UNIVERSITY OF TROMSØ UIT

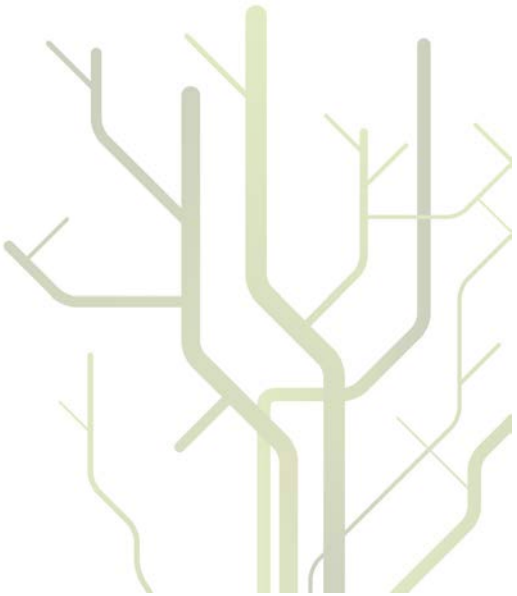
FACUTLY OF HEALTH SCIENCES
DEPARTMENT OF PSYCHOLOGY

Stabilization groups for heterogeneous samples of trauma clients.

Presentation of a new treatment approach, and a hermeneutical-phenomenological analysis of help seeking, treatment participation, and ways to positive change.

Signe Hjelen Stige

A dissertation for the degree of
Philosophiae Doctor
May 2013



UNIVERSITY OF TROMSØ UIT

FACUTLY OF HEALTH SCIENCES
DEPARTMENT OF PSYCHOLOGY

Stabilization groups for heterogeneous samples of trauma clients.

Presentation of a new treatment approach, and a hermeneutical-phenomenological analysis of help seeking, treatment participation, and ways to positive change.

Signe Hjelen Stige

A dissertation for the degree of
Philosophiae Doctor
May 2013

Reisa

Vi dukka endeleg fram att
av natt-skodda.
Ingen kjende einannen no.
Sansen var mist på ferda.
Ingen spurde heller krevjande:
Kven er du?

Svara kunne vi ikkje,
vi hadde mist
namna våre.

Langt borte dundra det
frå eit ubendig hjarte
som stadig var i arbeid.
Vi lydde utan å skjønne.
Vi var komne
lenger enn langt.

– Tarjei Vesaas –
Liv ved straumen, 1970

Det er den draumen

Det er den draumen me ber på
at noko vedunderleg skal skje,
at det må skje –
at tidi skal opna seg,
at dører skal opna seg,
at berget skal opna seg,
at kjeldor skal springa –
at draumen skal opna seg,
at me ei morgonstund skal glida inn
på ein våg me ikkje har visst um.

– Olav H. Hauge –
Dropar i austavind, 1966

Scientific environment

This PhD project was completed as a joint venture between Northern Norway Regional Health Authority, Finnmark Hospital Trust (Division of Psychiatry) and the Department of Psychology, Faculty of Health Sciences, University of Tromsø, Norway.

Table of contents

Acknowledgements vi
English summary viii
Norsk samandrag ix
List of papers x
Abbreviations xi
1. Organizational context of the thesis 1
2. Theoretical and empirical context of the thesis 5
2.1 Concept of 'trauma' 5
2.2 Situating the thesis in the field of psychological trauma 7
2.2.1 Phase-oriented trauma treatments 7
2.2.2 Sensorimotor psychotherapy 9
2.2.3 Theory of shattered assumptions 10
2.3 Empirical studies on the prevalence of exposure to PTEs 11
2.4 Empirical studies on the sequelae of exposure to human-inflicted PTEs 13
2.5 Empirical studies of help seeking following exposure to trauma 15
2.6 Empirical studies on the effectiveness and efficacy of trauma-specific treatment 17
2.6.1 Group-based trauma treatment 18
2.7 First-person perspective of trauma recovery 20
3. Aims of the thesis 23
4. Method 25
4.1 Methodological approach 25
4.2 Data collection 27
4.3 Recruitment 29
4.4 Participants 29
4.5 Data material 30
4.6 Data analysis 30
5. Summary of papers 35
5.1 Paper I: A stabilization group approach for heterogeneous populations of trauma clients (Stige, 2011) 35
5.2 Paper II: The process leading to help seeking following childhood trauma (Stige, Træen, & Rosenvinge, in press) 36

5.3 Paper III: A meaningful struggle: Trauma clients' experiences with an inclusive stabilization group approach (Stige, Rosenvinge, & Træen, 2013) 37
5.4 Paper IV: Stories from the road of recovery– How adult, female survivors of childhood trauma experience ways to positive change (Stige, Binder, Rosenvinge, & Træen, 2013)39
6. Overall discussion of findings 41
6.1 A précis of the findings 42
6.2 Processes of meaning-making in the aftermath of childhood trauma 44
6.3 Sense of agency in the aftermath of childhood trauma 48
6.4 Reflections on the trustworthiness of the study 53
6.4.1 Engagement and processes of reflexivity 54
6.4.2 Balancing the need to protect participant identity with the need to situate and contextualize the findings 55
6.4.3 Conducting research in a setting of standard treatment 57
6.5 Reflections on the transferability of the findings 58
6.6 Limitations 60
6.7 Implications for future research 61
6.8 Implications for clinical practice 62
6.8.1 Recognizing the client's continued efforts during treatment and recovery 62
6.8.2 Benefits of a multimodal focus in trauma treatment 62
6.8.3 The multiple meanings of self-management, help seeking, and symptom load .63
6.8.4 Opportunities for facilitating participation in trauma-specific treatment 63
6.8.5 Possible implications for the provision of trauma treatment 64
7. Conclusion 67
8. References 69

Acknowledgements

First of all, I want to thank all of the research participants for sharing their experiences with us, and the two external interviewers, Kristin Jakoba Dahn and Ragnhild Dalvik. Without your combined efforts the research project would not have been realized in its current form.

To my supervisors, Jan H. Rosenvinge and Bente Træen: Thank you for believing in this project; for trusting my ideas, judgement, and ability to complete processes; and for giving me the opportunity to explore and develop my ideas and my skills as a researcher.

To my faithful co-therapist, Kjersti Utstøl: Thank you for being so open-minded and supportive, and for continuing to run the stabilization groups together with Vibeke Mathisen-Grøtte when I dedicated more time to research and other clinical tasks.

I also want to thank Northern Norway Regional Health Authority for funding my PhD scholarship, Finnmark Hospital Trust for funding travel costs and costs of Open Access for all four articles, and Nord-Norsk Psykiatrisk Forskningssenter (NNPF) and Elene Fleischer for their support in the initial stages of developing my research ideas.

Tush Grafisk: Thank you for constructive and helpful inputs on the design of the model of help seeking.

Several other people have been important in this process. I particularly want to thank Per-Einar Binder for his valuable contribution to paper IV (recovery), and all the wonderful people in the HEL-8008 course, UiT, and the Group for Qualitative Research on Mental Health, UiB, for their valuable input, discussions and friendships.

To my colleagues, family, and friends: Thank you for encouragement, help and support!

Finally, my loved ones: Olav Inge, Maria and Johannes: I could not have done this without your support and inspiration! Thank you!

English summary

Trauma-specific treatment groups have traditionally been offered based on the type of trauma exposure. This has left such treatment unavailable to trauma clients in areas where homogenous trauma groups cannot be offered, such as rural areas. In this thesis a new treatment approach is presented, an inclusive stabilization group, which can be applied in a broader range of settings.

Qualitative, semi-structured interviews with 13 clients in the inclusive stabilization groups have been used to explore the first-person perspective of help seeking, treatment participation, and ways to positive change (i.e. recovery). A hermeneutical-phenomenological approach was used for the data collection and analysis. The analysis revealed that help seeking was initiated after a prolonged period of time, where participants had relied heavily on a strategy of managing on their own. A model of how this delay in help seeking could come about is presented. Participation in the inclusive stabilization group was experienced as a meaningful struggle that required continuous efforts but also rewarded participants with new and important experiences, such as meeting other trauma survivors. The analysis of the participants' experiences of ways to positive change underlined the significance of opportunities for new meaning-making, increased emotional contact and a strengthened sense of agency, along with multiple entries to the road of recovery.

