Somerset & Avon
rape & sexual abuse support

Survivors of Sexual Violence
Group Research Project
Report

Contents

1. Introduction

1.1 Overview

Somerset and Avon Rape and Sexual Abuse Support have employed an independent consultant to research and produce a clear report with recommendations on effective group work models SARSAS could deliver for survivors of rape and childhood sexual abuse.

1.2 Scope and Purpose

The main objectives of this report are:

i. to provide an extensive literature review and evidence base of effective group work models suitable for survivors of rape, sexual assault and childhood sexual abuse
ii. to investigate and provide a valid experience of current group work service provision from a broad and thorough cross section of consultation with other specialist organisations local and nationally who currently deliver group work with survivors of sexual violence
iii. to investigate and provide a valid experience of current service users' experience of group work
iv. to review the current group work provided by SARSAS in light of this research
v. to make recommendations and brief the SARSAS Board of Trustees about how best to deliver group work for survivors of rape and childhood sexual abuse.

2. Methodology

The report is defined as a qualitative research method and is best divided into three clear areas;

1. An extensive literature review of group work models and their effectiveness
2. Qualitative design of semi-structured interviews either face-to-face, telephone or via email from a broad cross section of local and national specialist and non-specialist organisations that offer group work
3. Qualitative design of structured interviews and pre-fabricated questionnaires of SARSAS' current service user experience of group work

Fifteen service providers and two relevant experienced consultants undertook semi-structured interviews and thirteen service users undertook structured interviews through a pre-fabricated questionnaire. These were completed either by the consultant, SARSAS' Engagement and Support Worker, or a number of volunteer support workers for SARSAS. Service providers and service users were included to allow for multiple perspectives to be considered. These multiple sources of data collection allowed for a greater understanding and increased validity of the report.

2.1 Inclusion Criteria

This report is aimed at managing women who are survivors of rape, sexual assault and/or abuse who are now aged 18 and above based in the geographical counties of Avon and Somerset. Therefore, the service users who participated in this research are all aged 18 or over and based in the counties of Avon and Somerset.

The service providers and consultants included in this report are based on a list provided to the consultant from SARSAS staff, a call out for help in a national rape crisis newsletter, and additional internet based research to establish a comprehensive list of service providers offering group work. From this, a long list of over fifty organisations was established, and all were contacted to take part. Some organisations responded without prompting, and some were chased up by the consultant, if felt that the groups that the organisation offered was of value to SARSAS. The aim was to have feedback from at least ten organisations and the ones that have contributed to the report are listed below:

Specialist Rape Crisis Organisations	**Local Organisations**	**Independent Consultants**
Barnsley Sexual Abuse and Rape Crisis Services (BSARCS)	Womankind	Harvey Ratner (BRIEF)

Women's Rape and Abuse Centre in Bodmin	LIFT	Brenda Billinghurst
East Kent Rape Line	Kinergy	
Manchester Rape Crisis	Bristol Mind	
Oxford Sexual Abuse and Rape Crisis Centre	Bristol Drugs Project	
Sheffield Rape Crisis	Developing Health and Independence	
The Haven	The Southmead Project	
North London Rape Crisis		

2.2 Data Collection

For the semi-structured interviews with service providers, question guides were developed through research of previous literature so no assumptions were made. For the structured interviews, questionnaires were developed with input from the Engagement and Support Worker to ensure questions were constructed to maintain confidentiality and promote a safe environment for discussion.

2.3 Analysis

Reoccurring themes and issues were noted and headings were adjusted to allow for representation of data, similarities and differences between themes, issues and explanation.

Quotes, taken from transcripts have been used to demonstrate interpretations and conclusions of expected or deviant data.

2.4 Methodological Limitations

Many service providers were too busy or had too limited capacity to be able to take part. This meant that there were many other service providers who had knowledge of experience of group work that we were unable to interview.

Participant selection was carried out by SARSAS and therefore they had an influence over participant recruitment and therefore the findings, a potential source of bias.

Further, the small sample size of service providers and service users meant that they may not reflect the workings and opinions of other service users and service providers. This reduces the generalizability of the data. However, as the geographical area covered by SARSAS is small, the service providers included in the report covers the majority of service provision of group work for survivors of sexual violence in the area and the service users are all within the geographical area so therefore, the

study is appropriate for the area. Reliability of research could be increased by increasing the sample size of service providers and service users. Due to time and capacity restraints, this was not possible.

3. Literature Review

3.1 Overview

There is a substantial body of knowledge about the nature, extent and effects of rape, sexual assault and abuse. Therapeutic interventions are delivered either in individual or group format.

Therapeutic group work has been widely used in the treatment of women with a history of childhood sexual abuse and sexual violence, as it provides them with an opportunity to share their experiences with others who can relate to their trauma. Groups provide the opportunity of collective empowerment. Though each woman is suffering and in need of help, each also has something to contribute and therefore, the group has the ability to bear and integrate traumatic experience greater than on an individual level, drawing on shared group resources to help with individual integration. (Herman, 1997)

There is however, only a small amount of research done to evaluate outcomes in group therapy, as large sample sizes and effective control groups are difficult to achieve. (Meekums, 2000)

Many survivors who seek support report being disappointed by the lack of service provision, lack of specialist therapists, the waiting lists of up to 12 months, and the short-term support that is on offer, which often, does not allow sufficient time to fully explore the impact of their trauma. (Sanderson, 2013)

3.2 Impact of Sexual Violence

The literature mostly indicates that there is a substantial difference between those who experience trauma in adulthood compared with those who experience trauma in childhood. Herman best explains this:

"Repeated trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood forms and deforms the personality … The child trapped in an abusive environment is faced with formidable tasks of adaptation, finding ways to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is unpredictable, power in a situation of helplessness." (Herman, 1997)

The brain learns through positive early life experience. If early life includes neglectful parenting or trauma, they do not grow links in their brain that enable them to manage their feelings. They turn to other ways

to manage emotions in the short term, e.g. eating disorders, self-harm, suicidality and substance misuse. (Spring, 2014)

Herman (1997) shows how a childhood sexual abuse survivor's interpersonal relationships in adult life are driven by the need of protection and care, but haunted by the fear of abandonment and exploitation. She claims that the risk of rape, sexual harassment or battering is doubled for survivors of childhood sexual abuse and quotes Diana Russell's study that two thirds of women who had been incestuously abused in childhood were subsequently raped.

3.3 Impact on Mental Health

The impact of trauma can have an impact on one's mental health, and there have been various studies that report the long term mental health effects of abuse, including depression, anxiety, PTSD, psychosis, substance abuse, eating disorders, self harm and suicide. (Itzin, 2006)

Both the BASHH and NICE guidelines highlight the link between violence and abuse and the impact on mental health. The BASHH guidelines indicate that anxiety and depression after sexual assault appear early and are common, and some will develop PTSD and experience symptoms including re-experiencing of trauma, avoidance of stimuli and numbing of general responsiveness, concentration and memory problems, irritability, sleep and appetite disturbance, relationship difficulties, sexual dysfunction, feelings of guilt, shame, self-blame, suicidal ideation and self-harm. (British Association for Sexual Health and HIV, 2011) The NICE guidelines stresses the importance of understanding that childhood experiences of abuse and domestic violence are all linked with a range of mental disorders as well as self-harm. (Itzin, 2006)

Further, childhood sexual abuse is associated with four times greater risk for depression, up to five times greater risk of anxiety disorder and a threefold risk for substance abuse. (Lewis, Griffin, Winstead, Morrow, & Schubert, 2003) Herman et al. found that 81% of patients diagnosed with borderline personality disorder reported histories of childhood trauma; of those 68% reported a history of sexual abuse. (Lubin, Loris, Burt, & Johnson, 1998)

Therefore, it can be argued that a simple diagnosis of PTSD as it is currently defined does not fit accurately enough with survivors of childhood sexual abuse, as it is based on the prototypes of combat, disaster and rape, not of prolonged, repeated trauma and as the symptom picture is more complex, so should the definition. (Herman, 1997)

3.4 Group Work Models

Generally, there are three areas of group work:

a) Psychoeducational – giving people the tools to make changes about how they think and feel
b) Process-oriented therapeutic – leading people to discuss and share things as a group
c) Humanistic therapies, which focus on self-development in the present and future

This is a generalization as most psychotherapy usually overlaps, techniques are blended and combined, so many take on elements of different models.

