Abstract

Purpose:

The aim of this study was to provide the first formal evaluation of a unique 12-session group therapy programme developed by the UK-based National Association for People Abused as Children (NAPAC). Method: The therapy outcomes of this programme were assessed using the CORE-OM tool. Clients comprised 26 individuals (7 males and 19 females), with an age range of 19 - 67 (Mean = 41; SD = 12.76). Clients were survivors of sexual, physical, emotional or neglectful childhood abuse, or a combination of these and were from four different locations: London (n = 9), Bury (n = 4), Belfast (n = 8), and prison (n = 5). Findings: Across all CORE domains, improvements were shown from pre- to post-therapy. No gender or age differences were revealed and improvements were shown across both community members and prison inmates. Implications: A person-centred approach to group therapy is beneficial to a wide range of adult clients within the community and prison settings that require therapy after historical sexual, physical, emotional or neglectful childhood abuse.

KEY WORDS: CORE-OM; Group therapy; Person-centred approaches; Evaluation

Introduction

In recent years, there has been increasing pressure on services that support people with mental health issues to adopt assessment and outcome measures in their work, and this is now also the case across a wide range of survivor counselling and therapy organisations. As such, it is important that assessment measures are suitable for particular client groups (Barkham, Gilbert, Connell, et al, 2005), and capable of tracking the client's progress through any specific therapy programme.

The National Association for People Abused as Children (NAPAC) is a UK-based organisation that supports adults who were abused as children (NAPAC, 2014). The topic of child abuse has been in the UK media spotlight since the sexual abuse revelations concerning the late Jimmy Savile and the subsequent police investigation, Operation Yewtree. The media attention on high-profile offenders has encouraged many people to come forward to receive support for their abuse experiences, which have often occurred many years previously. Up to now, many thousands of child abuse survivors have lived with the legacy of their abuse into adulthood without telling anyone, or have been dealing with mental health issues in services ill-equipped to deal with them (see, e.g. Lowe & Balfour, 2015). Fear of being blamed or shunned by their families (Davies, Patel & Rogers, 2013), shame, depression and low self-esteem to name but a few negative effects of child abuse have prevented survivors coming forward. One may argue that the floodgates have been opened, and more and more historical child abuse survivors may now be ready to reach out to be heard.

NAPAC supports men and women, both within the community and in prison settings, to deal with all kinds of abuse histories including physical, sexual, emotional, ritual and neglectful experiences, and has thus far done so via telephone support lines. Traditionally, NAPAC has offered telephone support, but since 2011, this telephone service has been extended to face-to-face support groups of up to 12 people over 12 sessions, which focus on change, emphasising trauma recovery, empowerment, self-awareness and coping with the long term effects of childhood abuse. Such sessions utilise a person-centred, psycho-education approach, with some elements of cognitive behaviour therapy (CBT) (NAPAC, 2014).

The current study assessed therapeutic outcomes of NAPAC's group therapy sessions, and the aim of this study was to provide a first formal evaluation of NAPAC's therapy programme. Literature has long been available to show that group therapy programmes show positive benefits for clients who have abuse and trauma histories. For example, psychoeducational group therapy, based on cognitive behavioural principles has been successful in reducing symptoms post-therapy and at a six

month follow-up, in multiply-traumatised women (Lubin, Loris, Burt & Johnson, 1998). NAPAC's group therapy programme utilises an eclectic therapeutic-base and as such requires evaluation in its own right.

