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A SYSTEMIC REVIEW AND META-ANALYSIS OF PSYCHOEDUCATIONAL GROUPS
FOR THE TREATMENT OF PSYCHOPATHOLOGY RESULTING FROM CHILD SEXUAL
ABUSE

by

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ABSTRACT

A SYSTEMIC REVIEW AND META-ANALYSIS OF PSYCHOEDUCATIONAL GROUPS FOR THE TREATMENT OF PSYCHOPATHOLOGY RESULTING FROM CHILD SEXUAL ABUSE

Alexis Lynnette Wilkerson
Old Dominion University, 2020
Chair: Dr. Nina Brown

It is estimated that 16% of men and 26% of women have experienced child sexual abuse (CSA), and studies have shown a strong association with long-term psychosocial consequences. The use of psychoeducational groups with survivors of CSA has been found to produce favorable outcomes; however, no meta-analyses have been conducted on studies assessing the use of psychoeducational groups to treat victims of CSA. The purpose of this systematic review and random-effect meta-analysis was to examine the efficacy of psychoeducational groups for the treatment of psychopathology subsequent to child sexual abuse (CSA) by addressing the following research questions (1) Are psychoeducational groups effective in treating CSA? (2) What are the themes across studies used in the meta-analysis? and, (3) What psychoeducational group factors and topics emerged from the qualitative analysis? The aim of this study is to examine how effective psychoeducational groups were on reducing symptoms of anxiety, depression, dissociation, PTSD, and externalizing behaviors across a wide range of CSA survivors. A thematic analysis was completed to identify themes pertinent to the efficacy of the psychoeducational groups. Nine studies met the inclusion criteria and were included in the meta-analysis. The meta-analysis indicated that psychoeducational groups have a medium effect (Cohen's $d = 0.40$) on treating psychopathology individuals experience subsequent to CSA. Two themes emerged from the thematic analysis: group factors and group topics which are integral

parts of the group experience and were useful in balancing the didactic, experiential, and processing components of the psychoeducational groups.

Keywords: Psychoeducational groups, group treatment, child sexual abuse, systematic review, meta-analysis, thematic analysis

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This dissertation is dedicated with love to my mother Selena Everette, my father Lynn Wilkerson, and my sister, brother-in-law, and nephew, Tracina, Derek, and Derek Jr. Grimes. Their strength, resilience, and devotion are qualities I exemplified as a doctoral student and it is because of their support, encouragement, and existence that I successfully completed this program. To my unborn one who knows me from within, you will always remain a part of my narrative, I will never forget you. I also dedicate this dissertation to my Hicks and Wilkerson family. To my Lord and Savior, none of above would exist without you, Thank You!

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CHAPTER 1

INTRODUCTION

Chapter one provides an introduction to the current study by providing an overview of the problem, purpose, and rationale of the study. The research questions are presented along with a brief description of the research procedures and methodology. An overview of the theoretical foundations from which the research was designed and guided is detailed. Finally, this chapter provides an overview of the research method limitations followed by definitions of relevant terms and concepts that will be used throughout the study.

Problem Statement

According to the Center for Disease Control and Prevention (CDC) child sexual abuse (CSA) “involves pressuring or forcing a child to engage in sexual acts. It includes behaviors such as fondling, penetrating, and exposing a child to other sexual activities” (CDC, n.d., para.1). Based on data collected annually from child welfare agencies in every state by the Children’s Bureau of the U.S. Department of Health and Human Services (DHHS) through the National Child Abuse and Neglect Data System, 58,114 children were victims of sexual abuse in the United States in 2017, accounting for 8.6% of those reported for maltreatment (Child’s Bureau of the U.S. DHHS, 2019). It is estimated that approximately 16% of adult men and 26% of adult women have experienced CSA (Perez-Fuentes et al., 2013) and studies have shown a strong association with long-term mental health and social consequences.

Anxiety disorders are frequently experienced by those with a history of CSA (Devlin, et al., 2019; Ehring, et al., 2014). CSA is also linked to low self-worth, high-risk behaviors, and suicidality (Perez-Fuentes, et al., 2013). Individuals who have experienced CSA are at a greater risk for substance abuse, sexual dysfunction, depression, and specific phobias (Bornefeld-

Ettmann, et al., 2018; Devlin, et al., 2019; Perez-Fuentes, et al., 2013). The need, therefore, exists to continue research on psychopathological manifestations that arise among survivors of child sexual abuse.

Common Outcomes of Child Sexual Abuse

Survivors of CSA can experience a series of common adverse outcomes including posttraumatic stress disorder (PTSD) and externally-focused behavioral symptoms, such as aggression and hyperactivity (Trask et al., 2011). While other factors, such as family dysfunction and socioeconomic deprivation, may be confounding and exacerbating adverse outcomes for studies, some researchers have controlled such confounding variables and still found that the effects of CSA contribute to the progression of mental health and interpersonal problems compared to other forms of maltreatment (Fergusson et al., 2008).

Common Treatment for Child Sexual Abuse

Empirically supported treatment frequently used to treat survivors of CSA include cognitive behavioral therapies (CBT), Eye Movement Desensitization and Reprocessing (EMDR), and psychoanalytic/psychodynamic psychotherapy and may involve various formats: individual, group, or e-therapy. CBT combines cognitive and behavioral techniques, EMDR combines the repetitive, systematic eye movement and repeated recounting of the traumatic event (Wilens et al., 2017). Psychodynamic psychotherapy involves the use of techniques that taps into the unconscious in an effort to discover patterns of mental and emotional processing that are manifested in behaviors (Parker & Turner, 2014). Further, some approaches to treating adverse outcomes of CSA involve the use of manualized protocols such as prolonged exposure therapy (PE). The purpose of PE is to aid in clients' healthy life reengagement by desensitizing

clients (to a certain extent) to the traumatic experience by utilizing psychoeducation, breathing training, imaginal and in vivo exposure (Wilén et al., 2017).

Researchers have focused on the use of psychotherapy for the treatment of CSA and moderating effects of treatment, such as duration of treatment, that may strengthen the effects of psychotherapy for the treatment of psychopathological outcomes of CSA (Trask et al., 2011).

However, research inquiries have yet to systematically examine the use of psychoeducation groups in the treatment of psychopathological manifestations resulting from CSA.

Psychoeducational groups are broadly defined as groups that have a significant educational component *in addition* to the psychological component (Brown, 2011). They differ from other forms of treatment in that the focus is on education regarding their diagnoses/complaints and optimal management of mental health diagnoses/complications and to process emotions that have been activated in the group (Brown, 2018).

Purpose of the Study

The purpose of this study is to conduct a systematic review and meta-analysis of studies assessing the efficacy of psychoeducational groups for the treatment of psychopathology associated with CSA in children, adolescents, and adults. Psychological interventions have been found to help ameliorate the effects of CSA trauma (Hanson & Wallis, 2018; Pérez-Fuentes et al., 2013; Skowron & Reinemann, 2005). Treatment approaches have included trauma-focused cognitive behavioral therapy (Deblinger et al., 2011) strengths-based therapy (Walker-Williams & Fouché, 2017), EMDR (Chen et al., 2018), family therapy (Blumer et al., 2012), and psychoeducation (American Association for Marriage and Family Therapy [AAMFT], n.d.; Devlin, et. al., 2019). Some of these interventions are used in individual and/or group therapy formats. Psychoeducational groups can help survivors of CSA learn to break dysfunctional

family and interpersonal patterns and learn healthier ways in which to interact (AAMFT, n.d.). Psychoeducational groups may also focus on enhancing social support, increasing awareness of resources, decreasing trauma symptoms, and increasing resilience (Domhardt, Munzer, Fegert & Goldbeck, 2015; Roe-Sepowitz, Pate, Bedard & Greenwald, 2009). Equally important to address social consequences resulting from CSA, is addressing emotional consequences. Combining the cognitive component of psychoeducational groups with the interpersonal interactions that occur provides leeway for group members to process emotional reactions and verbal responses that are activated by disclosed shared interpersonal trauma experiences. The results show that psychoeducational groups do contribute to the positive outcomes, but it is not clear what group related variables contribute. This study will use the findings across a variety of studies meeting a set of inclusion criteria to identify psychoeducational group variables that aid the efficacy of psychoeducational groups for this population.

An initial search of seven databases (google scholar, PubMed, PsychArticles, PsychInfo, Child Development & Adolescent Studies, Science Citation, and Medline) for studies addressing the use of psychoeducational groups with survivors of CSA indicated that this approach to treatment is utilized with favorable outcomes. This systematic review and meta-analysis aims are to determine the variables that contribute to the efficacy of using psychoeducational groups in the treatment of psychopathology resulting from CSA.

Rationale of the Study

The current pool of literature has meta-analyses on CSA prevention programs (Davis & Gidycz, 2000), the treatment effects of common treatment (e.g., individual, group) without a focus on psychoeducational groups (Trask et al., 2011), and parent-involved treatment for CSA (Corcoran & Pillai, (2008). No meta-analyses have been conducted on studies assessing the use

of psychoeducational groups to treat survivors of CSA. This systematic review and meta-analysis used studies conducted since 2000 to determine the efficacy of psychoeducational groups used for the treatment of the psychopathological manifestations that arise among survivors of CSA.

Wells and Littell's (2008) assertion that there is a dire need "for the identification of evidence-based practices and policies to promote prosocial development and well-being to ameliorate widespread psychosocial and cultural problems..."(p.52), supports the need for this systematic review and meta-analysis. Specifically, the systematic review involves the comprehensive process of selecting, evaluating, and synthesizing selected studies on the use of psychoeducational groups to treat the adverse outcomes of CSA. The meta-analysis involves statistically synthesizing the effect sizes of selected studies to a single, quantitative summary effect size of using psychoeducational groups to treat the adverse outcomes of CSA (Borenstein et al., 2009).

The findings of this study will contribute to the helping profession by deriving conclusions regarding the utility of psychoeducational groups as an intervention for survivors of CSA. Further, the findings of this study may contribute to the development and/or enhancement of psychoeducational group protocols by centering on the variables that may contribute to positive outcomes.

Research Questions

This systemic review and meta-analysis aim to address the following research questions:

Research question 1 – Are psychoeducational groups effective in treating CSA?

Research question 2 – What are the themes across studies used in the meta-analysis?

Research question 3 – What psychoeducational group factors and topics emerged from the qualitative analysis?

Research Design

Systematic Review

The broad stages of a systematic review involve (1) determining research question(s), (2) determining inclusion and exclusion criteria, (3) developing search strategies and exploring studies, (4) selecting studies based on the inclusion and exclusion criteria, (5) extracting data, (6) conducting a critical appraisal of selected studies.

Meta-analysis

The meta-analysis broadly involves (1) statistically synthesizing data and interpreting results, and (9) disseminating the findings (Uman, 2011). The Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA – P) was utilized to facilitate the systematic review and a random-effects model meta-analysis. Card (2016) asserted,

that many areas of social science research are in less need of further research than they are in need of organization of the existing research. A second obstacle is that studies are rarely exact replications of one another, but instead commonly use slightly different methods, measures, and/or samples. This imperfect replication makes it difficult (1) to separate meaningful differences in results from expectable sampling fluctuations, and (2) if there are meaningful differences in results across studies, to determine which of the several differences in studies account for the differences in results (p. 4).

Thus, systemic reviews and meta-analysis are growing in social science research as such methodological and statistical approach provide solutions to the aforementioned obstacles (Card, 2016) and aid in discovering the effect of treatment, for example, across studies and provide avenues to new directions in various social science fields (Davis et al., 2014). Further, in 1976, Gene Glass asserted that research scholars are utilizing meta-analysis out of necessity, he coined

the term meta-analysis and defined it as “the statistical analysis of a large collection of analysis results from individual studies for the purpose of integrating the findings” (p.3). Surely, as research targeting the treatment of CSA continues to expand, utilizing a meta-analysis is necessary to combine psychoeducational group outcome research regarding its use to address the adverse manifestation of CSA. In other words, “the goal of [this meta-analysis] is to understand the results of any study in the context of all the other studies [included in the meta-analysis]” (Borenstein et al., 2009, p. 9).

Theoretical and Conceptual Framework

There are several theories (Family Systems Theory, Attachment Theory, and Feminist Theory) that address the *who* and *why* of CSA (Bolen, 2002). However, the Traumagenic Dynamic Model (TDM) was used as the framework for this study on treating outcomes of CSA as this model expands the identification and impacts of the adverse outcomes of CSA.

Traumagenic Dynamics Model (TDM)

Finkelhor and Browne (1985) developed TDM as a comprehensive model to systematically analyze and identify the traumatic outcomes of CSA. TDM consists of four traumagenic dynamics of CSA: traumatic sexualization, betrayal, powerlessness, and stigmatization. As defined by Finkelhor and Browne (1985), a traumagenic dynamic is “an experience that alters a child’s cognitive or emotional orientation to the world and causes trauma by distorting the child’s self-concept, worldview, or affective capacities” (p. 354). Research has shown that the altered cognitions and other adverse outcomes can extend beyond childhood and exist during adulthood (Schoedl et al., 2010).

Traumatic Sexualization

Traumatic sexualization encompasses the CSA survivor's development of sexuality. More specifically, it is the "developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse" (Finkelhor & Browne, 1985, p. 532). Finkelhor and Browne also asserted that survivors of CSA may begin to engage in risky sexual behaviors with multiple partners as their potential for healthy sexual functioning was disturbed by the sexual trauma. Of the psychological impacts, Van der Merwe (2009) asserts that a survivor of CSA may present with sexual and gender identity crises. Regarding behavior manifestations, a survivor may view affection solely through the lens of sexuality in that a simple touch on the shoulder may be perceived as sexual or the survivor may engage in inappropriate touching of others (Van der Merwe, 2009).

Betrayal

Betrayal refers to a sense of loss in that one was exploited by the perpetrator (Van der Merwe, 2009). Betrayal also refers to the CSA survivor's recognition that 'the trusted' one, for example, has caused harm through acts, such as manipulation. This act of manipulation does not exclude family members as experiences of CSA may be intrafamilial and/or extrafamilial. Should a survivor of CSA disclose the sexual abuse to a relative or friend, Finkelhor and Browne (1985) assert that the survivor may feel betrayed if that relative or friend minimizes the reported experience of sexual abuse. Further, after reporting sexual abuse, they can receive unwanted reactions, such as being told to keep silent or discouraged to take legal actions. The psychological impacts may include suppressed longing and emotional numbness, withdrawing from society and/or atypical attachment (Van der Merwe, 2009).

Powerlessness

There is a level of powerlessness that occurs when children's territory, such as their body space, are invaded against their will (Finkelhor & Browne, 1985). Power is defined as a "possession of control, authority, or influence over other" (Power, n.d.). Having a perceived lack of control of one's sexual interactions (e.g., inability to say no) may lead to revictimization. Revictimization may occur as a result of children perceiving themselves as unable to exert their will or to protect themselves. The psychological impact may include an impaired investment in control, feeling helpless, and feeling trapped. The behavioral manifestations may include depression, delinquency, phobias, regression, suicidal ideations, suicidal attempts, and sleep disturbances (Van der Merwe, 2009).

Stigmatization

The negative responses to CSA may include feelings of guilt and shame which may lead CSA survivors into internalizing multifaceted beliefs and feelings about themselves, such as their bodies and self-worth. Survivors of CSA may "feel isolated and may gravitate to various stigmatized levels of society" (Finkelhor & Browne, 1985, p. 535). The psychological impact may involve having a tainted sense of self resulting in low self-esteem leading to avoidance behaviors (Van der Merwe, 2009). Further, the behavioral manifestation may include exhibiting aggression, lowering of morals, and sexual disorders.

The psychological injuries covered by the traumagenic dynamics explain the multilateral psychological and sexual outcomes of CSA. Beyond the traumagenic dynamics, TDM explains how CSA is not an isolated event, but rather a process conducive to extended traumatization. Cantón-Cortés et al. (2012) assert that although TDM has influenced the field of CSA, few research inquiries have focused on the empirical evidence of the model. Thus, the authors

conducted a study to examine the outcomes of CSA while exploring the role of the traumagenic dynamics in the psychological adjustment of adult survivors of CSA. Of a sample of 182 students (23 males, 160 females) between the ages of 18 to 50 years who reported experiencing sexual abuse before the age of 13 and a matched-comparison group of 182 non-abused participants. Sexual abuse in this study was defined as exhibitionism, touching, oral sex, and penetration. In the CSA group, nearly 41% reported extrafamilial abuse, while nearly 59% reported intrafamilial abuse. A series of questionnaires and scales to measure CSA and related information (i.e., type of act, relationship to abuser, thoughts, and feelings as a response to CSA, anxiety, depression, and self-esteem) were used. Analyses using Pearson correlation between the traumagenic dynamics and four adjustment variables (state anxiety, trait anxiety, depression, and self-esteem) found a significant relationship between each traumagenic dynamic and each adjustment variable for the experimental groups. Specifically, a significant correlation was found between state anxiety and betrayal ($r = .31, p < .001$) stigmatization ($r = .36, p < .001$), powerlessness ($r = .38, p < .001$) and traumatic sexualization ($r = .30, p < .001$). Trait anxiety was significant correlated with betrayal ($r = .48, p < .001$) stigmatization ($r = .48, p < .001$), powerlessness ($r = .52, p < .001$) and traumatic sexualization ($r = .3, p < .001$). Depression was significantly correlated with betrayal ($r = .39, p < .001$) stigmatization ($r = .42, p < .001$), powerlessness ($r = .40, p < .001$) and traumatic sexualization ($r = .37, p < .001$). Finally self-esteem was significant correlated with betrayal ($r = -.42, p < .001$) stigmatization ($r = -.51, p < .001$), powerlessness ($r = -.45, p < .001$) and traumatic sexualization ($r = -.41, p < .001$). These findings strongly support and confirm the traumagenic dynamics. Van der Merwe (2009) in the conclusions asserts that possible intervention to address traumagenic dynamics during treatment of CSA includes psychoeducation.

