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A meaningful struggle: Trauma clients' experiences with an inclusive stabilization group approach

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Abstract
The present study explores how trauma clients experience participation in an inclusive stabilization group approach. Upon completion of treatment, all 31 clients from six stabilization groups for women were invited to participate in a qualitative post-therapy interview study. Thirteen clients consented to participate. All interviews were carried out by a team of three health-care workers shortly after completion of treatment. Five main themes were identified: Dreading and Hoping—Preparing for Participation; Tuning in and Staying Put; Meeting Other Trauma Survivors; Acquiring a Stabilizing Ballast; and Being Receptive to Change. Participating in the stabilization group was experienced as demanding, while also providing new and helpful experiences. Participants emphasized the importance of being receptive to help in order to benefit from treatment.

Keywords: stabilization group; trauma-specific treatment; client perspective; qualitative interviews

Group-based treatments are commonly offered to clients with trauma-related symptoms. These treatment approaches often rely on clinical experience and theory, and there is sparse empirical investigation in terms of effects or client experiences (Ford, Fallot, & Harris, 2009). Little is therefore known about clients' experience of participation in trauma-specific group treatment. This is unfortunate given the active role clients have in their healing processes (Bohart & Tallman, 1999). It has also been argued that more inclusive approaches are needed, where clients with a wider range of trauma exposure and symptoms can be included in the same group (Fritch & Lynch, 2008). In this article we explore female clients' experience of participation in a gender-separated stabilization group approach (phase one trauma treatment) tailored to include clients with a wide range of human-inflicted traumas and trauma-related symptoms. "Human-inflicted trauma" is defined as any type of trauma where another person causes the trauma—be it childhood maltreatment, child abuse, rape, assault, domestic violence, robbery, and so on. It is thus a wider concept than "complex trauma" (Courtois & Ford, 2009), where the nature of the trauma has to be relational and long-lasting.

"Trauma" is a much used concept in our society, often given different content. We understand "potentially traumatizing events" as events involving actual or threatened death or serious injury, where "experienced trauma" is characterized by experiences of incomprehension, disrupted attachment, inescapability, and physiological response (Saporta & van der Kolk, 1992). Unfortunately, exposure to potentially traumatizing events is common, with 72% of Americans reporting exposure to some type of trauma and 50% reporting being victim of interpersonal violence (Elliott, 1997). Trauma exposure has consistently been associated with an elevated risk of developing long-lasting problems (Briere & Elliott, 2003; Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006), and efficient treatment approaches focusing on trauma-specific problems are needed.

Group-based trauma treatments are regularly offered to clients in need of trauma-specific treatment. Expert clinical opinion supports this practice, emphasizing the importance of meeting other trauma survivors and the potential such encounters in a therapy setting bear for corrective emotional experiences (Boon, Steele, & van der Hart, 2011; Ford et al., 2009; Yalom & Leszcz, 2005). These treatment groups are offered within a variety of theoretical

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orientations; while some adhere to a phase-oriented approach to trauma treatment, other approaches do not emphasize this.

The group treatment explored in this article is based on a phase-oriented approach to trauma treatment (e.g. Herman, 1992; Steele & van der Hart, 2009). Within this framework, stabilization is considered a necessary first phase. The focus is on understanding and handling trauma-specific symptoms, as well as on safety, restoration of control, empowerment, building skills, and the establishment of new relations (Herman, 1992). Trauma histories are not explored in this initial phase, and the stabilization phase is expected to leave the trauma survivors better equipped to face their trauma histories without getting flooded or detach from them. The stabilization phase is therefore viewed as a necessary foundation for successful integration of traumatic memories, and acquiring skills for efficient regulation of arousal is emphasized (Herman, 1992; Steele & van der Hart, 2009).

Numerous group approaches to stabilization work are available. Treatment is often offered on the basis of exposure characterisics, such as groups for women exposed to child sexual abuse (Chard, 2005; Wolfsdorf & Zlotnick, 2001), or groups of clients with similar symptom presentation such as clients with severe dissociative symptoms (Boon et al., 2011). It has been argued, though, that too strict an adherence to homogeneity of groups for trauma clients may limit therapeutic options (Viola, Ditzler, & Batzer, 1996) and that more inclusive treatment approaches are needed (Fritch & Lynch, 2008). More inclusive approaches, which include clients with a broader range of symptoms and exposure history, could be offered in areas with low population density and they could also result in a shorter treatment delay following referral in urban areas. Thus, inclusive stabilization group approaches have the potential of reaching more clients in need of trauma-specific treatment. Acquiring more knowledge of the potential opportunities and challenges of such approaches is important.