Clients comprising members of the community - based in London, England; Bury (a town in Greater Manchester, England); and Belfast, Northern Ireland - and prisoners (based in Manchester, England) were included in the current evaluation. Prisoners are among the most vulnerable and prevalent survivors of historical child abuse and dysfunctional childhood family backgrounds. For example, a UK Ministry of Justice report (Williams, Papadopoulou & Booth, 2012) found that 24 percent of prisoners in England and Wales had lived with foster parents or in an institution, or had been taken into care at some point when they were a child, and 41 percent had observed violence at home. Moreover, 27 percent of male and 53 percent of female prisoners in the Williams et al (2012) study had experienced emotional, physical or sexual abuse as a child. Indeed, rates of child sexual abuse victimisation amongst male prisoners far exceeds that of the general population. For instance, Fondacaro, Holt and Powell (1999) reported that 40 percent of the male inmates in their study had been victims of child sexual abuse, compared to rates of between 5 and 25 percent of males within the general population. Despite this, offenders are marginalised in society, and in the main, negatively evaluated not only for the offence(s) they have committed, but generally as human beings (Rogers, Hirst & Davies, 2011). Giving prisoners a method by which they can be supported through the negative effects that child abuse has caused, is important as a method of approaching their future rehabilitation. With the support of the Ministry of Justice, NAPAC is currently providing support groups in a number of HM prisons.

The current study forms the first formal assessment of NAPAC's work with prisoners as well as survivors of historic abuse within the community. It was predicted across all measures, that improvements would be shown from baseline, through week 6 and finally at the end of the course. Improvements were predicted across both community members and prison inmates. No gender or age differences were predicted.

Method

Participants and Procedure

In total, 26 clients (7 males and 19 females) attended the NAPAC group therapy sessions, with an age range of 19 - 67 (Mean = 41; SD = 12.76). The clients were victims of sexual, physical,

emotional or neglectful childhood abuse, or a combination of these from the four different locations: London (n = 9), Bury (n = 4), Belfast (n = 8), and prison (n = 5). The allocation to therapy modality, twice weekly, once weekly, or once fortnightly was determined by the client's location. The prison sample attended twice weekly; London and Belfast attended once weekly; and Bury attended fortnightly.

Upon self-referring to NAPAC directly, each client was contacted by a facilitator for a preliminary telephone interview where the following criteria were checked:

- Client was able to attend all sessions at the arranged venue.
- Client was able to attend sessions without being under the influence of drugs or alcohol.
- Client had not made any suicide attempts within the past 6 months.
- Client had some effective coping mechanisms which they were able to utilise for distressing thoughts or feelings.
- Any self-harming actions were safely managed.
- Ideally, that the client already had some support in place.

If the above criteria were met each client was required to complete the CORE Therapy Assessment Form (v.2) during a face-to-face interview**.** Forms were completed individually alongside a facilitator. Assistance was provided if necessary but mostly people were happy to complete them alone.

Throughout the duration of the 12-session group therapy course, clients also had the option of undertaking one-to-one therapy outside of the group. A range of one-to-one therapies were offered, with the majority of clients undertaking both integrative (n = 25) and person-centred (n = 19) interventions. Art, psychoanalytic, cognitive and behavioural therapies were also offered, but none of the clients undertook those types of intervention.

Evaluation took place across the 12-session group therapy course. Measures reported in the current study were recorded at baseline (pre-therapy), after week 6 (midway through the course) and at session 12 (end of the course, post-therapy measures). The CORE Short Form B (SFB) was administered at the end of each session. The mean number of sessions attended by clients included within this study was 11.52 (SD = 1.23). One participant left at session 6 due to work changes. All other participants completed the whole course

Ethical approval for conducting the research was attained from the second author's university, and the study was undertaken using guidelines from the British Psychological Society Code of Human Research Ethics (2010). All client data was anonymised before analysis, such that no names, addresses or other identifying information was given to the research team.

Key Measures

The Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE–OM; Barkham, Evans, Margison, et al, 1998, Barkham, Margison, Leach, et al, 2001; Evans, Connell, Barkham, et al, 2002) has become a widely used self-report measure across service settings that deliver psychological treatments. It was designed to measure levels of psychological distress, with items covering four domains: subjective well-being; specific problems; functioning, and risk of harming self or others. A revision of the original CORE tool - the CORE SFB – that contained 18 items reflecting the four key dimensions was used in the current programme. Clients are instructed to "*Please read each statement and think how often you have felt that way last week*". All items were rated on a scale of 0 (Not at all) to 4 (Most of the time), and example items include item 1 "*I have felt terribly alone and isolated*" and item 16 "*I have been able to do most of the things I needed*". Items 3, 7, 9, 13, and 16 were reverse scored, thus 4 = Not at all and 0 = Most of the time, and the four domain scores were summed and an overall mean calculated (WPFR). The total (and then mean) was also calculated minus the Risk domain scores (WPF-R).

