Results of Group Psychotherapy for Abuse, Neglect and Pregnancy Loss

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ABSTRACT

The pre and post evaluation of 65 patients undergoing intensive group psychotherapy by the Hope Alive method, yielded useful information on the 28 parameters. Visual analogue scores were converted to whole numbers. The data was analyzed using a non-parametric ANOVA. The results provide sufficient evidence of benefit to warrant continued use of this program and to investigate the various components in order to delineate the most effective aspects of the program. There is statistically significant global improvement, but some areas of change, e.g. self-esteem, relationship with partner etc. are greater than others. Whenever patients did their homework assignments consistently and well, there was increased likelihood of insight, diminished symptoms and personal growth.

Keywords: treatment, group therapy, insight, behaviour changes, abuse, neglect, pregnancy loss, abortion, depression, anger, hope, relationships

INTRODUCTION

There is a pressing need to treat men and women who have been injured by a combination of conflicts arising from childhood mistreatment and later pregnancy losses. These traumatic events appear to be related to each other. To date there appears to be no treatment programmes dealing with the issues that arise from both these experiences. Using a time-limited, closed group psychotherapy program we found significant improvements in most major symptoms when the patients were given pre and post assessments.

Hope Alive is an intensive group psychotherapy technique developed to address the psychiatric problems observed in women and men affected by childhood mistreatment and pregnancy losses. After evaluation and in consultation with the referring family physician, a recommendation is given to appropriate patients. With their informed consent, they are given a schedule with the dates of all the sessions. The referring physicians are provided an outline of the entire process. The groups consist of 4-6 men and women. There are 30 – 32 sessions of two hours twice per week. There are a number of unusual features including homework assignments at which patients spend considerably more time than they did in group.

LITERATURE REVIEW

A search of the literature indicates an increasingly large number of studies on problems following pregnancy loss, particularly grief. Lewis' [1] early research found unresolved grief following a stillbirth interfered with the parents' ability to bond to subsequent children. Others have confirmed these results and extended the research to other types of pregnancy loss. [2, 3] Buchegger [4] states "if a couple decides to terminate a pregnancy as a consequence of the

diagnostic outcome (prenatal diagnosis), the ensuing mourning process is known to be similar to mourning after stillbirth." "Deliberate termination intensifies guilt feelings, especially if, as in Down's Syndrome, the anomaly would not have affected the child's viability." After assessing 30 women at 6 weeks, 6 months and 12 months after termination, a group at the Tavistock Clinic in London concluded that whether it was a first or second trimester termination for fetal abnormality, psychological morbidity is "prevalent and persistent." [5] Broen, Moum et al [6] compared the impact on women of miscarriage (n=40) to those who had an abortion, (n=80). They found that although the short-term emotional response was greater to miscarriage, those who experienced induced abortion had significantly more avoidance of thoughts and feelings related to the event for longer. Compared to 12 women who gave birth to a healthy child, 12 women who terminated their child for fetal abnormality showed neural activation similar to that of those in physical pain (7). Men also grieve following a miscarriage (8) and feel a desire to protect their partner.

Guilt and grief following the termination of an unwelcome child would be expected to be greater since it is known that the greater the ambivalence toward the lost object the greater difficulty in detaching. Careful studies have shown that grief, depression and poor health may occur following an abortion. [6, 7, 9,10] Fergusson, Reardon'

Although little is written about a combination of pregnancy loss and childhood mistreatment, data from research would make one suspect that possibility. Kumar and Robson [8] (11) found that women are more likely to be depressed following the birth of a child that has been preceded by an abortion. Benedict et al [9] (12) did a retrospective matched pair study in families

physically abusive to one or more of their children as compared to non-abusive families. They found mothers in maltreating families were younger, had shorter birth intervals, had less prenatal care and were significantly more likely to have a stillbirth or reported abortion or prior child death. Coleman et al (13) [10] found that compared to women with no history of perinatal loss, those with one loss voluntary or involuntary had a 99% higher risk for physically abusing their child, and women with multiple losses were 189% more likely. Women with a history of one induced abortion were 144% more likely to physically abuse their children compared to women who had no abortions. We [**14]** found that childhood mistreatment and pregnancy loss were cyclically related. Parents coming with backgrounds [11] of abuse and neglect were more likely to terminate pregnancies. Those with pregnancy terminations were statistically more likely to abuse and neglect subsequent children. The reasons for this statistically significant association are complex, but they appear to include:

1) The increased likelihood of post-partum depression interfering with bonding to a child born subsequent to an abortion.
2) Interference to the instinctual protective mechanism of a parent once they have participated in the death of one of their children.
3) A greater frequency of partner loss following an abortion, with anger to the abandoning partner displaced onto the fetus.
4) Poor physical and emotional health resulting partly from an unresolved grief. [12, 13 15,16] Reardon,death, Ney Preg outcome 15,16

Kent and Nicholls [14] [17] found that women in group therapy for post-abortion women appeared to have had a termination, sometimes in revenge for abortions their mothers had. Gordon [15] [18] found that one two-hour counselling session with men after fetal loss decreased

their anxiety.

Tourigny et al [16] [19] at the University of Sherbrooke found their psycho-educational group therapy of 20 weekly two-hour sessions for sexually abused adolescent girls was effective on measures of post-traumatic stress, coping strategies, relationship with the mother and empowerment compared to a control group. Ryan et al [17] [20] in London compared the effectiveness of 12 group or individual sessions for childhood sexual abuse (CSA) to a waiting list control. Measures before, after and at 4 then 8 months follow-up showed significant improvement for both treatments. The gains were maintained except on one measure for the group psychotherapy patients. Reay et al [18] [21] in Canberra found that interpersonal group psychotherapy for mothers with post-natal depression "may improve symptom severity."

There appears to be no reports of group psychotherapy designed for women or men who are affected by a combination of early childhood mistreatment and later complicated pregnancy losses. The results of Hope Alive group therapy have been presented at the annual meetings of the American Group Psychotherapy Association in Los Angeles, May 2000 and the Canadian Psychiatric Association in Vancouver, November 2005. Since the Hope Alive technique has been taught in over 30 countries, there are other reports of outcome data for this technique. [19] [22]

METHODOLOGY

A case-control study design was used to examine treatment outcomes in 65 people undergoing Hope Alive treatment. Twenty-eight parameters evaluating psychological and physical well-being were assessed prior to the commencement of therapy and then re-evaluated at the end of therapy. Most parameters were assessed using self-reporting on visual analog scales. For the

purposes of analysis, the visual analog scale markings were converted to whole number scores from 1 to 9. Data were analyzed with SPSS using Wilcoxon signed rank tests (non-parametric ANOVA).

Fifty-three women and twelve men, provided useful pre- and post-evaluation of Hope Alive group psychotherapy designed to deal with the complicated conflicts following childhood mistreatment and pregnancy loss. These are mixed-sex groups of four or five patients, a therapist and a facilitator (someone who has successfully completed a previous group, and/or a trainee) for an average of 32, two hour sessions and two follow-up sessions at three and six month intervals. All these patients were referred by family physicians to the consulting psychiatrist usually for the evaluation and treatment of a persistent depression. About one half had previous counselling and/or cognitive behaviour therapy. Those who had a history of childhood abuse and neglect plus the experience of one or more pregnancy losses, (a few did not have both) were able to tolerate intense feelings, could understand metaphors, appeared to benefit from insight and had the time to devote to 16 weeks of intense therapy were invited to consider this group treatment. It was not always possible to select the most appropriate patients and there was a one in six dropout rate. The co-insured government Medical Plan of British Columbia Canada, costing approximately, funded the treatment…….. The typical patient was female, aged 42 years, from a divorced family with neglect and divorce because of alcohol, now married with 2 children from 4 pregnancies (the others were an abortion before marriage and a miscarriage between the girl and boy), working part time, and depressed for 3 years following a fight with her boss. There was temporary symptom improvement on 5 different antidepressant medications, worsening marital relations, loss of libido, little enjoyment in eating but gaining weight, sleep loss, irritability with

her children culminating in uncontrolled screaming for which she feels guilty, poor self esteem, moderate level of anxiety, major persistent depressive mood, feeling life is not worth living and she doesn't deserve to be alive but would not commit suicide. She states, "Now I must get to the bottom of this or my family will fall apart and then I won't care what happens to me".

