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College of Allied Health

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Walden University
2024

Abstract

Female Incest Survivors' Perceptions of Cognitive Processing Therapy in a Group Setting

by

Julie Kerley

MS, Walden University, 2020

MA, American Public University, 2015

BS, Northern Illinois University, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

January 2024

Abstract

Cognitive processing therapy (CPT) is a type of cognitive behavioral therapy that has been found effective in reducing the symptoms of those who have experienced trauma due to rape, natural disasters, combat, and child abuse, which makes it a potential treatment for survivors of incest. The perceptions of female incest survivors who had completed CPT as part of group therapy for posttraumatic stress disorder (PTSD) were not known. The purpose of this study was to address the effectiveness of cognitive processing group therapy for women who have survived incest and have also been diagnosed with PTSD as a result. The theoretical framework consisted of Bandura's social learning theory. As part of this basic qualitative study, interviews were conducted with nine female incest survivors who had been diagnosed as having PTSD and who had completed CPT as part of PTSD group therapy. Results indicated that group therapy was beneficial in increasing social skills and the feeling of belongingness and in decreasing the negative symptoms associated with PTSD. The study addresses a gap in research on treatment modalities and interventions for those who have survived incest. It may lead to positive social change by increasing survivors' understanding of the efficacy of a new therapeutic alternative to help learn positive social skills and regain a sense of autonomy. The use of CPT in PTSD group therapy may empower women survivors of incest by offering the opportunity to forge social networks with trusted others. This may have a beneficial impact on the lives women who have endured trauma and feel a sense of isolation that few others understand.

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Dedication

I dedicate this paper to my wife, Janna, without whom I would not have had the strength and determination to continue through this journey. You are my rock, and I love you. Secondly, to all the brave women who helped contribute to this study: Without your participation and strength, this could not have happened. Finally, "without God, none of this would have been possible"—Philippians 4:13.

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Chapter 1: Introduction to the Study

In this study, I investigated the impact of cognitive processing therapy (CPT) on incest survivors who had experienced trauma, as a possible alternative to other therapies. The American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) stated that more than 50% of female incest survivors who were abused by a relative suffer from posttraumatic stress disorder (PTSD). According to Lawson and Akay-Sullivan (2020), victims of incest often report reexperiencing the trauma, making them victims of multiple traumas as opposed to a single incident. The evidence indicates that the impact of incest creates real "stuck points" in the lives of the women they affect (Chard 2005; Resick et al., 2012; Nixon et al., 2016). Stuck points are defined as areas in one's life where as a result of a trauma, our cognitive brain gets stuck and stops processing in a rational and realistic manner (Chard 2005; Resick et al., 2012; Nixon et al., 2016) Because incest has potential lifelong damaging effects on survivors, Yildirim et al. (2014) stated that it requires more studies. Researchers who have studied incest have been examined it with other sexual assaults such as rape and childhood abuse; thus, treatment modalities and interventions have not been isolated for this specific form of abuse.

There are important implications for discovering whether CPT can be an effective treatment intervention for sufferers of incest with PTSD. According to the American Psychological Association (2023), CPT is a type of cognitive behavioral therapy (CBT) that has been found effective for reducing the symptoms of those who have experienced trauma due to rape, natural disasters, combat, and child abuse, which makes it a potential

treatment for survivors of incest. Chard et al. (2012) examined the efficacy of CPT on sexual assault survivors by combining individual and group therapy and found that CPT treatment significantly reduced symptoms of PTSD, depression, and dissociation in survivors with improvements persisting for over 3 months. Research shows that CPT can be an efficacious way to manage incest or sexual violence-based trauma (Chard 2005; Chard et al., 2012; Nixon et al., 2017). However, what was not known is how well CPT works with incest survivors in a group setting. Women who have survived incest could potentially find comfort and healing while building skills in a group setting that fosters safety, trust, power/control, esteem, and intimacy (Chard 2005; Chard et al., 2012; Nixon et al., 2017). The presence of other women who have endured similar trauma would provide comfort.

In this chapter, I will briefly summarize the literature related to the study topic and describe the gap in knowledge that I aimed to address as well as the background of the study. This chapter will also include overviews of the study's theoretical framework and methodology. I will define key terms used in the study. The assumptions, scope and delimitations, limitations, and significance of the study will be discussed as well.

Background of the Study

The term *mental health conditions* encompass conditions that cause significant distress, difficulty in functioning, and the possibility of self-harm (World Health Organization, 2022). Lawson and Akay-Sullivan (2020) conducted a study on incest as a form of sexual assault, finding that when done by a child's parent, it leads to especially severe psychological and physical symptoms. This trauma has associations with self-

loathing; feelings of worthlessness, helplessness, and contamination; lower functioning; and somatization of psychological symptoms (Lawson & Akay-Sullivan, 2020). Victims will also often involuntarily and voluntarily disconnect from others and themselves, engaging in the compartmentalization of the experiences. Another pertinent issue is betrayal trauma, which is specific to incest (Lawson & Akay-Sullivan, 2020). Incest often entails revictimization or recurrent harm, according to Testoni et al. (2018) The authors questioned trauma treatment center patients in Italy and found incest to be sneaky and concealed because it involves members of the same family. Pathak (2016) described incest as a hidden sin. Abuse behind closed doors is often hard to detect. Pathak called incest a "family conspiracy of silence" (p. 69). In underdeveloped nations like India, 1,074 judicial cases were reported in 2015, according to Choata and Charan (2021), who noted that incest has disclosure hurdles, measurement problems, social norm consequences, and definitional concerns.

The literature indicates that female incest survivors suffer from considerable trauma (Bohus et al. 2020; Matulis et al. 2014). Victims may believe, for instance, that the incest was their fault, experience self-loathing, or even deny themselves mental health care (Lawson & Akay-Sullivan, 2020). As described by Tull (2022), PTSD occurs after a trauma like sexual assault and causes a variety of troubling symptoms.

A sexual assault occurs when a person's autonomy, control, and mastery over their body are violated by sexual contact without voluntary consent (Merriam-Webster's Collegiate Dictionary, n.d.). When the traumatic event is not addressed by therapy or some type of therapeutic intervention, the likelihood of reliving a traumatic event could

occur increasing the probability of PTSD psychological distress (Chivers-Wilson, 2006). When symptoms last longer than 1 month, patients receive a diagnosis of PTSD (Chivers-Wilson, 2006).

Previous literature indicates that CPT can be an effective intervention for trauma and that incest survivors frequently suffer from PTSD. CPT therapists concentrate on how cognition and secondary emotions—such as reduced quality of life, guilt, and shame—caused by erroneous interpretations of the traumatic event impact patients' future actions and emotional processes (Lenz et al., 2014). In this sense, CPT is somewhat like CBT in that therapists use the Socratic method to facilitate critical thinking in the client to reorient faulty cognitions and improve effect (American Psychological Association, 2023).

Individual and group studies have demonstrated that CPT is valid and effective (Chard 2005; Chard et al. 2012; Nixon et al., 2017). Most researchers (Bohus et al. 2020; Matulis et al., 2014; Chen et al., 2017; Suris et al., 2013) who have examined CPT's effectiveness in treating PTSD for female sexual violence survivors have focused on individual sessions. In a study conducted by Liverant et al. (2012), patients receiving CPT-cognitive (without the written account of events), and CPT individually experienced a reduced level of PTSD and depressive symptoms. The physical or sexual assault occurred in childhood or adulthood in all patients, resulting in PTSD and depression. The studies indicate that CPT can be effective in treating PTSD, but there is a gap in how well CPT for PTSD in a group setting works for incest survivors. Children who have been abused by their parents or family members at any age often experience long-term effects

to varying degrees, according to Lawson (2018). The physical and psychological effects of incest are, however, particularly severe for many survivors.

The gap that was addressed in this study was the lack of research on the perceptions of CPT for PTSD in a group setting for incest survivors. Most studies on CPT have involved military veterans with PTSD. Hathaway (2022) noted that the main difference between CBT and CPT is that CPT specifically focuses on treating trauma, whereas CBT can be more general. CPT also has a more delineated structure, whereas CBT is more conversational. Because of this intense focus on trauma, many studies on CPT have not included incest victims; a more common approach has been to include victims of sexual assault.

There are multiple studies on CPT used by Veterans Affairs. Atuell et al. (2019), for instance, examined the impact of CPT on veterans in the United States. Currently, Veterans Affairs is implementing the method as a manualized, trauma-focused psychotherapy according to the latest Veterans Affairs/Department of Defense Clinical Practice Guidelines (Atuell et al., 2019). The U.S. Department of Veterans Affairs (2022) also has a distinct chapter in its guidelines outlining the efficacy of CPT for war veterans, citing this intervention as critical for this population.

There are several reasons why this study was needed. First, I explored the personal experiences of those who have survived incest and examine whether CPT can be an alternative therapeutic tool for incest survivors that will also provide a different setting for the women to not feel as alone and isolated as they might in a one-on-one setting. In addition to this, CPT could also provide incest survivors the feeling of safety and

protection in knowing that they are not alone in their healing journey by being in a group setting with others who have gone through similar experiences.

Problem Statement

The problem was that little is known about what the perceptions of CPT for PTSD in a group setting are for women who have survived incest. The study is important because it can potentially help facilitate a debate or discourse about the potential of using CPT for survivors of incest victimization. From a global, social, and socioeconomic perspective, broader access to mental health resources means more equity, services for victims, and social cohesion, based on the World Health Organization's (2022) observation about the deleterious effects of poor mental health. Researchers at the World Health Organization stated that mental health is a condition of mental well-being that allows individuals to manage the demands of life, develop their potential, study, and work effectively, and give back to their communities. This study will close the gap and gain a better understanding of womens perceptions of CPT for PTSD in a group therapy setting.

Purpose of the Study

The purpose of this basic qualitative study was to gain a more comprehensive understanding of the experiences of CPT group therapy as a treatment modality for female incest survivors diagnosed with PTSD in Arizona. The experiences of female insect survivors after CPT for PTSD group therapy have not been examined, according to my review of the literature. I investigated how individuals felt and perceived group therapy as a treatment modality and therapeutic approach. The information gained from

this study could expand understanding of additional therapies that could be offered to women who are recovering from familial incest.

Research Question

What are the experiences of female incest survivors diagnosed with PTSD who have undergone CPT for PTSD in a group setting in Arizona?

Theoretical Framework

The theoretical framework for this study was the cognitive theory that emerged from thinkers like Albert Bandura, Lev Vygotsky, and Jean Piaget. Cognitive theory has been influential in the treatment of PTSD, featuring an approach that encompasses the way the social environment affects cognitions, either in a positive or negative way (Kretchmer 2021; McLoud, 2016). A person learns how to work through trauma by understanding how their thoughts and emotions are related, according to Resick et al. (2017). CPT was originally developed in 1993 by Dr. Resick and Dr. Schnicke to help people with various traumas work through stuck points; this is done by helping patients to replace their old thinking processes that have been fractured by trauma with new ones through cognitive restructuring (Castillo et al., 2014). This aspect makes cognitive theories an excellent conceptual apparatus for understanding the impact of CPT on PTSD victims of incest.

Vygotsky's (1978) three key concepts include the premise that self and mental development originate through social interactions. The zone of proximal development controls whether children obtain direction. Bandura (1977) stated that seeing others' activities was vital for cognitive growth (see also Sankey & Mohler, 2022). People

imitate environmental acts. Sexual assault happens in a social context, which affects how victims regard others and themselves. Due to societal standards, female survivors may be victim-blamed and stigmatized. In turn, female abuse victims may blame themselves and feel humiliated (Kennedy & Prock, 2016). Dorresteijn et al. (2019) found that self-blame helps abuse victims cope with anxiety and sadness.

Bandura's (1989, 2011) social cognitive learning theory posits that during instances of trauma, victims are embedded within relevant contexts. The foundation of CPT is the idea that memories of an incident must reactivate in the present to correct faulty attributions, expectancies, and related symptoms that interfere with patients' emotional processing (Lenz et al. 2014). The mechanisms and strategies inherent in CPT can assist those with PTSD, including victims of incest, by offering concrete tools to use. The therapist helps to replace these faulty cognitions with more optimal ones critical to emotional well-being (Lenz et al. 2014). CPT assumes that traumatic event survivors assume distorted perceptions of the trauma that occurred, which alters their views of the world, others, and themselves, frequently leading to self-blame (Watkins et al., 2018). It can therefore be an excellent mechanism for improving how PTSD patients view themselves and their realities.