Taken together, the findings illustrate the dual roles, and differential influences, of meaning-making processes and a sense of agency in the aftermath of childhood trauma, as they functioned both as catalysts for help seeking and important promoters of recovery in this sample. The finding further showed a potential for the inclusive stabilization group approach as a way to reach more trauma clients in need of treatment, underlining the importance of continued empirical exploration and testing of such approaches. Several clinical implications of the findings are the importance of recognizing the active role clients play in trauma treatment and recovery and the multiple meanings of self-management, help seeking and symptom load.

Norsk samandrag

Forsking har vist at det å oppleve eit psykologiske traume er relativt vanleg, og at mange slit med traumerelaterte plager mange år etter slike opplevingar. Medan traumebehandling viser lovande resultat, har den tradisjonelle måten å organisere slik behandling på gjort traumebehandling i gruppe utilgjengeleg for traumeklientar utanfor dei store byane. Ei ny behandlingstilnærming, som gjer det mogleg å inkluderer klientar med ulike traumeerfaringar i same gruppe, blir presentert i denne avhandlinga.

13 klientar frå den nye behandlingstilnærminga vart intervjua med kvalitative djupneintervju for å utforske klientane sine opplevingar av a) prosessen som førte til at dei søkte hjelp, b) den nye behandlingstilnærminga, og c) betringsprosessar. Ei fortolkande og opplevingsnær forskingstilnærming vart brukt i intervju og analyseprosess.

Det finns svært lite systematisert kunnskap om traumeklientar sine opplevingar av det å søke hjelp, traumebehandling og betring. Avhandlinga bidreg difor med ny kunnskap om klientperspektivet på desse prosessane. Funna nyanserer fokuset på ønsket om å klare seg sjølv som einaste ei barriere for det å søke hjelp, og viser korleis det å søke hjelp i seg sjølv kan representere ei stor endring for traumeklientar. Deltaking i den nye behandlingstilnærminga vart opplevd som krevjande men givande. Den aktive rolla klientar har, både i betringsprosessen og i behandling, vart understreka av funna, og viser betydinga av å respektere klientane sine individuelle prosessar knytt til hjelpsøking og betring når ein planlegg og tilbyr behandling. Funna illustrerer også dei mange måtane endring kan bli initiert på og samspelet mellom ulike betringsfremmande element, dermed betydninga av å ha ei brei tilnærming til tilfrisking etter traume. Prosessar knytt til meiningsdanning og kjensle av å vere agent i eige liv vart viktig for å forstå funna knytt til hjelpsøking, samt den opplevde vegen frå sjølvberging til tilfrisking. Medan funna samla sett viser eit potensial for meir samansette traumegrupper treng ein meir forsking før ein kan konkludere.

List of papers

I 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

II Stige, S. H., Træen, B., & Rosenvinge, J. H. (2013). The process leading to help seeking following childhood trauma. *Qualitative Health Research, in press.*

III Stige, S. H., Rosenvinge, J. H., Træen, B. (2013). A meaningful struggle: Trauma clients' experiences with an inclusive stabilization group approach. *Psychotherapy Research,* doi: 10.1080/10503307.2013.778437

IV Stige, S. H., Binder, P. E., Rosenvinge, J. H., & Træen, B. (2013). Stories from the road of recovery – How adult, female survivors of childhood trauma experience ways to positive change. *Nordic Psychology,* doi: 10.1080/19012276.2013.796083

Abbreviations

Abbreviations frequently in use:

CSA	Child sexual abuse
DPS	Norwegian abbreviation for District Psychiatric Centre
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
ICD-10	International Classification of Disease-10
IPV	Intimate partner violence
NIPHTP	Norwegian Institute of Public Health Twin Panel
PTE	Potentially traumatic event
PTSD	Posttraumatic stress disorder
REK Nord	Norwegian abbreviation for the Regional Committee for Medical and Health Research Ethics, North Region
SOC	Sense of coherence

1. Organizational context of the thesis

In this thesis a new approach to trauma-specific group treatment, an inclusive stabilization group approach (Stige, 2011), is presented, along with a hermeneutical-phenomenological exploration of the client perspective of (a) experiences leading to help seeking; (b) treatment participation; (c) ways to positive change (i.e. recovery process). The inclusive stabilization group approach was developed and carried out within the context of the Norwegian mental health care system, particularly in response to challenges arising from the homogeneous organization of mental health care provision despite diverse demographic conditions.

Influenced by mental health care provision in neighbouring countries, like the United Kingdom (UK), the Norwegian mental health care system emphasises deinstitutionalization and strengthening of community-based services (Norwegian Directorate for Health and Social Affairs, 2006). The Norwegian mental health care system has undergone massive changes in response to a strong political interest in decentralizing specialist mental health services through the establishment of District Psychiatric Centres (in Norwegian abbreviated DPS; Norwegian Ministry of Health and Social Affairs, 1997–1998). From 1970 to 2002 the number of beds in psychiatric institutions was reduced by 57%, and strong economic incentives were used to stimulate the development of mental health services locally (Hansen & Øiesvold, 2004). New DPSs have therefore been established all over the country, in total 75 DPSs by the end of 2006 (Norwegian Directorate for Health and Social Affairs, 2006).

While the Norwegian mental health care system has been influenced by the organization of such services in for example the UK, Norway and the UK have distinctly different demographics. Norway has a population density of 16 persons/km^2 (Norwegian Central Bureau of Statistics (SSB), http://www.ssb.no/minifakta/main_03.html). The corresponding number in the UK is 257 persons/km^2 (http://www.tradingeconomics.com/united-kingdom/population-density-people-per-sq-km-wb-data.html), 16 times the population density found in Norway. In addition, Norway has vast areas with small population sizes and densities and larger towns and cities with greater population sizes and densities. For example, the two counties of Oslo and Akershus cover only 1.6% of the area in Norway, but house 23.5% of the Norwegian population. In contrast, the three northern-most counties of Nordland, Troms, and Finnmark, where the

present project took place, covers 34.9% of the area in Norway but only house 9.5% of the Norwegian population (SSB; http://www.ssb.no/minifakta/main_03.html). The challenges rising from a homogenous organization of health care provision despite diverse conditions, particularly in rural parts of Norway, are also reflected by the Norwegian government's need to clarify the desired organization and type of services to be provided by the DPSs (Norwegian Board of Health Supervision, 2001; Norwegian Directorate for Health and Social Affairs, 2006).

Parallel to the establishment of DPSs, specialized clinical environments were reorganized into regional and national competence centres. These centres were to focus on research, education and supervision of health care workers at the DPS level. Within the field of psychological trauma, the Norwegian Centre for Violence and Traumatic Stress Studies (in Norwegian abbreviated NKVTS) was established in January 2004, replacing specialist, clinical environments, like Psychosocial Centre for Refugees, and National Resource Centre for Sexually Abused Children. In addition, five regional resource centres on violence, traumatic stress, and suicide prevention (in Norwegian abbreviated RVTS) were established, replacing psychosocial teams working clinically with refugees.

In this same period a massive reorganization of the whole health care system in Norway took place. Five health regions were established (later reduced to four), with regional health authorities deciding the distribution of resources and organization of health services in their regions. Mental health care services became incorporated into these larger health regions. As part of this reorganization a new philosophy of leadership was introduced, with a strengthened focus on economic indicators, like budget balances, reduced waiting lists, and productivity (Gjertsen, 2007). This had implications for the service provision within the sector of mental health.