In *The Theory and Practice of Group Psychotherapy,* Yalom (2005) outlines the key principles of group therapy:

1. Instillation of hope – individuals are inspired and encouraged by other members
2. Universality – the recognition of shared experiences, reducing isolation, validating experiences and raising self-esteem
3. Imparting information – learning factual information from other group members
4. Altruism – individuals can help each other – lifting self esteem and developing more adaptive coping styles and interpersonal skills
5. Corrective Recapitulation of the primary family group – gain understanding of the impact of early experiences on their personality to avoid unconsciously repeating them
6. Development of socialization techniques – a safe, supportive environment to improve social skills and interpersonal behaviour
7. Imitative behaviour – sharing feelings, showing concern and supporting others through modeling
8. Interpersonal learning – achieve a greater level of self-awareness through interacting with others
9. Group cohesiveness – where all members feel a sense of belonging, acceptance and validation
10. Catharsis – relief from emotional distress through the expression of emotion
11. Existential factors – learning to take responsibility for one's own life and the consequences of one's own decisions
12. Self understanding – achievement of insight into one's own problems and the unconscious motivations that underlie one's behaviour

These principles are utilized across all of the various areas of group work listed below.

3.4.1 Psychoeducational

> Psychoeducational interventions are used to maintain the focus on women's adaptational strategies in response to the experience of being traumatised rather than the relationships among members of the group. (Lubin, Loris, Burt, & Johnson, 1998)

Psychoeducation provides information about specific topics to give additional resources or information. These tend to be more structured and group participants have the opportunity to discuss and explore these topics.

Psychoeducation involves sharing information that improves awareness and cognitive understanding. When survivors are equipped with knowledge and trauma and recovery, they are able to normalize reactions, and take control, enabling them to create an order to the chaos. (Sanderson, 2013) It is useful for women who have not previously had the opportunity to develop important life skills. Although it can be ongoing, it is suited to the early stages of therapy.

Sanderson (2013) advocates psychoeducation, as survivors can make sense of their symptoms and normalize them within the context of complex trauma. Psychoeducation, she maintains is "critical in preparing survivors for the therapeutic process, enabling them to feel more in control over their recovery and healing."

3.4.2 Cognitive-behavioural / trauma-focused

This approach has origins in psychodynamic model which stresses the importance of the past shaping current behaviour, by focusing on changing problematic behaviours, feelings and thoughts through discovering their unconscious meanings. It views the group members as the vehicle for change. Through focusing on the ways in which one behaves, one recognises that it is possible to change or recondition thoughts and behaviours. This is achieved through cognitive restructuring (changing negative thinking patterns), correcting beliefs related to the traumatic experience (e.g. the belief that the child is responsible for the abuse), providing support and skills to help cope effectively, and utilize exposure to prevent PTSD symptoms. The educational ethos is inherent, although non-specific interpersonal factors play a part.

One example of this approach is the Pattern Changing programme, an innovative educational group program focusing on the victim and the power she has to change the course of her life, and is a balance between a structured educational syllabus and time for sharing and support. (Goodman, 1995) It offers education, support and practice in developing the skills and techniques for positive change. Group experience is critical, as it allows women to meet others with similar situations, relieving the feeling of complete isolation.

The interpersonal approach involves techniques borrowed from cognitive-behavioural and psychodynamic. The focus is on the interpersonal relationships in your life. By emphasizing self-defeating

patterns, you can change patterns that don't work and develop healthier ones.

3.4.3 Process-oriented

Process-oriented therapy focuses on the experience of being in a group as a healing opportunity, through sharing thoughts, feelings and experiences.

Herman (1997) sees that the "restoration of social bonds begins with the discovery that one is not alone." Irvin Yalom, an authority on group psychotherapy calls this experience "universality.'' Traumatized women feel isolated and alienated by their experiences and thus, survivor support groups have a key place in the recovery process. Women have repeatedly described the comfort of being with other women who have a shared experience to them and are then able to view their experience from a new perspective.

Herman (1992) favours group work as it allows people to break though the secrecy that surrounds sexual abuse. She argues that telling others is the first step towards recovery, bringing a sense of belonging and lessening isolation.

Yalom's 'adaptive spiral' shows how group acceptance increases with each member's self-esteem as each woman becomes more accepting towards others.

3.4.4 Feminist

The feminist model encourages survivors to examine societal factors contributing to abuse against women and children. The model proposes that the socialization of some men leads them to sexualize power and intimacy and that power imbalances may act as contributing factors. The goal of the feminist model is to reduce the consequences of abuse and empower women to work towards changing norms that allow sexual exploitation. (Hébert & Bergeron, 2007)

3.4.5 Solution Focused Brief Therapy

This focuses on positive change rather than dwelling on past problems. Although it acknowledges present problems and past causes, it focuses predominantly on an individual's current resources and future hopes, helping them look forward and use their own strengths to achieve their goals.

It involves a variety of techniques to clarify spoliations and help the person find ways of achieving them. Clients are encouraged to focus

on what they do well, and to set goals and work out how best to achieve them. These last no more than 3 or 4 sessions.

3.4.6 Art Therapy

This approach involves the use of creative arts such as music, art, drama and dance in a therapeutic environment. Meekums (2000) proposes that creative arts therapies, because of their emphasis on metaphor, may be a useful tool. Sometimes survivors have no words for what has happened to them. She acknowledges that they are no appropriate for everybody, but in certain circumstances, they can provide a useful alternative.

3.4.7 Integrative or holistic therapy

This is when several models of therapy are used together. Many therapists don't tie themselves to any one approach and they blend elements to tailor their treatment according to each woman's needs.

3.4.8 Herman's Model for Recovery

Herman (1997) argues that recovery can only take place within the context of relationships; it cannot occur in isolation. She views that recovery is unfolded in three group stages, which all have roots in the various approaches listed above:

1. Establishment of Safety
2. Remembrance and Mourning
3. Reconnection with ordinary life

There is no such thing as a generic group suitable for all survivors – different types of groups are appropriate at different stages of recovery. Herman (1997) sees that the group types should depend on which stage of recovery the participants are in, so that 1st stage groups concentrate on establishing safety, 2nd stage groups concern themselves with traumatic event and 3rd stage groups concentrate on integrating the survivor into the community.

Stage One: Establishing Safety

Herman argues that group work in the first stage should be highly cognitive and educational rather than exploratory, utilizing psychoeducational and cognitive-behavioural approaches. It should exist as a forum for exchanging information on traumatic syndromes, identifying common symptoms and sharing strategies for self-care and protection. Groups should focus on developing their strengths and coping abilities whilst offering a cognitive framework for

understanding symptoms that may be secondary complications of trauma.

They should be didactic in purpose whereby detailed storytelling should not be encouraged. The membership is homogenous in this group, as facilitators will have defined common problems and symptoms. Variants of this stage group include short-term stress management, which Herman argues is promising for survivors of chronic trauma in early stages of recovery. Further, similar psychoeducational groups can be adapted to a wide variety of social situations.

Stage Two: Remembrance and Mourning

Stage two focused on process-oriented work, providing a safe space for survivors to share their stories and be a sustaining source of emotional support. The key is that the group should be highly structured, and clearly oriented towards uncovering work.

Herman and Schatzow identified two features that they consider essential to effective group work at this stage:

1. Established time limit – this is important for boundaries and gives women to knowledge that the high intensity won't last forever and therefore promotes rapid bonding
2. Focus on personal goals

Herman argues that length of time here is less important that the fact of its existence: most of her groups lasted 12 weeks, but several have lasted for 4, 6, 9 months or longer. She says that most women complain about the time limit, no matter how long the group lasted, but many also state that they would not have wanted, or been able to cope with an open-ended group. The focus on the personal goal is also key, as it takes them think about what they want to accomplish within the time limit and encourages them to seek help from within the group.

