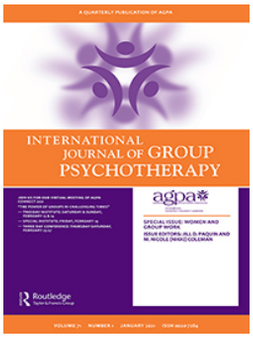

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Relationship Variables in Group Psychotherapy for Women Sexual Trauma Survivors

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ABSTRACT

This study examined relational group psychotherapy processes, including group cohesion, bond with group leaders, perceptions of shame, and posttraumatic stress disorder (PTSD) symptomatology for sexual trauma survivors. Six separate treatment groups of women who were either adult sexual assault survivors (N = 24) or adult survivors of childhood sexual abuse (N = 9) participated in the study. Participants completed the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) pre- and posttreatment, the Group Climate Questionnaire, Bond scale of the Working Alliance Inventory Short Form (WAI-S), and Compass of Shame Scale at four intervals. Growth curve models analyzed Engagement, Bond, and Shame Reactions over time. PCL-5 scores were compared pre- and posttreatment and examined in relationship to the process variables of Engagement and Bond. Results showed increases in group cohesion and perceptions of Bond with group leaders and decreases in PTSD symptoms and attacking self-shame reactions. Clinical implications and recommendations for this population are presented.

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INTRODUCTION

Sexual trauma survivors are a population in need of additional support due to the complexity of their psychological presentation and social difficulties. *Sexual trauma* refers to instances of sexual assault where there is forcible, unwanted sexual contact and also encompasses sexual abuse wherein the unwanted sexual contact occurred when one was a minor (Walsh et al., 2012). Statistics have shown only 21% of women reported receiving victim services following sexual trauma (National Crime Victims' Rights, 2017), yet recent media attention and the call for the destigmatization of sexual trauma through movements such as #MeToo have influenced increased help-seeking behaviors from persons who have experienced sexual abuse or assault. Experiences of sexual trauma may teach survivors that no one can be trusted, potentially resulting in pushing people away in an effort to protect themselves from continuous personal injuries and this, then, contributes to an internalization of emotions that perpetuates their distress (Ullman et al., 2007). Current findings have demonstrated that group therapy treatment is effective for addressing trauma symptoms and social functioning for those who have been exposed to sexual trauma (Ehring et al., 2014). Although research strongly points to the damage caused by sexual trauma to interpersonal relationships, assessing relational variables within group treatment has not been a concentration in the literature and leaves questions unanswered about how relational factors of group psychotherapy influence treatment with this population.

Affective Symptomatology Resulting from Sexual Trauma

It has been theorized that the development of post-traumatic stress disorder (PTSD) symptoms is a common reaction after surviving sexual trauma (Pacella et al., 2013). The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013) outlines the diagnostic criteria for PTSD, including the symptom clusters of intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. It also has been speculated that the interpersonal and intrusive nature of sexual

trauma in comparison to other traumas may exacerbate the occurrence of these symptoms and place women at higher risk of developing PTSD (Charuvastra & Cloitre, 2008; Foa et al., 2009). Of note, survivors of sexual trauma are often at higher risk for revictimization than those who have not been abused (Classen et al., 2005; DePrince, 2005), and this may lead to a presentation Judith Herman (1992) termed as *complex PTSD*. Although complex PTSD (C-PTSD) is not included in the *DSM-5* as a stand-alone diagnosis, the theoretical implications explain elements of a survivor's presentation. Complex PTSD encapsulates struggles, including changes in self-perception, alterations in relationships with others, and significant emotional dysregulation (Herman, 1992), in addition to the classic trauma symptom clusters in the *DSM-5*.

It has been speculated that the long-term effects of sexual abuse may include the development of psychiatric and social problems such as major depression, anxiety disorders, dissociative symptoms, borderline personality disorder, alcohol or substance abuse, eating disorders, and suicidality (Elkjaer et al., 2014). It is estimated that approximately 80% of individuals with PTSD also live with additional disorders (Foa et al., 2009). This results in complications in the treatment of sexual trauma survivors, as the different or multiple diagnoses may require adjustments throughout the course of psychological care.

Sexual Trauma and Shame

The extant literature has previously focused heavily on the correlation between fear and PTSD symptoms, yet attention also has looked at the link between trauma symptomatology and the construct of shame (Andrews et al., 2000). Earlier studies showed that childhood and adult sexual trauma resulted in intense affect, including shame, a sense of being contaminated, and a sense of guilt (Gelinas, 1983; Herman, 1981). The internalization of negativity for survivors also can be attributed to feelings of shame that develop in the aftermath of their sexual trauma (Weiss, 2010). Shame has been found to be prevalent among sexual trauma survivors and studies have found it to be related to the development of PTSD symptoms (Rahm et al., 2013; Sayin et al., 2012). The impact of shame may also be connected to a sense of *alienation*, or the

belief that one is disconnected from oneself and others (DePrince et al., 2011), resulting in inhibiting the development of new relationships. Thus, the experience of "fitting in" in social settings is transient for many survivors (Courtois & Ford, 2013), and this highlights the importance of creating a supportive and social group treatment environment that provides a corrective experience.

Social support has been shown to buffer the effects of trauma symptom development and may help prevent the development of PTSD symptomatology (Hyman et al., 2003), whereas negative social reactions can contribute to the cultivation of higher rates of PTSD among survivors, frequently resulting in them not reaching out for support from others about their trauma due to a concern about negative, unsupportive, or blaming reactions (Ullman & Peter-Hagene, 2014; Ullman et al., 2007). Studies on social support point to the importance of the relationship between a survivor and therapist in individual psychological treatment. The therapeutic relationship has been shown to be vital in the process of healing, and the ability of a therapist to establish a safe environment and supportive relationship may help form a bond in therapy that could be the first step in helping the survivor develop and improve their personal relationships (Charuvastra & Cloitre, 2008). The therapeutic relationship has been shown to be a strong predictor of outcome, and the modeling of appropriate interactions in therapy that emphasize developing trust and safety may provide opportunities for survivors to experience a new kind of interaction (Cloitre et al., 2012; Ehring et al., 2014; Parry & Simpson, 2016).

Group Psychotherapy Treatment for Sexual Trauma

Although individual therapy holds the capacity for relational development, group psychotherapy provides an environment where those who have been sexually abused can engage in a form of treatment where they have an increased opportunity to develop relationships both with members in the group and the group leader(s). These interactions may help bring out the commonalities among the group members, and this normalization can help address the shame and stigmatization of sexual abuse that contributes to the psychological distress found among survivors (Yalom & Leszcz, 2005). Unlike

individual therapy where there is a power imbalance between client and therapist, group therapy addresses some of this dynamic by allowing group members to approach each other on equal ground, and to provide and receive compassionate support where they can begin to feel that they are of value to the group and the members within it (Herman, 2011). It has also been suggested that group interventions may be especially beneficial for sexual trauma survivors to help foster social support and enable observational learning (Ehring et al., 2014).