Over the past decades the client perspective has become increasingly recognized as providing unique and valuable knowledge to the field of psychotherapy research (Connolly & Strupp, 1996; Elliott & James, 1989; Rennie, 2000). Supplementing the symptom reduction approach to defining positive therapy-related change, a client perspective has also underlined the importance of changes in self-concept (Connolly & Strupp, 1996) as well as in self-understanding and interpersonal relations (Levitt, Butler, & Hill, 2006). This illustrates the importance of incorporating the client perspective when evaluating clinical practice. We see clients as active participants in therapy, where therapists assist and promote positive change by providing a relational context providing support, information, feedback, and so on, that helps clients mobilize and use their resources for change. The clients' experience of treatment is therefore regarded as important, as it may increase our ability to tailor treatment approaches to increase efficacy, tolerability, acceptance, and compliance.

The client perspective has been incorporated in research on group therapy, and has contributed to the development of the framework of group-therapeutic factors (Yalom & Leszcz, 2005). Within the field of psychological trauma in general, and in the field of inclusive group-based trauma treatment in particular, little research has, however, focused on the client perspective. To the best of our knowledge there is only one relevant study (Parker, Fourt, Langmuir, Dalton, & Classsen, 2007), and this one showed that clients had to get used to treatment, and the research participants underlined the influence of new experiences, beliefs and behaviours in the experience of recovery, as well as the importance of being open to change in order to benefit from treatment. In particular, while more inclusive trauma groups have the potential for reaching more clients in need of trauma-specific treatment, we have been unable to locate any study exploring the client perspective of such approaches. Using a qualitative interview approach, the present study aims to fill this gap of knowledge in the literature by exploring clients' experiences of participating in an inclusive stabilization group approach.

Methods

The study was approved by the Regional Committee for Medical and Health Research Ethics (North Region) and by the Norwegian Social Sciences Agency.

Study Setting

The results presented in this article stem from a larger study investigating how female, adult survivors of childhood trauma, currently in treatment, describe and experience their help-seeking process, the process of recovery, and their participation in trauma-specific treatment. The study was conducted in remote areas of Northern Norway at an outpatient setting of the specialized mental health services that offer stabilization groups tailored to clients with mixed trauma histories and trauma symptoms.

The development and nature of the approach have been described in detail elsewhere (Stige, 2011). In brief, it consists of 17 weekly group sessions which focus on understanding and handling trauma-specific symptoms. The trauma histories are not shared in the group, and participants only know that everyone

in the group has been exposed to some form of human-inflicted trauma, and struggles with some form of trauma-specific symptoms today. The approach is fairly structured, with an alternation between psycho-education, the exchange of experiences between clients, and building skills for the efficient regulation of arousal, including grounding exercises (Boon et al., 2011; Najavits, 2002). By using cognitive techniques, and a focus on breathing, the senses, and the body, clients are helped to regulate arousal. In states where clients are flooded by their experiences (hyperarousal) they are guided to detachment from emotional pain using both cognitive and physical techniques, thus reducing arousal levels. In states where they dissociate from their experiences (hypoarousal) active focus on breathing, the senses and the body helps clients increase arousal levels, thus increasing awareness of the present moment.

Trauma-related topics are introduced by psycho-education, and then linked to client experiences. Building on Herman's (1992) work, safety, restoration of control, empowerment, building skills, and the establishment of new social connections are emphasized in the approach. Allowing clients to be active in shaping the focus and content of each session is regarded as important, and member–member interactions are encouraged. The approach is currently offered in gender-separated groups, and all clients receive concurrent individual treatment.

The inclusion criteria for the stabilization groups are: (a) fulfilment of the official guidelines for access to specialized health services, (b) exposure to human-inflicted traumas in childhood, adulthood, or both (i.e., childhood abuse or neglect, domestic violence, rape, assault, etc.), and (c) active trauma-related symptoms assessed by clinical interviews and self-report measures (i.e., the ICD-10 classification of PTSD, F43.1; WHO, 1993, complex PTSD (Herman, 1992)), or symptoms/disorders of dissociation (ICD-10, F44.x; WHO, 1993). Exclusion criteria are (a) severe and ongoing substance abuse that interferes with the client's ability to meet regularly and on time, (b) a current psychosis or manic episodes, or major depressive disorder that interferes with cognitive functioning, or (c) severe suicidal ideation. Potential clients were referred from their general practitioner, or from their individual therapist. The group therapists assessed potential group candidates, determining which clients were suitable to participate in the stabilization groups.

Recruitment Procedure and Participants

Because all potential participants for the study fulfilled the criteria for receiving specialized mental health services and received treatment in the public health-care system, the regional committee of ethics required that no information about the research project was given until the clients had completed their treatment group. A letter with information about the research project was therefore sent to all clients from six different treatment groups for women (31 in total, including three who had dropped out) within 3 weeks of their completion of the stabilization group. Those who wanted to participate had to actively respond by returning a reply letter. All who responded were included in the study. A total of 13 participants,[1] all of whom had completed the treatment approach, were recruited between August 2008 and March 2011.

The 13 research participants were between 18 and 60 years old (mean age 39 years) and had attended between 60 and 100% of the group meetings. Prior experiences of therapy varied from none to several years. All research 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 on either sick leave, disability benefits, or rehabilitation benefits. Ten participants had children.

