By Survivors, for Survivors: A Pilot Study into the Efficacy of a Peer-Operated Service for Adults Exposed to Childhood Maltreatment

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Introduction

Childhood maltreatment has extensive long-term societal, personal and economic costs across the globe. The body of research overwhelmingly concludes that maltreated children tend to grow into adults that suffer from a myriad of physical and psychological problems that persist throughout the lifetime. Symptoms of intrusion, arousal and avoidance that meet the clinical threshold for PTSD are common, as are insecure attachment styles and dissociative, substance, mood, eating and personality disorders (Colman et al., 2013; Herrenkohl, Klika, Herrenkohl, Russo, & Dee, 2012; Moretti & Craig, 2013; Mulder, Joyce, Beautrais & Fergusson, 1998; Tasca et al., 2013; Schalinski & Teicher, 2015; Van Der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005; Zannarini et al., 2014). The psychological sequelae of childhood maltreatment is so extensive that for many years now some researchers have been arguing for the addition of a complex/developmental trauma disorder diagnosis to the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013; Courtois, 2004; Van der Kolk et al., 2005).

Analyses of data from the Australian National Survey of Mental Health and Wellbeing indicates that those having experienced both physical and sexual abuse (i.e., complex trauma) are 1.5 times more likely to suffer from a mental health condition, and in a year will spend an average of $1856 more than their non-abused counterparts on healthcare (Reeve & Van Gool, 2013). Childhood emotional abuse and neglect are also associated with long-term negative

psychological consequences (Maschi, Baer, Morissey, & Moreno, 2012; McCormack & Sly, 2013; Moretti & Craig, 2013). Across males and females in Australia, prevalences are estimated to be 8.3% and 9.2% for physical and sexual abuse, respectively (Reeve & Van Gool, 2013). A more recent meta-analytic study of global prevalence rates indicates that the sexual abuse of girls in Australia may be as high as 21%, the highest of all continents examined (Stoltenborgh, Bakermans-Kranenburg, Alink & IJzendoorn, 2014). Alleviating the consequences of childhood maltreatment is clearly a social issue that deserves further research attention.

There are many interventions available to adults who have experienced trauma, with cognitive-behavioural therapy currently considered to have the highest level of empirical support (Bisson & Andrew, 2007). However, there are problems in generalising this body of research to childhood maltreatment (see Dorrepal, Thomaes, Hoogendoorn, Veltman, Drainer & Van Balkom, 2014, for a review). The vast majority of research demonstrating the efficacy of CBT have either used a population exposed to adulthood trauma or focussed almost exclusively on measures of PTSD symptomology as primary outcomes (Dorrepal et al., 2014). This is problematic when research consistently shows that trauma occurring in childhood produces additional and more severe impairment than trauma occurring later. This is particularly true of traumas that are interpersonal in nature, and *all* forms of child maltreatment are interpersonal because they take place within the context of a relationship characterized by power imbalance (Cloitre, 2004; Van der Kolk et al., 2005).

The therapeutic relationship too, is characterised by an inherent power imbalance that has the potential to impede progress for those exposed to childhood maltreatment by echoing the power dynamics of early dysfunctional relationships. While it is impossible to completely balance the status of provider and recipient, organisations that employ peer-support workers remove some of this inequality. This is achieved both through increased similarity between

worker and client, and through the philosophical foundations of peer-support in general. Regardless of the format, process, content and purpose of specific entities, peer-support services are generally based on the same core values of equality, inclusion, experiential empathy, and mutual respect (Onken, Craig, Ridgeway, Ralph & Cook, 2007; Solomon, 2004).

To the best of this author's knowledge, to date there has been few studies on peer-support interventions specific to adults exposed to childhood maltreatment. Quantitative research has been restricted to cancer patients or adults with serious mental illnesses. One review that explored peer-support programs within mental health services noted that randomised control trials seldom reported significant differences between peer-support and comparison groups on various outcome measures (Repper & Carter, 2011). However, the failure to find significant differences may be due to the outcomes assessed, which were most often measures of coping and quality of life (Hooey, Ieropoli, White, & Jefford, 2008). This is supported by Repper and Carter's (2011) review, which located several quantitative studies reporting increased scores on measures of empowerment for mentally ill individuals who had received peer-support. Reduced admission rates to psychiatric facilities and increased social support was also reported (Repper & Carter, 2011). Taken as a whole, quantitative research at best indicates peer-support models in various settings are helpful but no better than usual care (Repper & Carter, 2011). However, participants in qualitative studies often endorsed feelings of belonging, connection, understanding, empathy and hope that they attributed to their experience of peer-support (Hoey et al., 2008; Repper & Carter, 2011).