Limitations

There are limitations to systematic reviews and meta-analyses. Meta-analyses do not correct problems or limitations that were presented in the design and conduction of studies included in the meta-analysis. Second, careful attention must be placed on the selection of studies such that combining rigorous studies with imprecise research studies may diminish the integrity of the comprehensive meta-analysis and result in misleading conclusions (Garg et al., 2008). Third, the effect size of the selected articles may vary scientifically, if such is true, one must compute and consider the proportion of the variance to minimize producing misleading conclusions (Borenstein et al., 2009).

Terminology

There are several terms and key concepts used throughout this study. The following are definitions of the terms and key concepts to rationalize and provide an understanding of the intended meaning.

Child sexual abuse –This study uses the definition of CSA as the types of sexually abusive acts towards children, including sexual assault, rape, incest, and the commercial sexual exploitation of children. (Murray et al., 2014). No matter the difference in age or level of power between the child and perpetrator (World Health Organization, 2012), child sexual abuse in this study refers to sexual abuse of someone under the age of 18.

Psychoeducational Groups – Psychoeducational groups offer a “balance of cognitive and affective material with both assuming equal importance” (Brown, 2018, p.1). These are also groups that offer members opportunities to become informed about a concern, issue, or problem. Psychoeducational groups provide a safe environment for the dissemination of information

aiding in, for example, self-understanding, alleviation of blame, exploration of coping skills, and healing (Brown, 2018).

Psychological manifestations – For the purpose of this study, psychological manifestations are defined as the signs and symptoms of mental health, behavioral, and/or substance use diagnoses that may present as acute and progress to chronic. Examples of signs and symptoms include anxiety, hopelessness, self-destructive behaviors, insomnia, hypervigilance, socially withdrawn, delinquency, flashbacks, and sexual or non-sexual intrusive thoughts. (Amado, Arce, & Herraizm 2015; Paolucci et al., 2001).

Psychopathology –Psychopathology is the significant restriction in the ability of an individual to engage in deliberate action and, equivalently, to participate in available social practices relative to time, the individual's culture, and situation (Bergner, 1997; Ossorio, 1985).

Psychotherapy – The broad psychological interventions for a multitude of psychological, behavioral, and somatic problems, symptoms, and disorders and thus rightfully considered as the main approach in mental and somatic health care management (Goldfried, 2013; Locher et al., 2019; Prince et al., 2007).

CHAPTER 2

REVIEW OF LITERATURE

Chapter 2 provides a review of the existing body of literature related to CSA in support of the research problem and purpose. This chapter outlines the prevalence of CSA and provides an overview of CSA within a historical context. Further, this chapter addresses the short and long-term adverse outcomes resulting from CSA as well as common treatment approaches. Literature that focuses on the use of psychoeducational groups or groups with psychoeducational components for the treatment of psychopathology resulting from CSA will be presented and the gap in literature leading to this research study. Finally, this chapter ends with a review of articles found from the initial review of studies to include in the systematic review and the meta-analysis.

Sexual Abuse: A Form of Child Maltreatment

Child maltreatment is distinctly defined by the World Health Organization (WHO) as

the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (World Health Organization, n.d.).

Child maltreatment is a global issue having chronic lifelong consequences (American Society for the Positive Care of Children, 2020). In the United States, it is estimated that 700,000 children experience child maltreatment a year with the majority experiencing sexual abuse (National Child Abuse Statistics from NCA, 2020). Sexual abuse as a distinct form of maltreatment is defined as the employment, use, persuasion, inducement, enticement, or coercion of any [one] to engage in or assist any other person to engage in any sexually explicit conduct or simulation of

such conduct to produce a depiction of such conduct (U.S. Department of Justice, 2020). From the definition provided, *sexually explicit conduct* refers to the “actual or simulated: sexual intercourse, bestiality, masturbation, sadistic or masochistic abuse, or lascivious exhibition of the genitals or pubic area” (U.S. Department of Justice, 2020). Synonymous terms such as *sexual violence* take into account unwanted sexual attention during dating or domestic situations. The World Health Organization (2012) refers to sexual violence as

acts that range from verbal harassment to forced penetration, and an array of types of coercion, from social pressure and intimidation to physical force” that include, but is not limited to, rape within marriage or dating relationships; rape by strangers or acquaintances; unwanted sexual advances or sexual harassment (at school, work, etc.); systematic rape, sexual slavery and other forms of violence, which are particularly common in armed conflicts (e.g. forced impregnation); sexual abuse of mentally or physically disabled people; rape and sexual abuse of children; and ‘customary’ forms of sexual violence, such as forced marriage or cohabitation and wife inheritance (p.1).

When experienced with other forms of maltreatment, such as physical abuse, the adverse outcomes of CSA become more complex. For instance, Bonomi et al. (2007) found that experiencing sexual and physical abuse simultaneously may result in a surge of trauma manifestations (e.g., drug use, suicidality, physiological symptoms). Hulme and Agrawal (2004) postulate that women with a history of childhood emotional or physical abuse are at a higher risk of experiencing CSA with force or threat. As one can see, sexual abuse is a multifaced phenomenon. As Hulme and Agrawal (2004) explained, CSA can be described by (1) the relationship between the victim and abuser, (2) invasiveness, (3) duration and frequency, (4)

level of use of force/threat, (5) age of victim and abuser (including age difference, and (6) the number of abusers.

Child Sexual Abuse

Child sexual abuse as described in Murray et al. (2014), “encompasses many types of sexually abusive acts towards children, including sexual assault, rape, incest, and the commercial sexual exploitation of children” (p. 1). Castro et al. (2019) described CSA as “an activity aimed at providing sexual pleasure, stimulation, or sexual gratification to an adult who uses a minor for this purpose, taking advantage of the situation of superiority” (p. 1). Some literature highlight the unique interpersonal characteristics associated with CSA and its effect on development, such as boundary invasion, betrayal, and/or secrecy, all of which are *not* linked with other forms of maltreatment (Noll, 2008; Trask et al., 2011).

Prevalence of Child Sexual Abuse

Child sexual abuse is a global distress. Pereda et al. (2009) conducted a meta-analysis on the prevalence of CSA. From 65 articles that covered 22 countries, 7.9 percent of men and 19.7 percent of women experience CSA. Within the United States, 25.3 percent of women experienced CSA, while 7.5 percent of males experienced CSA. Likewise, Barth et al. (2013) conducted a systematic review and meta-analysis on the prevalence of CSA worldwide and examined 55 studies from 24 countries. The authors focused on four types of CSA: non-contact sexual abuse (e.g., indecent exposure), contact abuse, forced intercourse, and mixed sexual abuse. The results indicated that the prevalence of CSA based on the four types of CSA ranged from 0 to 69 percent for girls and 0 to 47 percent for boys. The most adverse outcomes of CSA are fatalities and in the year 2017, 2.2% of cases of fatalities resulting from child maltreatment were from sexual abuse (Child Welfare Information Gateway, 2019a).

Child Sexual Abuse in Historical Context

Bolen (2002) so clearly states, “Child sexual abuse is a social construction. It is surely a reality—a tragic reality—but the definition and scope of child sexual abuse, and its conceptualization, are socially constructed phenomena” (p. 11). Therefore, to fully comprehend CSA, one must consider the historical, sociocultural context from which CSA evolved from an uncompounded social phenomenon to a complex, problematized social phenomenon. In the 19th century, a family French forensic physician, Ambroise Tardieu, examined multiple forms of child maltreatment. Specific to CSA, he examined 934 cases of male and female survivors (Labbe, 2005). Tardieu’s scientific rigor was different from that of other forensic studies in that he was the first physician to concede the high prevalence of child maltreatment by parents (Labbe, 2005). Yet, it was not until the mid-1800s when people other than the survivors of CSA recognized and acknowledged the act of CSA (Bolen, 2002). Nonetheless, though Tardieu detailed more of the physiological outcomes of CSA than psychological outcomes, his work denounced the many historical myths about CSA, such as it being a cure for sexual diseases and, attested to the numerous adverse outcomes such as hysteria and death by suicide (Labbe, 2005).

Towards the end of the 20th century, CSA evolved to a specialty subdiscipline and monographic work began between the 1970s and 1980s (Smaal, 2013). It was during this time that advanced theories of CSA erupted in an effort to discover *what*, *why*, and *who* (Bolen, 2002). What is uniquely known as the “backlash” period, during the 1990s, some of the inadequate, misleading research from 1980s induced debates and controversies regarding the underrepresentation of women as offenders of CSA, spiteful behaviors of women charging ex-parents with CSA of their children, and even the accusations of clinicians using their power to direct children to disclose, often perceived as false allegations. It was not until the voice of some

survivors of CSA and public discussions when more accurate depictions and conceptualization of CSA emerged. During these discussions, women found that their experiences of CSA paralleled; however, men's voices continued to be ignored (Whittier, 2009). Ambroise Tardieu (1857) statement, "It is sad to realize that kinship is not a barrier to these culpable acts but on the contrary makes it easier. Fathers abuse their daughters, brothers abuse their sisters" (p. 51) demonstrates the perception of many during that era that the majority forms of CSA, such as incest, were a result of male domination, ignoring the males' experience of CSA. Activism and research advances gave space for male survivors' voices to be heard and there continue to be a growing body of research specific to male experiences of CSA. However, today there still exists gender socialization of males to uphold masculinity norms resulting in their choice of silence (Payne et al., 2014).

Theories of Child Sexual Abuse

Several theories that aim to provide a base knowledge of the *who* and *why* regarding CSA (Bolen, 2002). Of the many theories, family systems theory, attachment theory, and feminist theory are the most popular used in scholarly work.

Family Systems Theory

Label as the first formal theory of CSA, the family systems theory conceptualize CSA within a family context and explains how CSA impacts physiological and psychological health across one's lifespan (Bolen, 2002). In this case, CSA must be view within the context of a larger system as family systems theorists believe families/communities all contribute to the problem of CSA, emphasizing father-daughter incest (Karakurt & Silver, 2014), which is one of the major criticism of the family systems theory (Hodson & Skeen, 1987). Another major criticism is family systems theory is its removal of blame from the offender to the family systems (Bolen,

2002). From a family systems perspective, the dysfunction of the systems may result in children becoming impaired from inadequate learning of daily living skills (e.g., social and instructional skills). This type of inadequacy may increase the child's risk of CSA due to the child's lack of, for example, assertiveness or unmet attachment needs. In summary, dysfunctions in the family may contribute to CSA, and family systems may expedite or maintain psychopathology resulting from CSA and vice versa (Gold et al., 2004).

Attachment Theory

Attachment theory (Bowlby, 1988) is biologically based in that behaviors are view within the attachment between an attachment figure, typically a parent, and a child. Bowlby asserted that dyadic and reciprocal attachments between a child and the attachment figure serve two purposes: protection and regulation of negative emotions. Bowlby's work asserts that "When children have secure and healthy attachments with their attachment figures, they also have an expectation of others as trustworthy, while also recognizing that their needs will be met" (Bolen, 2002a, p. 103). In the same effect, attachment relationships that are not secure and healthy may result in children exhibiting avoidant or ambivalent behaviors. Concerning CSA, the attachment theory views the *who* as a child having insecure and unhealthy attachment relationships. That is, children who are insecurely attached to their attachment figure are at a higher risk of CSA. Depending on the child's response to the unsecured attachment, children who exhibit ambivalent behaviors may be at higher risk of CSA from a trusted one, while children who exhibit avoidant behaviors may be at a higher risk for CSA by a stranger (Bolen, 2002a).

Feminist Theory

From a feminist theory lens, CSA is a phenomenon in which unequal and gendered power relations are often played out (Bolen, 2002). Young (1993) explained that from a feminist

view, “sexual abuse is about power, and is one of the ways in which women are oppressed by patriarchy” (p. 102). However, one of the main criticism of the feminist theory is how some of the theory’s tenets perpetuates perceptions that feminism is defiant in acknowledging acts of female sex offending (Hovey, 2005). For instance, scholars discovered that the majority of feminist theory work focused on men often being offenders and less on the *why*. Gender socialization has led to the views that male dominance/power increases the likelihood of male sex offending and female’s nurturing role decreases the likelihood of female sex offending. However, Briere and Elliott (2003) found that 9% of the females and 39 % of the males who reported experiencing CSA also reported being sexually abused by at least one female, demonstrating women are capable of sexual offending. Consequently, research of CSA from a feminist theory expanded to argue that an underlying factor in CSA is the power dynamics between men and women, the *why* (Bolen, 2002).

Intrafamilial and Extrafamilial Child Sexual Abuse

Intrafamilial CSA refers to sexual abuse by family members, while extrafamilial CSA refers to sexual abuse by non-family members. It is known that perpetrators of extrafamilial CSA are often a person that the victim knows (e.g., schoolteacher, coach, friend of family, stranger). Intrafamilial CSA tends to occur when there is a substantial level of dysfunction within the family system. Specifically, Valle et al. (2018) assert that intrafamilial sexual abuse occurs when there is “a reversal of roles between parents and children and low family cohesion” (p.2). Intrafamilial [and extrafamilial] CSA are global social problems causing significant psychological and physiological issues (Seto et al., 2015). A study conducted by Hulme and Agrawal (2004) with 130 females with a mean age of 35 years old (*SD* 8.5) found that occurrences of penetration intrafamilial CSA with force were linked to significant poor health in

adulthood. While noncontact extrafamilial CSA without force impacted adult health less. The authors examined outcome differences from clusters of CSA ranging from one episode of noncontact intrafamilial or extrafamilial CSA without force to multiple episodes of penetration intrafamilial or extrafamilial CSA with force.

Outcomes of Child Sexual Abuse

Survivors of CSA may experience short and long-term outcomes. Horner (2010) purported that most children who experience sexual abuse will be “moderately to severely symptomatic at some point in their life” (p. 359). Of the many long-term outcomes (e.g., anxiety, depression, posttraumatic stress, psychosis, suicide attempts, substance misuse, HIV, sexual offend) presented from an umbrella review of existing meta-analyses studies of the outcomes of CSA, only substance misuse and posttraumatic stress disorder (PTSD) were found as significantly associated with CSA with “high quality assessment scores” (Hailes et al., 2019, p. 835). Studies have found that there is a correlation between CSA and risky sexual behaviors for girls and boys (Homma, Wang, Saewyc, & Kishor, 2012; Murray et al., 2014). In addition, research has suggested that CSA has led to adverse health outcomes (as cited in Murray et al., 2014). Also, further traumatic experiences may follow CSA such as continued sexual abuse and removal from the home, especially if Child Protective Service is involved. In addition to the intergenerational transmission of abuse or neglect resulting from CSA (Child Welfare Information Gateway, 2016), children of adult survivors of CSA experience higher adjustment complications when compared to children of women who have not experienced CSA (Roberts et al., 2004). Given the various types of sexually abusive acts towards children and numerous outcomes, researchers have sought to examine the efficacy of psychotherapeutic treatment in managing CSA. As cited and suggested in Hulme and Agrawal (2004), women who experienced

CSA are more likely to experience physical and psychosocial symptoms, depression, and more health care utilization when compared to women without a history of CSA. Men who have experienced CSA often struggle with identity confusion as they are often faced with the worldview of masculinity (Kia-Keating et al., 2009) and often suffer in silence (Sorsolia et al., 2008).

Cultural Considerations of Child Sexual Abuse

While there are universal outcomes of CSA no matter the gender, race, or ethnicity, there are cultural considerations to consider when conceptualizing the outcomes of CSA because cultural factors can influence the cognitive, behavioral, and emotional responses CSA survivors have. Payne et al. (2014) conducted a study on male survivors of CSA from three ethnic backgrounds: Blacks, Latinx, and non-Latinx Whites. The authors sought to examine qualitatively examine the psychological and behavioral outcomes of CSA of male survivors. Of various outcomes, the findings suggest significant differences. Black men either denied having adverse outcomes as adults or reported more issues with drug use and hypersexual behaviors. White men reported more adult experiences of isolation, low self-esteem, and loneliness, while Latino men reported more adult experiences of anger, hyper-vigilance, flashback, and communication issues. Compared to White men, Black and Latino men experience more feelings of guilt, shame, and sexual identity concerns. As for women, there is a higher prevalence of sexual abuse for cultures that uplift the sexual objectification of women (Kalra & Bhugra, 2013). Likewise, for some cultures, experiences of CSA from a known person are high. For instance, compared to non-Hispanics Whites and African Americans, Hispanic women are more likely to know and live with the perpetrator. Further, Hispanic females, compared to African Americans, are more likely to experience CSA from fathers/stepfathers. In regard to disclosing CSA,

Hispanic females wait longer to disclosure their experiences, (Fontes & Plummer, 2010) and African American girls are less afraid of disclosing CSA compared to their White counterparts (Kenny & McEachern, 2000). Regarding the emotional, behavioral, and cognitive responses to CSA, Asian-Americans are more likely to experience suicidal ideations, suicidal attempts, and completed suicide compared to Whites and African Americans, Hispanic females experience more symptoms of depression compared to African Americans, and non-White survivors experience more distortions of self-esteem and exhibit more externalizing behaviors compared to their White counterparts (as cited in Kenny & McEachern, 2000). While there are contradictions in existing literature regarding racial, ethnic, and cultural factors CSA, survivors' and victims' social and cultural context of the experience is the source of authentic cross-cultural understanding of CSA.