The survivor is ready for this group, according to Herman, when her safety and self-care are securely established, her symptoms under reasonable control and has reliable social support. The rewards of group participation here she argues are proportional to demands – the group cohesion develops quickly, with the feeling of being understood, often for the first time. (Herman, 1997)

It is important to note that whilst many leave this group with a restored sense of self, this may not lead to better relationships with others. Herman reports that family relationships and sex lives became worse, or more conflictual, because women were no longer routinely disregarding their own wishes and needs. (Herman, 1997)

Herman also makes clear that there are some limitations with the effectiveness of this group treatment. Many claimed that they were still troubled with flashbacks, especially during sex. She concludes that whilst group treatment complements the individual exploration of trauma, it does not replace it. (Herman, 1997)

Stage Three: Reconnection with ordinary life

At this stage, Herman claims that there are more options and different types of group that may be useful, depending on priorities. For example a trauma-focused group may still be the most appropriate if she wishes to tackle a specific trauma-related problem. Residual problems such as hyperarousal and fearfulness can be tackled productively in a group setting, such as a self-defence class. Or, broader difficulties in relationships are better addressed in an interpersonal psychotherapy group. It is important to note however, that a group focused on interpersonal relationships have a different time focus to trauma-focused. Whilst stage two trauma is focused on the past, interpersonal ones are focused on present-future. Solution-focused therapy would also be appropriate in this stage, encourage women to reconnect with ordinary life and look towards the future.

3.4 Effectiveness

3.4.1 Overview

There is much literature that describes the issues associated with violence and abuse and various treatment approaches for resolving these issues. Yet, empirical data is necessary that the treatments are effective. The body of research supporting the efficiency of group therapy for sexual violence survivors is small, but encouraging. (Kessler, White, & Nelson, 2003)

This section looks at the various studies that have contributed to an understanding of the effectiveness of group treatment in that it helps to alleviate symptoms, and that it is certainly more effective than no treatment in reducing trauma symptoms. (Kessler, White, & Nelson, 2003)

3.4.2 Evidence of effectiveness

Group treatment is seen as effective in enhancing self-esteem, reducing mistrust, improving interpersonal skills and reducing isolation. Yet, the reduction of PTSD symptoms has been seen as the aim of individual therapy, leading many to recommend group therapy after an individual course of therapy. (Lubin, Loris, Burt, & Johnson, 1998)

Sloan et al. reviewed the effectiveness of working with survivors in groups rather than 121 sessions. They found that compared to other

treatments for trauma (e.g. 121 therapy), group treatment was no more or less effective. (Sloan, Feinstein, Gallagher, Beck, & Keane, 2011)

Psychoeducational studies

Burrowes wrote a report on Portsmouth Abuse and Rape Counselling Service (PARCS) who provide group support for women on their waiting list as a way of supporting them whilst they wait for therapy, as an opportunity to meet other women, tackle isolation and give them a series of tools that will help them in their 121 therapy. Burrowes interviewed women who attended this pre-therapy group and found that being in a group reduced the sense of feeling alone and introduced a sense of belonging. They found that by learning new ways of understanding their behaviour, they were given hope that they could do something about it. They also found that they were able to see a number of things from a different perspective and felt much better equipped at going into 121 therapy. (Burrowes, The courage to be me. Evaluating group therapy with survivors of rape and sexual abuse, 2013)

McDermut et al. evaluated behavioural, psychodynamic and/or interpersonal principles. Control conditions were the waiting list or individual therapy. It was concluded that group therapy was favourable to no therapy, but that individual and group therapies had a similar outcome. Dissatisfaction with the group format was associated with reduced effectiveness, and it was stressed to take into account patient preferences regarding the format of group therapy. (Roth & Fonagy, 2005)

Resick et al.'s study demonstrated the possibility that group treatment is effective in reducing core PTSD symptoms as well as problems with self-esteem and interpersonal relationships. (Lubin, Loris, Burt, & Johnson, 1998) Their research showed that group therapies with a more structured, psychoeducational format was more efficient in symptom reduction.

Cognitive-behavioural studies

NICE guidelines indicate that cognitive trauma therapy for battered women saved £15 million but reducing the harm from domestic violence, compared with no intervention. (National Institute for Health and Care Excellence, 2014)

Lundqvist analysed women's mental health before and after group therapy and found that trauma-focused group therapy for women who were sexually abused in childhood had positive impact on their mental health, both short and long term. (Lundqvist, Svedin, K., & Broman, 2006)

Richter et al. (1997) looked at group treatment within the generalist problem-solving framework and found that symptoms continued to

decrease after the termination of the group. (Kessler, White, & Nelson, 2003) This study is unique in that with follow up assessments, there was an even greater reduction of depression and increase in self-esteem than reported at the end of the group therapy.

Lubin et al. evaluated the effectiveness of a 16-week trauma focused cognitive-behavioural group therapy, named the Interactive Psychoeducational Group Therapy in reducing the primary symptoms of PTSD. They found that women showed significant reduction in PTSD symptoms and that these improvements were sustained when they followed up six months later. They concluded that the use of structured cognitive-behavioural elements within a group format would allow for more targeted treatment. (Lubin, Loris, Burt, & Johnson, 1998)

Westbury and Tutty (1999) evaluated the Integrative Body Psychotherapy model of treatment where the focus was cognitive, emotional, physical and spiritual. Women met weekly for 10-12 weeks in additional to concurrent individual therapy. They found that concurrent individual treatment enhanced gains realized in group treatment. (Kessler, White, & Nelson, 2003)

Process-oriented studies

Generally speaking, there were fewer studies that were solely process-oriented. Yet, there are still important points that can be taken from the few that have been done.

Lubin et al. found that improvements were greater for those women who had perceived other group members with having similar experiences. (Lubin, Loris, Burt, & Johnson, 1998)

Morales Campo et al. (2009) found that Hispanic immigrant women attending support groups for abuse reported improvements in self-esteem, stress management, independence and feelings of support. (National Institute for Health and Care Excellence, 2014)

Hazzard, Rogers and Angert (1993) looked at a year long therapy program for incest survivors using a three phase process-oriented group psychotherapy model developed by Yalom (1975) and Courtois (1988). Treatment was found to be equally effective regardless of extent or details of the abuse, and there was a positive correlation between prior treatment and treatment outcome, suggesting that women who participated in therapy prior to group work had more successful outcomes. (Kessler, White, & Nelson, 2003)

Short-term symptom relief therapies Sanderson (2013) sees as less effective than longer-term process-oriented therapies, which focus on relational skills to facilitate post-traumatic growth.

3.4.3 Problems with previous studies

Empirical evidence into the outcome of group therapy for traumatised women is limited.

Burrowes reviewed the literature on rape and sexual assault and was unsurprised by the lack of empirically robust, large sample size research being conducted. Organisations who work with survivors are seldom provided with the capacity and resources to evaluate their work, and when evaluation occurs, it tends to be small-scale as organisations work independently from each other. (Burrowes, A Review of the literature on rape and sexual assault, 2011)

In addition, some studies claim it is difficult to assess the effectiveness of group work, as many patients continue similar or different forms of therapy after completing group work. (Longstreth, Mason, Schreiber, & Taso-Wei, 1998)

Evaluative studies of group therapy for survivors remain scarce. Few studies include a follow up to verify maintenance of gains. Few studies verify the uniformity of the intervention against the model, and studies have failed to report on levels of attendance or participation, all factors that can influence results. (Hébert & Bergeron, 2007)

Although effective, many therapies require months to years to achieve recovery and many women do not achieve this due to high drop out rates and high costs of care. (Posmontier, Dovydaitis, & Lipman, 2010)

3.5 Boundaries and Safeguarding

When working with survivors, counselors need to be aware of a range of factors that can impact of the effectiveness of the therapeutic process. Sanderson (2013) identifies core boundaries crucial to consider when planning an effective group model: Explicitness, Safety, Confidentiality, Duration of Therapy, Length of Session, Out of session contact, touch, self-disclosure, pacing.

Learning about boundary settings is an important process that helps women gain control of their lives. (Goodman, 1995) Negotiating boundaries that both facilitator and survivor consider reasonable and fair is essential for building a relationship. (Herman, 1997)

Groups need to have rigid boundaries as members can become attached and rely on each others' presence. The absence of a member can therefore also be highly disruptive. Herman (1997) recommends time limited closed groups and for members to plan to attend every meeting.