The literature suggests that the most widely studied evidence-based treatment for sexual trauma is trauma-focused cognitive behavioral therapy (TF-CBT) (Foa et al., 2009). This treatment modality showed superior efficacy when treating childhood sexual abuse survivors when compared to other treatment modalities such as nondirective, supportive counseling, and community therapy approaches in group therapy formats (Kendall et al., 2012). TF-CBT groups typically focus on behavioral skills training, cognitive restructuring, and trauma exposure (Foa et al., 2009).

At this time, research provides some confidence that group treatment works well for outcomes, such as reducing PTSD symptoms (Burlingame et al., 2013; Burlingame et al., 2014; Cloitre et al., 2002; Elkjaer et al., 2014; Krupnick et al., 2008; Vilencia et al., 2013), and indicates gains in interpersonal interactions and relationships (Lundqvist et al., 2009). Foa et al. (2009) explained that much of the group research with this population is focused primarily on symptom reduction and daily functioning. However, this outcome-based emphasis gives little focus on the relational aspects of trauma and does not consider how the social aspects of group may influence other areas of a survivor's experience.

Valerio and Lepper (2010) suggested that certain interpersonal factors found in group treatment, such as being able to voice emotions, receive feedback from group members about relational behaviors, and learning new interpersonal behaviors in group may be vitally important when working with sexual trauma survivors. Disclosures allow members the opportunity to identify with other group members who have similar experiences, which helps to diminish the stigmatization and isolation often felt by sexual trauma survivors (Yalom & Leszcz, 2005). The concept of group cohesion suggests that the connections made between members in the group will allow them to begin to perceive the group as a setting that holds

opportunities for social relationships (Yalom & Leszcz, 2005) and has been shown to have a strong positive relationship with client outcome (Lo Coco et al., 2016). The term *cohesion* has become synonymous with the therapeutic relationship in group therapy and is often researched as a force that causes group members to remain in the group and develop an element of "sticking-togetherness" (Burlingame et al., 2011). Group theory postulates that cohesion develops in stages throughout treatment, with an initial focus on orientation and dependency on the leader and later stages showing cohesion, interdependence among members, and a tolerance for conflict within the group (Yalom & Leszcz, 2005). The notion of *congruence* within groups, referring to the individual's sense of fit in the group environment, also has been shown to be important, with some research demonstrating that congruence within a group therapy context may be a critical component to overall therapy outcome (Paquin et al., 2013).

Current findings have demonstrated that group treatment is effective for addressing PTSD symptoms and aspects of social functioning for those who have experienced sexual trauma (Ehring et al., 2014). Research strongly points to the damage caused by sexual trauma to interpersonal relationships, however assessing relational variables within the context of group psychotherapy has not been a concentration of the literature. This study addresses these gaps by examining the group members' perceived relationship with the group leader, as well as with other group members, in trauma-focused cognitive behavioral therapy groups at a local rape crisis agency. In addition, the present study sought to examine the construct of shame within survivors in group treatment, to assess if the universality of group treatment was beneficial to addressing the internalized negative sense of self that so frequently limits interpersonal connections. Assessment occurred at four different time points during treatment to measure group perceptions of cohesion, bond, and shame reactions over time. The relationship between the process variables of cohesion and bond to the outcome variable of PTSD symptomatology was explored. Similar to other research with this population, PTSD symptom severity was assessed pre- and posttreatment to evaluate treatment efficacy for trauma symptomatology.

HYPOTHESES

This study examined five hypotheses. The first hypothesis was derived from research that shows that cohesion often increases across sessions (Burlingame et al., 2011) and is a construct that encompasses the connection that develops between members in a group. It was hypothesized that cohesion among group members, as assessed by the Engagement Subscale of the Group Climate Questionnaire (MacKenzie, 1983) would increase across the four time points, demonstrating an increase in the relational capacity between group members across time (Hypothesis 1). The establishment of a safe therapeutic environment and the influence of the group leaders to encourage empowerment and engagement may be vital components in working with individuals with a diagnosis of PTSD (Corey & Corey, 2010). The therapeutic alliance within group therapy models the notion of healthy boundaries and mitigates social difficulties faced within this population (Payne et al., 2007). The second hypothesis examining the bond between group leader and group members was measured by the Bond scale of the Working Alliance Inventory (Horvath, 1994). It was hypothesized that there would be an increase in Bond scores across the four time points (Hypothesis 2). Research has noted that perceptions of cohesion and bond contribute to therapy outcomes (Burlingame et al., 2011, Payne et al., 2007), and it was hypothesized that increases in Bond and Engagement scores would be significant predictors of overall posttreatment outcome PTSD scores (Hypothesis 3).

Shame was another focus of this research as it is often present for survivors of sexual trauma (Gelinas, 1983; Herman, 1981). Four different shame reactions were assessed by the Compass of Shame Scale (Elison et al., 2006), including Avoidance, Attacking Self, Withdrawal, and Attacking Others. It was hypothesized that each of the four shame subscales would decrease across the four time points (Hypothesis 4).

Research consistently has found that PTSD is a common disorder for those experiencing sexual trauma (Robinaugh & McNally, 2011). Previous research has demonstrated the efficacy of group therapy for PTSD symptom reduction (Burlingame et al., 2013; Burlingame et al., 2014). Therefore, it was hypothesized that PTSD symptom scores assessed by the Posttraumatic Stress Disorder Checklist (Weathers et al., 2013) would decrease from pre- to posttreatment in this study (Hypothesis 5).

METHODS

Participants

Initial participants in this study consisted of 34 adult women (ages 18 and older) survivors of sexual trauma. One member of one of the adult survivors of sexual trauma group left the group midway through treatment (after two time points) due to medical problems; her data are not included, resulting in a final total of 33 participants. Group members were heterogeneous in age (median age = 29, age range = 20 to 55), and assault type. In terms of racial/ethnic background, 79% of group members identified as Caucasian/White (N = 26), 12% as Hispanic/Latino (N = 4), and 9% as multiracial (N = 3). Twenty-four participants identified as survivors of adult sexual assault and nine as adult survivors of childhood abuse. The group demographic form captured the primary assault type that participants were seeking treatment to address; however, it did not capture whether participants had experienced multiple sexual traumas throughout their lifetime (See Table 1).