Data Collection

In-depth, semi-structured interviews were chosen to obtain access to the first-person perspective of treatment participation. Interviews were audio-recorded, and were carried out within 3 months of participants' completion of the group treatment. All questions were open, aiming at eliciting rich data of the participants' experiences and how they had given meaning to these experiences. Examples of questions asked are: "Can you tell me, in your own words, how you have experienced attending the stabilization group?" (dwelling with this question, following-up questions linked to the information provided by the informant); "Focusing on the treatment approach, what did you hope group participation would give you, prior to starting in the group?"; "If your best friend was to start in a similar stabilization group, what would you tell her/him?". Throughout the interviews, the interviewers used follow-up questions to check their understanding with the participants, to validate the interviewers' interpretation (Kvale, 1996), and to allow the participants to clarify or elaborate their statements.

The first author is a clinical psychologist with a special training and interest in psychological trauma, and she was one of two therapists in five of the six

treatment groups. To avoid the situation arising where research participants were interviewed by their former therapist, interviews were conducted by a team of three. The first author performed interviews with the sixth group, where she had not been a therapist, and all other interviews were performed by two female mental health-care workers with no previous relation to the participants. The procedure adhered to the requirements of the Regional Committee for Medical and Health Research Ethics for securing the principles of free consent and counteracting the possible influence of the power imbalance between therapist and client on the emerging data material.

The first author listened to each interview shortly after completion and provided feedback to the interviewers to ensure that the interviewers were updated on the latest adjustments and developments in the research focus, while also allowing for follow-up interviews with participants to clarify information appearing in interviews not conducted by the first author. A total of 17 interviews were conducted with the 13 participants. One follow-up interview was conducted to clarify information appearing in the original interview, and three other participants were interviewed twice at their own request because they did not have time to complete the interview the first time. All interviews were transcribed verbatim by the first author.

Data Analysis

The analysis was explorative and a hermeneutical-phenomenological approach was chosen to explore the first-person perspective of the emerging stories, while acknowledging the inevitable influence of the act of interpretation in all human activity (Alvesson & Sköldberg, 2000; Laverty, 2003). Throughout the research process a particular emphasis was put on reflexivity (Alvesson & Sköldberg, 2000); this was achieved by including inteviewers and co-authors in the process of analysis, stating the first author's preunderstanding as in the article describing the treatment approach (Stige, 2011), and constantly taking a meta-position to see how the first author's preunderstanding might influence the research process and emerging results. This was considered particularly important given the multiple roles of the first author.

The NVivo 8 software (QSR International, 2008) was used as a technical support for analysing the interview transcripts, allowing easy, updated access to the parts of the interview text that comprise each theme and subtheme. NVivo allows you to mark all text relevant to the research question as you read the interview transcripts, and mark each segment of text with a separate label. Segments of text can then be chunked together, forming hierarchies of themes and sub-themes. The program also provides an overview of how many participants have contributed text to each theme or sub-theme.

The first author carried out the primary analysis of the material, while the co-authors contributed to a critical transformation of this initial organization of data through dialogue. The emerging analysis was also presented to the two mental health-care workers (interviewers). Their responses on how the presented analysis resonated with their first impressions of the data from the interview settings served as the starting point for further discussions and reflections on ways to organize the data.

Even though there was a constant alternation between particular parts of the data material (extracts of individual interviews) and the whole (patterns of meaning across interviews), the general sequence of the analysis can be described as follows:

1. Analysis was initiated by reading and re-reading the transcripts to obtain a good overview of the material, capturing the first impression of important topics in the texts.
2. Each interview was studied in detail and all parts of the text relevant to the experiences of participation were examined and labelled.
3. All parts of the text expressing different aspects of the participants' experiences were marked and named as meaning units.
4. Meaning units across interviews were abstracted and condensed through continuous comparison, staying as close to the informants' use of language as possible.
5. Main themes and sub-themes were abstracted from the meaning units, reflecting what emerged as the most important aspects of the participants' converging and diverging experiences.
6. Following this first organization of the data, the analysis was critically transformed through dialogue between the three authors.
7. Emerging analyses were presented to the two mental health-care workers (interviewers), and their feedback contributed to deepening and focusing the thematic structure.
8. The first author referred back to the overall text to check that all relevant aspects of the participants' experiences had been included in the analytical process.

Results

Protecting the identity of the participants was one of the challenges of this study, given its rural setting,

the participation in a specific treatment approach, and the multiple roles of the first author. Quotes are therefore presented with suboptimal contextualization and participant-specific information to balance the need to situate the study and the researchers and stay close to participant descriptions in the presentation of the results with the need to avoid compromising the anonymity of the participants.

