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An Evidence-Based Group Coping Intervention for Women Living with HIV and History of Childhood Sexual Abuse

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Abstract

Women living with HIV/AIDS and a history of childhood sexual abuse often exhibit sexual trauma symptoms and elevated rates of HIV-risk behaviors. In this paper, we describe a coping skills group intervention that reduced traumatic stress and sexual-risk behavior in a recent randomized clinical trial. We focus on clinical issues that emerged among female participants receiving the intervention. Clinical observations showed that recognizing connections between trauma, psychological distress, and high risk behaviors was a new and powerful experience for many participants. Participants successfully applied psychoeducational material, expressing an increased sense of power and control over their relationships and behaviors as they developed more adaptive cognitive and behavioral skills. Women expressed high levels of satisfaction with the intervention. Recommendations for clinical practice are provided.

Childhood sexual abuse (CSA) is experienced by approximately 27 – 33% of women in the general population (Briere & Elliott, 2003; Finkelhor, 1990). Among samples of women who are HIV-positive, 32% to 76% have experienced sexual abuse or assault (Kalichman, Sikkema, DiFonzo, Luke, & Austin, 2002; Liebschutz, Feinman, Sullivan, Stein, & Samet, 2000; Whetten et al., 2006). A possible explanation for the higher prevalence of HIV/AIDS among survivors of sexual abuse is their higher rate of risk behaviors documented consistently in the literature (Arriola, Loudon, Doldren, & Fortenberry, 2005; Senn, Carey, & Vanable, 2008). Specifically, CSA has been associated with earlier first consensual intercourse (Noll, Trickett, & Putnam, 2003), higher rates of unprotected intercourse (Kalichman et al., 2002), multiple sex partners (Cohen et al., 2000; Thompson, Potter, Sanderson, & Maibach, 1997; Wyatt et al., 2002), engagement in sex work (Cohen et al., 2000; Zierler et al., 1991), and higher rates of substance use (Cohen et al., 2000; Kalichman, Sikkema, & Somlai, 1995). A recent prospective study documented higher rates of sex work, early sexual contact, and sexually transmitted infections in people who experienced maltreatment as children compared with matched controls after a 30-year follow-up period (Wilson & Widom, 2008; 2009).

The causal pathways linking CSA with HIV risk behaviors are not yet fully understood. However, many of the psychological consequences of CSA, including chronic depression, denial, and low self-esteem, are related to increased risk behavior and therefore may mediate the relationship between CSA and HIV (Allers, Benjack, White, & Rousey, 1993; Briere & Elliott, 2003). Psychological symptoms that can result from general traumatic experience, such as intrusion or avoidance, also have been related to sexual risk behavior (Gore-Felton & Koopman, 2008). Further, some studies have identified specific mediators, showing that avoidant coping styles (Merrill, Guimond, Thomsen, & Milner, 2003) and sensation-seeking and risk-taking propensity (Bornovalova, Gwadz, Kahler, Aklin, & Lejuez, 2008) may help explain higher rates of risk behavior among survivors of CSA.

History of CSA also has been associated with poorer medical outcomes among people living with HIV/AIDS. Kimerling and colleagues (1999) documented lower CD4 to CD8 ratios among women with histories of traumatic stress. Studies have further shown that having a history of CSA is related to more disease complications (Liebschutz et al., 2000) and poorer medication adherence (Catz, Kelly, Bogart, Benotsch, & McAuliffe, 2000). Like the link between CSA and HIV infection, relationships between CSA and medical outcomes could be mediated by the psychological sequelae of CSA that may limit individuals' abilities to engage in health protective behaviors. Also, for many women, stressors associated with CSA and an HIV diagnosis are accompanied by stressors related to poverty, low social support, caregiving responsibilities, and relationship difficulties – all factors that can affect one's resources for self-care (Catz, Gore-Felton, & McClure, 2002; Semple et al., 1993; Stein et al., 2000). In sum, many women who are HIV-positive are experiencing the combined stress of living with HIV and symptoms associated with CSA. These women are at increased risk for psychological and medical complications and may be likely to engage in HIV risk behaviors that can lead to transmission to others. Together, these data point to the need to address symptoms of sexual trauma as an integral part of secondary prevention interventions. Careful intervention research on the most effective ways to integrate CSA treatment for HIV-positive individuals is particularly important, as treating trauma in people living with HIV may pose unique clinical challenges that need to be addressed.

Group interventions are common approaches for supporting individuals living with HIV (Himelhoch, Medoff, & Oyeni, 2007; Sherman et al., 2004) and treating trauma symptoms related to CSA (Briere & Scott, 2006). While benefits of group treatment for CSA have been documented (Briere & Scott), some researchers and clinicians caution that exposure to others' trauma in a group also can have adverse effects, such as increased memories of abuse resulting in more severe PTSD (Bloakes, 1997; Briere & Scott). Therefore, any research on group therapy for trauma survivors must assess both for benefits and adverse treatment effects, especially in groups likely to have multiple additional stressors, such as those associated with HIV.