Treatment Groups

The study focused on women who were members of six closed psychotherapy groups held at a rape crisis center in a large western city in the United States. Each group consisted of four to eight members. Six treatment groups were comprised of survivors of adult sexual assault (n = 4) and two others were comprised of adult survivors of childhood sexual abuse (n = 2). Mean group size was approximately six group members (M = 5.88, SD = 1.09). All groups focused on the reduction of PTSD symptomatology. Groups for survivors of adult sexual assault were conducted for 16 weeks, and groups for adult survivors of childhood sexual abuse were held for 24 weeks. Adult survivors of sexual assault were defined by the agency as those who experienced sexual assault at the age of 18 years or older, and survivors of childhood abuse were women who experienced sexual abuse when they were a minor. The agency operates under the philosophy that childhood sexual abuse results in a more severe trauma presentation that requires a longer course of treatment, thus explaining the different

Table 1. Overview of Participant Demographic Characteristics

Demographics	Frequency	Percentage
Total Participants	33	
Age Range		
19–25	9	27.27
26–30	9	27.27
31–35	9	27.27
36–40	1	3.03
41–45	4	12.12
46–50	0	0
51–55	1	3.03
Racial/Ethnic Group		
Caucasian/White	26	78.78
Hispanic/Latino	4	12.12
Multiracial	3	9.09
Assault Type		
Adult Sexual Assault	24	72.72
Adult Molested as Child	9	27.27

treatment lengths. Some authors also have suggested a longer course of treatment is warranted for childhood sexual abuse due to the possibility of heightened symptomatology (Courtois, 1997).

Each group followed similar curricula based on principles of trauma-focused cognitive behavioral therapy. This format of treatment has been shown to be effective in the treatment of PTSD and is often cited as the treatment of choice for trauma (Foa et al., 2009; Seidler & Wagner, 2006). Trauma-focused cognitive behavioral therapy also has been found to have positive results across different sites and diverse populations, showing it to be a culturally sensitive method of treatment (Kendall et al., 2012). The protocols used by the community agency in this study were developed by providers at the clinic after researching critical elements of TF-CBT treatment, including behavioral skills training, cognitive restructuring, and trauma exposure (Foa et al., 2009). Stages of treatment in each group consisted of establishing safety within the group and providing psychoeducation, an exposure component of having group members share their trauma narrative and receive feedback, and a concluding stage of learning how to integrate new skills into their daily lives.

All groups employed cofacilitators and all group leaders (both staff and trainees) received 40 hours of training from the agency about how to work with survivors. This training included psychoeducation about PTSD symptomatology, considerations of working with sexual trauma survivors, and crisis management strategies. Each group leader dyad consisted of one staff therapist at the agency with a master's degree in counseling or social work and one master's level student in training in one of these disciplines.

Procedures

Participants were screened for their appropriateness to engage in group therapy by the rape crisis center that conducted the group treatment. Prior to beginning treatment, all participants completed an initial diagnostic intake interview at the center (with staff therapists at the agency) to discuss their clinical history and the nature of their trauma to determine a treatment plan. Potential group members who endorsed current psychosis, substance use, or active suicidal intent were excluded from group treatment for the safety of themselves and the environment of the group. Participants who met criteria and were willing to be in group treatment then met with a therapist at the agency to complete a pregroup interview, which further ascertained goodness of fit for the group and also provided the participants with information about group treatment (i.e., expectations, meeting times, norms).

Informed consent for the study was provided to all members by the group leaders who had been trained to disseminate this information. Groups were occurring in the community and participants were informed that their consent to take part in the study was voluntary, and no treatment would be withheld should they decide not to participate. Although the length of therapy differed for the two types of groups (the Adult Sexual Abuse group was 8 sessions shorter that the Childhood Sexual Abuse group), all group measures were administered at weeks 1, 5, 10, and 25 of treatment to control for dose effect. The Posttraumatic Stress Disorder Checklist (PCL-5) was given at the beginning of the first session and again at the end of each group treatment (either week 15 or week 23) to assess for posttreatment effects. All measures were de-

identified and disseminated by the group leaders. Group members placed the measures into a designated envelope after completion to maintain participant anonymity.

Measures

Demographic Information Form. Each participant completed a demographic information form that included age, ethnicity, and type of sexual trauma (adult sexual assault or child sexual abuse). This form was completed at the onset of group treatment, following group members consenting to participate in the study. Participants were then assigned identification numbers to protect their confidentiality in the study.

Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5; Weathers et al., 2013). This measure is given to all clients who receive treatment at the rape crisis center, both prior to and at the completion of treatment. As part of the research, participants were provided with informed consent for their scores to be included as part of the study. The PCL-5 is one of the most widely used self-report measures to assess for PTSD symptoms (Bovin et al., 2016). Total PCL scores correlate highly with total scores of other self-report PTSD measures, including the Clinician-Administered PTSD Scale (CAPS) with an alpha of.79 (Bovin et al., 2016). The PCL-5 includes 20 items that correspond to the 20 PTSD symptoms outlined in the *DSM-5* (Bovin et al., 2016). The questionnaire is based on a Likert scale of 0 to 4, with scale descriptors ranging from 0 (*not at all*) to 4 (*extremely*). A total score ranges from 0 to 80, and a clinical cutoff of 33 suggests the presence of PTSD symptoms (Bovin et al., 2016). *DSM-5* symptom cluster severity scores can also be obtained from the measurement by summing the scores for an item within a given cluster. The measure has a test–retest correlation of .82 and has demonstrated excellent convergent validity scores with the PHQ Depression and Generalized Anxiety Disorder scales (Bovin et al., 2016). Subscales have shown internal consistency scales ranging from acceptable to good (alpha coefficients of .57 to .078) (Sveen et al., 2016). Cronbach's alpha coefficient for this sample was calculated as .92 for total PTSD symptom scores. Subscales were calculated at .83 for

Intrusion, .72 for Avoidance, .79 for Negativity, and .79 for Hyperarousal for the sample in this study.

Group Climate Questionnaire Short Form (GCQ; Mackenzie, 1983*)*. The Group Climate Questionnaire Short Form (GCQ; MacKenzie, 1983) is commonly used in group studies to measure group cohesion. It contains 12-items rated on a 7-point Likert scale and consists of three subscales (Engagement, Conflict, Avoidance) and represents behavioral descriptions of group climate in simple and understandable language (Johnson et al., 2005). For this study, only the Engagement subscale was included in the data analysis, as the primary research question surrounded the construct of group cohesion and relationship development within the group. Although the other constructs of Conflict and Avoidance measured by the GCQ are influential to cohesion, the analyses in this study were directed toward examining ratings of self-disclosure and understanding within the group, which are best captured by the Engagement subscale (Johnson et al., 2005). The Engagement subscale consists of five items and describes constructive therapy work and the group bond. The GCQ has shown good construct validity with demonstrated links to determining group processes and outcomes (Johnson et al., 2005). Coefficient alphas for the Engagement subscale have been reported at .94 (Kivlighan & Goldfine, 1991) and Cronbach's alpha coefficient for Engagement was calculated at .90 in this study sample.