In the presentation of the results, we will apply terms such as "all", "some", and so forth, to give the reader an idea of how many participants shared information on that particular theme or sub-theme. In this article, "all" refers to all 13 participants, "most" indicates 10–12 participants, "many" refers to 6–9 participants, "some" 3–5 participants, and "a few" refers to one or two participants. However, it is important to keep in mind that all participants have not been asked about every aspect of the presented thematic structure, because the interviews were semi-structured, and our use of these concepts does not indicate that we have quantified the data providing percentages of participants reporting on each aspect of each theme or sub-theme.

As stated above, all the clients in the stabilization groups received concurrent individual therapy. The role of the individual therapy was not explored explicitly in this study, which focused on the client experiences of group participation. The frequency of meeting their individual therapist was adjusted to the participants' needs, and varied from twice during the course of the stabilization group to every week. Most participants reported, though, that the combination of individual and group therapy was beneficial. Many clients reported access to additional support from an individual therapist as particularly important.

The first four themes identified in the analysis depict the participants' experiences of the stabilization group: Dreading and Hoping—Preparing for Participation; Tuning In and Staying Put; Meeting Other Trauma Survivors; and Acquiring a Stabilizing Ballast. The last theme, Being Receptive to Change, represents the participants' reflections about why they benefited from the treatment. The interview questions were open. Therefore all participants did not provide information regarding every aspect of every theme and sub-theme, but none of the informants reported experiences that contradicted the thematic structure presented below.

Dreading and Hoping—Preparing for Participation

Deciding whether to participate, and preparing for the stabilization group, was demanding for all participants, and it took time and effort for them to get used to the idea of joining a stabilization group. They were attracted to the group by the hope of improving their life situations and equipping themselves with tools to better manage the symptoms they experienced, yet they also feared the implications of group commitment.

The initial decision to participate did not exclude feelings of uncertainty and ambivalence regarding the first encounter with the group. Living in a city of 20,000 inhabitants there was a chance that group members would meet in settings outside treatment. Because the group in question was a stabilization group for clients exposed to human-inflicted trauma, just being present in the group meant admitting and showing publicly that one had been exposed to trauma and currently experienced trauma-related symptoms. Many participants therefore felt vulnerable and that their façade was crumbling just by showing their face in the group. This made the uncertainty of who the other group members would be and the need to maintain discretion about the identity of the group participants pressing. The uncertainty and ambivalence was, for obvious reasons, exacerbated and prolonged for participants with social anxiety, and therapist support was needed to make these individuals face the group, particularly at the first group session. Mary said:

> Initially, I dreaded the group, because I know I am not a verbal person, really. (. . .) Maybe because I am so anxious and a bit scared of talking; it takes some time for me to formulate everything the way I want, so I don't see it as my strength. So I dreaded beginning to speak in front of a group.

Because the decision to participate felt so challenging, many participants did not remember the information given to them by the group therapists in the assessment sessions. This left them uncertain about what to expect from the treatment. Most participants therefore expressed their view that the first group meeting was the most challenging part of participation in the group, and this was particularly so for those with co-morbid social anxiety.

Tuning In and Staying Put

Once the initial barrier of actually turning up for the first group session was overcome, participants described how the continuation of treatment was experienced as demanding, and required continued efforts. For some, getting acquainted with the structure of therapy required much energy. For others, the processes that the therapy started within them were experienced as the most challenging part of the group therapy. Isabelle's words illustrate this:

I experienced it as quite demanding in the beginning. But I got the impression that all of us felt that way. (...) It was really difficult, but at the same time I wanted to do it. (...) The most difficult part was to be confronted with yourself, or what you were thinking and how you were doing—yes, with the things that happened during the treatment within yourself.

For most participants getting acquainted with the treatment structure (i.e., not talking about their trauma histories, talking in front of the other group participants, participating in the grounding exercises, relating to different needs and the tempo of the other group members) was an important part of the initial stages of the treatment. Some of the more negative and demanding experiences in therapy were related to this process of getting acquainted with the therapy structure and adjusting to the group setting, where it was not only the participants' own needs that influenced the structure and pace of therapy.

The elements of the treatment that the participants found most challenging also varied between participants. For example, most participants viewed the non-sharing of trauma histories in the group as a positive attribute of the treatment—an attribute which made the decision to join the group easier. During treatment these participants felt the non-sharing of trauma histories helped them focus on their current symptoms. They expressed being relieved they did not have to listen to and relate to the other clients' trauma histories. However, for a few participants this was a challenging idea, because they initially found it difficult to see how they could participate actively in the group without telling their trauma histories. Over time these participants found ways to participate without sharing their histories, and found that this constraint also became a help in staying present in the here-and-now as it provided opportunities for focusing on what they could do in their present situation.

Another example of a treatment element that was initially challenging for some participants was the practising of grounding exercises for the efficient regulation of arousal. These participants talked about how they initially felt stupid using their bodies to do strange and unfamiliar exercises in front of others. Over time most of these participants felt, though, that the exercises helped them loosen up and provided opportunities for symptom relief. For a few with co-morbid social anxiety, this remained the most challenging part of group participation.