In order to encourage locally provided mental health care services the government has established a powerful economic incentive system. The DPSs are paid per completed consultation, and the health regions have to pay if they cannot provide the required services and clients are treated outside their health regions. As a result, leading clinical environments have become less accessible to clients from other health regions. Within the field of psychological trauma, which is the field of focus in this thesis, this development has had implications for treatment provision. Previously, small clinical environments, like those found in many DPSs, had the opportunity to refer their clients to the leading clinical

environments in Norway when local competence was not considered sufficient to help a particular client. For example, Modum Bad, which is now part of the South-Eastern Norway Regional Health Authority[1], has had a central position in treating Norwegian clients struggling with problems related to child sexual abuse (CSA). Because of the new organization of health care services, the other health regions now have to pay much more to send clients to Modum Bad.[2] Given the strong focus on economic balance in the health regions, this has left treatment at Modum Bad less accessible to clients in health regions outside South-Eastern Norway. The DPSs therefore have to come up with new ways of providing specialist mental health care services, compensating for the support previously offered by centralized and leading clinical environments.

In the autumn of 2007, DPS of Western-Finnmark[3] received funding to establish a group therapeutic team. I was one of three health care workers in this team, and in the following months and years the team developed, initiated and ran groups that complemented the treatment already offered at the outpatient clinic. I already had a special interest in the field of psychological trauma for many years and was regularly travelling to Oslo to attend a training program on the treatment of complex trauma, based on a phase-oriented understanding of trauma treatment (Ogden, Minton, & Pain, 2006; van der Hart, Nijenhuis, & Steele, 2006). Given the large number of clients referred to the DPS who had been exposed to trauma, the reduced access to specialized treatments, like Modum Bad, and the lack of existing phase-oriented trauma treatment in DPS of Western-Finnmark, the group therapeutic team found it important to explore how phase-oriented trauma treatment could be provided within the given setting.

On this background I started the work of developing a treatment approach that could be applied in contexts where it would not be possible to offer homogeneous trauma groups, such as in areas with small population sizes and densities, or in urban areas where one needed to provide treatment quickly after a referral.

[1] South-Eastern Norway Regional Health Authority covers the south-east parts of Norway, including the capital Oslo. Serving a population of 2.7 million it is by far the largest health region in Norway. Northern Norway Regional Health Authority, where the current project took place, only serve a population of 468,251 distributed across the counties Nordland, Troms, and Finnmark (Pedersen & Bremnes, 2011).
[2] Modum Bad is privately owned. Previously 90% of the costs were covered by the state. Now health regions other than South-Eastern Norway have to cover the full cost of the treatment.
[3] DPS of Western-Finnmark covers the western part of the northernmost county, Finnmark. As of 01.01.12 the DPS served 29,120 persons above 16 years of age, distributed across seven municipalities.

2. Theoretical and empirical context of the thesis

2.1 Concept of 'trauma'

The focus of this thesis is the presentation of an inclusive stabilization group approach in which heterogeneous samples of trauma clients can be treated in the same group, and an exploration of the clients' perspectives on (a) help seeking; (b) treatment participation; (c) ways to positive change (i.e. the process of recovery). The research participants were women who had been exposed to 'human-inflicted traumas', i.e. traumatic exposure where another person inflicts harm: for example, childhood abuse or neglect, intimate partner violence (IPV), rape, assault or robbery. It is thus a wider concept than 'complex trauma' (Courtois & Ford, 2009; van der Hart et al., 2006), which requires a long-lasting, relational trauma.

The concept 'trauma' is central to this thesis. However, 'trauma' is a widely used concept with context-dependent meanings from everyday language, media, and clinical practice. The concept is often given a broader meaning in the general population and media, often just indicating that something was dramatic or scary, than it is within the academic and clinical field of psychological trauma. However, the concept has also changed within the field of psychological trauma. In the 1970s and 1980s the concept of 'trauma' was confined to catastrophic events falling outside the perimeter of everyday life (McNally, 2004). Today the concept is applied in a much wider context, and some claim that the concept is losing its meaning from being applied to such an array of events (Summerfield, 2004).

The two main diagnostic systems in use in the Western world, the International Classification of Disease (ICD-10; WHO, 1993) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000), define 'trauma' as exposure to 'a stressful event or situation (either short- or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone' (WHO, 1993, p. 99), and experiencing, witnessing, or being confronted with an event involving actual or threatened death or serious injury, or threat to the physical integrity of self or others, accompanied by intense fear, horror, or helplessness (APA, 2000, p. 463) respectively. Posttraumatic stress disorder (PTSD) is considered a trauma-specific diagnosis in both diagnostic systems and requires the person to have been exposed to a traumatic event

and to be re-experiencing the traumatic event, avoiding trauma-related stimuli, and experiencing symptoms of increased arousal. The symptoms should interfere with the level of function or cause clinically significant distress for at least a month (APA, 2000).

Whether or not something represents a traumatic experience depends on the combination of the external event (trauma exposure) and the subjective experience and reactions to this event (e.g. intense fear or horror). Not everyone who experiences an event involving actual or threatened death or serious injury will be traumatized, as defined by exhibiting symptoms of PTSD. This is evident by the discrepancies found between the prevalence of trauma exposure and the prevalence of trauma-specific symptoms, like PTSD. For example, Resnick and colleagues (1993) reported that 69% of their representative, national sample of women had been exposed to a traumatic event once in their lives, but only 12% of the sample reported symptoms of PTSD in their lifetime. This discrepancy illustrates why it is vital to separate exposure to potentially traumatic events (PTEs) from experienced trauma.

Because the subjective experience of an event is critical for determining whether or not something represents a trauma, estimating the true prevalence of experienced trauma in any given population is difficult. This relates to the fact that seemingly similar exposure might differ significantly from a subjective, experiential stance. The experience of control and predictability has, for example, proven vital in understanding why exposure to the same type of stressor results in very different outcomes, independent of individual vulnerability, in both animal studies (e.g. Weiss, 1968, 1970) and in experiments with human subjects (e.g. Glass & Singer, 1972). Additionally, our interpretation of meaning of a given event and how this is influenced by historical and cultural factors influence the impact of that event (McNally, 2004).

Scholars and clinicians working with survivors of early and long-lasting human-inflicted trauma have additionally led to increased attention on how single traumas, like assault, differ from long-lasting, relational traumas, like child abuse or IPV (Herman, 1992b). Through their work they have argued for why existing diagnostic categories, like PTSD, are too narrow to capture the full range of trauma-reactions, such as attachment issues, dissociation, bodily reactions and shattered assumptions (Courtois & Ford, 2009; Herman, 1992a; Janoff-Bulman, 1992; Ogden et al., 2006; van der Hart et al., 2006). This work has resulted in increased awareness of, for example, the importance 'dissociation' plays in

understanding posttraumatic reactions, and the DSM-IV-TR now explicitly states that dissociative symptoms are part of the clinical picture following traumatization and that symptoms of PTSD also indicate dissociative symptoms (APA, 2000, p. 519).

In this thesis, 'trauma' is understood, in line with the DSM-IV-TR (APA, 2000) and ICD-10 (WHO, 1993), as an event involving threat to a person's integrity, accompanied by experiences of incomprehension, disrupted attachment, inescapability and physiological response (Saporta & van der Kolk, 1992). The significance of the subjective experience of an event and its given meaning is emphasized in determining whether or not an event represents a trauma to a particular person. Moreover, in line with phase-oriented approaches to trauma treatment (e.g. van der Hart, et al., 2006) symptoms of PTSD are seen as an indication that part of the traumatic experience (e.g. bodily sensations, memories or feelings) has not been fully integrated, and therefore highlight the need for phase-oriented, trauma-specific treatment.

2.2 Situating the thesis in the field of psychological trauma

The work presented in this thesis rests on a general clinical orientation best described as eclectic and integrative. It is based on a humanistic theory of change, where the therapist is seen as a co-traveller rather than an expert. The clients narratives are emphasized, and symptoms and reactions are considered to have functions and bear meaning—they are the results of the person's attempts to cope with their life situations (Axelsen, 2009). In addition, the understanding of trauma and trauma treatment underpinning the work in this thesis is influenced by three theoretical approaches to psychological trauma, namely phase-oriented trauma treatments (Herman, 1992b; van der Hart et al., 2006), sensorimotor psychotherapy (Ogden et al., 2006) and the theory of shattered assumptions (Janoff-Bulman, 1992). As they serve to situate the thesis theoretically, they will be presented briefly below.