Working Alliance Inventory Short Form (WAI-S; Horvath, 1994*)*. The Working Alliance Inventory Short Form (WAI-S, Horvath, 1994) consists of 12 items that reflect the client's judgment on the level of agreement on therapeutic tasks, treatment goals, and the strength of the affective bond (Smits et al., 2015). The WAI-S was used in this study to assess group members' perceived bond with the group leader. The Bond subscale consists of four items on a 7-point Likert scale. The Bond subscale has reliability coefficients ranging from .85 to .92 (Horvath & Greenberg, 1989) with good convergent and discriminant validity (Falkenstrom et al., 2013). Although there is a lack of psychometrics about this measure in regard to its use in group settings (Woody & Adessky, 2002), Horvath and Luborsky (1993) suggest that the pantheoretical nature of the WAI-S may allow it to be a flexible measure within groups. Cronbach's alpha for the Bond subscale in this sample was calculated at .89.

Compass of Shame Scale (CoSS; Elison et al., 2006*).* The Compass of Shame Scale (CoSS; Elison et al., 2006) is a 12-item, scenario-based measure that was developed to assess an individual's use of the four styles of shame reactions and coping styles described by Nathanson's (1992) compass of shame model (Elison et al., 2006). The four poles of the compass of shame model are represented in subscales of the CoSS and assess different types of shame reactions and coping styles. While other shame scales and measures are used to assess emotional states or traits, the CoSS was developed to be a self-report measure designed to assess how individuals regulate shame once it is experienced (Schalkwijk et al., 2016). It has been used in previous research exploring shame reactions and coping following physical or sexual abuse (Dorahy et al., 2013). The CoSS was used in this study in the context of examining treatment efficacy, as recognizing shame coping and reactions are likely important for symptom reduction, and also influence relationship development between group members and in the therapy relationship.

The four subscales are comprised of Withdrawal, Attack Self, Avoidance, and Attack Other (Elison et al., 2006). Participants were provided with a series of statements that describe potentially shame-inducing situations and four responses, each of which characterizes a different type of shame reaction to the prompt. Individuals were instructed to rate each item using a Likert scale ranging from 0 (*never*) to 4 (*almost always*) (Elison et al., 2006). Subscales are totaled by summing the ratings for each shame reaction for all the prompts with a range of scores from 0 to 48. The CoSS has been shown to be a reliable measure and has internal consistency coefficients ranging from .74 to .91 (Elison et al., 2006). Alpha coefficients for subscales in this sample were calculated as .80 for Avoidance, .94 for Attack Self, .91 for Withdrawal, and .91 for Attack Other.

RESULTS

Hierarchical Linear Modeling Data Analyses

Hierarchical Linear Modeling 7 (HLM-7; Raudenbush et al., 2017) and the Statistical Package for the Social Sciences (SPSS; IBM Corp., 2017) were used to test the hypotheses of this study. HLM was used as this study design has three levels of observation. Level-1 consists of the

time points of the study (Time 1 through Time 4), Level-2 is composed of individual participants in the study, and Level-3 represents the different groups in the study. The time points of Level-1 are then nested within the individuals of Level-2 and share the impact of Level-2 variables (McCoach, 2010). The individuals of Level-2 are nested within groups that compose Level-3. As there were two lengths of treatment groups in this study (i.e., 16- and 24-week groups), Level-3 of the HLM models was used in this study to control for the differing lengths. This model can estimate a mean growth slope, determine the reliability of status and change, estimate the relationship between initial status and rate of change, provide general descriptive statistics, and model relations of person-level variables to status and growth rate (McCoach, 2010). To determine the model of best fit in HLM analyses, both unconditional linear and quadratic models were built with no Level-2 predictors, and with only time as a Level-1 predictor (time as a predictor is a necessity for all growth models in HLM) for comparison to determine model of best fit for analysis.

Engagement. It was expected that group members would show an increase in their perception of cohesion with other members, as measured by the Engagement subscale of the GCQ, across four time points. The growth of Engagement/Cohesion over time was best modeled by the quadratic model in HLM with a significant X^2 value ($p < .001$). An intraclass coefficient (ICC) of 75.74% demonstrated that approximately 76% of the total variance in Engagement was explained as occurring between observations from the same cluster (i.e., repeated measures for individual group members). This percentage also demonstrates the anticipated correlation between two observations that are randomly chosen from the same cluster (i.e., the correlation of two time point measurements from the same individual). The final model used time as a Level-1 predictor, Pre-PTSD scores as a Level-2 predictor, and Group Length as a Level-3 predictor.

Results showed that group members varied significantly ($p < .001$) in their average Engagement scores at the start of group treatment, which highlighted the individual differences in members at the onset of treatment. Possible Engagement scores on the GCQ ranged from 1 to 7. A mean fixed intercept of 4.14 showed that an average Engagement score was approximately 4.15 points at the start of treatment. The random intercept was also significant ($p < .001$), suggesting

that group members varied in their Engagement scores at the start of treatment. The slope was significant ($p < .005$), showing a significant difference in growth rate for group members throughout treatment and demonstrating each group member's different trajectory in growth and the variance in scores across time points. There was an average increase of approximately 1.34 points in their Engagement score for every time point. The random linear slope varied significantly across individuals ($p < .001$), suggesting participants varied in their rate of growth in Engagement over time. The acceleration of growth was also significant ($p = .016$), indicating that changed slowed over the treatment with a coefficient of −0.26 points in Engagement over time. The random effect for acceleration of growth was significant ($p = .001$), showing that participants varied significantly in the speed of growth of Engagement scores across time. These results support the hypothesis that group member Engagement would increase across the four time points (See Figure 1).

The growth curve model built in HLM to analyze the trajectory of Engagement over time also examined Pre-PTSD scores to determine if differing initial PTSD symptomatology significantly impacted initial Engagement scores or the growth of Engagement across group psychotherapy. Pre-PTSD scores were not found to be significant in the prediction of initial Engagement scores ($p = .895$), nor were they significant in predicting the growth of Engagement over time ($p = .989$). The two different group treatment lengths (i.e., 16 weeks and 24 weeks) were also controlled for in the growth curve model to examine any significance in the prediction of Engagement scores. Treatment length was not found to be a significant predictor of initial Engagement scores ($p = .506$), nor growth in these scores over time ($p = .519$).

Bond. It was hypothesized that group members' perception of bond with the group leader, as measured by the Bond scale of the WAI-S, would increase across the four time points. The linear model was determined to be the best fit to examine these data with a nonsignificant X^2 ($p = .500$). An ICC of 53.70% indicated that approximately 54% of the total variance in Bond was explained as occurring between observations from the same cluster. This model used time as a Level-1 predictor, with Pre-PTSD scores used as a Level-2 predictor, and Group Length as a Level-3 predictor.