The focus of this paper is the description of a group coping skills intervention, *Living in the Face of Trauma* (L. I. F. T.), developed by Sikkema and colleagues (2007; 2008) to reduce symptoms of sexual trauma and improve coping with HIV. In a recent randomized controlled trial including 107 women and 91 men, participants in the group coping intervention condition showed greater reductions in traumatic stress immediately post-treatment than those in the comparison condition, a time and attention-matched therapeutic support group (Sikkema et al., 2007). The group coping intervention also exhibited greater reductions in unprotected intercourse over the 4, 8, and 12-month follow-up periods (Sikkema et al., 2008). Based on these findings, L.I.F.T. is designated as a best-evidence intervention in the Centers for Disease Control and Prevention 2008 compendium of evidence-based HIV prevention interventions (Centers for Disease Control and Prevention, 2008).

The purpose of this paper is to describe the implementation of L.I.F.T. with women in the group coping intervention condition of the trial. We aim to describe the intervention and to provide an analysis of the clinical processes that emerged; a previous article presented a process analysis of L.I.F.T. with gay and bisexual men (Masten, Kochman, Hansen, & Sikkema, 2007). In both articles, we focus on clinical issues that were most salient and offer recommendations for delivering the intervention to these different client populations.

Intervention: Theory and Content

L.I.F.T. is a coping skills group intervention based on Lazarus and Folkman's (1984) cognitive theory of stress and coping. According to this theory, one can appraise stressors as either changeable or unchangeable to identify appropriate coping strategies. Specifically, changeable stressors can be addressed most effectively through problem-focused strategies (e.g., following problem-solving steps, using effective communication skills), while emotion-focused strategies (e.g., mindfulness, relaxation, cognitive restructuring) are more adaptive in response to unchangeable stressors (Lazarus & Folkman, 1984). During L.I.F.T., clients learn to appraise stressors and to develop and apply effective coping skills. L.I.F.T. also includes cognitive-behavioral strategies to treat symptoms of trauma (Briere, 2002; Najavitz, 2002), including exposure-based techniques and skills for building healthy relationships. An overarching goal of cognitive-behavioral strategies is to help clients identify connections between thoughts, feelings, and actions and to learn ways to alter components of this triad to reduce distress and improve coping. Specific training in skills to reduce HIV risk is not a specific focus of the intervention, though the process of developing adaptive strategies to cope with HIV and trauma involves decreasing maladaptive coping strategies and improving intimate relationships, sometimes addressing sexual risk and substance use behavior.

The treatment components are integrated in L.I.F.T. in ways that emphasize parallels between the traumatic experiences of living with CSA and HIV. Clinicians guide clients to understand how symptoms related to CSA may lead to current emotional distress, relationship difficulties, and behaviors that serve as maladaptive attempts to cope. Throughout this process, the group context of the intervention allows for support among members, normalization of shared experiences, and the creation of a safe, cohesive environment – essential elements for effective group therapy (Yalom, 1985). The psychoeducation and cognitive-behavioral skills training emphasize connections between CSA- and HIV-related stressors and resulting behaviors; these are unique aspects of L.I.F.T. that distinguish it from interventions targeting only CSA symptoms, risky sex behaviors or substance abuse.

L.I.F.T. includes 15 sessions, each of which combines a psycho-educational component with opportunities for application and group processing (see Table 1). The first sessions build group trust and cohesion through establishing group structure and facilitating first disclosures of personal experiences. Exposure-based strategies are introduced in these sessions, as clients are asked to begin sharing their trauma narratives and to identify emotional and behavioral symptoms associated with CSA and HIV. As a next step, clients work to identify their *current* emotional responses and coping strategies while learning about maladaptive coping patterns common among survivors of trauma. The treatment then shifts to a focus on the Lazarus and Folkman coping model and to training in adaptive problem-focused and emotion-focused coping strategies. Coping strategies include those related to emotion regulation, cognitive restructuring, behavioral activation, and communication/decision-making skills. The final sessions address interpersonal relationship skills and self-care, including adherence to medical regimens. These are important for improving

psychological well-being, decreasing risk behavior and enhancing health protective behaviors.

Clinical Trial: Participants and Measures

Participants and Procedures

Participants were recruited from community organizations in New York City from March 2002 to January 2004 and completed a structured interview that assessed demographics, sexual abuse history, depression, and posttraumatic stress.. This included an expanded version of the Traumatic Experiences Questionnaire (TEQ; Kaplan, Asnis, Lipschitz, & Chorney, 1995), which assesses exposure to traumatic events, including sexual abuse during childhood, adolescence, and adulthood. Eligible participants were HIV positive and had experienced CSA before age 18, which was defined as any unwanted touching of a sexual nature by an adult or by someone at least 5 years older than the participant when the incident occurred. Exclusion criteria were extreme, acute distress as indicated by: suicidal intention (not ideation), severe depression as defined by a score of 30 or above on the Beck Depression Inventory (BDI; Beck & Steer, 1993), and/or acute distress due to sexual revictimization in the past month; and impaired mental status. Participants provided informed consent and were then randomized to experimental (coping skills) or a comparison therapeutic support group intervention.

