A Decade In Review: A Literature Review Spanning Ten Years of Group Psychotherapy for Adult Survivors of Childhood Sexual Abuse

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Abstract
This review summarizes and evaluates research published from 1999-2008 studying the efficacy of group psychotherapy for adult survivors of childhood sexual abuse (CSA). Several studies compared group psychotherapy and individual psychotherapy. Several different populations were examined, including individuals with chronic mental illness, HIV/AIDS, low socioeconomic status, and inmates. Most studies were conducted on an outpatient basis, while some examined the use of groups for inpatient populations. While most groups focused on treating female survivors, some groups worked with male survivors as well. Overall, group psychotherapy was effective in symptom reduction, regardless of theoretical orientation or treatment duration. Future research is needed with several populations, specifically males and individuals with chronic mental illness or severe symptom presentation.

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A DECADE IN REVIEW:

A LITERATURE REVIEW SPANNING TEN YEARS OF GROUP
PSYCHOTHERAPY FOR ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE

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ABSTRACT:

This review summarizes and evaluates research published from 1999-2008 studying the efficacy of group psychotherapy for adult survivors of childhood sexual abuse (CSA). Several studies compared group psychotherapy and individual psychotherapy. Several different populations were examined, including individuals with chronic mental illness, HIV/AIDS, low socioeconomic status, and inmates. Most studies were conducted on an outpatient basis, while some examined the use of groups for inpatient populations. While most groups focused on treating female survivors, some groups worked with male survivors as well. Overall, group psychotherapy was effective in symptom reduction, regardless of theoretical orientation or treatment duration. Future research is needed with several populations, specifically males and individuals with chronic mental illness or severe symptom presentation.
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INTRODUCTION

The sexual abuse of a child is a controversial issue, in nearly every aspect from prevalence rates to possible symptoms to treatment methods. One fact that is difficult to dispute is that experiencing childhood sexual abuse (CSA) affects an individual, often dramatically. Whether or not there is agreement in other areas, most would concur it is important to find a way to successfully treat clients suffering from a history of CSA.

Prevalence rates of CSA are one topic with little consensus; what numbers do we use? There are rates from government offices such as the National Child Abuse and Neglect Data System who generate an annual report of children who received services. Using this data, in 2006 nearly 80,000 children in America sought government services after being sexually abused (Child Maltreatment, 2006). While this number seems large, it only counts children who went through the state’s system and had their abuse corroborated. Unfortunately, as Jim Hopper, a professor at Harvard Medical School who specializes in child abuse, clearly states, “Most abused and neglected children never come to the attention of government authorities” (Hopper, 2008).

Another option is to examine approximate prevalence rates found in national surveys. A study of adverse childhood effects conducted at Kaiser Permanente found that approximately 20% of the population has experienced CSA (Felitti et al., 1998). Given the high levels of shame associated with experiencing CSA, especially for males, it is likely that this number is still too low. Another study estimated that 9.6 million American women and
1.8 million American men experienced CSA (Molnar, Buka, and Kessler, 2001). Regardless of the exact number of cases, it is clear that there is a large population of survivors of CSA.

The effects of CSA are many, and often both severe and chronic. Molnar, et al. (2001) found high rates of mood disorders, posttraumatic stress disorder, specific phobias, social phobia, and drug and alcohol problems among adult survivors of CSA. CSA has also been linked with anger, dysfunctional sexual behaviors, dissociation, impaired self-esteem, hospitalization, suicidality, personality disorders, somatization, and interpersonal difficulties (Briere & Elliot, 2003). Lundqvist, Hansson, Svedin and Ekström (2006) found that, in a study of 45 women survivors of CSA, 87% reported suicidal thoughts, 47% had made at least one suicide attempt, and 64% experienced problematic somatic pain. They also found that 91% of the participants had tried individual therapy yet were still seeking professional help with their symptoms.

Herman (1992) proposed a new diagnosis for survivors of prolonged abuse, including childhood sexual abuse. This new diagnosis, complex posttraumatic stress disorder, encompasses many of these symptoms, including alterations in: affect regulation, consciousness, self-perception, perception of perpetrator, relations with others, and systems of meaning. Often survivors receive diagnoses of somatization disorder, borderline personality disorder, and dissociative identity disorder, all of which carry a negative schema. Complex PTSD would include all three of these disorders and remove blame from the survivor.

Considering the large number of individuals affected by CSA, along with the long list of potential symptoms associated with CSA, the need for effective, affordable treatment is clear. Due to high demand and limited resources, often treatment takes the form of a
psychotherapy group. Groups are a proven method of delivering psychotherapy, with the added benefit of helping many individuals at the same time. The benefits from groups have been proven many times to be equal to, if not to exceed, the benefits received in individual therapy (Yalom, 2005). Reviews of published research focused on group therapy for CSA indicate that group therapy is likely a beneficial treatment for survivors, yet indicate a need for future research to confirm these findings (Higgins Kessler, White, and Nelson, 2003; Martsof & Draucker, 2005). In the years since these reviews, many additional articles have been published outlining the efficacy of a variety of treatment groups for survivors of CSA.

The purpose of this thesis is to review articles published in the last decade outlining research done on psychotherapeutic groups for adult survivors of CSA. The main goal is to create a consolidated review of all recent research for this population to assist clinicians in utilizing the research. Another goal is to examine the research critically to find strengths and opportunities for improvement. The hope is that, throughout this process, additional questions and new directions for research will emerge.
GROUP THERAPY VS. INDIVIDUAL THERAPY

Few studies have specifically compared the efficacy of group therapy and individual therapy with adult survivors of CSA. The majority of the studies reviewed within this thesis failed to report whether group members received individual therapy during the study, and the presence or absence of individual therapy likely affected the individual’s outcome. However, six studies specifically examined the effects of group therapy with or without concurrent individual therapy.

One study specifically compared the use of individual therapy with the use of group therapy, keeping the treatments as similar as possible. Stalker and Fry (1999) conducted a study to compare brief individual treatment with brief group treatment using a feminist approach. Participants were randomly assigned to either 10 weekly 50-minute individual sessions or 10 weekly 90-minute group sessions, with 32 women completing the individual treatment and 33 women completing the group treatment. All participants completed a 10-week waiting period to form a control group. Researchers utilized six separate measurement tools: the Symptom Check List (SCL-90-R; Derogatis, 1992), the Dissociative Experiences Scale (DES-2; Carlson & Putnam, 1993), the Traumatic Symptom Checklist (TSC-40; Elliot & Briere, 1992), the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976), and the Client Perception Scale (CPS), a scale created by the researchers. All tools were administered at five points in time: assessment, the beginning of treatment, the end of treatment, 6-month follow up, and 12-month follow up.
The researchers found no significant differences between individual treatment and group treatment. However, there were significant improvements for both groups on all scales except the DES-2 from assessment to post treatment when compared to improvements from assessment to pretreatment. At 6-month follow up participants had retained improvements on all scales except the GAS, yet at 12-month follow up all scales showed improvement, even when compared to post-treatment scores. The researchers hypothesized that participants had some decline in functionality immediately following treatment, yet at the 12-month follow up their symptoms had significantly decreased and they were functioning at a much higher level. Post-treatment therapy was examined as a possible contributing factor; however, no differences were found between individuals who sought post-treatment therapy and those who did not.

The limitations discussed by the authors were the lack of a DSM-IV (APA, 1994) diagnosis for participants and the use of a random assignment to treatment. The inclusion of a DSM-IV diagnosis may have provided additional information regarding treatment success for different diagnoses. The use of a random assignment to group treatment limits the generalizability because many group facilitators select group members based on their appropriateness and fit for the group. However, using random assignment strengthens confidence that the improvements are a result of the treatment rather than a result of self-selection or bias. This is an unique challenge for researching groups, as random assignment is ideal for research, yet limits real-life applicability of the treatment.

One limitation not discussed by the authors was the fact that four of the seven therapists were registered nurses (RNs). The authors noted that all therapists had experience in psychiatric settings, but failed to mention whether additional training was provided for the
RNs. I am unaware of training provided to RNs that would make them qualified to provide individual therapy to survivors of CSA, even with experience in a psychiatric setting. I hope that these therapists received adequate training to allow them to conduct therapy, and this information really needed to be included in the authors’ description of their study. Overall, this study revealed that a brief feminist approach, either in individual or group format, could be successful at reducing symptomology and improving functioning in adult women survivors of CSA.

The next study examined differences between individual therapy alone and individual therapy concurrent with group therapy. Ryan, Nitsun, Gilbert, and Mason (2005) designed a study to compare the relative effectiveness of individual therapy alone and individual therapy coupled with group therapy for women survivors of CSA. Participants were recruited from a pool of women referred for services at three UK National Health Services Trusts in England. All participants who met inclusion criteria were given the choice of individual therapy or combined individual and group therapy. A total of 22 participants completed group treatment and 26 completed individual treatment. Both groups received treatment for 12 weeks, and the focus of treatment included psychoeducation, exploration of emotions, and self-disclosure. Participants in both group treatment and individual treatment constructed most of their treatment experience, resulting in varying treatment methods. The researchers constructed a list of themes that could be covered in therapy, and each group or individual selected the themes that most applied to their situation. While this method of tailoring treatment to the individual or group of individuals may be more beneficial to the participant, it is difficult to generalize these findings due to the fluctuating treatment method.
The researchers administered four questionnaires, including: the Brief Symptom Inventory (BSI; Derogatis, 1993), the Beck Depression Inventory (BDI; Beck & Steer, 1987), the Belief Inventory (BI; Jehu, 1988), and the Self Concept Questionnaire (SCQ; Robson, 1989). All four questionnaires were administered to each participant at five points in time: when the participant was initially assigned to the waiting list, immediately before beginning treatment, immediately after completing treatment, 4 months after completing treatment, and 8 months after completing treatment. While 48 participants completed treatment, only 28 completed the 8-month follow up assessment. Nearly half of the participants are not included in the 8-month assessment measures, which likely affected the results.