All participants reported that participation in the stabilization group required continuous effort, and was demanding. This was true even when the participants experienced many positive changes. Lauren explained: "When so much change happens, so much in your life that is very personal, it is demanding! It takes so much energy! You can get exhausted, even if it is a positive exhaustion." These participants' experiences shed light on how starting and remaining in group therapy requires continuous effort, and how different participants experienced different aspects of treatment as particularly challenging.

Meeting Other Trauma Survivors

Meeting others who had been exposed to trauma represented a key experience of participation in the treatment, and this main theme had two related, but distinct sub-themes: *I am not alone* and *Exchanging experiences*. Because the trauma histories in the group were not shared, the participants did not know what traumas the other clients had experienced. Still, meeting others who had endured some form of trauma and who currently experienced trauma-related problems was important to all the participants. Rationally, they had each realized that they would not be the only one who had experienced trauma. However, prior to participation many of them felt that their reactions were unusual or abnormal, or that they were weak because they had not managed to put these experiences behind them.

I am not alone. An important benefit of participating in the group was a better understanding of their own symptoms through listening to the others' experiences. Amanda's words illustrate this:

You sat there, looking at the others telling how they were feeling. They can be people that you think are doing great—it looks like that on the outside—but who are struggling. (...) And you have realized: "My God! I am not alone!" Others too carry burdens and struggle. It is not just me.

Meeting the other group members thus contributed to a normalization of their own experiences, and an experience of not being the only one struggling with trauma-related problems.

Exchanging experiences. The opportunity to share their experiences with the other group members, and listen to the experiences of others, contributed to the feeling of not being alone. It also helped them relate more closely to each other and discover things about themselves, and provided new ideas for problem solving. Sitting there listening to how others handled their flash-backs, gave them ideas on how to handle their own flash-backs, and gave them hope that it was possible to influence their symptoms.

For some participants, hearing others respond to the experiences they shared helped them feel that their experiences were worthwhile and that they

could be of help to others. In turn, this seemed to diminish social anxiety. For others, listening to the others provided a help in sorting things out. They achieved a distance from their own experiences that helped them see themselves and their experiences more clearly. This led them to an understanding of what they could do something about, and what they had to learn to live with. The exchange of experiences also provided a feeling of having a choice about how to lead one's life. Brenda expressed this the following way:

> It became clear to me that people choose to live their lives differently. We had experienced different things, but also, people handle things differently and have different strengths. And that made it easier for me to think that I am free to choose my way.

Exchanging experiences with the other group members was reported as being particularly significant by these participants. It resulted in a normalization of their experiences, a feeling of being competent, and the validation of their own experiences.

Acquiring a Stabilizing Ballast

All participants expressed the view that attending the stabilization group had provided them with something of importance, despite the effort required by participation. This related largely to the experience of gaining competence that enabled them to stand more steadily in their own lives—a stabilizing ballast specific to each participant.

Many experienced that the psycho-education and metaphors used in the group helped them understand more of themselves and their situations. The new knowledge normalized the symptoms they experienced, enabling them to understand the reasons for their symptoms. This helped many to shift from negative personal attribution of flaws and failures to taking account of their traumatic experiences and the context in their attribution of their problems, thus reducing their feelings of guilt. It also helped them discover how they could influence their symptoms and their life situations, leading to a feeling of no longer being at the mercy of their symptoms.

For other participants, obtaining new tools through building skills was decisive in enabling them to address their symptoms more constructively. They felt they had ways to influence their situation if intense emotions intruded on them, or if they felt that their bodies went into a protective mode. The tools thus improved their sense of personal control, as Lauren said:

> It has been informative to learn about the body. That you actually have the tools in your body to recover! They are there! You just have to use them. (...) It is only I who have and can use the tools I possess. Nobody can go into my body and heal me, but I must be able to. (...) If I get some help, I might manage to use those tools and keep focused on it. I can manage to heal myself.

For most participants the group came to represent a safe context, where they could recharge their batteries, show how they were feeling, and seek support. These experiences allowed many participants to open up and get closer to, and become more at ease with, their own experiences and feelings. For some, the group was the first place where they had dared to open up and show how they were feeling.

For many participants the stabilization group also became a help in keeping focused on the fact and the feeling of being able to influence their own life situations. For some participants, the inter-session homework assignments helped them to keep this focus and to relate more closely to themselves and their everyday situations. Naomi narrated:

> I think it has to do with the homework, where we had to reflect on different topics, and what we could do regarding ourselves. Because, we were going to try to praise ourselves, things like that. So it started there. When you get yourself as homework you have to engage yourself in yourself.

Some participants described how participating in the group helped them stay focused on their trauma-related issues, instead of just pushing them away. Brenda said:

> I am a champion at pushing things away! In the group you are reminded all the time, so you have to relate to things. You cannot think that you only don't sleep well, or things like that. Maybe it's because you start sorting things out, seeing what is what. And then you have to relate to things.

