



# Stories from the road of recovery – How adult, female survivors of childhood trauma experience ways to positive change

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## Abstract

The aim of this study was to explore how female survivors of childhood trauma who have sought treatment experience ways to positive change. Little knowledge exists regarding the first-person perspective of the recovery process following childhood trauma, and getting access to this perspective might contribute to better understanding of these processes, hence offering opportunities for health promotion. All clients (31, including 3 who dropped out) from six stabilization groups for women exposed to human-inflicted traumas were invited to participate in the study. Experiences of the recovery process were not restricted to the period of receiving treatment, and all clients who volunteered were included in the study. Qualitative, in-depth interviews with 13 consenting clients were carried out shortly after completion of the group treatment. All interviews were transcribed verbatim, and a hermeneutical–phenomenological approach to analysis was applied. The analysis resulted in five interrelated, but distinct main themes: *finding new ways to understand one's emotions and actions, moving from numbness toward vital contact, becoming an advocate of one's own needs, experiencing increased sense of agency, and staying with difficult feelings and choices*. The themes support, yet supplement trauma theory, by underlining the relationship between emotional contact and meaning-making, while downplaying the necessity of symptom elimination in the experience of recovery. The findings also underline that the active role trauma survivors play in their processes of recovery.

Keywords: childhood trauma, recovery, client perspective, qualitative interviews, stabilization group

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## 1. Introduction

The process of recovery from childhood trauma is not well understood. Yet, exposure to childhood trauma is common, and many struggle with trauma-related problems decades after the original traumatic event. From this perspective, it is important to access the first-person perspective of the recovery process following childhood trauma. In this article we explore: How do female survivors of childhood trauma, who have sought treatment, experience the process of recovery?

The concept of "recovery" may refer both to a process and an outcome (Davidson & Roe, 2007), and the relationship between these two conceptions of recovery has been unclear (Davidson, Tondora, & Ridgway, 2010). In this article, the concept of recovery will be defined as a process, a personal journey, during which recovery is pursued actively. In line with the U.S. Department of Health and Human Services, we recognize that there are many different pathways to recovery and that each individual determines his or her own way. Mental health recovery is thus defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2011). Within this line of thinking, recovery is not conditioned to outcome in terms of symptom reduction or alleviation, and is much linked to the concept of "empowerment", i.e., supporting people in their efforts to lead full lives in the face of serious mental illness, including actively participating in their local communities (Davidson, Strauss, & Rakfeldt, 2010).

In the general population, there is a high exposure to potentially traumatizing events. A range of 7–36% of females and 3–29% of males report a history of sexual abuse (Olafson, 2011), and 71% of American children aged 2–17 report some type of victimization in the past year (Finkelhor, Ormrod, & Turner, 2007). Exposure to potentially traumatizing events is associated with an elevated risk for developing enduring problems (Foote et al., 2006). Reported prevalence of trauma-specific disorders, such as posttraumatic stress disorder (PTSD), vary greatly, though, and might in part be associated with differences in diagnostic criteria applied (O'Connor, Lasgaard, Spindler, & Elklit, 2007). Moreover, a history of sexual abuse is correlated with a range of non-trauma-specific mental disorders, including depression, eating disorders, and sleep disorders (Chen et al., 2010).

This article draws on data from a larger study exploring how clients in an inclusive stabilization group approach experience help seeking, recovery, and treatment participation. Within this context, we understand "psychological trauma," in accordance with the American Psychiatric Association (APA, 2000), as experiences of events involving actual or threatened death or serious injury (p. 467). Furthermore, we view the differentiation between potentially traumatizing events and experienced trauma as essential, where "incomprehension," "disrupted attachment," "inescapability," and "physiological response" are seen as core characteristics of traumatic experiences (Saporta & van der Kolk, 1992). Trauma-related symptoms, such as intrusions, avoidance, and dissociation are understood as indicative of a failure to integrate traumatic experiences. Hence, phase-oriented trauma treatment is considered necessary when trauma exposure has resulted in the development of such symptoms, and where problems with affect regulation and efficient handling of symptoms interfere with daily functioning.