Given this gap in the literature, the far-reaching social, personal and economic costs of child abuse and neglect in Australia, and the problems in generalising evidence for the efficacy of CBT to a childhood maltreatment exposed population, further investigation of treatment options is warranted. Peer-support programs are a viable alternative to other therapies because of their cost-effectiveness and potential to overcome issues that may arise from power dynamics in traditional therapies. The current research therefore aims to conduct a preliminary investigation into the efficacy of an Australian peer-operated service for adult survivors of childhood maltreatment. Using

measures at pre- and post-treatment it will assess changes in non-specific distress and general health. It will also examine participant satisfaction with the program, and the likelihood of post-treatment changes to psychiatric status. As peer-support interventions with this population have received very little research attention, specific hypotheses are not justified.

Method

Participants

Participants were recruited by the Heal for Life (HFL) Foundation from individuals who had registered to attend a HFL program. Although the use of a convenience sample such as this prevents generalisation of results beyond the cohort examined, random sampling was not feasible at this early stage of the research. Of those approached, 84% agreed to participate, giving a sample size of 139. A response rate of 71% gave a final sample size of 98 (76% female) for analyses. Nine participants did not complete the program or follow-up questionnaires and were not included in analyses. Some participants that did not complete psychometric tests agreed to complete HFL feedback surveys, thus the sample size used in these analyses was 157.

Ages ranged from 19 to 67 (M=42) and 80% were born in Australia, including four of Aboriginal descent (further demographics are contained in table one). All but one participant spoke English at home and all but one reported a history of childhood abuse, with the majority of the sample reporting three or more types of abuse. Emotional and sexual abuse were the most common experiences (see table two).

Over half of participants reported a substance or gambling problem. Multiple addictions were reported by 27% (see table three). The majority (82%) of participants had also been diagnosed with a psychiatric disorder, with over half of these currently receiving some form of treatment, mostly psychoactive medication. Of participants with a psychiatric diagnosis, 29% had been hospitalised at least once, with 11% of these hospitalisations having occurred in the six months prior to attending the program. Although 61% of those reporting problems with addictions

also reported seeking help, 29% still had a problem at the time of the study. Overall, 94% of participants had at some point in their lives sought professional help, most commonly with counsellors, then psychologists. Only one third indicated that the assistance they received had been effective.

Measures

All outcome variables were measured using self-report scales. All are suitable for self-administration and with the exception of one (the guest satisfaction questionnaire), all have shown adequate validity and reliability when used within the population of interest (Bonomi, Cannon, Anderson, Rivara, & Thompson, 2008; McHorney, Ware, Lu & Sherbourne, 1994; Ware & Sherbourne, 1992; citation for K-10). The guest satisfaction survey was designed by the HFL Foundation and is distributed to all guests at the conclusion of their programs. Using Likert scales, it asks attendees to rate their perceived influence of the program on their recovery from childhood trauma.

Given the numerous, varied and co-occurring pathology frequently experienced by adult survivors of childhood maltreatment, the Kessler Psychological Distress Scale (K10; Kessler et al., 2002) and the Short Form Health Survey (SF-36; Ware & Sherbourne, 1992) were used as primary outcome measures. The K-10 assessed changes in non-specific psychological distress and the likelihood of being classified as having a psychiatric disorder from pre- to post-treatment, while the SF-36 measured changes in general health. The SF-36 has eight indices that assess bodily pain, energy and fatigue, health perceptions, limitations in physical, social and usual role activities due to health, and general mental health (Ware & Sherbourne, 1992). From these, the SF-36 produces two summary scores (the physical components and mental components summary) that assess overall physical and mental health. Together, the SF-36 and K-10 provide a broad indication of participant's overall mental and physical wellbeing before and after treatment.

Design & Procedure

Participants attended HFL for five days between 2008-09 and completed measures before and after. All pre-treatment measures except client satisfaction were taken on participant arrival at HFL's property. Post-treatment measures (including client satisfaction) were distributed by post six months after program completion. As another unpublished study into the HFL program conducted time-series analyses with immediate post-treatment measures, these were not performed within the current sample.

The HFL Foundation runs a five-day emotion-focussed residential program comprised of daily workshops that provide psychoeducation and therapeutic strategies, and individual counselling with trained peer-support volunteers who have previously attended the program themselves. Peer-support volunteers are directly supervised by program facilitators with external tertiary qualifications and HFL training. Like HFL's peer-support volunteers, all HFL facilitators are also survivors of childhood trauma who have previously attended a HFL program.