In sum these experiences of gaining knowledge and tools, approaching new feelings, and keeping focused on their problems were considered to lead to an increase in competence and empowerment in terms of feeling more robust about facing the everyday situations, symptoms, and future challenges.

Being Receptive to Change

The participants expressed the view that the stabilization group had provided them with opportunities for positive experiences that had led them in the right

direction. Reflecting upon what made this possible, many of the participants considered that not everyone would be able to benefit from the group at any given time. They underlined the active role they had to take in order to benefit from treatment in terms of being open to change, giving things a go, and being ready to work with oneself with a sense of patience and with respect as to when the many small changes they made would show their influence on their life situations. In Lauren's words:

> When you change a tiny thing, eventually, without you noticing, you have changed many little things that make a huge difference! You don't think the little things matter, but they are vital, the little things! (. . .) So, really, it is about giving it time. You have to give it time!

Many participants also underlined the importance of good timing between the individual process of being able to relate to oneself, and the problems one experienced, and the treatment provided. Naomi expressed this the following way:

> Now I was receptive! I had identified myself with having problems. I had understood that it is not the German measles. It doesn't help to eat painkillers. I was receptive to getting help. Earlier, when I lived like a machine, I wasn't receptive at all. That is the difference.

Group benefits aside, most of the participants stated that the benefits would have not been realized at an earlier time in their lives, when they had been less receptive to change due to an unstable life situation, difficult interpersonal relations, or a poor identification with the role of having a trauma-related history.

Discussion

The present results are in accordance with general knowledge about the vulnerability, ambivalence, and decision-making processes which are characteristic of the initial phases of group therapy (Yalom & Leszcz, 2005). Interestingly, vulnerability and ambivalence did not result in the high drop-out rate that often represents a major challenge in stabilization groups (Boon et al., 2011; Najavits, 2002).

Vulnerability and ambivalence are indicated by the first two main themes (Dreading and Hoping—Preparing for Participation and Tuning In and Staying Put). Our results concur with other results related to participation in trauma groups (Parker et al., 2007), but extend this previous knowledge by pointing to some additional demands relating to

participation in a stabilization group. These themes thus shed light on the tremendous efforts clients put in when participating in inclusive stabilization groups, even when they are completers of the group and perceive group participation to be beneficial. We did not fully anticipate the extent of effort participants described putting in throughout the course of the group therapy, and the centrality of these experiences. We believe this result has important clinical implications.

Although the trauma histories were not shared in the group, the participants were reminded of specific, painful life experiences that many had evaded for years. Moreover, choosing to attend a stabilization group signals to others the experience of particular trauma-specific symptoms that influence one's life. An important clinical implication is that therapists need to focus on the pre-treatment motivation and preparation of their clients, and particularly so for clients experiencing co-morbid social phobia. In doing so, therapists are well advised to take into consideration and explore their clients' feelings of being vulnerable, and thus hesitant about either directly or indirectly revealing sensitive personal information, and how this influences clients' readiness to enter different types of treatment (e.g., individual versus group treatment, or general group therapy versus trauma-specific group treatment). These implications may be universally valid, yet they may be particularly important in a small-town setting where there is the possibility of encountering fellow group members in non-therapeutic settings. The results thus point to the importance of stressing within-group confidentiality when preparing clients for, and running, stabilization groups. Providing written information about the treatment as well as written guidelines addressing concerns about confidentiality might prove vital to prepare clients for stabilization group participation.

Our results can also be seen in relation to more general group therapy theory (Yalom & Leszcz, 2005). Group therapists typically pay close attention to the processes of preparing clients for group therapy and the demands of the initial phases of such treatment. Our results support this practice, and suggest an extended focus on these issues in inclusive stabilization groups. Getting one's feelings recognized by others is important to all humans, but may be particularly important for survivors of trauma, who often have experienced that their feelings have been neglected and that it was unsafe to reveal their feelings (Courtois & Ford, 2009). Thus, it might be particularly important to focus explicitly and continuously on how clients experience participating in inclusive stabilization groups,

and explore how to reduce the burden of participation.

We argue that our results also relate to more general psychotherapy research, and remind us of how both therapists and clients influence the development and outcome of therapy. Our results then underline the general findings that clients do play an active role in making therapy work (Bohart & Tallman, 1999; Duncan, Miller, & Sparks, 2004; Rennie, 2000). Our findings further show that clients explicitly recognize this active role, as illustrated by the theme Being Receptive to Change. While the group therapists can select clients who are ready to participate in group therapy, and who can work well together as a group (Yalom & Leszcz, 2005), this will not suffice for a successful outcome. In fact, our participants underline the importance of timing, clients giving therapy a chance, and working hard in order to benefit from the stabilization group. Through their willingness to give the group treatment a chance, and their determination to continue treatment even in the face of hardship, the participants described how they felt that they gained something of importance to them, and they described experiences of feeling more robust and better prepared to face whatever life throws their way.