Whilst it is recommended to define clear boundaries, Herman (1997) stresses the importance of having areas of ambiguity and that a degree of flexibility is key. Sanderson (2013) warns of possible strong reactions to the setting of boundaries, as some will welcome this, some may feel controlled by the facilitator. She stresses that therefore psychoeducation is paramount, as it encourages healthy boundary of safety rather than one of control.

3.6 Group Characteristics

Whilst in principle, groups are a good idea, in practice, its organisation is no simple matter and there are many factors that need to be considered. In order to be successful, a group must have a clear understanding of its therapeutic task and a structure that protects the women against the dangers of traumatic reenactment. (Herman, 1997)

Leadership

The majority of group treatment approaches utilizes two group facilitators, which are predominantly female, as there is indication that female leaders result in easier self-disclosure and that with some survivors, male facilitators may not be tolerated at all. (Stice)

When looking at groups that focus on the shared experiences of trauma in their past, not on interpersonal difficulties in the present, conflicts and differences between group members do occur and divert group from its overall task. Therefore, leaders need to intervene actively to promote sharing the space, creating a safe space and ensuring all group members are protected. Sanderson (2013) points out that leaders must be aware of being too distant, clinical or protocol driven, needing to provide an engaged position.

It also can be emotionally demanding, as leaders need to be able to demonstrate that they can hear the groups' experiences without becoming overwhelmed. Herman therefore recommends shared leadership, with each leader complementing the other, using peer cooperation, not dominance and subordination. (Herman, 1997)

Group Size, Duration and Location

Group size, duration and location of groups all have an impact on the effectiveness of the group. Stice recommends that group sizes ranges from 6-10 women and the majority of studies did not have more than 12 women attend with two facilitators. The reasoning behind this was to ensure that all participants would be able to contribute within one session and any more or less than this was not beneficial to the outcome.

Meekums (2000) recommends for the group to meet in a location that is accessible with public transport, wheelchair accessible toilets and privacy

/ soundproofed rooms. Further, she continues that it should ideally be between 10-2, so that children can attend, and that they should be scheduled around term time. Evening groups are best suited to women who are in employment. In the studies that have been read, most sessions have not lasted for longer than 2 hours, yet it is the duration of the number of group sessions that has varied across studies.

Herman and Schatzow (1984) found that time limited group therapy for survivors was found to contribute positive change for the women. (Kessler, White, & Nelson, 2003) Meekums (2000) argues that 20 sessions in closed groups satisfied the current trend towards short-term focused work, whilst still enabling some in-depth work. Sultan and Long (1988) examined the psychodidactic-support model of treatment and found that the time period at which significant change occurred was 12-16 weeks into treatment. (Kessler, White, & Nelson, 2003) Lubin's psychoeducational therapy consisted of a 90 minute session once per week over 16 consecutive weeks. The group would have a brief psychoeducational lecture, followed by interactive discussion followed by a educational wrap-up. The results show that this form of group therapy was consistently effective across five group of women and the gains were largely retained at 6-month follow up. (Lubin, Loris, Burt, & Johnson, 1998) Carver et al. (1989) looked at time limited incest survivors group and how the treatment was extended from 10-15 weeks due to a request from participants. (Kessler, White, & Nelson, 2003)

Further, few studies have looked at the duration and intensity of how group therapy impacts the outcome. Kreidler (2012) analysed the psychological outcomes of women who attended 6-month therapy group compared to women who had received 12 months group therapy. Each group met once per week for 2 hours, and all participants had experienced childhood sexual abuse as a child. Kreidler discovered the women in the 6-month group had greater gains than those in the longer treatment group. Shorter therapy duration could minimize the opportunity for women to withdraw, escape and avoid their emotions and these findings, whilst small-scale, could help therapists design more effective interventions. (Kreidler & Einsporn, 2012)

It is hard to directly compare these studies, as each study has different models, characteristics and requirements. Certainly, the size and duration has an impact on the effectiveness of group work, but this cannot be viewed in isolation, without looking at other contributing factors, including group model, characteristics, safety and dynamics.

Group dynamics

The studies highlight the importance of balancing dynamics as a key to a successful group work, and that a good facilitator that can manage this is essential. There is a risk that betrayal issues can emerge in group

dynamics, which needs careful handling by the facilitator. (Meekums, 2000)

Herman (1997) warns that conflicts can erupt amongst group members can easily re-create the dynamics of the traumatic event. Campling and Culverwell (1990) also warns of how abusive dynamics can be replayed in a group setting. (Meekums, 2000) They found that in their group, which had all white women except one Asian woman, racism was one of the issues which emerged through which abuse dynamics were replayed.

Lubin argues that one advantage of the psychoeducational format is that it heightens the treatment effects by redirecting the members' attention away from potentially complex interpersonal dynamics. (Lubin, Loris, Burt, & Johnson, 1998)

3.7 Group Criteria

Group therapy is not a treatment that is suitable for all survivors. In order to identify women who would be suitable for group work, some outcome researchers identified women who were more likely to benefit, and those who were more likely to complete the course.

Kessler, White & Nelson (2003) found that women most likely to benefit were those who had less severe trauma symptoms prior to treatment. They also found that women who were employed, not involved with inpatient treatment in the past and were only participating in group therapy were also more likely to complete a course of group therapy. Hazzard et al. (1993) also found that women with prior hospitalization were less likely to complete yet no other variables, including abuse characteristics and previous treatment predicted drop out rates. Follette et al. (1991) found that previous individual therapy was predictive of a positive outcome. (Meekums, 2000)

A detailed assessment is an important and essential part of a successful therapy group for survivors. Sanderson (2013) strongly highlights the importance not only of a good assessment, but on the use of assessment scales that measure PTSD and dissociative symptoms. These can be divided into three types of symptoms:

1. Primary – trauma reactions elicited by the trauma
2. Secondary – attempts to manage the primary effects such as self harm, self medication and withdrawal
3. Associated disorders that develop over time – self-destructive behaviour, substance dependency, chronic depression

Sanderson (2013) argues that the assessment should be ongoing through therapeutic process as it helps the facilitators keep on top of any new or emerging symptoms or difficulties in utilizing any new skills.

3.8 Group Safety

The need for safety is often referred to as the most important element in recovery. This sense of safety can be generated in the following ways: (Meekums, 2000)

1. Group agreements – particularly around concerns over confidentiality
2. Value not judge individual differences – improves the sense of trust
3. Sharing concerns makes survivors no longer feel alone
4. Increased understanding of abuse which will reduce the sense of guilt
5. Careful timings and length of sessions
6. Use of hunour as a way of providing safe distance from difficult material
7. Right to say no to participation
8. Freedom to disclose when ready
9. Delicate balance between freedom and structure

Meekums (2000) also recommends following these guidelines of ensuring safety in group work:

1. Identified previous mental health symptoms
2. Confidentiality
3. Structure in early sessions to provide sense of containment, empowerment and cohesion

It is important to maintain a predictable and constant therapeutic space, safe from intrusions, or unexplained noises, with easy access to toilets or the exit should someone need to leave. (Sanderson, 2013)

Anxiety and elevated stress can revive terror states, and women can be overcome by nausea, or need to evacuate bowels so access to toilets and drinking water is paramount, particularly as many will not ask for help. (Sanderson, 2013) It is widely thought that new memories emerge during group work through strong group cohesion, as vivid narratives provokes other women to recollect similar stories. This has given rise to a concern that 'survivor' groups have adverse consequences as well as beneficial ones. (Boakes, 1997)

Participants of group work often report that their symptoms initially worsen, but they also experience a sense of empowerment at being recognised and understood. Feelings of guilt and shame are first absolved though others before women then come to apply the same logic and forgiveness to themselves. (Boakes, 1997)

One cannot assume that satisfaction and effectiveness always coincide. Some studies showed participants reporting new symptoms, adverse effects on relationships and preoccupation with abuse. Instead of being freed from the past, they were obsessed by it and exhibited PTSD symptoms that were related not of the abuse itself, but of the recollection of the abuse. Some consider that worsening of symptoms is necessary to

recovery, yet there is evidence that some women did not improve with time. (Boakes, 1997) Boakes therefore errs caution when someone seeks treatment for past sexual abuse rather than for current problems. Individuals should be assessed carefully and for the assessor to think about how the past abuse is manifested in the current problems.