Treatment Modalities for Child Sexual Abuse

Treatment of CSA has included individual, group, and a combination of treatment modalities. As stated in Murry et al. (2014), PTSD is a common outcome of CSA; thus, most treatments involved the treatment of PTSD. Treatment has involved forms of CBT, narrative therapy, and EMDR. In addition, group treatment has involved animal-assisted therapy (Dietz, et al., 2012), affect-management (Wolfsdorf and Zlotnick, 2001), and art therapy (Pretorius and Pfeifer, 2010). Specifically, Dietz et al. (2012) evaluated the use of animal-assisted group therapy for the treatment of CSA. The research compared three groups: no dogs, dogs without stories, and dogs with stories. Results indicated groups with dogs, whether with or without stories, show a significant reduction in pretest and posttest scores of the Trauma Symptoms Checklist for Children (TSCC). While Wolfsdorf and Zlotnick (2001) randomly assigned females survivors to an affect-management group or a waitlist having controlled conditions,

Pretorius and Pfeifer (2010) utilized a quasi-experimental design with non-equivalent groups, having two experimental groups (art therapy group) and two control groups. The results of both studies indicate improvement in symptoms of PTSD, depression, and anxiety following experiences of CSA after the intervention.

Lev-Wiesel (2008) stated that individual therapy and family therapy are the two most used treatment modalities for survivors of CSA. He further explains that group therapy has been used “exclusively or in combination with individual therapy” (p. 667). Lev-Wiesel delineates that the use of TF-CBT has resulted in significant improvement for survivors. TF-CBT is the “strongest evidence base” treatment for child trauma and CSA (Olafson, 2011). A meta-analysis conducted by Silverman and colleagues (2008) indicates that researchers have found TF-CBT to be the most effective treatment that resulted in survivors showing significant improvements in outcomes, such as depression, shame, and symptoms of PTSD.

While there are several components of TF-CBT: psychoeducation, parenting skills, relaxation skills, affective regulation skills, cognitive coping skills, trauma narrative and cognitive reprocessing, in vivo mastery of trauma reminders, conjoint child-parent sessions, and enhancing safety and future developmental trajectory, all of the components involve psychoeducation in that facilitators provide education so clients can learn the skills to manage emotional and behavioral issues resulting from their exposure of trauma (Cohen & Mannarino, 2008). For this study, research inquiries that utilize TF-CBT as an intervention for the treatment of psychopathology resulting from CSA were included in the review and meta-analysis as TF-CBT has psychoeducational components.

CSA Treatment with Psychoeducational Groups

Treatment for CSA has involved psychoeducational groups. However, no meta-analyses have been conducted on studies assessing the use of psychoeducational groups to treat victims of CSA. From an initial search of relevant articles, the majority of studies that examine the effectiveness of psychoeducational groups for CSA included youth as participants. Kenny (2010) examined the impact of psychoeducational groups that focused on prevention for 202 male and female children and their parent(s) and found that the participants' knowledge of safety concepts and personal safety rules improved and sustained 3 months after the study was conducted. Cencen-Erogul and Hasirci (2013) examined the impact of psychoeducational groups in a school setting that focused on 36 fourth graders and found that the psychoeducational groups were effective in enhancing the participant knowledge of sexual abuse. Trowell et al. (2002) examined the impact of psychotherapy versus psychoeducational groups on psychopathological outcomes of CSA that focused on 71 diverse girls who either attended individual therapy (n = 35) or psychoeducational group therapy (n = 36). The results of this study indicated no difference between the results of individual sessions and psychoeducational groups, as both modalities resulted in a significant reduction in psychopathological symptoms.

A smaller percentage of articles focused on adults. Karatzias et al. (2014) examined the impact of psychoeducational intervention *Survive and Thrive* that focused on the management of mental health problems among male and female adult survivors of CSA (n = 37). The results indicated that the psychoeducational intervention "may be useful for stabilizing behavioral problems..."; however, concerning to psychopathology, the intervention resulted in "less favorable outcomes" when compared to previous research (p. 509-510). Additionally, Chin et al. (2014) study involved 37 HIV-positive women to examine the impact of psychoeducational

groups as a trauma intervention and found that the participants' trauma burden improved and sustained at a 6-month follow-up. Likewise, Wyatt et al. (2004) examine the effectiveness of psychoeducational groups for risk reduction among 147 HIV-positive women and presented favorable outcomes.

Psychoeducational Groups for Treatment of Child Sexual Abuse

An additional way in which articles address psychoeducational groups for treating CSA vary is with regard to their focus. Some are focused on prevention, while others focus on intervention/remediation. Kenny (2010) conducted a study that examined the effectiveness of a psychoeducational group aimed at enhancing families' knowledge of safety concepts and safety personal rules to prevent CSA. Rothman et al. (2019) examined the effectiveness of My Life My Choice, a prevention program consisting of psychoeducational groups aimed at preventing "at-disproportionate-risk" youth from sexual exploitation. The results of this study suggested that the psychoeducational program served well by reducing the risk of child sexual exploitation and enhancing conditions of the participants who were identified as at a disproportionate risk for child sexual exploitation.

Researchers have focused on examining psychoeducational groups as an intervention/remediation specifically for children with a history CSA that resulted in experiences of symptoms of PTSD and behavioral problems (Hébert and Tourigny, 2010; Tourigny et al., 2005), and other psychopathological outcomes (i.e., separation anxiety; Trowell et al., 2002). Women survivors of childhood sexual abuse may experience intense outcomes such as contracting HIV; thus, psychoeducational groups have been established as an intervention to manage trauma burdens related to HIV (Chin et al., 2014) and sexual risk reduction (Wyatt et al.,

2004). Likewise, psychoeducational groups have been utilized as a method to assist women to understand their symptoms and reframe trauma messages (Walker-Williams & Fouche, 2017).

Initial Search for Meta-Analysis Articles

The initial search of articles resulted in 3 quantitative articles meeting the inclusion criteria and 3 quantitative articles meeting inclusion. Efforts were made to contact the author(s) to solicit data regarding effect sizes. Of the 6 articles, 3 included children/adolescents as participants (Hérbert & Tourigny, 2010; Tourigny et al., 2005; Trowell et al., 2002) and 3 included adult participants (Chin et al., 2014; Karatzias et al., 2014, Wyatt et al., 2004). All but 1 of the articles from the initial review utilized a comparison or control group. There were no qualitative studies found during the initial review meeting the inclusion criteria; however, one study (Karatzias et al., 2014) utilized a mixed-method approach.

Quantitative Studies with Control Group

Of the studies having control groups, Wyatt et al. (2004) utilized a randomized clinical trial with participants being post-tested 3 months and 6 months after the intervention. The intervention, an integrated risk reduction intervention catered to women who are HIV positive with a history of CSA, consisted of 11 weekly sessions lasting 2.5 hours. The psychoeducational contents address were directly related to CSA and HIV statuses, such as sexual risk reduction and medication compliance. Participants included a diverse sample of 147 women ranging from the ages of 18 or older. The findings suggest that women who experience a higher severity of CSA reported a reduction in sexual risk. Chin et al. (2014) utilized a logistic regression analysis with post-intervention follow-ups at 3 and 6 months. The psychoeducational groups consisted of 11 weekly sessions, lasting 2.5 hours having the same focus on addressing CSA and HIV related issues. The sample consisted of 105 women identifying as African American, Latina, or

European Americans. The results of this study indicated that the psychoeducational group was effective in improving trauma burdens; however, these results were significant only for women with high trauma burdens which was measure by a composite variable that combined all types of abuse created by the authors.

Tourigny et al. (2005) targeted teenage girls (N = 42) and conducted a quasi-experiment with a control group. The psychoeducational group consisted of group discussions, lectures, testimonies, and collective exercise. The objective of the psychoeducational group (a) to reduce the negative and traumatic consequences of sexual abuse (b) to reduce social isolation; (c) to reduce the shame and culpability (d) to help teenagers rely on and use their personal resources. Each group last 2 hours and occurred for 20 weeks, facilitated by two leaders. The pre/posttest indicated that the psychoeducational groups were effective in reducing reported symptoms of CSA.

Quantitative Studies with Comparison Group

Of the 2 studies that used a comparison group, both included children participants. Hébert and Tourigny (2010) sample included 90 children (boys and girls), while Trowell et al. (2002) focused strictly on a diverse sample of girls (N = 71). Hébert and Tourigny's (2010) psychoeducational group aimed to reduce the consequences of CSA, foster positive self-esteem, and identify personal coping skills, to name a few. The results of this study indicated that the psychoeducational group intervention aid in the reduction of anxiety and symptoms of PTSD and participants decrease their use of avoidance behaviors when compared to the comparison group. Uniquely, Trowell et al. (2002) compared the use of an individual format to a psychoeducational group. The results suggest that while both interventions aided in the reduction of psychopathology, the individual sessions were more effective in alleviating symptoms of PTSD.

Quantitative Study without Control or Comparison Group

Karatizias et al. (2014) utilized a mixed-methods approach to examine the effectiveness of psychoeducational groups for the management of psychopathology. Participants included 4 males and 33 females ranging from the ages of 19 to 65. The intervention, Survive and Thrive, consisted of 10 manualized psychoeducational groups session lasting approximately 1.5 hours which were facilitated by 2 group facilitators. The psychoeducational content included safety, stabilization, and affect management skills. Although no control or comparison group was utilized, the researchers utilized a pre/post and a 3-month follow-up of participants. Results indicated that although the intervention had no effect on psychological distress, anxiety, or depression, participants were less likely to report self-harm, drug use, antisocial behavior, or illegal behaviors at the end of the intervention and 3-month follow-up.

CHAPTER 3

METHODOLOGY

The purpose of this chapter is to present the methodology used for this systematic review and meta-analysis of the use of psychoeducational groups for the treatment of psychopathology arising from the experience of CSA. The systematic review aided in collecting and examining studies providing empirical evidence surrounding the use of psychoeducation groups or groups with psychoeducational components for the treatment of CSA, while the meta-analysis consisted of utilizing statistical methods to analyze and combine the effect sizes of each study into a single effect size. The application of a systematic review and meta-analysis are presented in detail in this chapter. The inclusion, search, and coding procedures were implemented using the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA – P; see Appendix A) (Moher et al., 2015). The PRISMA – P is a 17-item checklist designed to create a well-defined guideline for conducting systematic reviews and meta-analyses.

Research Questions

This systematic review and meta-analysis aimed to evaluate the effectiveness of the use of psychoeducational groups for the treatment of adverse outcomes resulting from CSA. To this end, this systematic review and meta-analysis aimed to answer the following research questions:

Research question 1 – Are psychoeducational groups effective in treating CSA?

Research question 2 – What are the themes across studies used in the meta-analysis?

Research question 3 – What psychoeducational group factors and topics emerged from the qualitative analysis?

Systematic Review of the Literature

A systematic review of the literature was conducted to examine quantitative evidence since the year 2000 regarding the use of psychoeducation for the treatment of psychopathology following CSA. As defined by Moher et al. (2015), systematic review “attempts to collage all relevant evidence that fits pre-specified eligibility criteria to answer a specific research questions. It uses explicit, systematic methods to minimize bias in identification, selection, synthesis, and summary of studies” (p. 3). The Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMS-P) was utilized to guide the systematic review and meta-analysis. As outlined in the PRISMA-P (2015), items 8-14 of the systematic review protocol were utilized to outline the eligibility criteria, information sources, search strategy, study records, data items, outcomes and prioritization, and risk of bias in individual studies (Moher et al., 2015). Item 8, eligibility criteria, involves the researcher selecting criteria that studies must meet. Item 9, information sources, involves the researcher identifying literature search strategies, including specifying which electronic databases may be used. Item 10, search strategy, involves specifying, for example, indexing terms, date restrictions, or any other search filters. Item 11, study records, involves identifying how the research managed and record data (11a), selection processes (11b), and methods to extract data processes (11c; Moher et al., 2015). Item 12, data items, refers to the researcher defining all variables for which the data was being sought. Item 13, outcomes and prioritization involves the researcher defining and listing all outcomes for which data were sought and item 14, risk of bias in individual studies, includes the researcher detailing methods for assessing the risk of bias of the individual studies (Moher et al., 2015).

Eligibility Criteria

The following information will describe the specific inclusion and exclusion criteria studies must meet to be examined. Criteria relating to the type of study designs, participants, interventions, control conditions, and outcomes of CSA will be detailed. This information will be followed by a rationale for the selected criteria.

Type of Study Designs

Only studies that included the use of psychoeducational groups/interventions or groups having psychoeducational components were considered. Studies included manuscripts published in English after the year 2000. Pilot studies, randomized controlled trials, nonrandomized control-group design, mixed methods, single group design, nonrandomized, quasi-experimental design, pretest/post-test design with a control group, and comparison design with random allocation were included. To conduct a meta-analysis, the primary sources must include the sample size (n), mean (M), and standard deviation (SD) for each outcome variable (Borenstein et al., 2009). Therefore, only quantitative research designs that reported enough data to calculate effect sizes were included. Efforts were made to include unpublished works in the forms of dissertations and thesis papers. If the same author or groups of authors are identified in the course of the search, emails were sent to solicit data from any unpublished work.

Manuscripts were excluded from the systematic review and meta-analysis if they were published before 2000, were not in English, and/or had insufficient data to calculate an effect size. Therefore, conceptual, and descriptive works were not included. Studies that only used participant satisfaction as an outcome variable were also be excluded as well as any studies where the psychoeducational outcome was incomplete or not included.

Type of Participants

Studies were included with cisgender female and/or male survivors of CSA of any age (children, adolescents, or adults). Studies that included participants from various cultural backgrounds were sought out and included. Further, this systematic review and meta-analysis included studies addressing CSA survivors of intrafamilial and/or extrafamilial CSA. The participants included experienced CSA ranging from one experience to multiple experiences, one perpetrator to multiple perpetrators, and the age difference between survivor and perpetrator varied.

Type of Interventions

Only studies having psychoeducational groups or groups with psychoeducational components as an intervention to treat psychopathology following CSA were included. Psychoeducational groups are classified as “a broad spectrum of groups that have a significant educational component *in addition* to the psychological component” (Brown, 2011, p.8). Studies were only included if it reported results of the psychoeducational group separate from that of the psychological component of treatment.

Type of Control Condition

Eligible control or comparison conditions included individual therapy, psychotherapy groups, waiting list, no treatment, and any other interventions not classified as psychoeducational groups.

Outcomes of CSA

The outcomes of CSA of interest included symptoms of anxiety, depression, dissociation, PTSD, and externally-focused behaviors as measured by any scale selected by authors of selected studies. Internalizing behaviors were not included as an outcome of interest as

symptoms of depression and anxiety are categorized as internalizing behaviors. Scores from scales that measure two outcomes collectively, for example, depression and anxiety, were not included because the outcomes were not measured separately. When the same outcome was measured by separate scales, such as measuring symptoms of externally-focused behaviors for two different age groups, the means, the number of participants, standard deviations were combined into one group as suggested by Cochrane Collaboration using Cochrane's formula for combining groups.

Rationale for Criteria

In addition to there not being a meta-analysis of the use of psychoeducational groups to treat psychopathology in individuals who experience CSA, the rationale for the criteria was to reduce publication bias, search bias, and selection bias. The results of this study may be generalized in clinical practices as the inclusion criteria are balanced between broad (e.g., since 2000) to narrow (e.g. psychoeducational groups to treat CSA).

Information Sources

To select studies, manuscripts were found from computerized databases including, but not limited to Google Scholar, Medline, Psych Articles, Psych Info, Pub Med, Science Citation, and Science Direct.

Search Strategy

The search strategies that were used included using the following search terms with Boolean operators to extend or narrow the number of manuscripts for consideration: psychoeducational groups OR psycho-educational groups OR psychoeducation AND childhood sexual abuse OR youth sexual abuse OR childhood sexual trauma OR child sexual abuse OR child sex abuse. To further search for articles and to warrant literature saturation, the references

of included studies were hand-examined. The search was restricted to full-text manuscripts written English since the year 2000.

Study Records

The following information details strategies used to manage records and data. Further information regarding the selection process and what and how data items were extracted from the manuscripts will be discussed.

Data Management

An Excel spreadsheet was created to organize records by authors, year of publication, title, participants, whether CSA was intrafamilial or extrafamilial, methodology, intervention, comparison or control groups, measurements, outcome variables, effect size, and analysis results. The PRISMA flow diagram (see Appendix B) was used to visually represent the search process and subsequent narrowing of the article pool considered. Data was coded and extracted using QSR International's NVivo 12 Plus qualitative data analysis software (2018). NVivo software is designed to code data for both qualitative and mixed-method designs. For this study, NVivo was used to identify psychoeducational groups variables that were presented in the Methods and Results sections of selected manuscripts (e.g., participants, durations of groups, group facilitator characteristics, outcome measures, means, standard deviations, etc.). In addition, NVivo was utilized to extract and maintain descriptive data of the psychoeducational group provided by each manuscript. By using NVivo, data were visually represented in charts, graphs, and frequency counts. Additionally, data were exported to other statistical software for later analysis (e.g., SPSS, Comprehensive Meta-Analysis – 3 software).

Selection Process

Once search terms are entered in the database, the manuscripts' titles and abstracts were examined to determine if basic inclusion criteria are met. If the article passes the screening process, the full text was examined, and data were extracted if the manuscript met all inclusion and exclusion criteria.

Data Items

Data extractions were done independently. Data extracted from selected articles included PICO items: populations, intervention type, control/comparison, and outcomes. Further, the location where the study was conducted, the methodology of the study, and details of the CSA experience were sought out such as whether the CSA was intrafamilial and/or extrafamilial. Lastly, data surrounding the psychoeducational groups were extracted such as the group factors, group topics, the setting of the psychoeducational group (e.g., classroom vs office space), and the results of the psychoeducational group as part of treatment compared to the control/comparison intervention.

Risk of Bias in Individual Studies

Systematic reviews and meta-analyses rely on data from selected studies; therefore, the results presented in a systematic review are only “as good as, or as free from bias as, the primary data sources” (Drucker, Fleming, & Chan, 2016, p. 112). There are methods to utilize to assess the risk of bias in individual studies included in a systematic review and meta-analysis. The risk of bias in studies was assessed by utilizing the Cochrane risk of bias tool for randomized and/or non-randomized studies (Higgins et al., 2019).