Data was gathered from clinical observations and a self-report questionnaire which included a combination of visual analog scales, multiple choice questions and questions requiring descriptive answers. These scales have been checked for validity and reliability and reported in previous studies. [20, 21 23,24]

The Phases of the Hope Alive Treatment Programme.

1. Informed consent, Introductions and Commitment confidentiality, completion etc.
2. Defences and resistances to knowing and growing, with role plays, eg. "Please listen to me" Etc.
3. Learning from past painful experience, patterns in family trees, tracing triggers etc.
4. Changing patterns of anger, seeing pain behind the rage, learning appropriate assertion etc.
5. Recognizing the fear behind the fear and learning when and how to face it or to run.
6. Real and imagined guilt. Learning about tragic triangles and percentage contribution.
7. Discovering the authentic person behind the dancer and urchin masks.
8. Grieving the Person I Should Have Become and welcoming the Person I Am
9. Identifying, welcoming, committing then mourning unresolved pregnancy losses.
10. Reconciliation with Perpetrator, Observer and Victim, forgiving and forgetting.
11. Negotiating realistic expectations with mate, children, family and employers.

12. Attenuating unwelcome and unnecessary pair bonds

13. Making difficult decisions using their recognition of key conflicts and blueprint.

14. A project to help prevent what happened to you, happening to other susceptible people.

15. Celebration of gains made and finding joy in life, if only you will pause long enough.

16. Expressions of gratitude and respect then good good-byes.

Each phase is accompanied with "home work" designed to initiate consideration of aspects not usually brought to mind. Spontaneous insights are recorded in a journal the patient keep close by. About eighty percent of the patients did almost all their homework, most of the time. They soon realized that the more effort they put into their assignments they more insight they gained. Anyone who missed more than 3 sessions for any reason was discharged. A few were invited to try again with a subsequent group.

RESULTS

The distribution of demographic variables for these patients whose mean age was 42.57 years, Std. Deviation 11.22 yrs, indicates they are not significantly different from most Canadians according to Stats Can. (Table I). The most prominent reason for attending the group was chronic anxiety or depression for which most patients were taking anti-depressants. Ninety-five percent of the group members had been mistreated during their childhood in more than one way. The closest association of types of mistreatment is between verbal and physical abuse, (Table 2.) This data is taken from the results of another questionnaire given to the patients in the same groups. That questionnaire is designed to determine the effects of transgenerational abuse and neglect. [22, 23]

The overall group changes (Fig. 1) show significant improvement and so do most of the 21 clinical variables we measured (Table 3). Obsessive thinking and physical health did not show significant improvement. There is significant decrease in the patient's the hurt or kill themselves. On the post treatment questionnaire we asked what factors the patients felt where most helpful in their treatment. Using step-wise analyses we looked for which of these factors was most closely associated with certain areas of improvement, (Tables 4– 7). It appeared certain group exercises and new insights were most useful to the overall improvement.

Table 4 indicates those components of the treatment programme most closely associated with a decrease in feelings of sadness. Clinical impressions would support the data that shows discovering and asserting a sense of one's authentic self closely correlated with less depression.

Table 5 indicates those components of the treatment programme most closely associated with the decreased chance that the patient will hurt somebody close to them. When patients understood how being a survivor of a pregnancy loss in their family affected them, it was closely related to less hurting others.

Table 6 indicates that when a stepwise regression is done on components of the program, it appears that those factors that most closely correlate with a sense of better functioning are: the ability to celebrate life, humanize losses, forgive the person's self, know why they can't resist, and understanding of the Universal Ethic of Mutual Benefit. Each component is represented in a question answered by each patient on whether or not they had understood or completed this

aspect of treatment. The variables that are excluded in the first model, but are still significant, include (not a comprehensive list): I recognize my resistance to knowing and growing; I learn to push through my resistance to change; I understand how my defences operate; I understand the patterns and themes from my time line; I understand how triggers now operate in my life; I remembered and felt the early experience of pain and fear; I evaluated the damage done to me by childhood mistreatment and unborn pregnancy losses. From the 135 factors in this program, the group members selected as most influential in their overall improvement, gaining insight, (Table 7). A sample of histograms show the distribution of the variables in question, Figs 2 to 5 show results analyzed by Wilcoxon Signed Ranks for significance. It appears the "before and after" treatment measures of self-respect, sadness, relationship with partner and hopelessness improved particularly. Others also show significant, sometimes marked improvement.