2.2.1 Phase-oriented trauma treatments

In the tradition of phase-oriented trauma treatment both the work of Judith Herman (1992a, 1992b) and the Dutch theoretical tradition of structural dissociation of the personality (van der Hart et al., 2006) have informed the development of the work presented in this thesis. Both traditions build on the work of the French physician Pierre Janet, who in the late nineteenth century argued that symptoms of hysteria were caused

by psychological trauma. He suggested that unbearable emotional reactions to traumatic events produced altered states of consciousness, which in turn induced the symptoms of hysteria. Janet called this alteration in consciousness 'dissociation', and suggested recovery progressed in three stages: establishment of safety, remembrance and mourning and reconnection with ordinary life (Herman, 1992b; van der Hart et al., 2006).

In this theoretical tradition, trauma-specific symptoms, like intrusions, avoidance and dissociation, are interpreted as an indication of incomplete integration of the traumatic experience. The lack of integrative capacity to fully process the traumatic experience is therefore seen as a core characteristic of trauma. The concepts of 'dissociation' and 'integrative capacity' are therefore central to this understanding of trauma and trauma-related symptoms. Persons with lower integrative capacities (e.g. children), are considered more vulnerable to exposure to PTEs. The observed relationship between the age of traumatisation and degree of dissociative symptoms (younger age associated with more dissociative symptoms) is taken as support of the significance integrative capacity plays in understanding the negative consequences of trauma exposure.

Additionally, the phase-oriented approaches emphasize how long-lasting trauma, and early, relational trauma in particular, influences the developmental opportunities of a person, notably the attachment system and developmental processes related to learning how to effectively regulate arousal. This might lead to extensive and long-lasting problems. These approaches therefore argue that one needs to use a multimodal and transtheoretical, developmental approach to treatment that addresses a wider range of issues when treating survivors of long-lasting and human-inflicted trauma. The challenging, but important work of establishing a good therapeutic alliance between client and therapist is also emphasized. This might be particularly difficult to accomplish due to the way chronic trauma influences the attachment system. Yet, such a relation may highly promote recovery, as the social engagement system is seen as important in helping clients regulate arousal and overcome their trauma-related problems (Courtois & Ford, 2009; Herman, 1992b; van der Hart et al., 2006; van der Kolk, 1996).

Within this model of understanding, persons who experience problems with affect regulation and efficient handling of symptoms that interfere with daily functioning need to expand their integrative capacities so that the traumatic experience can be fully integrated

and recovery can be achieved. Consequently, a phase-oriented approach to trauma treatment is suggested. Phase one (stabilization) focuses primarily on the establishment or re-establishment of safety (Herman, 1992b). Other key elements are the efficient regulation of arousal, social engagement, increasing one's sense of agency (i.e. 'There is something I can do to influence my situation'), expanding one's action repertoires and enhancing one's body awareness (Fisher & Ogden, 2009; Herman, 1992b; Ogden et al., 2006; Steele & van der Hart, 2009; van der Hart et al., 2006).

The inclusive stabilization group presented in this thesis represents an example of a phase-one treatment approach. Together, the elements in the stabilization phase aim at preparing clients to work more directly with trauma content in the second treatment phase. In this second phase, the aim is to integrate traumatic memories without getting overwhelmed. Phase three, according to Herman (1992b) focuses on reconnection and creating a future. The theory of structural dissociation of the personality (van der Hart et al., 2006), which more explicitly addresses dissociation following traumatization, puts emphasis on the integration of the personality and rehabilitation in phase three.

2.2.2 Sensorimotor psychotherapy

Sensorimotor psychotherapy adheres to the phase-oriented approach to trauma treatment, but explicitly emphasises how posttraumatic reactions also include somatic components, and suggests ways to include an explicit focus on these somatic components when working with trauma survivors (Fisher & Ogden, 2009; Ogden et al., 2006). Therapists in this tradition pay close attention to clients' body posture, signs of autonomous activation and small, subtle movements that appears as trauma content is approached. The therapists then mirror and use this information actively in interventions to assist clients in regaining their ability to observe and regulate bodily states that have been altered (Fisher & Ogden, 2009).

In this tradition some of the toxic effects of trauma are assigned to the way trauma hinders the completion of actions, particularly defensive responses (fight, flight or freeze). Accessing the uncompleted actions and working with this is therefore seen as an important part of healing following trauma, and therapists mirror observations on bodily movements, posture and autonomic arousal in order to access these uncompleted actions. In addition, the autonomous arousal of clients is monitored closely, to ensure they are inside the window of tolerance as much as possible. To help clients become aware of and

learn how to modulate autonomic arousal, therapists use interventions such as: 'What does your body want to do now?', body-focused experiments (e.g. 'Notice what happens in your body as you feel your feet resting on the floor.'), and mindfulness exercises (Fisher & Ogden, 2009).

2.2.3 Theory of shattered assumptions

The theory of shattered assumptions was developed by Janoff-Bulman (1992; Janoff-Bulman & Frieze, 1983). It aims at explaining the reactions observed in trauma survivors, by focusing on how our cognitive schemas, our assumptions, are affected when we are confronted with a traumatic event. The theory was developed based on persons exposed to PTEs in adulthood, and who therefore have had the opportunity to establish a positive, assumptive world prior to trauma. The theory may therefore not be directly applicable to survivors of childhood trauma, who might never have had the opportunity to establish positive schemas of the world. The focus of meaning-making processes to understand trauma-related difficulties has nonetheless been important in shaping the understanding of trauma underpinning the work presented in this thesis.

The theory suggests that most people share a common set of abstract beliefs about themselves, the external world and the relationship between the two. These are not consciously accessible beliefs, but instead beliefs that constitute the core assumptive world used to organize, understand and predict the world and the experiences encountered. Even though the concrete content of these beliefs might vary, the theory proposes that three fundamental assumptions are shared by most people, namely: The world is benevolent; the world is meaningful; the self is worthy (Janoff-Bulman, 1992; Janoff-Bulman & Frieze, 1983).

According to the theory, posttraumatic reactions and psychopathology can largely be explained by the effect the traumatic event has on these basic assumptions. Confronted with a traumatic event, basic assumptions prove wrong, and the capacity to create meaning and one's existing world view are heavily affected. An individual's basic assumptions are shattered because the traumatic experience cannot be assimilated into existing assumptions and cognitive schema. Trauma survivors thus face the challenge of redefining the traumatic event so it fits their existing, basic assumptions, or altering their basic assumptions so that they can assimilate the traumatic experience. When the threat the trauma represents to the basic assumptions is too great, the traumatic experience

might be dissociated from the rest of a person's experiences (Janoff-Bulman, 1992; Janoff-Bulman & Frieze, 1983). Recovery following trauma exposure according to the theory of shattered assumptions is therefore centred on rebuilding the assumptive world, where the new, negative experience (trauma) is integrated into the assumptive world.

2.3 Empirical studies on the prevalence of exposure to PTEs

When researchers have looked at exposure to the full spectrum of PTEs in the general population, particularly in North America, the majority of subjects report having experienced a PTE in their lifetime (Copeland, Keeler, Angold, & Costello, 2007; Elliott, 1997). One large study exploring the prevalence of exposure to PTEs in representative samples in six European countries reported a lifetime exposure to PTEs of 64% (Darves-Bornoz et al., 2008). Some European studies report a substantially lower prevalence, with the Zürich cohort study reporting a lifetime exposure to PTEs of 35% (Hepp et al., 2006) and the Norwegian Institute of Public Health Twin Panel (NIPHTP) reporting a lifetime prevalence to any PTE of 27% (Amstadter, Aggen, Knudsen, Reichborn-Kjennerud, & Kendler, 2012). The latter study only mapped eight cases of PTEs, two of which are very unlikely occurrence in a Norwegian setting (e.g. a terrible war experience and being threatened by the use of a weapon). This might have contributed to the relatively low prevalence estimate in this study.