Of the 63 women assigned to the group coping skills treatment, 52 attended at least one session. Analyses in this paper include these women who received at least this minimum exposure to the intervention. Participants were equally divided into 6 groups that met for 90 minutes once per week for 15 weeks. Each group had two female leaders, a clinical social worker and a clinical psychologist. All leaders had prior experience working with people living with HIV/AIDS and histories of CSA, as well as training and experience in both CBT and group work.

Measures

During the trial, attrition and attendance data were collected. At the end of the intervention, participants were administered two qualitative, free response questionnaires: (a) a *Participant Attendance Questionnaire* assessing factors related to high or low levels of attendance and (b) an *Expectations Questionnaire* assessing initial expectations of the intervention and ways in which those were or were not met. Clinicians also wrote clinical process notes after each session about participants' responses to session content and interactions among group members and clinicians; these notes were a primary source of data for this paper. Therefore, quotations from clients included in the following sections are paraphrased based on the clinicians' memory and may not reflect the exact words used by the clients. Four follow-up assessments were administered to measure changes in psychological and behavioral variables at time points after the intervention; results of these have been reported in intervention-outcome papers (Sikkema et al., 2007; Sikkema et al., 2008).

Clinical Analysis

Participant Characteristics

Participants were 52 women living in New York City ranging in age from 26 to 57 years. Women were poor, with 71.2% earning less than \$10,000 per year and 78.8% reporting they were unemployed or disabled. Most (75%) reported current involvement in a dating or marriage relationship, 75% reported having children, and the majority were African American and heterosexual. Substance use was common, with over 50% of the sample

reporting lifetime use of alcohol, marijuana, or crack/cocaine; 34.6 % reported receiving substance abuse treatment in the four months prior to study enrollment. Many participants (38.5 %) reported that they were taking psychotropic medications at the time of participation; some participants were currently seeing psychiatrists, and/or participating in HIV support groups. The most common mental health symptoms included anxiety with 90.4% of women meeting criteria for severe anxiety on the Beck Anxiety Inventory (Beck & Steer, 1993a) and depression with 36.5% scoring 16 or above on the BDI (Beck & Steer, 1993b). Additionally, 34.6% met screening criteria for a diagnosis of PTSD. The women reported high lifetime rates of homelessness, incarceration, and transactional sex. Most participants reported sexual abuse beginning before age 12, with first abuse experiences occurring at a mean age of 7.41 years. The majority of participants reported penetrative vaginal or anal sexual abuse and multiple episodes of abuse during childhood and adolescence. On average, participants had been diagnosed with HIV for 10.8 (S.D. = 4.9) years at the beginning of treatment.

Clinical Themes: Observation of Participant Responses

Certain aspects of the treatment seemed particularly meaningful for the women participants. Additionally, the women raised issues and nuanced interpretations of the intervention content that were not fully anticipated when the treatment was developed. In this section, we describe clinical themes that emerged as important during six core portions of the intervention. These themes correspond to various intervention sessions (Table 1) and highlight aspects of the group process and dynamics that developed. For each theme, we discuss both the aspects of the intervention that worked well and challenges that emerged.

Developing Group Cohesion and Beginning CSA Narratives—In the first three sessions, participants began to share their trauma narratives and to process the emotions and symptoms related to those experiences. This aspect of the treatment asked participants to begin to work towards openness and vulnerability with the group almost immediately. While participants varied in their willingness to disclose experiences early in treatment, women began to identify with, support, and trust one another as these very personal stories were shared. The result was an unexpected and quick bonding of the groups in this early stage of the intervention.

The willingness of some women to disclose their trauma narratives early in treatment was surprising, as we expected this client population to be resistant and cautious when entering a new group. Several factors may help explain this. First, all participants had prior experience participating in some type of HIV-related group. Second, all participants had completed a thorough trauma history during the pre-treatment assessments for this study and had thus begun the process of disclosing their CSA experiences; some women explicitly expressed feeling more motivated to participate in the group after disclosing their trauma in the assessment phase. Third, the structure of L.I.F.T. may have increased clients' feelings of safety and motivated them to begin participating actively early in treatment. Clients knew that the intervention included psychoeducation and skills training to help them cope with effects of trauma. Therefore, the direction and content of treatment were clear, as were the expectations of participants. Setting expectations may increase predictability and thereby decrease anxiety and resistance. Finally, fourth, we observed that women seemed more ready to trust other group members because they knew they all shared the experiences of both CSA and living with HIV. As women disclosed their stories, others listened with empathy and very little judgment. Hearing others' stories normalized participants' experiences without minimizing them, and the groups joined together to gain a sense of empowerment and control over their collective experiences of CSA. While many participants were willing to begin disclosure of CSA experiences early, others exhibited

significant resistance and needed more time. Some women presented as clearly resistant, expressing apathy, while others presented as reserved and anxious. Notably, other group members generally responded positively towards women who chose to share minimal personal information early in the treatment.