DISCUSSION

Clinical observation and intuition supports the belief that group psychotherapy works well to improve communication, social behaviour and insight, but this is difficult to demonstrate. Using pre- and post-subjective impressions of the group patients represented on visual analogue scales, that data we present supports the use of the Hope Alive method of doing groups for a clinical sample of patients. They suffered from various combinations of depression, anxiety, obsessive thinking, phobias, anorexia and other neurotic disorders that have arisen from the conflicts associated with childhood mistreatment and pregnancy losses. Their improvement appears to be most closely related to a better understanding of the roots to the turmoil in their thinking. Is it possible that humans are programmed with a need to understand and resolve the residual turmoil of their confusion engendered by life threatening experiences?

Hope Alive has some distinctive features that may contribute to its usefulness with these patients. “Homework” which requires 6 to 8 hours of thinking and writing between sessions introduces each task and optimizes the time spent in the group. The phases have a natural sequence that help patients make sense of their painful trauma in the order they have had confusing experiences in life. The most difficult phase is when reconciling with those who have hurt them and those they have hurt. However, they find that once they forgive, they forget, their thinking is clearer and they more often experience joy.

There appears to be a correlation between childhood trauma and later pregnancy losses, particularly miscarriage and abortion. The combined experiences may result in intense conflicts that are often impossible to resolve without assistance. Those affected may attempt to resolve the persistent turmoil by repeatedly re-enacting them, only to deepen the distress and extend the confusion.

The natural progression in the Hope Alive programme, one phase readily following the other. Not infrequently, patients anticipate the next phase. Group members express appreciation for the home assignments, and many useful insights occur outside the group session. They recognize that a major direction of the program is to teach new skills in analyzing confusing experience. They can use these and other newly acquired for the rest of their lives. Patients often report that following the termination of the group process there is a short honeymoon period followed by a familiar crisis. If they review heir homework and apply their newly acquired skills, they are able to use the crisis to further build their confidence and self esteem.

From doing both individual and group psychotherapy, it appears to me (PGN) that groups are both more effective and efficient. For any psychiatrist in a busy consulting practice with a never-ending waiting list this is vitally important. There is no study where patients have been randomly assigned to either individual or to this type of group therapy. Doing extensive homework means the patients are almost continually and effectively working on their problems so that the time in-group is better used because it is more often focused. Patients appreciate knowing when the groups start and finish so they can plan their work and lives accordingly, eg. Ask their mother-in-law to baby-sit for a limited period only. It also puts reasonable pressure on them to use their opportunity well.

The data on 65 patients representing 8 groups indicates that overall, Hope Alive is a useful program in the treatment of those who have been injured by a combination of childhood mistreatment and pregnancy losses, but replication by other therapists using the same method is necessary. It appears that some components of the program are more useful than others. The measuring instrument that we used is reasonably sensitive to changes. These are supported by clinical evidence at 3 months, 6 months and long-term follow-up. Most patients are able to forgo further use of medication for anxiety and depression. They are often very grateful that, “Now my mind is no longer in a fog. I get down at times but I have real feelings and understand where they come from”.

We have a better understanding of which component of the program is best suited for which type of problems from the patients post treatment responses. On the follow-up questionnaire they are asked how well they are doing symptomatically and on a different segment how well they feel they completed the tasks and for each phase of the treatment. The underlying mechanisms are

more fully described elsewhere [24] but they include the following: a) Being able to connect childhood traumatic experience with conflicts that they attempt to resolve by obsessively searching for reasons and meanings to them and by re-enacting them with subconsciously picked and coached partners, job mates and friends. This understanding of their "key conflicts" helps them to more quickly realize just they are about to do it again and so choose a different direction, b) Become more human with a more respectful appreciation of their real though still damaged self, after they have recognized and mourned the loss of the person they should have become. c) Humanized and individualized their pregnancy losses, welcomed them into their family, symbolically buried them and committed their spirits into the hands of their Creator, d) Understood their contribution to the painful experiences of life, e) Written letters of reconciliation to those who have injured them and who they have injured, forgiven them and been forgiven and consequently forgotten the experiences of fear, pain, guilt and shame associated with those people. It appears that the brain no longer retains painful and confusing memories once it can usually make sense and when people have been able to grieve the net effect of mistreatment in the loss of the Person I Should Have Become. f) Once their thinking is not so absorbed in futile self analysis, they make more accurate perceptions and rational decisions. Not being so self-absorbed, they can see and appreciate the small joy and wonder filling moments of their life. They are more available to their children who respond with better appreciated delight in having a mother who can laugh and cry again.