From the clinicians' perspective, major foci of treatment goals following development of disabling trauma symptoms are self-regulation, sense of identity, core cognitive-affective beliefs, and relationships, along with strengthening skills for experiencing, expressing, and

regulating emotions. The goal is to increasingly relate to one's own emotional experiences without getting overwhelmed by them and reacting dissociative (Courtois, Ford, & Cloitre, 2009). Experiential and emotion-focused therapy (Fosha et al., 2009) also emphasize the potential in emotional experiences, where affective experiences are seen as leading to healing through providing opportunities for new meanings and views of self, others, and traumatic experiences. Little is known, however, about what trauma clients experience as the key components of the process of recovery.

While the process of recovery from severe mental illness, such as eating disorders, schizophrenia, and bipolar disorder, has been explored (Borg & Davidson, 2008; Dilks, Tasker, & Wren, 2010; Pettersen et al., 2012; Veseth et al., 2011), these processes have been understudied among survivors of childhood trauma. We have only located two qualitative studies of recovery following trauma. One study explored recovery linked to a specific treatment program for women exposed to abuse (Parker et al., 2007), while the other study explored life trajectories among female survivors of child abuse thriving in adulthood (Thomas & Hall, 2008). Given the important role the clients play in recovery (Tallman & Bohart, 1999), and the unique contribution of client perspective to knowledge development (Elliott & James, 1989), it seems important to focus on what constitutes the key experiences of the recovery process from the client's perspective. In this article we explore: What constitutes the key experiences of the recovery process for female, adult survivors of childhood trauma who have sought treatment?

## 2. Methods

A hermeneutical–phenomenological approach relying on in-depth, individual interviews was chosen for this study. This approach allowed us to explore the lived experience of the recovery process for the participants, while also acknowledging the interactive nature of interview material, and the influence we as researchers have on our findings through the inevitable influence of interpretation in all human activity (Alvesson & Sköldbberg, 2000; Laverty, 2003; Nielsen, 2007). To help the reader understand our starting point for interpretation, rather detailed information about the study setting is provided below, in an attempt to situate the study.

### 2.1 Study setting

The study was conducted in remote areas of Northern Norway at an outpatient setting of specialized mental health services. All participants in the study had attended a stabilization group approach developed by the first author. The approach is tailored to include clients with mixed trauma histories and trauma symptoms, and further details on the treatment approach can be found in a separate publication (Stige, 2011). The process of recovery was not restricted to the period of receiving treatment, though, and the findings should not be seen as outcome-specific to the treatment program. To contextualize the findings, the stabilization group approach will be described briefly.

The treatment approach builds on trauma theory (Herman, 1992; van der Hart, Nijenhuis, & Steele, 2006), and is a stabilization group in the strict sense, i.e., with no sharing of trauma histories in the groups. Important treatment foci are (re-)establishment of safety, restoration of control, empowerment, skill building, and establishment of new social connections (Herman, 1992). The groups are closed, with a maximum of seven clients in each group, with 17 weekly

group sessions, each session lasting 90 min. Through an alternation between psycho-education, skill building, and sharing of experiences between clients, the focus is on understanding and handling of trauma-specific symptoms. The approach is offered to gender-specific groups, and all clients receive concurrent individual treatment.

Eligible clients for the stabilization group had experienced human-inflicted traumas in childhood, adulthood, or both, and experienced active trauma-related symptoms. All clients had been referred by their general practitioner to the specialized health services, and had fulfilled the Norwegian government's criteria for receiving help from specialized health services.

## 2.2 Recruitment procedure and participants

Upon completion of the stabilization group, all 31 clients (including 3 who had dropped out) from six groups for women received a letter with information about the study. Those who consented to participate in the study had to do so by returning a response letter. Thirteen participants volunteered to participate between August 2008 and March 2011, and were included in the study.

One of the main challenges in this study was protecting the identity of the participants, given the rural setting, the specific treatment approach, and the multiple roles of the first author. Therefore, the participants are presented with less contextualization and participant-specific information than is ideal to balance the desire to properly situate the study and the researchers against the need to stay true to the participants' descriptions in the presentation of the findings without compromising the anonymity of the participants.