Researchers also report that exposure to PTEs starts early in life. Several studies on young children have reported exposure rates similar to the range reported by adults. For example, in a national US sample of children aged 2–17 years, 80% of the sample reported exposure to a PTE, and the children had on average experienced 3.7 PTEs (Finkelhor, Omrod, & Turner, 2009). Twenty-six per cent of 2- to 4-year-old children in a birth cohort study in the US had experienced some type of PTE (Briggs-Gowan, Ford, Fraleigh, McCarthy, & Carter, 2010). Factors such as low socioeconomic status (poverty) have also been found to increase the likelihood of exposure to PTEs (Walby & Allen, 2004). In one study 49% of the children living in poor families (20% of the sample) had been exposed to a PTE by the age of four. The corresponding number in non-poor children was 26% (Briggs-Gowan, Ford et al., 2010).

When focusing on exposure to human-inflicted PTEs in the general population the prevalence drops slightly, but remain high. For example, Elliott (1997) found that 50% of the respondents had been exposed to some form of interpersonal violence (excluding

emotional abuse, which was not measured). In a more recent study researchers used a large, nationally representative sample from England and Wales. They found that 45% of the women and 26% of the men in their sample reported lifetime exposure to interpersonal violence. Twenty-four per cent of the women and 5% of the men had been subject to some form of sexual victimization in their lifetime (Walby & Allen, 2004). In one Norwegian study 18% reported exposure to human-inflicted PTEs (Amstadter et al., 2012).

Children are also commonly exposed to human-inflicted PTEs. In a birth-cohort study in the US 14% of children had been exposed to violence by the age of four (Briggs-Gowan, Ford et al., 2010). In another study Briere and Elliott (2003) found that 32% of the women and 14% of the men in the U.S. reported exposure to CSA, while 20% of the women and 22% of the men reported exposure to child physical abuse. Van Roode and colleagues (2009) reported similar prevalence, with 30% of the women and 9% of the men in a birth cohort study reporting exposure to CSA. In one Norwegian study 18% of the women reported some form of childhood abuse; 7% reported CSA, 6% reported physical abuse, and 14% reported emotional abuse (Lukasse, Schei, Vangen, & Øian, 2009).

In a more recent Norwegian study exploring exposure to sexual abuse in a representative population sample, 35% of women and 13% of men reported some form of unwanted sexual experience before the age of 16 (Steine et al., 2012), and it has been estimated that 26–47% of clients in the DPSs have been exposed to childhood physical or sexual abuse (Fosse & Dersyd, 2007). In fact, according to Walby and Allen (2004) the highest incidence of exposure to interpersonal violence is found among persons below the age of 25 years. Exposure to PTEs in childhood also increases the risk for exposure to PTEs later in life, and children exposed to one type of abuse are often exposed to other types of PTEs as well (Olafson, 2011; Tjalden & Thoennes, 2000).

Exposure to different types of PTEs also seems to differ systematically with gender. Men seem to be more at risk for being exposed to PTEs in general (Amstadter et al., 2012; Darves-Bornoz et al., 2008; Tolin & Foa, 2006). Women, on the other hand, typically report exposure to fewer PTEs, but are consistently found to report higher prevalence of exposure to human-inflicted PTEs, like CSA and sexual assault (Briere & Elliott, 2003; Finkelhor, 1994; Hepp et al., 2006; Steine et al., 2012; Tolin & Foa, 2006; van Roode, Dickson, Herbison, & Paul, 2009). Women are also found to be more at risk for experiencing repeated interpersonal violence (Walby & Allen, 2004).

The epidemiological literature suggests then that exposure to human-inflicted PTEs is common, although estimates vary, that exposure starts in early childhood, and that higher levels of exposure to human-inflicted PTEs are reported by women than by men. What are the implications, then, of exposure to human-inflicted PTEs?

2.4 Empirical studies on the sequelae of exposure to human-inflicted PTEs

Researchers have consistently reported an elevated risk for health problems following exposure to PTEs. This association has been reported for somatic conditions, like autoimmune and functional gastrointestinal disorders (Mulvihill, 2005; Paras et al., 2009), non-trauma-specific mental disorders, like depression, eating disorders, and borderline personality disorder (Amstadter et al., 2012; Chapman et al., 2004; Chen et al., 2010; Steine et al., 2012); and trauma-specific disorders, like PTSD and dissociative disorders (Briere & Elliott, 2003; Darves-Bornoz et al., 2008; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993).

The projected lifetime risk of PTSD at age 75 in the general population is estimated to be 9% (Kessler, Berglund et al., 2005), and in Norway it is estimated that 25–42% of clients in DPSs are suffering from PTSD (Fosse & Dersyd, 2007). Trauma-specific disorders, like PTSD, have also shown to be very persistent, and spontaneous recovery is rare after the first three months (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). Moreover, it increases the risk for comorbidity of general mental health problems (Amstadter et al., 2012; Carey, Stein, Zungu-Dirwayi, & Seedat, 2003; Kessler, Chiu, Demler, Merikangas, & Walters, 2005) and somatic illness (Mulvihill, 2005).

There are consistent reports of a discrepancy between the number of people exposed to PTEs and the number of people reporting symptoms of psychopathology following such exposure (e.g. Amstadter et al., 2012; Briere & Elliott, 2003; Copeland et al., 2007; Finkelhor et al., 2009; Nilsson, Gustafsson, & Svedin, 2010). This discrepancy might partly relate to the lack of consensus on how to define and measure the concept of 'trauma' (Olafson, 2011), but researchers are also investigating complementary or alternative explanations for the observed discrepancy, and they are doing so from an array of different perspectives. A comprehensive review of this field of study is beyond the scope of this thesis, but a brief overview may suffice.

One line of research (e.g. Bowman & Yehuda, 2004) has focused on individual vulnerability for developing health problems following exposure, notably the personality traits like neuroticism. Others (e.g. Banyard & Williams, 2007; Hyman & Williams, 2001;

McGloin & Widom, 2001; Thomas & Hall, 2008) have focused on resilience, thriving, and personal growth following exposure to PTEs, and child maltreatment in particular, emphasising factors like supporting interpersonal relationships (Afifi & Macmillan, 2011; Roman, Hall, & Bolton, 2008), stable and supportive caregivers and care-giving environments, as well as positive self-esteem (Hyman & Williams, 2001). Researchers have also focused on the protective factor of 'sense of coherence' (SOC), i.e. the extent to which the world is experienced as predictable/understandable and meaningful, and tasks manageable (Antonovsky, 1987), and the extent PTEs are congruent with existing meaning structures (Gillies & Neimeyer, 2006).

Another line of research has explored a possible dose-response between exposure to PTEs and health problems (Anda et al., 2006; Felitti et al., 1998; Finkelhor et al., 2009; Nilsson et al., 2010). As the field of psychological trauma has matured it has become evident that a dose-response relationship is insufficient in explaining the discrepancy between exposure and health problems. For example, Finkelhor and colleagues (2009) exploring the impact of poly-victimization found that child maltreatment and sexual assault had a more severe impact compared to other types of victimization. In fact, these types of exposure had the same impact on the level of trauma symptoms as the combined effect of three to four other types of victimization. This accords with other research reporting a more severe impact of exposure to interpersonal, or human-inflicted PTEs, compared to exposure to non-interpersonal PTEs (Briere & Elliott, 2003; Briggs-Gowan, Carter, et al., 2010; Darves-Bornoz et al., 2008; Luthra et al., 2009; Nilsson et al., 2010; Olafson, 2011; Paras et al., 2009), irrespective of age at the time of the abuse (Chen et al., 2010).

In addition, survivors of ongoing or repeated trauma (complex trauma), in contrast to survivors of single-event trauma, display a more extensive constellation of symptoms than subsumed by PTSD (Courtois, 2008; Herman, 1992a). Up to 80% of persons exposed to child maltreatment report some form of long-term, negative after-effect, such as mental health problems and problems with completing education or acquiring employment (Hyman & Williams, 2001; McGloin & Widom, 2001; Roman et al., 2008). It is estimated that 30% of clients at outpatient facilities fulfil diagnostic criteria for a dissociative disorder (Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006). Some studies have also found that,

compared to exposure to physical abuse, CSA and neglect significantly decrease the impact of resilience (McGloin & Widom, 2001).