CONCLUSION

Intensive, time-limited group therapy with pre-determined phases appears to be effective in treating the difficult problems arising in people who have experienced a combination of

childhood mistreatment and pregnancy loss. The results from this study indicate sufficiently good outcomes to warrant further use of the Hope Alive method, but further study of its underlying mechanisms is necessary. There are a plethora of variables that might help explain the results. It is not possible to control for all of them in one study. We are currently extending this research and will report on data more concisely isolating which type of psychological symptoms and psychiatric diagnosis respond best to Hope Alive group psychotherapy.

Table 1 **Demographic Frequencies**

MARITAL STATUS			
CATEGORIES	FREQUENCY	VALID PERCENT	CUMULATIVE %
No Response	1	1.5	1.5
Married	34	52.3	53.8
Single	17	26.2	80.0
Divorced	3	4.6	84.6
Separated	3	4.6	89.2
Common Law	5	7.7	96.9
Widowed	2	3.1	100.0
OCCUPATION			
No Response	2	3.1	3.1
Professional	7	10.8	13.8
Service Industry	18	27.7	41.5
Support Industry	8	12.3	53.8
Clerical	7	10.8	64.6
Business	8	12.3	76.9
Unemployed	5	7.7	84.6
Student	5	7.7	92.3
Tradesman	1	1.5	93.8
Retired	3	4.6	98.5
Disability	1	1.5	100.0

TABLE 2. IMPACT OF ABUSE AND NEGLECT

	Physical Abuse	Verbal Abuse	Sexual Abuse	Physical Neglect	Emotional Neglect
Verbal Abuse	**.587***				
Sexual Abuse	**.353***	**.280***			
Physical Neglect	**.440***	**.431***	**.327***		
Emotional Neglect	**.376***	**.555***	**.266***	**.454***	
Impact On My Life	**.387***	**.567***	**.289***	**.437***	**.657**

* Partial correlation coefficients, controlling for age, sex, marital state, 2 tailed. p<.000

TABLE 3. RESULTS

	Z	p
Decreased desire to hurt self	-3.162	<0.01
Decreased desire to kill self	-2.971	<0.01
Decreased frequency of obsessive thinking	-2.217	=0.022
Decreased pessimistic thinking	4.128	<0.01
Decreased uncontrollable fears	-3.251	<0.01
Decreased frequency of bad choices	-3.289	<0.01
Decreased feelings of fearfulness	-3.987	<0.01
Decreased anger	-4.152	<0.01
Decreased sadness	-5.067	<0.01
Decreased loneliness	-4.250	<0.01
Decreased hopelessness	-4.250	<0.01
Decreased feelings of being alone	-3.257	<0.01
Decreased feelings of being trapped	-3.775	<0.01
Increased self-respect	-5.056	<0.01
Increased enjoyment of life	-3.298	<0.01
Improved memory	-2.929	<0.01
Improved ability to sleep	-2.432	=0.015
Improved physical health	-2.030	=0.042
Improved relationships with father	-2.537	=0.011
Improved relationships with siblings	-3.136	<0.01
Improved relationships with partner	-4.107	<0.01

Wilcoxon Signed Rank

TABLE 4 FACTORS MOST CLOSELY ASSOCIATED WITH DECREASED FEELINGS OF SADNESS

	Standardized Coefficients beta	**t**	**Sig.**
Constant		10.599	.000
Told trusted friend to remind me about my authentic self	.971	14.100	.000
Shared re: pregnancy losses	.578	8.496	.000
Repudiated my part in death of someone	.392	7.363	.000
Welcomed and accepted welcome	.509	6.509	.000
Understand my difficulties to celebrate	.303	3.130	.011
Resolved to use my life for benefit of others	.474	6.041	.000
Remembered earlier pain and fear	.311	4.110	.002
Said a good good-bye to the group counsellor	.176	2.408	.037