The idea of negative coping strategies is also relevant, as victims of sexual assault often develop strategies that are ill-conducive to well-being and that stem from toxic childhood environments. Psychological distress has been associated with disengagement coping strategies such as avoidance, social withdrawal, and denial following traumatic events (Dorresteijn et al., 2019). Guven et al. (2018) showed that there are four aspects or

facets of cognitive development, including memory, language, thinking, problem-solving, and decision-making. Sexual assault can break down normal processes of cognitive development.

Nature of the Study

I used a basic qualitative design with structured interviews because of the acute insight this approach offers into the personal and private world of participants, which is critical when approaching topics of mental health (Saldina 2014). I conducted qualitative interviews with participants occurred after their last session in a CPT for PTSD group therapy. During the interviews, I elicited participants' detailed responses and reactions to CPT as well as their perceptions as to whether they believed it helped to alleviate their PTSD symptoms. I also explored what the participants found to be the most beneficial.

According to Saldina (2014), CPT for PTSD this method is helpful for comprehensively exploring a topic because participants can offer more insightful responses. Through structured interviews, participants share their experiences without having to conform to survey parameters and questions, for instance. Qualitative interviews are useful for social research. According to Hutchinson et al. (1994), there can also be advantages for participants. The tendency is for research to indicate the risks associated with participants undergoing interviews, but here, the authors suggest that engagement in such research can facilitate a sense of purpose, empowerment, healing, voice, and catharsis for participants.

To summarize the methodology, data collection was from nine female participants between the ages of 18 and 80 who had a formal diagnosis of PTSD and who had

experienced sexual abuse in the form of incest. Participants had completed CPT group therapy intervention, and they answered questions that I developed. The data were then organized into clusters and themes. Careful descriptions were then examined for additional themes throughout the analysis process, which allowed me to uncover any additional experiences the participants had to offer that were not asked about.

Definitions

Cognitive processing therapy (CPT): A therapeutic intervention aimed at reducing or eliminating symptoms of PTSD (Tull, 2022). Similar to the use of exposure therapy to treat PTSD, CPT and other types of CBT assist patients in confronting unpleasant memories and thoughts related to PTSD.

Developmental disorder: A severe, chronic disability of a person who has a physical or mental impairment by the age of 22 that is likely to persist indeterminately and lead to major functional limitations in three or more key life activities (Bertelli et al., 2020).

Incest: A type of sexual abuse in which the sufferer experiences abuse from their immediate and blood-related family member such as father, uncle, or sibling (Merriam-Webster's Collegiate Dictionary, n.d.)

Posttraumatic stress disorder (PTSD): A mental health condition brought on by the experience or witnessing of trauma, according to the *DSM-5* (American Psychiatric Association, 2013). There are many symptoms associated with this disorder, including flashbacks, anxiety, nightmares, and uncontrollable thoughts.

Assumptions

The following are some assumptions implicit in the qualitative research paradigm undergirding this investigation. An epistemological assumption was that I would interact with participants because I would be conducting one-on-one, phone interviews with them. Furthermore, qualitative research often involves personally imposed values, which can be relative. They tend to involve ideologies facilitating or promoting social change (Saldina, 2014). In this study, I necessarily imported a justice and equity framework by identifying women as the subjects and positing incest as a distinct threat to women's mental health. The assumption was thus necessary for the context of the study, which concerned an issue that is highly prevalent in society.

There were also rhetorical and methodological assumptions. The data gathering process was inductive, which meant that there was no overarching theme, but I generated data as participants narrated their stories during the interviews. For this reason, qualitative research, particular involving interviews, can seem personal and informal (Saldina,2014). The inductive nature of qualitative research was important for this study because it allowed me to take on an emergent strategy, in which data appeared and flowed in an organic, less structured way. Taking an inductive approach and assuming no preexisting theory about CPT can also serve to mitigate or eliminate researcher bias. According to Pannuci and Wilkins (2011), bias is "any tendency which prevents unprejudiced consideration of a question." (28). I also needed to be cautious about not noting anything on a biased level or creating any expectations of outcomes that could threaten the validity of the study. Part of this was by listening to the various tones in

voices during the and conveying an overall neutral position throughout the interviewing process.

Scope and Delimitations

I chose to focus on the female population, ages 18 to 80, who have been clinically diagnosed with PTSD because of familial incest. Each woman in the study indicated that they had previously experienced incest as a form of sexual abuse. I focused on female survivors because women more frequently experience sexual abuse, especially in childhood (Centers for Disease Control and Prevention, 2022). This population was accessible in Arizona, and I was able to recruit participants to engage in telephone interviews. Arizona is familiar and near my own location, both culturally and geographically. The focus of the study was on CPT because the aim was to diversify literature and evidence to encompass CPT for PTSD in sexual trauma victims.

The conceptual framework for the study was the CBT, as an umbrella theory. Some theories not investigated were feminism and Ward and Siegert's (2022) pathway model, which delineates personality defects and dysfunctions, such as intimacy issues and antisocial thoughts. I did include Malamuth's observations about rape, which, adopting a feminist perspective, notes that men have programming to enjoy sex that is impersonal, leading them to higher rape tendencies (Gannon & Ciardha, 2012). Many of these theoretical and conceptual frameworks are not robust enough to encompass the victims of sexual violence and focus contextually on social conditions that emphasize male sexual aggression. One of the delimitations of this study was that the participants were over the age of 18. Although most incest occurs in childhood (Centers for Disease

Control and Prevention 2022), this population is highly vulnerable and difficult to access; therefore, the population for this study was limited to adults.

Limitations

There were limitations to this qualitative research. These included less interchangeable and transferable data because there were no numerical data measured and there were potential biases. I addressed biases by standardizing interviews and having an interview protocol. Another limitation was that the study was limited to one specific group of participants in one location and their specific views based upon their own individual experiences following CPT for PTSD group therapy as opposed to multiple groups over multiple locations. Qualitative reviews of CPT for PTSD are needed to further understand how perceptions contribute to the therapeutic benefit of CPT for PTSD in the group setting because this study was limited geographically as well in population size. Qualitative interviews also cannot cover all the important areas and experiences of each person's individual experiences following CPT for PTSD group therapy; therefore, valuable information could be missed.

Significance

The study is significant because it may add to the breadth and depth of existing literature on treating PTSD in sexual assault victims. However, the added advantage is that the study tackled incest, more specifically, which researchers have largely ignored within the context of CPT, and even other interventions. This study also adds to the literature on CPT for PTSD in a group therapy setting. I collected data from women who had survived incest and who offered their opinions and insights regarding their

perceptions of the validity of CPT for PTSD. Positive social change may also develop through this study as it could potentially allow other researchers to delve further into other areas of therapy where standard one-on-one therapy is not enough. After any type of trauma, many people have trouble with feeling safe or trusting others (Chard et al,2012). Socialization becomes a major part of group therapy and within the CPT for PTSD model.

Summary

In this chapter, I summarized the key elements of the study's background and methodology and addressed some of the reasons why the study was important to conduct. I also stated the problem and purpose of the study as well as the research questions I sought to answer. The groundwork for the conceptual framework was also established as well as the nature of the study including the design and participants. Data collection and analysis were also discussed. Finally, the key terms were defined and assumptions, limitations, and delimitations were established. It is important to gauge the efficacy of CPT for female survivors of sexual incest, with a particular focus on the PTSD and trauma such events can generate. I also described the literature on the therapeutic benefits of CPT for PTSD and justified why more research was needed on the experiences of CPT for PTSD in a group setting for female incest survivors.

In Chapter 2, I will provide a more extensive literature review of CPT, PTSD, and sexual trauma, as well as the strategy used to conduct the literature review. The theoretical foundation will be discussed in greater detail as well as the conceptual framework. Several studies will be reviewed from the existing literature on CPT and

PTSD. I will also discuss the effects of incest. Finally, the gap in the literature that the study addressed and the areas explored through the phenomenological review process will be discussed.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative study was to gain a better understanding of how viable CPT group therapy is as a treatment modality for female familial incest survivors diagnosed with PTSD in Arizona. CPT has been used effectively in various situations, especially among female veterans and in individual treatments (Brayn et al., (2015). What is not known is how well CPT for PTSD works for women of familial molestation in group treatment who have been previously diagnosed with PTSD, particularly in the state of Arizona.

Literature Search Strategy

The literature search for this study involved using the following key terms: *sexual trauma*, *rape*, *incest*, *familial molestation*, *posttraumatic stress disorder*, *cognitive processing therapy*, and *social cognitive theory*. I obtained the literature from the following Walden University Library databases: Dissertations & Theses at Walden University, PsychARTICLES, and PsychINFO. The literature was published from 2010 to 2022. I organized the information I gathered into categories.

Theoretical Foundation

Social Cognitive Learning Theory

Bandura's social cognitive theory (SCT) is fundamentally a learning theory. SCT views human development and learning through adaptation and change using the framework of triadic reciprocal causation (Bandura, 1989, 2011). Triadic reciprocal causation involves three sets of factors that interact with the self and society: personal

factors, behavioral factors (e.g., approaches and strategies), and environmental factors (e.g., events). Personal factors take the form of affective, biological, cognitive, self-reflective, self-regulatory, and vicarious processes.

The bidirectional interaction between these three groups of factors is transactional with the person as the agent of change in himself or herself and the environment (Bandura, 1989, 2011). This means that change cannot happen without human agency, the intentionality of behavior, and personal choice. To change, a person must choose and decide to change. Similarly, to learn, a person must choose and decide to learn. To achieve a cure, a person with PTSD must choose and decide to be cured.

A person's perceived self-efficacy is crucial in achieving desired therapeutic effects because it enhances the intensity and persistence of human effort without which therapeutic performance cannot be achieved (Bandura et al., 1977). It is also crucial in the exercise of human agency (Bandura, 1989). Yet, all these changes and learning are mediated by the person's interaction with society (Bandura, 2011).

SCT recognizes only two modes of learning: (a) direct experiential (trial-and-error) learning and (b) social modeling. Direct experiential learning has the advantage of experiential impact on the learner; strong self-mastery outcomes; and, therefore, a higher, more generalized, and stronger experience of self-efficacy (Bandura et al., 1997). However, it is associated with several disadvantages, such as potentially injurious mistakes, high time consumption, resource intensiveness, mobility constraints, opportunity limits, and excessive tediousness (Bandura, 2011). In contrast, social modeling skips the "hard knock" learning involved in DEL because of the acquisition of

non-experiential but modeled competencies and knowledge (Bandura, 2011). Beneficial and adverse behavioral consequences are already observed in the social model so the learning has the advantage of choosing and modeling beneficial elements, cost efficiency, and relative time efficiency (Bandura, 2011; House, 2006). However, social modeling has its disadvantages, too, such as vulnerability to contrived notions of reality (e.g., media portrayals of human nature, societal norms, and social relations), exposure to vicarious experiences from indirect sources, and a lack of impactful direct experience. Vicarious experiences have been found to produce a less generalized, lower, and weaker experience of self-efficacy (Bandura et al., 1977).

Considering the disadvantages associated with either learning mode, applying SCT for therapeutic purposes requires a professional with demonstrated objectivity and insight into human and environmental realities. A psychotherapist must also possess what Bandura (1991) called "human morality," which requires the internalization of a set of sound standards of cognitive and behavioral choices. This set of standards provides a person with a path to self-directedness (e.g., a clear purpose for everyday life) and a sense of continuity. Without human morality, self-regulation becomes unsustainable, cognitive choices are erratic, and behavioral decisions are unstable.

From the perspective of SCT, a shared morality is a necessity for a well-functioning and humane society (Bandura, 1991). This is so because behavioral choices can be personally beneficial but socially nefarious, infringing on other persons' rights. However, a shared morality can be tricky in a society that infringes on basic human

rights, such as the right of the unborn to live. Therefore, societal codes must be universally beneficial without bringing maleficence.

Cognitive Processing Therapy

Barrouillet (2015) stated that both Bandura and Vygotsky's three key concepts include the premise that self and mental development originate through social interactions. The zone of proximal development controls whether children get direction. Bandura thought that seeing others' activities was vital for cognitive growth (Sankey & Mohler, 2022). People imitate environmental acts. The study fits behavioral cognitive theories.