The CORE tool is designed to be sensitive to low- and high-intensity distress, positive attributes, and pathological symptoms, for use both in research-based and practice settings (Barkham et al., 1998). Evans, Mellor-Clark, Margison et al (2000) noted that in the analysis of over 2,000 responses, good reliability was found, with convergent validity against longer, less generic measures. It is widely used as a routine assessment and outcome measure in psychological and psychotherapeutic services in the United Kingdom, and in research across a range of clinical and non-clinical samples (see e.g., Cahill, Barkham, Stiles, et al, 2006). The CORE tool includes measures to screen client pre-therapy as a method of assessing suitability for therapy (as previously described in relation to the current sample), and post-therapy to assess any benefits that therapy has had.

Post-therapy, upon completion of the course, the CORE End of Therapy (v.2) questionnaire was used to record details of the therapy undertaken, including: Types of therapy undertaken (detailed in

Figure 1); duration (start and end date); frequency (twice weekly, once weekly, once fortnightly); and conclusion (planned or unplanned). It was also noted whether or not a follow-up appointment was offered. The clients' perceived severity of problems/concerns (15 items, e.g. depression) and risk (4 items, e.g. suicide) post-therapy were evaluated using the same items included in the pre-screening form. Finally, to determine whether clients felt an improvement in their day-to-day lives, the Benefits of Therapy scale was administered at the end of the final session. This scale consists of 10 items, such as item 1 *"personal insight/understanding*" and item 7 "*subjective well-being*", and clients ticked either improved, not improved, or not addressed. Finally, any "other" benefits and possible changes in medication were recorded.

Data Analysis

Within the design of this study, gender (male/female), age group (under 30, 31-45, over 45 years), and client-base (London, Bury, Belfast, and prison) were analysed as between subject variables, whilst the pre- and post-therapy outcomes were measured within subjects. The therapeutic outcomes included all CORE domains (wellbeing, functioning, problems, and risk); severity of problems/concerns; and overall benefits of therapy.

Results were analysed using SPSS v.20. Results were grouped into four sections. In section A, clinical outcomes across pre-, mid- and post therapy were tested. The four CORE domains, wellbeing (W), functioning (F), problems (P), and risk (R), were examined separately pre-therapy, after session 6 (mid-way), and post-therapy. In addition, overall WFPR and WFP-R (WFPR minus Risk) scores were calculated at each stage for overall reduction in dysfunction. Before the main analysis was completed, gender, age range (under 30, 31-45, above 46), and client base (London, Belfast, Bury, prison) were statistically tested for group differences using one-way between subjects ANOVA, and, as predicted, all comparisons post-therapy were not significant ($p > .05$). On that basis, the clients were treated as one sample. In sections B, C and D, therapy assessment of severity and risk, benefits of therapy across client demographics and additional benefits of taking the programme were assessed respectively. The results of the ANOVAs, t-tests and descriptive statistics undertaken within each section are included next.

Results

A) Clinical Outcomes in Routine Evaluation (CORE) across Pre- Mid- and Post-Therapy

A series of one-way repeated measures ANOVAs found that the overall CORE scores, on WFPR and WFP-R were statistically significantly reduced post-therapy when compared to pre-therapy and Session 6 scores, and (Risk aside) this is reflected in the CORE domains, wellbeing and problems. Risk levels remained static throughout the course of sessions. Similarly, clients' functionality only marginally fluctuated and the post-therapy F scores were not significantly lower than initial ratings. However, whilst a statistically significant change in CORE was observed across the three testing points, with the lowest mean CORE scores found at final testing point, changes were not clinically significant in the respect that the means for all domains (except Risk) still exceeded the clinical cut-off at the end of therapy: All domain values were multiplied by 10 to give a CORE range of 0-40 (as a whole number) and any value above 10 was classed as a dysfunctional score (Jacobson & Truax, 1991; Connell et al, 2007).