Thematic Analysis

During the initial review of studies, it was clear that there were emergent parallels between the psychoeducational groups provided to participants as interventions. To maximize the systematic review process, descriptions of the psychoeducational group as an intervention for CSA and relevant outcome data were extracted from each study (n = 14) and analyzed by utilizing a thematic synthesis approach to answer research questions 2 and 3. Thematic synthesis involves “the systematic coding of data and generating of descriptive and analytical themes” (Nicholson et al., 2016). Thus, systematically coding data from the descriptions of the intervention/psychoeducational groups and the result sections aided in systematically seeking out and identifying key elements regarding the structure/format of psychoeducational groups for the treatments of CSA. Thematic synthesis was selected for the review of the psychoeducational groups as interventions and the results as it is effective in aggregating data and identifying parallels and differences in the structure/format of each psychoeducation group as an intervention. Further, thematic synthesis has been utilized for the synthesis of quantitative results when there is heterogeneity in the outcome variables and measurements (Ryan et al., 2018).

The thematic synthesis was implemented during the data synthesis stages by the use of NVivo. The thematic analysis involved three stages. First, codes were developed by examining the descriptors of the psychoeducational groups as an intervention and the results section. Second, descriptive themes were developed by identifying similarities between the code identified in the first stage. Third, analytic themes were developed to interpret findings related to research questions 2 and 3 (Thomas & Harden, 2008).

Meta-Analysis Procedures

As stated (Borenstein et al, 2009), the meta-analysis is an essential element of systematic reviews. As outlined in the PRISMA-P (2015), items 15-17 of the systematic review protocol were utilized as part of the meta-analysis procedures including data synthesis, meta-biases, and confidence in cumulative evidence. The integration goal of this meta-analysis is to combine studies' effect sizes in an effort to estimate an average effect size (Card, 2016), to infer the effects of psychoeducational groups for the treatment of adverse outcomes of CSA. Item 15, data synthesis, involves detailing criteria for which studies will be quantitatively synthesized (15a) and describing methods of combine data from studies (15b).

Data Synthesis

The following sections detail the criteria under which the data from selected manuscripts were synthesized. This includes the type of meta-analysis conducted and why and the type of effect size measurement used. Analyses were performed with Comprehensive Meta-Analysis (CMA), a computer program that was developed in collaboration with medicine, epidemiology, and social sciences professionals (Borenstein et al., 2009). Two options were used to synthesize data (1) comparison of two groups, continuous, unmatched groups, pre- and post-data, means, SD, pre- and post-N, in each group, pre/post correlation, standardized by post score SD and (2) one group (pre-post), means, SD pre, SD post, pre/post correlation, and sample size, standardized by post score SD. The random-effect model was utilized given the inherent heterogeneity of studies.

Random-effects Model

The researcher utilized the random-effect model as the majority of the studies from the initial search were conducted by researchers independently. Although the studies focused on the

broad population and topic of survivors of CSA, there are appreciated variations across the studies in that each study's sample included survivors of diverse ages (children, adolescent, adult), gender (male or female), experiences of CSA (intrafamilial or extrafamilial; one versus multiple experiences, various age difference between survivor and perpetrator), and elements and focus of the psychoeducational group. Therefore, the objective of this meta-analysis is to “generalize to a range of scenarios” (Borenstein et al., 2009, p. 84) as the researcher does not assume that the effect sizes of the studies are identical.

Measures of Treatment Effect

Referred to as the “unit of currency” in a meta-analysis (Borenstein et al., 2009, p. 3), the effect size is a quantitative measure of the magnitude of a treatment impact, such as the impact of psychoeducational groups on psychological manifestations of CSA. For this current study, depending on the data available in the manuscripts, Cohen's d was calculated for studies to compute the summary effect, that is, a weighted mean of the effect sizes from each study included in the meta-analysis (Borenstein et al., 2009). Heterogeneity, the variation in outcomes between studies, was assessed and measured with I^2 statistical, and publication biases were assessed with the funnel plot of precision by the standard difference in mean as formulated by CMA.

Challenges of Social Science Systematic Reviews and Meta-Analyses

While the use of systematic review and meta-analyses are rapidly growing in social science research, systematic reviews and meta-analyses do come with limitations and challenges. One of the main limitations of meta-analyses is the data reporting of the primary studies. Some studies provide data solely regarding the statistical significance, while other studies may provide data regarding the statistical significance in addition to descriptive statistics (Davis et al., 2014).

To address this limitation, studies were only included that provided sufficient data to calculate Cohen's d effect size. However, for studies of particular interest that met criteria yet was missing, for example, standard deviations, efforts were made to contact the author to request further data. While randomized controlled research may have higher levels of evidence, social science research may involve non-randomized research design (e.g., quasi-experiment; Davis et al., 2014). Therefore, studies were included that utilized a variety of methodologies (e.g., randomized and non-randomized) besides conceptual and descriptive methodologies in the review and meta-analysis. Finally, regarding outcome variables, social science researchers may select to focus on different outcome variables while focusing on the same treatment intervention (e.g., psychoeducation for the treatment of physiological outcome of CSA vs psychoeducation for the treatment of psychological outcomes of CSA). Or, social science researchers may elect to focus on one outcome and measure the outcome with multiple measures. For instance, research may solely examine depression as an outcome of CSA by using the Beck Depression Inventory, the Child Behavior Checklist, and the Children's Depression Inventory; therefore there may seem to be a level of inconsistency in outcome variables deemed important to measure regarding CSA. For this reason, as suggested by Davis et al. (2014), outcomes of interest were selected a priori. In addition, internalizing behaviors (e.g., depression, anxiety) were examined separately; therefore, scales that measure internalizing behaviors collectively were excluded. Further selected studies must have included at least one of the chosen outcome variables.

Conclusion

This chapter provided an overview of the methodology of this study. A detailed outline of PRISMA-P, the set of items utilized for the systematic review and meta-analysis, was provided.

This chapter ends with a summary of the challenges of social science systematic review and meta-analyses and methods the research utilized to manage the challenges.

CHAPTER 4

RESULTS

The purpose of this research was to examine studies examining the use of psychoeducational groups to treat psychopathology resulting from CSA. While there are studies that demonstrate the positive outcomes resulting from the use of psychoeducational groups for this population, no meta-analysis has been conducted to determine its overall effect. In addition, psychoeducational group structures and formats were identified that contribute to the effectiveness of psychoeducational groups for this population. This chapter provides the results of the systematic review and meta-analysis to answer the research questions:

Research question 1 – Are psychoeducational groups effective in treating CSA?

Research question 2 – What are the themes across studies used in the meta-analysis?

Research question 3 – What psychoeducational group factors and topics emerged from the qualitative analysis?

Specifically, this chapter will present the results of the NVivo regarding themes found from articles to answer research questions 2 and 3. Next, the chapter will provide information regarding the effect of the psychoeducational group for each study followed by details of the effect of psychoeducational groups on impacting the selected adverse outcomes of CSA: anxiety, depression, dissociation, externalizing behaviors, and PTSD. Next, the effects of the psychoeducational groups on reducing symptoms of the selected adverse outcomes of CSA. Finally, this chapter ends with details surrounding the overall effect of psychoeducational groups on the psychopathology of survivors of CSA.

Data Selection

The following key terms: psychoeducational groups *or* psycho-educational groups *or* psychoeducation *and* childhood sexual abuse *or* youth sexual abuse *or* childhood sexual trauma *or* child sexual abuse *or* child sex abuse produced 69,073 articles from the following databases: Google Scholar, PubMed, PsycARTICLES, PsycINFO, Child Development & Adolescent Studies, Science Citation, Science Direct, and Medline. Specifically, the key words produced 496 results for Google Scholar, 26,729 for PubMed, 1,548 for PsycARTICLES, 31,792 for PsycINFO, 10 for Child Development and Adolescent Studies, 8,447 for Science Citation, 16 for Science Direct, and 35 for Medline.

The inclusion criteria for studies included (1) studies conducted since 2000, (2) psychoeducational groups were used in the treatment of CSA, (3) data was provided specific to the psychoeducational group, and (4) sample size, means, and standard deviations were provided to compute Cohen's *d* for the meta-analysis. Considering the inclusion criteria, only 1 article met criteria from Google Scholar, 0 from PubMed, 0 from PsycARTICLES, 1 from PsycINFO, 2 from Child Development and Adolescent Studies, 0 from Science Citation, 0 from Science Direct, and 4 from Medline. References of included studies were hand-searched to find other related studies.

Qualitative Synthesis of the Literature

The researcher conducted a systematic review of articles examining the use of psychoeducational groups for the treatment of psychopathology resulting from CSA. NVivo, a computer-based, qualitative data analysis software was utilized to thematically synthesize extracted data regarding the psychoeducational groups. Specifically, context descriptions and findings pertaining to the psychoeducational group as an intervention for CSA were extracted

and examined. Next, the data was coded followed by a further review. Finally, the codes were translated into themes. The themes below are the synthesized psychoeducational group findings across the studies and the interpretations are provided to answer research questions 2 and 3.

Group Factors

Group factors emerged from the thematic analysis using NVivo. The group factors consist of the structuring of the group, directing/facilitation of the group, implemented activities, lecturing/information giving, and rules regarding participants' disclosures of personal stories. These factors were discussed in each study no matter the varied population or varied settings. Each factors hold important implications for psychoeducational groups' approaches to treating psychopathology resulting from CSA. The following are group factors that emerged from the thematic analysis:

Structuring - Psychoeducational groups as a therapeutic modality to treat psychopathology in individuals who have experienced CSA have a level of structure, often guided by a psychoeducation manual.

Directing refers to the who and how the group is facilitated. All studies included in the meta-analysis required the facilitator to have some exposure to the social science profession. and were required to obtain training and routine supervision. Facilitators' work was guided by the use of prearranged topics provided in a manual.

Activities were used to enhance participants' acquisition of knowledge and foster positive interactions among group members. The use of activities was common, and the processing of activities expanded group members' knowledge and understanding.

Lectures served as a knowledge dissemination strategy and were predetermined in the manual.

Personal Stories – The use or discouragement of the sharing of individual trauma stories was found to be a pertinent group factor of each study and participants of groups that welcomed personal stories and focused on the commonalities of their stories felt a great sense of acceptance in the group setting.

Group Topics

There was a pattern of group topics discussed in the psychoeducational groups. Topics ranged from trauma characteristics, shame and guilt, internalizing and externalizing behaviors, protection and boundaries, affect expression and modulation, and coping strategies. The topics discussed were prearranged and purposed to change behavioral and emotional patterns group members exhibited after CSA, assist group members in having a happier outlook on their lives, and to introduce and promote the use of skills necessary to healthy coping and regain their sense of power. The following are common group topics that emerged from the thematic analysis:

Trauma characteristics include psychological and biological aspects, dissociative and re-experiencing states in post-traumatic stress. Other topics included educating group members about the physical, emotional, and psychological effects of trauma and how trauma characteristics can progress.

Shame and guilt feelings can emerge. Shame in that they may feel flawed, worthless, and fear that they will be being rejected by peers because of their experience of sexual abuse. Guilt arises when a survivor feels responsible for the sexual offense. Group topics also included ways to reframe feelings of shame, guilt, and embarrassment which often lead to fear of disclosure.

Internalizing and externalizing behaviors included topics of social skills, anger management, assertiveness and sexuality, substance use, and bolstering self-esteem. Also, techniques to monitor behaviors were presented and discussed.

Protection and boundaries included safe sleep, distrust, sex-education, prevention of revictimization, self-protection, assertive skills, self-protecting abilities, personal space and boundaries, and social skills.

Affect expression and modulation included the importance of correct recognition of emotions, affect regulation, self-regulation skills, and expression of emotions.

Coping strategies included self-care, self-soothing, relaxation, exercise, grounding techniques, stress management, cognitive coping, and processing sexual abuse experiences.

Meta-Analysis

Nine studies from the database search and reference search met the criteria for the meta-analysis. The majority of studies that did not qualify for the meta-analysis were for two reasons (1) insufficient data was provided to calculate Cohen's *d*, and (2) results were not provided specifically to the psychoeducational group. In addition, one study (Trowell et al., 2002) was not included; the author was contacted via email to request more statistical data; however, the author did not respond. The experimental groups in the meta-analysis used psychoeducational groups for the treatment of psychopathology resulting from CSA. Five out of the 9 groups included a control group. The control group varies as some studies utilized individual counseling sessions, while others utilized no treatment (waiting list), for example.

Included Studies and Samples

A total of 465 participants were included in the meta-analysis. Participants included males and females with ages ranging from 7 to 40.3 years old. Table 1 details the number of participants for each study, including the gender percentages of each group.

Table 1

Sample (Participants) of Meta-Analysis Studies

Author	Age		N		Female		Male	
	PE Grp	Con	PE Grp	Con	PE Grp	Con	PE Grp	Con
Dorrepaal et al. (2010)	34.1 (8.3)	N/A	36	N/A	100%	N/A	0%	N/A
Dorrepaal et al. (2012)	40.3 (10.7)	37.1 (10.3)	31	29	NP	NP	NP	NP
Hébert & Tourigny (2010)	8.67 (2.00)	8.64 (1.78)	51	39	74.5 %	87.2%	25.2%	12.8%
Karatzias et al. (2014)	38.3 (11.3)	N/A	37	N/A	89.2 %	N/A	10.8%	N/A
Misurell et al. (2011)	7.28 (1.78)	N/A	48	N/A	62.5 %	N/A	37.5%	N/A
O'Callaghan et al. (2013)	15.83 (1.27)	16.18 (1.34)	24	28	100%	100%	0%	0%
Springer et al. (2012)	7.93 (1.50)	N/A	32	N/A	59%	N/A	41%	N/A
Tourigny et al. (2005)	14.8 (NP)	14.3 (NP)	26	15	100%	100%	0%	0%
Trowell et al. (2002)	10.4 (2.0)	9.7 (2.4)	35	34	100%	100%	0%	0%

Dorrepaal et al. (2010), conducted a pilot study to examine whether a psychoeducational group experience for members who have experienced CSA would help them to manage PTSD, including complex PTSD. A total of 36 women who had experienced CSA before the age of 16 were included with a mean age of 34.1. Of the 36 women, 69% (n = 25) experienced CSA only, while 44% (n = 16) reported experiences of CSA and physical abuse. All of the participants were diagnosed with PTSD. Participants were excluded if they were diagnosed with comorbid dissociative identity disorder, had severe psychosis, or were simultaneously enrolled in another CSA treatment program. Dorrepaal et al. (2012), the randomized control full-scale trial, included participants who met the DSM-IV criteria for PTSD and excluded individuals who have a diagnosis of antisocial personality disorder, severe psychosis, dissociative identity disorder, and

severe alcohol or drug addiction (American Psychiatric Association, 2000). The mean age for the experimental group was 40.3, while the mean age for the control group was 37.1. Dorrepaal et al. (2012) focused strictly on PTSD outcomes, including complex PTSD symptoms. Of the sample, 97% (n = 37) of 38 participants in the experimental group and 91% (n = 30) of 33 participants in the control group experienced CSA which was deemed sufficient to include the study in the meta-analysis. The psychoeducational group focused on the here-and-now, reframing, reducing guilt, and ultimately aimed at reducing symptoms of PTSD. Both the pilot and full-scale findings demonstrate the efficacy of the psychoeducational group to reduce symptoms of PTSD. However, the addition of the control group in Dorrepaal et al. (2012) resulted in equivocal outcomes, such that both the experimental and control group participants greatly improved with the psychoeducational group having a large effect size and the control group having a medium effect size.

The Hébert and Tourigny (2010), a pretest-posttest design with a comparison group examined the following related experiences of CSA: depression, anxiety, distorted self-perception, PTSD, use of coping strategies, dissociation, and behavior problems. The male and female participants of this study consisted of 51 children, with the experimental group having a mean age of 8.67 and a comparison group having a mean age of 8.64 age range. Of the participants in the experimental group, 76% experienced intrafamilial CSA, while 24% experienced extrafamilial. Of the participants in the control group, 82.1% experienced intrafamilial CSA, while 17.9% experienced extrafamilial CSA. The psychoeducational group aimed to alleviate adverse outcomes associated with CSA, including but not limited to reducing internalizing and externalizing behaviors, enhancing the use of coping strategies, and fostering positive self-esteem and relationships. The findings indicate that the psychoeducational groups

produce significant outcomes compared to the comparison group such that intervention participants' symptoms of anxiety, depression, and posttraumatic stress decreased. Further, parents reported a decrease in externalizing behaviors.

Karatzias et al. (2014) mixed-methods study focused on the following consequences associated with CSA: psychological and psychosomatic outcomes, anxiety, depression, PTSD, dissociative experiences, diminished self-esteem, and decreased life satisfaction. Thirty—seven Participants included male (n = 33) and female (n = 4) participants with a history of CSA. The mean age of the participants was 38.3. Unlike the remaining studies, Karatzias et al. (2014) provided information about participants' use of psychotropic medication. Of the total sample, 13 were concurrently prescribed psychotropic medications and 24 were not. Individuals who had a diagnosis of personality, psychotic, or bipolar disorders were excluded. In addition, the researchers controlled for therapy effect by excluding individuals who have received formal psychotherapy; however, unlike Dorrepaal et al. (2012), this study did not exclude individuals with alcohol or drug addictions. The psychoeducational group aimed to provide knowledge and skills regarding safety, stabilization, and affect regulation. The findings indicate that while the intervention produced favorable outcome regarding stabilizing behavior issues (substance use, self-harm, smoking, and antisocial behaviors) the intervention did not produce favorable outcomes regarding psychopathology (depression, anxiety, self-esteem, life satisfaction, to name a few).

