

# Effectiveness of Group Psychotherapy for Adult Outpatients Traumatized by Abuse, Neglect, and/or Pregnancy Loss: A Multiple-Site, Pre-Post-Follow-Up, Naturalistic Study

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## ABSTRACT

*The New Experience for Survivors of Trauma (NEST) is a group psychotherapy intervention for clients traumatized by consequences of abuse, neglect, and pregnancy loss. This multiple site study is the first investigation of its effectiveness. Ninety outpatients from a naturalistic setting completed the Symptom Checklist and the Sense of Coherence questionnaire at baseline, end of treatment, and one-year follow-up. Effectiveness was tested with statistical significance, effect size, and clinical significance. Clients from the total sample as well as from the abortion subsample showed improvement at the end of treatment and at follow-up. Lack of a control group is balanced to some extent by the high ecological validity. The findings suggest that the NEST treatment may be beneficial for traumatized clients and call for further research.*

**C**linical observations (Bayatpour, 1992; Ney, Fung, & Wickett, 1993b) indicate that abuse, neglect, and pregnancy loss may all

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be experienced in the life of one individual. Research findings support this co-occurrence: for example, partner mistreatment (Russo, Horn, & Schwartz, 1992), sexual abuse (Allanson & Astbury, 2001), or childhood verbal and physical abuse and neglect (Lang, Rodgers, & Lebeck, 2006) have been found to increase the probability of pregnancy loss, especially miscarriage and abortion. On the other hand, those two types of pregnancy loss have been recognized as predictors of child abuse and neglect by adults (Coleman, Maxey, Rue, & Coyle, 2005a) or partner maltreatment (Lieh-Mak, 1979).

The latter correlation deserves some elaboration since it is sometimes believed that pregnancy loss, especially where termination is apparently freely chosen, is unlikely to result in any negative transgenerational aftermath. However, numerous studies conclude the contrary. For example, unresolved grief associated with any type of pregnancy loss may interfere with any subsequent attachment process (Ney et al., 1993b), reduce parental responsiveness to child needs (Harmon, Plummer, & Frankel, 2000), instill anger (Ney et al., 1993b), increase parental anxiety about child health (Coleman et al., 2005a), or increase risk for child abuse (Lewis, 1979). As for voluntary termination, research suggests that at least some women seek abortion with ambivalence and under the pressure of others (Kero, Hoegberg, Jacobsson, & Lalos, 2001). This could be the cause of the relationship between parental history of abortion and problematic parenting, including lower emotional support and heightened risk for both child abuse and neglect (Benedict, White, & Cornely, 1985; Ney et al., 1993b). There is also a body of literature suggesting that pregnancy loss and abuse can be experienced by the same individual (Coleman et al., 2005b; Gajowy, Simon, & Winkler, 2003; Lang et al., 2006; Ney et al., 1993b).

For purposes of this study, abuse was defined as sexual, physical, and verbal. Neglect was conceptualized as emotional, intellectual, and physical (Ney, Fung, & Wickett, 1993a). It has been explicitly established that both abuse and neglect result in long-lasting distortions of individual functioning (Allen & Lauterbach, 2007) and in deterioration of already preexisting transgenerational pathologies (Ney et al., 1993a). Pregnancy loss is usually defined as miscarriage, induced abortion, neonatal death, stillbirth, ectopic pregnancy, or giving away a child for adoption (Janssen, Cuisiner, Hoogduin, & de Graauw, 1996).

The understanding of trauma delineated in this paper has much in common with the definition of complex trauma proposed by Courtois and Ford (2009). Those authors make a point that such a trauma results from long-lasting or repetitive exposure to severe abuse or neglect, caused by significant others. The ramifications of such pervasive harm or abandonment are usually multifaceted in nature, resulting in dysregulation of, if not outright damage to, the emotional, cognitive, somatic, and interpersonal functioning of the individual.

Obviously, there are substantive differences between separate types of pregnancy loss. Their consequences are not necessarily universal, but range on a continuum depending on such factors as type of pregnancy loss, trimester of termination, age of the female, partner support, social support, history of abuse and neglect, pre-existing psychopathology, ambivalence about the pregnancy, and/or emotional attachment to the pregnancy (Allanson & Astbury, 2001; Coleman, Reardon, Strahan, & Cogle, 2005b; Remennick & Segal, 2001). Still, at least for some women and men, pregnancy loss, particularly miscarriage and abortion, have been recognized as stressful events which may lead to consequences ranging from psychological distress (Janssen et al., 1996) to posttraumatic stress (Engelhard, van den Hout, & Vlaeyen, 2003); from complicated grief (Hunfeld, Wladimiroff, & Passchier, 1997) to clinical depression (Korenromp et al., 2007); from disrupted attachments (Uren & Wastell, 2002) to anxiety disorders (Lok et al., 2004) and obsessive-compulsiveness or somatization pathology (Janssen et al., 1996).