A closer inspection revealed that the scores on most domains, including overall CORE scores, increased mid-therapy (as recorded at Session 6) to levels surpassing initial ratings. Due to lack of available data it is not possible to determine the precise session at which the increase initially occurred (e.g. Session 2-6), and this finding warrants further investigation. Descriptive and inferential statistics for the overall sample are shown in Table 1.

INSERT TABLE 1 ABOUT HERE

B) Therapy Assessment: Severity and Risk

Pre- and post-severity ratings (on a scale of 0-4) were recorded for the 15 identified problems/concerns, e.g. depression, addictions, and self-esteem, and a series of paired samples t-tests were conducted to determine whether there was a significant reduction in perceived symptoms for each. The following Problems/Concerns were excluded from the analysis due to small sample sizes ($n < 5$): psychosis, personality problems, cognitive learning, eating disorder, and work/academic. Descriptive and inferential statistics for these comparisons are included in Table 2 below. It was shown that there were statistically significant differences in measures on depression, anxiety/stress, physical problems, addictions, trauma/abuse-related issues, bereavement/loss-related issues, self-esteem, problems in interpersonal relationships and living/welfare. It was concluded that the group of clients reported significant improvements in all areas of concern, most noticeably with respect to clients' self-esteem and the problems associated with the trauma/abuse experienced; clients had previously reported they experienced these two specific problems/concerns *'most or all of the time*' (self-esteem mean = 3.58 & trauma mean = 3.50) and this was reduced (on average) to

only '*sometimes*' over the last week (mean = 2.04 for both).

Risk levels for suicide and self-harm were also significantly reduced post-therapy, though it should be noted that both risk ratings remained below 1 (no risk) before and after therapy. Likelihood of harm to others remained the same at .13, whilst legal/forensic risk was rated as 0 at both pre- and post-testing, thus no comparisons needed. It was concluded that the clients were not deemed at risk (to self and others) at any stage, and this is to be expected given the pre-screening procedures adopted.

INSERT TABLE 2 ABOUT HERE

C) Client Demographics and Therapeutic Benefits

To determine whether the success of the group therapy applied equally across all client groups, the effects of client demographics (gender, age group and client base) on post-therapy CORE and severity ratings for Problems/Concerns were tested using a series of independent samples t-tests (see Table 3 for descriptive and inferential statistics). With respect to client gender and CORE scores (WFPR and WFP-R), no significant effects were found. This finding extended to all CORE domains separately.

For the individual concerns identified, it was also found that males and females did not significantly differ on the following post-therapy measures: anxiety/stress, physical problems, addictions, trauma/abuse related issues, bereavement/loss related issues, self-esteem, problems in interpersonal relationships and living/welfare. However, one significant difference was found and warrants comment. That is, females (Mean = 3.79) had significantly higher severity of depression ratings than males (Mean = 3.00) post-therapy. To determine whether the significant improvements documented for the sample overall applied to the female sub-sample specifically, an additional paired samples t-test was conducted: It was confirmed that female clients reported a significant improvement in the severity of problems identified with depression following therapy compared to males ($t [15] = 3.87$, $p = .002$).

INSERT TABLE 3 ABOUT HERE

D) Additional Benefits

To explore additional benefits of therapy, clients were also asked whether they had observed an improvement or not in 10 areas of psychological functionality e.g. coping strategies and subjective well-being. The percentage of clients reporting improved, not improved and not addressed for each function is illustrated in Figure 2 below. It is evident that this sample of clients felt they had benefited from the course of therapy undertaken. However, due to the absence of baseline measures for these items, the significance of these benefits cannot be confirmed.