Stepwise regression

TABLE 5. FACTORS MOST CLOSELY ASSOCIATED WITH A LESSENED CHANCE TO HURT THOSE CLOSE TO ME

	Beta	**t**	**Sig.**
Constant		4.966	.000
Understood how being a survivor or pregnancy loss in my family affects me now	.74	4.037	.001
Shared the events and emotions surrounding my pregnancy losses	.453	2.483	.025
Having received no responses, I decided to say good-bye to those with whom I tried to reconcile	.353	2.181	.046

Stepwise regression

TABLE 6. HOW ARE YOU FEELING AND FUNCTIONING NOW?

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	2.588	.153		16.964	.000
I understand why it is difficult for me to celebrate life	.211	.024	.872	8.801	.000
I humanized and individualized all my losses	.355	.038	1.510	9.238	.000
I wrote a letter of reconciliation to myself and forgave myself	.155	.034	.656	4.540	.000
I found out why I couldn't say, "Stop it."	.122	.029	.517	4.191	.000
I recognised how the Universal Ethics of Mutual Benefit could operate in my life	8.269E-02	.027	.350	3.082	.004

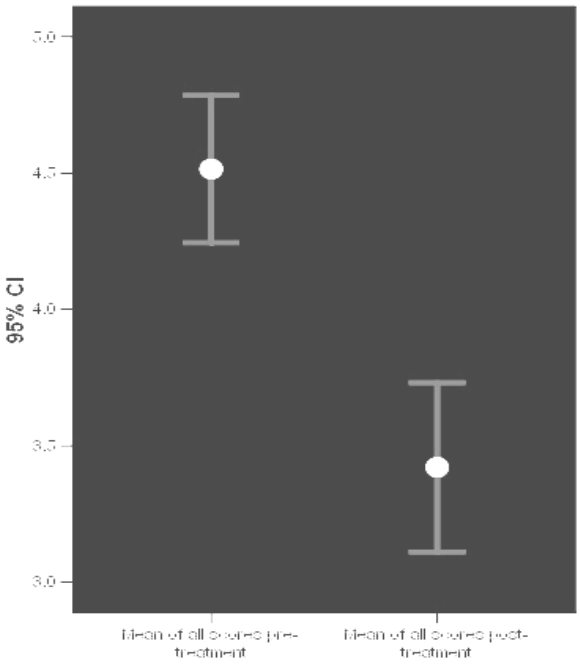
Dependent Variable: POST, Feeling and Functioning Now
Stepwise regression on 28 components of Hope Alive group therapy

TABLE 7: FACTORS MOST INFLUENTIAL ON OVERALL IMPROVEMENT DURING TREATMENT

Post Treatment	Unstandardized Coefficients		Standardized Coefficients	t	**Sig.**	95% Confidence Interval for B	
One of the best features of group	B	Std. Error	Beta			Lower Bound	Upper Bound
INSIGHT INTO ROOTS OF BEHAVIOUR	1.420	.362	.475	3.919	**.001**	.652	2.189
EMPATHETIC UNDERSTANDING	1.251	.417	.312	3.001	**.008**	.367	2.136
THEORETICAL BASIS OF CONFLICTS	1.117	.419	.292	2.665	**.017**	.228	2.006