The 13 participants had all completed the stabilization group, and had attended between 60% and 100% of the group meetings. They were all continuing in individual therapy at the time of their interviews. Participants were between 18 and 60 years old (mean 39 years), and their experience with therapy prior to participation in the stabilization group varied from none to several years. They had waited from 13 to 58 years before they sought professional help for their trauma-related problems. During this time, many participants had managed to lead "normal" lives where they had found ways to manage so that their trauma histories did not interfere with their ability to work, study, and starting families. Yet, they reported having experienced high levels of distress prior to seeking help. All participants reported being younger than 5 years old at the time of their first traumatic experience, and all had experienced multiple traumas, including incest, sexual abuse, physical abuse, rape, partner abuse, and/or psychological abuse. At the time of the interviews, four participants were studying or working and nine were either on sick leave, disability benefits, or rehabilitation benefits. Ten participants reported having children.

## 2.3 Data collection

Participants were interviewed within 3 months of completing the stabilization group. Interviews were semi-structured and exploratory in nature, lasting from 1 to 2 h. The main topics covered in the interview guide were the help-seeking process, experience of ways to positive change/process of recovery, and experience of participation in treatment, along with examples of follow-up questions. As part of the interview, participants were asked to draw a timeline, indicating experienced fluctuation in distress over time (from birth to date of interview). This was used as a starting point for exploring the participants' process of recovery. Follow-up

questions were used to check interviewers' emerging understanding of the participants' experiences (Kvale, 1996), and to allow the participants to clarify or elaborate their statements.

Two female mental health care workers with no previous relation to the participants and no other involvement in the research project interviewed the participants from five treatment groups, where the first author had been one of the group therapists. The first author carried out interviews with participants from the sixth treatment group. The first author listened to each interview shortly after completion, and gave feedback to the external interviewers. This procedure was required by the Regional Committee for Medical and Health Research Ethics to ensure that the dual role of the first author did not corrupt ethical principles of free consent. All interviews were transcribed verbatim by the first author, with non-verbal aspects of the communication, such as emotional tone, indicated by short descriptions added in parentheses.

## 2.4 Data analysis

A hermeneutical–phenomenological approach (Binder, Holgersen, & Nielsen, 2010; Laverty, 2003) was used to explore how these women had experienced their process of recovery over time. The analysis was exploratory, emphasizing reflexivity (Alvesson & Sköldböck, 2000). The NVivo 8 software (QSR International, 2008) was used as a technical support in the analysis of the interview transcripts.

Although constantly alternating between parts of the data material (extracts from individual interviews) and the whole (patterns of meaning across interviews), a general sequence of the analysis can be described as follows: (1) analysis was initiated by the first author in a process of reading and rereading of the transcripts to get a good overview of the material, capturing the first impression of important topics in the texts. (2) Each interview was studied in detail, examining every part of the text relevant to the research question. (3) Every part of the text expressing different aspects of the participants' experiences of recovery was marked and named as meaning units. (4) Looking at the meaning units across interviews, converging meaning across different participants were identified and condensed, staying as close to the informants' use of language as possible. (5) Following this first organization of the data, the analysis was critically transformed through dialog between the first and second authors. (6) Meaning patterns and themes were abstracted in collaboration, reflecting what emerged as the most important aspects of the participants' converging and diverging experiences. (7) We referred back to the overall text to check that all relevant aspects of the participants' experiences have been included in the analytic process. (8) Preliminary results of the analysis were presented to the two external interviewers, and their feedback contributed to deepening and focusing the thematic structure.

## 3. Results

Our analysis revealed five main themes: *finding new ways to understand one's emotions and actions, moving from numbness toward vital contact, becoming an advocate of one's own needs, experiencing increased sense of agency, and staying with difficult feelings and choices*. The main themes and sub-themes are illustrated by quotations, and presented separately to give justice to the richness in data. All the participants' names are fictive, and quotes are presented with minimal participant-specific information to protect the identity of the participants.

### 3.1 Finding new ways to understand one's emotions and actions

In the participants' stories, an overarching theme was the importance of gaining a new understanding that resulted in the experience of substantial changes in the way the women perceived themselves, their symptoms, and their histories. The theme has two sub-themes: *new understanding of one's own reactions and experiences* and *new understanding of own part in trauma*.