3.9 Equality of Representation

Few studies have primarily focused on the equality of representation, diversity and the make-up of individual groups. Meekums (2000) believes that social class does not affect likelihood of childhood sexual abuse and there have been a few studies mentioned previously that mention class, race, age, disability and ethnicity.

Bowland at al. (2011) stresses the importance of the need to increase awareness and sensitivity towards the needs of older survivors. For example, group work with survivors in assisted living facilities and / or low-income communities to be considered.

Hazzard et al. (1993) found that the more similar the group membership was in terms of type of abuse, the more likely the members were to display a positive outcome. (Meekums, 2000) They also found that Caucasians also did better, which may have been related to similarity issues, as the facilitators were White and Caucasians were the majority. This supports Campling and Culverwell's study (1990) whereby racism emerged through abuse dynamics due to the fact that one Asian lady was the minority in an all-white group.

Despite the lack of data around this, what is clear is that the group make-up needs to be carefully considered and managed by the group facilitators.

4. Findings – Organisational Feedback

4.1 Overview

This section looks at the findings of the semi-structured interviews and pre-fabricated questionnaires of 15 different providers and two independent consultants, some of which were both local and national, and specific to rape and sexual abuse services and also other service providers that offers group work for a variety of other issues, including substance abuse and mental health. For a breakdown of questions asked, please see appendix one.

4.2 Group Models

Out of the 17 organisations that were interviewed, only one did not offer group work in some form. Over 55% of these organisations offered one or two different types of group, and the highest amount of groups on offer came from North London Rape Crisis, who offered over ten different types

of groups. The types of groups on offer ranged from purely psychoeducational, some process-oriented, support groups, solution-focused, yet the majority of groups were a combination of many of the different types of group, with over 80% of groups offered containing an element of psychoeducational work.

The length of group work varied, ranging from 1 hour to whole day sessions although the average and majority was around the 1.5 / 2 hour mark. These tended to be weekly, although there were a few that were twice weekly, or a few times a week. The duration of these groups ranged from about 6 weeks to 20 weeks, although there were a few that had an open-ended time frame, meaning that it was up to the individual when they wanted to leave the group. Psychoeducational groups all had a fixed time period, averaging between 8-12 weeks as did solution oriented, which offered between 3 and 6 sessions. The longest groups were those offered by Womankind, where groups were open-ended and women as an average would leave after 2.5/3 years.

The organisations were a mixture of rape and sexual abuse services, some local and some across the country. The three organisations that did not have sexual violence as a focus looked instead at drug and alcohol abuse or general anxiety disorders. The main criteria for establishing what kind of abuse the group was focusing on tended to be dependent on the funding of the organisation. For example, a SARC would only be able to offer groups where rape or assault had happened in the last twelve months. There were a small number of organisations who offered numerous types of group. With these organisations, because they offered several groups, they were more likely to separate the different types of group models, as well as separate survivors of adult rape with childhood sexual abuse, although the majority that only offered 1 or 2 groups tended to not distinguish between survivors, and offered a mixture of psychoeducational, therapeutic and process-oriented work.

The majority of groups were closed, particularly if it was psychoeducational, which had a fixed set of topics and themes. The open-ended groups tended to be therapeutically led, with a focus on peer support. Two organisations also offered drop in sessions, which specifically was not designed for story-telling, but offered women the flexibility of attending a group without a defined structure.

4.3 Assessment, Group Criteria and guidelines

All organisations were asked about criteria and guidelines for joining the groups that they offered. All organisations used an assessment procedure to assess suitability for women to attend groups. The more time spent making sure the assessment was well thought out, and appropriate for the group in question, the more likely the organisations believed that retention and effectiveness would be successful. Whilst there were

varying degrees of difference between organisations, all tended to have criteria of assessment along similar themes.

For example, all organisations considered the stage that each individual was at to decide whether they are appropriate for group work. Some of the groups were pre-therapy groups, to support women who had not yet received individual therapy, but were on often long-waiting lists. These were often psychoeducational, offering coping strategies and familiarizing women with the organisations services before starting with more in-depth work, so therefore having previous individual therapy was not a pre-requisite in these groups. In the groups that were more therapeutically based, peer-support, and dealing with storytelling and sharing experiences, having attended previous individual therapy was a strict requirement.

All organisations considered mental health issues, self-harm and substance misuse when considering women for group work. Yet, organisations attitudes towards these varied, with some specifically stating that women could not be misusing substances to attend group sessions, whereas others said that whilst it is considered, it forms part of an individual's risk assessment and suitability and would be dealt with on a case-by-case basis. Generally, women with severe mental health issues were not offered a place on a group as the level or risk was considered too high. The Haven, a SARC in London specifies in its criteria that if an individual had a PTSD diagnosis, they would be signposted to the psychoeducational group, rather than an interpersonal one. North London Rape Crisis offered women with severe mental ill health the option of attending their drop-in sessions rather a specific structured group. Another criteria that came up with many organisations was that the women had not had a major life event in the last six months, or that they were not going through a court process, as this was felt to prevent group work from working effectively.

Engagement during group sessions, and strict attendance (in terms of both not missing sessions, and also turning up on time) was the other main criteria for membership.

The first session of the groups tended to discuss guidelines of the group. Many groups had a guidebook or a list of guidelines for the women to adhere to, and some also offered women the option of designing some of the ground rules themselves. Whilst many of the guidelines were the same across the organisations, for example, creating a safe space, confidentiality, listening to others, strict attendance, having a breakout space and keeping in the present, the main guideline that organisations found difficult to manage was around whether women could meet with group members outside of the space. Some organisations were strict on not letting women do this outside of group, as it affected the dynamics during the group, others would be happy with women forming friendships within the group and that they could meet after group had

finished, whilst others, whilst wanting women to not meet up outside of group, found that women did it anyway, and it was difficult to manage and monitor. This also posed some additional issues around confidentiality and was stressed to ensure that this issue is thought through before commencing a group.

4.4 Evaluation

All women attending groups had an assessment with the facilitator before they were assigned an appropriate group. 75% of organisations then had an evaluation procedure to assess both the women and the group after the course had finished. Some of the organisations used specific Rape Crisis toolkits for evaluation, some used NHS guideline measurement scales of PTSD and some devised their own evaluation that was appropriate to their course. A third of organisations would evaluate and assess the women throughout the course, especially if they thought it would be useful for women to see their own progress. Similarly, a small handful used self-assessments for the women to see their progress too.

Only two organisations did a follow up a set number of months after the group had finished to assess the level of retention and long-term effectiveness of group work. Of those that didn't do a follow up, some cited that they didn't have the capacity or resources in order to be able to do this, but would like to have done this, whilst others used the fact that the women had not returned to use their service as an indicator of group work success.

4.5 Successes

The organisations and consultants were asked what they thought was the most successful thing about group work. The question was not multiple choice, but open to allow fair and unbiased responses. Common themes included how women would be on a journey together, dealing with blame, isolation, confidence, self-esteem together in a safe space. The most common response was that groups are a space for women to support each other, and this was found to be key in their journey of recovery. Also a common choice was how group work helps women normalise reactions to trauma and identify with others. Whilst dealing with blame etc., is something that could be tackled in individual therapy, many organisations felt that there was something powerful about group work, where women would identify behaviours in other women, and draw parallels and similarities with their own, and through this identification, be able to support others around them, but also be better equipped to deal with their own trauma. It was this support and identification structure to group work that organisations said was a key element of recovery.

4.6 Problems and risks

The service providers were also asked whether they had encountered any particular problems in organizing or facilitating group work, and if they had done (or would do) anything differently in response to these problems.

Managing group dynamics was the most common response, as they felt it was important that women felt safe in their space, and having a group member who was more vocal or opinionated than others could be detrimental to the group's success. The key in mitigating and preparing for this was to have an experienced facilitator(s) who was able to steer and control the group dynamics and to ensure that you have clear ground rules at the beginning of the group. Having said this, the second most common response was organisations reporting that sticking to the criteria and ground rules was easier said than done, and that this would also be a common problem. Some issues, like for example, not getting distracted by your mobile phone, poor attendance, turning up under the influence of substances, could be more easily managed by clear ground rules that are communicated clearly at the beginning of group work.