As treatment progressed, however, some expressed anger at women who were not disclosing because they felt everyone should be engaged in mutual sharing of experiences. In these situations, group members were encouraged to express their emotions, but at the same time to understand the perspective of the other. As coping skills were introduced, members who had difficulty were asked to problem-solve about ways to participate more actively while coping with the distress of disclosure. For example, one participant agreed to write portions of her narrative in her journal to read aloud to the group. The process of increasing disclosure happened somewhat naturally, with most members adding to their narratives over time as they gained the skills to talk about aspects of the narrative that were more difficult. Additionally, some women who were more resistant to disclosing CSA experiences focused first on discussing trauma and stress related to HIV until they were ready to begin their CSA trauma narrative.

Understanding Trauma Symptoms—Session 3, which focuses on symptoms that can result from sexual trauma, was a particularly crucial point in the treatment. For many women, it was the first time that they had ever discussed their emotions and behaviors related to CSA -- or even recognized them as symptoms resulting from early abuse experiences. Presenting a visual diagram of common sexual trauma symptoms seemed particularly useful for normalizing the symptoms and decreasing avoidance around acknowledging the presence of feelings that many had experienced. This was important in creating a safe atmosphere for sharing emotions, as many of the women expressed that these symptoms typically led to feelings of isolation and shame. Through the discussion, participants recognized how symptoms of sexual trauma had complicated their relationships, limited their ability to cope with HIV, negatively impacted medical and self-care, and contributed to sexual risk behavior and substance abuse. Thus, this was a powerful and often painful session. When participants returned for Session 4, some disclosed discomfort during the week and reluctance to return to the group. They indicated that they were motivated to come back by the feelings of mutual purpose and safety among the group members, as well as by the sense that they were now moving forward by acknowledging the impact of CSA on their lives. This underscores the usefulness of a group intervention for these women, as connection with the group was a prime motivator for continued attendance in treatment. We also believe the structured nature of the treatment was helpful again at this juncture, as the clear direction of the intervention seemed to motivate clients to tolerate the emotional distress of continuing.

At this point in the intervention, it was important to note issues of transference that emerged. We observed that most participants responded to the therapists as good, helpful maternal figures. This was particularly powerful because many women reported that their mothers did not believe their abuse was happening despite the women's attempts to tell her. Therefore, they responded to the therapist's validation, empathy, and support with relief that they were being heard. This dynamic continued as the therapist took a typical "parent" role as a teacher providing psychoeducation and coping skills training. The process of learning from and being nurtured by the therapist may have played a role in the clinical improvement of the clients. Negative transference also occurred in some cases, with some clients initially viewing a therapist as a harsh parental or authority figure. This occurred most often towards less active therapists, as clients felt misunderstood and interpreted silence as judgment. This was not surprising given the clients' past negative experiences, but such transference

occurred much less frequently than expected. Most often, negative transference decreased over time as therapists responded to clients with validation and support.

Recognizing the effects of victimization on relationships and behavior—Most women identified themselves as “victims,” and the discussion in Session 4 allowed them to express their feelings associated with this role. Participants most commonly described “victim feelings” as including depression, anxiety, and hopelessness. Some also described feelings of passivity, helplessness, powerlessness, fearfulness, and a sense of having little or no control in their lives. Throughout the session, women identified ways in which these emotions became incorporated into their behaviors such that they were reacting as victims in all situations they perceived as threatening. The women particularly noticed how this was affecting their close relationships and support systems. These insights are shown clearly in their statements during Session 4. One recognized her fear and passivity in relationships, saying:

“I always give in first. I cannot handle the thought of any confrontation. Then later I resent giving in and get angry at myself and the other person involved - it is so confusing.”

Another woman recognized how her loss of power, control, and sense of self was manifested:

“I need to be the good person and always need to be seen as giving and caring, even when I really don’t feel that way,”

While many tended towards this passive role, some noticed an opposite reaction in that they identified with the aggressor and acted out in rage and violence towards others in their lives.

For many, this was also the first time they connected the influence of their past victimization with their current coping behaviors – often alcohol and drug use – they used to escape negative emotions. They also noticed how behaving as a victim led to increased sexual risk, often because they felt unable to negotiate condom use. One woman said:

“I just give in to my partner concerning using condoms - I can’t tell him what I want, nor can I disclose why I am this way,”

and another stated:

“I seem so passive in my relationships - including the sexual ones.”

The issue of disclosing CSA also became salient as women recognized the impact of sexual trauma on their relationships. Many identified deep shame and guilt that prevented them from being honest within their social support systems. Several women revealed they felt unable to disclose their CSA, particularly if a non-abusing caregiver had not believed or supported the woman when she disclosed CSA as a child. The shame and guilt of sexual abuse and lack of caregiver validation combined to lead to a belief that others also would be dismissive or rejecting if the abuse was disclosed. In contrast to these beliefs, however, women had experienced the validation of the group therapists and members, providing key evidence that disclosure was possible without increasing shame and guilt. This provided an opportunity to use their experience in the group to help them challenge cognitive distortions related to disclosure.