#### 3.1.1 *New understanding of one's own reactions and experiences*

Many of the women had previously experienced their symptoms as fragmented and incomprehensible. Gaining an understanding of their own reactions and experiences was, therefore, an important component of the recovery process. Morgan, for example, experienced that the psycho-education provided in the stabilization group helped her comprehend, and thus manage, her trauma-related problems:

I have had these problems for years. It has been a dark cloud. Something completely unwieldy, that I could not touch, that I didn't manage to do anything about. But I had hoped . . . I have believed that I can make it go away if I got help. And now, after the stabilization group, it is no longer a cloud of things that I don't know what is. It is almost like building blocks. And on each and every one of them it says what it is. I know what the things are now. [. . .] It is almost like, when I have gotten some blocks in the right position, it is like a jigsaw puzzle. Everything else falls into place. Now I know which pieces are still missing from my jigsaw. And it is such a wonderful feeling!

Carrie too experienced that knowledge about trauma-related symptoms changed the way she viewed herself and her symptoms:

Well, I wasn't even aware that all these symptoms were symptoms, you see? And then to see that all these things are connected. [. . .] You didn't have 1000 problems. It was just one problem; so you focus on that problem, right? It is more tiring, to put it that way, if you, during a day first have to fight away the anxiety, then being depressed for a while, and then you must . . . Compared to working on the reason you get all of this, see?

#### 3.1.2 *New understanding of own part in trauma*

The new ways of understanding their experiences also influenced the way many of the women looked at their part in the traumas they had endured. Johanna had taken responsibility for her own and her family's situation, and had struggled to prevent new traumatic experiences all her life. At some point, though, she was confronted with a new dramatic situation that made her step back and look at herself and her situation. This resulted in her letting go of some of the blame she had put on herself: "To see that distress increased here [points to time-line], it made me realize more and more that this is not my fault! These are crazy people! And it is not my fault."

Although experienced as an important component of recovery for all 13 participants, the way this new understanding was acquired differed. Some participants experienced that new meaning occurred in the context of forming relational bonds with significant others. Others experienced that the interactions with other clients in the stabilization group helped them to gain new understanding, while others reached a new understanding through information and knowledge from the Internet or from psycho-educational sessions in the stabilization group.

A common feature of these experiences was, however, that the participants felt empowered by them, i.e., by better understanding their own reactions or by redefining their role in their traumas.

### 3.2 Moving from numbness toward vital contact

This theme has three sub-themes: *increased contact with the body, relating to one's symptoms, and improved relations with others.*

#### 3.2.1 *Increased contact with the body*

For many participants, an increased awareness of, and contact with, their bodies were an important component in the recovery process. Carrie had not been in touch with her bodily sensations for years. As she slowly started to explore how it felt to stop and notice the things around her and feel her body more often, she realized that this contact also helped her to stay focused mentally:

I feel how much my bodily reactions mean to be able to complete my thoughts, to put it like that. I feel it in the body now, when I start to drift off. [...] I have a new contact with this whole part of myself. [...] And all of a sudden it is so much easier to leave my little bubble, when I have more contact between my head and my body, and the world around me. That it is not only the head and the world, or the head and yourself, and then you have a body that just sits there. It became a more holistic picture of yourself.

Carrie's experiences illustrate how increased contact with the body also helped her to stay more present, and not dissociate and drift off so easily.

#### 3.2.2 *Relating to one's symptoms*

Relating to their symptoms instead of ignoring them, pushing them away, or avoiding them, was experienced as an important component of the recovery process for many participants:

Well, if I have a flashback now, I think: 'Why does it come now? Is it something that reminds me of it? Or is it something in particular that has happened here?' And I think: 'I don't have to be afraid anymore, because now it is several years ago.' [...] I think about it to understand it, if such thoughts suddenly appear, or if I get sad, or don't dare to do something. To use the knowledge I got in the group, and get an understanding of why I have it. I take time to think about it, instead of just pushing it away. I think about it and get through with it. (Fay)

Fay's words illustrate how the experience of their symptoms changed for many participants as they responded differently to their symptoms. By attempting to understand why they appeared, and support themselves in facing their symptoms, many participants experienced that their symptoms impacted their everyday lives less.