Research on therapy for traumatized individuals has proliferated during recent decades, supporting the effectiveness of different approaches, including (1) cognitive-behavioral models such as cognitive restructuring (Möller & Steel, 2002), a cognitive-behavioral trauma-focused model (Taft, Murphy, King, Musser, & DeDeyn, 2003), and dialectical behavior therapy (Linehan & Dimeff, 2001); (2) interpersonal models such as trauma recovery and empowerment (Fallot & Harris, 2002) and emotion-focused therapy (Fosha, Paivio, Gleiser, & Ford, 2009); (3) psychodynamic models (Lundqvist, Svedin, Hansson, & Broman, 2006); (4) process-oriented therapy (Longstreth, Mason, Schreiber, & Tsao-Wei, 1998); (5) family system therapy (Ford & Saltzman, 2009); (6) contextual therapy (Gold, 2009); (7) sensorimotor psychotherapy (Fisher & Ogden, 2009); and (8) multimodal models (Vaa, Egner, & Sexton, 2002; Zamanian & Adams, 1997).

The majority of therapies focus on homogeneous groups of clients, usually either female victims of child sexual abuse (Lundqvist et al., 2006; Vaa et al., 2002) or male perpetrators of sexual abuse (Taft et al., 2003). Other highly specific programs include groups for survivors of sexual abuse (Möller & Steel, 2002) or boys maltreated by their mothers (Zamanian & Adams, 1997). As for pregnancy loss, a few existing therapeutic approaches are also highly focused, targeting clients troubled by stillbirth or neonatal death (Lewis & Bourne, 2000), miscarriage (Neugebauer et al., 2007), or induced abortion (Bunrell, Dworsky, & Harrington, 1972). It is debatable to what extent those highly focused approaches can address accurately the comprehensiveness of trauma. Obviously, they may produce concrete results. However, specialist programs may reflect reductionism in conceptualization of trauma and subsequently may result in less effective treatment. Although there are a few therapeutic programs (Hughes, 2004; Linehan & Dimeff, 2001; Wright, Woo, Muller, Fernandes, & Kraftcheck, 2003) including patients with multiple traumatic events, they tend to omit potential ramifications of pregnancy loss. The literature suggests that there is still a need for a treatment model acknowledging: (1) co-occurring ramifications of abuse, neglect, and pregnancy loss; as well as (2) the rotating of roles often seen in trauma participants.

Certainly, there are significant differences in psychopathology related to abuse and neglect when compared to pregnancy loss. Nevertheless, as indicated above, those experiences are often interrelated. Therefore, it seems valuable to include attention to the experience of pregnancy loss in a treatment approach that specifically targets survivors of abuse and neglect. We think that the New Experience for Survivors of Trauma (NEST) is currently the only approach designed for individuals suffering from various forms of abuse, neglect, and pregnancy loss. The NEST program is based on clinical experience and has not been validated by research. Therefore, this study aims to investigate its effectiveness for the first time.

### **Treatment**

Detailed descriptions of the theoretical assumptions and clinical tenets underlying the NEST program are provided elsewhere (Konya et al., 2003; Simon & Gajowy, 2002). In short, it is a manualized

time-limited, stage-oriented model of group therapy for adults of both genders who have experienced several types of abuse, neglect, or pregnancy loss. The NEST therapy lasts for about 8–10 months, with 2-hour sessions every week. Three follow-up sessions take place 3, 6, and 12 months after therapy termination. Groups are closed and usually consist of 6–10 clients, one therapist, and one co-therapist. The main therapeutic goal is to overcome intrapersonal conflicts and relational difficulties associated with traumatic experiences. Separate phases of the program involve: (1) providing informed consent, developing a working alliance, and analyzing genograms, (2) linking repressed traumatic events with present difficulties, expressing and handling disturbing feelings, and recognizing one's partial contribution to a given trauma, (3) identifying defense mechanisms, analyzing triggers, and providing assertiveness training, (4) addressing survivor guilt, distinguishing guilt from responsibility and blaming, (5) gradual recognizing of the central self, (6) experiencing mourning for what happened or has never emerged, (7) handling the consequences of pregnancy loss, (8) processing an active forgiveness and reconciliation, (9) redefining one's relationship to the world, working on relational rehabilitation, and attenuating disadvantageous past pair bonding, and (10) achieving mindful orientation to present living and future planning, celebrating, and saying good-bye.

The NEST program is not strictly a linear process; rather, phases alternate according to individual timing as well as group process. Clients often return to a previous session's theme, and sometimes they decide not to engage in an available topic. The seventh phase, for example, is usually attended only by a portion of those clients who have experienced some kind of pregnancy loss, whether their own or in their family of origin. Such an approach can be achieved only if the therapist is well attuned to the needs of the group members and treats the protocol more as an insightful guideline conveying potentially helpful suggestions than a rigid list of orders.

The NEST model combines concepts from psychodynamic attachment theory, the Eriksonian developmental model, cognitive-behavioral restructuring, transactional analysis, existential reflection, client-centered alliance, and systemic analysis. Such an integrative approach is regarded as typical for treatment of

complex trauma disorders (Longstreth et al., 1998; Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001), since it enables therapists to tailor techniques to the needs of the particular individual, and consequently allows the comprehensiveness of the trauma experience to be accurately addressed (Lazarus & Beutler, 1993).

The unique understanding of psychopathology of traumatized clients in the NEST model is based on the following assumptions: (1) the roles of victims, perpetrators, and observers can rotate; (2) long-lasting effects of childhood abuse and neglect frequently contribute to subsequent pregnancy loss, and vice versa (Benedict et al., 1985; Ney et al., 1993b); and (3) abuse and neglect are complex phenomena, and usually more than one maltreatment type appears during the life of a single individual (Ney et al., 1993a).