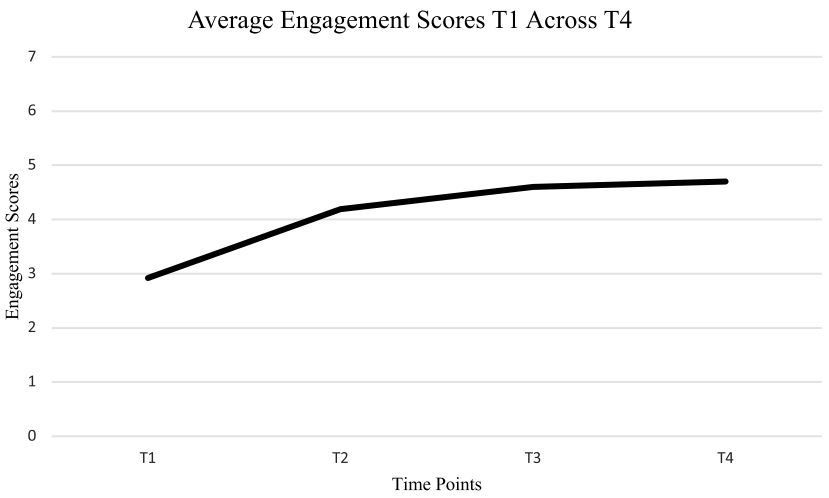

Figure 1. Average Engagement Scores T1 Across T4.

Results suggested that group members varied significantly in their average Bond scores at the start of group treatment ($p = .001$). Bond is measured on a 1- to 7-point scale. The average fixed effect Bond score for a group member at the start of treatment was approximately 6.16. The random intercept for Bond was significant ($p < .001$), demonstrating that participants initial Bond scores varied significantly. The slope coefficient was significant ($p = .028$), suggesting that group members significantly increased their Bond scores over time with a .17 increase in scores at each time point. The random effect for slope was not significant ($p = .217$), suggesting that participants' Bond scores did not vary in growth rates over time. This supports the hypothesis that Bond scores with the group leader(s) would increase across group treatment. See Figure 2.

Pre-PTSD scores were controlled for in the HLM growth curve model analyzing the trajectory of Bond across sessions to examine if initial PTSD symptom scores impacted beginning Bond scores or the growth of Bond across sessions. Pre-PTSD scores were not found to be significant in the prediction of initial Bond scores ($p = .596$), nor were they significant in predicting the growth of Bond over time ($p = .669$). Group treatment length also was controlled for in the HLM model to

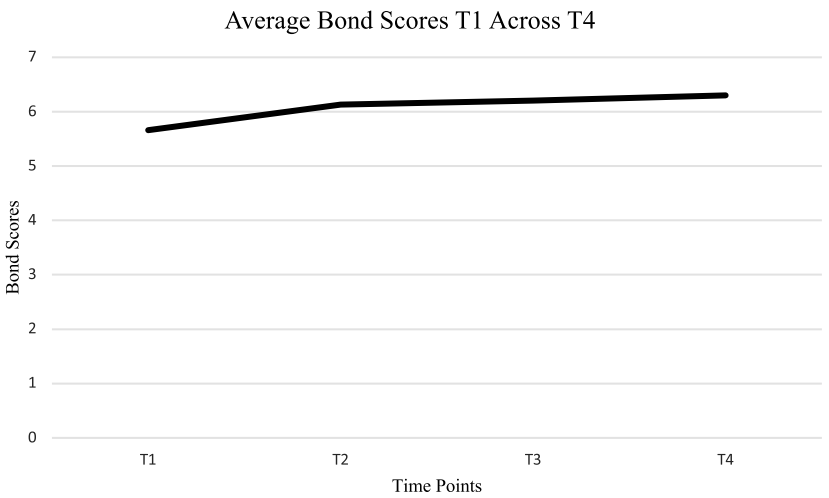

Figure 2. Average Bond Scores T1 Across T4.

assess any impact that the different treatment lengths might hold on the trajectory of Bond with the group leaders. Treatment length was not found to be a significant predictor of initial Bond scores (p = .206), nor in the growth of these scores over treatment sessions (p = .555).

Engagement, Bond, and Post-PTSD Symptoms. It was expected that changes in Bond and Engagement scores would be significant predictors of overall posttreatment outcome PTSD scores. As shown above, growth in Engagement and Bond were examined with three-level models to show trajectories of change over time. To illustrate these variables as predictors of posttreatment PTSD scores, another model was constructed with retained Engagement and Bond coefficients as Level-2 predictors of group member's initial PTSD scores and the change in scores across time. The final model used time as a Level-1 predictor, retained Engagement and Bond coefficients as Level-2 predictors, and Level-3 controlled for the different treatment lengths of the groups.

The linear model was determined to be the best fit to examine these data with a nonsignificant X^2 (p > .500). An ICC calculation of .2228 indicates that approximately 22.28% of the total variance in

Post-PTSD scores was explained as occurring between individual group members and indicates a cluster/nesting effect in the data.

Results showed that individuals differed significantly ($p < .001$) in their initial PTSD scores, with a mean score of 30.68. Changes in Bond scores were not significant in initial PTSD scores ($p = .296$) nor in the change of these scores over time ($p = .193$). The random intercept for Bond was not significant ($p = .203$). The random effect for slope was significant ($p < .001$) showing that Bond significantly varied among group members across time. Changes in Engagement scores were not shown to be significant in initial PTSD scores ($p = .068$), nor in the change of PTSD scores over time ($p = .071$). The random intercept for Engagement was not significant ($p = .394$). The random effect slope was significant ($p < .001$), suggesting that Engagement varied among group members across time. Length of treatment was not shown to be a significant predictor for Bond in the prediction of initial PTSD scores ($p = .124$), nor in effect of Bond on PTSD scores over time ($p = .340$). Length of treatment was also not demonstrated to be significant in the prediction of initial PTSD scores ($p = .866$), nor in the effect of Engagement on PTSD scores over time ($p = .759$). This does not support the hypothesis that changes in perceptions of Engagement and Bond with group leaders influences outcome symptom measures of PTSD.

Shame. It was expected that there would be a significant decrease in group member perceptions on the four Shame subscales across the four time points. Shame reactions included Attacking Self, Withdrawal, Shame Avoidance, and Attacking Others. Growth curve modeling was used to analyze the change in Shame Reaction scores across time. All models used time as a Level-1 predictor, Pre-PTSD scores as a Level-2 predictor, and Group Length as a Level-3 predictor.

Only one of the Shame subscales was found to decrease significantly across time in this study. Results showed that individuals had significantly different Attacking Self (AS) reaction scores at the start of treatment ($p < .001$), with a mean fixed Attacking Self shame reaction score of 28.57. The random effect coefficient was also significant ($p < .001$). The fixed slope coefficient of −1.55 indicated that group members decreased 1.55 points in their Attacking Self shame score for each time point, and this was a significant decrease in scores

(p = .041). The random slope coefficient was significant (p = .007) showing that members varied significantly in their rate of change in AS shame scores across time. Pre-PTSD scores were controlled for in Level-2 of the HLM model and were not found to be significant in the prediction of initial AS scores (p = .126), nor were they significant in predicting the change of AS over time (p = .861). The different treatment lengths were controlled for in Level-3 of the growth curve model and were not significant in the prediction of initial AS scores (p = .688), nor in the growth of these scores over time (p = .351). An ICC of 25.66 showed that approximately 26% of the total variance in AS shame reactions was explained as occurring between observations from the same cluster. These results support the hypothesis that Attacking Self shame reactions would decrease across treatment (See Figure 3).