In response to the women’s struggle with powerlessness, we discussed the term “survivor” related to CSA. Though “surviving” indicates a positive outcome after trauma, women felt this word was passive and that it indicated completion. Therefore, one group decided to re-frame this as a time of translating their feelings and behaviors from “surviving” to “thriving.” They thought this was a more powerful word with a present and future focus,

rather than a focus on the past; they felt it set a goal for them to achieve in their daily lives. Given the sense of empowerment this generated, we incorporated this distinction between surviving and thriving into the intervention manual.

Teaching and Applying New Coping Strategies—Sessions 5 through 8 focus on the utilization of the “Transactional Model of Stress and Coping” (Folkman et al., 1991). A visual diagram was used throughout the remaining sessions as the frame of reference for discussing coping strategies related to HIV and CSA. Therefore, it was important for participants to gain both intellectual and applied understanding of the concepts in the model. In teaching the model, it was clear that participants varied in their levels of understanding and ability to apply the concepts. It was useful to accept this and to allow participants to use the model at widely varying levels. As a general strategy, we substituted words to make it easier for all participants to understand (e.g., coping = “dealing with,” adaptive = “what works well”). It was also effective to use their actual experiences as practice exercises for applying the model during each session.

The majority of women were particularly interested in the cognitive restructuring coping strategies. They identified easily with the cognitive distortions presented: all or nothing thinking, focusing and dwelling on negative details, rejecting positive experiences, and jumping to conclusions, among others. The process of re-evaluating cognitions was new and meaningful for the women, as they recognized that they could have control over the thoughts that typically pushed them towards maladaptive, avoidant coping behaviors. One woman reflected on developing these cognitive and self-talk strategies, stating: *“I learned to talk to myself in a more positive tone.”*

Most women had a long history of relying on only very few coping strategies, usually including alcohol or drug use and other forms of avoidance and denial. In learning that they could develop other ways of coping, the women expressed feeling a new sense of control and freedom. We often described having a “shopping bag” full of coping strategies that could be pulled out when they were a good fit for different situations. This was especially important for participants who were feeling overwhelmed, believing that their problems and circumstances were too large to overcome. One woman reflected on the coping skills training, saying:

“Now I know I can break things into smaller pieces and take baby steps instead of dealing with everything at once. I can have more control that way.”

In this statement, the client is referring to her ability to use active coping strategies to approach the problems in her life by analyzing the problem step by step. In fact, she is using the language of the intervention, which, following the Transactional Model of Stress and Coping, acknowledges that global stressors can be overwhelming, thus it is more adaptive to identify smaller, more manageable stressors and focus on these. This allows her to choose effective coping strategies for the difficulties that can be solved rather than becoming overwhelmed and hopeless when she is facing multiple challenges.

Recognizing effects of CSA on sexual relationships—Sessions 9 through 11 focused on exploring relationship patterns sometimes generated by CSA experiences and on developing new, adaptive relationship skills. Throughout these sessions, participants readily recognized the effects of CSA on their sexuality. Many noted that they avoided sexual encounters, as sex often elicited the same feelings and reactions present during their CSA experiences. Several women reported that during prolonged or repeated abuse, they began to dissociate from all feeling, which often helped them endure the abuse. As a result, they found themselves having the same reactions in their current consensual sexual experiences; that is, many reported that they took a very passive role during sex, felt numb and often did

not reach an orgasm. One woman described, “*I just lie there like a corpse.*” Some women reported that their lack of interest and pleasure during sex led to relationship conflict, with their partners perceiving their resistance or passivity as rejection. In some cases, this perceived rejection seemed to lead to partners leaving the relationship or becoming physically or verbally abusive.

In contrast to this passivity, other women perceived themselves as sex objects and expressed the belief that sex was synonymous with love. Some women who were sex workers described sex work as a way they had attempted to regain power. One participant said:

“It [sex work] puts me in the driver’s seat. I get paid for what someone took from me before.”

The majority of women desired to have meaningful sexual relationships. They found exploring the connection between their early sexual trauma and their current sexual experiences to be a liberating experience: They began to understand that their difficulties were understandable, even expected, reactions to trauma, rather than evidence that something was “wrong” with them. Yet, for some women, making these connections was frightening as they wondered whether their sexual trauma histories would prevent them from ever enjoying healthy sexual relationships. Therefore, it was important for the facilitators to recognize and process these clients’ feelings of hopelessness. Therapists balanced the conversation by presenting positive elements of successful relationships as a model and frame of reference for the participants as they began to look towards repairing or entering into relationships. The “SIPS” acronym (Safety, Intimacy, Power, and Self-Esteem) presented in Session 11 provided an effective method for introducing positive relationship characteristics. These four elements gave the women something to use as a marker to evaluate the quality of their relationships and their feelings about their relationships; perhaps even more importantly, they gave the women a goal to strive towards in relationships they wanted to improve.