Our results also have implications for the organization of trauma-specific treatment. Traditionally, treatment groups for trauma clients have often been offered based on homogeneity regarding trauma exposure (e.g., all group members have been exposed to child sexual abuse), or type of trauma-specific symptoms clients experience today (e.g., groups for clients with dissociative identity disorder). This practice may have made group-based treatment unavailable for numerous clients in need of trauma-specific treatment. The need for more inclusive approaches has been recognized (Fritch & Lynch, 2008), and it has been argued that allocating clients with heterogeneous trauma experiences to the same group might expand therapeutic options (Viola et al., 1996).

The opportunity to participate in group-based treatment may be particularly important and beneficial for clients dealing with stigma and social isolation, and who seek new coping skills (Yalom & Leszcz, 2005), such as clients with trauma-related problems. The importance of meeting other trauma survivors was also underlined by the participants in the present study, and might bear significance beyond the general benefits of group therapeutic factors like universality and interpersonal learning (Yalom & Leszcz, 2005). It has been argued that incomprehensibility, disrupted attachment, inescapability, and physiological responses represent the core characteristics of traumatic experiences (Saporta & van der Kolk, 1992). In this context, meeting other trauma survivors, experiencing that they are not alone, and developing new ways of handling their problems might represent new emotional experiences that help participants recover from their trauma-related difficulties. Participants reported that group participation helped them understand what happens to them, and that they learned how to deal more effectively with their symptoms. These experiences potentially counteract the experiences of incomprehension and inescapability imposed by the traumatic experience, and later sustained by the post-traumatic symptoms. Do our results then indicate that trauma treatment can always be offered in heterogeneous, inclusive groups?

We argue that the organization and structure of the treatment in question are important to understand our results. In this study the participants took part in an inclusive stabilization group approach with no focus on trauma histories. We believe that this was important in facilitating participation providing new and helpful experiences, despite the range of traumatic experiences and trauma-specific symptoms different clients were experiencing. The treatment had an explicit focus on the current trauma-related problems the clients were experiencing, rather than on their trauma histories. This allowed a common focus. By introducing psycho-education linked to the clients' own experiences, the range of different trauma-specific symptoms could be addressed, compared, and differentiated. As the participants' examples show, they recognized themselves in the psycho-education and information shared by the other clients, while also learning how they were unique, and how they had to go about things.

Our results therefore indicate that focusing on stabilization in a strict sense, with no focus on trauma histories, might be particularly important when offering more inclusive trauma groups. Our results cannot, however, shed light on how more inclusive treatment groups would work in the integration phase of trauma treatment, where the trauma history is dealt with in detail. Listening to these participants' experiences, it seemed that the opportunity for member–member interactions in the groups was particularly important in facilitating new and helpful experiences. Arguably, between–member interactions and the exchange of experiences may be generally beneficial and should be facilitated, especially in more inclusive approaches.

Limitations and Possible Directions for Future Research

A high external validity may be reached by the fact that the positive therapy experiences were found

using an ordinary treatment approach offered in the public health-care system. On the other hand the transferability of the results is limited by a relatively small sample size as well as the lack of information about reasons why some signed up for the study while others chose not to do so. Moreover, using a qualitative approach evaded the issue of effect. Future research may benefit from combining and comparing subject experiences and key effect measures, and exploring how and when concurrent individual therapy is beneficial for clients participating in inclusive stabilization groups.

Some concerns can also be raised with respect to the recruitment procedure. The study setting implied special attention to the issue of informed consent to avoid clients feeling a pressure to participate in research, or being resistant to treatment because they do not want to take part in research. In this perspective, the chosen recruitment procedure was important, as it leaves minimal impact on the treatment delivered. Information about the research project was only provided by letter, and after completion of treatment. The procedure requires quite high levels of functioning, though, while clients in the treatment groups vary greatly in their levels of functioning. We fear that the recruitment procedure might have excluded clients who wanted to participate, but whose level of functioning was exceeded by the demands of the recruitment procedure. This potentially leaves us prone to both low response rate and a selection bias that could have resulted in under-communication of negative, or at least more mixed, group participation experiences. Future studies should thus aim to explore study settings where the demands of the recruitment procedure could be lowered, to include clients with a greater variation in levels of functioning.

Conclusion

The results underline the importance of meeting other trauma survivors in a group setting that facilitates a sharing of trauma-related experiences and results in being more prepared to encounter difficult feelings and daily life situations. The results also underline the active role trauma-inflicted clients have in their treatment in terms of psychological investment, responsibility and effort. Group participation was therefore experienced as a meaningful struggle, and the overall positive benefits were not diminished by the heterogeneous nature of trauma and client characteristics. The results thus indicate the scope for more inclusive stabilization group approaches, and the opportunities to reach more trauma survivors in need of trauma-specific treatment.

Note

[1] The recruitment of participants from each of the six treatment groups: Three participants from group 1, one from group 2, two from group 3, three from group 4, one from group 5, and three participants from group 6.