#### 3.2.3 *Improved relations with others*

Several participants also experienced that their increased contact with their bodies and feelings had a positive influence on their relations with significant others:

I have been so exhausted! I have been outside myself, in a way. I have not managed to focus. Even though I have been with my kids, and felt that I was together with them, I have not really been there. I feel it now, when I am with my kids, that I am really there

with them. I feel a different kind of joy, a different harmony with my kids. And that is a big difference. And I feel that the kids feel the difference, that they feel I am more present. And I become more aware that what I feel now when I laugh with my kids is actually real joy. (Lauren)

On their journey through life following childhood trauma, a key strategy for many of the women had been to manage their symptoms and histories by keeping it at a tolerable distance, rather than relating to it. They had numbed their feelings and histories. Even though previously experienced as a necessity in order to function, many of the women described how this strategy also led to detachment from themselves, their feelings, and from their significant others. For many participants, a substantial part of the recovery process, therefore, entailed increased contact with themselves and a movement toward connecting with significant others.

### 3.3 Becoming an advocate of one's own needs

The experience of becoming more aware of, and respecting their own limits and needs, was an important component of the recovery process for most participants. The theme has two sub-themes: *letting go of excessive focus on others* and *increased self-care*.

#### 3.3.1 *Letting go of excessive focus on others*

Many participants had previously turned the focus away from themselves and toward others, as part of their coping strategies to keep their trauma-related problems in check. Letting go of some of this focus was, therefore, an important part of the recovery process:

'It is no problem. Johanna will fix it!' I have heard that sentence so many times! And it has been incredible things, and I have always found a solution, somehow. [...] I don't have to do that anymore. I can do it if I feel like it. But I don't have to. Because it has not been a choice before. (Johanna)

Johanna's words illustrate how many of the women experienced a change in their relations to others. From being an imperative, helping others became a choice – *their* choice, where they could take their own needs into consideration.

#### 3.3.2 *Increased self-care*

Some of the participants discovered how little attention they had paid to their own well-being: "I have become more aware of how poor I was at choosing what is good and important for me. And when I became aware of this, I managed to make better choices" (Brenda).

Letting go of some of their high expectations of themselves – or giving themselves a break, was experienced as important for many participants: "Give yourself a chance to take breaks, and not striving to become the best in the world, being there for everyone, in addition to everything you struggle with" (Amanda). For some participants, this meant allowing themselves time before responding to requests: "I try to make wise choices for myself, almost being an advocate for myself, thinking in advance what is good for me, and what is bad for me" (Morgan). An important component of the recovery process for these participants was, therefore, how their own well-being and needs came to influence their decisions.



### 3.4 Experiencing increased sense of agency

For all participants, the recovery process involved concrete changes in how they lived their lives, and an increased sense of being able to do something to influence and improve their situation. Small or large, the changes entailed a feeling of taking charge of their own situation, especially if faced with negative situations or symptoms. Amanda's words illustrate this: Now I can do something different when such things [trauma content] pop up. I don't just sit down and dig myself further down and back in time, and feel sorry for myself and feel bitter. Now I can go for a walk, try to do something else to change the focus.

Isabelle had experienced severe sleep problems for years. The discovery that she could do things to change her situation was liberating to her:

For the past 10 years it feels like I have slept several times each night. I have slept short periods and then woken up and struggled. So I made a habit of not turning off the light, sleeping with my glasses, with the pen in my hand and the crossword next to me – so I could start solving crosswords once I woke up [...] Now I have made an evening routine that I follow. Simple things like having a quiet time before I go to bed, where I don't watch TV or listen to the radio. And I go outside to get some fresh air. [...] Earlier just stretching to turn off the light was enough for me to be wide awake again. So now I have bought a remote control for the bedroom light. [...] I do not experience sleep as a problem anymore, to put it like that.

Although Isabelle related her increased sense of agency to therapy-related processes, other participants, such as Lauren, experienced that accomplishment that were not related to their trauma history helped them feel more confident that they could act to change their life situation:

Three years ago I quit smoking. I had been smoking for 14 years, and it was a big accomplishment that I managed to recognize as that at the time. And it gave me confidence. Because I saw: 'I can manage this! I managed to quit smoking!' And it is a big thing. I know of many who do not manage to quit. Then I realized that there is strength in me. So there is a lot of things that has happened through the years that have given me the confidence to approach and handle these difficult [trauma-related] things.

From feeling that they were at the mercy of their trauma-related symptoms, the women described discovering ways they could influence their symptoms, taking control and feeling that there is something *they* could do to influence their own situation. Their sense of agency seems strengthened.

### 3.5 Staying with difficult feelings and choices

This theme has three sub-themes: *increased robustness in staying with difficult feelings*, *recovery brings about an increase in symptoms*, and *recovery brings about difficult choices*.