After completing a two-way ANOVA for each of the four questionnaires, the authors concluded that there was significant improvement from pre-treatment scores to post-treatment scores and that these improvements were maintained at 4-month and 8-month follow ups. Interestingly, there was no significant difference in scores between the group treatment participants and the individual treatment participants, indicating that both forms of therapy were equally effective in decreasing symptoms for these participants. Unfortunately, this also indicates that the addition of group therapy to individual therapy did not result in greater improvement when compared to individual therapy alone. One important point the authors made is that client choice may be very important in delivering effective treatment, particularly with this population. As force, coercion, and manipulation often accompanies sexual abuse, the ability to make decisions about treatment methods may be an important piece in helping survivors begin to recover. Perhaps the individuals self-selecting group and individual therapy benefited more than they would have had they only received individual therapy.
The authors acknowledged several limitations to this study, including: limiting inclusion criteria, failing to include male survivors, and failing to conduct an economic analysis to determine the financial feasibility of treatment options. Another limitation to the generalizability of the results that was not mentioned by the authors is the lack of a manualized treatment method. The lack of a model of treatment creates the possibility of numerous confounding variables that may have influenced the outcome. While it is always preferable for the client to have input into the treatment goals, the lack of a manual or guideline for treatment unfortunately limits the use of the results of this study. It is nearly impossible to replicate the treatment, so essentially this study simply tells us that the therapy these participants received was beneficial for them.

The remaining studies examined whether group therapy was more or less effective when controlling for concurrent individual therapy. Morgan and Cummings (1999) designed a study to examine the efficacy of a feminist-based group therapy focusing on the five responses highlighted by Herman (1992), including: depression, social maladjustment, self-blame, anger, and posttraumatic stress. They controlled for concurrent individual therapy, but did not use this as inclusion or exclusion criteria. Forty women completed the 20-week program, and an additional 40 women completed a control group. Participation in either group was voluntary, which resulted in the control group having significantly less previous therapy than the treatment group.

The treatment group completed assessments when they initially requested treatment, the first group session, the last group session, and at 3-month follow up. The control group completed assessments twice, with the average time between assessments of 191.98 days. Four assessment scales were utilized: the History of Victimization Questionnaire (Wolfe,
Gentile, & Bourdeau, 1987), the Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979), the Social Adjustment Scale Self-Report Form (SAS-SR; Weissman & Bothwell, 1976), and the Responses to Childhood Incest Questionnaire (RCIQ; Donaldson & Gardner, 1983). Since not all of the participants experienced incest, the word incest was replaced with sexual abuse. The authors reported a need for more assessment tools for this population. Results indicate that all participants significantly improved on measures of depression, social maladjustment, self-blame, and posttraumatic stress from the first session to the last session, with no significant changes between initial assessment and the first session or between the last session and the 3-month follow up. Additionally, no significant differences were found between participants receiving concurrent individual therapy and those not receiving individual therapy.

Limitations for this study include the reliance on self-report measures and the use of a voluntary control group. Because there were differences in previous therapy between the treatment group and the control group, this may have indicated that participants in each group were in different stages of healing, thus their results cannot be accurately compared. However, the results do indicate that women who voluntarily seek group treatment could benefit from this type of group therapy. The lack of difference between participants receiving individual therapy and those not receiving individual therapy may simply indicate that individual participants may be the best judges of their own needs. Perhaps those in individual therapy felt a desire for additional support, while others did not experience this need. This study, like the Ryan et al. (2005) study, illustrates the potential importance of individual choice in treatment for survivors of CSA, especially considering their lack of choice during their abuse.
Saxe and Johnson (1999) also examined the use of group therapy while concurrently receiving individual therapy. They hoped to extend findings from a previous study using the “Victim to Survivor Group,” a 20-week program aimed at improving interpersonal and intrapersonal difficulties. The authors used a wait-list control group, with 31 women completing the control group and 38 women completing the treatment group. An inclusion criteria for both treatment and control groups was concurrent individual therapy; however, the individual treatment was not controlled for other than its presence. Six of the treatment group participants were determined to be outliers and were deleted from the study, leaving 32 women in the treatment group. The authors failed to report how they made the decision to delete the outliers.

Several measures were administered pretreatment, post treatment, and at 6-month follow up. Measures intended to determine intrapersonal difficulties included: the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961), the Centre for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977), the Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979), and the Brief Symptom Inventory (BSI; Derogatis, 1975). Interpersonal difficulties were measured using the Perceived Social Support from Friends and from Family Scales (PSS-FR, PSS-FA; Procidano & Heller, 1983). The Self-Description Questionnaire III (SDQ-III; Marsh & O’Neill, 1984) was used to assess both intrapersonal and interpersonal functioning. Significant improvements from pretreatment to post treatment were found on all scales except the PSS-FA for the treatment group, while the control group showed no change except significantly worse scores on the BDI. All improvements found at post treatment were maintained at the 6-month follow up, with the exception that scores on the IES showed continued improvement.
The authors note two specific limitations to this study: nonrandomized participants and a lack of control for individual therapy. This sample also has a relatively small sample size, and no demographics were reported. This limits the generalizability of this study. The lack of control for individual therapy does somewhat limit the results, yet the fact that, as a whole, the treatment group improved indicates that the group treatment potentially contributed heavily to this improvement. The improvements found in these participants likely were bolstered by concurrent individual therapy, and this is consistent with other theories of combining group and individual therapy. A limitation not discussed by the authors is the deletion of the outliers. Nearly 16% of the treatment group results were deleted as outliers, with no discussion of why. If the participants were determined inappropriate for the study, the deletion would have been understandable. However, if the outliers skewed the results then separate analyses with and without the outliers may have been more appropriate. As the authors failed to report the reason for deletion, it is unclear how these results may have influenced the study, which indicates that one should use caution when interpreting the results of this study. Overall, this study provides additional support for the use of group therapy for adult survivors of CSA, as well as the concurrent use of individual therapy, yet questions remain as to the reliability of the results based on outlier deletion.

Another potential factor in the efficacy of group therapy is previous therapy. Westbury and Tutty (1999) examined the efficacy of a body-focused feminist group, using psychoeducation and exposure. All participants had completed a minimum of six-months of individual therapy working specifically on CSA prior to the start of group, and maintained individual therapy for the duration of the study. For the purpose of having a control group,
the researchers compared the scores of 22 women who completed treatment to 10 women on a waitlist for treatment. The treatment groups met for 2 ½ hours each week for 10-12 weeks.

All participants were administered three measures after their first group session (or beginning the control group) and again prior to the last group session (or after 10-12 weeks for the control group). The three measures administered were: the Beck Depression Inventory (BDI; Beck & Steer, 1987), the Coopersmith Self-Esteem Inventory (CSEI; Coopersmith, 1990), and the Trauma Symptom Checklist (TSC-33; Briere & Runtz, 1989). Westbury and Tutty conducted an ANCOVA to determine effects of treatment (group or wait-list control) on the three measurement scales, while controlling for pretreatment scores. Significant improvements were found on the BDI as well as the TSC-33 Anxiety Scale. Nearly significant improvements were also found on the CSEI. The means for all measures for both the treatment group and the waitlist group improved at post-treatment, although the treatment group reported a higher degree of improvement. It is important to note that the wait-list control group was still receiving individual therapy, which may account for some of this improvement.

The authors did not discuss any limitations to this study, yet the limitations merit some discussion. First, as with many of these studies, the sample size is very small; this greatly limits the generalizability of the results. Another limit to the generalizability of the results is the lack of demographic information about the participants. While income and education levels are discussed, ethnicity, race, sexual orientation, and several other important areas of diversity are not discussed. Without this knowledge, it is difficult to determine what populations this approach might be appropriate for.
Another important limitation to this study is the lack of control for individual therapy. While participants were required to have completed a minimum of six months of individual therapy, the researchers did not report controlling for length of time in individual therapy. The researchers did not discuss the type of individual therapy participants received prior to, or during, group therapy. Without this information, it is impossible to know whether the treatment group and the waitlist control group received similar individual therapy. In spite of these limitations, the results from this study are encouraging and suggest that concurrent individual therapy and group therapy may be more beneficial than individual therapy alone. Future research into the efficacy of combining individual and group therapy may help determine the most effective way to treat symptoms of CSA.