Group members differed significantly in their initial fixed Shame Avoidance (AV) scores (p = .001), with an average initial score of 21.48. The random effect intercept coefficient was also significant (p < .001), as group members significantly varied in their initial AV scores. The fixed slope coefficient was not significant (p = .780), nor was the random slope coefficient (p > .500). Pre-PTSD scores were

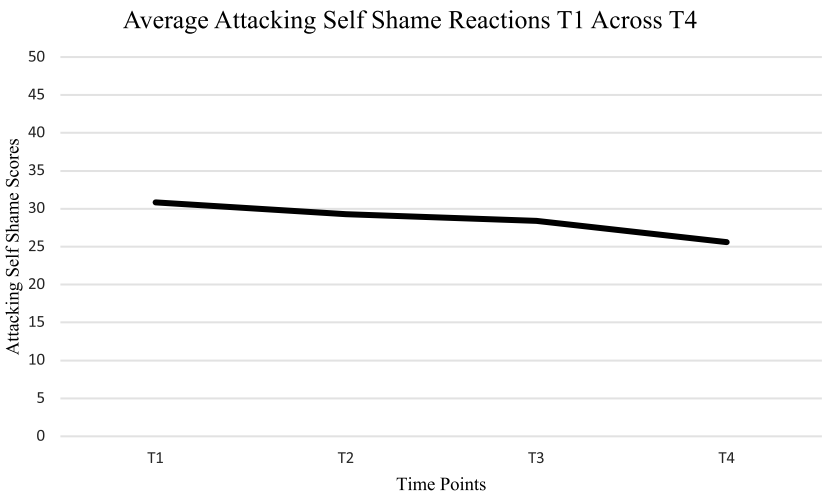

Figure 3. PCL-5 Scores Pre- and Posttreatment.

controlled for and were not significant in the prediction of initial AV scores ($p = .456$), nor in the change in scores over time ($p = .244$). The different treatment lengths also were controlled for in the HLM model and were not significant in the prediction of initial AV scores ($p = .240$), nor in the growth of these scores over time ($p = .363$). An ICC of 37.70 showed that approximately 38% of the total variance in AV shame reactions was explained as occurring between observations from the same cluster. The hypothesis for a decrease in Shame Avoidance (AV) scores was not supported.

Individuals had significantly different Shame Withdrawal (WD) reaction scores at the start of treatment ($p < .001$), with a mean fixed Withdrawal shame reaction score of 26.72. The random intercept coefficient was also significant ($p < .001$) showing that group members varied significantly in WD scores at the onset of treatment. The fixed slope coefficient was not significant ($p = .100$), and the random slope coefficient was also not significant ($p = .118$), demonstrating that the scores did not significantly change across treatment. Pre-PTSD scores were controlled for at Level-2 of the model and were not found to be significant in the prediction of initial WD scores ($p = .316$), nor were they significant in predicting the change of WD over time ($p = .920$). Different treatment lengths were controlled for in Level-3 of the HLM model and were not significant in the prediction of initial WD scores ($p = .149$), nor in the growth of these scores over time ($p = .488$). An ICC of 44.59 showed that approximately 45% of the total variance in WD shame reactions was explained as occurring between observations from the same cluster. These results do not support the hypothesis that Shame Withdrawal scores would significantly decrease across treatment.

Results demonstrated that individuals had significantly different Shame Attacking Others (AO) reaction scores at the start of treatment ($p < .001$), with a mean fixed Attacking Others shame reaction score of 13.77. Random intercept coefficient was also significant ($p < .001$) showing that group members significantly varied in their initial AO reaction scores. The fixed slope coefficient of .17 was not significant ($p = .648$), nor was the random slope coefficient ($p > .500$). Pre-PTSD scores included in the growth curve model were not found to be significant in the prediction of initial AO scores ($p = .697$), nor were they significant in predicting the change of AO over time ($p = .112$).

The model in HLM also controlled for the different treatment lengths, and these also were not significant in the prediction of initial AO scores (p = .447), nor in the growth of these scores over time (p = .092). An ICC of 26.38 showed that approximately 26% of the total variance in AO shame reactions was explained as occurring between observations from the same cluster. These results do not support the hypothesis that Attacking Others scores would significantly decrease across treatment, and instead demonstrated a nonsignificant increase in scores.

One-Tailed Student's *t*-test Analysis

It was hypothesized that there would be a significant decrease in overall PTSD symptoms, and all symptom subscales, from pre- to posttreatment. The PCL-5 was given at pre- and posttreatment, week 15 for the 16-week treatment group and week 23 for the 24-week treatment group. All assumptions of normality and homogeneity of variance were examined and found to be tenable, with no outliers in the distribution. One-tailed Student's *t*-tests were conducted in SPSS to determine the difference in PTSD scores from pre- to posttest. A critical value of −1.692 was obtained from a Student's *t*-table and used for hypothesis testing. See Figure 4.

There were statistically significant decreases in Overall PCL symptom scores (M = 21.19, SD = 15.85, mean difference = − 14.99, d = .92), Cluster C (Avoidance) symptom scores (M = 3.28, SD = 2.96, mean difference = − 1.84, d = .71), Cluster D (Negative Alterations in Cognition and Mood) symptoms scores (M = 7.22, SD = 5.75, mean difference = − 5.64, d = .95), and Cluster E (Hyperarousal) symptoms scores (M = 6.60, SD = 4.37, mean difference = − 2.92, d = .57). There was no significant decrease in Cluster B (Intrusion) symptom scores (M = 7.43, SD = 6.48, mean difference = − 1.21, d = .21). All PTSD symptom scores, with the exception of Cluster B (Intrusion) scores, significantly decreased from pre- to posttreatment. Except for Cluster B, these data support Hypothesis 3 that PTSD symptom scores would decrease from beginning to end of group treatment (see Table 2).