Confidentiality was a topic that would also come up, and service providers stressed that a good way to create the safe space and for women to feel clear about confidentiality was to have a discussion on this when agreeing ground rules. Encouraging women to ask questions to clarify, and get the group to talk about their concerns around confidentiality was seen as a good way of mitigating any potential problem with confidentiality. Not rushing the beginning sessions on ground rules seemed like a vital way of not having further problems later down the line.

Other problems mentioned included assessing risk, how to deal with triggering, flashbacks, complex needs and the mix of women in a group that included both survivors of childhood sexual abuse and rape and sexual assault. The majority felt that these issues could be mitigated by a well-planned group structure, strong facilitation and supervision. Of the groups that had women who were childhood sexual abuse survivors as well as rape and assault survivors, there was a consensus that there may be more work skewed towards childhood sexual abuse, so that thought around this should form part of the planning of the group sessions.

4.7 Equality of Representation

All service providers were asked whether they had encountered any class, ethnic or cultural barriers in relation to group work. Only one organisation considered it irrelevant, but most other organisations differed in how they tackled it as an issue. Language barriers were a common theme, and some service providers organized separate groups with separate facilitators that would speak in the mother tongue of that particular cultural group. However, many organisations highlighted that many ethnic groups are generally under-represented in group treatment.

Other groups would vet the group with ethnicity and class in mind, so that it was well balanced and would contain many different perspectives that women could utilize in helping them identify with others. Womankind was keen to ensure that diverse membership of the groups was crucial, alongside diverse facilitation. They thought that women from different backgrounds and culture would be more likely to succeed in group work if it was facilitated by diverse and representative women.

Some organisations mentioned that trafficking was an issue, and that the facilitators would need to be experienced with dealing with this, as often it could cause tensions in group dynamics if not handled well. Perception of isolation, as well as class differences would also sometimes cause tension, with a particular mention to class differences between survivors of childhood sexual abuse and those of adult rape and assault. Careful planning and facilitation could manage this risk.

4.8 What makes a good facilitator

Many of the problems and successes identified by service providers could equally be found or resolved by good facilitation of the group, so organisations were asked what three skills would they look for in a good facilitator. The overwhelmingly common favourite skill identified was group work experience, which was mentioned by 65% of service providers. Following this, the ability to hold the space, balance group dynamics and have a good breadth and depth of knowledge were the next popular choices.

The personality of the facilitator was also mentioned, stressing flexibility, having a good memory, a sense of humour, confidence, creativity, approachable, real and non-judgmental. These were all buzzwords mentioned by service providers.

As many organisations used two facilitators, a few mentioned that having different qualities for the two facilitators work well, to ensure that their relationship is not based on power relations, with one more dominant than the other.

5. Findings – Service User Feedback

5.1 Overview

This section looks at the findings of the thirteen pre-fabricated questionnaires that were answered by service users. Two questionnaires were designed, one for those service users who had experience of group work, and another for service users who had no experience of attending groups. The independent consultant travelled to attend the SARSAS Bath group and asked the service users questions within a group setting. Other service users provided answers to the questionnaires when asked by SARSAS volunteers during 121 support work and the Engagement and

Support Worker also approached service users to complete. For a breakdown of questions asked, please see appendix two.

5.2 Service Users who had no prior experience of group work

Eight service users completed the questionnaire of no prior experience of group work. Of these eight, 50% were brought to SARSAS due to adult rape or assault, 38% were brought to SARSAS due to childhood sexual abuse, and 12% (one service user) did not specify but wanted to expand her support network.

All of these service users had received previous individual therapy, mostly of which had 121 counseling with 25% having had some cognitive behavioural therapy in the past. 75% were interested in further group work and all whom expressed an interest cited the reason for doing so was because they wanted to have mutual support, and be able to share, listen and identify with others' experiences.

They were asked what kind of group they wanted to attend, and what knowledge they had of group work. Answers were brief, as many had little or no knowledge of group work, apart from that it is talking and sharing, supporting each other. Therefore, most were unsure of what groups they would want to attend or simply stated that they would like to attend something where they could share listen to others in a group setting.

Out of the service users who wanted to attend a group, 83% thought that attending a group every fortnight would be appropriate, with weekly being the only other option cited.

They were asked what they would like to achieve, and they all cited similar responses; supporting each other, identifying with others, broaden their support network, reduce isolation and improve confidence.

They were also asked about their concerns about group work, and many important concerns were raised including, fear of not being believed, fear of being judged, fear of not being accepted, confidentiality and opening up in front of people. The two service users who were not interested in attending groups cited their reasons for this because of concerns over confidentiality, panic attacks, dealing with emotions in front of strangers, finding sharing stories distressing and feeling exposed.

5.3 Service Users who have prior experience of group work

Five service users completed the questionnaire who had prior experience of group work. Of these five, three attend(ed) the group currently offered in Bath. In order to review the Bath group separately, the results of these have been separated out of the other two questionnaires and will be discussed in the next section.

The two service users who had prior experience of group work were both brought to SARSAS due to childhood sexual abuse. They had both received previous individual therapy and attended psychoeducational groups and mutual support groups over a year previously. They were both satisfied with their experience of groups, whilst one highlighted that one of the groups she attended was not facilitated by a professional and she was dissatisfied by this experience. The other found the facilitator irritating and didn't control the group dynamics well. The ability to control and manage the group was therefore highlighted as something that was liked least about their previous experiences.

They both found the group helpful in identifying and empathizing with others, stating that overall, the group had a positive impact on their wellbeing, that they would recommend group work to a friend. One however did highlight that group work isn't good for your wellbeing all the time, and to expect to get worse before getting better. The other, whilst finding the group encouraged her to engage, interact, improve her confidence and learn new skills, also suggested that she would find groups useful if she was on a waiting list for individual support.

The questionnaire asked them to provide three recommended pieces of advice to give to other women who may want to attend group. One woman highlighted the importance of embracing, listening to others and to go with the flow. The other highlighted to be wary of how ones language, behaviour and attitude can impact others, to be aware of triggers and to remain open-minded.

6. Recommendations

The independent consultant also spoke with SARSAS staff to find out what they thought the service user needs were and what would be appropriate for the organisation. This feedback has been combined with the literature review and service user and organisation feedback to develop a series of recommendations for SARSAS Board of Trustees. There has been no cost implication or considerations in regards to budget and that the recommendations need to be considered with sustainability and longevity in mind.

6.1 Development and Expansion of Group Work

Currently, there is only one therapeutically led self-help empowerment group, which runs in Bath. Whilst the service users who attend this group find it of enormous value, it is small scale and the boundaries have been shifted which has resulted in a sense of insecurity. There is are also few places for the women to go to once they leave the group so there needs to be a structured expansion of groups on offer to better support SARSAS service users.

Recommendation One: Expand the group work offered by SARSAS by using Herman's three stages of recovery

Using Herman's three stage model of recovery, it is proposed that SARSAS develop three stages of groups.

Stage One: Establishing Safety

Recommendation 1A: Develop a psychoeducational group

Recommend that SARSAS develops a psychoeducational group with the main aim of establishing safety. This should be designed for women who may or may not have attended therapy previously. This should be between 10-14 weeks, on a weekly basis for 1-2 hours per week and be well structured so that women can identify symptoms, develop and sharing coping strategies, learn how to manage stress, and an opportunity to meet other women, which will tackle isolation, and equip the women better for moving into 121 therapy or support, and further group work. This should be a time limited, closed group.

The Women's Rape and Sexual Abuse Centre in Bodmin have developed a Power Programme that could be developed for SARSAS. Their 14 week educational programme covers childhood sexual abuse, rape and sexual violence as adults, looking at human rights, impact of abuse, boundaries and patterns of behaviour, understanding and dealing with feelings and anger, the healing process, the cycle of shame, identifying triggers, sexuality and intimate relationships and celebrating change.