#### 3.5.1 *Increased robustness in staying with difficult feelings*

Some of the women experienced recovery, despite having a comparable symptom load. This related to their experiences of their symptoms changing as they discovered new ways of relating to them:

No, I have the same load of symptoms still, really, but it is a bit easier when they come, because I know how I ... I try, at least to ... And I know how I can try to get out of it, not bundling up in it even more. (Amanda)

Earlier, when I got it [anxiety] I have just panicked more and more. I thought, 'My God!' Because I did not know why it happened. Now I have more explanations on why it happens, and then I am not so scared. The fear has gone away a bit. Even if I get anxiety now, and get the breathing-stuff, that the body in a way controls, I have discovered that you can control a lot that you don't think you can control. I did not believe that earlier. It was something I wasn't aware of before I started in the group, that there is plenty you think you can control that you cannot. And there is plenty you don't think you can control, that you actually can control. (Lauren)

These examples illustrate how the experienced process of recovery need not be linked to an experience of symptom decrease.

### 3.5.2 *Recovery brings about an increase in symptoms*

For a couple of participants, who had previously felt numb and out of touch with their experiences, an increase in symptoms was experienced as part of the recovery process:

I have more pain in my body now that I did not have before. Never had a problem with that earlier, but I got more of it now. And I feel that I am more scared. I manage to feel, maybe, that I am more scared. [...] I think there has been a change, that makes me more scared, but which in a way also makes life more worth living. Yes. But then I have to be able to feel that I am scared – really, really terrified at times. (Heather)

Despite being painful, this increase in symptoms is somehow giving Heather hope, and creating meaning. The ability to stay with one's experiences is not, however, experienced as one-sidedly positive.

### 3.5.3 *Recovery brings about difficult choices*

A couple of participants discovered that they had to rethink who they were, and their way of being in the world. Naomi realized she does not know who she is, and has to renegotiate her way of being in the world – a demanding and scary process:

There needs to be room for me to feel anger, joy; there should be happiness. I have not felt those things before; it has been automatic. So I knew how to be a machine that could handle anything. [...] But I know who that person was, and is. But I don't know who I am, because I am not that person anymore. And I don't want to be that person anymore. So I need to get to know *me* now. [...] I am not the illusion that I have lived by all these years. I am a human being. Now I have to feel when I have pain, when I have a fever, when I have a headache, when I want to do things, when I am hungry. Not eat because others are hungry, you see? All these things.

Morgan was faced with the realities of her current relationship to her husband, and how this affected her:

You become more aware of everything you say and do, and how those around you treat you. And that is the reason why I am hurting now. I finally have been able to understand something that has been very difficult with my husband. After all those episodes with my husband, I have managed to forget the whole thing. I have been a bit sad, but not very, more apathetic. When I haven't felt my limits, I have let others run over me. I have almost invited: 'Welcome! Run over me!' [...] Now, when I have become calmer and feel better, I have eventually managed to do something about the problem, what I have understood is a problem. I have thought a little about it earlier, but I have not been able to do something about it. Only now have I managed to set the limit, and say, 'Enough!'

As these women's words illustrate, the process of recovery is no "walk in the park." It is hard work, where they experience facing new and scary experiences, difficult feelings and choices, in addition to feelings of strength, agency, and a new sense of understanding. However, it represents a journey where the women have found something toward which to navigate, which gives their hard work meaning, and makes it worthwhile.

#### 4. Discussion

Although presented as separate themes above, experientially these themes were interrelated, and may best be described as a positive loop, as illustrated in Figure 1. The point of entry into this loop was of less importance for these participants. While some, such as Morgan, entered the loop of recovery through getting information and learning about their own situations and symptoms, others, such as Carrie, entered the loop through new actions that increased their contact with their emotions and bodies. This in turn helped them understand things differently. Others, such as Isabelle, entered the loop through discovering that there was something they could do to influence their own situations.

Regardless of how the loop was entered, participants experienced that once a substantial positive change occurred, a process leading to more positive change often was elicited. For example, finding new ways to understand their emotions and actions could facilitate increased contact with these emotions and actions, which in turn made it easier to stay with difficult feelings. Similarly, the increased feelings of agency made it easier to become an advocate for one's own needs, as well as facing and staying with difficult feelings and choices.