Finally, the last study examined the use of both individual and group therapy, and incorporated both types of treatment into the approach. Chard (2005) conducted a study designed to incorporate both individual therapy and group therapy in a unique way. Participants completed a 17-week group, with concurrent individual therapy during the first 9 weeks and again during the last week. The intention behind this was to allow members individual time to process the group work and discuss homework, but then after the group members had time to become comfortable in group, to remove the individual therapy as a way to encourage these discussions to occur in group. Individual and group treatment used a manualized treatment based on Cognitive Processing Therapy (Resick & Schnicke, 1993) for rape victims. Groups met for 90 minutes each week and individual sessions were 60 minutes. A control group was used to compare results, with 27 women completing the control group and 28 women completing the treatment group.
Assessments were completed pretreatment, post treatment, and at 3-month and 1-year follow-ups. Seven measurement tools were administered at each assessment, including: Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995), Structured Clinical Interview for DSM-IV Non-Patient Versions I and II (SCID-I; Spitzer, Williams, & Gibbon, 1995; and SCID II; First et al., 1995), Standardized Trauma Interview (Resick, Jordon, Girelli, Hutter, & Marhoefer-Dvorak, 1988), Sexual Abuse Exposure Questionnaire Part I (SAEQ; Rowan, Foy, Rodriguez, & Ryan, 1994), Modified PTSD Symptom Scale (MPSS; Falsetti, Resnick, Resick, & Kilpatrick, 1993), Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), and Dissociative Experiences Scale-II (DES-II; Bernstein & Putnam, 1986). Results indicated that the treatment group showed significant post-treatment improvement on the CAPS, MPSS, BDI-II, and the DES-II, while the control group had no significant changes from pretreatment to post treatment. Additionally, the treatment group showed significant improvement on the CAPS at 3-month follow up assessment when compared to post treatment, indicating that improvements made during treatment continued after termination. All other measures showed no significant changes from post treatment to the 3-month and the 1-year follow ups, indicating that gains were maintained at the 1-year mark.

Limitations for this study are similar to other studies, including a small sample size and a lack of direct comparison to other forms of treatment methods. The author discussed the limited ethnic diversity in this study, and as a result the limited generalizability of the results. A lack of ethnic diversity has been the case for many studies but few authors comment on this limitation, so I commend this author on her attention to cultural diversity. Overall, this study is methodologically strong, and, based on these results it is likely that a
brief Cognitive Processing Therapy model incorporating both individual and group treatment could be successful in reducing symptomology for a similar population.

These six studies, while they have various outcomes, all seem to point toward one fact: group treatment for survivors of CSA is beneficial. Some individuals may benefit from utilizing both individual and group therapy at the same time, while others may prefer one or the other. An important factor is likely the individual’s preference. Empowering survivors to make their own decisions about treatment and encouraging them to navigate their own healing process may be an important step in reclaiming their lives.
INPATIENT TREATMENT

An all-too-common experience for adult survivors of CSA is hospitalization, and inpatient units have a high prevalence of survivors. While group therapy is the treatment of choice for inpatient units, there is very little published research specifically examining group therapy for adult survivors of CSA at an inpatient setting. Talbot et al. (1999) conducted a study examining the effectiveness of the Women’s Safety in Recovery (WSIR) treatment model developed by the authors, as well as to determine the feasibility of using an abuse-focused group treatment in a short-term inpatient setting. Participants received either Treatment-As-Usual (TAU), or WSIR. Participants assigned to TAU received 20 hours of group and activity therapies each week, which utilized cognitive, psychoeducational, and supportive approaches to treatment. WSIR participants received 17 hours of treatment-as-usual group therapy, as well as three 1-hour sessions each week specifically addressing abuse recovery. The authors modeled WSIR after Herman’s (1992) trauma theory, and focused on educational methods to teach self-care and safety.

The initial 38 participants received TAU, and the final 48 participants received the WSIR group. These treatment groups were conducted at separate times, with the length of time each group lasted held constant for both treatments. While 86 women began treatment, only 42 completed the six-month follow up. The authors note that 69% of the women who began the study but did not complete treatment withdrew from the study for reason
unrelated to the study (i.e. early discharge, transfer, or insufficient resources of the researchers.)

Researchers administered three separate measurement tools: the Life Experiences Scale (LES; Bryer, Nelson, Miller, & Krol, 1987), The Symptom Checklist-Revised (SCL-90-R; Derogatis, 1983b), and a three-item questionnaire utilizing a self-report Likert scale to rate experience in treatment. Participants completed the LES at admission, and the SCL-90-R at admission, discharge, and 6-month follow-up, and both participants and therapists completed the experience in treatment questionnaire at admission and discharge. Statistically significant differences between the WSIR group and the TAU were found in several areas, including: interpersonal sensitivity, anxiety, hostility, phobic anxiety, and paranoid ideation. The authors concluded that the WSIR groups yielded more symptom improvement than the TAU groups.

Several limitations were outlined in the article, including a need for less attrition as well as a better understanding of causes of attrition for this treatment. A smaller attrition rate is an important factor in a successful treatment method. It is especially important to note that three participants from the WSIR group were not assessed at discharge due to insufficient funding by the study. The authors do not indicate whether failure to assess some of the participants at the six-month follow up was also due to insufficient funds, nor do they specify whether these three participants received the full treatment. This is concerning particularly with this population because safety and stability is essential in effective treatment, and if treatment was interrupted due to a lack of funds this may have lead to a worsening of symptoms. However, these individuals did not receive assessment so there is no way of knowing. Even if the participants received all the treatment but not the
assessment, if they expected an assessment, this may have caused disruption and distress for the participants. While financial restraints are an unfortunate reality, every effort must be made when working with this population to create a safe, predictable environment for healing.

In a follow-up study, Talbot, Duberstein, Brutzel, Cox, and Giles (2003) conducted the same WSIR group made up of 21 women compared to a TAU group with 22 women. The aim of this study was to examine whether personality traits were correlated to outcomes. The same procedures were followed in the second study. At admission, participants completed the Life Events Scale (LES; Bryer et al., 1987), the NEO FFI personality measure (Costa & McCrae, 1992) and the Symptom Checklist Revised (SCL-90-R; Derogatis, 1983b). Participants also completed the SCL-90-R at discharge and at a 6-month follow-up. Researchers found several interactions between personality traits and treatment outcomes. For the WSIR group, lower agreeableness scores and lower extraversion scores were associated with improved outcome on the SCL-90-R at discharge. Lower extraversion scores were also associated with improved outcome for the TAU group. Reversely, the TAU group reported an association between higher agreeableness scores and increased improvement.

The authors provided some hypotheses about these associations. For example, perhaps women with lower levels of agreeableness learned social skills they were previously lacking, resulting in more improvement. Additionally, perhaps women with lower scores of agreeableness are more comfortable with conflict and anger expression, resulting in more improvement. Finally, perhaps women with more introverted scores are more introspective and were better able to utilize the training. However, with more strictly controlled studies replicating these findings, generalizability of the results is limited. In addition, these
hypotheses need to be tested in order to determine the validity. The authors also cite the use of one outcome measure as a limitation, and suggest utilizing inventories specifically designed for symptoms of sexual abuse. Another limitation the authors did not mention is the lack of a treatment comparison group. The TAU group essentially acted as a control group because no specific focus was given to recovery from sexual abuse. While the results of this study indicate that introverted women with low scores on agreeableness may benefit more from a WSIR group, there is no indication as to the type of treatment that would work better for any other combination of personality traits. Given the preliminary nature of this research, much more study needs to take place before results can be generalized and utilized.
OUTPATIENT TREATMENT

The majority of the studies published since 1998 examine the use of group therapy for survivors of CSA on an outpatient basis. Lundqvist, Svedin, Hansson and Broman (2006) researched the efficacy of a long-term psychodynamic trauma-focused group for women survivors. A total of 45 women participated in the study group by attended group for 18 months, with three separate phases. During the initial phase, participants met twice per week for approximately 5 months and focused on telling their story. The second phase lasted four months, with participants meeting weekly to discuss relationships within their family of origin. During the final phase, participants met once per month to work on separation and practice autonomy, which lasted for nine months. An additional 22 women completed a 20-week trauma-focused group following a similar model at an accelerated pace. Additionally, 10 women participated in a waitlist control group for an average of 11.5 months.

All participants completed three assessment measures upon entering treatment and immediately after treatment, which included the Symptom Checklist (SCL-90; Derogatis, 1979), the Sense of Coherence (SOC; Antonovsky, 1993), and the Life Events (LE; Reiss et al., 2001). Additionally, researchers compared inpatient days and sick days for two years prior to treatment and two years after treatment. Finally, participants from both the study group and the short-term group completed these assessments at a one-year follow up. Researchers noted that the last five study groups met for additional sessions during phase one, and 14 of the 22 women in the short-term groups received 15 minutes of body-awareness therapy.
Participants in both treatment groups reported statistically significant improvements on the SCL-90 as well as the SOC, with the waitlist control group reporting no differences. There were no statistically significant differences found between the two treatment groups; however, it may be important to note that members from the study group reported improvements on eight of nine scales on the SCL-90, while members of the short-term group reported improvements on only five scales. No differences were reported on the LE scale, indicating that the changes were due to therapy rather than other life events. The number of inpatient days decreased after treatment, yet the number of sick days increased.