The PCL-5 typically uses a clinical cutoff score of 33 (Bovin et al., 2016). At the start of treatment, 20 participants were above the clinical

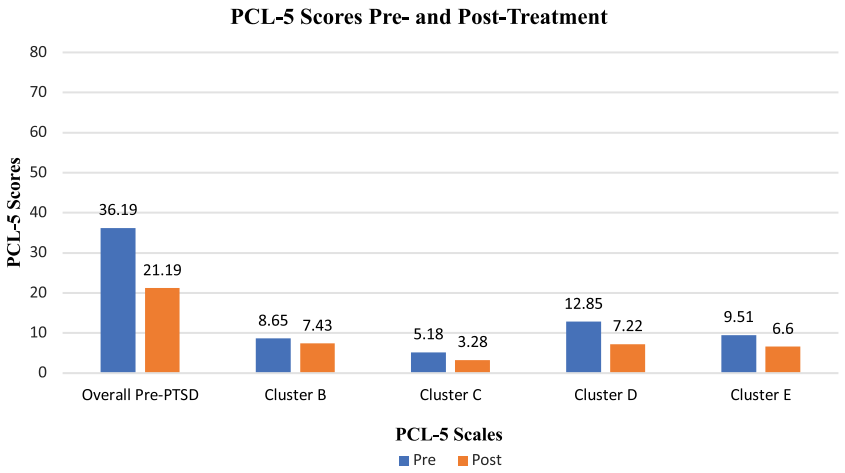

Figure 4. Average Attacking Self Shame Reactions T1 Across T4.

cutoff score, suggesting that they likely met full criteria for a PTSD diagnosis. Thirteen participants were below the PCL-5 clinical cutoff score at the onset of treatment, indicating that they were subthreshold for a PTSD diagnosis when beginning group psychotherapy. At the end of treatment, all participants showed decreases in their PTSD symptom scores. Twenty-four participants were below the clinical cutoff posttreatment. Although 9 participants remained above the clinical cutoff of 33 (ranging in scores from 36 to 53), each demonstrated decreases from their pretreatment scores.

Results supported the hypotheses that both Engagement among group members and Bond with the group leaders would increase across treatment sessions. PCL-5 scores indicated significant decreases in Overall PTSD symptom scores, as well as decreases in subscale symptom cluster scores including Avoidance, Negativity, and Hyperarousal. Of the four shame reactions examined (Avoidance, Attacking Self, Withdrawal, and Attacking Others), significant reductions were shown in Attacking Self shame reactions.

Table 2. PCL-5 Scores from Pre- to Posttreatment for All Groups Combined

Scale of PCL	Pre *N*	Pre-Mean/*SD*	Post *N*	Post Mean/*SD*	Mean Diff.	*t*	*df*	Sig. (1-tailed)
Overall Pre-PCL – Overall Post-PCL	33	*M* = 36.19 *SD* = 16.66	33	*M* = 21.19 *SD* = 15.85	−14.99	−5.435	32	.000
Cluster B Pre – Cluster B Post	33	*M* = 8.65 *SD* = 4.79	33	*M* = 7.43 *SD* = 6.48	−1.21	−1.075	32	.146
Cluster C Pre – Cluster C Post	33	*M* = 5.18 *SD* = 2.11	33	*M* = 3.28 *SD* = 2.96	−1.84	−3.566	32	.000
Cluster D Pre – Cluster D Post	33	*M* = 12.85 *SD* = 6.09	33	*M* = 7.22 *SD* = 5.75	−5.64	−5.631	32	.000
Cluster E Pre – Cluster E Post	33	*M* = 9.51 *SD* = 5.96	33	*M* = 6.60 *SD* = 4.37	−2.92	−3.835	32	.000

DISCUSSION

This study aimed to examine relational processes in group psychotherapy for sexual trauma survivors, including the group members' perceived relationship with the group leader, as well as with other group members. The construct and trajectory of shame reactions were additionally assessed to determine if the factor of universality in group treatment was beneficial to address the internalized negative sense of self that so frequently limits interpersonal connections. Similar to other research with this population, this study assessed PTSD symptomatology pre- and posttreatment to evaluate treatment outcomes.

This study demonstrated that group members increased their engagement with the other group members across the group sessions. There is considerable research that suggests that sexual abuse survivors experience relationship problems (Charuvastra & Cloitre, 2008; DePrince et al., 2009; DiLillo, 2001; Feiring et al., 2009; Lassri et al., 2018) and one of the advantages of group treatment is that it can provide the opportunity for connections to develop within the safety of the group environment. Despite having varying levels on the Engagement scale at the start of treatment, the participants in the study reported increases in their perceived connections with other group members and of being engaged in constructive therapy work within the group. The increase in Engagement scores over time suggests the possibility that factors occurring within the group, such as interpersonal interactions and social support, helped participants increase their trust and connections with others. Results from this study were inconsistent with other research that has demonstrated the positive impact of cohesion on group outcome measures (Lo Coco et al., 2016; Paquin et al., 2013). It is possible that the nonsignificant finding from this study ($p = .07$) is due to the small sample size or the variability of the Engagement scores at the beginning of treatment. It will be important to look at this connection again with a larger sample size, as these results do suggest a possible trend toward Engagement being a critical component in the prediction of treatment outcomes in group psychotherapy.

The trauma-informed group curriculum used by the agency may have contributed to the development of connections among group

members. The stages of group at the agency first focused on the development of safety, then the sharing and processing of trauma narratives. The initial focus on safety may have allowed members to exchange information about mutual symptoms and share techniques for coping and self-care that fostered a feeling of protection for members as they entered into the exposure phase as a more cohesive unit. As they shared their trauma experiences, group members may have recognized similarities among them that promoted support, empathy, and a growth in connections between members. This echoes findings from Kivlighan and Paquin (2014) who suggested that group leaders may want to increase engagement in order to increase intimate behaviors, or vice versa, focus on increasing intimate behaviors to increase perceptions of engagement. This speaks to the importance of safety development within the group climate to allow for greater disclosure at later stages in the group.

Another noteworthy finding was that participants had a strong bond with the group leader even at the first session and it became stronger as sessions went on. From past research, bond, also known as therapeutic alliance, has been shown to be key in psychotherapy group treatment (Charuvastra & Cloitre, 2008). One possible explanation for the high Bond scores in this study is that each group member had contact with the facilitators prior to the start of therapy in the form of pregroup interviews and phone contact. This may have helped provide information and connections that, then, influenced perceptions in treatment. Group leaders are responsible for setting group norms, creating group culture and safety, and by doing so protect and deter forces that threaten the cohesiveness of the group (Kivlighan & Paquin, 2014; Yalom & Leszcz, 2005). Bond scores in this study were not predictive of posttreatment PTSD symptom outcomes; however, it may be that the high initial Bond scores indicated that group members felt able to develop trust in the group leaders, which then helped them develop trust with the group members and allowed for deeper therapeutic process and disclosure. High perceptions of Bond with the group leader may have also contributed to group members developing a sense of allegiance in the group, which could result in lower attrition rates within group treatment. It is notable that only one participant left treatment (due to health problems, not concerns with the treatment). This is remarkable, given that it is generally

estimated that approximately 20% of participants drop out of research studies (Swift & Greenberg, 2012), and the one participant in this study accounted for 2.9% of the sample.