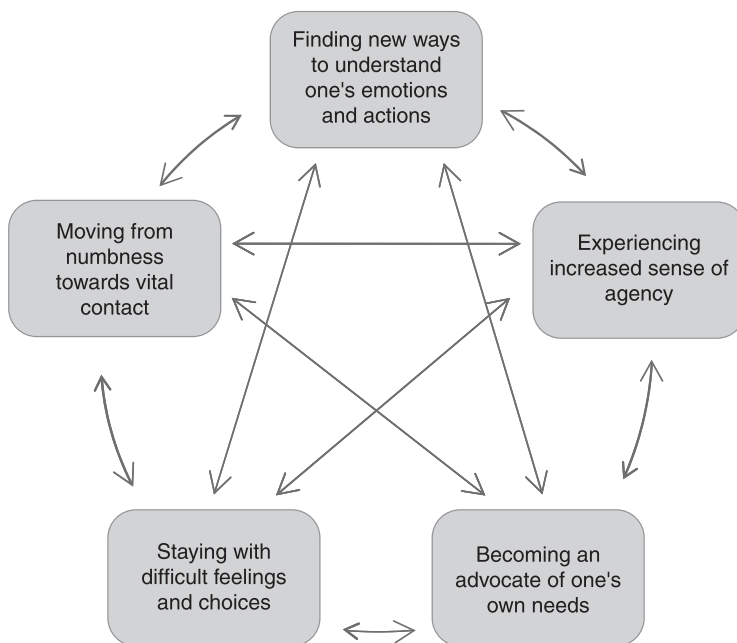


Figure 1: The figure illustrates how the main themes are interrelated. It also illustrates the experiential aspect of recovery as a positive spiral, where the client may enter the loop at any place.

This interrelation between the main themes may have implication for clinical work with survivors of trauma. Our findings thus indicate the active use of different modalities (i.e., cognition, emotion, and action), as well as having different foci (i.e., meaning-making, skill building, and increased robustness in staying with difficult feelings), might be important in therapeutic work with survivors of childhood trauma in order to promote recovery.

Although the themes are interrelated, the facilitation of new meaning-making was particularly crucial in these participants' experiences of ways to positive change. It has been argued that incomprehensibility, disrupted attachment, inescapability, and physiological response represent the core characteristics of traumatic experiences (Saporta & van der Kolk, 1992), while successful meaning-making following exposure to trauma has been associated with posttraumatic growth (Nelson, 2011). From this perspective, the breakdown of meaning-making and lack of control is at the heart of traumatic experiences, and traumatic memories can be characterized by a lack of a coherent narrative, and a fragmentation of cognitive, emotional, and bodily components of the event (van der Hart et al., 2006). The result is often a lack of symbolization of traumatic experiences, where the survivors often are overwhelmed by their re-experiencing symptoms, and feel they do not understand what happens to them.

Without a coherent system of meaning, it becomes close to impossible to take an observational stance toward one's own experiences. In this context, the women's description of finding new ways to understand their emotions and actions bears significance beyond what has been described in the general psychotherapy research literature. As the women found perspectives that helped them give new meaning to their experiences, symptoms, and actions, this allowed them to become more in touch with their bodily sensations, feelings, and symptoms. Previously, all participants had found ways to keep trauma-related content at a tolerable distance, often dissociating from it, so they would not be overwhelmed. The new systems of meaning helped them pause, observe, understand, and approach their internal experiences and daily situations differently without acting on them directly. The participants describe how they could start to explore their symptoms and bodily sensations, thus gaining vital contact with themselves and others. Through feeling their needs better, and becoming an advocate of these needs, they became acquainted with new possible actions. In this way, the recovery process comprised meaning-making, emotional contact, and new actions.

Although better self-understanding has been found in much psychotherapy research (Binder et al., 2010; Elliott & James, 1989), including research on clients with a history of childhood trauma (Parker et al., 2007), its connection to increased emotional contact has not been emphasized. While overcoming phobias of mental content is seen as important in trauma theory in order to integrate traumatic memories (van der Hart et al., 2006), it is not necessarily considered an end in itself. Experientially, in these participants' stories, both the independent value of increased contact with experiences and bodily sensations as well as its importance for meaning-making was evident. The strength of this relationship was something we did not anticipate. Although trauma theory has not explicitly addressed this connection, experiential approaches to therapy have explicitly addressed the interrelation between emotional contact and meaning-making (Greenberg & Pascual-Leone, 2006). Adding this perspective to trauma theory might, therefore, provide one perspective from which we can understand the processes of recovery described by these participants, and the inherent relations between the various elements of the recovery experience. Keeping these complementary perspectives in mind might, therefore, be important when working with survivors of trauma, in order to utilize the

opportunities for new meaning-making provided by increased contact with one's emotions and experiences.