The program itself is informed by current research into the neurobiology of childhood trauma, and principles of humanist-experiential and emotion-focussed therapies. Therapeutic strategies primarily consist of utilising the peer-to-peer relationship as a platform for corrective emotional experiences with the aim of client empowerment. In keeping with the philosophical foundations of peer-support, HFL also emphasises client empowerment through equality, choice and mutual respect.

Peer-operated services are not amenable to traditional experimental approaches. Randomisation into an active treatment or control group undermines choice and autonomy. The very use of a control group undermines the principle of equality in that active treatments are designed to facilitate positive outcomes while control conditions *are not intended to work* (Westen & Bradley 2005). For this reason, the addition of a control group also does little to improve methodological rigour; all that can be conclusively demonstrated by comparisons of an active treatment to a control condition is that treatments *intended* to produce improvement are more effective at producing improvement than those that aren't. Ideally, efficacy studies of emergent

clinical interventions should use a comparison treatment with empirically established efficacy. Unfortunately, this was not feasible for this pilot study due to financial constraints. Thus, although considered the lowest level of evidence in the empirical hierarchy, a single group, repeated measures design utilising a sample that has freely chosen to participate in the intervention is an experimental approach that can conduct a preliminary assessment of peer-operated services without compromising the principles underpinning such services.

Following data collection, paired t-tests were performed on K-10 and SF-36 scores to assess post-treatment changes. Chi square analyses of K-10 scores were used to predict the likelihood of participant changes in psychiatric status. Frequency statistics were used to describe participant perceptions of program effectiveness.

Results

Statistically significant changes in non-specific distress were observed, with mean K-10 scores reducing from 32.4 pre-treatment to 25.7 post-treatment (t=32.25, df=93, p<.0001). Chi square analyses of these scores also demonstrated that the likelihood of being classified as having a psychiatric disorder reduced significantly post-treatment (x^2=15.51, df=1, p<.0001). Post-treatment admission rates to psychiatric facilities also decreased, but this was not statistically significant.

Significant increases were observed on the SF-36 pain index, vitality, social functioning, role-emotional and mental health dimensions. Post-treatment increases in the SF-36 mental components summary score were statistically significant (t=??, df=??, p<.001). Post-treatment physical health as measured by the SF-36 physical components summary score improved but increases were not statistically significant. Over half the sample perceived the HFL program to be “life-changing”, with the remainder describing it as “very positive” or positive.

Discussion

Overall, the mental and physical health of the current cohort improved after attending HFL's residential peer-support program. Unfortunately, the design of the study prevents the generalisation of these results beyond the current sample. Without a comparison group, results cannot without doubt be fully attributed to the HFL program. However, the magnitude of changes across measures for the majority of the sample is unlikely to have been achieved without some form of intervention. The majority of the sample experienced significant psychological distress and problems with general health. It is unlikely that the magnitude of these difficulties so substantially decreased by pure coincidence after participating in the HFL program. Although most participants had previously sought professional assistance to which improvement may be attributed, two thirds of those participants also reported this assistance was ineffective while 57% of participants described the HFL program as "life-changing" . The remainder described the program as "very positive" or "positive".

Participants' subjective interpretation of causal mechanisms should not be ignored. Nonetheless, as a convenience sample was utilised, it is possible that participants prior beliefs regarding the program's efficacy influenced their response. That is, participants were recruited after having registered to attend. It is unlikely that any person would seek any form of psychological assistance without some belief that this assistance would be helpful. However, the same premise stands for the one third of participants that had previously sought other forms of help and found this to be ineffective.

The current study also replicated the results of previous peer-support research (Repper & Carter, 2011) in that participants showed increased social functioning and reduced admission rates to psychiatric facilities. Although changes in admission rates were not statistically significant, any reduction in the use of psychiatric inpatient treatment is a huge economic benefit of peer-support programs. In Australia, the average cost of five days inpatient treatment per client in a public psychiatric facility is almost five thousand dollars (Australian Institute of Health & Welfare, 2012). In contrast, the HFL program costs 1200 per

client per week. The contributions of peer-support volunteers allows low-income clients to pay on a sliding scale, with individuals receiving government benefits paying only often as little as $250 for the week. (At the time it was $150) some paying nothing of course

These results demonstrate that the current cohort of individuals substantially improved in various mental health outcomes after attending a five day residential peer-support program in Australia. The HFL program and others like it would certainly seem to be worthy of future investigation. If similar results can be obtained in research with increased methodological rigour, peer-support programs such as that run by the HFL Foundation provide a viable alternative or complement to traditional therapies for adult survivors of childhood trauma.