cohesiveness were the most helpful therapeutic factors. This finding supports the rationale for using group psychotherapy in trauma treatment, because, as previously stated, a safe and structured group environment helps members to feel supported, heard and believed and lessens their feelings of stigma, isolation and shame (Feiring et al. 1996, Talbot 1996, Westbury & Tuttly 1999).

We have two hypotheses to explain why group members chose these particular factors. First, we believe that the setting had a significant effect upon ‘cohesiveness’. The groups were run in the private office of one of the authors. Members were permitted to come half an hour before the group started. Many group members chose to do this, and they often brought food with them, drank coffee and talked with each other. This somewhat resembles ‘women’s day’ in Turkish culture, social events where women come together regularly to eat, drink and talk with each other. We believe these ‘before-the-group’ talks encouraged the occurrence of cohesiveness. In addition, most of the group members continued to meet regularly after the whole group process ended. Some of them even began to organise community education programmes. Second, we think that ‘culture’ had an important effect on ‘universality’. The most common perpetrators for our sample were first-degree family members (29.8%) and husbands/lovers (29.8%). Incest is a major social taboo in Turkey, and usually, both the victims and their families would rather ‘keep it a secret’ instead of talking about such abuse. Incest may even result in murders within families. Sexual abuse by husbands/lovers is sometimes not considered illegal in Turkey. For these reasons, women in Turkey who are sexually abused by first-degree relatives and/or husbands usually do not share their trauma story with anyone else. Shame and fear may be the main emotions for women who choose to remain silent after this kind of sexual abuse. Understanding this helps us to understand why these women might choose ‘universality’ as one of the most helpful therapeutic factors. Hearing other women’s stories and realising that they are not the only people who have had to face such an event may have lessened these women’s feelings of isolation, and this may have helped them through their healing process. This is also closely related to the ‘existential factors’; these women may have learned that ‘life is not always fair’ by listening to other women’s stories. Existential well-being, defined as having a sense of being unique, having a purpose in life and finding meaning in a ‘hostile and hurtful’ world, has previously been shown to be an important factor in recovery from sexually abusive experiences (Feinauer 2003, Shaw et al. 2005). Rating existential factors as one of the most helpful therapeutic factors in group psychotherapy suggests that group participants were able to make meaning in their lives that has become more significant to them than their sexually abusive experiences. They were able to see themselves as having survived a difficult and destructive experience resulting from another person’s disturbance. Once freed from self-blame, these women could believe they have an opportunity to change their lives and could put their traumatic experiences into the past. This finding is beautifully reflected in a comment made by one of our group members: ‘I used to carry my life on my shoulders like a burden. Now I am ready to flow with it’.

We had a third exploratory goal in this study and that was to observe similarities and differences with regard to responses to sexual trauma–related issues and the group therapy setting between Turkish women and women from other countries reported in the literature. One of our therapists (L.W.) had run groups with sexually abused women in the USA for 20 years, so she had a chance to compare these similarities and differences. Another paper compares observations of group patterns for sexual abuse survivors in these two countries with significantly different cultures. But, to summarise, we report that although groups from these two countries were overwhelmingly similar in many ways, differences emerged in expression and containment of
effect, cohesion and relatedness, perceptions of reaction to authority and power, and external/internal locus of control (L. Welkin, S. Candansayar and A. Sayin, unpublished results). Religiously and culturally determined contrasts in perception, attitude, communication and behaviour may have significant effects on patients’ perceptions about therapeutic factors (Salvendy 1999). Turkish culture is often described as a culture of relatedness or collectivism where interpersonal relations are of central importance, in contrast to a culture of separateness and individualism where personal autonomy is more highly valued (Kaçıncıbaşı 1994). People in more relational cultures are thought to seek high levels of relatedness and moderate levels of autonomy to maintain their mental health, while people in more individualistic cultures seek high levels of autonomy and moderate levels of relatedness (Sato 2001). Universality and cohesiveness are, we believe, therapeutic factors that can be closely related to ‘relatedness’. In a study conducted with Turkish psychiatric inpatients, it was reported that patients rated existential factors, instillation of hope and self-efficacy as the most helpful group therapeutic factors (Salvendy 1999). Turkish culture is often described as a culture of separateness and individualism where people in more relational cultures seek high levels of relatedness and moderate levels of autonomy to maintain their mental health, while people in more individualistic cultures seek high levels of autonomy and moderate levels of relatedness (Sato 2001).

Although our results are promising, this study has some major limitations. First, our sample is small and is not representative of all Turkish sexual abuse victims, because it includes only women living in the capital city of Turkey. Second, this is not a controlled study, and we did not compare the therapeutic effect of group psychotherapy to any other form of treatment or a waiting list. Third, all the treatment outcome ratings were performed by one of the therapists in the group and that may have created a bias.

Conclusion

We believe that this study, despite its limitations, provides further support for the effectiveness of group psychotherapy for women from different cultural backgrounds with a history of childhood sexual abuse. Group psychotherapy was significantly effective for reducing levels of depression, anxiety and PTSD symptoms in this sample of women. Dissociation had a significant effect on both treatment outcome and treatment adherence. Further studies conducted with sexually abused women from different countries would surely enrich the literature and help us to understand better how to help victims of sexual abuse.

Relevance to clinical practice

Mental health treatment for sexually abused women should be planned with careful consideration of both local cultural differences and universal human fundamentals. Group psychotherapy can be a preferable treatment for these women, because it especially helps to reduce feelings of stigma, isolation and shame.

Contributions

Study design: AS, SC, LW; data collection and analysis: AS and manuscript preparation: AS, SC, LW.

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