The reported gender-specific risk of psychopathology following exposure to PTEs, where women are more at risk than men for developing symptoms of PTSD following exposure to PTEs (e.g. Amstadter et al., 2012; Darves-Bornoz et al., 2008; Tolin & Foa, 2006) might be related to the more severe impact of human-inflicted PTEs. There are, for example, a few studies where this gender difference is not observed. Notably, Hjemmen and colleagues (2002) found no gender difference when looking at the association between exposure to sexualized violence and mental health problems. Some scholars thus claim that women's increased risk for developing health problems following exposure to PTEs might be related to the fact that women consistently are found to be exposed to human-inflicted PTEs such as CSA, sexual assault and domestic violence, more frequently than men (Darves-Bornoz et al., 2008; Hjemmen, Dalgard, & Graff-Iversen, 2002; Tolin & Foa, 2006). It has even been observed that sexually abused boys generally experience worse short- and long-term outcomes than girls who have been sexually abused (Olafson, 2011).

To summarize, exposure to PTEs is associated with an elevated risk for developing a range of mental and somatic health problems even decades after the exposure. However, not everyone exposed to a PTE will develop health problems. It seems human-inflicted PTEs are particularly strongly associated with lifetime mental and somatic health problems. Given the relatively high prevalence of individuals exposed to human-inflicted PTEs in the general population, a substantial proportion will develop trauma-related health problems at some point in their lifespan. To what extent, then, do trauma survivors who need treatment actually seek professional help?

2.5 Empirical studies of help seeking following exposure to trauma

Little is known about trauma survivors' help-seeking behaviours, particularly among those with a history of childhood trauma. Research has explored the *type* of help seeking (e.g. Macy, Nurius, Kernic, & Holt, 2005), the average *delay* from onset of psychiatric disorders until help is sought (e.g. Wang, Berglund et al., 2005) and the proportion of persons with mental disorders who eventually get in touch with the health care system (e.g. Demyttenaere et al., 2004). Less is known about what makes people seek help at the time

they do and the mechanisms leading up to help-seeking behaviour following trauma exposure (Burgess-Proctor, 2012).

Research has consistently reported that up to 50% of those fulfilling diagnostic criteria for a mental disorder are not in treatment (Demyttenaere et al., 2004; Gavrilovic, Schutzwohl, Fazel, & Priebe, 2005; Kessler et al., 2001; Wang, Lane et al., 2005). Moreover, most of these people eventually seek help. Yet, delays can be substantial, usually six to eight years from onset of a mood disorder and nine to 23 years from onset of an anxiety disorder (Wang, Berglund et al., 2005).

As these results indicate, help-seeking patterns vary across different psychiatric disorders. Researchers have therefore explored the factors associated with such variations, including barriers to seeking help. Several studies have shown that an earlier age of onset is associated with longer delays and less probability of seeking help, both for PTSD (Fikretoglu, Liu, Pedlar, & Brunet, 2010; Wang, Berglund et al., 2005) and other mental disorders (de Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2012). Sayer and colleagues (2009), who have been studying military veterans, have argued that the avoidance of trauma-related stimuli, one of the three core symptoms in PTSD, contributes to the extensive delays observed in help-seeking behaviours among trauma survivors.

Another reported barrier to seeking help is the desire to solve the problem on one's own/the belief that one can handle it on one's own (i.e. self-management) (Kessler et al., 2001; Koenen, Goodwin, Struening, Hellman, & Guardino, 2003; Wang, 2006). Kessler and colleagues (2001) found this to be the most commonly reported reason for both failing to seek treatment and for dropping out of treatment among those with PTSD and those with other mental disorders. Moreover, Koenen and colleagues (2003) used a national screening sample of 2713 persons with PTSD. They found that the belief that one is capable of handling it on one's own had a significant negative association with readiness for treatment. Similar results have been reported in a qualitative study of military veterans, where veterans' pride in their self-reliance reduced their interest in seeking mental health treatment (Sayer et al., 2009).

There is also some research indicating that the type of trauma exposure might influence help-seeking patterns, with exposure to human-inflicted trauma in adolescence or adulthood possibly increasing the likelihood of seeking help (Haavet, Straand, Hjortdahl, & Saugstad, 2005) and reducing delays in help seeking (Fikretoglu et al., 2010). Exposure to

sexual and/or physical abuse in childhood may, however, both inhibit and promote help seeking when exposed to interpersonal trauma in adulthood (Burgess-Proctor, 2012), and a substantial number of persons exposed to human-inflicted trauma never seek help. For example, Barret and St. Pierre (2011) found that 34% of the women in their study did not use any type of formal support in response to violence, and Smith and colleagues (2000) found that 28% of women who had experienced CSA never told anyone about the abuse, with 47% waiting at least eight years before they told anyone. Walby and Allen (2004), using a large, nationally representative sample from England and Wales, found that 40% of the women who had been raped in adolescence or adulthood had never told anyone about their worst rape-related experience.

Thus, while the majority of persons with trauma-specific symptoms eventually seek help, the reported delays in help seeking are substantial. Furthermore, it seems persons exposed to human-inflicted trauma, and particularly childhood trauma, are more likely never to seek help, or to wait for many years, even decades, before they do so. Little is known, though, about the mechanisms leading survivors of trauma to seek help at the time they actually do, and the first-person perspective of the help-seeking process. This thesis may then contribute in expanding our knowledge in this field. Such knowledge would potentially contribute to ongoing mental health promotion efforts to shorten the time people experience mental illness (Jané-Llopis & Anderson, 2006).

2.6 Empirical studies on the effectiveness and efficacy of trauma-specific treatment

Today there is an array of trauma treatment approaches available from a range of different therapy traditions. Treatment approaches targeting PTSD have been developed, including cognitive and behaviour therapies, psychodynamic psychotherapies, eye movement desensitization and reprocessing (EMDR), and psycho-educational approaches (APA, 2004; Foa, Keane, & Friedman, 2000). Other specialized treatments have focused on clients exposed to early and long-lasting human-inflicted trauma, often related to dissociation. This particular group of clients often have a more difficult and chronic treatment course and higher drop-out rates (Brand, Lanius, Vermetten, Loewenstein, & Spiegel, 2012; Bromberg, 2003).

Despite the number and widespread use of trauma-specific treatments, few studies have examined their effectiveness and efficacy (APA, 2004; Courtois & Ford, 2009; Taylor & Chemtob, 2004). Those that do generally find that, given a trauma-specific focus, they all may succeed in reducing PTSD symptoms and that no particular treatment approach appears superior (APA, 2004; Bisson & Andrew, 2007; Bisson et al., 2007; Seidler & Wagner, 2006). However, the long-term outcome of these approaches is uncertain as this is an understudied area (APA, 2004; Gillies, Taylor, Gray, O'Brien, & D'Abrew, 2012). Moreover, there is a general need for psychotherapy research studies exploring standard treatment, as previous research has reported a substantially poorer effect in routine care settings compared to clinical trials (Lambert & Shimokawa, 2011).

Because this thesis focuses on an inclusive stabilization group approach, the psychotherapy research regarding group-based trauma treatments will be presented briefly to contextualize the presented treatment approach.

2.6.1 Group-based trauma treatment

There is a long tradition of group therapy being used to treat trauma clients. The opportunity to participate in group-based treatment might 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. Even though most trauma treatment groups are more structured than pure process groups, there is substantial variation among the various group approaches in terms of group composition, facilitation of member-to-member interactions and development of key group therapeutic factors, like interpersonal learning, group cohesiveness, self-understanding and universality (Yalom & Leszcz, 2005).

Most often trauma treatment groups are homogenous regarding trauma exposure experiences (Foy et al., 2000). Treatment groups exist for women exposed to CSA (Chard, 2005; Wolfsdorf & Zlotnick, 2001), adults exposed to IPV (Tutty, Bidgood, & Rothery, 1993) and rape victims (Resick & Schnicke, 1992). A few group approaches are offered on the basis of diagnosis (e.g. Boon, Steele, & van der Hart, 2011). Heterogeneous groups for clients with a wider range of trauma-histories (Lubin, Loris, Burt, & Johnson, 1998; Najavits, 2002) are less common. The practice of offering treatment groups based on the type of trauma clients have experienced may have reduced the availability and accessibility of group-based trauma treatment for trauma clients living in areas where such groups cannot

be offered, such as in rural areas. More inclusive approaches are thus needed (Fritch & Lynch, 2008). Moreover, including clients with different trauma experiences in the same group may expand therapeutic options (Viola, Ditzler, & Batzer, 1996).