The idea of negative coping strategies is also relevant, as victims of sexual assault often develop strategies that are ill-conducive to well-being and that generate from toxic childhood environments (Chard,2005). Psychological distress has been associated with disengagement coping strategies such as avoidance, social withdrawal and denial following traumatic events (Dorresteijn et al., 2019). Guven et al. (2018) showed that there are four aspects or facets of cognitive development, including memory, language, thinking, problem-solving and decision-making. Sexual assault can break down normal processes of cognitive development. A breakdown in these processes may result in an individual developing communication and academic issues.

Patricia Resick introduced CPT in 1988. CPT is an evidence-based cognitive treatment especially meant for individuals with PTSD and related symptomatology, including anxiety, depression, and guilt. CPT facilitates PTSD patients through their natural recovery process by making them examine the trauma-related thoughts that are

interfering with their recovery. CPT has become a frontline therapy for traumas including PTSD, intimate partner violence, sexual abuse, motor vehicle accidents, and military traumas (Galovski et al., 2022). Therapists who practice CPT focus on how cognition and secondary emotions, such as decreased quality of life, guilt, and shame, resulting from distorted interpretations about the traumatic incident, affect the behaviors and emotional processes of the patients in the future (Lenz et al., 2014).

CPT is founded on the assumption that recollections of an event need to be reactivated in the present so that false expectations and attribution and associated symptoms interfering with the emotional processing and mindset of the patients can be rectified and replaced with new more positive information (Lenz et al., 2014). CPT assumes that survivors of a traumatic event often believe their distorted versions of the trauma that happened to them and that this distorted version alters their prior perceptions about themselves, the world, and others, and as a result, they suffer from self-blame (Watkins et al., 2018). An example of such an assumption is that the survivors believe that it is their fault that they were assaulted because they did not fight harder. Sexual assault survivors often overaccommodate by changing their perceptions about the world being full of dangerous and untrustworthy people and therefore, they develop the instinct of not trusting anyone. The crux of CPT is that it helps identify where an individual becomes stuck in their healing process and thus allows the therapist to help the individual work through the various stuck points, become unstuck, and continue through the healing process.

There are two approaches embraced by CPT counselors, including CPT with written accounts of trauma and without written accounts of trauma. When the treatment does not involve written accounts of trauma, the treatment is called "CPT-cognitive" (Healy et al., 2015). CPT comprises 12 weekly long sessions delivered in a serial manualized manner. This treatment process can be administered individually, in a group, or a combination of individual or group formats (Resick et al., 2017a). Some common features of a group CPT include a selection of homogeneous group members with possible similar types of traumatic experience, normalization of traumatic responses, mutual support to each other, and acknowledging and validating the traumatic experience. Unlike individual CPT in which the patient only interacts with the therapist in the group therapy the patient apart from interacting with the therapist also interacts with individuals with similar types of experiences. Group therapy with other group members having similar experiences can help the patient population overcome the erroneous belief that the therapist cannot help them as the therapist himself or herself has not experienced the trauma (Chen and Spry, 2017).

Between the first and fourth sessions, patients receive educated knowledge on the theory behind CPT and are asked to give an expression to their traumas by writing an impact statement as regards why they think the traumatic event took place and how that event has influenced their perception about self, the world, and others, especially about trust, safety, esteem, intimacy, and power/control (Healy et al., 2015). Patients are encouraged to give a detailed account of the traumatic event, including their feelings, thoughts, and sensory details. The therapist helps the patients develop a connection

between the traumatic event, and their thoughts and feelings by utilizing the ABC sheet, and then the therapist helps patients identify their stuck points in their thought process. Stuck points refer to the thoughts that represent the patient's interpretation of the traumatic event (Healy et al., 2015).

Between the fifth and seventh sessions, the therapist teaches the patients about the core cognitive therapy skills, such as the use of the Challenging Questions Worksheet (CQW) to investigate a single perception. The CQW comprising 10 questions help the patients assess their stuck points from a variety of perspectives by making them examine the context from which the perception was developed, look at the evidence in favor of or against the perception, and realize to what extent the perception is based on feelings rather than thoughts (Healy et al., 2015).

The therapist introduces the patterns of problematic thinking worksheets in session 6 so that the patients become aware of some of the common erroneous thinking patterns that may influence their recovery from PTSD. The patient is made to examine each of the stuck points to identify which of the common faulty thinking patterns is influencing the patient's thought process. The Challenging Beliefs Worksheet (CBW) is introduced to the patient so that the patient challenges their perceptions and develops a more balanced and realistic belief system (Healy et al., 2015).

Between the eighth and twelfth sessions, patients are made to focus their thoughts on analyzing five critical areas, such as safety, intimacy, esteem, trust, and power and control. In the last session, the patients are asked to rewrite that impact statement so that they can compare the new statement with the earlier version developed in the first few

sessions of the therapy, thereby allowing the patients to look towards the future and identify any area of concern that may cause problems for the patients in the future and discuss potential ways to mitigate those issues by using the CPT principles.

Individual or Group Cognitive Processing Therapy

As mentioned earlier CPT can be administered in individual or group formats. The individual sessions of CPT last for 60 min each for 12 sessions and each session is typically conducted once or twice a week. On the other hand, the group format of CPT has 12 sessions lasting between 90 and 120 min (about 2 hr.) each (Resick et al., 2017b). The group format includes between 8 and 10 patients per group. Literature shows that both individual and group CPT have been effective in mitigating PTSD synonyms. Lenz et al. (2014) conducted a meta-analysis of 11 studies while investigating the effectiveness of CPT on PTSD symptoms and found that CPT not only mitigates PTSD symptoms but also protects the patient population from negative psychosocial outcomes, such as reduced peer relations, poor academic performance, and difficulty in getting employment. Asmundson et al. (2019) in their meta-analysis found that the patient population treated with CPT performed better than 89% of the patient population in alternative treatment options. Matulis et al. (2014) conducted individual CPT on treating 12 adolescents with a history of PTSD associated with childhood physical abuse and childhood sexual abuse and found CPT to be an effective treatment for reducing PTSD symptoms and psychological comorbidities. Haller et al. (2016) compared the effectiveness of individual CPT and CBT in reducing PTSD symptoms, depression, and substance use disorder and produced the finding that individual CPT was more effective than CBT in showing

improvements in individuals with PTSD and heavy drinking problems. Bryan et al. (2015) investigated the effectiveness of group CPT in mitigating suicide risks among 108 soldiers diagnosed with PTSD and found that suicide ideation and the extent of suicide ideation decreased dramatically during the treatment and posttreatment. Dillon et al. (2019) investigated the effectiveness of group CPT on military-affiliated patients diagnosed with PTSD and found a significant reduction in depression and PTSD symptoms. Similar observations of the effectiveness of CPT on active-duty service members were noted by Dondanville et al. (2016) and Forbes et al. (2012).

Several studies have been conducted and support the validity and success of CPT in both the individual and group settings. Most of the studies that were conducted on the usefulness of CPT in treating PTSD issues among female sexual violence survivors focused on individual sessions of CPT. A study conducted by Liverant et al. (2012) showed that CPT effectively reduced depression and PTSD symptoms among female patients who received CPT-cognitive and CPT in individual formats. All these patients experienced physical or sexual assault in childhood and adulthood and suffered from PTSD and depression because of the assault.

A similar observation was witnessed by Suris et al. (2013), who while investigating the effectiveness of individual CPT in treating PTSD among both male and female victims of sexual trauma, found CPT to be an effective treatment for reducing the severity of PTSD symptoms. Nixon et al. (2016) evaluated the effectiveness of individual CPT and compared its effectiveness with treatment as usual on sexual assault survivors and the evaluated the effectiveness of both treatments at pretreatment, posttreatment-

treatment, and at the follow-up of 3, 6, and 12 months. They found that even though sexual trauma survivors in both groups showed significant reductions in depression and PTSD symptoms, the effectiveness of CPT participants was better at 12-month follow-up sessions than treatment as usual. Even though the efficacy of individual CPT is well-established for PTSD treatment, the number of literatures supporting group CPT is limited. Resick et al. (2017b) conducted the effectiveness of CPT in an individual or group format on the PTSD symptoms of veterans and found individual CPT to be more effective in PTSD treatment than group treatment.

This finding matched with the findings reported by Lamp et al. (2019), who investigated the effectiveness of individual and group CPT when they were administered in many PTSD clinics of Veteran Affairs. Both individual and group CPT involved written accounts of trauma. Lamp et al. found that individual CPT was more effective in reducing PTSD and depression symptoms than group CPT. individual sessions were more effective in mitigating PTSD symptoms than participants of individual CPT had the flexibility to reschedule their sessions as per need, but participants enrolled in group CPT did not have such flexibility and as a result, they were more likely to miss a session. The group CPT participants also received less individual attention than participants in individual CPT (Lamp et al., 2019). However, Resick et al. (2015) in a previous study compared the effectiveness of group CPT with a group present-centered therapy and found the group CPT to be more effective in reducing PTSD symptoms, especially depression. Somer (2012) investigated the effectiveness of group CPT for female familial molestation survivors and found that the group CPT can be an effective treatment for

female familial molestation survivors because the group therapy can help them realize that the self-blame and shame, they suffer because of the traumatic experience are not something unique to them. Self-loathing and shame are common distressing symptoms associated with sexual assault victims. This realization can help them come out of their distorted interpretation of the experience and self-attribution of responsibility (Somer, 2012). However, according to Chen and Spry (2017), group psychotherapy may not be effective for all types of patients because patients with acute PTSD symptoms, severe depression, and acute psychosis may not receive the benefits of group therapy. Chen and Spry (2017) observed that even though group CPT is effective in improving PTSD and depression symptoms, group CPT was more effective in a long-term process group in PTSD symptoms reduction, whereas individual CPT contributed to greater improvements in reducing the severity of PTSD symptoms compared to the group CPT.

Chard et al. (2012) investigated the effectiveness of CPT by combining individual and group treatment on the sexual assault survivors and found that the CPT treatment reduced the symptoms of PTSD, dissociation, and depression among the survivors significantly and continued to decline when followed up after 3 months. Bass et al. (2013) investigated the effectiveness of CPT on female sexual violence survivors with high intensity of PTSD symptoms. As part of the study, 65% of the participants were included in the CPT group while 52% of participants were included in the individual CPT. Bass et al. (2013) witnessed that even though both the recipients of individual CPT and CPT in group format showed significant improvement during the treatment, higher effectiveness of the treatment was noticed in the patient population who received CPT in

a group format compared to the individual format. After 6 months of receiving treatment, only 9% of the participants in the group therapy as compared to 42% of the participants in the individual CPT showed symptoms of anxiety, depression, and PTSD.

Cognitive Learning Theory

CPT is grounded in the SCT of PTSD and centers on how a person reacts to the events of the traumatic event (Monson et al., 2006). CPT is a type of therapy in which a person learns how to understand the relationship between their thoughts and emotions and thus understand how to cognitively work though their trauma (Resick, Monson, & Chard, 2016). Cognitive theory has been influential on the treatment of PTSD, featuring as an approach that encompasses the way social environment affects cognitions, either in a positive or negative way. A person learns how to work through trauma by understanding how their thoughts and emotions are related, according to Resick et al. (2017).

Since CPT involves cognitive restructuring by replacing the old thought process of the patients with the renewed thought process, this type of treatment involving cognitive restructuring comes under cognitive learning interventions (Castillo et al., 2014). Some of the psychologists who contributed to the development of cognitive learning theories include Edward Chase Tolman, Jean Piaget, Vygotsky, and Albert Bandura.

Behaviorism predominated the learning theories in the early decades of the 20th century, but certain observations and concerns associated with behavioral theories led to the rise of cognitive learning theories. Behavioral theories focused on the environmental

stimulus and response but failed to take into consideration the mental processes or cognition behind the change of behavior and a thought pattern. Cognitive learning theories filled in this gap by focusing on information processing, memory retention, and application of the previous knowledge stored in the memory to resolve current situations (Barrouillet, 2015). Tolman is the pioneer in starting the cognitive learning movement. His experiment with rats in the 1920s first brought to light the importance of cognition. Tolman in his rat experiment showed that rats knew about the structuring of the maze they were put into because they had the map of the maze drawn in their minds.