The first concept, since it is relatively unknown, requires some elaboration. The theory of rotating roles (Gajowy et al., 2003), known also as the theory of triangles of trauma (Ney et al., 1993b), speaks to the complex contextual aspects of transgenerational trauma. This theory is based on the assumption that roles of all participants of trauma (perpetrators, victims, and observers) can change with time and circumstances. Obviously, in the moment of abuse, those roles are usually clearly defined: the perpetrator hurts another person, the victim is a person who is damaged, and the observer is an individual who witnesses the event. However, life is too complex to assume that a person could remain in the role of a victim or a perpetrator throughout his/her entire life (Madanes, 1991). For example, individuals who were victims of childhood abuse often become perpetrators in their adulthood (Bentovim 2002; Glasser et al., 2001).

With regard to the idea of rotating roles in trauma, the dynamic and contextual aftermath of guilt, fear, hate, resentment, and/or sense of loss is often experienced by each participant in the traumatic event. Each person involved is thought to contribute, in varying extent, to the origin of a given traumatic event. Contribution is not to be confused with responsibility or guilt, though. Indeed, viewing trauma through the theory of rotating roles is not about excusing, justifying, or condemning anyone. It rather allows a person to see the humanity in each individual, including

perpetrator and victim. Therefore, it may facilitate the process of forgiveness and potentially reconciliation.

The NEST therapists also apply some unique techniques designed or modified for clients who experience complex trauma of abuse, neglect, and pregnancy loss, such as (1) closure of pathologically delayed or protracted mourning with visual imagery facilitating mourning the family and childhood one could have had, mourning the person one could have become (Simon, 2009), and mourning the children lost due to pregnancy loss; (2) symbolic funerals, in the case of pregnancy loss, helping to humanize, as well as attach to and say farewell to the children; (3) a reconciliation process facilitated by writing letters to oneself, observers, victims, and perpetrators; (4) the group analysis of genograms, focused on searching for intergenerational patterns; (5) an analysis of rotating roles of victims, observers, and perpetrators in order to gain insight and accept an appropriate portion of the contribution to the tragedies; (6) assertiveness training with acknowledgment of personal strengths and limitations; (7) attenuation of disadvantageous pair bonding (Simon, Gajowy, & Śliwka, 2006); and (8) negotiating realistic expectations and making rational decisions.

### **Hypothesis**

We hypothesized that the NEST group psychotherapy applied in an outpatient setting for clients with experience of abuse, and/or neglect, and/or pregnancy loss is an effective treatment both at post-treatment and one-year follow-up. Psychotherapy effectiveness was conceptualized as the change of symptoms (measured by the Symptoms Check List) and the change of coherence (measured by the Sense of Coherence scale).

## **METHOD**

### **Participants**

The only inclusion criterion was a history of any type of abuse, neglect, or pregnancy loss. Exclusion criteria included serious suicidal ideation, psychosis, major depression, active substance abuse,

dissociative symptoms, self-mutilating behaviors, and eating disorders. The convenience sample consisted of 141 walk-ins to private outpatient clinics across Poland who were subsequently referred to the NEST therapy. At the intake interview, all ascribed a traumatic meaning to the events of abuse, neglect, or pregnancy loss. All respondents also met the criteria for complex trauma and complex posttraumatic sequelae as defined above. All respondents signed informed consent. Eighteen of them dropped out and returned only the initial sets of tools; 10 completed the treatment but returned measures only at baseline; 11 completers provided post-treatment assessments but failed to submit follow-up measures; 4 returned all sets, however with an unacceptably high ratio of uncompleted items; another 2 completers did not return any set of measures; and 6 clients did not appear at one-year follow-up. Therefore, 90 respondents (63.83% final response rate) completed the treatment, attended one-year follow-up, and filled out the questionnaires at each stage of the procedure. Those who completed the program ( $n = 90$ ) and those who did not ( $n = 51$ ) did not differ significantly on demographic variables, initial scores on all the measures, or frequency of reported trauma, with the exception of greater sexual abuse ( $p = 0.018$ ) among the drop-outs. From a clinical perspective, no difference has been detected between the completers and non-completers in terms of sexual abuse history (specific type, duration, intensity). The completers came from 19 different closed therapy groups across nine clinics.

All participants ( $n = 90$ ) were Caucasian, with 69 females (76.67%) and 21 males (23.33%). Ages ranged from 19–24 years (20%), 25–34 years (58.89%), 35–44 years (12.22%), 45–54 (7.78%), and above 55 (1.11%) with a mean age of 29.6 years ( $SD = 7.11$ ). Fifty-two clients were single, 28 married, 8 divorced, 1 widowed, and 1 living in common law. Fifty-seven clients finished college, 32 high school, and 1 vocational program.