The women in this study experienced the process of recovery as finding their way, finding something to navigate after. However, it was not experienced as an easy process characterized by immediate decrease in distress and symptoms. Rather they used expressions indicating recovery as hard work, facing painful feelings, and having to take a stand on who they wanted to be, thinking through how they were affected by the people around them. The tedious, painful, and hard work of recovery have also been reported in studies of life trajectories among women thriving following child maltreatment (Thomas & Hall, 2008). This has implications for clinicians working with survivors of trauma. The demanding processes of recovery need to be recognized, so survivors can be supported in their efforts. Equally important, the findings illustrate the importance of openly exploring the clients' experiences of increases in symptoms, where the client perspective of this might have great influence on the clinical interventions required.

The presented findings also underline the active role the clients play in their processes of recovery (Asay & Lambert, 1999; Bohart & Tallman, 1999). In the midst of their descriptions of hard work, the participants still expressed a consistent optimism – a belief that their situation will improve, and that they have the power to facilitate that change. This optimism, as we see it, is fueled by having found a framework within which their experiences gain new meaning. Understanding what happened to them, why it happened, and what will help them, opened up an array of new possibilities. New actions and ways of approaching their experiences and daily situations were tested, new resources discovered, hence strengthening the belief in one's own ability to cope, underlining the importance of agency in recovery (Davidson, Strauss, & Rakfeldt, 2010). This allowed the women to approach their own emotions and symptoms rather than avoid them or numb them, which had been a widely used strategy.

The present findings are also interesting when contrasted to the women's own descriptions of what brought them in touch with the health care system. When talking about their help-seeking process, it became clear that a majority of them sought help due to a feeling of loss of control over intrusive symptoms, and exhaustion, with a resulting negative influence on significant others. Given the long delay in help-seeking behavior, one way to understand this finding is to say the loss of control over intrusive symptoms and exhaustion represent the most inhibiting symptoms to these participants. If this was true, one would expect these symptoms to be emphasized when talking about the process of recovery. However, these symptoms are only indirectly present in the described process of recovery. This surprised us, and underlines the importance of studying recovery in a broader sense, not only in terms of reduction or absence of symptoms of mental disorders or distress.

## 5. Study limitations and future directions

The retrospective nature of this study with one-time-point interviews only limits the opportunity to investigate recovery processes directly. Transferability of the present findings may also be deflated by the fact that this study was carried out in a rural setting where all participants were females and had sought treatment. Future studies should then adopt a prospective design with multiple-time interviews in order to trace the recovery process directly. To understand the

extent of transferability of our results, future studies involving both genders as well as non-help seeking participants will be needed.

The multiple roles of the first author (i.e., intervention developer, group therapist, and researcher) also deserve a comment. Such roles may create a better background for understanding the first-person perspective of the participants, and thus be an advantage in interpreting the interview texts. Multiple roles might, however, also make it challenging to obtain the necessary distance to obtain a reflexive stance when interpreting the data material. It was, therefore, important to include the external interviewers as well as the external researchers in the processes of collecting and analyzing the data material. This helped bringing new perspectives into the research process, thus facilitating the processes of reflexivity. Nevertheless, future studies should avoid such multiple roles.

## 6. Conclusion

This article provides new knowledge about the experiential aspects of the recovery process following childhood trauma. The findings support but also supplement trauma theory by underlining the independent importance of increased emotional contact, as well as its relationship to new meaning-making. The findings are also a reminder of the hard work of recovery and the decisive role trauma survivors play in their own processes of recovery. They are the active agents who must discover their ways of entering the loop of recovery, where the elimination of symptoms might not be the best indicator of experienced recovery. Above all, recovery from these women's perspectives was about finding a path through life that allowed for new meaning to be created, from which new experiences and possibilities could be discovered.

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