The various trauma group approaches also differ in the degree to which they are trauma-focused (i.e. focusing in detail on the traumatic experience) or more present-centred (i.e. focusing more on coping with present issues while recognizing the impact of the trauma history) (APA, 2004; Foy et al., 2000), and to the degree they follow a phase-oriented treatment model.

Despite the frequent use of group therapy, knowledge about the effectiveness and efficacy of such approaches is scarce (APA, 2004; Taylor & Chemtob, 2004). Most studies compare the effects of treatment with a waiting listor pre- and post-treatment symptom scores, without a control group. There are almost no studies comparing the effects of different group-based trauma treatments. Some studies suggest that both present-centred and trauma-focused group therapies may reduce PTSD symptom severity (APA, 2004; Foy et al., 2000). However, similar to individual approaches, no treatment model has proven more effective (Alexander, Neimeyer, Follette, Moore, & Harter, 1989; Classen, Koopman, Nevillmanning, & Spiegel, 2001; Dorrepaal et al., 2010; Foy et al., 2000; Lubin et al., 1998; Schnurr et al., 2003), and studies generally fail to establish statistically significant differences in the effect sizes of different treatment approaches (APA, 2004; Schnurr et al., 2003; Sloan, Feinstein, Gallagher, Beck, & Keane, 2011).

Details from existing research may nevertheless point to areas that need further exploration and issues that may be considered when planning and initiating trauma treatment groups. For example, trauma-focused cognitive behavioural therapy groups may be effective in treating PTSD, yet such trauma-focused groups generally may be less tolerable for some trauma clients and thus associated with a higher drop-out rate (Bisson & Andrew, 2007; Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002; Schnurr et al., 2003). On the other hand, there is no difference in the efficacy of individual and group treatment in children, but children receiving group treatment are significantly less likely to drop out (Taylor & Chemtob, 2004). Moreover, group therapeutic concepts, such as group composition (Yalom & Leszcz, 2005), may influence effectiveness. For instance, one study (Cloitre & Koenen, 2001) found women exposed to CSA participating in interpersonal therapy groups experienced a reduction of symptoms. However, when clients with

borderline personality disorder were included in the group, there was no such positive treatment effect. In fact, in the mixed groups treatment effects were no better than wait-list controls. In addition, a significant increase in post-treatment anger was observed.

To sum up, the available evidence suggests that trauma treatment groups may significantly reduce symptom levels, but more research is needed to establish the differential effectiveness and efficacy of available approaches. Traditionally, such groups have been offered on the basis of trauma exposure. This practice might exclude clients in need of trauma treatment in contexts where the provision of homogeneous treatments groups is not possible. Examples of such contexts are rural areas with small populations or low densities, and urban areas where rapid treatment is wanted following referral. There is therefore a need to develop more inclusive trauma treatment group approaches that can be offered in a wider range of contexts and to explore such approaches empirically.

2.7 First-person perspective of trauma recovery

Recent trends in the field of psychotherapy research have increasingly explored the first-person perspective of illness, therapy, and recovery (Binder, Holgersen, & Nielsen, 2010; Bohart & Tallman, 1999; Duncan, Miller, & Sparks, 2004; R. Elliott & James, 1989). Clients' active role in healing has been emphasized, and it has been argued that more studies exploring what clients find helpful are needed to complement the medical model (Bohart & Tallman, 1999; Hodgetts & Wright, 2007; Knight, Richert, & Brownfield, 2012). The significance of getting access to clients' perspectives in order to understand the field of psychotherapy is illustrated by research on one of the most important common factors for successful therapy—alliance. Studies have shown that a client's experience of the therapeutic relationship (alliance) is more precise in predicting therapy outcome than the therapist's experience of the alliance (Horvath, Del Re, Flückiger, & Symonds, 2011). Thus, while exploring the client-perspective is vital to obtain a good understanding of the phenomena of therapy and change, psychotherapy research exploring the first-person perspective of treatment participation and recovery among trauma survivors is scarce.

The concept of 'recovery' may refer to both a process and an outcome (Davidson & Roe, 2007). In this thesis, recovery is understood as a process, where the person pursues recovery actively, and where the process of recovery unfolds in everyday life. Symptom elimination might be a part of the experienced process of recovery, but is not a prerequisite (Borg & Davidson, 2008). This understanding of recovery is 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). This way of viewing recovery is in line with how adult, female survivors of CSA themselves define recovery (Banyard & Williams, 2007).

There are some qualitative studies exploring the first-person perspective of healing and recovery following human-inflicted trauma. In one study 12 women who had experienced sexual assault in adulthood were interviewed within five years of their assault. One overarching theme, described as 'Moving within the spiral: the process of surviving,' illustrated how healing was experienced as a process that did not necessarily have an end. Following an assault, in their healing process, the women described how their struggles to create meaning from their experiences to understand what had happened to them was important in moving on (Murphy, Moynihan, & Banyard, 2009). Other researchers have explored how the process of recovery from sexual violence often is experienced as a long and challenging journey, where important elements are managing memories, making sense of their experiences, relating to significant others, re-evaluating the self and creating a safe place for themselves (Draucker et al., 2009).

The movement toward an increased sense of agency has also been emphasized in narrative research on trauma recovery (Adler, 2012; Harvey, Mishler, Koenen, & Harney, 2000; Phillips & Daniluk, 2004). For example, Harvey and colleagues (2000) studying meaning making in the aftermath of sexual abuse found that feelings of powerlessness were replaced with a new sense of agency during the process of recovery. Also Adler (2012) reported on the significance of an increased sense of agency in client narratives during the course of successful psychotherapy, and how this change was related to improvement in participants' mental health. Phillips & Daniluk (2004) also studied survivors of CSA, and found that the transition from victim to survivor identity provided participants with a more agentic position from which they could view themselves.

There is also some research exploring how different coping strategies are used by survivors of CSA at different points in time. In one small interview study, survivors of CSA described the process of recovery as gradual and dynamic, where they initially adopted avoidant coping strategies before turning to more problem-focused ones. At the time of interview participants reported having reached a higher degree of acceptance of themselves and their experiences. Hope and social support were experienced as important

contributors in being able to use more problem-focused coping strategies (Phanichrat & Townshend, 2010).

While the experienced process of healing and recovery following human-inflicted trauma has been described in some detail, it is seldom linked to experiences of treatment participation. Only one study that explores clients' perspectives on group-based trauma treatments has been found in the existing literature. Thus, Parker and colleagues (2007), interviewed seven participants from a group-based treatment approach for women who had a history of child maltreatment. Analysing the interviews, the researchers arrived at three main themes describing the clients' experiences of participating in the treatment group. The first theme was 'breaking trauma-based patterns', where the women described how treatment helped them change their beliefs and behaviours. They felt more connected to other people, and managed to open up to new experiences. The second theme, 'doing therapy', described participants' experiences of being in therapy. Participants reported having to figure out how therapy worked and learning helpful strategies and techniques. The final theme, 'the healing journey as a continuous journey', underlined both the importance of clients being ready to change in order to benefit from treatment, how they continued experiencing problems after treatment, and how treatment helped them take the next step on their healing journey (Parker et al., 2007).

The results from studies exploring the first-person perspective of trauma recovery and treatment participation complement the studies of treatment effectiveness and efficacy. They show how recovery unfolds over time, requires personal effort, and influences the way life is lived. The contrast in focus and results illustrate why including the first-person perspective more actively in psychotherapy research within the field of psychological trauma potentially will provide a more holistic understanding and knowledge of the processes in trauma treatment and recovery.