All respondents had experience with more than one type of trauma, and all had experienced neglect. The majority of clients (93.33%) reported some form of abuse: sexual, verbal, and/or physical. The six clients (6.67%) without any exposure to abuse experienced pregnancy loss and emotional neglect. Abortion occurred for 20% and miscarriage for 7.78% of clients. Most of the clients had never been pregnant or gotten a partner pregnant (72.22%). Diagnoses, as well as trauma and loss experiences, were assessed

during the intake interviews by a clinician who relied on DSM-IV and/or ICD-10 diagnostic criteria and consisted of: moderate depressive disorder 33.33%, social phobia 20%, dependent personality disorder 15.56%, avoidant personality disorder 12.22%, borderline personality disorder 10%, obsessive-compulsive disorder 6.67%, and panic disorder 2.22%. Three clients were on antidepressants during the therapy and five during follow-up. No client was concurrently treated with individual therapy while attending the NEST sessions, although four had additional therapy during follow-up. Twenty-five percent of respondents had some experience of therapy and 12% were on medications prior to the NEST program.

Although, the study focused on the co-occurrence of trauma, results were also presented separately for clients with the history of abortion. Such an approach seemed relevant since: (1) although abuse and abortion often interrelate, the potential post-abortion consequences are distinctively different from those of abuse; and (2) effectiveness of post-abortion therapy is greatly under-reported in the literature.

### **Therapists**

Nine psychotherapists (seven females and two males; six psychologists, two counselors, and one psychiatrist; four with a Ph.D.) from nine treatment sites were involved in data collection. Their experience with the NEST program ranged from 1 to 8 years. Their mean age at baseline was 42.44 (SD = 6.97). All of them received supervision during the study. The supervisor was an observer of every fifth session. The feedback to the therapist included an adherence check to the NEST model based on protocols provided in the treatment manual (Konya et al., 2003).

### **Procedure**

Data were collected at three data points: T1, pretreatment; T2, post-treatment (before the last group session); and T3, one-year follow-up.

### **Assessment Instruments**

*The Symptom Checklist.* The Symptom Checklist (SCL-90-R; Derogatis, 1992) is a widely used, valid, and reliable psychotherapy

outcome measure assessing the following groups of symptoms: aggression-hostility, retarded depression, agitated depression, phobic anxiety, interpersonal hypersensitivity, obsessions-compulsions, and somatization. Two psychotic subscales were excluded from the Polish adaptation due to limited validity for neurotic clients (Mroziak, Czabała, & Wójtowicz, 1997). Global severity index (GSI) is computed as a measure of general distress. All subscales of SCL-90-R relate to specific symptoms observed among traumatized clients: for example, aggression-hostility (Brom, Kleber, & Defares, 1989), depression (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005), somatization (Ford & Kidd, 1998), and interpersonal hypersensitivity (Van der Kolk et al., 2005). Moreover, SCL-90-R is regarded as an adequate measure of psychotherapy effectiveness in the case of abuse, neglect (Lundqvist et al., 2006), and pregnancy loss (Janssen et al., 1996; Korenromp et al., 2007). The psychometric properties of the Polish version include internal consistency 0.7–0.95; test-retest reliability correlations 0.73–0.87 at  $p < 0.0001$  (Mroziak et al., 1997). Also, gender-sensitive standard errors, means, and standard deviations for both normative patients and non-patient's group are provided by the Polish adaptation.

*The Sense of Coherence.* The Sense of Coherence (SOC-29; Antonovsky, 1987) scale assesses the perception of the world as comprehensible (predictable and explicable), manageable (with personal resources), and meaningful (therefore worthy of engagement). The sense of coherence correlates highly negatively to symptoms of anxiety, depression, and posttraumatic stress (Mroziak et al., 1997) and to symptoms of pregnancy loss (Engelhard et al., 2003; Uren & Wastell, 2002), and as such is found to be a protective personality feature for traumatized individuals (Lundqvist et al., 2006). The Polish adaptation (Mroziak et al., 1997) has 0.83 temporal stability and an internal consistency  $\alpha$  of 0.87 at  $p < 0.0001$ . Normative means for patients and non-patients, as well as the standard error of the Polish version, are also available.

### Data Analysis

This multiple site study used a pre-post follow-up, naturalistic, and incomplete repeated measure design. The high ecological validity compensates to a certain extent the lack of randomization. The

total sample—both gender subgroups as well as some SCL-90-R (GSI, aggression-hostility, obsessions-compulsions) and all SOC-29 subscales—fulfilled the criteria of normal distribution. In such a case the paired t-Student test (1-tailed) was applied. Other SCL-90-R subscales did not fulfill the criteria of normality. Therefore, a non-parametric Wilcoxon signed ranks test was used ( $p$ -value for both cases can be found in Table 1). The Cochran, Hartley, Bartlett, Levene tests (2-tailed) were employed in order to verify the homogeneity of variance. The sphericity was verified with the Mauchly test. Whenever the sphericity was not confirmed (SOC total score with  $p = 0.03$  and comprehensibility with  $p = 0.02$ ), MANOVA with Greenhouse-Geisser correction was used. The repeated ANOVA measures were applied for demographic variables to determine the appropriate subgroups.

The standardized mean difference statistic,  $d$  effect size (Cohen, 1988) was applied. Effect sizes were weighted by sample sizes. Cohen's classification of  $d$  (large  $> 0.79$ , medium  $0.50$ – $0.79$ , or small  $< 0.50$ ) was used.