The authors noted two important limitations to this study: the lack of a randomized control group and the difference in availability of the treatment groups. The study group was not suggested as an alternative regularly, meaning that women had to ask specifically to be a part of this study or be specifically referred. This may have resulted in more motivated, dedicated participants in this group. Another limitation is the change in treatment methods partway through the study. Without controlling for this, there is no way to determine whether this change affected the groups, and whether there was a significant difference between the first groups and the final groups. Finally, participants reported some differences between post-group and follow-up, so it would be beneficial to report if participants continued treatment on their own or if the continued improvement can be attributed to the initial group treatment. The authors of this study used statistically sound measures, and the use of both a waitlist control as well as another treatment comparison group strengthened the results. Based on the results of this study it seems that both a short-term and long-term group following this model may be useful in reducing symptoms in women survivors of
CSA, and that attending a long-term group may allow survivors to address and reduce more symptoms.

Another team of researchers compared the efficacy of a trauma-focused group and a present-focused group for women and reported their results in two separate articles (Classen, Koopman, Nevill-Manning, & Spiegel, 2001; Spiegel, Classen, Thurston, and Butler, 2004). Within each study, they also compared both groups to a waitlist control group with the intention of determining whether any treatment is better than no treatment, and whether either trauma-focused or present-focused groups resulted in better outcomes. Fifty-five women received assignment to one of the three treatment groups, and both therapy groups met weekly for 6 months. The goal of the trauma-focused group was to help survivors improve current functioning by integrating their trauma histories into their current lives. This process involves reconstructing their experiences, learning to integrate the emotions they experience in response to the trauma, alter their negative self-views caused by the trauma, and incorporate their traumatic history into their sense of self. The present-focused group focused on reducing problems in participants’ everyday lives by reducing maladaptive patterns of behavior and increasing healthy coping skills.

Participants in all three groups completed three assessments at baseline and at a 6-month follow up. These measures included the Trauma Symptom Checklist-40 (TSC-40; Elliott & Briere, 1992), the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988), and the Sexual Experiences Survey (SES; Koss & Gidycz, 1985). Additionally, participants in both therapy groups completed these assessments again at a 12-month follow up. Participants in both therapy groups reported reduction on several subscales, including dissociation, sexual trauma, being vindictive/self-centered, nonassertive,
and overly accommodating. Interestingly, the researchers found that at the 12-month follow up, the trauma-focused group reported improvement on the IIP, while the present-focused group reported improvement on the SES. Researchers had expected the present-focused group to report more improvement on interpersonal measures due to the focus of the group. In addition, the researchers were surprised that the present-focused group reported almost half the number of negative sexual experiences as the trauma-focused group. The findings from this study have prompted the researchers to work on a current study examining the efficacy of a present-focused group in reducing risky sexual behavior and HIV infection.

While no limitations were discussed in the article, the small sample size was eluded to during the discussion of the statistical results. Another potential limitation is some of the inclusion criteria, specifically the requirement that participants were required to have discussed the details of their abuse with another person at least 6 months prior to beginning the group. This seems to be a strange requirement since many times a support group is the first time survivors feel safe enough to share their stories. Additionally, the authors were hoping to examine risky sexual behavior, yet participants were excluded if they met criteria for drug or alcohol dependence. The authors then note in the description of their current study that women with drug and alcohol problems will be included, so it appears that including them in this study may have added important information to their results. Even with a small effect size, it seems likely that both a trauma-focused and a present-focused group may result in reduced symptomology. Further research examining more closely the differences in symptom reduction may help professionals determine which type of group is most appropriate for certain symptom presentation.
One study was designed to look specifically at symptom reduction in adult women survivors of CSA when treated with an adaptation of Cognitive Processing Therapy for survivors of child sexual abuse (Chard, Weaver, & Resick, 1997). The researchers published two articles outlining their study, one examining the statistical significance and the other examining the clinical significance (Möller & Steel, 2002; Rieckert & Möller, 2000). The researchers examined the efficacy and effectiveness of a 10-week Rational-emotive behavioral therapy group focused on decreasing dysfunctional beliefs and increasing behavioral skills for reducing symptomology in women who were seeking help to deal with unresolved emotional problems related to childhood abuse, but did not meet criteria for a diagnosis of PTSD or mood disorder. Two separate treatment groups, consisting of six women each, were compared to a delayed treatment control group, made up of fourteen women.

All participants completed a series of assessment tools, including the Trauma Symptom Checklist (TSC-40; Elliot & Briere, 1992), the Beck Depression Inventory (BDI; Beck et al., 1961), the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983), the State-Trait Anger Expression Inventory (STAXI; Spielberger, 1988a), the Guilty-Inventory (GI; Kugler & Jones, 1992), the Coopersmith Self-Esteem Inventory (CSEI, Coopersmith, 1981), and the Survey of Personal Beliefs (SPB; Demaria, Kassinove, & Dill, 1989). The researchers compared scores from the control group and the treatment group at pre-treatment, post-treatment, and at 8-week follow up. Statistically significant improvements were found for the treatment group from pre-treatment to post-treatment scores on all dependent variables. Clinically significant improvements were made for the treatment group on the BDI, the STAI, and the STAXI. Additionally, more
participants reported either a lack of improvement or deterioration on the GI and the CSEI than showed improvement. Finally, the researchers conducted a stepwise logistical regression to determine which variables are useful at predicting therapeutic outcome and found that five symptoms combined to significantly predict outcome, including: relationship to the perpetrator, awfulizing, self-directed should, other-directed should, and self-worth.

The authors listed several limitations, such as a small sample size, an arbitrarily selected criterion for clinical recovery, a limited number of predictor variables, and statistically significant pre-treatment differences between the treatment group and the control group on every dependent variable. The authors hypothesize that, because the control group reported statistically significant scores in the direction of health on all scales, this strengthens the research showing improvement for the treatment group. While this may be the case, it does raise questions as to the usefulness of the control group since even with random assignment this group reported significantly better functioning on all measures used. Perhaps examination of individual results for potential outliers or a post-hoc examination of other possible factors for the difference would have shed light on this oddity. Another limitation not mentioned by the authors is the large number of deteriorated clients with respect to guilt and self-esteem. As these can be particularly distressing symptoms, it raises questions about the utility of this approach with individuals struggling with feelings of guilt and low self-esteem. While this treatment may be effective in reducing depression, anxiety and anger, there are several other interventions shown to be equally useful at reducing these symptoms without increasing guilt and low self-esteem.

One hypothesis is this type of treatment, where “emphasis was particularly placed on dysfunctional beliefs” (Möller & Steel, 2002, pp 54) may in fact resemble victim-blaming,
accounting for the increased feelings of guilt and decreased self-esteem. The authors’
description of treatment relied heavily on teaching participants about their “irrational
beliefs,” when in fact many feelings of fear and anger are justified and appropriate, or rather,
are quite rational. While fear, anxiety and anger may not seem functional for people who
have never experienced interpersonal violence, convincing survivors that the feelings that
give them a sense of safety is actually what is wrong with them will very likely magnify
previous feelings of guilt and self-deprecation. Therefore, while this form of therapy appears
to be successful in reducing some symptoms of CSA, it also appears to exacerbate other
symptoms and might actually do more harm than good.

In a similar attempt to examine guilt and hopelessness, Gorey, Richter, and Snider
(2001) performed a secondary analysis on the effectiveness of group therapy on feelings of
guilt, isolation, and hopelessness in female survivors of CSA. The original study included 80
clients in a wait-list control group and 78 women in small, closed process groups meeting 15
weeks for 90 to 120 minutes each week (Richter, Snider & Gorey, 1997). The treatment
group focused on exploring personal experiences of abuse, depression, self-esteem, anger,
fear, grief, and relationships. Because this article outlines a secondary analysis, the original
groups did not focus directly on hopelessness, guilt, or isolation. The original analysis
revealed significant improvements for the treatment group, with improvements maintained
at 6-month and 12-month follow up.

In this re-evaluation, Gorey et al. (2001) examined the original results from the Beck
Depression Inventory (BDI, Beck et al., 1961), the Generalized Contentment Scale (GCS,
Hudson & Proctor, 1977), and the Index of Self-Esteem (ISE; Hudson, 1992). Out of the
pool of 71 items, the authors created three new scales with 15 items each the Guilt Scale, the
Isolation Scale, and the Hopelessness Scale. Each scale was analyzed using Cronbach’s alpha, with the resulting scores of .90, .90, and .88, respectively. Results indicated that survivors completing the treatment group reported significantly less guilt, less isolation, and more empowerment. Interestingly, survivors completing the treatment group who had previously attempted suicide reported even more hopefulness than those who had not attempted suicide, as evidenced by a higher effect size (0.898 versus 0.831). In addition, the results were greater at a six-month follow-up.

The authors noted several limitations, beginning with the fact that this was secondary analysis and cannot be viewed as research, but rather as theoretical groundwork. Another limitation was the lack of diversity in the original study: this study was comprised of only women, nearly all of whom were Caucasian. Future research needs to examine whether similar effects are evident in a more diverse population before generalizations can be made. Another limitation to this study, which I believe falls under the umbrella of secondary analysis, is the lack of measures specifically designed to examine hopelessness, guilt, and isolation. However, even with the preliminary nature of this article it certainly offers hope that group intervention for survivors of CSA can, in turn, offer hope to those struggling with the aftermath of abuse. The authors make an important note that this type of intervention is not only improving lives, but more importantly, it is saving lives.