Conceptualizing termination as a new beginning—During the final four sessions, women continued to identify the ways in which CSA was related to some of their risky behavior and preventing them from engaging in positive and healthy self-care behaviors. At this point in treatment, however, the women were just beginning to understand how to translate their new insights into behavior change. Therefore, it was helpful during Sessions 12 through 15 to frame the skills training as the *beginning* of an ongoing process of gaining knowledge and power to improve one’s healthy behaviors. At termination, most women expressed feeling a sense of progress and liberation after sharing their CSA experience and developing skills to make positive life changes. They perceived the intervention to be the beginning of a change process. One participant stated:

“I learned about my negative thinking and behavior, and how to turn it around with a solution.”

The participants’ feelings that the conclusion of the intervention was the beginning of important emotional and behavioral change processes were supported by results of the trial, showing reductions in risk behavior and traumatic stress (Sikkema et al., 2007; Sikkema et al., 2008). A challenge during termination, however, was the participants’ desire for the group to continue. To address this, we took time to mourn the passing of the group, and referred participants with persisting mental health needs or desires to continue treatment to other individual or group therapies. We also encouraged participants to stay in any support groups in which they were currently participating.

It is worth noting that some participants did not feel ready for a group, and found this experience somewhat overwhelming at first. It is possible that individual psychotherapy may

have helped to prepare them for the group. Others felt the group was helpful, but that there was not enough focus on their individual needs. In fact, several group members expressed that following the group they finally felt ready to deal with their problems. It is possible that participating in individual therapy concurrently the group, or perhaps following completion of the group, could be beneficial to these participants.

Intervention Attendance

The mean number of group sessions attended was 10.2 (SD = 3.9). Only 11 women (21.2%) attended fewer than 8 of the 15 sessions and 18 women (34.5%) attended 13 or more sessions and were exposed to most of the intervention content. Among those who attended fewer sessions, many attended sporadically throughout the treatment, rather than dropping out at the beginning; they were therefore able to report on barriers to their attendance. On the *Attendance Questionnaire*, women shared factors that motivated them to attend, or not attend, group sessions. The most commonly reported reasons for not attending were illness and schedule conflicts with work and other appointments for medical or social services. A very small minority mentioned factors related to the actual treatment that contributed to absences, reporting that they sometimes felt unwilling or unable to discuss the intervention topics. Beyond this self-report of reasons for absences, we did not observe clear overall differences between those who attended few versus many sessions. In a few specific cases, clinicians observed increases in depressive symptoms or substance abuse during treatment that may have contributed to low attendance, though this was not necessarily common. Regarding motivating factors for attendance, the majority reported they enjoyed sessions and felt supported by the group and facilitators; many said that they found particular comfort in the fact that all group members had experienced CSA. Numerous women also stated that they recognized their need to address CSA experiences. One woman wrote:

“My mother died and I never told her what happened, so maybe I wanted to tell somebody...I’ve been holding it in so long I thought it was time to talk.”

Many reported finding the group to be a safe place to share experiences, express feelings, and learn information not available through other psychosocial or substance use treatments. Some also expressed feeling motivated by a desire to help and support other group members.

Participant Expectations and Satisfaction—To accompany clinician observations, data were also collected from participants about their experiences during the intervention. On the *Expectations Questionnaire* administered during the final session, participants shared expectations they recalled having prior to beginning the intervention. Many women reported positive expectations related to gaining support from peers and having a place to talk about CSA experiences. Some participants, however, reported having initial negative expectations. Most commonly, they expected the sessions to be boring, that they would not like other group members, or that sessions would focus on topics that were not relevant for them; some also mentioned expecting to feel sad and ashamed when talking about CSA.

When asked whether expectations were met during the intervention, most women reported that their positive expectations were met and that their negative expectations were not. Responses suggested that most women enjoyed interacting with group members and leaders more than they expected. For example, one woman wrote she expected other group members to be “bullshitters,” but indicated that this was not true, writing, “They are wonderful women.” Further, women reported gaining more from participation than they expected in terms of learning new ways of coping. Within these responses, many women noted that the intervention was not long enough and that they would like additional sessions.

Clinical Recommendations

During the trial, clinicians identified four core recommendations for implementing L.I.F.T. that emerged as particularly important:

(1) Clinicians delivering this intervention should have training and experience in group therapy

Though L.I.F.T. is a manualized intervention, the group process is an essential component of the treatment. Too often, practitioners adhere strictly to treatment manuals while allowing group process issues to become secondary, or entirely absent. In the clinical trial of L.I.F.T., however, clinicians were experienced group therapists who were continually observing, responding to, and processing participants' interactions. Further, clinicians were focused on identifying times when interactions within the group provided opportunities for members to have therapeutic interpersonal and emotional experiences in the moment. For example, when participants exhibited anger in response to another client's opinion or actions, the response was acknowledged in the moment and reasons for the reaction were addressed; in these situations, the clinicians attempted to facilitate conversation between the clients in order for them to experience owning and expressing emotion, working through conflict, learning from other's responses, and repairing relationships. This is a more process-oriented approach than may be expected from other manualized treatments that focus solely on psycho-education. Therefore, consideration must be given to the experience and clinical training of the therapists in order to integrate didactic and group therapy components.