The ratio of recovered, improved, deteriorated, and unchanged patients was derived from clinical significance based on Jacobson and Truax (1991) criteria, modified by Lambert, Hansen and Bauer (2008). According to those guidelines, change is recognized as clinically significant under two conditions: (1) it must be statistically reliable according to a reliable change index; and (2) the score must change from the dysfunctional to the functional range, passing the specific cut-off point for each measure. In other words, an individual client could be categorized as: recovered (with both criteria fulfilled), improved (when reliable change occurred in the positive direction), unchanged (when reliable change did not take place), or deteriorated (when reliable change was noted in the negative direction).

## RESULTS

### Total Sample

All symptoms decreased and coherence features increased from baseline to the end of treatment, at statistically significant levels (see Table 1). A similar, yet less significant trend was noted from

Table 1. Change from Start of Treatment to Termination and Termination to Follow-Up in the Total Sample ( $n = 90$ ), Abortion Subsample ( $n = 18$ ), and Non-Abortion Subsample ( $n = 72$ )

	Total sample						Clients with abortion			Clients without abortion			
	Mean	SD	t (1-2)	t (2-3)	Mean		SD	t (1-2)	t (2-3)	Mean	SD	t (1-2)	t (2-3)
	P						P			P			
<b>SCL-90-R</b>													
<b>GSI</b> (global severity index)	T1	20.97	5.16	5.21	3.02	21.13	3.92	1.99	1.57	20.94	5.37	4.26	3.13
	T2	18.15	5.80	0.000	0.003	18.44	5.35	0.046	0.116	18.34	5.52	0.000	0.002
	T3	16.66	4.86			15.5	2.91			16.85	5.11		
<b>aggression-hostility</b>	T1	21.86	6.13	3.43	2.60	23.21	3.68	2.17	1.57	21.63	6.45	2.65	2.58
	T2	19.30	6.40	0.001	0.011	19.29	5.57	0.03	0.117	19.55	6.18	0.008	0.010
	T3	17.70	6.64			16.67	3.63			17.88	5.91		
<b>agitated depression</b>	T1	22.17	6.44	3.61	2.38	23.76	6.21	1.99	1.07	21.90	6.47	2.53	2.52
	T2	19.37	7.18	0.000	0.019	19.49	7.96	0.046	0.286	19.61	6.73	0.011	0.112
	T3	17.69	6.09			16.84	4.15			17.84	6.37		
<b>retarded depression</b>	T1	22.74	7.07	4.52	2.09	23.25	6.13	1.71	1.71	22.65	7.25	3.81	2.06
	T2	19.49	7.57	0.000	0.039	19.35	6.26	0.087	0.087	19.77	7.48	0.000	0.010
	T3	18.05	7.07			16.15	5.61			18.37	7.27		
<b>obsessions-compulsions</b>	T1	21.97	6.56	4.98	3.23	21.73	5.85	1.50	1.57	22.01	6.71	4.21	3.24
	T2	18.79	6.60	0.000	0.002	19.13	7.02	0.133	0.117	18.98	6.20	0.000	0.010
	T3	17.04	5.73			15.29	3.89			17.34	5.96		
<b>phobic anxiety</b>	T1	17.09	5.72	2.91	3.05	16.84	4.86	0.90	1.51	17.13	5.88	2.78	3.48
	T2	15.41	5.35	0.005	0.003	15.64	4.31	0.367	0.131	15.57	5.24	0.005	0.068
	T3	13.75	4.74			13.59	4.67			13.78	4.78		

<b>interpersonal hypersensitivity</b>	T1	22.08	6.30	5.13	1.82	19.89	3.62	1.37	0.56	22.45	6.59	4.45	1.91
	T2	18.14	7.44	0.000	0.072	18.02	7.53	0.170	0.575	18.40	7.17	0.000	0.056
	T3	16.95	5.99			15.93	3.49			17.12	6.32		
<b>somatization</b>	T1	18.86	5.71	3.99	2.25	19.23	6.37	0.73	1.99	18.79	5.63	3.88	2.25
	T2	16.56	5.20	0.000	0.027	18.13	5.48	0.463	0.046	16.52	4.78	0.000	0.025
	T3	15.40	4.44			14.01	3.18			15.64	4.60		
<b>SOC-29</b>													
<b>SOC total</b>	T1	109.33	22.36	-5.64	-2.23	106.4	16.81	2.94	1.26	109.8	23.22	4.59	2.27
	T2	121.36	21.87	0.000	0.028	120.8	13.57	0.003	0.208	121.4	23.05	0.000	0.123
	T3	125.41	22.75			122.5	17.06			125.9	23.64		
<b>comprehensibility</b>	T1	36.12	8.39	-5.94	-1.93	35.08	7.5	2.62	0.59	36.30	8.56	4.58	1.86
	T2	41.27	8.50	0.000	0.057	40.38	5.98	0.009	0.552	41.42	8.88	0.000	0.063
	T3	42.76	9.30			40.77	7.99			43.09	9.51		
<b>manageability</b>	T1	38.29	10.07	-3.54	-2.38	37.00	7.71	2.67	0.53	38.51	10.44	3.22	2.47
	T2	41.44	8.56	0.001	0.019	41.77	5.67	0.008	0.594	41.39	8.98	0.001	0.013
	T3	43.24	9.17			42.15	6.79			43.43	9.54		
<b>meaningfulness</b>	T1	34.92	7.52	-4.92	-1.11	34.31	6.80	2.39	0.93	35.03	7.67	3.73	1.07
	T2	38.64	7.78	0.000	0.268	38.69	5.59	0.017	0.351	38.64	8.12	0.000	0.285
	T3	39.41	7.29			39.62	5.56			39.38	7.57		
<b>N</b>		90				18					72		
<b>df</b>		89				17					71		