A group of researchers in the United Kingdom published an article outlining their evaluation of a time-limited therapy group within their community (Buckingham & Parsons, 2005). The Groupwork for Adult Survivors of Childhood Abuse (GASCA) was developed for use in prisons for males and females, but this study reviewed two groups run in the community for women, with four women from each group participating. GASCA is a client-
centered group focused on empowering individuals. Participants met weekly for ninety minutes, for a total of 15 weeks. Groups were customized to focus on the unique needs of each group, yet the first two sessions focused on building shared experiences and safety, along with exploration of important relationships. While six participants had utilized individual therapy in the past, no participants received concurrent therapy during this study.

Researchers administered both the Trauma Symptom Inventory (TSI; Briere, 1995) and the Symptom Checklist (SCL90-R; Derogatis, 1983b); however, they only reported results from the TSI because both measures showed similar results and the TSI is a more trauma-specific measure. It is more typical to report all data, so this raises questions about why all the data was not reported. Participants completed assessments pre-treatment, post-treatment, and at a 2-month follow-up. Researchers found significant improvements on all clinical scales of the TSI from pre-treatment to post-treatment. At follow-up, participants reported some worsening of symptoms since post-treatment, but none of these increases were statistically or clinically significant. The authors hypothesize that symptoms may have elevated due to the loss of the group support, and that symptoms would eventually reside. However, without longer-term follow-up it is not possible to know whether this is the case.

The authors acknowledge the limitations that come with small sample sizes and the lack of a control group. They chose not to use a control group because they intended to evaluate their program’s effectiveness rather than add quantitative research. While these limitations do affect the generalizability of this study, the results are promising for the use of a short-term client-centered group. Possibly more important than numbers is the impact it made on women in this study. The authors reported quotes from participants, including the following:
“I am totally free. I feel I can walk with my head held high. I no longer feel like a victim” (Buckingham & Parsons, 2005, pp 21).

While symptom reduction is an important part of treatment, it seems that many studies forget to measure for the impact treatment makes on survivors’ evaluation of the abuse and of themselves. Often the realization that a survivor is not alone is more important than relief from symptoms, and may actually be the first step in recovering.

Hébert & Bergeron (2007) conducted a study examining the efficacy of a feminist-based group treatment hoping to correct some limitations found in previous research. Specifically, they included the use of a wait-list control group and measured self-blame, stigmatization, and powerlessness in addition to PTSD, depression and self-esteem. The authors conducted the study in a community center in Quebec with a long history of providing free services to survivors of sexual abuse. The wait-list control group, made up of 11 women, was compared to the treatment group, consisting of eight different groups with a total of 41 women. The treatment group met for 15-17 weeks, for three hours each week. A crucial focus of this group was helping participants view their symptoms as ways of coping and adapting to their situations rather than as pathology. Several sessions were also spent discussing the feelings of guilt associated with being a survivor, as well as placing the blame back on the perpetrator.

In an effort to examine several different aspects of CSA, the researchers included a number of measurement tools, including scales for depression, psychological distress, self-esteem, PTSD, sexual anxiety, coping, trauma-related beliefs, assertiveness, and conflicts. Participants in the control group completed all assessments at the beginning of the study and again after 15 weeks, while participants in the treatment group completed all assessments
pre-treatment, post-treatment, and at 3-month follow-up. After completing separate ANOVAs for each dependent variable, researchers found significantly greater improvement for the treatment group when compared to the control group on all measures with the exception of PTSD symptoms and probability of assertiveness. Additionally, follow-up results indicate that improvements were maintained. Interestingly, both the treatment group and the control group reported significant improvement on PTSD symptomology. The authors hypothesized that the improvement in the control group may have resulted from taking the first step to receive services.

The authors reported several important aspects of this study, including a low attrition rate (16%), a high attendance rate (95%), and no interaction between concurrent individual therapies while completing this study. The low attrition rate is particularly surprising when compared to several other studies reviewed here, which reported much higher rates. Also important is the control for concurrent individual therapy, resulting in no differences. Limitations discussed by the authors included the completion of pre-treatment measures after the first group, the need for longer follow-up assessments, and the lack of qualitative assessment. Another limitation may be the statistical analysis used. With the large number of dependent variables, a MANOVA would have limited the chance of a type I error, or finding significant differences simply by chance. Including several measures is a strength of this study because simply measuring depression and PTSD symptoms does not give a complete picture of the difficulties survivors face. However, a more stringent statistical analysis would have allowed for more confidence in the results. In spite of this limitation, this study was well controlled, tapped into several symptom areas, and resulted in yet more evidence that group treatment for survivors of CSA is usually beneficial.
Lau and Kristensen (2007) conducted a comparison study looking at outcome differences between systemic and analytic group psychotherapy for adult women survivors of intrafamilial CSA. They also utilized a waitlist comparison group to examine differences between treatment and no treatment, with the hypotheses that both groups would be equally effective at reducing symptoms, and both would be more effective than the waitlist control group. Specifically they wanted to address psychiatric symptoms, psychosocial functioning, and quality of life. The systemic groups met twice a week for 2.5 hours each session over a period of 5 months, with 46 women completing the group and assessments. The analytic groups met once per week for 2.25 hours over a period of 12 months, with 40 women completing both the group and assessments. Participants completed the initial assessments once they contacted the researchers, and then received a random assignment to a treatment method. They completed assessments again before their first group session and after their last session. Any changes between the initial assessment and the pre-treatment assessment were attributed to the waitlist group.

To assess for psychiatric symptoms, researchers used the DSM-IV and ICD-10 personality questionnaire (DIP-Q; Ottosson et al., 1998), the Symptom Checklist-90-R (SCL-90-R; Derogatis, 1994), and a flashback questionnaire designed for this study. Participants also completed a self-report version of the Global Assessment of Functioning (GAF; Bodlund, Kullgren, Ekselius, Lindstrom, & von Knorring, 1994) and the Registration Chart Questionnaire (RCQ; Husby, Dahl, Heilberg, Olafsen, & Weisaeth, 1985) to report psychosocial functioning. To assess for quality of life, participants completed a Global Life Quality measure (GLQ; Husby et al., 1985), and finally they completed a questionnaire designed to measure patients’ expectations to therapy and perceived change. After
completing pretest posttest comparison analysis, the authors concluded that both group treatments resulted in significant improvement on all measures, with the exception of problems in relationships. In addition, the systemic group reported a much higher effect size on all measures, again excepting problems in relationships. These results highlight that an analytic group resulted in reduced symptoms similar to other forms of group interventions, yet systemic groups reported a much higher level of symptom reduction.

Limits to this study described by the authors include the lack of a follow-up study, a high attrition rate, and that the difference in outcome can be attributed to several things, including differences in therapeutic technique, length of time, number of sessions per week, or the intensity of the therapy. Another hypothesis the authors purposed was that improved outcome might be attributable to the presence of structure in the systemic group, whereas the analytic group did not provide as much structure. The study might have been more useful if both groups had met for the same number of sessions and months, with similar lengths of sessions. Meeting twice a week may have allowed the systemic group more cohesion and more support to do some intense work. More study is needed to explain what specific components of treatment are most effective, and why. However, the results of this study indicate a strong possibility that this form of group, whether due to the systemic nature or the time-intensive nature, may result in much better outcomes than either short-term therapy or long-term, less time-intensive therapy.

The prior sections have focused on the general effectiveness of group treatment for survivors of CSA. Other studies have examined the effectiveness of group intervention for specific populations of survivors, and will be reviewed next.
Krupnick et al. (2008) conducted a study examining interpersonal psychotherapy groups (IPT) for low-income women with chronic PTSD. They hypothesized that IPT would be more effective than a waitlist control group for: reducing severity of PTSD symptoms, decreasing the rate of comorbid depression, and increasing interpersonal functioning. The treatment group, which consisted of 24 women, received 16 two-hour sessions, with assessments done at pretreatment, post-treatment, and 4-month follow-up. The control group, made up of 16 women, received no treatment, but received assessments on the same schedule as the treatment group. To assess symptomology researchers administered the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) and the Current and Lifetime Diagnostic Version (CAPS-1; Blake et al., 1990), and to assess interpersonal functioning they administered the Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988).

The researchers found that, overall, the IPT group participants reported significantly lower scores on the HRSD and the CAPS-1. At termination, 71% of wait-list participants still met criteria for PTSD, while only 30% of IPT participants continued to meet criteria for PTSD. On the IIP, participants in the IPT group improved significantly more than the control group on the following scales: Interpersonal sensitivity, Need for Social Approval, Lack of Sociability, and Interpersonal Ambivalence. Neither group reported significant improvements on the Aggression scale. This study suffered the same limitations as many
others, including a small sample size, the lack of a treatment comparison group, and attrition. The generalizability of this study is limited due to these limitations, but initial results are promising.

Another possible limitation to this study that the authors did not discuss was the monetary incentives offered to participants. If participants completed all stages of the study, they earned $105, which for a low-income population may have been such a strong incentive that it potentially influenced the results. In addition, none of the participants included in this study were seeking mental health services. It is unclear whether this affected the results of the study, but there is a possibility that, coupled with the monetary incentive, participants may not have invested in the study. It would be interesting to see this study replicated with controls for both recruiting means and incentives.
CHRONIC MENTAL ILLNESS

Given the chronic and severe nature of symptoms related to CSA, it is understandable that survivors often experience chronic mental illness. Ironically, however, researchers often include exclusionary criteria of severe, persistent mental illness such as psychotic symptoms and suicidality. Unfortunately, this often means that the population needing treatment the most is excluded from the very treatment they need. However, two studies included in this review examined treating this underserved population.