Another prominent cognitive learning theorist was the Swiss psychologist Jean Piaget, whose cognitive learning theory referred to the theory of learning that is based on perception and information processing (McSparron et al., 2018). According to Piaget, cognitive development is a biological act, and children respond to external stimuli because of some mental process going on in the back of their minds. Schema plays a significant role in Piaget's theory. Schema refers to the cognitive structure that organizes and represents events and abstract concepts stored in the minds of human beings as common patterns. Schema can be referred to as a range of interconnected index cards representing various environmental patterns in the cognitive structure of a human (Barrouillet, 2015). Schema constantly experiences restructuring as an individual experiences' new patterns in learning experiences. This concept of schema is applied in CPT when the therapist tries to restructure the thought patterns of the patients.

Four fundamental cognitive learning stages proposed by Piaget include the sensorimotor stage, preoperational stage, concrete operational stage, and formal

operational stage. The sensorimotor stage starts from the birth of a child until the child is 2 years old. Children at this stage try to understand objects using sensory activity. Children at this stage develop the capability of imitating others, which has been termed as "deferred imitation" by Piaget. Deferred imitation refers to the ability to reproduce an activity that the children have experienced at some point in the past (Babakr et al., 2019). During the preoperational stage, lasting from 2 years of age to 7 years of age, children develop symbolic ability by using images and words to interpret the physical world. Children at this stage cannot think logically and suffer from the limitation of egocentrism, which refers to their inability to differentiate between the perspective of others and that of their own (Babakr et al., 2019). At the concrete operational stage, lasting between 7 years of age and 11 years of age, children become less egocentric and demonstrate the ability to understand concrete things and solve complex problems. At the final formal operational stage when children approach the threshold of 11 years of age, they approach the final stage of cognitive development when they can think logically and handle abstract topics, such as mathematics (Babakr et al., 2019).

The cognitive learning of a child gets impacted when they experience sexual abuse. Guven et al. (2018) pointed out that the four stages of cognitive development mentioned above involve changes in intellectual abilities, including thinking, memory, language, reasoning, decision-making, and problem-solving. However, when children experience sexual abuse the development of their intellectual abilities is negatively impacted. Their communication skills suffer, and their school performance deteriorates (Guven et al., 2018). Since children imitate the actions of others when they are exposed

to sexual abuse, they imitate risky sexual behaviors such as unprotected sex, multiple sexual partners, and engagement in early consensual sexual activity. These risky sexual behaviors continue in adulthood and adolescence (Latzman & Latzman, 2015). Guven et al. (2018) highlighted that the impact of child sexual abuse leads to long-term psychological damage which the victims carry into adulthood, such as mental health issues like depression, low self-esteem, anxiety, eating disorders, PTSD, and fear. Since sexual abuse changes the self-perception of children, it reduces their self-esteem and puts them at risk of suicidal ideation and depression in adulthood (Guven et al., 2018).

Piaget theorized that adaptation to the environment takes place when learners continuously engage in the environment and organize and reorganize the information received from different experiences (Lefa, 2014). Piaget pointed out that adaptation takes place alongside the complementary process of assimilation and accommodation. Assimilation refers to the process through which individuals apply the lessons learned from previous experiences to a new situation (Lefa, 2014). Assimilation is a product of cognitive schemas where assimilation dominates accommodation. Accommodation refers to the adaptation component in which the added information received by the learner conflicts with or contradicts the existing cognitive structures of the learner (Lefa, 2014). In accommodation, the learner must reshape or adjust the existing cognitive structures to make space for storing the current information (Lefa, 2014). Accommodation takes place specifically when the added information received is very much unlike the existing knowledge. Accommodation leads to the modification of the existing cognitive structures of the learners (Lefa, 2014). This theory of Piaget on the cognitive structure applies to

interpreting how the cognitive processing of a female familial molestation survivor may function. When female familial molestation survivors experience stigmatization in the hands of the tormentors and the extended community, they adapt to their existing situations by developing a cognitive structure in which they engage in self-blame, holding themselves responsible for whatever happened to them. This thought pattern affects their future relationships because they apply this existing cognitive structure when they encounter new situations. According to Caffaro (2014), interventions oriented toward cognitive structuring can help female survivors in the development of a more accurate selfie myth that will help the survivors in forming more realistic and positive relationships with others. Caffaro (2017) highlighted that when survivors are made to face the trauma repeatedly in a therapeutic environment with a therapist helping the survivors go through their troubling experience, the therapist can help the survivors receive current information to interpret the trauma incident from an unfamiliar perspective, and this current information can modify the existing structure, leading to accommodation.

Vygotsky is another well-known cognitive learning theorist whose social cognition learning model takes into consideration the role of culture in the development of cognition. Vygotsky's learning theory focused on the interplay between human beings and society and how language and social interaction affect the learning process and cognition development (Barrouillet, 2015). Vygotsky proposed three principles in the theory of cognitive development, including (a) the general law of genetic development that refers to the mental process as a product of an interaction between people; (b)

auxiliary stimuli that impact one's behavior as the individual can think and remember logically by using auxiliary stimuli; and (c) the zone of proximal development, which refers to the potential development levels or what one can achieve with adult guidance (Barrouillet, 2015).

Another related cognitive theory is the social cognitive learning theory of Albert Bandura, which can also be applied to female familial molestation survivors who suffer from PTSD. Just as Vygotsky took into consideration the role of culture, language, and social interaction in the development of cognition, Bandura took into consideration the importance of the environment and observation of others' actions playing a role in the development of cognition.

According to Bandura (1989), certain behaviors are developed by individuals from the environment they are exposed to (Sankey & Mohler, 2017). Bandura proposed that through observation and remodeling, one can learn from the environment. For example, when children grow up seeing adults acting violently towards others, children also imitate the aggressive actions of the adults and engage in aggressive behavior (Sankey & Mohler, 2017). Learning is a complex process in which when an individual is exposed to a certain environment, the individual observes the actions of others by internalizing what she sees and develops her behavior on how he or she interprets the social context. As per cognitive learning theory, while learning a behavior, individuals should pay attention, process, and retain the information learned, and use motivation and opportunity to execute an action based on the information (Sankey & Mohler, 2017).

In the case of female familial molestation survivors, the sexual assault takes place within a social context influencing how they view themselves and are looked upon by others. Since sexual assaults fall into gendered sexual crimes that transgress social norms, female survivors go through stigma which involves victim-blaming messages from the society as well as stigmatizing reactions from others when the sexual assault incident is disclosed (Kennedy & Prock, 2016). When female familial molestation survivors experience stigmatization from the abusers and the broader society, they internalize this stigmatization and develop a thought pattern in which they engage in self-blame and shame. Here based on the observation of how others stigmatize them for the sexual assault they experienced, they attribute the responsibility of the incident to themselves, feeling unworthy and guilty for their suffering.

Literature Review

PTSD is a known psychosocial sequela of sexual assault or rape. The *DSM-5* noted that the highest rates of PTSD cases, apart from combat and captivity, mass internment, and genocides, had been found among survivors of rape (American Psychiatric Association, 2013). PTSD is also more pronounced in women with a history of childhood sexual abuse (Owens & Chard, 2001). For this victim group, CPT historically had been called "cognitive processing therapy for sexual abuse" (CPT-SA; Chard, 2005; Chard et al., 1997). The 17-week treatment had been a historical recommendation, which often includes 26 sessions that typically combine individual and group therapeutic modalities (Chard et al., 1997; Hall & Henderson, 2007). However,

other format variations (e.g., 12 weeks) have been observed in the literature (e.g., Resick & Schnicke, 1992).

In adults who were sexual assaulted or raped but with unknown histories of childhood sexual abuse, CPT also had been found highly efficacious. In a systematic review of 32 articles, representing 20 adult participants, Vickerman and Margolin (2009) noted that CPT (and Prolonged Exposure) received the most efficacy, ahead of other therapeutic models, such as stress inoculation training, eye movement desensitization, and reprocessing. In Resick and Schnicke (1992), significant improvement had been observed after a 12-week group therapy, which persisted in improvement after the maximum 6-month follow-up. This is significant in the proposed study as it will investigate the perceptions of the effectiveness of CPT in a group setting from women who have survived incest.

Among women with military sexual trauma, CPT also had been found of high efficacy. Military sexual trauma involves high rates of PTSD, poor well-being emotionally and psychologically, lower overall life satisfaction, and poorer general health (Mead, 2019). Mead (2019) found that CPT had improved the symptoms of veteran female soldiers with military sexual trauma ($N = 21$), particularly in their quality of life and well-being, and a reduction in PTSD symptoms. The form of CPT used involved a feminist perspective and was administered through a provider at the Department of Veteran Affairs. This data supports the proposed study in that the decrease of PTSD symptoms were observed in female veterans who were sexually assaulted and later went on to CPT therapy where they research supports a decrease in their PTSD symptoms.

In women with a childhood sexual abuse history, CPT also demonstrated high efficacies. Hall and Henderson (2007) observed “greatly reduced symptoms” after administering CPT-SA for 17 weeks both in the individual and group formats. Pretreatment symptoms included highly restricted affect range and demonstrable affective detachment from others, both of which are avoidance symptoms. Chard (2005) also found CPT-SA in an individual format more effective in reducing PTSD symptoms than minimal attention. Its efficacy continued for a minimum of 1 year after the end of treatment. However, the introduction of skills training for dialectical behavior therapy, as a component of CPT-SA, had not been found to be strongly efficacious for treating PTSA and depression (House, 2006). House (2006) had an added disadvantage of involving a small sample size (N = 6), making any efficacy rate less robust. Once again, this data supports the proposed study in that the decrease of PTSD symptoms were observed in women who were sexually assaulted and later went on to CPT therapy where they research supports a decrease in their PTSD symptoms.

Overall, CPT had been almost unanimously demonstrated for its high efficacy in reducing symptoms for as long as a year in individuals with PTSD. This generalization applies to PTSD-diagnosed civilian or veteran sexual assault survivors. It is also exclusive of any history of sexual assault or rape or childhood sexual abuse.

CPT was initially created to treat individuals who suffered from military and various combat traumas and subsequently were diagnosed with PTSD. It was later found through various research that CPT was effective for all types of traumas and not specifically limited to military and combat veterans. The first CPT group trial involved

35 participants, and another trial involved nine individuals in 1993 yielding positives results for the reduction of PTSD symptoms (Resick et al., 2017).

Research continued throughout the years and continued to yield positive results in the reduction of PTSD symptoms. In (2012) Monson et al., found that veterans who were previously diagnosed with PTSD showed that social adjustments were positive in those veterans who participated in CPT (Monson et al., 2012). Similarly, in (2021) Shnaider et al., found that individuals with PTSD can improve emotional regulation, which does not negatively impact treatment outcomes (Shnaider et al., 2021). This data supports the proposed study in that the decrease of PTSD symptoms were observed in women who were sexually assaulted and later went on to CPT therapy where they research supports a decrease in their PTSD symptoms as well as an increase in emotional regulation, and positive social adjustments.

Asmundson et al. (2019) found that 89% of the CPT participants were better posttherapy, and 82% remained better at the follow-up when compared to those in the controlled conditions. Similarly, in (2013) Suris et al. (2013) found that veterans who had PTSD and who were treated with CPT had the most significant reduction in self-reported PTSD symptoms. In a different study of the frequency of administration of CPT therapy, Bryan et al. (2022) found that CPT delivered either daily or weekly was equally effective at reducing PTSD symptoms but that adding in a recreational activity did not add any additional benefit. These findings support this study in that not only did CPT therapy work well for the individuals, initially, but also long term in the reduction of PTSD symptoms.

Once the development of CPT for PTSD evolved and adapted to work for non-military people diagnosed for PTSD, success was soon discovered with sexual assault survivors. In (2005) Chard found that PTSD symptoms in women who had previously been sexually assaulted and participated in CPT group therapy maintained a decrease in PTSD symptoms after 1 year (Chard, 2005). These results are at the heart of the proposed study in that PTSD symptoms of incest survivors in Arizona will have favorable, long-term decreases in PTSD symptoms once they have gone through CPT for PTSD therapy in a group setting.