Note: SD: standard deviation, t: t-Student test, df: degrees of freedom, p: p-value of two-tailed significance, T1: start of the therapy, T2: end of the therapy, T3: follow-up, SCL-90-R: Symptoms Checklist Revised, SOC-29: Sense of Coherence questionnaire.

the end of therapy to follow-up. Importantly, mean values at baseline were above cutoff levels for clinically meaningful distress on all SCL-90 and SOC-29 subscales, as well as their global scores. The weighted effect sizes were medium or small from the start to the end of treatment and small from the end to follow-up. The average  $d$  was 0.53 for duration of therapy and 0.23 from the end to follow-up, which indicates, with regard to the percent of clients who are better off, the success rate of the treated persons at 0.7 and 0.59, respectively. Most of the clients (see Table 2) left treatment recovered or improved, with the best results for interpersonal sensitivity (94.44%) and obsessions-compulsions (88.88%). A similar trend was observed from the end of therapy to follow-up, with the best results for obsessiveness-compulsiveness (83.33%) and aggression-hostility (75.55%). The unchanged clients' ratio reached 56.66% on the manageability subscale for duration of therapy and 47.77% (43/90) for meaningfulness from the end to follow-up. The ratio of deteriorated clients varied from 18.89% to 2.22% for duration of therapy and from 21.11% to 8.89% from the end of treatment to follow-up.

As for the SOC-29, comprehensibility produced the best clinically significant results from baseline to the end of treatment, with 62.22% of clients recovered or improved, while the lowest ratio was obtained for manageability 28.89%. From the end of therapy to follow-up, comprehensibility yield 46.67% and meaningfulness noted 35.56% (32/90) of recovered or improved clients.

#### Abortion Subsample

For the small abortion subsample ( $n = 18$ ), all coherence variables and some symptoms changed significantly, from baseline to the end of therapy (see Table 1), although not between termination and follow-up. The weighted effect sizes for duration of therapy and from the end of treatment to follow-up ranged from medium to large. The average  $d$  at the end was 0.7, which indicates with regard to the percent of clients who were better off the success rate of the treated persons at 0.76. The follow-up average  $d$  was 0.37, and the success ratio was 0.65. Most of these clients recovered or improved on all scales from baseline to the end of therapy, reaching 77.77% on both the GSI and SOC-29 (see Table 3). From

Table 2. Clinical Significance between the Start of Treatment and Termination and between Termination and Follow-Up in the Total Sample

Scale	Subscale	Recovered % (N)			Improved % (N)			Unchanged % (N)			Deteriorated % (N)		
		T1-T2	T2-T3	T1-T3	T1-T2	T2-T3	T1-T3	T1-T2	T2-T3	T1-T3	T1-T2	T2-T3	T1-T3
<b>SCL-90-R</b>	<b>GSI</b>	24.44 (22)	22.22 (20)	62.22 (56)	57.78 (52)	4.45 (4)	8.89 (8)	11.11 (10)					
	aggression-hostility	52.22 (47)	27.78 (25)	31.11 (28)	47.77 (43)	10 (9)	14.45 (13)	6.67 (6)	10 (9)				
	agitated depression	18.89 (17)	14.45 (13)	46.67 (42)	42.22 (38)	22.22 (20)	24.44 (22)	18.89 (17)					
	retarded depression	37.78 (34)	31.11 (28)	50 (45)	42.22 (38)	2.22 (2)	10 (9)	16.67 (15)					
	obsessions-compulsions	33.33 (30)	32.22 (29)	55.55 (50)	51.11 (46)	3.34 (3)	4.45 (4)	12.22 (11)					
	phobic anxiety	11.11 (10)	8.89 (8)	44.45 (40)	56.66 (51)	25.55 (23)	18.89 (17)	15.56 (14)					
	interpersonal hypersensitivity	24.44 (22)	20 (18)	70 (63)	48.89 (44)	3.34 (3)	22.22 (20)	8.89 (8)					
	somatization	30 (27)	23.33 (21)	38.88 (35)	36.67 (33)	14.45 (13)	18.89 (17)	21.11 (19)					
<b>SOC-29</b>	<b>SOC total</b>	38.88 (35)	25.55 (23)	26.67 (24)	20 (18)	27.78 (25)	37.78 (34)	16.67 (15)					
	comprehensibility	40 (36)	27.78 (25)	22.22 (20)	18.89 (17)	33.33 (30)	38.88 (35)	14.45 (13)					
	manageability	17.78 (16)	12.22 (11)	11.11 (10)	24.44 (22)	56.66 (51)	44.45 (40)	18.89 (17)					
	meaningfulness	25.55 (23)	18.89 (17)	27.78 (25)	16.67 (15)	28.89 (26)	47.77 (43)	16.67 (15)					

Note. T1-T2: time between start and the end of therapy, T2-T3: time between the end and follow-up, SCL-90-R: Symptom Checklist Revised, GSI: global severity index, SOC-29: Sense of Coherence questionnaire.