Figure 1

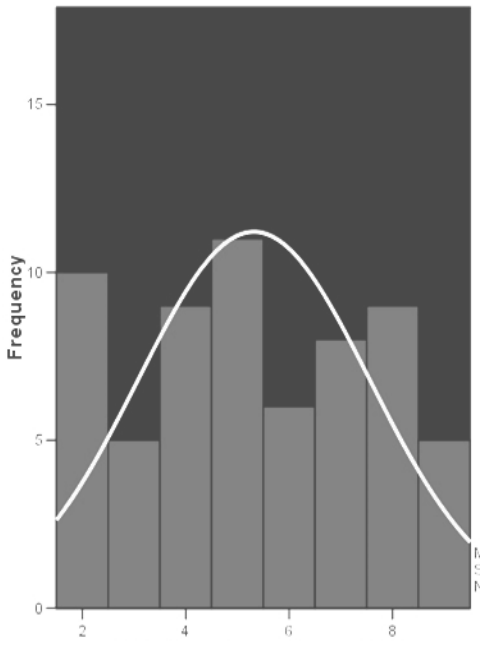
Overall Changes



FIGURES 2 TO 5 ARE EXAMPLES OF THE DISTRIBUTION OF MEASURES SHOWING

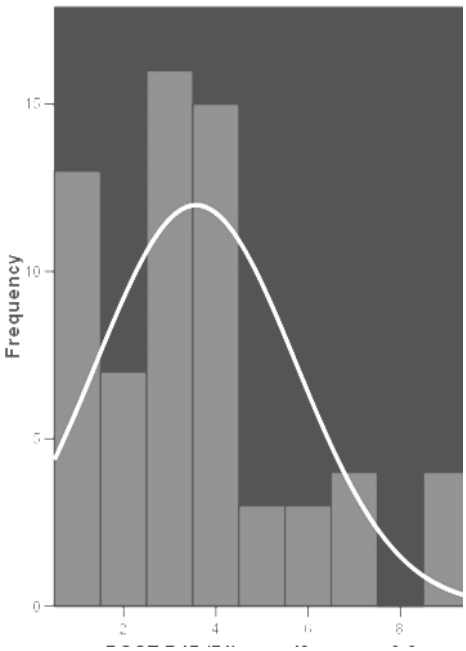
CHANGES FROM PRE TO POST TREATMENT.

Pre-treatment



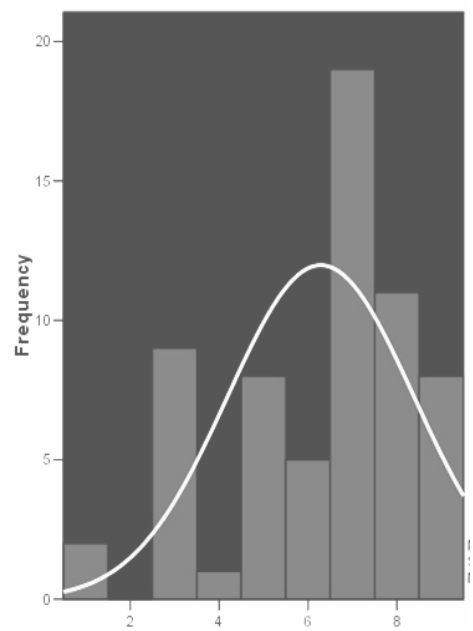
My Self-respect
Mean=5.32
Std Dev.= 2.242
N=63

Post-treatment



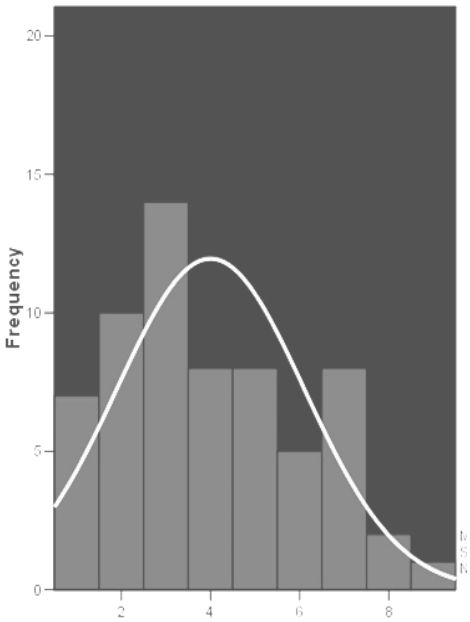
My Self-respect
Mean= 3.57
Std Dev= 2.165
N=63