Bass et al. (2013) compared results of sexual assault survivors in the Congo. All participants went through CPT. However, 65% of the women were put into group therapy, and 52% of the women went through individual CPT. Though both groups saw improvements at the end of treatment, 1.5 months after, and 6 months after, the women in the group therapy setting had statistically significant better improvements over those who completed CPT individually. In another sexually exploited situation, Clemans et al. (2021) found that CPT group therapy was effective in showing a statistically significant decline in PTSD symptoms for teenage girls who were sexually exploited in Cambodia upon completion, 1 week after, and again 3 months after posttreatment. Once again, these results are at the heart of the proposed study in that PTSD symptoms of incest survivors in Arizona will have favorable, long-term decreases in PTSD symptoms once they have gone through CPT for PTSD therapy in a group setting.

Similarly, in (2015) Iverson et al., found that women who were previously diagnosed with PTSD and had written their impact statements for CPT at their first

session, last CPT session, and 5–10-year follow-up showed lower PTSD symptoms, depression symptoms, and their thoughts of overaccommodation had also changed (Iverson et al., 2015) These results are enough to make an inquiry and ask female incest survivors about their perceptions of CPT for PTSD in a group setting and learn what is working for them and what is not working so that future work can continue in this area and lead therapists to better, less intrusive therapy options for incest survivors.

Summary and Conclusions

Many studies utilizing CPT therapy involve military veterans and the PTSD they have sustained. However, the current gap in literature allowed for the following study to occur and involve another vulnerable population, familial molestation survivors. This study attempts to narrow the gap and search for answers through cognitive learning theory so that additional therapy options may be offered in the future to familial molestation survivors.

The intention of this qualitative study is to explore the experiences of familial molestation survivors who have participated in CPT group therapy and gain a better understanding of their perceptions of effectiveness and how it has impacted and improved their overall quality of life. The goal and design are to better understand familial molestation as well as the success of CPT group therapy for these familial molestation survivors while inspiring positive social change. This study will also fill the gap into what is not known in literature of how effective CPT group therapy works for familial molestation survivors in the state of Arizona.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study was to examine the experiences of CPT for PTSD in a group setting for female incest survivors. I conducted qualitative, structured interview with survivors of familial molestation who had been diagnosed with PTSD. This chapter will include the research rationale, discussion of my role in the research, and a comprehensive description of the methodology such as instrumentation, and discussion of trustworthiness issues.

Research Design and Rationale

As described in Chapter 1, the research question for the study was, what are the experiences of female familial molestation survivors diagnosed with PTSD who have undergone CPT for PTSD in a group setting in Arizona? The central phenomenon I explored was the efficacy of CPT for female survivors of familial molestation. I conducted a basic qualitative study to explore the perceptions of CPT's efficiency in a group setting. According to Gallifa (2018), the logical, empirical science tradition is associated with deriving observations from a world in which I assume there is an objective reality. This tradition has three main components, according to Guba and Lincoln (1994, p. 108): ontological (What is the nature of the person's perceived reality, and what can be known about it?), epistemological (What is the nature of the relationship between the participant and the researcher, and what can be learned?) and methodological (How can researchers obtain the information they are looking for from the participants of the study?). The rationale for using this tradition was that it allowed me to integrate

findings from the research into a broader perspective. This was suitable for the study because it allowed me to measure the efficacy of CPT for survivors of familial molestation.

Role of the Researcher

My role was multifold and involved extensive engagement with prospective and actual participants. I was responsible for replying to individuals in Arizona who expressed interest in participating in the study. Individuals who met the inclusion criteria were given flyers from a not-for-profit agency in Arizona at which they had completed CPT for PTSD group therapy. Participants were in a geographically proximal location and had already undergone the 12-week CPT sessions. I did not intervene in the sessions, as clinical experts in mental health had already administered CPT to the participants. After individuals agreed to be in the study, they participated in a qualitative interview that lasted approximately 5 min. I had no existing professional or personal relationships with the participants that would indicate a power dynamic.

Possible ethical issues that could have come up included emotional harm to the participants due to the sensitive nature of the study, issues with maintaining patient confidentiality, and concerns about informed consent (Cherry, 2020). For instance, there could have been a case in which the participant could not gauge the possible emotional impact of reliving her traumatic experiences during the interview. I would have addressed this issue by having a comprehensive consent structure while maintaining confidentiality by assigning each participant a unique number. These interviews were also conducted via

telephone where no one outside of the study was able to identify them for an additional layer of confidentiality.

Methodology

Participant Selection Logic

An important consideration for this study was the proximity of the participants to a health care clinic that offers in-person therapy catered to victims of familial molestation as a form of sexual abuse. There are also special considerations for recruitment protocols. According to Memon (2020), recruiting participants can be a complex process and involves leveraging personal networks, reaching out through internet communities and social media, and creating the relevant pool. It is always good to have incentives ready (Memon, 2020). The challenge in this study was finding a mental health care facility that uses the 12-week CPT for PTSD program to treat trauma survivors. Once I had identified a health care facility that met this criterion, I obtained the agreement of the facility's leaders to participate and to help identify familial molestation survivors for the study.

Interested individuals contacted me to express their interest in the study, using my contact information from the recruitment flyer. I emailed each participant their consent to sign and then scheduled a telephone interview with each of them. At the beginning of each call, oral consent was also obtained prior to starting the interview. Hennink and Keiser (2021) noted that the saturation point for qualitative interviews is typically achieved with nine participants.

The study consisted of nine adult female survivors of familial molestation with diagnosed PTSD ages 18 and 80. I used nonprobability sampling to generate participants

who fit the inclusion criteria. The use of purposive sampling ensures that all participants chosen for the study will be qualified (McCombes, 2015). The reason for this type of sampling was that the participants had been prescreened and selected from the mental health organization. The participants had already met the inclusion criteria and volunteered to partake in the study. I did not have to be present for the CPT intervention as the intervention was already completed.

Instrumentation

Chard et al. (2013) published a manual for group CPT sessions from the Department of Veterans Affairs, which a health care practitioner can use for nonveteran clients. The document notes that the key components of group CPT include identifying the meaning of the event, feelings and thoughts, remembering the trauma, and providing the first account. Clients will then ask themselves challenging questions and identify patterns of problematic thinking. It includes an assessment of issues related to safety, trust, esteem, intimacy, and power/control issues (Chard et al, 2013).

According to Mueser et al. (2004), traumatic events often result in dysfunctional or distorted beliefs and schemas that lead to PTSD. A person who experienced extensive physical and sexual abuse throughout childhood may have held these beliefs or schemas because they were accurate or adaptive. The CPT therapist is responsible for managing negative emotions and transforming them by restructuring cognitions. Another term for this is “cognitive restructuring.” The CPT providers will modify their therapy delivery and infuse principles associated with treating victims of familial molestation.

I used a qualitative structured interview that I manually transcribed. Qualitative interviews were conducted via telephone with the participants from one not-for-profit agency in Arizona. Frost et al. (2020) noted that interview questions are an effective way of obtaining data from participants in qualitative research in psychology because it allows the participants the opportunity to give as much or as little information as they want without feeling like they are locked into specific answers such as a multiple-choice survey. Using this method, individuals make sense of life events and experiences, producing discourse content that can be analyzed for its relationship to larger cultural discourses and narratives. I took notes during the interview to make the interview process feel less intimidating for the participants. Interviews were also recorded and stored in a secure location where only I can access the data for analysis purposes. The interviews consisted of six questions and were no longer than 10 min.

Data Analysis Plan

I coded the interview data. Caulfield (2019) noted that the process of coding involves five steps: gaining familiarity with the data, coding the data, generating themes, reviewing themes, and defining/naming themes. For the first step, I reviewed the notes I had taken during the individual interviews, which then were entered into the transcription. The next step involved grouping interview extracts and creating codes for them.

I then generated overarching themes developed from the individual codes. For instance, cognitive restructuring, strategies for coping, cognitive tools, and learning to cope with trauma could be associated with a theme such as cognitive and coping

strategies of CPT. I then reviewed the themes to ensure that they accurately reflected codes and were classified and grouped accordingly (Caulfield, 2019). I then ensured that the themes in the data analysis portion adequately reflected their codes.

I then coded the interview results manually, without the use of software. However, I used the highlighter function on MS Word to highlight pertinent components of the interview extracts to match them with codes. There was an insignificant risk of getting discrepant cases, as I carried out the study in an inductive way, meaning participant responses emerged based on questions asked by me.

Issues of Trustworthiness

I used appropriate strategies to ensure maximal credibility (internal validity) Credibility means that interpretations and findings accurately reflect reality as participants view it. In the case of this research project, the interviews were open-ended and allowed the participants to express their true feelings and perceptions about CPT in the group setting which will allow for maximum credibility.

For transferability, I used thick descriptions, which include sufficient information about the site, participants, and methods used to collect data (Farnsworth Group, 2021). For instance, I strengthened the study's methodology section by standardizing interview questions and protocol.

I also tried to maximize dependability, which refers to the idea that the researcher considers different natural changes within the participant's environment. One of the best ways to do this is to have an audit trail, which includes documentation of products and processes of data analysis, raw data, reflexive notes, and information about developing

instruments. I also have available interview transcripts from participants' subjective narratives.

To maximize confirmability and the ability to authenticate interpretations, recommendations, findings, and data, I have an audit trail that includes participants' interview transcripts and audio recordings. The findings should not be biased (Farnsworth Group, 2021) means avoiding the automatic assumption that, based on its character and hitherto efficacy, CPT will be optimal for familial molestation. Reflexivity is one practice researchers can use to establish maximal confirmability. It refers to reflecting on results to ensure they are not biased. During this project, particularly for the coding stage, I was careful about analyzing language choice by participants during the interview, recognizing that there are certain intonations and implications of words. For instance, the term 'I enjoyed it, may not indicate any formal therapeutic success. Still, it does indicate that the client perceived a derived benefit from the CPT sessions.

I used syntactic judgment to organize themes and codes in ways that are relevant and that minimally subjectively interpret the clients' words and phrases. I maximized intra-coder reliability (inter-coder is not relevant in this case because there is only one coder) by establishing concrete parameters for the recognition of syntactic and emotional nuances.

Ethical Procedures

As for agreement to gain access to participants, I contacted the health care organization providing CPT in a group therapy format. I asked if mental health care providers who are licensed and qualified are currently conducting a 12-week program

course for women living with PTSD who are survivors of familial molestation. I acquired documentation from the mental health care provider (i.e., clinical psychologists, counselors, or psychiatrists). I noted their consent, willingness to participate in the program, and overview of the CPT course.

Prior to conducting the study, I obtained IRB approval (approval number 07-11-23-0970399) There were certain ethical concerns related to conducting this study, with the main ones being confidentiality, informed consent, and risk of emotional harm. Confidentiality refers to the right of participants to have their data in a secure location, without disclosure of personal information to third parties. Haigh & Witham (2015) offer a distress protocol for participants undergoing qualitative interview research. Researchers are to implement it when participants express higher than normal levels of distress or are crying or shaking. I stopped and asked the participant about her safety, including how she felt. The interview commenced if the participant indicated they were secure enough to proceed; if not, I could remove the participant from the study and suggest that they immediately contact a licensed health care provider at the facility.

I utilized the distress protocol to ensure that the participants felt they could safely engage in the study. In addition, I included a section on potential emotional distress reactions in the consent form. All participants provided consent prior to beginning the interview process. The participants signed the consent either digitally, through a PDF Filler, or print it out, scan it, and send it as an image/PDF file prior to the telephone interview.

I minimized and dealt with ethical concerns related to data collection, including participant rights to privacy, power relationships, and data storage. To ensure participants' privacy, during the write-up of the research, I refrained from using personal identifiers, such as first or last names. Instead, I referred to participants as "Participant 1," "Participant, 2," "Participant 3," and so forth. I will safely store the electronic data for at least 5 years, as required by Walden University. I also have the hard copies in a secure location as well. No one else has access to these files except me.

In addition to this, there are other data storage and dissemination considerations. I have ensured that the data remains in a central location, without dissemination to external agents, even within the academic community. Suppose another member of the academic community would like access to the data. In that case, I will contact the participant first to let them know and to offer or decline permission.

Summary

In review, the purpose of this qualitative study was to explore the possibility of alternative therapy solutions for female incest survivors in Arizona. It was the hope that CPT for PTSD in a group setting would be a valuable therapy tool for those who have endured such a heinous trauma and will receive valuable therapy support without having to relive the trauma like with so many other therapy options.