**Table 3. Clinical Significance between the Start of Treatment and Termination and between Termination and Follow-Up in the Abortion Subsample ( $n = 18$ ) and No Abortion Subsample ( $n = 72$ )**

Scale	Subscale	Trauma	Recovered		Improved		Unchanged		Deteriorated	
			%		%		%		%	
			(N)	(N)	(N)	(N)	(N)	(N)		
			<b>T1-T2</b>	<b>T2-T3</b>	<b>T1-T2</b>	<b>T2-T3</b>	<b>T1-T2</b>	<b>T2-T3</b>	<b>T1-T2</b>	<b>T2-T3</b>
<b>SCL-90-R</b>	<b>GSI</b>	<b>ABO</b>	33.33 (6)	27.77 (5)	44.44 (8)	55.56 (10)	16.67 (3)	11.11 (2)	5.56 (1)	5.56 (1)
		<b>NoABO</b>	30.55 (22)	22.22 (16)	37.50 (27)	44.44 (32)	26.39 (19)	23.62 (17)	5.56 (4)	9.72 (7)
<b>SOC-29</b>	<b>SOC total</b>	<b>ABO</b>	50.00 (9)	22.22 (4)	27.77 (5)	22.22 (4)	16.67 (3)	38.89 (7)	5.56 (1)	16.67 (3)
		<b>NoABO</b>	37.50 (27)	22.22 (16)	38.89 (28)	20.83 (15)	13.89 (10)	38.89 (28)	9.72 (7)	18.06 (13)

*Note.* T1-T2: time between start and the end of therapy, T2-T3: time between the end and follow-up, SCL-90-R: Symptoms Checklist Revised, GSI: global severity index, SOC-29: Sense of Coherence questionnaire, ABO: abortion subsample, NoABO: no abortion subsample.

termination to follow-up, this trend continued on the GSI. The ratio of deteriorated clients reached 5.56% from the start of treatment to the end, and 16.67% from termination to follow-up. The non-abortion subsample obtained overall less favorable clinically significant results.

## DISCUSSION

### Total Sample

The results suggest that NEST group psychotherapy is—within the limitations of this study—an effective treatment for outpatients with history of trauma, both at the end of therapy and at follow-up. These results are of importance, especially given that mean values for all SCL-90 and SOC-29 subscales and their global scores were above cut-off levels before the treatment. Still, while statistical significance and Cohen's  $d$  portrayed generally favorable results, clinical significance indicates less positive outcomes, which is a common phenomenon (Möller & Steel, 2002). The statistically significant changes are reflected in predominantly small or medium effect sizes measured from baseline to the end of treatment and small effect sizes from termination to follow-up. Small effect

sizes are typically noted at follow-ups in outcome studies of traumatized clients (Lundqvist et al., 2006). This phenomenon may occur due to the nature of complicated grief, which frequently hinders post-traumatic functioning, and may require more time than provided in time-limited therapy (Piper et al., 2001). Still, since at follow-up one usually hopes to find maintenance of treatment gains and not necessarily further treatment improvements, even minuscule effect sizes are worth appreciation. Also representative of findings in similar studies (Piper et al., 2001) are the percentages of recovered, improved, unchanged, or deteriorated clients. It is noteworthy that the ratio of deteriorated clients obtained in this study stays within the range of deterioration noted across therapy outcome studies (Lambert & Ogles, 2004). Therapy gains are generally maintained at one-year follow-up, which is frequently seen across outcome studies of therapy for abused clients (Vaa et al., 2002). *Overall*, since the total sample of respondents having a history of multiple co-occurring types of trauma still achieved significant change, the results of this study are promising. Further, the uniqueness of these findings is underscored by the fact that issues of multiple traumatic events (neglect, abuse, and pregnancy loss) and rotating roles of trauma participants are often omitted in the trauma literature.

*Symptoms and coherence in total sample.* Aggression-hostility is the only subscale on which a majority of clients recovered during the therapy. It is of special importance since traumatized clients are likely to be conditioned to respond aggressively as a way of coping with their internal and external problems (Bandura, 1977). Since aggressive behaviors are often triggered in the group, due to transference vis-a-vis the therapist and fellow clients, the group setting could be a particularly suitable environment for corrective re-enactment of hostile experiences. This seems to be particularly true for those clients who suppressed their hostility toward perpetrators, fearing vengeance or condemnation as much as alternating between rage and affective emptiness.

The decrease of interpersonal hypersensitivity appears to be particularly relevant for clients who experienced abuse or neglect in their early development (Blanck & Blanck, 1986), and, as a result, struggle with intense feelings of inadequacy. Our clinical impressions suggest that group cohesion, group and individual

working alliances, alliance to leader, and group climate (Burlingame, MacKenzie, & Strauss, 2004) all contributed as group processes to this change.

The decrease of obsessions-compulsions is another relevant outcome of the NEST therapy, since the impulsive and irresistible nature of thoughts and behaviors arising from abuse (Gershuny et al., 2008) or pregnancy loss (Janssen et al., 1996) is particularly chronic and hard to treat. The results obtained in this project are more favorable than in other studies (Gershuny et al., 2008), which could be due to the fact that the NEST therapy does not focus on reduction of specific symptoms, but rather treats them as manifestations of overall quality of individual functioning.