Kreidler (2005) examined the efficacy of group therapy with women survivors who have a chronic mental illness (CMI), including schizophrenia, delusional, dissociative, mood, and personality disorders. This study did exclude women who were actively suicidal or did not have 6 months of sobriety. Women who met Ohio’s criteria for mental disability made up the chronically mentally ill group, totaling 56 participants, while women who did not meet these criteria made up a control group, totaling 65 participants. Both groups participated in 50 weekly 2-hour group therapy sessions, as well as received individual therapy. Groups were formed based on availability of participants, so there were groups with only CMI women, with both CMI and no CMI women, and only no CMI women.

Participants completed four assessment instruments at three separate points in time: pretreatment, halfway through treatment, and post-treatment. The researchers used the Beck Depression Inventory (BDI; Beck & Steer, 1987), the Symptom Checklist-90-Revised (SCL-
90-R; Derogatis, 1983b), the Responses to Childhood Incest Questionnaire (RCIQ; Donaldson & Gardner, 1983), and the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965). Pretreatment differences were found on all assessments between groups, with the CMI group reporting significantly worse symptoms than the no CMI group. However, both groups reported symptoms within the clinical range. At post-treatment measurement, both groups reported statistically significant improvements on all four measures.

The author mentioned two specific limitations in this study: the use of a convenience sample and a low percentage of minorities in the study. Another possible limitation is the lack of control for individual therapy. All participants were required to have ongoing individual therapy through the group intervention, yet no data about the individual therapy was reported in this study. While the use of individual therapy can be beneficial while participating in group therapy, it is important to control for the possible effects of this treatment to the study. However, even when considering these limitations this study provides hope that this population can benefit from a group intervention, and may not need to be treated separately from survivors without CMI. The author discusses the importance of screening for sexual abuse histories by nurses since many survivors experience somatic symptoms and may present to a physician’s office before seeking therapy. She stressed the importance of educating nurses about the effects of CSA and ensuring that they are able to provide appropriate referrals.

Cloitre and Koenen (2001) examined the impact of Borderline Personality Disorder (BPD) on interpersonal process group outcome. Within this study, they also examined the effectiveness of interpersonal process group therapy with women survivors of CSA who currently meet criteria for PTSD. Participants included 49 women making up three treatment
conditions: group treatment with no members with BPD, group treatment with at least one member with BPD, and a waitlist. Treatment consisted of 12 weekly sessions lasting 90 minutes.

Researchers assessed participants at pretreatment and post-treatment using several criteria, including: the Structured Clinical Interview for the DSM-III-R (SCID I; Spitzer, Williams & Gibbon, 1987; and SCID II; Spitzer, Williams, Gibbons & First, 1989), the Posttraumatic Stress Disorder Symptom Scale (PSS-SR; Foa, Riggs, Dancu & Rothbaum, 1993), the State Anxiety Inventory (STAI; Spielberger, Gorsuch & Luchene, 1970), the Beck Depression Inventory (BDI; Beck et al., 1961), the General Severity Index of Brief Symptom Inventory (BSI; Derogatis, 1983a), the Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988), and the State-Trait Anger Expression Inventory (STAXI; Spielberger, 1991). Analysis revealed statistically different racial composition, so ethnicity was used as a covariate in statistical analysis. Participants in groups without a diagnosis of BPD reported significant improvements in PTSD symptoms, emotion-related problems, interpersonal problems with assertiveness, and anger problems. Participants in groups with at least one member with a BPD diagnosis did not report improvement, and actually reported deterioration in measures of anger. The waitlist group reported no changes. Further analysis was conducted to examine individuals from groups with a BPD diagnosis. Researchers found that all members of the group deteriorated when at least one member received a diagnosis of BPD.

The authors reported several limitations to this study, including the lack of a randomized controlled trial, the use of many symptom measures, and the lack of follow-up data. Another possible limitation to this study is the use of outdated diagnostic criteria. This
study used the Diagnostic and Statistical Manual of Mental Disorders, Third Version, Revised (APA, 1987). The fourth edition was published in 1994 (APA), a full 7 years before the publication of this article. While the use of an older version may not weaken the results of this study, it does raise the question of why current publications were not used. Does this indicate that the researchers may not have been up to date with the research in this field, or perhaps was this study conducted several years ago and not published right away? Some explanation in the article would have helped to ease potential worries of the consumer of this research.

Another limitation in this study is the exclusion criteria. This study was designed to look at women survivors with BPD, yet the researchers excluded several symptoms associated with BPD, including suicidality, recent hospitalization, and active substance abuse. These are some of the severe, often lethal symptoms associated with a history of CSA, yet these are the symptoms being screened out for treatment. Finding an effective way to treat members of this population is crucial to improving overall research in this field, and excluding this population is doing them a disservice. While the results of this study indicate that interpersonal process groups were not successful when treating women with a diagnosis of BPD and, in fact, that the presence of an individual with BPD had a negative impact on the outcome for the entire group, it only highlights the need to find effective treatment for women with a diagnosis of BPD. These results also, unfortunately, lend merit to the argument that this diagnosis is untreatable. Many argue, however, that this population has received a pejorative label, and has been treated as difficult clients rather than clients suffering from difficult symptoms.
INCARCERATED WOMEN

The rate of childhood abuse among incarcerated women is higher than the general population, (Browne, Miller, & Maguin, 1999) which indicates that there is a need for an effective treatment for this population. Bradley and Follingstad (2003) created a group combining skills building and written exposure to treat incarcerated survivors of CSA. Their study included 49 participants who self-reported as survivors of CSA and who reported significant impairment. Along with CSA, many of the participants reported childhood physical abuse, as well as adult physical and sexual abuse.

Participants were randomly assigned to either the treatment group or a no-contact control group. Attrition rates were high due to participants being paroled or transferred, along with those who dropped out of the program voluntarily. The treatment group received eighteen sessions lasting 2.5 hours each week. The initial nine sessions were focused on skill building and were based on Linehan’s DBT model (Linehan, 1993). The last nine sessions focused on exposure and used written assignments to conduct the exposure. The authors used three measurements: Beck Depression Inventory (BDI; Beck et al., 1996), Traumatic Symptom Inventory (TSI; Briere, 1995) and Inventory of Interpersonal Problems (IIP-32; Barkham, Hardy & Startup, 1994).

Clinically significant decreases were found on the BDI, as well as the following scales from the TSI: Dissociation, Anxious Arousal, and Intrusive Experiences. The average effect size was moderate to large for differences from pre-treatment to post-treatment for the
treatment group. The control group reported a small effect size. The results of this study indicate that this treatment method may be beneficial to incarcerated women survivors of CSA. Two noteworthy limitations to this study are the high attrition rate and the lack of a treatment comparison group. Since the authors only used a no-contact comparison group there is no way to tell what caused the improvements. If the authors had included a treatment-as-usual comparison group it would have been possible to compare the two treatment groups to see if the proposed method yielded superior improvements than the treatment-as-usual group. Unfortunately, due to the lack of a treatment comparison group, all this study really indicates is that this treatment method is better than no treatment. Further studies need to compare this treatment model with other forms of treatment to determine how effective this treatment is.

Cole, Sarlund-Heinrich, and Brown (2007) published an article describing a study they conducted on incarcerated women survivors of CSA. The purpose of their study was to collect initial data on the effects of a treatment group for this population. All participants volunteered for treatment at the beginning of their sentence, and were randomly assigned to either a treatment group or a no-treatment control group. Four women completed the treatment group and five women completed the control group. The treatment group met twice a week for 2.5 hours, for a total of eight weeks. The group included four phases: self-soothing and safety, psychoeducation, processing, and termination. Seven sessions were spent on setting healthy boundaries, improving self-esteem, and learning relaxation techniques. Four sessions focused on teaching participants about trauma, and ways to identify interpersonal patterns of abuse. One session was spent writing a personal story of
trauma and a discussion of the stories. The final four sessions focused on processing and ending the group.

The authors used four assessment instruments: the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1994), the Trauma Symptom Inventory (TSI; Briere, 1995), and the Rorschach Inkblot Method (RIM; Exner, 2003). All participants completed the three assessment instruments prior to beginning treatment and immediately following the conclusion of treatment. The results indicated a decrease in the Trauma Content score of the RIM, but no changes in the TSI or SCL-90-R scores. The control group reported greater severity on the TSI and SCL-90-R scores post treatment than before treatment, indicating that while there was no improvement in the treatment group, neither was there deterioration as was observed in the control group. Participants in the treatment group reported a strong belief that the group was beneficial and that they gained a new understanding that they were not alone.

The authors hypothesize that the changes from the group are occurring at an unconscious level, which would explain why improvements were seen on the projective test rather than on the objective tests. In addition, the brevity of this treatment may have influenced the potential for symptom reduction. Perhaps the maintenance of current symptom levels for incarcerated women indicates significant improvement as the norm for this population is an increase in symptoms.