There are several key points discussed in this chapter. First, I conducted qualitative structured interviews with nine participants who previously attended a CPT for PTSD group therapy program. The sessions ran for 12 weeks for 2 hr. a week. An

advantage of the project was that CPT is a form of therapeutic intervention that tackles traumatic events and PTSD (Chard et al.,1997).

Wiltsey et al (2013) conducted a study showing that cognitive therapy providers successfully modified their treatment protocols and processes to suit the specific needs of client groups. I conducted a qualitative interview with 9 familial molestation survivors who completed the 12-week CPT for PTSD group therapy sessions at 1 not-for-profit mental health facility in Arizona to gauge whether they were effective in alleviating PTSD symptoms. I also analyzed the data using manual coding, with an open mind toward emergent results. The inductive approach to the study ensured that I gathered participants' data as the participants shared their stories during the interview. In Chapter 4, I will analyze the data that was collected from the participants as well as discuss the findings and potential benefits of the data for future therapy options. Chapter 4 will also include details of how the data were collected and analyzed and how the results were confirmed.

Chapter 4: Results

Introduction

The primary purpose of the study was to gain a more comprehensive understanding of the experiences of CPT group therapy as a treatment modality for female incest survivors diagnosed with PTSD in Arizona. CPT for PTSD is an evidence-based therapy for treating many psychological disorders including PTSD (Chard et al.,1997). The analysis of CPT's efficacy in this population group is critical because many victims of incest develop PTSD. Investigating the perception of CPT for PTSD in a group setting may yield knowledge that stakeholders can use to improve the therapeutical approaches used to address incest survivors' emotional distress, upset from trauma reminders, and changes in mood and cognition by helping to alleviate feelings of isolation and shame.

The research question focused on the subjective experiences of survivors of incest with CPT and their personal evaluation of this therapy. I concentrated on the perceptions of CPT for PTSD group therapy of women who had recently undergone this therapy. CPT for PTSD is not typically used for treating survivors of incest, as this treatment regimen is still an under researched phenomenon for this population group. By investigating and analyzing the subjective experiences of survivors of incest with CPT for PTSD, it may be possible to detect whether this intervention is viable as a therapeutical approach to the incest survivor's population and if it has any gaps. Because the survivors of abuse represent a vulnerable population group, their participation in this study had to

be safeguarded by limiting the interview questions to their experience with the CPT for PTSD in the group setting rather than their traumatic experience.

In this chapter, I provide detailed information on how I conducted the study. The chapter includes descriptions of the study setting, the participant demographics, and the data collection and analysis procedures. Also, the chapter includes evidence of trustworthiness. The chapter continues with a detailed description of the results and their interpretation in the context of the research question. The chapter concludes with a summary that recaps all aspects of the research.

Setting

I am aware of no personal or organizational conditions that affected the participants or their experience during the study. All interviews were conducted via telephone to ensure participants' privacy, per the guidance of the Walden University Institutional Review Board (IRB). Before their phone interviews, all participants typed "I consent" on their consent form and emailed the response to me. Therefore, I do not believe that the setting affected the participants' responses. The participants were not exposed to uncomfortable or inappropriate experiences (e.g., going to an agency and potentially being identified as an incest survivor). By completing the interviews via telephone, the participants were able to complete the study in the comfort and privacy of their own homes. Each interview took about 5 min to complete.

Demographics

I recruited nine female incest survivors from Arizona. The participants ranged from 18 to 80 years of age, and all reported experiencing familial incest during their

childhood. The participants were recruited to the study by responding to an invitation that was handed out by their therapist with my name and telephone number; the participants were receiving treatment at one not-for-profit agency in Arizona. The therapist was notified ahead of time of the specific criteria needed for the study and gave the flyers to participants who met the criteria. The inclusion criteria required three components: (a) the participants needed to be at least 18 years old, (b) they must have experienced familial incest in childhood, and (c) they must have undergone CPT for PTSD in a group setting. The name of the setting is not included in this study to preserve the participants' confidentiality. The participants were each assigned a number so that their confidentiality could remain intact.

Data Collection

I developed interview questions that included six open-ended questions (see Appendix). The questionnaire included items analyzing the participant's personal perception of the CPT for PTSD intervention in terms of its benefits and challenges, as well as the comparison between one-on-one and group-setting therapies. All participants fully answered the questions. No respondents withdrew from the study. No unusual circumstances were encountered during the data collection process.

I collected data from nine participants. A structured interview was used to collect the data. The interview questions can be found in Appendix. No changes were made to the list of questions during the interviews, although, after every question, I asked each participant if they had anything else they would like to add. Finally, at the end of the

interview before concluding, I also asked each participant if there was anything else that they would like to add that I did not ask. All nine declined to add any additional details.

I scheduled the interviews with an individual interviewee in advance once the individual returned their consent form. The convenience of participants was the main priority when scheduling. The first step in data collection was scheduling the interviews. After the participants made contact, I called the participants on a specific day and time. I initially thanked the interviewee for their participation at the beginning of the interview. I also confirmed that I received their emailed consent but also asked for verbal consent prior to beginning the interviews as well. The participant responded to my questions one by one while I recorded their answers and labeled them for convenience with their digital participant number. After the interview was completed, I thanked the participant once again and stopped the recording. Overall, the data collection procedure took about 3 weeks to gather all the raw data. Because the preservation of raw data for the analysis was critical, each interview was recorded. The recording of the interviews was critical to conducting a proper and accurate analysis of the provided information by participants.

Data Analysis

I engaged in manual coding as a way of analyzing the data. The raw data were transcribed and cleaned by carefully reviewing each interview and identifying the common themes and units. I then moved inductively from coded units to larger representations, including categories and themes. First, I thoroughly read through the data to search for the similarities, differences, and identifications of aspects related to the research question. The second reading included identifying the units of data signifying

important information in each interview. After I inspected the highlighted units, noted similarities and differences in answers, identified the specificity of each unit in relation to the participant, and considered the relation of each unit to the context of the study, I was then able to ascertain the common themes and among the participants and create a flow chart of what the liked and unliked as well as get an understanding of what future research could look like.

When the analysis of units was completed, I grouped the data into categories by using a similarity principle as copied and pasted the units under each category within a table. In The next step involved inspecting (or reviewing) the categories to create overarching themes. Again, the principle of contextual similarity was used to relate a specific category to the theme. After I analyzed the data, I was able to create an outline of the data, which made interpreting the findings much easier. The analysis focused on the efficacy of the CPT for PTSD group therapy, the personal reactions and experiences of participants to the therapy, and their overall perception of the intervention. The categories and themes that emerged from the data are shown in Table 1.

When the analysis of units was completed, I grouped the data into categories by using a similarity principle by copying and pasting the units under each category within a table (for convenience). The next step required the inspection of the categories in order to create overarching themes. Again, the principle of contextual similarity was used to relate a specific category to the theme. After completing this process, I developed a table with the themes, categories, and examples. I then engaged in thematic analysis, which allowed me to interpret the findings and put them in the context of the study. The thematic

analysis focused on the efficacy of the CPT for PTSD group therapy, the personal reactions, and experiences of participants to the therapy, and their overall assessment of the intervention. Detailed codes, categories, and themes that emerged from the data are provided in Table 1. Discrepant cases were not observed in the data due to the relatively limited capacity of the raw data.

Evidence of Trustworthiness

Credibility strategies for this study included the application of clear data reporting, which entailed transparent and comprehensive reporting of research methods, data collection, and analysis. Also, data saturation was utilized by involving enough participants and generating the necessary amount of data to answer the research question. Finally, researcher reflexivity was applied by preventing bias and interpreting the information based on the analysis rather than the personal perception of the topic.

Transferability is maintained through the qualitative thick description of the research process, participation, and emerging themes. Contextual information is provided in the study to offer transferability in application to the current study and its needs. I was able to accomplish this by finding several themes throughout the research process. Also, I recruited a sufficient sample size ($N = 9$; see Hennink & Keiser, 2021). Finally, I created a step-by-step process on how the recruitment process was done so it can be repeated.

Dependability was facilitated by providing clear research designs and protocols, which were standardized and preestablished. Detailed documentation and consistency checks were used to ensure that the protocols and processes were followed and no deviations from the initial procedures were made such as meticulous note taking on my

part, as well as having a copy of the questions in front of me as the interviews were being conducted. I was able to identify and follow a clear research design that allowed for the best dependability possible. I utilized flow charts and check lists that allowed me to keep from deviating from the task at hand. Finally, while conducting each interview I had a list of the interview questions in front of me and read them clear and concisely allowing each participant to answer as much or as little as they wanted. Finally, transparency in reporting was implemented to show comprehensive reporting of the research processes, including the provision of limitations and challenges. Overall, transparent reporting allowed for achieving dependability. I offered transparency in detailing a step-by-step explanation in how the study was completed.

Confirmability was attained through coding and theme development by following an established and evidence-based procedure for coding and analysis. An audit trail was also developed by documenting each step in the research and checking if it complied with the initially developed protocols. The audit trail assisted me in conformability because it allowed me to focus on the developing themes. Reflexivity contributed to the facilitation of confirmability as well by decreasing the possibility of using bias or subjective interpretation of data. I was able to exercise reflexivity by keeping an open mind and looking for statistical outliers which I was unable to find. I initially thought there would be obvious themes that did arise but was able to avoid the bias by looking to the outliers and other developing themes.

Results

This study had one research question: What are the perceptions of CPT for PTSD group therapy for incest survivors in Arizona? I gathered data from nine female incest survivors who had gone through CPT for PTSD group therapy. The results of the manual coding are presented in Table 1, which shows the five themes and 10 overall categories along with illustrative participant responses.

Table 1

Themes, Categories, and Illustrative Participant Responses

Theme	Category	Example quote
Belongingness	Support of others	"Knowing others are there to support you, and you support them as well." (Participant 8)
	Not feeling alone	"Sharing: knowing I was not alone" (Participant 4)
Vulnerability	Exposing self to past trauma	"Facing fears and traumas: having to think about them and ultimately let them go." (Participant 3)
	Reminiscing the traumatic events	"Having to think about the past traumas and hearing some terrible things done to others." (Participant 5)
Stuck points	Stuck points in behavior	"Letting go of my toxic behavior." (Participant 7)
	Stuck points as a concept	"Leaning that stuck points are everywhere in life and that they don't have to define who I am." (Participant 2)
Group vs. individual	Social support	"When I was feeling down, I called to someone from the group to talk." (Participant 9)
	Learning from others	"I learned from others how to help and use new tools." (Participant 1)
Relief	Letting go of past traumas	"We need to give problems back and not take them on." (Participant 7).
	Coping	"Learning new coping strategies and knowing I wasn't alone." (Participant 6)

Theme 1: Belongingness

The most noticeable and ever-present theme was the sense of belongingness that all respondents experienced in CPT sessions. They all noted the benefits of social support and the possibility to interact with women who had similar experiences, allowing them to feel united. Some examples of evidencing this theme are the following: "knowing I'm not alone," "I realized I was not alone," "people understanding, and they can relate to the same things," "similar situations and have a similar perspective as myself" (Participants 1-3, 5). Many respondents mentioned the experiences of feeling isolated, feelings of loneliness, and feeling misunderstood by others, which CPT managed to address. Interviewees experienced a safe environment to share their traumatic experiences,

thoughts, feelings, and reflections with their group and a psychologist in a safe and supportive manner. In general, the participants stated that they felt better understood by other women who had experienced the same traumas.

Theme 2: Vulnerability

All participants referenced the issue of feeling vulnerable. Some considered the need to remember or encounter their traumatic experiences very challenging yet cathartic. For example, Participant 7 claimed that “opening up and talking” was the most challenging practice in group therapy. Others pointed out that this was the most beneficial aspect of CPT. The ability to not only share their traumatic experiences but also to allow themselves to be vulnerable in the group setting was healing for most of the participants. According to Participant 9, “knowing [she] could work through the trauma without talking about it directly” was important to her due to the difficulty of describing actual experiences. Shared vulnerability in CPT groups was named by many interviewees as an important practice, as they do not have similar opportunities in their daily lives. For example, the biggest benefit was “knowing I wasn’t the only broken person and was allowed to heal,” according to Participant 8. Some participants revealed that they had to undergo the unpleasant experience of hearing what was done to their counterparts, which triggered their own memories. It was challenging for Participant 5 “hearing some terrible things done to others.” However, despite the challenges and uncomfortable practices, this approach to CPT was viewed as positive by all nine participants.