INSERT FIGURE 1 ABOUT HERE

Discussion

As predicted, statistically significant improvements across all CORE-OM domains were shown from baseline compared with measures at the end of the course. Specifically, when compared to pre-therapy and Session 6 scores, and (Risk aside), Wellbeing and Problem Solving improved. Risk levels remained static throughout the course. Scores on most domains, including the overall CORE-OM scores, increased mid-way through the course (as recorded at Session 6), which surpassed initial ratings. This is perhaps not unsurprising for practitioners who are aware that mid-course sessions can trigger and exacerbate negative reactions in some clients in the short term, who are dealing with complex and long-standing post-trauma issues, such as shame, guilt, grief and the transfer of responsibility from themselves to the abuser(s) (Lilienfeld, 2007). As in previous research (see e.g. Foa, Zoellner, Feeny, Hembree & Alvarez-Conrad, 2002, Tarrier, Pilgrim, Sommerfeld, et al, 1999) despite the mid-point reduction in CORE-OM scores, clients within this study went on to show the predicted improvements by the end of the course. Indeed, the main aim of the programme was to show improvements by the end of the course, with temporary mid-course reduction deemed part of resolution-reaching. It is thus essential that the possibility of a mid-course increase in negative emotion or functioning is discussed with clients and that steps are in place to offer additional support to any individual that feels particularly affected by the mid-course content. As clients within this study also has the option of receiving one-to-one therapy in addition to their work within the group therapy situation, the authors are confident that a good level of support was offered to individuals who did show an exacerbation of issues around the mid-point of the course.

As predicted, severity of symptomology ratings went down from pre-to post-therapy. Statistically significant improvements in all areas were revealed, most noticeably with respect to clients' self-esteem and the problems associated with the trauma/abuse experienced; clients had previously reported they experienced these two specific problems/concerns 'most or all of the time' and this

was reduced (on average) to only 'sometimes' over the last week. These findings are consistent with large-scale work that has used the CORE-OM to evaluate the positive impact of therapeutic interventions, including person-centred approaches and CBT, on mental health (including but not exclusive to depression, anxiety, and the effects of trauma and abuse) in clients who had received therapy within the UK National Health Service primary care system (see Stiles, Barkham, Twigg, Mellor-Clark & Cooper, 2006; Stiles, Barkham, Mellor-Clark & Connell, 2008). Within the current study, the risk of suicide and self-harm was also significantly reduced from pre-to post-therapy. At no point in the programme were scores on suicidal thinking or risk (to self and others) problematic, although this is not unsurprising for this sample given the pre-screening procedures adopted, and shows the importance of pre-screening assessment and continual monitoring.

It is positive that women and men across all age groups and location (community versus prison) fared equally well post-therapy, with all statistically significantly improving across the measures. This is also consistent with previous large-scale UK-based research (Stiles et al, 2006; 2008). This finding is encouraging because it acknowledges that in this instance the NAPAC group therapy course is equally well-suited to the needs of a diverse range of survivors within the United Kingdom. One unpredicted gender difference however is worthy of note and should be of interest to other researchers and practitioners. That is, although both women and men scored at the lower end for depression, women on average reported significantly higher ratings than men did on post-therapy measures. However, both genders made a considerable decrease in their depression scores from pre- to post-course (pre-therapy scores on depression: male = 3.00; female = 3.24, ns) which indicates the therapeutic benefits of the course on this measures. Subjective improvements and benefits of therapy were also recorded, in areas of psychological functionality, such as coping strategies and subjective well-being. It is clear that clients felt they had benefited from the course of therapy undertaken.

Limitations

The study is not without limitations. Although the CORE-OM tool was used, which gives a detailed picture of improvements across a range of domains, post-therapy improvements were scored immediately after the final session of the course and it is thus not possible to ascertain from these data whether improvements were sustained in the longer term. The authors acknowledge that it is not clear whether benefits are sustained. Follow-up work might be to re-test the participants in the current study several months after therapy completion to evaluate whether improvements have been consistently maintained over time.