Misurell et al. (2011), a pilot study, examined the use of a CBT group to treat children who have experienced CSA. Specifically, the researchers integrated gaming in the treatment. There was a total of 30 girls and 18 boys between the ages of 5-10, with a mean age of 7.28 years. The inclusion criteria for participants included the following (1) between the ages of 5-10,

(2) the child disclose their CSA experience or there was strong evidence of the experience, (3) completion of pre/post assessments, and (4) 8 out of 12 psychoeducational groups must be attended, Those who presented with significant cognitive impairments, psychosis, or severe behavioral issues were excluded from the study. In addition, participants who were revictimized during their participation or missed more than 4 sessions were excluded from the study. Springer et al. (2012), the full-scale, nonrandomized, quasi-experimental study, included a larger sample of 91 children; however, for this meta-analysis data was only use for the 32 children (19 girls, 13 boys) who completed all time points. The participants of this study aged between 6 and 10 years old, with a mean age of 7.93. The authors of this study extended the inclusion and exclusion criteria for the participants. The inclusion criteria were extended to include the child participants must have a level of maturity and self-control to attend the psychoeducational group. The exclusion criteria were extended to include (1) primary problems were found to be unrelated to the experience of CSA, (2) if the participant was not prepared to participate in the psychoeducation group (such as having significant social anxiety), and (3) if the participants did not complete the assessment at required time points. Social learning and gaming were incorporated in the psychoeducational group and aimed to provide knowledge, skills, and practice to enhance self-esteem, set safe boundaries, enhance affect expression and regulation, and managing anger. Misurell et al. (2011) measured internalizing behaviors, externalizing behaviors, sexually inappropriate behaviors, deficits in social skills, issues with self-esteem, and knowledge of healthy sexual and protective skills. Springer et al. (2012), measured internalizing behaviors, externalizing behaviors, and sexually inappropriate behaviors as a result of CSA in addition to knowledge of sexuality and safety. The findings of the pilot and full-scale study suggest that the psychoeducational group was effective in alleviating internalizing behaviors,

externalizing behaviors, depression, and anxiety and the treatment gains were maintained at a three-month follow-up. Further, Springer et al. (2012) found that the psychoeducational group was effective in increasing knowledge of sexuality and safety, and the gained knowledge was maintained at three-month follow-up.

O'Callaghan et al. (2013), a randomized controlled trial, examined the use of Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) aimed to reduce symptoms of depression, PTSD symptoms, anxiety, externalizing behaviors, and increase prosocial behaviors for a specialized sample of war-affected, sexually exploited girls. Participants who received TF-CBT included girls ($n = 24$) with a mean age of 15.83, while participants of the control group ($n = 28$) had a mean age of 16.18. Regarding CSA, 100% of the treatment group and 86% of the control group experienced inappropriate touch, and 67% of the treatment group 75% of the control group experienced rape. Individuals who presented with intellectual disabilities, a history of psychosis, or had severe emotional or behavior problems were excluded from participation. The psychoeducational group aimed to enhance participants' affect expression and modulation, cognitive coping, and cognitive restructuring. O'Callaghan et al. (2013) asserted that the psychoeducational produce significant favorable outcomes including the reduction of symptoms of PTSD and the enhancement of prosocial behaviors.

Tourigny et al. (2005) conducted a pretest-posttest design without a control group and sought to examine the following adverse outcomes associated with CSA: PTSD, anxiety, internalizing behaviors, and externalizing behaviors in the study on 42 teenage girls, with the mean age of 14.8 for the experimental group and 14.3 for the control group. Characteristics of the perpetrator were provided and of the experimental group the sex offender was an immediate family member for 34.6% of the experimental group, 34.6% were extended family, and 0%

reported their perpetrator as a stranger. Further 92.3% of the group reported they knew the perpetrator and 80.8 reported the perpetrator was 18 or older. For the control group, 46.2% reported that the perpetrator was immediate family member, 38.5% reported the perpetrator was an extended family member, and 7.7% of the participants reported the perpetrator as a stranger. In addition, 84.6 reported knowing the offender, and 84.6 reported the offender was 18 or older. The percentage may not equal 100 as participants in the experimental group (11.5%) and control group (23.1%) reported having more than one perpetrator. The psychoeducational group provided to the treatment group aimed to reduce symptoms for teenagers who experience CSA by educating and processing content related to the cycle of abuse, adverse outcomes of CSA, relationships. The findings indicate that the psychoeducational group was significantly effective in reducing symptoms of PTSD, internalizing and externalizing behaviors, and enhancing coping strategies and a sense of empowerment.

Trowell et al. (2002) comparison design with random allocation studied PTSD and psychiatric symptoms resulting from CSA. The participants of this study included 71 girls with a history of CSA between the ages of 6 and 14. At the time of the initial evaluation, girls who presented with severe developmental delay, a history of psychosis, and/or a need for hospitalization were excluded from participation. Of the 36 participants in the experimental group, 50% (n = 18) were abused by a parent, 36% (n = 13) experienced CSA by more than one abuser, 47% (n = 17) experienced more than 10 CSA incidents, and 36% (n = 13) experienced CSA for more than 2 years. Of the 35 participants in the comparison group, 34% (n = 12) were abused by a parent, 43% (n = 15) reported experiencing CSA by more than one offender, 63% (n = 22) reported more than 1 incidents, and 40% (n = 14) reported experiencing CSA for more than 2 years. The psychoeducational group aim at reducing symptoms of PTSD was found to

produce favorable outcomes; however, the comparison group did as well. In fact, the findings suggest that individual therapy (control group intervention) had a great impact on reducing symptoms of PTSD compared to the psychoeducational group.

Treatment Integrity and Fidelity

Treatment integrity and fidelity refer to researchers assuring that the treatment provided in a research study is conducted consistently and reliably as prescribed by the study protocols (Petticrew & Roberts, 2006). Psychoeducational groups were used as the intervention for all of the studies included in this review. Most studies included in this review 89% (n = 8) used manualized psychoeducational groups. One study, Hébert and Tourigny (2010), did not specifically say whether the psychoeducational group was manualized; however, the study was conducted at the same community agency as Tourigny et al. (2005). The majority (n = 8) of the psychoeducational groups were facilitated by at least 2 providers having a helping professional/social science background. O'Callaghan et al. (2013) did not provide information regarding the number of facilitators per session. Eight out of the 9 studied mandated treatment providers to receive supervision during the course of facilitating the psychoeducational group. However, only 67% (n = 6) of researchers mandated that the treatment providers received training on the delivery of the psychoeducational group. Tourigny et al. (2005) article did not specify whether the provider received training; however, the intervention took place at the same community agency as Hébert and Tourigny (2010). The majority of the psychoeducational groups lasted at least 2 hours (n= 5), while some lasted 1.5 hours (n = 3) and one lasting 50 minutes. The majority were conducted for 20 weeks/20 sessions (n = 3), 1 study provided treatment for 18 weeks/18 sessions, 1 study provided treatment for 14 weeks/14 sessions, 2 studies involved treatment for 12 weeks/12 sessions, and 1 psychoeducational group lasted for 10

weeks/10 sessions. Only one study provided psychoeducational groups 3 times a week for 5 weeks. See Appendix D for a table detailing the experimental groups duration, provider, and topics.

Study Settings

The studies included in the meta-analysis were conducted at various locations. Of the 9 studies included in the analysis, 22% ($n = 2$) were conducted in Canada, 11% ($n = 1$) was conducted in the Netherlands, and 22% ($n = 2$) was conducted in the United Kingdom, 22% ($n = 2$) were conducted in the United States and 11% ($n = 1$) was conducted in the Republic of Congo. Dorrepaal et al. (2010) did not provide information regarding the locations of the study; however, as the pilot study for Dorrepaal et al. (2012) one may assume it was conducted in the same or nearby location. Regarding the psychoeducational groups, 33% ($n = 3$) took place in a medical setting, 33% ($n = 3$) took place in a community agency, while 22% ($n = 2$) took place in a school setting. Again, Dorrepaal et al. (2010) did not provide details of the setting for which the treatment was provided. See Appendix E for a table describing individual studies settings.

Measured Psychopathology Resulting from CSA

The meta-analysis included 9 studies that examined and measured at least one of the following consequences of CSA: depression, anxiety, posttraumatic stress, and externalizing behaviors. The outcome measures used by researchers of the included studies were formal assessments, self-reports, and parent reports. All studies provided sufficient data to calculate Cohen's d to examine the effects.

Anxiety

While anxiety is a natural adaptive reaction to stressful events (Steimer, 2002), the focus of this study is on the levels of anxiety that impair one after experiencing CSA. Anxiety, in this

case, refer to excessive worry or fear. According to the DSM-V, anxiety disorders have the following criteria (1) excessive worry, (2) difficulty managing worry, (3) excessive worry is combined with 3 or more of the following symptoms: restlessness/feeling on edge, fatigue, difficulty concentration, irritability, muscle tension, or sleep disturbance (American Psychiatric Association, 2013). Five out of the 9 studies addressed anxiety resulting from CSA and found that psychoeducational groups were effective in treating anxiety. See Table 2 for details the individual study results (M , SD , d) for anxiety. Anxiety was measured with the scales: *Youth Self-Report and Profile* (Tourigny et al., 2005), *Revised Children's Manifest Anxiety Scale* (Hebert & Tourigny, 2010), *Hospital Anxiety and Depression Scale* (Karatzias et al., 2014), and the *Trauma Symptom Checklist for Children* (Misurell et al., 2011, Springer et al., 2012). See Table 2 for individual study results (M , SD , d).

Table 2

Anxiety Studies Results

Study	n	Pretest $M(SD)$		Posttest $M(SD)$		d	
		PE Grp	Con	PE Grp	Con	PE Grp	Con
Herbert & Tourigny (2010)	88	5.63 (3.42)	6.69 (2.34)	4.04 (3.07)	5.92 (3.26)	.489	.271
Karatzias et al. (2014)	37	14.2 (3.8)	N/A	14.0 (3.4)	N/A	.055	N/A
Misurell et al. (2011)	17	51.00 (8.84)	N/A	46.59 (7.35)	N/A	.542	N/A
Springer et al. (2012)	21	59.24 (9.17)	N/A	52.81 (11.96)	N/A	.603	N/A
Tourigny et al. (2005)	41	17.2 (7.3)	14.2 (7.6)	10.1 (5.9)	18.9 (6.5)	1.070	.665

Each study that examined the impact of psychoeducational groups in reducing symptoms of anxiety as an adverse outcome of CSA found that psychoeducational groups were impactful and produced favorable results; however, with a variety of effects. Herbert & Tourigny (2010) found that the psychoeducational group had a medium effect ($d = .49$), while the control group (individual therapy) had a small effect ($d = .27$). Karatzias et al. (2014) found that the psychoeducational group had a small effect ($d = .06$) while both Misurell et al. (2011) and Springer et al. (2012) found that the psychoeducational group had a medium effect ($d = .54$ and $d = .60$, respectively). The effect size for Tourigny et al. (2005), however, was found to exceed Cohen's convention for a large effect ($d = 1.07$) compared to the control group (no treatment) medium effect ($d = .67$).

Depression

Depression is a mood disorder that affects how a person feels, thinks, and behaves. According to the DSM-V, there are a set of criteria and symptoms that must be met to be diagnosed with major depressive disorder (mild, moderate, or severe). The symptoms include (1) depressed mood, (2) decrease interest/pleasure, (3) weight loss or gain, (4) loss of sleep or excessive sleep, (5) psychomotor agitation or retardation, (6) loss of energy/fatigue, (7) feelings of worthlessness, (8) decrease concentration, (9) thought of death, suicidal ideations, suicide plans, or suicide attempt (American Psychiatric Association, 2013). Five of the 9 studies included in the meta-analysis address depression as a result of CSA. The following scales were used to measure symptoms of depression: *Children's Depression Inventory* (Hebert and Tourigny, 2010), *Hospital Anxiety and Depression Scale* (Karatzias et al., 2014), *Beck Depression Inventory* (Dorrepaal et al., 2010), and the *Trauma Symptom Checklist for Children*

(Misurell et al., 2011, Springer et al., 2012). Table 3 details the individual study results (M , SD , d) for depression.

Table 3

Depression Studies Results

Study	n	Pretest $M(SD)$		Posttest $M(SD)$		d	
		PE Grp	Con	PE Grp	Con	PE Grp	Con
Dorrepaal et al. (2010)	11	34 (10)	N/A	22 (12)	N/A	1.086	N/A
Herbert & Tourigny (2010)	88	66.33 (24.95)	65.30 (19.48)	56.73 (26.46)	65.24 (20.95)	.374	.003
Karatzias et al. (2014)	37	10.5 (4.6)	N/A	10.4 (4.7)	N/A	.022	N/A
Misurell et al. (2011)	17	48.94 (7.76)	N/A	45.41 (6.34)	N/A	.498	N/A
Springer et al. (2012)	16	58.19 (6.35)	N/A	49.36 (8.45)	N/A	1.181	N/A

Of the studies that examined the use of psychoeducational groups for the treatment of depression as an adverse outcome of CSA, two of the psychoeducational group interventions, Dorrepaal et al. (2010) and Springer et al. (2012) had a large effect ($d = 1.09$ and $d = 1.18$, respectively). Herbert and Tourigny (2010) found that compared to the control group who received individual counseling ($d = .00$), the psychoeducational group had nearly a medium effect ($d = .37$). In addition, Misurell et al. (2011) psychoeducational group produced a medium effect ($d = .50$). Finally, the psychoeducational group provided in Karatzias et al. (2014) had a small effect ($d = .02$).

Dissociative Symptoms

Dissociation is defined as a “disconnection and lack of continuity between thoughts, memories, surroundings, actions, and identity” (Dissociative Disorder, 2017). Dissociative symptoms may include amnesia, depersonalization, derealization, identity confusion, and identity alteration. A common example of dissociating is driving and arriving at your destination and not remembering what occurred during your travel. Derealization can occur in different ways, flash backs to their experience(s) of CSA and feel their location at the time of the flashback is unreal or may look at themselves and not recognize themselves. Three out of the 9 articles examined symptoms of dissociations. The following scales were used to measure symptoms of dissociation: *Child Dissociative Checklist* (Herbert & Tourigny, 2010), and *Dissociative Experiences Scale* (Dorrepaal et al., 2010, Karatzias et al., 2014). Table 4 details the individual study results (*M*, *SD*, *d*) for the dissociation. Summary of findings?

Table 4

Dissociation Studies Results

Study	<i>n</i>	Pretest <i>M(SD)</i>		Posttest <i>M(SD)</i>		<i>d</i>	
		PE Grp	Con	PE Grp	Con	PE Grp	Con
Herbert & Tourigny (2010)	80	4.94 (5.20)	6.86 (4.30)	3.52 (3.89)	5.81 (3.78)	.309	.259
Dorrepaal et al. (2010)	16	33 (21)	N/A	29 (21)	N/A	.190	N/A
Karatzias et al. (2014)	37	31.2 (19.3)	N/A	32.4 (18.9)	N/A	.063	N/A

Out of the 3 studies that examined the impact psychoeducational groups have on reducing symptoms of dissociation survivors have after experiencing CSA, the psychoeducational group intervention provided in Dorrepaal et al. (2010) had a small effect (.19) and Karatzias et al.

(2014) had a small effect ($d = .06$). Herbert and Tourigny (2010) found that both the psychoeducational group ($d = .31$) and the control group ($d = .26$) who received individual therapy produce a small effect.

Externalizing Behaviors

Five out of the 9 studies addressed externalizing behaviors. Externalizing behaviors refer to external conflicts with others in addition to the violation of social norms (e.g., rule-breaking). Externalizing behaviors may include physical aggression towards people and/or animals, arson, drug use, vandalism, disobeying home and school rules, or sexual misconduct. The following scales were utilized to measure externalizing behaviors: *Youth Self-Report and Profile* (Tourigny et al., 2005), *Child Behavior Checklist* (Hebert & Tourigny, 2010), *Child Behavior Checklist* (Misurell et al., 2011, Springer et al., 2012), and *African Youth Psychosocial Assessment Instrument* (O'Callaghan et al., 2013). Table 5 details the individual study results (M , SD , d) for externalizing behaviors.

Table 5

Externalizing Behaviors Studies Results

Study	<i>n</i>	Pretest <i>M(SD)</i>		Posttest <i>M(SD)</i>		<i>d</i>	
		PE Grp	Con	PE Grp	Con	PE Grp	Con
Herbert & Tourigny (2010)	80	57.16 (13.19)	62.11 (9.85)	54.62 (11.79)	61.89 (9.07)	.203	.023
Misurell et al. (2011)	47	58.83 (12.58)	N/A	55.30 (13.06)	N/A	.275	N/A
O'Callaghan et al. (2013)	52	8.58 (6.33)	8.07 (6.67)	1.96 (3.17)	9.36 (8.93)	1.322	.164
Springer et al. (2012)	64	62.11 (8.24)	N//A	58.77 (10.03)	N/A	.364	N/A
Tourigny et al. (2005)	41	17.8 (8.4)	14.4 (6.8)	15.0 (7.8)	15.8 (8.0)	.345	.189

Five studies examined the use of psychoeducational groups on reducing externalizing behaviors after experiences of CSA. As for two studies that included a control group, Herbert & Tourigny (2010) found that the psychoeducational group had a small effect ($d = .20$) and the control group which received individual sessions had a small effect ($d = .02$). Tourigny et al. (2005) findings indicate that the psychoeducational group had nearly a medium effect ($d = .36$) and the control group (no treatment) had a small effect ($d = .19$). Misurell et al. (2011) findings indicate that the psychoeducational group has a small effect ($d = .28$) and Springer et al. (2012) psychoeducational group had nearly a medium effect ($d = .36$). O'Callaghan et al. (2013), however, found that the psychoeducation group had a large effect ($d = 1.32$) compared to the waiting list control group having a small effect ($d = .16$).