Pre-Treatment



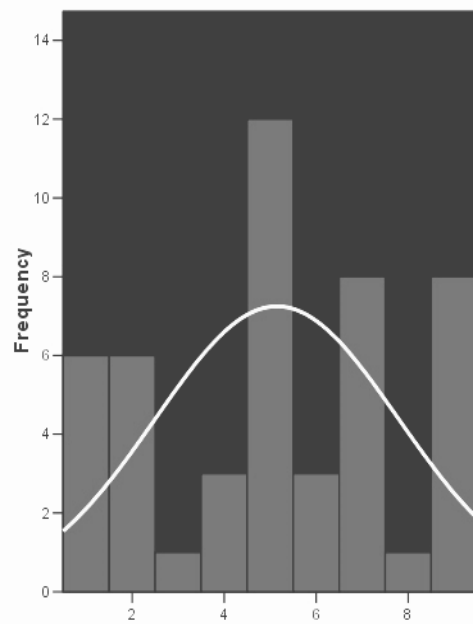
I feel sad
Mean=6.29
Std Dev=2.098
N= 63

Post-Treatment



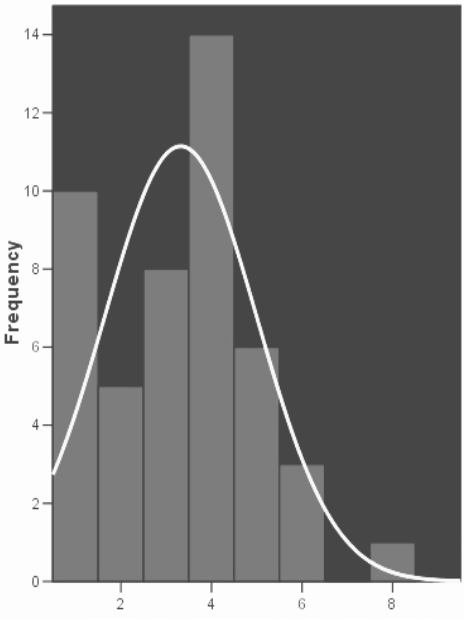
I feel sad
Mean=4.0
Std Dev= 2.102
N=63

Pre-Treatment



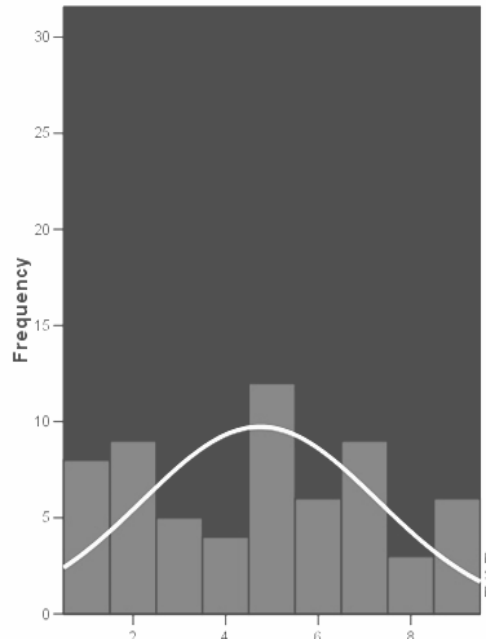
My relationship with my partner
Mean=5.15
Std Dev= 2.642
N= 63

Post-Treatment



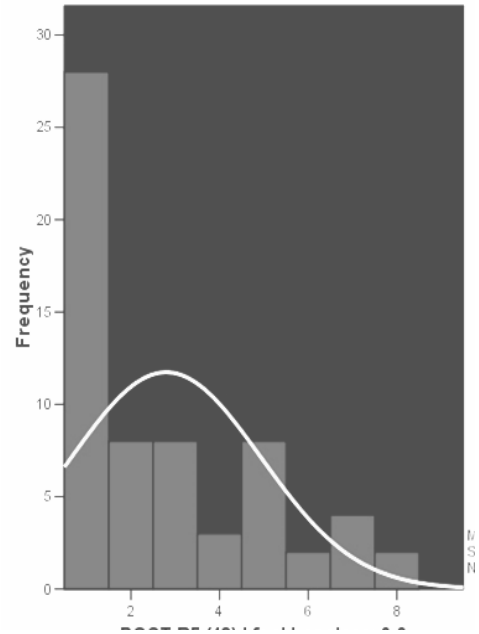
My relationship with my partner
Mean+ 3.32
Std Dev=1.682
N=63

Pre-Treatment



I feel hopeless
Mean= 4.74
Std Dev= 2.541
N= 63

Post-Treatment



I feel hopeless
Mean: 2.79
Std Dev= 2.141
N= 63

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