Additionally and importantly, although statistically significant improvements were made in all domains, on further inspection changes were not clinically significant, as in that clients entered therapy scoring within the clinical population and with an exit score within the normal range, defined as moving from above to below the recommended CORE-OM clinical cut-off score (see Stiles et al, 2008 for a further discussion). Thus, whilst it is valid to report that improvements were made as a result of undertaking the programme, the reader must be mindful of the magnitude of such changes. The authors acknowledge this issue, but given that clients themselves, who entered the programme with a wide range of complex long-term issues, felt that they had benefitted from this therapeutic intervention, they are confident that the statistically significant differences reported in this evaluation show genuine, positive changes to the mental health and wellbeing of the clients. Indeed, it is positive that clients showed improvements across all domains, with no evidence of individual or group deterioration post-therapy. Whilst it is not unusual for some clients to show deterioration of psychological functioning post-therapy (see Lilienfeld, 2007 for a discussion), this clearly was not the case on this programme.

A further limitation is that of use of the CORE-OM tool itself. Although this tool is widely utilised and provides adequate assessment criteria within clinical and general population samples (Connell et al, 2007), there is scope for further development of evaluative tools for survivor-based samples, to capture the wealth of complex issues that such populations may bring to the therapeutic environment.

Implications

It has long been known that clients are likely to demonstrate benefits of receiving a range of psychotherapeutic techniques (Luborsky, Singer & Luborsky, 1975). Therapies based on cognitive behavioural principles have been evaluated extensively (see e.g. Bisson, Ehlers, Matthews et al, 2007 for a systematic review). However, the success of psychotherapies, such as person-centred therapy (PCT), a therapeutic method that the clients received in the current study are less well studied. That said, research indicates that PCT is as good as CBT in achieving therapeutic improvements in mental health conditions (Stiles et al, 2006; 2008). Moreover, it is currently debated whether non-directive therapies such as PCT are less effective than forms of CBT, specifically trauma-focused CBT (TFCBT), at treating the effects of posttraumatic stress disorder (PTSD). A meta-analysis conducted by Benish, Imel, Wampold et al (2008) indicated that TFCBT and PCT were comparable in their effectiveness at treating PTSD. This has been disputed by Ehlers,

Bisson, Clark et al (2010) in a further review of available studies, who asserted that PCT is less effective than TFCBT.

However, the study of the value and efficacy of PCT as an intervention for mental health and post-trauma conditions has been fraught with methodological problems in design and execution (Olsson, Jakobsson, Swedberg & Ekman, 2013). Some studies have indicated limitations in their designs such as not being able to independently check on how therapies were delivered and/or no precise descriptions of what specific treatments comprised (Stiles et al, 2006; 2008), which may mean that benefits of some person-centred based therapies are understated. One positive aspect of the current study is that it provides a detailed analysis of therapeutic improvements from pre-to-post therapy, across a specifically-defined PCT-based programme that has shown benefit to adult survivors of historical child abuse who are based both in the community and in prisons. For that reason this study can be seen as a step forward in providing evidence still needed in the academic literature.

Overall, research is a valuable tool for demonstrating the effectiveness of particular therapeutic approaches or interventions and the need for service providers to show that their clients show post-therapy improvements has important funding implications. Moreover, independent evaluations increase the confidence of both staff and clients that the therapeutic approach offered works well for specific client groups.

In conclusion, the findings in this report show the effectiveness for clients undertaking a PCT-based course, such that the NAPAC group therapy programme provided, regardless of any measured demographics. This is a positive finding for NAPAC, who may now aim to recruit further clients on to this course. Future research might aim to re-evaluate the course with larger numbers of participants, from more diverse backgrounds, such as ethnic or sexual minorities, using other methodologies, such as a qualitative approach. It would be expected that this programme should continue to be successful across any available demographic, but that remains to be seen. Other service providers may wish to adopt and evaluate this model with their own client groups.

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