Many sexual trauma survivors feel shame and frequently report feeling "dirty" afterward or placing blame on themselves for being assaulted (Feiring & Taska, 2005; Sayin et al., 2012). Other studies have suggested shame to be correlated with poor mental health and feelings of being alone and different (Rahm et al., 2013; Weiss, 2010). Women in this study significantly reduced their Attacking Self shame response. Although group members did not demonstrate significant decreases in their perceptions of Avoidance or Withdrawal shame reactions, their significant decrease in Attacking Self shame scores, along with the nonsignificant finding of a slight increase in Attacking Others shame scores, is an important avenue for further investigation. An emphasis in treatment for sexual trauma survivors often is to address the shame reactions related to victims blaming themselves for the assault. The reduction in Attacking Self is a positive sign that group treatment may have helped to decrease feelings of self-blame. At the same time, group treatment may have increased scores related to blaming others (i.e., the perpetrator) for the abuse or assault, suggesting a movement from internalized shame to an outward expression of blame.

Brown's (2006) shame resilience theory postulates that feelings of shame are combated by recognizing and accepting personal vulnerability, gaining awareness of the impact of social/cultural influences on shame, developing the ability to have empathic relationships, and cultivating skills to "speak shame." Aspects of this theory seem consistent with tenets of group cohesion, and it may be that focusing on these properties within the context of group therapy could deplete the feelings of isolation often perpetuated by shame. This could be a powerful force in recovery, allowing group members to feel heard, supported, and validated by other members in the safe environment of the group treatment. This finding highlights the importance of focusing on commonalities within the group, as this may hold powerful implications for the reduction of shame in the context of group psychotherapy.

An important finding in this study is that survivors significantly decreased their PTSD symptoms after participating in group treatment for sexual abuse. This is consistent with other studies that

found group psychotherapy to be effective in PTSD symptom reduction with women sexual trauma survivors (Elkjaer et al., 2014; Sloan et al., 2013). These results demonstrate that group treatment is a powerful format for reducing PTSD symptoms, and add to the existing body of literature about the efficacy of group psychotherapy for this population. It is also interesting to note that all 33 women who participated in this study completed their entire therapy groups with few missed sessions.

The current study showed that every group member experienced a decrease in their overall scores of PTSD symptom severity. Results in this area were robust, and significant symptom reduction was found on Overall PTSD symptoms, as well as in subscales for Avoidance, Negative Alterations in Cognition and Mood, and Hyperarousal. The decreases in the various symptom clusters appear to be consistent with theories regarding the maintenance of PTSD symptoms, including that of Keane et al.'s (1985) classical conditioning theory. In this conceptualization of PTSD, a stimulus generalization of fear occurs following the traumatic event. Avoidance of trauma-related stimuli or memories becomes negatively reinforced over time, as anxiety decreases when one avoids exposure to feared stimulus. Over time, this avoidance results in more reexperiencing and hyperarousal symptoms, as there is no opportunity for the extinction of the feared stimulus to occur.

The exposure content found within the group treatment in this study may be an important element in the treatment of trauma survivors. In most trauma work, clients are encouraged to engage in exposure and approach, rather than avoid trauma stimuli, aiding participants to decrease the anxiety caused by the stimuli. Discussing these stimuli within a group context may target avoidant behaviors and have an impact on Cluster C (Avoidance) and Cluster D (Negative Alterations in Cognition and Mood) symptoms. The supportive environment of the group in this study may have helped shift group members' maladaptive beliefs about self, others, and the world that commonly develop following a traumatic event. However, a decrease in avoidance of trauma-related stimuli also may have influenced an increase in thinking about the traumatic event more frequently, which in turn may have resulted in intrusive thoughts about the event occurring more often. This may explain the nonsignificant decrease in Intrusion symptom (Cluster B) scores.

Although group members varied in their endorsement of PTSD symptoms at the onset of treatment, all participants reported a decrease in their symptomatology at the end of treatment. The variance in initial symptom endorsement also suggests that each individual group member likely varied in their course of recovery throughout group treatment and speaks to the importance of group leaders being aware of individual differences found between group members. Continually checking in with group members and emphasizing the universality of the group experience in addressing concerns may help elicit feelings of cohesion within the group and help each participant to feel heard and supported by group members.

It was unexpected that the 16- and 24-week groups did not differ on any of the findings, suggesting that shorter groups can be quite powerful in reducing PTSD symptoms, increasing engagement and bond, and addressing shame. Future research is needed to compare different lengths of treatment. One caveat of these findings is that there were only nine women in the two groups for adult survivors of childhood sexual abuse. It may be that the length of time commitment necessary to complete a 24-week group is a barrier to those seeking treatment, and the findings highlighting the possible change in the shorter time frame may be of large benefit to increasing access to treatment.

Limitations

This study used self-report measures, and participants could have under- or overreported their experiences. It is also possible that participants responded in a socially biased manner, and this too could have impacted the results. However, even with these limitations, self-report from victims of sexual trauma is the best, and often only way, to provide a representation of their perceived progress. This method also honors their voice in the process, something that is often silenced due to sexual trauma.

Another limitation is that some participants received individual therapy in addition to group therapy, and this may have resulted in participants experiencing effects of the treatment other than what was being measured in the study. It is also possible that some participants experienced multiple trauma types (i.e., sexual abuse as a child and adult sexual assault) and this was not controlled for in the data.

Additionally, there may have been differences between the group leaders of the various groups, and this could have added extraneous variables. This study was implemented in a community mental health agency and resulted in inherent difficulties in obtaining a larger sample size, as well as the sample including group members with different types of trauma histories and varied PTSD levels. Although the obtained sample size was adequate to observe changes in individuals over time, it may not have been large enough to observe differences between groups or the connection between Engagement scores and PTSD symptom outcomes.

CONCLUSIONS

This study specifically focused on examining relational group psychotherapy processes, including group cohesion and bond with the group leaders, as vital components in treatment for sexual trauma survivors. Results demonstrated that perceptions of group cohesion increased over time spent in treatment, pointing to important interpersonal developments within group members. Perceptions of Bond with the group leader(s) also speak to the development of trust within the group environment. The high initial Bond scores hold clinical importance and suggest that the focus given to prepare clients for group treatment may result in the composition of groups with members who are fully able to engage with the group material and may also influence the members' initial feelings of safety within the group. Results from this study demonstrated that group treatment is an effective treatment modality in decreasing PTSD symptomatology from pre- to posttreatment. An exciting result from this research is the significant reduction in Attacking Self shame reaction, demonstrating that the feelings of self-blame that frequently accompany sexual trauma survivors decreased throughout treatment.

Trauma is often debilitating and yet the strength and courage of persons who have experienced sexual trauma, along with treatment, can help in the healing process. Identifying effective psychological treatments for the unique struggles faced by survivors of sexual trauma is imperative to their recovery. This study provides support that the social and relational aspects of group psychotherapy hold important implications in the process of recovery for sexual trauma survivors and suggests

the need for more research attention and for clinical practice to emphasize these elements throughout group practice with this population.

DISCLOSURE STATEMENT

No potential conflict of interest was reported by the authors.

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