Several limitations are discussed, including the small sample size and a lack of generalizability, no control for extraneous variables, no long-term post-treatment assessment, and limited resources available to the authors. This study did not control for several confounding variables, such as age, substance use, medication, length of
incarceration, or comorbid disorders. In addition, due to limited resources no follow-up assessments were conducted. The authors suggest that a follow-up assessment would have directly affected the outcome data. For this population it may be more useful to consider the lack of deterioration as evidence of the benefits of treatment. The hostile atmosphere of the prison system it likely to either retraumatize these women or reactivate existing symptoms. Perhaps the best possible outcome for inmates is the lack of deterioration, and once the participant has re-entered the general population actual healing can occur. Long-term research following the participants after release may be valuable in determining whether this is the case. However, in spite of these limitations the results of both this study and the study conducted by Bradley and Follingstad (2003) indicate that treatment for this population is both desperately needed and is likely beneficial.
ADULTS DIAGNOSED WITH HIV/AIDS

A group of researchers in New Haven, Connecticut created a group treatment designed specifically for adult survivors of CSA who also have a diagnosis of HIV, and published two articles describing the outcome of their research (Sikkema et al., 2007; Sikkema et al., 2004). The authors argue that because rates of HIV/AIDS are elevated in adults with a CSA background, and because HIV/AIDS is a traumatizing experience, it is important to develop an effective treatment modality to address both childhood trauma and current trauma related to a diagnosis of HIV. Sikkema et al. (2004) first published the results of a pilot study examining the preliminary results of a group intervention for coping with HIV/AIDS and CSA. The goals of the intervention included: improving psychological functioning and coping ability, reducing high-risk behaviors, and promoting healthy behaviors in adults living with HIV.

Twenty-eight participants completed the study (7 men and 21 women). Participants were separated into five groups: three groups for women with 7-8 members and two groups for men with 3-5 members. The women’s groups lasted for sixteen weeks while the men’s groups lasted for eight weeks, and all groups met for 90 min each week. The intervention used a combination of behavioral exposure and coping skills training, tied together with an interpersonal process component. All participants completed the Trauma Symptom Checklist-40 (TSC-40; Briere, 1996) and the Personality Assessment Inventory (PAI; Morey, 1991) as screening measures. Additionally, all participants completed the Trauma Symptom
Inventory (TSI; Briere, 1995) 2 weeks prior to beginning treatment and 2 weeks after the completion of the last session.

To determine clinically significant improvements, the researchers used normative data from the TSI scoring manual to determine clinical significance cutoff points. The cutoffs and Reliable Change Index (RCI) were used to determine each participant’s change as either recovered, reliably improved, no change, or reliably deteriorated. Overall, 76.9% of participants reported clinically significant improvement on at least one TSI subscale, which included both participants reporting improvement and recovery. The breakdown of improvement follows: 10 participants improved on one TSI subscale, 4 participants improved on 2 TSI subscales, 2 participants improved on 3 TSI subscales, and 1 participant each improved on 6, 7, 8, and 10 TSI subscales. The authors argue that these results indicated that a coping group intervention could improve trauma-related symptoms in survivors of CSA living with HIV.

While this preliminary data is cause for optimism, several limitations in the study design need to be considered. The authors list several limitations, including a small sample size, the lack of a control group, differing levels of treatment, the use of the TSI as an outcome measure, and the fact that some participants had recently completed a research study prior to this study (Sikkema et al., 2004). In addition to the authors’ cautions, one might wonder about the creation of cutoff points. Since there was no normative data on individuals with HIV, the authors used the normative data of individuals with traumatic histories to determine clinically significant cutoffs. While this may be an adequate sample to use, it does not account for the additional trauma of an HIV diagnosis. The mean scores of the sample population appear to vary drastically from the pretreatment sample mean,
although no statistics were reported. The difference in scores may account for some of the improvement seen in the sample, so the results should be interpreted with caution.

In their follow up study, the researchers addressed many of these limitations (Sikkema et al., 2007). The second study included 198 participants (107 women and 91 men) who were recruited from community organizations and referrals. Participants were randomly assigned to one of three treatment conditions: the HIV and trauma coping group, an HIV time-matched support group, or a waitlist control group. Treatment groups lasted fifteen weeks and met for 90 min each week. The HIV and trauma coping group was similar to the treatment approach used in the pilot study, with the time length modified. The goals of the HIV support group were to provide a supportive environment for participants to discuss issues with HIV and childhood trauma but the format was left open. All control group members were provided treatment immediately following the control period.

The researchers were not satisfied with the use of the TSI as an outcome measure for the pilot study, so they chose to use the Impact of Event Scale (IES; Horowitz et al., 1979) for their follow-up study. Each participant completed the IES prior to treatment and within two weeks after completing treatment, and participants were paid $35 for completing the initial assessment and $45 for completing the post-treatment assessment.

The results of this study indicate that the coping group reported statistically significant improvement on the Intrusion and Avoidance subscales. The support group reported statistically significant improvement on the Avoidance subscale, but not the Intrusion subscale. In terms of clinical significance, the coping group reported reliable improvement or recovery 20% more on the Intrusion subscale than either the support group or the control group, and 10% more on the Avoidance subscale. The authors are hopeful
that the results of their study indicate this new intervention style is beneficial for adult survivors of childhood sexual abuse who receive a diagnosis of HIV.

The authors discussed several limitations in this study, including only 60% of the participants in both groups receiving the complete intervention, with approximately 40% of participants attending sessions sporadically or dropping out of treatment. However, the completion rates in this study are similar to related studies. Another limitation is the lack of heterosexual males and the authors suggest further research into the effectiveness of this treatment method with this population. The authors also reported that the benefits of this study may be short-term and suggested a long-term follow-up assessment.

One possible additional limitation is the inclusion of compensation for the participants, especially when considering that 92% of participants earned less than $20,000 per year. Compensation of $80 may have influenced their willingness to participate. However, it is more likely that this compensation did not cover transportation costs for interventions and assessments. Given the preliminary nature of this research, the information gained from these studies vastly outweighs the limitations. This is an understudied population and the severity of their condition makes it important to gain some understanding of how to decrease their psychological symptomology. The researchers carefully controlled this study and reported statistically sound improvements. It is hoped these authors plan to build on this research and refine the intervention to develop the best treatment for this population.
ADULTS DIAGNOSED WITH A LEARNING DISABILITY

Barber, Jenkins, and Jones (2000) studied the effectiveness of group intervention for adult women survivors of sexual abuse who also have a learning disability. The goal of this intervention was to improve self-esteem, increase assertiveness, and lower anxiety. Six women participated in the study, all of whom experienced either a mild or a moderate learning disability. The group met 2 hours each week for 10 weeks, and focused on psychoeducation regarding sexual knowledge, assertiveness training, and teaching relaxation techniques. All participants completed three assessment measures prior to treatment, immediately after completing treatment, and at a 12-month follow-up. These measures included the Culture-Free Self-Esteem Inventory (Battle, 1981), the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), and an assertiveness questionnaire developed by the researchers.

Outcome data is difficult to utilize in this study because the authors did not appear to run any statistical analysis on the data. Rather, they reported raw scores along with mean scores. Any increase or decrease in scores was reported as improvement without statistical significance considerations. Without running statistical analyses, it is impossible to tell whether these changes are due to error or whether actual improvement took place. Given the inability to interpret the data, these results offer little to no information. It is unfortunate that the authors did not report statistical analysis because this was the only study focused on treatment for adults with learning disabilities. It is possible that this intervention method was
effective in reducing anxiety and improving assertiveness for these women; however, without properly analyzed data the results are inconclusive. The cognitive limitations of this population may make them especially vulnerable to this type of abuse, so more research in this area is desperately needed.
MALES

Although statistics and prevalence rates indicate that boys are often the victims of CSA, there is little research focused on treating male survivors. Five studies have been published in the past decade that include male survivors, two of which have been previously discussed as they focused on treating CSA survivors with a diagnosis of HIV/AIDS. Two studies were designed to evaluate group therapy specifically designed for male survivors, and the last study included both male and female survivors.

Morrison and Treliving (2002) evaluated the effectiveness of a psychodynamic, long-term open group for male survivors of CSA. The researchers modeled this group after a women’s group currently running at the psychiatric day hospital where the male groups were also run. Because the group was an open format and was offered long-term, the length of time participants attended the group varied. Thirteen men attended the group for at least six months, making up the treatment group, with the average length of attendance of 17 months. An additional four men attended the group for two to five months, and five men were new to the group when the research concluded. These nine men made up the control group. The participants determined the agenda, with four main areas of focus: identification with the aggressor, self-esteem, guilt, and sexual arousal.

The Symptom Check List 90 Revised (SCL-90-R; Derogatis, 1994) was used to assess symptomology at pre-treatment as well as post-treatment. All participants were assessed at the conclusion of this study. If the participant had attended the group for at least six months
they were included in the treatment group. Those participants who had not attended for at
least six months were included in the control group. Participants in the treatment group
reported significant improvements in several areas, including: somatization, obsessive-
compulsive behaviors, interpersonal sensitivity, depression, paranoid ideation, psychoticism,
global sensitivity index, and positive symptom distress index. Participants in the control
group reported significant improvement in interpersonal sensitivity.