In addition to having trained therapists, it is important for the clinicians delivering this intervention to address their own emotional responses, as emotional distress, including vicarious traumatization, is a concern even for experienced therapists treating trauma. To address this, our co-therapists met before and immediately after each session. They reflected on session content, but spent most of the time processing their emotional responses with each other. We found the co-therapy model to be invaluable for running these groups, and for allowing this pre- and post-processing.

(2) Establishing group safety and cohesion should be prioritized

While this is always true in group therapy, the client population for which this intervention was developed can bring particular challenges to building a group where members feel safe and supported. For instance, because Axis II pathology is more common among women with histories of CSA, some group members are likely to have significant difficulty with emotion regulation and interpersonal relationships. Therefore, clinicians should be prepared for verbal and physical aggression during groups, as well as strong emotional reactions that may be upsetting for other members. When this occurs, the therapist should be prepared to take action first to preserve the safety of the group, but then to involve the group in the problem-solving process of resolving the issue.

(3) Clinicians should focus on providing a balance between didactic and process-oriented material

Because L.I.F.T. includes large amounts of psychoeducational material, it is important to be intentional about balancing the need to present information with the need to attend to important participant reactions and group process issues. This essential balance of structure and flexibility was achieved in part by alternating one clinician to take a lead role in presenting material, while the other co-leader focused on attending to the process as clients worked to understand and apply the material. This therapist took the lead in recognizing resistance and transference, both positive and negative. This was particularly important for this population, as many women expressed difficulty trusting people in authority or "parent"

roles given the common combined experiences of CSA *and* feeling unsupported by caregivers in the past. Though positive transference occurred most often, as discussed earlier, it was important to have a therapist dedicated to assessing these processes, as any negative transference or interactions needed to be addressed. The therapists were also able to balance one another, particularly when clients needed to be challenged and supported at the same time. It is worth noting that clients did occasionally attempt to split co-therapists, and would occasionally challenge the less active therapist. While clients tended to frame the less active therapist as “judgmental,” they may also have seen the therapist in this role as the weaker of the therapists. In any case, having therapists regularly meeting before and after groups helped therapists discuss these issues, anticipate when they would emerge, and be more effective in addressing them. Also, the structured nature of the intervention seemed to make these events less likely to occur, and provided useful tools for addressing these events (e.g., practice communication skills, examine the evidence that the therapist is being judgemental and explore alternative explanations). Additionally, the co-leading model seemed to help clients feel safe and develop trust with clinicians, even as they were presented with information that was emotionally difficult to process.

Some clinicians may perceive that manualized and process approaches to group therapy are mutually exclusive. However, we found the integration of the two to be effective. To achieve this, we used the manual as a guide to provide structure and goals. The content was then delivered within the context of the group process. That is, the content affected the process and in turn, the group process guided the way we continued to discuss and explain the information. For example, one client might share a personal example of relationship difficulties related to her marriage, and another client may begin to cry. The therapist would then explore with the second client if the example was a trigger for her. The clients at this point would also have an opportunity to validate and support one another. This process-oriented interaction relates directly to the core psychoeducational components of the intervention: connecting trauma symptoms to current reactions and learning new ways to understand and cope with the triggers and situations causing current distress.

(4) Clinicians should emphasize validation and provide opportunities to process resistance

As discussed earlier, there were several points during this intervention that proved to be emotionally difficult for participants. This was expected as this was the first time many of the women had disclosed CSA experiences or considered the effects of CSA on their current functioning. Clinicians should be exceedingly mindful about the varying emotional reactions of participants and should validate the difficulty inherent in participating in L.I.F.T. This is particularly important for women who may be experiencing intense shame, guilt, and anxiety about sharing their trauma narrative or disclosing their current trauma symptoms. To facilitate participants' recognizing these emotions, therapists should foreshadow the possibility of these feelings with the group, letting them know ahead of time that these are common responses to exposure-based trauma treatment. Further, clinicians should regularly invite participants to process their feelings about the current and previous sessions.

Of particular importance are emotions and thoughts related to avoiding or stopping participation in the group. Many women expressed this resistance in the trial but were able to work through this to see the benefit of continuing. Not unexpectedly, this was most frequent the week following a particularly emotional group session. When this occurs, it is important to assess possible issues of negative transference, extreme anxiety, or problems within the group by exploring with clients the emotions and motivations underlying the desire to quit. Therapists should also normalize the feelings of wanting to stop treatment to encourage clients to disclose these desires. This is essential to consider, as some women who feel a strong need to avoid treatment may receive great benefit from further exposure to

the intervention, while others may be experiencing acute distress or retraumatization, requiring further assessment and possible referral for individual treatment. We found that forecasting these feelings, particularly at the close of an intense session, was helpful. We also found that women frequently returned out of a sense of obligation to the other women in the group—they did not want to abandon them. This speaks to the importance of the group bond that occurred in the initial sessions of this intervention.