A psychoeducational group of this nature would help them develop important skills, whilst creating a space for them to engage, interact, improve their confidence, and identify common characteristics with others without sharing distressing experiences. By learning techniques and coping mechanisms will help women then attend 121 counseling & support and have the right tools for stage two of their journey of recovery. The number of psychoeducational groups on offer would depend on SARSAS budget. This could be developed as one group in the Central Bristol hub, or if budget allows, to run other psychoeducational groups across Somerset and Avon to include also Taunton, Bristol and Weston-Super-Mare. This would very much depend on the number of service users across the counties who would be interested in a group of this nature. If funding allowed, this psychoeducational group could be split – with one for survivors of adult rape and assault, and another for survivors of childhood sexual assault, although this would depend on funding and capacity.

Stage Two: Remembrance and Mourning

Recommendation 1B: Expand group support to run several support groups

Recommend that SARSAS expands and develops the current group support to include process-oriented support groups. This could be more flexible in structure, and include a mix of therapeutically led work, with a facilitated support group. Recommend that these groups are smaller in number, as there needs to allow more time at each session for each women to have the opportunity to bring and share their experience.

Propose no bigger than 6-8 women, which could be run on a fortnightly basis. There is a discussion over whether this could be an open rolling group (similar to the current Bath group) with a maximum length of time that a woman can stay, or a closed group with a specific time limit. By establishing a time limit, women join the group knowing that it will not last forever, which will also promote rapid progression. Further, evidence that shorter therapy minimizes the opportunity for women to withdraw suggests that a time limit of between 6-12 months would be prudent.

The main issue with the time-limit imposed on the Bath group was that there was nowhere else for the women to go after the group had finished which is why having some groups at stage three is key so that women feel supported after the conclusion of stage two.

As the size of the groups are small and the duration of groups is much longer, recommend that more than one process-oriented support groups are developed. This should be spaced out throughout the counties of Somerset and Avon so that women don't feel that they have to come to major hubs to attend support, although the location of these would be dependent on waiting lists.

Stage Three: Reconnection with Ordinary Life

Recommendation 1C: Offer a series of further support groups that tailor the needs of the service users

Recommend that SARSAS develops a series of stage three groups that include some or all of the following:

- Solution Focused Therapy
- Art therapy or creative writing groups
- Trauma specific groups
- Mindfulness / relaxation groups
- Eco-therapy groups – walking / gardening
- Peer supported coffee mornings
- LBT groups
- Drop in sessions

Options here have expanded, as different types of group may be useful, depending on each individual priorities.

Solution focused therapy is already offered at SARSAS on an individual basis but the consultant has offered this in a group setting. This would be no more than six sessions with a focus on the future, by identifying what

is working and not working, helping clients notice their coping strategies they use to survive. This would be a weekly or fortnightly intervention. The approach is different to most of the other groups, so this should be developed on a trial basis and evaluated to assess its effectiveness.

Trauma focused groups may be appropriate if the service user wishes to tackle a specific trauma related problem that interferes with her day to day life, or development of relationships.

Other groups, including art therapies, mindfulness and relaxation, eco-therapy groups and peer supported coffee mornings allow SARSAS to continue to support long-term women with skills, techniques that help them to continue to explore particular issues, tackle isolation and provide a broader support network for women across Somerset and Avon. These groups could be run by experienced or trained volunteers, which would help with its long-term sustainability. Similar groups of this nature are run at North London Rape Crisis and Manchester Rape Crisis, so if there was a plan to develop these, recommend that SARSAS meets with them to design a group of supportive groups.

Some of SARSAS staff highlighted a need for some service users who identify as transgender, lesbian or bisexual to have a separate support group, to support their different needs. If this was a possibility, North London Rape Crisis also offer this and would be happy to discuss how this group is run in more detail.

Lastly, a drop in group could be developed to support women who may need one off immediate emotional support or to support women with complex needs. This allows women to speak to trained counselors without a waiting list or on the waiting list for other groups. This has also been developed by North London Rape Crisis and would be happy to discuss the development of this group.

6.2 Assessment

Recommendation Two: Develop a New Rigorous Assessment Procedure to incorporate the new group work on offer

If these three stages of group work were developed by SARSAS, a new assessment procedure will also have to be developed. Throughout the literature, and feedback form organisations, all stressed that a rigorous assessment procedure was key to successful and effective group work. Indeed, it would also be beneficial for frequent re-assessments after each group stage, to best assess whether the service user is suitable for the next stage, and to assign to each group leader or facilitator to then re-assess for each group. Whilst this may seem to be time-consuming and take up resources and capacity, it has been stressed constantly throughout the literature and experienced consultants how crucial assessments are, and the risk associated to groups can be high. Groups

can be highly traumatizing, so individuals need to be equipped with the skills and tools to cope with each group, so time and money spent in ensuring a rigorous assessment is key.

Recommendation Three: Identify inclusion / exclusion criteria for participation

This has been common across studies within the literature review and within the feedback from organisations. The inclusion criteria used in the studies and across organisations varies widely, although there are some common features whereas exclusion criteria was much more consistent. Most studies and organisations did not want women to attend group work if they were using harmful substances or were suicidal, as it compromises the safety of themselves and the other women attending the group. (Kessler, White, & Nelson, 2003) Currently, the Bath group offers a greater degree of flexibility over this matter, and some of the other organisations that were interviewed carefully consider each individual's needs, as well as in consideration of others and the overall wellbeing of the group. It is recommended to introduce guidelines around mental health issues, and clinical supervision for group facilitators to moderate risk.

Attendance needs to be stressed at assessment stage, as both arriving on time, and turning up is essential for improved effectiveness. Making this clear at assessment stage should also reduce the drop out rate. Similarly, women should only be accepted onto group work if they self-refer rather than are referred by another organisation. This will ensure that they are committed to attending the groups.

It is also important at assessment to think about the balance of group members, to ensure representation across different ages, classes, cultures and backgrounds. Whilst this may not be possible, it is important to ensure that women do not feel isolated during the group so individual needs need to be considered at assessment stage. Some organisations organized separate groups for older women, as the needs of older survivors can differ to those of young women, whilst other organisations thought that a good variety of ages was key to increased understanding of others. As a starting point, it would be sensible to have a diverse age group, but consider the differing needs of women of different ages in the evaluation, and should this become problematic, re-assess this at a later stage.

Meekums (2000) has developed a useful checklist for pre-assessment which is recommended to be considered when re-developing the current assessment procedure:

1. Problems with English
2. Relationship of survivor to abuser, nature of abuse, and mental health outcomes

3. Level of disclosure
4. Issues need to be addressed
5. Levels of support available
6. Indication of motivation
7. Problems with childcare
8. Risks of treatment
9. Level of dissociation
10. Special considerations, for example, ethnicity or mobility

6.3 Boundaries and Safeguarding

Recommendation Four: Develop group work guidelines to inform participants

Developing clear boundaries is key to an effective group, and therefore it is imperative to mitigate the concerns highlighted in the service user feedback (which included fear of not being believed, fear of being judged, fear of not being accepted, confidentiality, opening up in front of people).

Ensuring stability even at assessment stage is critical, so a set of guidelines introducing them to group work, with information such as duration, frequency and expectations around attendance should be developed, as this will maintain their sense of safety and manage their expectations of group work and of SARSAS.

It is important to also ensure sufficient time is spent discussing boundaries and guidelines to ensure that risk is mitigated and will allow for fewer dropout rates and more effective group work.

6.4 Facilitation and Leadership

Recommendation Five: Create a recruitment strategy for the hiring of effective group facilitators

Hiring good facilitators are also essential to ensuring effective group work. Burrowes highlights the importance of the clinical skill and experience of therapists facilitating the group. (Burrowes, The courage to be me. Evaluating group therapy with survivors of rape and sexual abuse, 2013) Feedback from organisations indicate that direct group work experience was the most important skill to consider alongside:

- Breadth and depth of knowledge
- Ability to hold the space
- Flexibility
- Good memory
- Sense of humour
- Confidence
- Creativity
- Approachable

- Non-judgmental

It is recommended that facilitation is shared, so that individual facilitators are not too overwhelmed, and can complement each other's skills and attributes, with clear mutual shared leadership, being aware not to replay power dynamics of dominance and subordination.

It is also recommended to use a variety of facilitators from different cultural backgrounds and classes to reflect the diversity of the group.