The authors discussed several limitations, including a small number of participants,
only focusing on symptomology for measures of improvement, and an inability to control
for additional support received by the participants such as psychiatrists and medication.
Another limitation is the formation of the control group. Because some of the participants in
the control group may have received services for up to five months, it seems likely that they
would show signs of improvement whereas a true no-contact control group may not report
improvement. This is apparent in the significant improvement reported by the control group
on measures of interpersonal sensitivity. Another limitation to this type of study is the
inability to replicate the treatment. This is a catch-22 when doing research with this
population. It is beneficial to adapt the treatment but using a personalized treatment is nearly
impossible to replicate to prove efficacy. While this study had several limitations, the results
do indicate that a long-term psychodynamic group therapy is likely beneficial for male
survivors of CSA. Because research with this population is still in its infancy, nearly any new
studies specifically examining male survivors add to the knowledge base of the field.

Sharpe, Selley, Low and Hall (2001) also studied the effectiveness of a slow-open
long-term analytic group for male survivors of CSA. They ran the group for 28 months and
meet weekly for 90 minutes. Group members attended for 6-12 months and focused on
several core themes, such as a lack of trust, a need for control, and guilt. The authors did not report a format or agenda for sessions. Participants were invited to complete the Beck Depression Scale (BDI; Beck et al., 1961) and the Spielberger State-Trait Anxiety Scale (SSTAS; Spielberger et al., 1983), and volunteers were assessed at pre-treatment, post-treatment, and at six months follow-up. While 27 men completed therapy, only 22 opted to complete pre-treatment assessments and 10 opted to complete post-treatment assessments. Additionally, seven participants completed the follow-up BDI and five completed the follow-up SSAS.

Participants reported a statistically significant improvement on both scales from pre-treatment to post-treatment. However, while improvements were maintained at follow up for the SSTAS, improvements were not maintained on the BDI. In addition, only about one-third of participants completed these measures, which limits the generalizability. Additionally, researchers compared the male group to past female groups and found several similarities and differences. Both men and women survivors exhibited guilt, felt stigmatized by the abuse, had low self-esteem, felt fear and shame, and were hypersensitive to criticism. While women survivors often exhibited depression, powerlessness, and focus on expressing painful emotions during group, men hid similar feelings behind a macho front and expressed more hostility in group. In addition, men used drugs and alcohol to numb their emotions and took out aggression on people in their lives. Another important difference is the men’s intense fear of becoming a perpetrator. This fear drove one man to avoid visiting his grandchildren.

The authors mentioned some limitations to this study, including a small sample size, no control group, restricted focus of questionnaires, and the low number of participants who
completed the post-group questionnaires. In addition, the lack of description for group sessions limits the ability to replicate this study. However, while the results of this study indicate that this type of intervention is potentially helpful for male survivors, the biggest contribution these researchers make is the insight into the unique needs of male survivors. Because this group is so understudied, little is known about the specific needs for treatment as well as the unique expression of symptomology for male survivors. While women survivors often feel shame and guilt, these feelings are likely intensified for males in a homophobic society where masculinity is highly valued. More research examining how symptoms present and what works best with this population is desperately needed.

Finally, Nisbet Wallis (2002) examined a short-term group therapy including both males and females. Groups met for twelve weeks and focused on psychoeducation and interpersonal relationships. A waitlist control group, made up of 14 women and 3 men, was compared to the treatment group of 50 women and 16 men. All participants completed the Trauma Symptom Inventory (TSI; Briere, 1995) pre-treatment and post-treatment. The authors did not provide any additional information about the group logistics. Participants reported significant improvements on seven of the ten clinical scales of the TSI: anxious arousal, depression, anger/irritability, intrusive experiences, defensive avoidance, dissociation, and trauma reduction behavior.

The author discussed the limitations of this study, which included a non-random assignment to groups, unequal cell sizes, and the use of a waitlist control group. Additionally, the lack of reported information greatly limits the utility of this study. The author did not mention whether groups consisted of men and women or if there were separate groups for men and women. In addition, there is no mention of whether gender affected the treatment
outcome, or whether treatment was adapted to meet the unique needs of men and women. Based on the information reported in this article, it would be extremely difficult to replicate this study or to utilize this form of treatment, as so many important details are not present. However, it does add to the mounting research indicating that group therapy is likely a useful intervention for survivors of CSA.
DISCUSSION

Over the past ten years, research in the area of group psychotherapy with adult survivors of childhood sexual abuse has multiplied. A total of 28 articles were reviewed for this project, with nearly every research group reporting success in symptom reduction by using group treatment. Many different subpopulations have been studied in an attempt to gain a clearer picture of which interventions are beneficial for specific survivors, including inpatient and outpatient, men, women, individuals with chronic mental illness, incarcerated women, and many others. Even with the wide array of subpopulations, researchers have found group therapy, overall, to be very successful in reducing symptoms related to CSA. The authors of these studies ran into several difficulties, including small sample sizes, trouble using a control or comparison group, and limiting assessment tools. However, these limitations have presented some clear directions for future researchers.

Several separate studies found that group therapy was at least as effective as individual therapy, and combining group therapy with individual therapy may result in even more symptom reduction (Chard, 2005; Morgan & Cummings, 1999; Ryan et al., 2005; Saxe & Johnson, 1999; Stalker & Fry, 1999; Westbury & Tutty, 1999). While the debate over whether individual or group therapy is more efficient in treating this population is far from over, it is relatively clear that some form of group therapy helps reduce many debilitating symptoms associated with CSA, and often creates a sense of community where survivors feel safe enough to share their story. Sharing a story of abuse is usually an important step in
healing, and often the first place a survivor feels safe enough and strong enough to tell their story is in group therapy, with people who have experienced similar traumas.

Another common experience for survivors of CSA is chronic, often severe symptomology that can present as resistant to treatment. Several studies outlined here reported success with the use of group therapy for populations with more severe symptom presentations. These presentations include women who are incarcerated, living with chronic PTSD or other chronic mental illness, and individuals diagnosed with HIV or AIDS (Bradley & Follingstad, 2003; Cole et al., 2007; Kreidler, 2005; Krupnick et al., 2008; Sikkema et al., 2004; Sikkema et al., 2007). Often these individuals are excluded from group treatment due to the severity of their condition, such as individuals experiencing suicidal ideation or psychotic symptoms. The Kreidler study in particular was valuable because the researchers found that groups were successful even with the inclusion of individuals with chronic mental illness (2005). Perhaps this research will encourage other clinicians to consider allowing individuals with more severe symptom presentation to participate in group treatment.

Another vastly understudied population is male survivors of CSA. The few available studies that either included male survivors or focused on male survivors were reviewed here, thus contributing some much-needed insight into working with this population. Two studies found significant improvements when utilizing a long-term group with only male survivors (Morrison & Treliving, 2002; Sharpe et al., 2001); while a third study included male and female survivors in a short-term group (Nisbet Wallis, 2001). Possibly the most important information gleaned from this research is the distinct presentation of symptoms for male survivors. Increasing knowledge about symptomology is the first step toward creating
effective treatment for this population. Nisbet Wallis’s study is also valuable in that it shows that men and women can successfully attend group therapy together. This may be especially healing for individuals abused by members of the opposite gender as an opportunity to connect in a supportive way.

Several common limitations were found in the studies reviewed here, including a small sample size, the lack of a control group or treatment comparison group, and high attrition rates. While prevalence rates for CSA are very high, it can be difficult to find survivors willing to take part in a treatment group for a variety of reasons. Small sample sizes do limit the generalizability of results, but these results are still valuable in guiding future research and treatment modification. Not using a control group is more difficult because it does not allow researchers to attribute improvements to their treatment intervention. Future research needs to continually use an effective control group in order to show that the intervention is causing, or at least contributing to, the improvement. In addition, including a treatment comparison group helps to illustrate what works and what does not. This can be especially helpful when treating a specific population of survivors as a way to find more effective population-specific interventions. Another common limitation found among the current research is the lack of detailed descriptions of interventions being used. Often treatment guidelines were eluded to or briefly outlined, without specific details. This lack of clarity greatly reduces the ability to replicate studies, thus making it nearly impossible to determine whether the intervention is efficacious.

The research from the past decade has also highlighted several areas needing future study. Given the scarcity of current research, more studies are needed examining effective
treatments for male survivors, along with the incorporation of male and female survivors in coed groups. More research is also needed for severe symptom presentation, such as individuals with dual diagnoses, suicidality, or personality disorders. Another terribly understudied population is that of adult survivors of CSA who have also been diagnosed with a learning disability or other cognitive limitation. Given the potential vulnerability of this population, modifying treatment to be more effective for this group may be particularly valuable. Because of the high prevalence of risky sexual behaviors in survivors of CSA, continued research in the area of survivors with HIV could potentially lead to better understanding of preventative interventions. Finally, long-term follow-up studies are needed to determine the lasting power of interventions, and whether ongoing treatment for this population is needed.

Overall, the research reviewed here strongly supports the use of group interventions for adult survivors of CSA. Nearly all interventions studied resulted in significant symptom reduction, including both short-term or long-term improvements. Many different theoretical perspectives were represented, including cognitive-behavioral, rational-emotive behavioral, psychoanalytic, feminist, interpersonal, and systemic. Group therapy was found to be as effective as individual therapy and, when paired with ongoing individual therapy, may be even more effective. Future researchers will likely continue to find success with group interventions for this population, and will hopefully continue to refine intervention methods to treat the many subpopulations more successfully.
REFERENCES