Somatization is also recognized as particularly difficult to treat (Ford & Kidd, 1998). Usually, this group of symptoms correlates exceptionally highly with the experience of neglect (Heckman & Westefeld, 2006), which is a strong predictor of both abuse and pregnancy loss (Ney et al., 1993b). This may explain why clients with the history of trauma experienced a relatively small decrease of somatization during the therapy. Since such clients tend to be heavily troubled with somatic symptoms (Janssen et al., 1996), they may need more time than provided in time-limited therapy to improve.

The increase of coherence noted in this study is of paramount importance since it reflects the client's tendency to lean toward health and away from sickness (Antonovsky, 1987). Such an increase is also conceptualized as a sign of personality integration (Mroziak et al., 1997) and often translates into the improvement of social coping skills, resulting in perceiving life difficulties as developmental challenges rather than threatening situations. This is of relevance, since trauma usually seriously compromises the ability to perceive the world as coherent as much as it gravely limits flexibility in coping (Lundqvist et al., 2006). Comprehensibility in this study almost reached the level of normal range (Mroziak et al., 1997).

*Abortion subsample.* The respondents from the abortion subsample obtained on average more favorable results than clients from the non-abortion subsample, especially in terms of effect sizes and clinical significance. Still, in contrast to the non-abortion subsample, the abortion group showed no statistically significant changes from the end of therapy to follow-up. The increase in coherence is

especially relevant for clients with the history of abortion since coherence has been recognized as an important protective personality feature for traumatized females (Lundqvist et al., 2006). The results noted for the abortion subsample are pertinent since clinical and scientific discussions related to consequences of induced abortion are often clouded with ideological arguments. The existing literature on post-abortion therapy (Bunrell et al., 1972) is very limited and provides only narrative descriptions and does not allow for precise comparison of our results. Therefore, the results from the abortion subsample seem to be of relevance, especially in the face of the predominantly ideological dispute about this phenomenon. However, since this study did not account for either factors contributing to abortion decision or for trimester of abortion, generalizations of these results can only be tentative.

#### **Strengths and Limitations**

The strengths of this study include: (1) a unique group psychotherapy for clients with differing types of trauma, (2) rare naturalistic subsamples of clients with histories of abortion, (3) a one-year follow-up, (4) a diverse set of established outcome criteria suggesting improvement, (5) manual-based therapy, (6) adherence checks to treatment protocols through supervision, (7) assessment of equivalence of the different subgroups at the outset, and (8) a relatively large number of participants. These strengths help to uncover relationships between the variables as well as to allow for a few tentative conclusions about treatment effectiveness.

However, it should be underlined that this project is based on natural groups and an incomplete repeated measure design suffers from lack of a control group. Such, non-randomized allocation neither eliminates the Hawthorne effect, nor counterbalances the practice effect. Furthermore, it is impossible to rule out the possibility that other factors may have influenced the positive outcome. It is therefore difficult to draw more far-reaching conclusions of causal nature. Still, it is important to note that the nonrandom sample of walk-in participants may reflect the realities of clinical practice (Buckley, Newman, Kellett, & Beail, 2006), especially for clients with abortion history who are usually reluctant to be part of a control condition or randomized trial (Coleman et al., 2005b).

The lack of standardized assessment to ensure pre- and post-treatment diagnostic validity is also a concern. Instead, diagnoses were based on consultant psychiatrist opinions. Still, designing treatments for individuals with a common target problem such as trauma sequelae, rather than adherence to common DSM diagnosis, is consistent with effectiveness research principles (Seligman, 1995).

### **Future Studies**

Although findings obtained in this study are promising, numerous limitations call for randomized control trials. At this stage, it is impossible to attribute the observed change purely to the NEST treatment since there are other factors, like passage of time and perhaps some other aspects of group treatment not specific to the NEST itself, that may caused the changes.

Studies with more rigorous methodology could attempt to assess whether in the case of clients with the experience of abortion any of the following clinical aspects of the NEST indeed results in clinically significant changes: (1) linking abortion circumstances and consequences with long-term effects of childhood mistreatment, (2) completing the pathologically procrastinated mourning, or (3) initiating the process of reconciliation. As for the total sample, it is important to explore which techniques contribute to the decrease of symptoms and increase of coherence: for example, (1) analyzing the family and individual patterns with the assumption of the rotating roles of victims, perpetrators, and observers, (2) recognizing one's partial contribution to a given trauma, or (3) addressing survivor guilt.

Future studies may also employ a wider range of measures, for example addressing more specifically trauma-related symptoms, interpersonal functioning (e.g., trust, dependency, boundaries, etc.), body image, and/or sexuality. Additionally, future studies could focus on three interrelated structural levels of the group process: intrapersonal, intragroup, and interpersonal. This could help uncover the role of such features as: (1) the dynamics between the clients; (2) interactions between clients and the therapist; (3) demographic characteristics of the clients; (4) personality characteristics and demographic features of a group leader; and

(5) therapeutic skills, including openness and empathy, of the therapist.

Respondents of different races need to be attended in future studies since the current findings may not be generalizable across ethnicities. Longer than a one-year follow-up would also be of benefit. Moreover, future studies, in order to limit the researcher allegiance, need to be conducted by scholars not associated with the NEST program. In other words, the NEST psychotherapy still awaits its complete trial in order to test to what extent this approach may be beneficial for people with different types of traumatic experiences.

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