Posttraumatic Stress Disorder

All of the studies included in the meta-analysis addressed symptoms of posttraumatic stress disorder (PTSD). According to the DSM-IV, “The essential feature of PTSD is the development of characteristic symptoms following exposure to one or more traumatic events” (American Psychiatric Association, 2000). According to the DSM-V symptoms of PTSD include (1) recurrent distressing memories, (2) recurrent distressing dreams, (3) dissociation (i.e., flashback) accompanied by feeling or behaviors as if the traumatic event was recurring, (4) psychological distress when exposed to internal or external cues that reminds one of the traumatic event, (5) physiological distress when exposed to internal or external cues that reminds one of the traumatic event, (6) persistent avoidance of reminders associated with the traumatic event (7) negative change in cognition and or mood after the traumatic event, and (8) change in arousal and reactivity after the traumatic event (American Psychiatric Association, 2013). The following instruments were utilized to measure symptoms of PTSD: *Trauma Symptoms Checklist for Children* (Tourigny et al., 2005), *Children’s Impact of Traumatic Event Scale-II* (Hebert & Tourigny, 2010), *PCL-C* (Karatzias et al., 2014), *Davidson Trauma Scale* (Dorrepal et al., 2012, Dorrepal et al., 2010), and *Structured Interview For Disorders Of Extreme Stress* (Dorrepal et al., 2012). For this study, only data from the *Davidson Trauma Scale* from Dorrepal et al. (2012) was gathered which assessed for DSM related post-traumatic stress outcomes following CSA (not complex) as the *Structured Interview For Disorders Of Extreme Stress* domains to assess complex PTSD extend beyond the DSM criteria (e.g., affect dysregulation, somatization, systems of meaning). Further, the *Trauma Symptoms Checklist for Children* (Misurell et al., 2011 & Springer et al., 2012), *UCLA PTSD Reaction Index* (O’Callaghan et al, 2013), and the *Kiddie Schedule for Affective Disorders and Schizophrenia* (Trowell et al., 2002) were utilized to

measure participants symptoms of PTSD. Trowell et al. (2002), focused on the re-experiencing of trauma and persistent avoidance of stimuli. For this study, data was only pulled from the re-experiencing of trauma scores as the persistent avoidance of stimuli scores overlapped with symptoms of depression and anxiety, in addition to other avoidance behaviors (e.g., decrease interest and restricted affect). Table 6 details the individual study results (M , SD , d) for symptoms of PTSD.

Table 6

PTSD Studies Results

Study	<i>n</i>	Pretest <i>M(SD)</i>		Posttest <i>M(SD)</i>		<i>d</i>	
		PE Grp	Con	PE Grp	Con	PE Grp	Con
Dorrepaal et al. (2010)	20	89 (22)	N/A	62 (29)	N/A	1.049	N/A
Dorrepaal et al. (2012)	60	91.4 (21.8)	80.5 (23.1)	66.7 (29.4)	65.5 (30.3)	.954	.557
Herbert & Tourigny (2010)	88	45.69 (18.99)	51.02 (13.17)	34.39 (19.13)	46.19 (18.28)	.593	.303
Karatzias et al. (2014)	37	56.7 (13.5)	N/A	58.2 (12.3)	N/A	.116	N/A
Misurell et al. (2011)	17	49.94 (7.39)	N/A	47.71 (8.13)	N/A	.287	N/A
O'Callaghan et al. (2013)	52	40.88 (10.03)	40.29 (10.91)	18.38 (10.53)	42.93 (13.67)	2.188	.213
Springer et al. (2012)	20	57.35 (6.84)	N/A	52.65 (6.88)	N/A	.685	N/A
Tourigny et al. (2005)	41	69.7 (26.0)	60.9 (26.1)	46.3 (18.3)	62.3 (20.7)	1.041	.059
Trowell et al. (2002)	68	7.0 (2.18)	7.9 (2.14)	0.50 (2.5)	1.82 (2.4)	2.771	2.674

All of the studies examine the impact psychoeducational groups have on reducing symptoms of PTSD. For the studies that did not include a control group, the effects varied.

Dorrepaal et al. (2010) found that the psychoeducational group had a large effect ($d = 1.05$) in reducing symptoms of PTSD and Springer et al. (2012) psychoeducational group nearly had a large effect ($d = .69$). However, the psychoeducational group intervention provided in Karatzias et al. (2014) and Misurell et al. (2011) produce a small ($d = .12$) and medium ($d = .29$), respectively.

In regard to studies that included a control group, Trowell et al. (2002) found a large effect for the psychoeducational group ($d = 2.77$) and the control group ($d = 2.67$) which received individual sessions. Tourigny et al. (2005) psychoeducational group had a large effect ($d = 1.04$), while the control group (no treatment) has a small effect ($d = .06$). Compared to the small effect of the waiting list ($d = .21$), the psychoeducational group provided in O'Callaghan et al. (2013) had a large effect ($d = 2.19$). Dorrepaal et al. (2012) psychoeducational group had a large effect ($d = .95$) as well compared to the medium effect of the individual sessions ($d = .56$). Lastly, Herbert and Tourigny (2010) found that the psychoeducational group has a medium effect ($d = .60$) compared to the small effect ($d = .30$) individual sessions had.

Meta-Analysis Results

The 9 articles included in the meta-analysis produce a sample size of 465 male and female participants. Of the 465 participants, 320 were included in the treatment group while 145 were included in the control group. Cohen's d was interpreted based Cohen (1988) suggested benchmarks: small ($d = 0.2$), medium ($d = 0.5$), and large ($d = 0.8$). The results relative to anxiety indicated psychoeducational groups overall were significant in reducing symptoms of anxiety with a medium effect size (Cohen's $d = 0.63$, 95% CI: .07 to 1.18) with substantial evidence of true heterogeneity ($I^2: 78\%$). Relative to depression, the results suggest that psychoeducational groups significantly reduces symptoms of depression with a medium effect

size (Cohen's $d = .48$, 95% CI: .10 - .87) with moderate evidence of heterogeneity (I^2 : 45%). The research also found a significant medium effect of psychoeducational groups in reducing externalizing behaviors (Cohen's $d = 0.46$, 95% CI: .17 to .74) with moderate evidence of true heterogeneity (I^2 :46%). Lastly, psychoeducational groups had the largest significant effect on reducing symptoms of PTSD (Cohen's $d = 0.66$, 95% CI: .27 to 1.05) with substantial evidence of true heterogeneity (I^2 : 75%). In contrast, regarding dissociative symptoms, psychoeducational groups had a small effect on reducing symptoms (Cohen's $d = 0.10$, 95% CI: -.19 to .39) with no evidence of true heterogeneity (I^2 : 0%). However, the results of the effect size for treating dissociative symptoms were non-significant. Nonetheless, psychoeducational groups were found significantly effective in reducing psychopathology for individuals who experience CSA, having a medium effect (Cohen's $d = 0.40$, 95% CI: .25 to .56). The results of the meta-analysis are presented in Table 7

Table 7

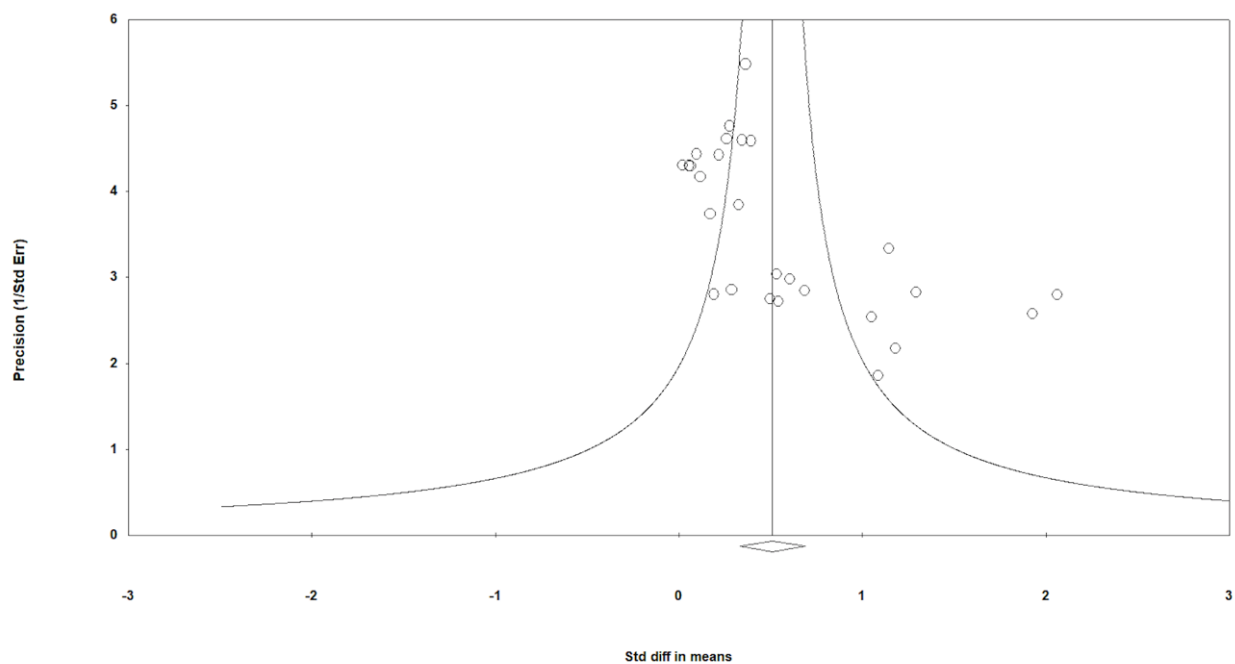
Meta-Analysis Results

Outcome of CSA	Cohen's d	Lower Limit	Upper Limit	p	I^2
Anxiety	.625	.070	1.180	.027	78.283
Depression	.482	.097	.868	.014	44.661
Dissociation	.099	-.190	.338	.502	0.000
Externalizing Behaviors	.455	.170	.740	.002	45.517
PTSD	.661	.274	1.049	.001	74.602
Overall	.402	.246	.559	.001	

Publication Bias and Internal Validity

Meta-analyses interpretations should be considered while accounting for publication bias and internal validity. Publication bias, a source of type I error, refers to studies with statistically significant findings having a better chance of publication and an increased chance of being published in prestigious journals (Greco et al., 2013). Figure 1 is a graphical representation that was used to evaluate the presence of publication bias for this study. In this funnel plot by precision, the effect size is shown versus the precision. Small studies tend to appear toward the bottom, while larger studies tend to appear toward the top of the graph. Figure 1 demonstrates an asymmetrical plot in the presence of publication bias due to the high quality of small studies. Also, the asymmetrical plot for this study may be a result of moderate to substantial true heterogeneity (Stern & Harbord, 2004). Internal validity was maintained by strictly following PRISMA-P. The study presented with focused research questions that were clinically relevant for a multitude of helping professionals (e.g., medicine, counseling, social work, social service). The literature search was comprehensive, and references of included articles were hand-searched to warrant article saturation. The characteristics of the study were thoroughly examined as there were inclusion and exclusion criteria. See Appendix C for details the standardized approach utilized to determine the internal validity for the meta-analyses (Russo, 2007).

Figure 1

Funnel Plot of Precision by Standard Difference in Means**Summary**

In summary, of the articles included in the meta-analysis, the psychoeducational groups had a significant medium effect on reducing symptoms of anxiety, depression, externalizing behaviors, and PTSD. However, psychoeducational groups had a non-significant, small effect on reducing dissociation symptoms. Overall, psychoeducational groups had a significant medium effect on reducing symptoms of anxiety, depression, dissociation, externalizing behaviors, and PTSD. Group factors and group topics were two themes that emerged from the thematic analysis by the use of NVivo. Group factors include the structuring and directing of the psychoeducational groups in addition to the use of activities, lectures, and personal stories. Group topics include trauma characteristics, shame and guilt, internalizing and externalizing behaviors, protection and boundaries, affect expression and modulation, and coping strategies.

CHAPTER 5

FINDINGS, CONCLUSIONS, AND DISCUSSIONS

Introduction

Chapter one provided an introduction to the study, presenting background information on CSA, the purpose and rationale of the study, and the research questions. In addition, chapter one provided a brief overview of the research design, the Traumagenic Dynamic Model as the conceptual framework, and limitations of systematic review and meta-analyses. Finally chapter one ends with the definitions of terms and key concepts. Chapter two provided a review of the literature relevant to CSA organized by definitions, prevalence, historical context, theories, outcomes of CSA, and treatment modalities in addition to psychoeducational groups. Further, chapter two provided an overview of the initial search for articles to include in the meta-analysis. Chapter three detailed the methodology of the study, the systematic review, and meta-analysis. As two distinctive processes, chapter three explains each step for the systematic review and each step for the meta-analysis. Chapter four presented the research findings from the systematic review, thematic analysis, and meta-analysis. The next section will present an overview of the study. This chapter will provide a review of the previous chapters followed by an overview of the study's procedures and major findings. Next, there will be a brief discussion of the findings followed by conclusions organized by the study's research questions. This chapter ends with a summary, synopsis of the generalizability of the study's findings, limitations of the study, clinical implications, and suggestions for future research.

Overview of Procedures

The purpose of this study was to examine the effectiveness of using psychoeducational groups for the treatment of psychopathology after CSA. Specifically, the study aimed to examine

how effective psychoeducational groups were on reducing symptoms of anxiety, depression, dissociation, PTSD, and externalizing behaviors across a wide range of CSA survivors. This research also sought to identify psychoeducational groups variables that may impact treatment outcomes and identify themes across studies. This was accomplished by conducting a systematic review and random effects meta-analysis on related studies that met a set of criteria and were conducted since 2000. Research inquires have found that psychoeducational groups produce favorable outcomes in treating the adverse cognitive, affective, social, and behavioral problems individuals exhibit after CSA. However, to the researcher's knowledge, no meta-analysis has been conducted to purport the overall effect. It is vital to consider the overall effect of psychoeducational groups to treat adverse outcomes of CSA as CSA continues and has been declared an epidemic. In addition, CSA is a risk factor for subsequent psychological and physiological concerns that may continue to manifest in adulthood. Thus, this study aimed to address the following research questions:

Research question 1 – Are psychoeducational groups effective in treating CSA?

Research question 2 – What are the themes across studies used in the meta-analysis?

Research question 3 – What psychoeducational group factors and topics emerged from the qualitative analysis?

Major Findings

The following provides an overview of the major findings. First, themes that emerged from the thematic analysis will be discussed followed by a synopsis of each theme that was discovered by the use of NVivo.

Themes

Two themes emerged from the thematic analysis: group factors and group topics. Group factors consist of the structuring and directing of the group and the use of activities, lectures, and personal stories. Group topics included trauma characteristics, shame and guilt, internalizing and externalizing behaviors, protecting and boundaries, affect expression and modulation, and coping strategies. Group factors and group topics were discussed in each study no matter the varied population, setting, or CSA experience.

Qualitative Synthesis

The qualitative analysis completed by NVivo produced codes that were generated into the aforementioned themes. Group factors consisted of the following codes: structuring, directing, activities, lectures, and personal stories. Group topics consisted of the following codes: trauma characteristics, shame and guilt, internalizing and externalizing behaviors, protection and boundaries, affect expression and modulation, and coping strategies. Structuring and directing refer to the structure of the psychoeducational group guided by a manual as well as who and how the group is facilitated. Group facilitators included individuals with exposure to social science professions and received training and supervision. Activities, lectures, and personal stories were used as a means to guide the didactic, experiential, and processing components of the psychoeducational groups. Group topics included trauma characteristics, discussions regarding the psychological and biological consequences of CSA, shame and guilt discussions included associated feelings and how to manage these, topics about internalizing and externalizing behaviors included social skills, anger management, and ways to monitor behaviors. Protection and boundaries topics included sex education, the use of assertive skills, and enhancing self-protecting skills. Affect expression and modulation discussions focused on the recognition,

expression, and management of emotions. Finally, coping skills included discussions of physical, emotional, and cognitive self-care strategies.

Meta-analysis Findings

Google Scholar, PubMed, PsycARTICLES, PsycINFO, Child Development & Adolescent Studies, Science Citation, Science Direct, and Medline were searched and produced 69,073 articles linked to the use of psychoeducational groups for CSA. Of the 69,073, 49,206 articles were published after 2000. The first 300 articles of each database were screened, totaling 2,400 screened articles. Of the 2,400 screened articles, 2,362 were excluded, leaving 38 full-text articles that were assessed for eligibility. The 2,362 articles were excluded because the study focused only on psychoeducation (e.g., providing psychoeducation during an individual session) versus psychoeducational groups. Of the 38 full-text articles that were assessed for eligibility, 24 were excluded, leaving 14 articles for the thematic analysis. However, only 8 of the 14 articles provided sufficient data to calculate Cohen's d . Considering all inclusion criteria, eight articles were initially included in the meta-analysis. Another article that met the criteria was discovered from the hand-search of article references resulting in nine articles included in the meta-analysis (see Appendix B). The nine articles provided a sample size of 465 diverse male and female participants of various ages. All studies met the following inclusion criteria (1) conducted since 2000, (2) psychoeducational groups were used as an intervention, (3) data was provided specific to the psychoeducational group, and (4) sufficient data were provided to compute Cohen's d . Of the 9 articles included in the meta-analysis, 5 produced Cohen's d scores ($n = 7$) for anxiety, 5 produced Cohen's d scores ($n = 6$) for depression, 3 produced Cohen's d scores ($n = 4$) for dissociation, 5 produced Cohen's d scores ($n = 7$) for externalizing behaviors, and all 9 articles produced Cohen's d scores ($n = 14$) for PTSD. As previously stated, the meta-analysis results

indicate that psychoeducational groups have a medium effect on treating symptoms of anxiety (Cohen's $d = 0.63$), depression (Cohen's $d = .48$), and externalizing behaviors (Cohen's $d = 0.46$) subsequent CSA. Further, psychoeducational groups had a medium effect on treating symptoms of PTSD (Cohen's $d = 0.66$), but a small effect on treating dissociative symptoms (Cohen's $d = 0.10$). Largely, psychoeducational groups have a medium effect (Cohen's $d = 0.40$) on treating psychopathology individuals experience after CSA.

Conclusions

While experiences of CSA incidents may include variations of age, race, ethnicity, type of CSA, and the number of incidents, psychoeducational groups are effective in treating the psychopathology that arises after the abuse. The following conclusions are derived from the analyses, findings, and details how the findings relate to or differ from the current pool of literature that was discussed in chapter two.