Conclusions and Future Directions

L.I.F.T. is a unique intervention that focuses on reducing traumatic stress and increasing adaptive coping among individuals with both HIV and a history of CSA. Clinical trial results (Sikkema et al., 2007; 2008) and this clinical analysis show ways in which addressing trauma symptoms and enhancing coping skills led to both improvement of psychological well-being and reductions in HIV risk. Bonding and mutual validation within the group were established early in the group process and were essential for providing a safe, supportive environment for the exposure-based components of treatment. Making connections between trauma symptoms, avoidant coping (e.g., substance abuse, risky sexual behavior), and relationship patterns also seemed to be a particularly powerful component of the intervention that prepared participants to work towards more effective, active coping strategies. Based on our observations, the combination and balance of these aspects of the treatment is what seemed most important. While facilitating supportive relationships in the group alone may improve mood and decrease some emotional symptoms, we believe that combining this with coping skills training is what gave participants the information they needed to achieve both the emotional and behavioral improvements in coping observed in the treatment outcomes. In fact, the sense of common purpose and catharsis resulting from early group sessions appears to motivate participants to more actively engage in skill-building and active coping strategies, which result in further gains and group cohesion, thus resulting in these two elements having a synergistic effect.

These results support the need for increased focus on treating mental health symptoms among HIV-positive individuals, especially those with history of CSA. Further, results showed that participants decreased high risk behavior – even in the absence of specific risk reduction skills training – as they received treatment focused on their psychological healing and adjustment. This has important implications for increasing mental health components of HIV prevention efforts, which have focused primarily on direct skills training approaches.

In future research and clinical work, there are several ways in which L.I.F.T. could be expanded or adapted. One possibility is to combine group and individual therapeutic approaches in order to allow each individual more time for exposure-based treatment of CSA and application of coping strategies to their specific stressors. This could be particularly important for participants who present with the most severe trauma symptoms. Individual therapy could be provided as a concurrent treatment or as a follow-up service to motivated participants after the group treatment has ended.

Combining the current intervention with family- or couples-based approaches also could have added benefits related to addressing the relationship difficulties of women more directly by bringing significant others, children, family members into the therapy process as active participants. Additionally, women expressed specific difficulties with parenting, especially as their children reached adolescence; they expressed that their CSA experiences led them to be over-protective of their children, which interfered with the adolescents' natural desires to become more independent. Therefore, adding a parenting skills or parent-youth communication component to the treatment could be beneficial for some women.

Research would be needed to compare these combined approaches to the original intervention approach to identify potential added benefits.

Further research is also needed to examine the efficacy of the intervention and identify clinical process issues that arise as the intervention is delivered to different populations of women. Though the current study included women of diverse ethnicities and sexual orientations, all participants were from New York City, which could limit generalizability of some findings. In particular, we are interested in how the intervention works for women living in non-urban areas who may have very different cultural backgrounds and less experience in mental health treatment and support groups than the participants in this study. We would also like to move towards adaptations of this intervention for international settings, particularly settings with very few mental health resources.

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Table 1**Intervention Content by Session**

Session	Focus	Activities
1	Introducing group structure Building group cohesion	1 Establish group rules and goals 2 Share personal narratives
2	Identifying emotions related to CSA and HIV Expressing emotions related to CSA and HIV	1 Expand trauma narratives 2 Discuss common emotions associated with CSA and HIV. 3 Discuss how CSA complicates coping with HIV
3	Symptoms and behaviors related to CSA	1 Learn and discuss common symptoms of sexual trauma 2 Discuss how sexual trauma symptoms can interfere with coping
4	Experiences of victimization Effects of victimization on responses to current social support systems	1 Identify emotions and behaviors associated with being a victim 2 Connect those emotions and behaviors with one's responses to perceived threats from social support systems
5	Stressors related to CSA and HIV Current coping strategies	1 Define stress, appraisal, coping 2 Identify problems/triggers 3 Discriminate between adaptive and maladaptive coping
6 – 8	Adaptive strategies for reducing stress	1 Learn Ways of Coping Model 2 Learn adaptive coping strategies (cognitive, behavioral, emotional) 3 Reduce maladaptive coping
9 – 10	Relationship patterns related to CSA	1 Learn how CSA can affect relationships 2 Discuss sexual behaviors and feelings about sex 3 Discuss trust and communication
11	Elements of successful relationships	1 Discuss SIPS: Safety, Intimacy, Power, and Self-Esteem in relationships
12 – 13	Effects of trauma on health and risk behaviors: Reducing risk behavior and Increasing health behaviors	1 Apply coping model to HIV risk behavior and health behaviors 2 Learn strategies to increase health protective behaviors
14 – 15	Review and Conclusion	1 Recognize progress and skills learned 2 Set goals for the future 3 Process through group closure