References

Alvesson, M., & Sköldberg, K. (2000). *Reflexive methodology: New vistas for qualitative research*. London: Sage.

Bohart, A.C., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington DC: American Psychological Association.

Boon, S., Steele, K., & van der Hart, O. (2011). *Coping with trauma-related dissociation: Skills training for patients and therapists*. New York: W.W. Norton & Company.

Briere, J., & Elliott, D.M. (2003). Prevalence and symptomatic sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse and Neglect*, 27, 1205–1222. doi: 10.1016/j.chiabu.2003.09.008.

Chard, K.M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology*, 73, 965–971. doi: 10.1037/0022-006X.73.5.965.

Connolly, M., & Strupp, H. (1996). Cluster analysis of patient reported psychotherapy outcomes. *Psychotherapy Research*, 6(1), 30–42. doi: 10.1080/10503309612331331558.

Courtois, C.A., & Ford, J.D. (Eds.). (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. London: The Guilford Press.

Duncan, B.L., Miller, S.D., & Sparks, J.A. (2004). *The heroic client. A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy* (Rev. ed.). San Fransisco, CA: Jossey-Bass.

Elliott, D.M. (1997). Traumatic events: Prevalence and delayed recall in the general population. *Journal of Consulting and Clinical Psychology*, 65, 811–820. doi: 10.1037/0022-006x.65.5.811.

Elliott, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review*, 9, 443–467. doi: 10.1016/0272-7358(89)90003-2.

Foote, B., Smolin, Y., Kaplan, M., Legatt, M.E., & Lipschitz, D. (2006). Prevalence of dissociative disorders in psychiatric outpatients. *American Journal of Psychiatry*, 163, 623–629. Retrieved from http://ajp.psychiatryonline.org/article.aspx?volume=163&page=623.

Ford, J.D., Fallot, R.D., & Harris, M. (2009). Group therapy. In C.A. Courtois & J.D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide*. London: The Guilford Press.

Fritch, A.M., & Lynch, S.M. (2008). Group treatment for adult survivors of interpersonal trauma. *Journal of Psychological Trauma*, 7(3), 145–169. doi: 10.1080/19322880802266797.

Herman, J.L. (1992). *Trauma and recovery: The aftermath of violence – From domestic abuse to political terror*. New York: Basic Books.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage.

Laverty, S.M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, *2*(3), 21–35. Retrieved from http://www.ualberta.ca/~iiqm/backissues/2_3final/pdf/laverty.pdf.

Levitt, H., Butler, M., & Hill, T. (2006). What clients find helpful in psychotherapy: Developing principles for facilitating moment-to-moment change. *Journal of Counselling Psychology*, *53*(3), 314–324. doi: 10.1037/0022-0167.53.3.314.

Najavits, L.M. (2002). *Seeking safety. A treatment manual for PTSD and substance abuse*. New York: The Guilford Press.

Parker, A., Fourt, A., Langmuir, J.I., Dalton, E.J., & Classsen, C.C. (2007). The experience of trauma recovery: A qualitative study of participants in the Women Recovering from Abuse Program (WRAP). *Journal of Child Sexual Abuse*, *16*(2), 55–77. doi: 10.1300/J070v16n02_04.

QSR International. (2008). NVivo 8. Victoria, Australia: QSR International.

Rennie, D. (2000). Aspects of the client's conscious control of the psychotherapeutic process. *Journal of Psychotherapy Integration*, *10*(2), 151–167. doi: 10.1023/A:1009496116174.

Saporta, J.A., & van der Kolk, B.A. (1992). Psychobiological consequences of severe trauma. In M. Başoğlu (Ed.), *Torture and its consequences: Current treatment approaches* (pp. 151–181). Cambridge: Cambridge University Press.

Steele, K., & van der Hart, O. (2009). Treating dissociation. In C.A. Courtois & J.D. Ford (Eds.), *Treating complex traumatic stress disorders. An evidence-based guide* (pp. 145–165). London: The Guilford Press.

Stige, S.H. (2011). A stabilization group approach for heterogeneous populations of trauma clients. *Journal of Aggression, Maltreatment & Trauma*, *20*(8), 886–903. doi: 10.1080/10926771.2011.627583.

Viola, J.M., Ditzler, T.F., & Batzer, W.B. (1996). Post-traumatic stress disorder: A comment on the value of "mixed trauma" treatment groups. *Australasian Psychiatry*, *4*, 258–259. doi: 10.3109/10398569609080498.

WHO. (1993). *The ICD-10 classification of mental and behavioural disorders*. Geneva: World Health Organization.

Wolfsdorf, B.A., & Zlotnick, C. (2001). Affect management in group therapy for women with posttraumatic stress disorder and histories of childhood sexual abuse. *Journal of Clinical Psychology*, *57*, 169–181. doi: 10.1002/1097-4679(200102)57:2<169::AID-JCLP4>3.0.CO;2-0.

Yalom, I.D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.