RQ #1: Are psychoeducational groups effective in treating CSA?

The conclusion is that psychoeducational groups produce favorable intervention outcomes, such as alleviating psychopathology individuals experience after CSA. In addition to decreasing symptoms of anxiety, depression, dissociation, externalizing behaviors, and PTSD, the individual studies examined during the thematic analysis indicate that psychoeducational groups produce favorable treatment outcomes, such as reducing internalizing behaviors beyond depression and anxiety and enhancing knowledge of safety and increasing use of safety skills. The positive behavioral changes and mental stability CSA survivors exhibited after participating in psychoeducational groups were also observed by parents of children and partners of adults.

RQ #2: What are the themes across studies used in the meta-analysis?

Conclusions from the thematic analysis confirm CSA as process-oriented in that the group factors and group topics aimed to address the processes of psychologically adapting to life following CSA. The group factors sustained a safe and secure structure and climate for participants to gain social knowledge of the mechanisms to adapt to life after CSA. The group topics elucidate the complex, process-orientation of CSA.

RQ #3: What psychoeducational group factors and topics emerged from the qualitative analysis?

The conclusion was that similar format, factors and topics contributed to the positive outcomes for the psychoeducational groups. Each psychoeducational group session had a similar format that centered the purpose and focus of the psychoeducational group. Each group factor and topics discussed hold important implications for psychoeducational group approaches to treat psychopathology succeeding CSA. Through the group factors, participants were able to have a safe, therapeutic experiential learning setting where they were able to acquire knowledge and practice skills. The structuring and sequence of topics are integral parts of the group experience and were useful in finding a balance between the dissemination of information and the processing of content.

Discussion

Psychoeducational group formats itself play a role in psychological adjustments in that they provide safe opportunities for group members to gain knowledge and begin practicing healthy social skills, safe boundaries, and gain a sense of social acceptance. The topics discussed elucidate the complex, process-orientation of CSA and how the traumagenic dynamics encapsulate the development of psychopathology subsequent to CSA that may emerge into

adulthood. For instance, stigmatization refers to a survivors' cognitive distortions resulting in post-traumatic guilt, a topic discussed in the psychoeducational group. These cognitive distortions may lead to externalizing behaviors and in turn, lead to other signs of psychopathology, such as withdrawal behaviors. Another example, powerlessness refers to survivors' feelings of helplessness and hopelessness, and these feelings may result in externalizing behaviors including delinquency, sexual violence, or aggression. Topics addressed in the psychoeducational group covered anger management, assertiveness, and sexuality demonstrating the need for body awareness, that is, how the survivor reacts to their body sensations. To illustrate, feeling of helplessness may come with body sensations (e.g., constricted, trembly, drained) which may result in, for example, the use of drugs to alleviate such body sensations. Contributing to CSA survivors' growing body of knowledge and body awareness is the starting point for survivors' psychological adjustments. Coupled with group factors (e.g., the use of activities) social interactions between the group members and group facilitators and the groups' connections were fostered by shared personal stories. Activities were used as stimuli to participants' sharing of their personal stories. The scope of topics focused on the enrichment of knowledge necessary for sustained psychological adjustments. Group topics guided CSA survivors in gaining insight into the CSA event, affording survivors opportunities to modify their cognitive distortions necessary for psychological adjustment and acceptance of their behavioral and mental changes subsequent to the treatment.

The use of lectures helped group facilitators present key content and background information about CSA. Stubbley and McCroy (2014) defined psychosocial adjustment associated with CSA as the psychosocial accommodation to a survivor's life after the CSA event and the group topics gave a clear indication of the psychoeducational groups' objectives of informing

survivors that (1) psychosocial accommodations are necessary, (2) CSA and psychological adjusting is a process, and (3) survivors possess the power to adjust to life after CSA. Group facilitators were creative in transmitting information to group members in an effort to promote and improve CSA survivors' use of knowledge outside of the group, such as using activities.

Activities utilized reflective diaries, making a list, creative disclosures, age-appropriate gaming (e.g., personal space relay race), group exercises, storytelling, therapeutic skits, and use of other creative activities (e.g., drawings, collages, paintings). Experiential activities, visual aids, and audio were also utilized. While the use of activities was common for these psychoeducational groups, it is the processing of the activity that required as much time as the implementation. The effectiveness of a psychoeducational group is based upon a balance of didactic, experiential, and processing components (Furr, 2000). The activities used in the psychoeducational group navigated the dissemination of information, practicing of skills, and processing of content and reactions. Brown (2013) further explains how the use of creative activities guides internal and external group experiences. Group member's growth and development and self-awareness are stimulated and enhanced through the production of activities, disclosure of reactions while engaging in the activities, and when receiving feedback from other group members which, in turn, promotes self-disclosures. Supporting the variance in the use of self-disclosures, Furr (2000) stated that self-disclosures should be initially guided by activities that promoted surface disclosures during the earlier sessions and gradually advance to a deeper intrapersonal level during the later sessions. Supporting Furr's recommendations of the use of self-disclosures, when self-disclosures were encouraged, it was through gaming or activities for nonverbal acknowledgments and disclosure (e.g., head nodding yes) or verbally when participants were guided in providing a narrative description of their experience.

The structuring of the group slightly varied with the majority of the psychoeducational group lasting 2 hours for 12 sessions. There were not any psychoeducational groups that allowed more than 12 participants. Furr (2000) asserts that the natural evolution of psychoeducational groups should be considered when designing. While earlier sessions aim to provide a sense of safety, later sessions gradually shift to a deeper interpersonal level. The structure, directing, and use of activities support this assertion in that, for example, the use of activities were used during what may have been viewed by survivors as a challenging session, such as disclosing personal stories which required an increased sense of support, safety, and social acceptance. Also demonstrated by the findings of the thematic analysis, participants' sense of safety may have been associated with the group facilitators directing, qualifications, and training. Whether it be a licensed professional (e.g., psychologist, psychiatrist, psychotherapist, social worker) or a master's or doctoral level student, the facilitators had been exposed to social science and were required to obtain training and routine supervision. Furr (2000) purported that once psychoeducational groups have been designed, implemented, and refined, the group can be facilitated by different facilitators without the loss of effectiveness. To add to this, facilitators' work was guided by the use of prearranged topics, activities, and processing provided in a manual.

Psychoeducational group enhances the therapeutic factor of universality (Yalom, 1995) through reducing the shame and stigma about CSA. Although survivors may have responded to CSA incidents in different ways, the psychoeducational groups helped CSA survivors recognize that their CSA experience is shared with others in the group and abroad. The psychoeducational groups allowed CSA survivors to encounter others CSA survivors who may be experiencing

similar cognitive, psychological, and physiology consequences of the sexual abuse which reduced their feelings of isolation and led to healing.

Summary

This study examined the effectiveness of psychoeducational groups to treat psychopathology following CSA. This was accomplished by conducting a systematic review of related articles meeting the following criteria (1) conducted since 2000, (2) used psychoeducational groups to treat CSA, and (3) provide data specific to the psychoeducational group. A meta-analysis was conducted on studies that met the aforementioned inclusion criteria and provided sufficient data to calculate Cohen's *d*. A thematic analysis was completed to identify themes pertinent to the efficacy of the psychoeducational groups.

From this study, it was determined that psychoeducational groups significantly produce favorable outcomes in treating psychopathology consequent to CSA. Specifically, the results of the meta-analysis indicate that psychoeducational groups are significantly effective in treating the consequences of CSA with a medium effect. Aiding in its efficacy is the commonality of psychoeducational group factors and group topics. As the need for effective treatment arises to treat individuals who have experienced CSA, psychoeducational groups must be facilitated by trained facilitators and strategically designed to have a balance of didactic, experiential, and processing components to meet this demand.

Generalizability

External validity, which is determining the generalizability of a study, was assessed by selecting a sample that is representative of the CSA population to which the results can be applied. When evaluating the effect of an intervention, it is important to consider ethical appropriateness as one intervention for a CSA survivor of a particular cultural background may

not be acceptable for another (Petticrew & Roberts, 2006). For this reason, the sample participants included children, adolescents, and adults of various racial, social, and cultural backgrounds with a history of CSA who exhibit psychopathology. While the participants differed in settings and cultural factors, the results of the individual studies show that psychoeducational groups are effective in reducing psychopathology for a myriad of CSA populations. While there were a low number of studies meeting the criteria for the meta-analysis, the individual studies were conducted in several settings with various populations; therefore there was a high indication that the results of the individual studies and the results of this study are generalizable. However, given the variability of topics discussed and structuring of the sessions (e.g., durations), there is a limit to the generalizability in that the psychoeducational group examined in this study, at a minimum, consisted of 10 weekly sessions that were facilitated by trained and supervised group facilitator with exposure to social science. There were no more than 12 group members in the sessions. Furthermore, there were exclusion criteria that do not allow generalizability to populations with diagnoses of severe psychosis, personality disorders, significant cognitive impairments, and did not allow for generalizability to CSA populations enrolled in more than one treatment program concurrently.

Limitations of Current Study

The primary limitation of this study is the number of studies included in the meta-analysis and not every study examined all of the selected outcomes of CSA. For instance, PTSD was examined by all nine articles; however, only three studies examined dissociations. The limitations of this study also include the limitations of the individual studies included in the meta-analysis. In regard to gender, while a few studies included male participants, females outnumbered male participants in the individual studies and collectively for this meta-analysis.

In addition, although studies excluded participants who were enrolled in other treatment programs concurrently with the research intervention, the heterogeneity of reported and not-report treatment history of participants may have led to treatment effects.

Implications of Current Study

Psychoeducational groups have been found useful in providing individuals with information that is directly applicable to their lives. Whether it be to instill greater self-awareness, promote healthy social skills, or inform individuals of psychological and physiological consequences following a particular experience, psychoeducational groups produced favorable outcomes. For this study, the purpose of the psychoeducational groups was to enhance CSA survivors' awareness of the emotional, cognitive, and behavioral consequences of CSA and to encourage CSA survivors to face these consequences with healthy coping and affect regulation.

Clinical Implications

Individuals who experience CSA may experience psychopathology extend beyond childhood and exist during adulthood. CSA is not a single incident, but a traumatic process during which the abused individual emotional, behavioral, and cognitive consequences much be considered within the context of the individual's childhood, culture, CSA experience, and life after the CSA event. Thus, helping professionals need to understand CSA from a theoretical perspective and the individual's standpoint. All things considered, the traumagenic dynamics play a role in the psychological adjustment and emotional regulation of CSA survivors. Thus, treatment focuses should be on interventions that are focused on aiding in the psychological adjustment of CSA survivors. Just as CSA is a process, psychological adjustment is a process and psychological adjustments play a major role in survivors' life after CSA. Helping

professionals should consider psychoeducational groups to treat individuals who have experienced CSA because the psychoeducational groups have been found favorable in stabilizing behavioral, emotional, and cognitive problems necessary for psychological adjustments. Further, the results of the individual studies indicate that psychoeducational groups were found useful for continued stabilization and reduction in psychopathology post-therapy and follow-up.

Implications for Psychoeducational Group Programs and Providers

Psychoeducational group providers need to remain aware of effective group factors and group topics and implement strategies that enhance treatment fidelity. Research has increase confidence in findings of research inquiries focused on examining the effectiveness of an intervention and psychoeducational group providers ought to engage in ongoing assessment and monitoring of the group to ensure the intervention is being implemented as intended. To maximize treatment fidelity, guidelines and strategies ought to include provider training and supervision. In addition, whether used throughout the entire session or partially used, curriculums or treatment manuals should be infused in the treatment design. Psychoeducation dissemination should focus on areas that provide group members with understanding and skills to being psychological adjustments after their experience of CSA. Not only are the group topics vital to the intervention outcomes, the structure and directing of the group may play a major role. Providers may select activities to implement to aid in the dissemination and processing of information which also provides opportunities for group members to practice skills, such as social skills and cognitive restructuring.

Implications for Counselor Education and Supervision

Notably, the use of psychoeducational groups to treat CSA survivors produce favorable results in that psychoeducational groups were found effective in reducing symptoms of

psychopathology. Particularly, this study found that psychoeducational groups were effective in reducing symptoms of anxiety, depression, dissociation, externalizing behaviors, and PTSD. The findings also indicate that psychoeducational groups have group factors and group topics that may aid in its efficacy to treat psychopathology resulting from CSA. Psychoeducational groups required just as much planning and preparation as psychotherapy groups. Counselor educators have a duty to gatekeep and equip emerging counselors. The prevalence and outcomes of CSA present an urgency to include related content in the classrooms to better equip beginner counselors to provide effective counseling services to vulnerable groups, such as survivors of CSA. Counselor educators should raise awareness, promote advocacy, and educate emerging counselors of CSA as a process-oriented.

Recommendations for Future Research

The limitations of this research offer opportunities for further research and practices. A limitation of this study is the limits to generalizability due to individual studies' samples. The individual studies' exclusion criteria did not allow for the findings of this study to be generalized to populations with diagnoses of severe psychosis, personality disorders, significant cognitive impairments. Future research needs to examine the use of psychoeducational groups for CSA survivors with diagnoses that often lead to exclusion of group treatment. In addition, very few of the meta-analysis articles included males as participants; thus, there is room for future research on male experiences of CSA and the use of psychoeducational groups to treat male survivors. Research on male participants will provide greater direction in the parallel and distinctive treatment needs of male CSA survivors compared to female survivors.

While the effectiveness of a psychoeducational group was found to be impacted by group factors and group topics, it is necessary to evaluate the process. Group processes and group

dynamics are major tenets of group counseling. As seen from the individual studies included in this study's analyses, researchers have focused on the directing of psychoeducational groups and group topics. Future research needs to address the process work (e.g., stages of group development) and group dynamics (e.g., group member resistance) of psychoeducational groups aimed to treat psychopathology individual exhibit after CSA. Utilizing a qualitative approach will allow researchers to gather an in-depth understanding of group members' perspectives on the process work and group dynamics. Further, qualitative approaches will allow researchers to rigorously generate CSA survivors' unique insight into their personal and shared experiences of the psychoeducational group.

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APPENDIX A

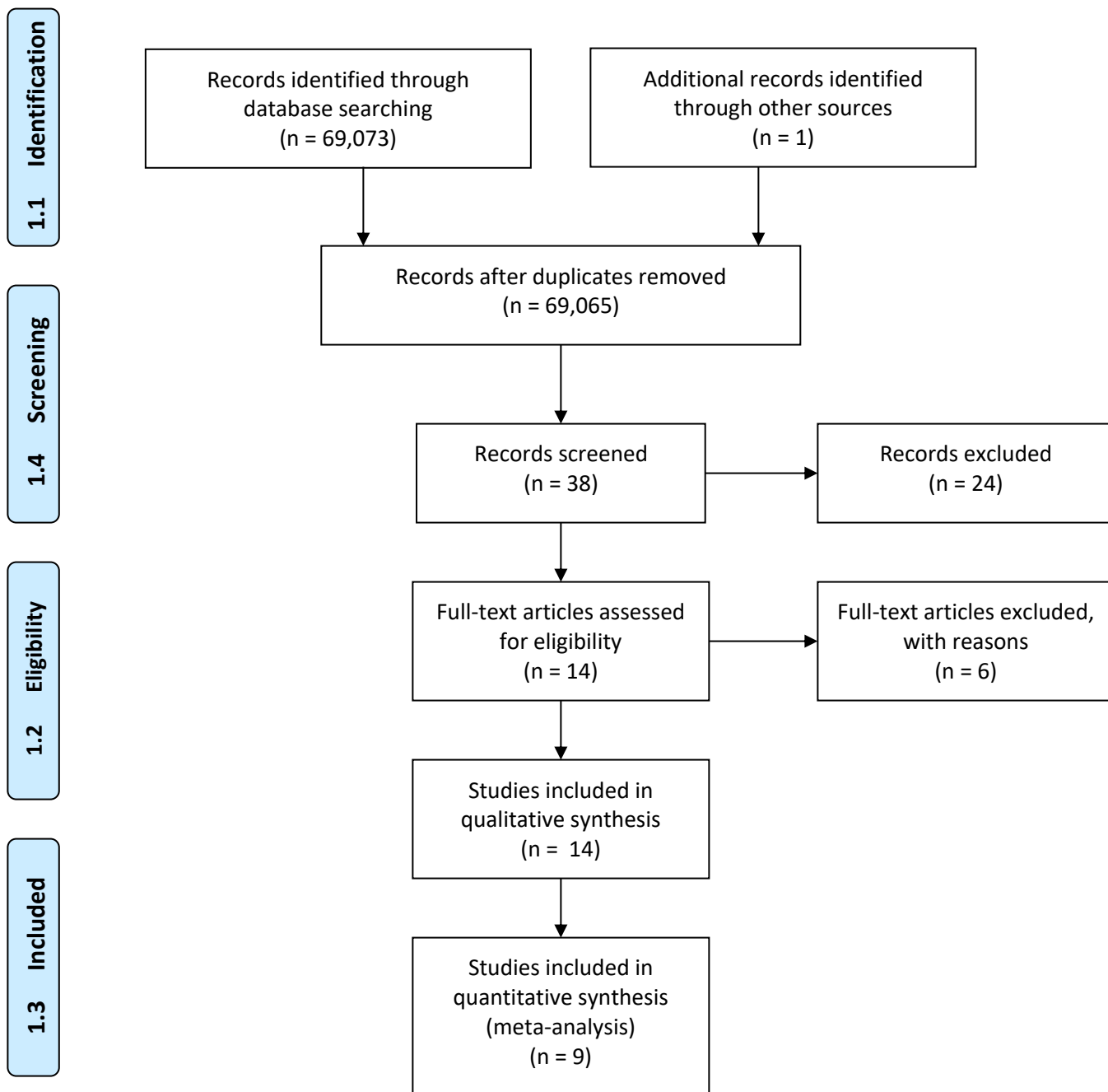
PRISMA-P (PREFERRED REPORTING ITEMS FOR SYSTEMATIC REVIEW AND META-ANALYSIS PROTOCOLS) 2015 CHECKLIST: RECOMMENDED ITEMS TO ADDRESS IN A SYSTEMATIC REVIEW PROTOCOL