6.5 Evaluation

Recommendation Six: Evaluate the group work using sound measurement procedures

It has been highlighted in the literature that there are few studies which are adequately evaluated to measure effectiveness, meaning that the many of the conclusions drawn in this report should be viewed with an err of caution.

Yet, by using established, reliable and valid assessment tools should be used to measure change and produce strong evidence of the successes and failures of the group work that SARSAS will offer, so that they can continuously improve their services and use their work to help and inform other organisations that specialize in group therapy.

Often academic studies use biomedical outcomes as evidence of effectiveness. Den Herder and Redner (1991) in (Meekums, 2000) have found that decreases in medication and self-harming rates was a useful way of evaluating treatment. Studies have frequently mentioned the Trauma Symptom Checklist, Symptom Checklist, Beck Depression Inventory and other measures of self-esteem. (Kessler, White, & Nelson, 2003) This should be considered alongside personal outcomes as well has behavioural change.

In order to increase effectiveness, having a control group is also important. This can easily be done by using current waiting lists for group programmes, so you can directly compare each group. By using pre-designed questionnaires before and after each course of group work, you can measure change and effectiveness of your programme.

It is also important to show that change is sustainable and therefore recommend that follow-up assessments should be utilized. Many academic studies have a follow up component to their study after six months from completion of group treatment. Many organisations used evaluation told at the end of treatment but little follow up at six month of twelve-month mark. It is key to see if participants have maintained the improvements that they achieved from their group work.

6.6 Other Points for Consideration

Care needs to be taken into practicalities of groups, including the venue, location, times of group settings and accessibility needs.

Recommendation Seven: Carefully choose an appropriate venue

The venue needs to be an accessible large space to suit the size of each group, with access to a kitchen to provide refreshments, accessible toilets and a potential break out space. The temperature of the Church room in the Bath group highlights the importance of creating a safe, welcoming and comfortable space to be able to fully participate in the group work. Creating a space that is therefore free of interruption is equally important, so considering the times that it will be in use, for example when there may be cleaners, caretakers or other users of the building using the venues' facilities.

Recommendation Eight: Times & Location of groups need to consider participants' needs

Whilst you have to bear in mind the times in which the venue is in use, you also have to consider the times in which participants can attend. Some organisations have one daytime session and one evening session that allows for working women to attend. Ensuring the venue, car park is well lit is also an important requirement. The daytime session should be during school hours to make it accessible to mothers also.

The location of the venue needs to be accessible via public transport. Considering that SARSAS' work covers the geographical areas of Somerset and Avon, care needs to be taken in providing groups in response to locational need – for example, prioritizing areas with high waiting lists. Currently, according to SARSAS' most recent waiting lists, Bath and Bristol have the largest number of service users that are waiting for counseling. These could be supported through the creation of psychoeducational groups whilst they await counseling. In addition, those awaiting structured support could be assigned a stage two support group. Care also needs to be taken to ensure that women outside of the Bristol / Bath locality are supported and there is not too much of a concentration on city services.

Another consideration is setting up a mentoring project to support clients who are travelling to Bristol and / or Bath for group services. The Southmead Project in North Bristol sees clients as far as Gloucester and Somerset who reported that many clients have anxiety issues using public transport, which does have an impact on retention rates. They reported a need for a mentoring project to support service users with help attending meetings by using volunteers to help them use public transport. This is something to consider at evaluation stage to assess reasons for any potential drop-outs.

Recommendation Nine: Ensure that SARSAS support women with Accessibility Needs

Barriers for women attending counseling and / or group work include when they are carers for children or parents, and therefore, considering supporting women with childcare needs or an onsite crèche could be extremely beneficial. Whilst this can be an additional cost, SARSAS could consider the most cost effective way of doing this. Single Parent Action Network based in Easton, Bristol, will provide crèche workers on a local basis, and there is a consideration to refund the cost of childminders or care workers should women require this. A decision would need to be made on a group-by-group basis once the facilitator has a clear understanding of childcare needs. It is imperative that this is asked at assessment stage.

Cost can sometimes be an important factor in assessing whether an individual can actually attend support work. Some organisations, for example, Bristol Drugs Project, reimburse bus fares for women that attend their women's mornings. It seems sensible that participants are income assessed and transportation costs are reimbursed to those on a low wage or on income support. Further, any groups that SARSAS develops in stage three could be subject to a small fee to help cover the costs of attending. Service users of the Bath group expressed an interest in continuing group work and would be happy to pay a nominal fee (which could be income assessed). This is also worthy of consideration, to help make the groups sustainable.

Recommendation Ten: Ensure that any SARSAS group work has supervision

To offer the best possible service to participants, but also the best support for facilitators, ensure that they are adequately supervised, by ensuring regular support with a trained clinical supervisor. This should not be optional, as it is essential for facilitators to debrief, discuss risks and concerns with a trained clinical supervisor.

7. Personal Reflection

"What treatment, by whom, is most effective for this individual, with that specific problem, and under which set of circumstances?" Paul (1967) in (Kessler, White, & Nelson, 2003)

While there is sufficient evidence that group treatment is effective, which type of treatment and its various components contributes to successful results is more unknown and the recommendations in this report may change after evaluations have been completed on further groups that SARSAS offer. The majority of organisations that were interviewed all had

improved their groups over time, based on service user feedback and evaluative reports, so whilst the recommendations given are appropriate currently, this may change as service user needs change. The stronger the assessment and evaluation processes, the easier it will be to efficiently assess effectiveness under different set of circumstances. Should SARSAS be applying for additional funding for group work, they should include costs for developing and evaluating their groups as well as the actual cost of groups.

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Appendices

One – Organisation Questionnaire

1. What group work is currently offered?
2. What are the characteristics of the group?
3. What is the criteria for membership?
4. What guidelines do you have?
5. What is your assessment and evaluation procedure?
6. What has been successful about group session?
7. What problems have you encountered?
8. What would you do differently next time?
9. What are the main risks identified with group work?
10. Have you encountered any class, ethnic or cultural barriers?

11. What are the pros and cons of this type of group therapy?

12. What makes a good facilitator? What 3 skills would you look for?

Two – Service User Questionnaires X2

Questionnaire for women who have received group work / therapy

1. Have you (at any point) taken part in group work / group therapy of some kind?

2. Could you please tell us a little bit of what brought you to SARSAS and what made you look to SARSAS for support?

3. Have you received prior individual therapy and what kind of therapy was this?

4. What kind of group therapy/group work did you attend? (e.g. Was it a support group, or therapeutically set?)

5. How was the group structured and facilitated?

6. Approximately how many group sessions have you attended over how long?

7. How long ago was your group therapy?

8. How satisfied were you with the quality of your group therapy experience? (Please tick and comment)

	Very Satisfied
	Satisfied
	Neither Satisfied or dissatisfied
	Dissatisfied
	Very dissatisfied

Any Comments?

9. Were you prepared for what would happen in the group therapy / group work?

10. What (if any) goals did you establish before joining group therapy / group work?

11. If you set goals, what progress did you make towards these goals during group therapy / group work?

12. How did you find the group counsellor or facilitator?

13. Do you think the group has been useful?

14. What did you like most about group therapy / group work?

15. What did you like least about group therapy / group work

16. What impact did the group therapy / work have on your overall well-being?

17. What would you say would be three important guidelines for women who want to attend groups?

18. How might the group be changed or improved?

19. What kind of group would you be interested in attending?

20. Would you recommend group therapy / work to a friend? And why!

21. Any additional comments!

Questionnaire for women who have not received group work / therapy

1. Have you (at any point) taken part in group work / group therapy of some kind? (if yes, please provide additional questionnaire)

2. Could you please tell us a little bit of what brought you to SARSAS and what made you look to SARSAS for support?

3. Have you received individual therapy and what kind of therapy was this?

4. Are you interested in joining group therapy / group work?

5. If yes, why are you interested in attending group work / group therapy?

6. If yes, what kind of group would you be interested in attending?

7. How frequently would you like to attend a group? For how long?

8. What knowledge (if any) do you have of what happens in group therapy / group work?

9. What would you want to achieve in group therapy / group work?

10. Do you have any concerns about attending group therapy / group work? If yes, what are your concerns?