Theme 3: Stuck Points

Four out of nine participants (44%) mentioned stuck points, which is a practice used in CPT. Many respondents stated that they did not hear about the concept of a stuck points prior to CPT for PTSD; others noted that learning about it was particularly important for their healing. According to Participant 9, the most enjoyable aspect of CPT was "learning what stuck points were and how they affect our everyday life." Stuck points refer to statements related to self and others, which represent exaggerated, extreme, and adverse aspects. In CPT for PTSD, stuck points of safety, trust, power and control, esteem, and intimacy are usually addressed. Participants reported that they realized how important it is to know about their stuck points are to overcome these negative outcomes of their PTSD and move on. One respondent (Participant 4) claimed that she would rather move deeper than focus only on the stuck points.

Participants could experience the inability to move past their traumatic experiences, as many of them reported being "stuck" in their current situations, which referred to feeling isolated and lost. For example, one of the participants (Participant 8) noted that "learning the stuck points and working through them after not realizing I was stuck was important." The findings indicated that CPT helped the participants to overcome their toxic behaviors, unhealthy relationships, and negative thoughts.

Theme 4: Group Versus Individual

Most participants (89%) agreed completely that CPT for PTSD in a group would be better than individual face-to-face therapy. Only one respondent stated that she saw both pros and cons of CPT when completed one-to-one. Participant 6 indicated that she

would like to ask more questions, yet it was impossible because it was a group setting. Stating "I could ask more questions if I had a chance." Some other participants agreed that CPT for PTSD group therapy is better than individual therapy, yet they would want to receive a more personal approach from the psychologist who moderated their group sessions. For instance, when comparing individual and group therapies, one of the participant (Participant 3) stated, "You do not know if therapist truly understands, but in a group, you know others understand you because they are there for same reasons."

One interviewee claimed that she would prefer it if her group would go deeper regarding past traumatic experiences and their analysis. At the same time, she expressed her understanding regarding the impossibility of doing that due to the group-based setting. The leader of the group in which Participant 4 was undergoing CPT for PTSD may have chosen to avoid analyzing traumatic experiences in depth. "I would have liked to have gone deeper though," Participant 4 stated. Because another participant confessed that it was very challenging for her to remember traumatic events and talk about them in depth, it is possible that the CPT for PTSD psychologist-moderator chose not to traumatize their more vulnerable participants in an effort to maintain balance.

Theme 5: Relief

The theme of relief was evident in the responses of three out of nine participants (33%). The respondents indicated that they were able to move on after the treatment, as CPT for PTSD helped them to move past their traumas, experience mutual support, and release these experiences. Participant 8 stated that she was able "take her life back." Participant 3 noted "healing and acquiring new knowledge" after the therapy. Participant

1 also pointed to "healing" as the main benefit of CPT for PTSD. The most important benefit of CPT for PTSD was its ability to assist participants in distinguishing the trauma from their personalities by understanding that the horrible things that were done to them do not define them as individuals. The participants were undergoing the inability to share their experiences with others until they were treated in CPT for PTSD groups.

Other Themes

Three respondents (33%) provided some details of the CPT for PTSD therapy that others did not mention. For instance, one respondent observed the benefit of this therapy versus the individual sessions by pointing to the impossibility of the psychologist to understand her trauma: "You do not know if therapist truly understands but in group you know others understand" (Participant 3). This interviewee confessed that she felt her previous psychologist could not provide the necessary help because she had never experienced the same traumas. In the CPT for PTSD group, she felt more understood, which led to more positive results compared to the individual therapy sessions. Other participants did not mention this specificity while indicating that CPT for PTSD put them in a circle of peers with similar experiences. This is an undiscovered issue in survivors who have gone through such traumatic events. Participant 5 stated, "They [group members] had similar situations and have similar perspectives as myself." This response revealed that it is possible that many survivors of incest and patients with PTSD might feel misunderstood by their therapists. Many patients with PTSD usually require more time to recover compared to other patients with different disorders.

Two respondents also mentioned that their group was inconsistent, or they were not satisfied with some participants in it. These mentions were scarce, yet they point to the need to consider the fact that the CPT for PTSD group therapy could have certain distinctions for participants, as they are treated in different groups. Even if the participants were treated in the same center in Arizona, all of them were treated in different groups of CPT. The makeup of the group might have an impact on the outcomes and the overall experiences of the participants. For example, one participant stated that she would prefer a deeper analysis of her trauma, while others did not mention this issue. Moreover, other respondents claimed that the self-analysis they conducted was challenging and personal. It is important to note that the differences in experiences of interviewees could have affected their overall evaluation of this therapy.

The participants had some differences in their takeaways concerning CPT for PTSD and its impact on them. Specifically, many stated that the therapy brought them healing from their traumas and allowed them to find more friends, as well as to find their community of people who have been through the same issues. Others pointed to the possibility of taking back their lives, moving past their problems, starting to explore the world and overcoming their traumas. Overall, the respondents stated that they were healed or were on the road to putting their trauma-related issues behind them. This means that CPT for PTSD was a successful experience for them. Participants were grateful for their CPT for PTSD group-based experience.

The challenges articulated by the respondents were somewhat similar regarding the ability to go through all parts of CPT, the practices, and the exercises. Yet, many

respondents approached the question by asking them to list their challenges during the therapy from a different perspective. Some interviewees named challenges from a positive perspective by pointing to the difficult but beneficial practices during group therapy. Others pointed to the problems in the group, organizations, or tasks. For example, two participants claimed that they found the exercises difficult to complete or understand. Others revealed that it was challenging to share their personal experiences. This points to the limitation of a structured protocol, which does not allow adding additional clarifying questions, which would be possible in a semistructured interview. Simultaneously, the differences in understanding of the concept of a "challenge" allows the investigation of this question in a more expanded way by analyzing what participants consider a challenge. Other differences in responses relate to the distinctive perspectives on the problems in the lives of women.

Research Question

Considering all aspects of responses provided by the participants, it is possible to answer the research question and reveal the perceptions of CPT for PTSD group therapy for incest survivors in Arizona. Table 1 summarizes the benefits and gaps of CPT for PTSD experienced by nine participants. Table 2 shows the advantages and drawbacks of CPT for PTSD group therapy based on the participants' experiences. The evaluation of pros and cons showed that CPT for PTSD group therapy suits incest and trauma survivors if they seek social support and need to reanalyze their traumatic experiences.

Table 2

Participants' Assessment of the Pros and Cons of Cognitive Processing Therapy

CPT pros	CPT cons
Sense of community	Experience depends on a specific group.
A safe and mutually supportive group	Experience depends on a specific moderator.
A deeper level of understanding	It could not be deep enough for some.
Work with shared trauma	Lack of individualized approach.
Analysis of universal stuck points	Focus on limited knowledge of trauma.
Ability to relive the trauma and move on	Reliving trauma could be too challenging for some.
Universal tools of how to work with trauma	A client-centered approach to trauma is lacking.

Note. CPT = cognitive processing therapy.

Table 2 shows the advantages and drawbacks of CPT based on the respondents' experiences. The evaluation of pros and cons showed that CPT suits incest and trauma survivors if they seek social support and need to reanalyze their traumatic experiences. Also, those seeking CPT group therapy must be prepared to share their experiences and talk about uncomfortable topics with people they have just met. This could be challenging for many victims of incest and those having PTSD. Group therapy cannot dedicate enough time to individual issues due to time constraints and the overall specificity of group therapy. Not all participants will find group-based CPT enough for their needs and in-depth analysis of their problems. Others might struggle with the need to conduct challenging and complex assignments. Overall, group-based CPT affects survivors of incest positively by providing them with social support, a sense of belongingness, analysis of their stuck points, evaluation of their trauma, and assistance

with moving on with their lives. It was revealed that CPT for PTSD helps the victims of incest to find peace with themselves and overcome painful experiences.

Summary

In answer to the research question, the study findings showed that group-based CPT for PTSD group therapy had a positive effect on the participants, all of whom were survivors of incest. All participants had positive feedback about their experience of CPT for PTSD group therapy, indicating that it was supportive, analytical, and helpful in terms of their trauma, negative experiences, disruptive behavior, and feelings of isolation and loneliness. The analysis also showed that victims of incest require proper support from those who understand their struggle, which makes CPT for PTSD group therapy intervention effective for this population group. Some issues with CPT for PTSD group therapy were also noted by the participants pointing to the unevenness of the group, lack of in-depth analysis, no personalization in approach, and challenging assignments. However, all these drawbacks did not affect the overall positive experience with CPT among the participants. They indicated positive outcomes by being able to move on from past traumas, unhealthy behavioral patterns, and ineffective relationships. Most of all, the participants emphasized the importance of support from their peers, as feelings of loneliness and isolation were the most common among the respondents.

This chapter is the basis for the analysis of findings in the context of the scholarly literature reviewed in Chapter 3. It is critical to analyze the findings in the context of past studies to detect if the current results support what has been found earlier. Chapter 5 concludes this study by providing the final thoughts on the research topic by generating

implications for this research, noting limitations, and providing a set of recommendations for further analysis of this topic. The conclusion is the final summary of this research recapping all its aspects, from its purpose and question to the method and results. The last chapter produces an analytical summary of interpretations of results and their implications for practice, theory, and several professional fields. The current study focuses on the field of psychology that could benefit from the findings generated by this research. Finally, the next chapter could serve as a basis for the next studies on this topic.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this basic qualitative study was to gain a more comprehensive understanding of the experiences of CPT group therapy as a treatment modality for female incest survivors diagnosed with PTSD in Arizona. The experiences of female insect survivors after CPT for PTSD group therapy have not been examined, according to my review of the literature. I investigated how individuals perceived group therapy as a treatment modality as apart of a therapeutic approach. The information gained from this study could offer insights regarding additional therapies for women who are recovering from familial incest. I conducted structured interviews by using an original questionnaire featuring six questions. After every question, I asked each participant whether there was any additional information she wanted to share.

Interpretation of the Findings

The following themes emerged from the research: belongingness, vulnerability, stuck points, group versus individual, and relief. Pertaining to the theme of belongingness, the findings revealed that most of the participants had favorable views of CPT for PTSD group therapy, finding it very beneficial in terms of social support and decreased feelings of loneliness. Owens and Chard (2001) stated that feeling isolated and alone were common issues in women who had suffered incest as children. Only one respondent reported that the group therapy format prevented emphasizing stuck points more deeply. The theme of relief also showed that the women had favorable responses as well stating that they learned new coping skills as well as learning new life skills. Nixon

et al. (2016) found similar results when they tested the effectiveness of CPT following sexual assault. All but one participant from my study found that the group setting was more beneficial than if the same therapy was conducted one-to-one because of the ability to learn from others and the ability to build new relationships. Resick (2017b) found opposing data when comparing individual and group CPT. However, Resick found that both group and individual therapies were effective. Stuck points were also a commonly mentioned theme from the participants in my study as knowing that everyone has a past that they must learn how to forgive and move on.

The analysis also revealed that survivors of incest found support and understanding from those that had similar traumatic experiences. Some issues with CPT for PTSD group therapy were also observed by the participants indicating the problems in their specific groups, including lack of personalization in methodology and problematic homework. However, these drawbacks did not affect the overall favorability of CPT for PTSD group therapy among most of the participants. Above all, the participants emphasized the importance of support from their peers, as feelings of loneliness and isolation were the most common among the participants.

All participants referenced the issue of healing. Some participants stated that they needed to remember or experience their traumatic experiences as really challenging yet necessary to be able to heal and move past their stuck points and start life over in a new and healthy way. Others explained that processing traumatic memories was the most helpful facet of CPT for PTSD group therapy. Asmundson et al. (2019) found that 89% of the patient population treated using CPT had better outcomes than other alternate

treatments, which supports my findings. In a study conducted by Matulis et al. (2014), adolescents diagnosed with PTSD found CPT for PTSD to be effective in decreasing negative symptoms associated with childhood sexual abuse. Haller et al. (2016) and Liverant et al. (2012) also concluded that CPT group therapy was a viable option for sexual assault survivors.