Section and topic	Item No	Checklist item
ADMINISTRATIVE INFORMATION		
Title:		
Identification	1a	Identify the report as a protocol of a systematic review
Update	1b	If the protocol is for an update of a previous systematic review, identify as such
Registration	2	If registered, provide the name of the registry (such as PROSPERO) and registration number
Authors:		
Contact	3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author
Contributions	3b	Describe contributions of protocol authors and identify the guarantor of the review
Amendments	4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments
Support:		
Sources	5a	Indicate sources of financial or other support for the review
Sponsor	5b	Provide name for the review funder and/or sponsor
Role of sponsor or funder	5c	Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol
INTRODUCTION		
Rationale	6	Describe the rationale for the review in the context of what is already known
Objectives	7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)
METHODS		
Eligibility criteria	8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review
Information sources	9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage
Search strategy	10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated
Study records:		
Data management	11a	Describe the mechanism(s) that will be used to manage records and data throughout the review
Selection process	11b	State the process that will be used for selecting studies (such as two independent reviewers) through each phase of the review (that is, screening, eligibility and inclusion in meta-analysis)

Data collection process	11c	Describe planned method of extracting data from reports (such as piloting forms, done independently, in duplicate), any processes for obtaining and confirming data from investigators
Data items	12	List and define all variables for which data will be sought (such as PICO items, funding sources), any pre-planned data assumptions and simplifications
Outcomes and prioritization	13	List and define all outcomes for which data will be sought, including prioritization of main and additional outcomes, with rationale
Risk of bias in individual studies	14	Describe anticipated methods for assessing risk of bias of individual studies, including whether this will be done at the outcome or study level, or both; state how this information will be used in data synthesis
Data synthesis	15a	Describe criteria under which study data will be quantitatively synthesised
	15b	If data are appropriate for quantitative synthesis, describe planned summary measures, methods of handling data and methods of combining data from studies, including any planned exploration of consistency (such as I^2 , Kendall's τ)
	15c	Describe any proposed additional analyses (such as sensitivity or subgroup analyses, meta-regression)
	15d	If quantitative synthesis is not appropriate, describe the type of summary planned
Meta-bias(es)	16	Specify any planned assessment of meta-bias(es) (such as publication bias across studies, selective reporting within studies)
Confidence in cumulative evidence	17	Describe how the strength of the body of evidence will be assessed (such as GRADE)

APPENDIX B

PRISMA 2009 FLOW DIAGRAM



APPENDIX C

STANDARDIZED APPROACH TO DETERMINE THE INTERNAL VALIDITY OF META-ANALYSIS

Study question	<ul style="list-style-type: none"> • Objectives clearly stated • Clinically relevant and focused study question included • Effectiveness of intervention not convincingly demonstrated in clinical trials
Literature search	<ul style="list-style-type: none"> • Comprehensive literature search conducted • Searched information sources listed (ie, PubMed, Cochrane database) • Terms used for electronic literature search provided • Reasonable limitations placed on search (ie, English language) • Manual search conducted through references of articles, abstracts • Attempts made at collecting unpublished data
Data abstraction	<ul style="list-style-type: none"> • Structured data abstraction form used • Number of authors (>2) who abstracted data given • Disagreements listed between authors and how they were resolved • Characteristics of studies listed (ie, sample size, patient demographics) • Inclusion and exclusion criteria provided for studies • Number of excluded studies and reasons for exclusion included
Evaluation of results	<ul style="list-style-type: none"> • Studies were combinable • Appropriate statistical methods used to combine results • Results displayed • Sensitivity analysis conducted
Evaluation for publication bias	<ul style="list-style-type: none"> • Publication bias addressed through evaluation methods such as funnel plot or sensitivity analysis
Applicability of results	<ul style="list-style-type: none"> • Results were generalizable
Funding source	<ul style="list-style-type: none"> • Funding source(s) stated • No conflict of interest seen

APPENDIX D

Table 8

Experimental Group Duration, Provider and Topics

Author	Duration	Experimental (PE) Group Provider	Topics
Dorrepaal et al. (2010)	20 weekly, 2 hours manualized session with 8-12 participants	2 facilitators who were a psychotherapist, psychiatrist, or psychiatric nurse Received training and supervision	(1) complex PTSD psychology and biology, (2) safe sleep, (3) dissociation, re-experiencing. (4) correct recognition of emotions and introduction cognitive model, (5) skills building: affect regulation, self-care/soothing, relaxation, self-esteem, (6) crisis management, (7) false beliefs, thinking errors (8) anger management, (9) assertiveness, bodily experiences and sexuality, (10) distrust, (11) guilt and shame, and (12) saying goodbye and future
Dorrepaal et al. (2012)	20 weekly, 2 hours manualized sessions with 8-12 participants	2 facilitators who were a psychotherapist, psychiatrist, or psychiatric nurse Received training and supervision	(1) complex PTSD psychology and biology, (2) safe sleep, (3) dissociation, re-experiencing. (4) correct recognition of emotions and introduction cognitive model, (5) skills building: affect regulation, self-care/soothing, relaxation, self-esteem, (6) crisis management, (7) false beliefs, thinking errors (8) anger management, (9) assertiveness, bodily experiences and sexuality, (10) distrust, (11) guilt and shame, and (12) saying goodbye and future
Hébert & Tourigny (2010)	14 weekly, 2 hours session with a 5- 8 participants	2 facilitators with a background in social science background (sexology, social work, psychology) Received training and supervision	(1) emotional regulation skills, (2) exercise, (3)cognitive coping skills, (4) sex education, (5) abuse prevention skills, (6) self-protection
Karatzias et al. (2014)	10 weekly, 1.5 hour manualized sessions with a max	2 facilitators who had a background in clinical psychology, psychotherapy, or counselling	(1) safety, (2) introduction to abuse and trauma, (3) physical, emotional, and psychological effects of trauma and abuse, (4) mental health associated with abuse and trauma (5) promoting skills to monitor behaviors, challenging negative automatic

	of 12 participants	Received training and supervision	thoughts, grounding techniques, assertiveness skills
Misurell et al. (2011)	12 weekly, 1.5 hour non-manualized, highly structured-gaming	3 facilitator who were clinical psychologist, master's level clinician, doctoral-level graduate student Received training and supervision	(1) self-regulation, (2) anger management, (3) emotional expression, (4) traumatic symptoms, (5) internalizing problems, (6) challenging cognitive distortions, (7) self-protecting abilities, (8) child sexual abuse, (9) building stress-coping skills
O'Callaghan et al. (2013)	15, 2 hours manualized sessions offered 3x weekly (5 weeks)	Facilitators who were social workers Received training	(1) rate and trauma, (2) safe places, (3) stress management, (4) feelings, (5) cognitive coping
Springer et al. (2012)	12 weekly, 1.5 hour non-manualized sessions that include developmentally appropriate gaming	3 facilitators who were supervising psychologist, master's level clinicians, and doctoral level externs Received training and supervision	(1) bolstering self-esteem, (2) personal space and boundaries, (3) social skills, (4) emotional expression, (5) assertive training, (6) anger management, (7) relaxation, (8) healthy sexuality, (9) building personal safety skills, (10) child sexual abuse, (11) processing sexual abuse experiences
Tourigny et al. (2005)	20 weekly, 2 hours manualized sessions with 6-8 participants	2 practitioners (generally one woman and one man) with at least an undergraduate in social work, psychology, or sexology Received supervision	(1) disclosure of abuse (2) cycle of abuse, (3) consequences of abuse, (4) relationship with the perpetrator, different issues related to sexuality, (5) prevention of revictimization, (6) intimate and romantic relationships.
Trowell et al. (2002)	18 weekly, 50 minutes manualized session a up to 5 participants	2 facilitators who were trainee psychotherapists or experienced MH professionals Received supervision	Prearranged topics, included use of notebooks, task sheets, and play materials, information and suggestions, relationships

APPENDIX E

Table 9

Studies Settings

Author	Settings	
Dorrepaal et al. (2010)	NP	NP
Dorrepaal et al. (2012)	The Netherlands	Mental Health Institutes
Hébert & Tourigny (2010)	Canada	Community Agency
Karatzias et al. (2014)	United Kingdom	Classroom Setting
Misurell et al. (2011)	United States	Medical Center
O'Callaghan et al. (2013)	Republic of Congo	Secondary School
Springer et al. (2012)	United States	Medical Center
Tourigny et al. (2005)	Canada	Community Agency
Trowell et al. (2002)	United Kingdom	Tertiary Centre & Community Clinic

VITA

ALEXIS LYNNETTE WILKERSON, MS, LPC, CSAC, NCC

Old Dominion University, Darden College of Education & Professional Studies
 Department of Counseling & Human Services
 2100 New Education Building
 4301 Hampton Boulevard
 Norfolk, Virginia 23529

PROFESSIONAL PREPARATION

Ph.D. Counselor Education and Supervision Old Dominion University, Norfolk, VA CACREP accredited program	Expected December 2020
M.S. Substance Abuse and Clinical Counseling East Carolina University, Greenville, NC CACREP accredited program	May 2017
B.S. Psychology (Counseling / Applied Track) Chowan University, Murfreesboro, NC	May 2014

LICENSURE/CERTIFICATIONS

Licensed Professional Counselor (LPC)	September 2020 – Present
National Certified Counselor (NCC)	July 2017 – Present
Certified Clinical Mental Health Counselor (CCMHC)	July 2017 – Present
Certified Substance Abuse Counselor (CSAC)	June 2018 – Present

SCHOLARSHIP

Published Articles

Wilkerson, A. L. (2020). Educational advances: Accounting for addiction and pregnancy treatment in counseling programs. *Chi Sigma Iota Exemplar*, 35(2), 27-30.

Manuscripts In Preparation

Tarver, S., Winfield, C., Preston, J., Wilkerson, A. L. (2020). *The preparedness of African American pastors to address issues of addiction*. Manuscript in preparation.

Grant, M., Tarver, S., Summers, L., Perry, B., & Wilkerson, A. L. (2018). *African American women's experiences of epistemic injustice*. Manuscript in preparation.

Manuscripts Under Review

Brown, N.W., Wilkerson, A. L., Dice, R., Abraham, J. (2020). *Focused journal writing for teaching group dynamics*. Manuscript submitted for publication.

State and Regional Referred Presentations

Pearce, J. & Wilkerson, A. L. (2018, February). *Teaching substance abuse courses through a social justice lens: A constructivist approach*. Education session Presented at the Virginia Association for Counselor Education and Supervision Conference, Hampton, VA.

.Wilkerson, A.L., & Dice, T. (forthcoming, February 2021). *A meta-analysis and systemic review of psychoeducational groups for survivors of child sexual abuse*. 90-minuted open session to be presented at the Annual American Group Psychotherapy Association Connect 2021.

AWARDS, PROFESSIONAL AFFILIATION, AND HONORS

2020 PSI and Perinatal Mental Health Alliance for People of Color <i>\$1,250 Scholarship to the 2020 PSI Virtual Conference</i>	Summer 2020
Group Foundation for Advancing Mental Health <i>\$3,300 Grant Award for Clinical Research Reviews On Group Psychotherapy</i>	Spring 2020
Michelle Dowdy Emerging Leader Award <i>Virginia Counselors Association</i>	Spring 2019
Chi Sigma Iota Omega Delta <i>Virginia Counselors Association</i>	Spring 2018 to Present Fall 2018 to Present
American Counseling Association	Spring 2018 to Present
Virginia Association for Counselor Education and Supervision	Spring 2018 to Present

PROFESSIONAL EXPERIENCE

Clinical Coordination/Director

Graduate Clinical Coordinator Assistant Old Dominion University, Norfolk, VA	August 2020 to Present
<ul style="list-style-type: none"> Assist Graduate Clinical Coordinator in tasks pertaining to graduate counseling students field placement; recruiting and evaluating sites; monitoring, assessing, and guiding field placement; and other prioritized tasks. Assist in expanding ODU's record keeping of clinical placement files and students' practicum/internship paperwork to HIPAA-secure Supervision Assist platform. Assist in planning and facilitating site supervisor workshops. 	

Clinical Co-Director The Ambulatory Care Clinic (IBH), Norfolk, VA	July 2020 to Present
<ul style="list-style-type: none"> Responsible for organizing and overseeing ODU counseling practicum students and interns and programs at our IBH facility. Responsible for organizing and facilitating orientation, staff meetings, and trainings. Provide weekly supervision of counseling students completing practicum and internship at site. 	

Research

Doctoral Research Assistant Old Dominion University, Norfolk, VA	August 2018 to August 2019
<ul style="list-style-type: none"> Provide research support by completing annotated bibliographies, literature reviews, revising manuscripts, editing publication submissions, and formatting IRB proposals. Perform administrative duties under the direction of research professor. 	

Teaching

Introduction to Substance Abuse (HMSV 447) <i>Co-instructor, Face to Face, Online</i>	Fall 2018, Summer 2020
Interventions and Advocacy w/ Children (HMSV 448) <i>Instructor of record, Face to Face</i>	Spring 2019
Substance Abuse Treatment and Research (HMSV 452) <i>Co-instructor, Online</i>	Summer 2020
Family Dynamics (COUN 691) <i>Co-instructor, Online</i>	Summer 2020
Group Counseling and Psychotherapy (COUN 644) <i>T-group facilitator, Online</i>	Summer 2020

Advising

ODU Human Services Advisor (Graduate Assistant)	April 2019 to August 2019
<ul style="list-style-type: none"> • Provide career and academic advising at the Career and Advising Resource Center (CARC). • Provided services to students in the Darden College of Education and Professional Studies. • Assist with students' planning for their academic program and explore career opportunities. 	

Clinical Supervision

Clinical Supervisor: Agency	July 2020 to Present
<ul style="list-style-type: none"> • Conduct 1-hour weekly individual supervision to master's level students completing practicum/internship at an IBH site, Ambulatory Care Clinic, where they provide mental health services to patients in inpatient and outpatient medical environments. 	
Clinical Supervisor: University	Spring 2019, Spring 2020, Summer 2020
<ul style="list-style-type: none"> • Conduct 1-hour weekly of individual supervision with practicum level supervisees in the counseling master's program at ODU (MH and/or school counseling concentration) • Provided individual, triadic and group supervision to four students enrolled in COUN 634, Advanced Techniques at ODU 	

Clinical Practice

Substance Abuse Clinician GHR Center for Addiction Recovery and Treatment, Norfolk, VA	August 2019 to September 2020
Substance Abuse Counselor Affinity Healthcare Group, Opioid Treatment Program, Franklin, VA	June 2017 to August 2018
M.S. Level Internship Sentara Norfolk General Hospital, Behavioral Health, Norfolk, VA	January 2017 to April 2017
M.S. Level Practicum PORT Human Services, Opioid Treatment Program, Greenville, NC	August 2016 to December 2016

Graduate Assistant/Counselor September 2015 to December 2016
ECU Navigate Pregnancy and Recovery Clinic, Greenville, NC

Professional Leadership and Service

Invited External Reviewer September 2020 to Present

COUN 633, Counseling and Psychotherapy Techniques

- Assigned to a triadic group of students. Watch students' mock counseling sessions and provide weekly written structured feedback paying particular attention to their use of micro-skills (i.e., minimal encouragers, reflection of content, paraphrases, open- and close-ended questions, reflection of feelings).

Virtual Reality Training Simulation Software (Mursions) August 2020 to Present

- Assist in developing demos for simulations of a mixed-reality office environment that simulates a counseling experience for human services and counseling students.
Moderator of Mursions simulations sessions.

Leadership Academy Committee February 2020 to August 2020

- Assist in planning the Virginia Counselor Association's first virtual Annual Leadership Academy. Moderator of virtual sessions.

Doctoral Student Mentor August 2019 to Present

- Provide mentorship to first- and second-year students in the CES doctoral program.
Provide mentorship to master's level counseling students.

Graduate Student Representative July 1, 2019 to July 2020
Virginia Association for Counselor Education and Supervision

Professional Development Chair May 2019 to May 2020
Chi Sigma Iota Omega Delta

Chowan University Open House May 2020
Representative of Chowan University's graduates of Psychology

Chowan University Guest Speaker October 2019
Department of Psychology

Mental Health Resource Table May 2019
Southampton Memorial Hospital, Franklin VA

Michelle Dowdy Emerging Leader May 2019
Virginia Counselor Association

Teen Girls Counseling Group May 2018 to June 2018
Stepping Stones Counseling Services, Franklin, VA

Guest Lectures and Panels

COUN 844, Advanced Group Counseling September 2020
 Guest lecturer in “Use of Creative Activities in Group Counseling”
 Old Dominion University, Darden College of Education and Professional Studies, Counseling
 Department, Norfolk, VA

COUN 655, Social and Cultural Issues in Counseling March 2019
 Guest lecturer in “African American/Black People and Counseling”
 Old Dominion University, Darden College of Education and Professional Studies, Counseling
 Department, Norfolk, VA

Doctoral Student Orientation November 2018, August 2020
 Panelist
 Old Dominion University, Darden College of Education and Professional Studies, Counseling
 Department, Norfolk, VA

PROFESSIONAL DEVELOPMENT

Virtual Leadership Academy	August 2020
Discussion Racism and Racial Trauma in Clinical Supervision	July 2020
2020 Postpartum Support International Virtual Conference	July 2020
Proactive Counseling in the Aftermath of a Major Racial Event	June 2020
Ethical Consideration for Tele-Mental Health	May 2020
Two-day Telehealth for Mental Health Professionals	March 2020
Disaster Mental Health/Psychological First Aid (Red Cross)	November 2019
Crisis Prevention Institute: Nonviolent Crisis Intervention	November 2019
Two-day ASAM Criteria Skill Building	October 2019
Recognizing and Responding to Suicide Risk	August 2019
Leadership Academy	