The capability to not only share their stressful experiences but also to allow themselves to be vulnerable in the group setting was shown to be a healing method for many of the respondents in this study. This is a crucial finding that aligns Bandura's (1977) and Vygotsky's (1978) assertions that self and mental development originate through social interactions. These concepts are the foundational premise for this study. All the participants responded that they learned, grew, and were able to overcome their traumas based on the social support provided by the women in their groups. Some even stated that they are still in contact with the women from their groups. This finding aligns with findings by Chen and Spry (2017), who stated that their participants found healing within the group setting because they were able to bond with the other group members more so than the therapist because of their belief that the therapist had not experienced the same or similar traumas.

Shared vulnerability in CPT for PTSD group therapy was mentioned by numerous interviewees as a crucial technique, as they all endured similar traumas in their lives. Some individuals revealed that they needed to undertake the unpleasant experience of hearing what was done to their counterparts, which caused their own repressed memories

to emerge. However, despite the difficulties this technique of CPT for PTSD group therapy was labeled favorably by all respondents.

Stuck points were referenced by four participants, which is part of CPT for PTSD group therapy. Many respondents stated that they did not become aware of the principle of a stuck factor before CPT for PTSD group therapy; others confided that finding out about it was especially essential for their healing. This finding aligns with Resick (2017) statement that "a person learns how to work through trauma by understanding how their thoughts and emotions are related" (p. 31). If the individual is unaware, they are stuck or unsure how their thoughts are related to their trauma, and they are unable to properly heal. Therapists who use CPT focus on helping the participants to become unstuck and to understand how these emotions affect quality of life and emotional processes (Lentz et al., 2014). Stuck points refer to statements related to self and others, which stand for exaggerated, severe, and damaging elements. In CPT for PTSD group therapy, stuck points in the areas of safety, trust, power and control, and esteem, as well as intimacy, are addressed by both the therapist and client populations (Chard, 2005). Participants from my study reported that they understood how essential it was to learn about their stuck points as well as to get rid of these negative thought processes that had developed because of their PTSD.

The obstacles verbalized by the respondents, namely the use of worksheets, were rather comparable in relation to the capacity to undergo all parts of CPT for PTSD group therapy. Some interviewees called the worksheets challenging but a useful technique during group therapy. Patients addressed other issues in the group. For instance, four

individuals stated that the exercises were too difficult to complete or comprehend. Others stated that it was difficult to share their individual experiences on some of the worksheets.

CPT for PTSD group therapy aided survivors in creating coping techniques and skills to handle stressful emotions and situations connected to the trauma. This feeling of empowerment can add to raised resilience and a feeling of control over one's life. Participant 4 stated that they were able to learn new life and coping skills which align with previous findings in literature. Incest trauma can affect relationships with others, including members of the family, friends, or intimate partners, as it was determined in past studies (Chard et al.1997). Participant 2 also supported these findings. Group-based CPT for PTSD assisted survivors of incest in recognizing how the trauma has influenced their partnerships and helped them establish much healthier patterns of connecting to others (Chard,2005) With CPT for PTSD group therapy, survivors get a much deeper understanding of themselves and their trauma, fostering increased self-esteem and self-compassion allowing them to move on as stated by Participant 3.

CPT for PTSD group therapy provides a supportive healing partnership where survivors can share their experiences without judgment and obtain validation for their feelings (Castillo et al. 2014). According to the CPT for PTSD outcomes, this treatment gave survivors the tools and skills to make enlightened choices regarding their lives, including setting healthy and balanced boundaries. It is important to keep in mind that each person's experience of incest trauma is special, and that the efficiency of treatment can vary from one person to another. In addition, the healing process may call for time

and patience as survivors resolve their own individual feelings and experiences. Seeking assistance from a qualified and experienced mental wellness professional who learned trauma-focused treatments like CPT for PTSD group therapy is critical for survivors of incest to receive the appropriate care and support they require.

Group treatment can create a safe, as well as encouraging environment where individuals can share their experiences, gain insights, and resolve the influence of sexual trauma (Chen & Spry 2017). Participants 1, 4 and 6 also supported this by stating they felt safe, supported and were able to learn from each other. Group treatment allows survivors to connect with others who have experienced similar traumas. This feeling of belonging and recognition can be extremely effective, as survivors may feel less alone as well as recognized in their journey of recovery because incest survivors typically experience feelings of isolation and embarrassment. This was supported under the theme of belongingness by participants 1, 3, 4, 6. Group therapy supplies a space where survivors can break the silence, share their stories, and find support from others that have gone through similar situations.

Participating in group therapy can promote a feeling of empowerment. As survivors witness the strength and development of others, they may be inspired to act in the direction of healing as well as recovery in their very own lives. Participant 3 stated that they knew they needed to let go of their stuck points to move on. This directly correlates with Piaget and his cognitive learning theory (Barrouillet, 2015). As stated by Lefe (2014) learners can take new information from others and apply it to their lives to benefit themselves. The exchange of concepts can be beneficial to learning. Group

therapy uses a structured setting to reveal emotions and find a healthy and balanced means of taking care of their emotional health.

Group participants can provide responses, motivation, and different perspectives to each other. This can advertise personal growth, provide understanding, and supply various methods of understanding one's experiences. Coping was another theme that emerged through the research. Participants 4 and 5 stated that they were able to learn new skills forgive to move on. Survivors of incest might have problems with feelings of a sense of guilt related to their responses to the trauma. In group therapy, they can learn that their reactions are normal to uncommon experiences, reducing and even eliminating self-blame. Shnaider et al. (2021) study had similar results with a decrease in PTSD symptoms as well as an increase in positive regulation. Group therapy can offer opportunities for survivors to exercise social abilities and boost their ability to connect as well as get in touch with others. Being accepted as well as sustained by a group can boost survivors' self-worth, as they get positive feedback and affirmation from others that identify their stamina and resilience. Pertaining to the theme of belongingness, Participant 2 stated they were happy to know they were not alone and that there were others there to support them. Group treatment can be an effective complement to private therapy or various other types of treatment. It can offer recurring assistance and a framework, boosting the total restorative experience for survivors.

CPT for PTSD group therapy might not be appropriate for every person or might be most efficient at certain stages of recovery. Some individuals may like individual therapy, while others might find group treatment to be extra advantageous. Inevitably, the

decision to participate in group therapy should be made based on the survivor's choice. Educated mental health and wellness specialists with experience in trauma-focused treatments ought to facilitate team treatment for survivors of sexual trauma to make certain a risk-free as well as efficient healing atmosphere.

Participants indicated the opportunity of taking back their lives, pushing past their trauma, and beginning to discover the world. In Chapter 2, I reviewed several studies (Bryan et al., 2022; Clemans et al., 2021; Hall & Henderson, 2007; Resick & Schnicke, 1992; Vickerman & Margonlin, 2009) who authors noted reductions in PTSD symptoms among clients who had undergone CPT. In these studies, participants were able to process their individualized stuck points and learn new positive ways of thinking. Generally, the participants stated that they were healed or were on the road to putting their trauma-related issues behind them. This indicates that CPT for PTSD group therapy was an effective experience for them. Individuals were grateful for their CPT for PTSD group therapy experience.

Limitations of the Study

Trustworthiness was not a factor during the study but there were several limitations in this study. The most significant limitation was that I did not ask additional follow-up questions during the telephone interviews. The reason for my failure to follow up is because I wanted to comply with what I assumed were Walden University's IRB rules and regulations. I was under the impression that I was only allowed to ask the IRB approved six questions. Furthermore, I also assumed I was only allowed to ask if there was anything else the participants wanted to add. Accordingly, I did not ask any probing,

follow up question to clarify or explore a participant's response. As a result, the results of this study are sparce and limited. Also, this study involved only women, which is limiting in terms of the specifics of experiences.

It is also important to acknowledge that since the respondents were recruited from only a single counseling center in Arizona there are limitations on the generalizability of the findings. During the analysis of participants' responses, it was observed that they experienced some minor differences in terms of their groups. Some participants had larger groups than others, some had groups where the participants wished more details were given about the traumas whereas others reported that hearing the details in their groups was difficult. These are small details but still must be considered minor limitations. Experiences of women in CPT for PTSD group therapy, groups had certain differences, yet, they did not have a drastic effect on their overall experience. The overall number of participants was small. Yet, considering the topic of research, this limitation could affect any study targeting the survivors of incest. Overall, minor limitations do not pose a major threat to this study.

Recommendations

Future studies should focus on the experiences of incest survivors, as this field of research is very limited. Survivors of incest require more attention to their psychological state, experiences, relationships with others, and socialization due to their embedded stuck points. The areas of safety, trust, power/control, esteem, and intimacy have all been greatly affected by their assault and are at the crux of rebuilding everyone upon completing their stuck points. As this study indicates, many survivors of incest

experience loneliness and isolation, which can be investigated in the context of therapy and social support. Future studies should include a rerunning of this current study adding additional probing questions that were not asked in this study to gain additional information. Additional studies should also be conducted to investigate follow-up data over longer periods of time such as 6 months and 1 year as one previous study has done such as Suris et al. (2013). Finally, this study could also be run again with additional probing questions together with additional data that was not gathered by myself. Future studies should also include a focus on male survivors of incest as well, as the research involving male survivors is even scarcer than that on women because men tend to not discuss sexual assault. Moreover, it is critical to determine if CPT for PTSD group therapy could assist male survivors of incest.

Implications

Overall, CPT for PTSD group therapy was beneficial for incest survivors. Additionally, those looking for CPT for PTSD group therapy treatment do not need to share their private experiences nor speak about them in the group setting which may not be for everyone. Some individuals want to talk in more detail about their individual traumas and therefore will not like the more controlled and privateness of CPT for PTSD group therapy. CPT for PTSD has good implications for incest survivors who are looking for support from others who can understand and empathize with them because of similar traumatic experiences and for those who do not want to talk about their trauma in detail but rather get through their stuck points. The implications for positive social change that

can be found in CPT for PTSD is that this is a new way of helping women heal and create new social connections that are safe and, on their terms.

Each of the participants in the study discussed their fears of being vulnerable but were more at ease with others who had been through similar situations. The implication that these women can create a social network where they can feel supported and safe to heal is huge and opens the door for them to start their healing journey in a safe and protected environment.

Not all participants will certainly find group-based CPT for PTSD group therapy sufficient for their demands and comprehensive evaluation of their issues. Group therapy cannot dedicate enough time to private concerns because of time restraints and the overall uniqueness of group therapy.

Others could battle with the requirement to carry out the weekly homework. Overall, group-based CPT for PTSD group therapy influences survivors of incest positively by supplying them with social assistance, a sense of belongingness, analysis of their stuck points, and support with moving on with their lives.

Conclusion

Overall, the study found that all study participants had favorable responses of CPT for PTSD group therapy stating that the group was valuable for reducing bad habits and a sense of isolation and loneliness. The analysis likewise showed that survivors of incest need proper assistance from those who comprehend they are having a difficult time, which makes CPT for PTSD group therapy efficient for treating this population. Some participants pointed out an absence of in-depth analysis, lack of personalization in

technique, and challenging worksheets as drawbacks. Nonetheless, none of these drawbacks impacted the overall positive experience with CPT for PTSD group therapy amongst the respondents. All participants stated positive outcomes by having the ability to process past traumas, break unhealthy behavioral patterns, as well as recognize ineffective and unhealthy relationships. Most of all, the participants noted the significance of assistance from their peers, as the feelings of loneliness, as well as isolation, were one of the most common among the respondents.

The objective of this study was to examine perceptions CPT for PTSD group therapy among female incest survivors. The study made use of a qualitative exploratory research study style by recruiting nine survivors of incest in one counseling center in Arizona. The study was performed to get a better understanding of female incest survivors' perceptions of CPT for PTSD group therapy. The research did a structured meeting by utilizing the initial set of six questions. CPT for PTSD group therapy showed positive outcomes in all survivors of incest. CPT for PTSD group therapy helped these incest survivors to not only process their traumas but to create a feeling of belonging, less isolation, and an expansion of a community as result of participation in CPT group therapy in an outpatient therapeutic setting.

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Appendix: Interview Questions

1. What did you enjoy most about CPT for PTSD group therapy?
2. What did you enjoy least?
3. What did you find to be the most helpful?
4. What did you find to be the most challenging?
5. Do you feel like the group setting was more beneficial than if the same therapy was conducted 1:1? Why or why not?
6. What was the biggest takeaway from your experience?