3. Aims of the thesis

The foundation of the work presented in this thesis was the work on developing a trauma-specific treatment group approach that could be applied in a wider range of contexts, such as small DPSs where it is not possible to offer homogeneous treatment groups. The rationale for this aim was based on the organizational, theoretical and empirical background discussed above, with an emphasis on the following:

- The prevalence of exposure to PTEs is high, with such exposure, particularly exposure to human-inflicted PTEs, associated with an elevated risk for a range of long-lasting health problems.
- Symptoms can be reduced or eliminated with the help of various trauma-specific treatments, but the existing practice of offering treatment on the basis of trauma exposure makes trauma treatment groups unavailable to many clients in need of trauma treatment.
- The organization of the Norwegian mental health care system with DPSs responsible for providing treatment for the full spectrum of mental health problems calls for new ways of organizing and providing treatment. This is particularly true in the context of small DPSs, where the direct application of established, international treatment approaches will be limited by a small population distributed over a large geographical area.

Based on this rationale, the first research question was:

1) Based on existing theory, research, and clinical experience, how could trauma-specific treatment be organized to reach the majority of trauma clients in contexts where the provision of homogeneous trauma groups is not possible or desirable?

The main aims of the thesis were, then, to explore clients' perspectives on the treatment approach developed in response to research question 1, and to explore what led these clients to seek help and how they experienced their processes of recovery. The rationale for these aims was based on the theoretical and empirical background discussed above, with an emphasis on the following:

- There is a general lack of empirical exploration of the first-person perspective of important phenomena within the field of psychological trauma, such as post-

trauma coping, help seeking, treatment participation, and recovery. This is unfortunate given the importance the first-person perspective has had in producing knowledge and new understanding within general psychotherapy research.

- Psychotherapy studies conducted in naturalistic settings (i.e. standard treatment) are needed, as previous research has shown differential treatment effects between clinical trials and routine care settings.
- In the initial stages of the empirical investigation of new treatment approaches it is essential to gather information about clients' experiences with such approaches. This type of knowledge will both contribute to a better understanding of the phenomenon of interest as well as guide future efforts to develop and carry out effectiveness and efficacy studies.

Based on this rationale three specific research questions were developed:

2) What experiences led to the decision to seek help for these trauma clients?

3) How do clients experience participating in an inclusive stabilization group tailored to include heterogeneous samples of trauma clients?

4) What constitutes the key experiences of the recovery process for these trauma survivors?

4. Method

4.1 Methodological approach

This thesis is based on a hermeneutical method, specifically alethic hermeneutics (Alvesson & Sköldberg, 2000, p. 56), where understanding is emphasized as a basic way of existing for every human being. All understanding is situated within a context of preunderstanding, and new experiences and phenomena are interpreted in light of our existing understanding of the world (Alvesson & Sköldberg, 2000; Angen, 2000). We, as researchers, thus interpret and understand the emerging data and phenomena of interest from a particular context-dependent perspective, which is important to clarify. New understanding is possible through an ongoing process of interpretation, where the researcher moves between the parts and the whole, between preunderstanding and understanding, to gradually gain a deeper understanding of the studied phenomena. Understanding is therefore never final or absolute.

A hermeneutic process resulted in the development of the inclusive stabilization group approach presented in paper I (i.e. research question 1). Elements of the process were (a) the initial preunderstanding of trauma and trauma treatment; (b) experiential knowledge from previous clinical encounters; (c) knowledge of the local context; (d) trauma literature on understanding, treatment and recovery; (e) ongoing clinical encounters with trauma clients. All elements influenced each other mutually through a circle of interpretation, resulting in a new and deeper understanding of the clinical needs at DPS of Western Finnmark, the core components of trauma treatments, and alternative ways to offer trauma treatment.

Research questions 2–4 focused on the first-person perspective of help seeking, treatment participation and recovery following trauma. It was therefore necessary to incorporate a phenomenological approach in order to explore the participants' experiences relevant to these research questions. Phenomenology is a philosophical approach to the study of experience, where experience is examined in the way it occurs, on its own terms (Smith, Flowers, & Larkin, 2009), and the two main traditions used in health sciences are descriptive (eidetic) and interpretative (hermeneutic) phenomenology (Lopez & Willis, 2004). Given the hermeneutic foundation of the thesis, a hermeneutical-phenomenological approach was chosen. This allowed an exploration of the participants'

experiences and perspectives on help seeking, treatment participation, and process of recovery, while acknowledging the inevitable influence of interpretation in all human activity (Alvesson & Sköldberg, 2000; Angen, 2000; Laverty, 2003).

In line with a hermeneutical-phenomenological approach, preunderstanding is both a prerequisite and a possible obstacle for understanding. The encounters between researchers and participants provide opportunities for discovering previously hidden parts of the researchers' preunderstandings and how this influences the research process. The meanings we derive from hermeneutical-phenomenological studies therefore represent a fusion of our own and our participants' experiential horizons (Alvesson & Sköldberg, 2000; Lopez & Willis, 2004; Smith, 2007). A dialogical view of reflexivity was thus central to the research process. The encounters with the participants' (and external interviewers') experiential horizons during interviews and analysis were used actively to reflect on our own pre-understandings and how these influenced the emerging research process (Alvesson & Sköldberg, 2000; Stige, Malterud, & Midtgarden, 2009).

My multiple roles in this research project (i.e. treatment developer, group therapist, and researcher) made it particularly important to facilitate reflexivity by bringing in external perspectives on the research process and emerging findings. While these multiple roles provided a broad and deep understanding of the study context and treatment approach being studied, it also implied a deeply rooted preunderstanding that would make it more challenging to acquire the necessary distance to explore the phenomenological aspects of the clients' experiences. The responses, reflections, discussions and questions provided by supervisors, the external co-author and interviewers in the course of the research process, and particularly during the process of analysis, were therefore vital in facilitating the process of reflexivity. Presenting the inclusive stabilization group approach in paper I (Stige, 2011) was additionally helpful in becoming aware of preunderstandings and to discover how they might influence the research process and findings related to research questions 2–4.

The research project was approved by the Regional Committee for Medical and Health Research Ethics, North Region (in Norwegian abbreviated REK Nord) and by the Norwegian Social Sciences Agency (NSD).

4.2 Data collection

To access the first-person perspective and lived experiences of help seeking, treatment participation and process of recovery we chose to use individual in-depth, semi-structured interviews with clients from the inclusive stabilization group approach. Interviews provide rich data about participants' experiences with the phenomenon of interest (Knox & Burkard, 2009; Kvale, 1996) and are therefore a suitable method for collecting data when interested in the first-person perspective of a phenomenon. In this study we chose to use face-to-face interviews. This would allow us to observe and use non-verbal communication when interviewing the participants, thus providing the interviewers with better opportunities to follow the participants sensitively, pace questions to their arousal level and possibly assist the participant in regulating arousal should this be necessary. This was considered particularly important as all potential research participants were struggling with trauma-related distress to such an extent that they fulfilled the Norwegian government's criteria for receiving specialized mental health services.

Interviews were conducted between August 2008 and March 2011, as there are only two treatment groups a year, with a total of 9–12 participants each year. All interviews were conducted at the clinic by a team of three, due to REK Nord's requirement that no research participants were interviewed by their former therapist. Two female mental health care workers (external interviewers) with no previous relation to the participants and no other involvement in the research project interviewed participants from treatment groups 1–5. I performed interviews with participants from the sixth group.

Interviews were carried out within three months of participants' completion of the group treatment. They were audio-recorded and lasted one to two hours. The use of three interviewers required a fairly detailed interview guide to ensure a common research focus, and the full interview guide is presented in appendix 3. The main topics covered were a) the process leading to help seeking, b) experience of treatment participation, and c) experience of change/recovery, along with examples of follow-up questions. All questions were open, aiming at eliciting rich data of the participants' experiences and how they had given meaning to these experiences. The follow-up questions were also used to check interviewers' emerging understanding of participants' experiences (Kvale, 1996), and to allow participants to clarify or elaborate on their statements.

Following the first interview the centrality of the process leading to help seeking became evident, and it was clear that the interview guide did not fully capture participants' experiences of this process. It was difficult for the interviewer to probe for more information without introducing too much of the interviewer's preunderstanding into the interview. I therefore developed a procedure where the participants were asked to draw a time-line where they indicated their experienced fluctuations in distress over time, the time of their traumatic exposure and when they initially sought help. Participants' drawings allowed the interviewers to explore the first-person perspective of the process leading to help seeking and the process of recovery more freely, and to stay closer to participants' experiences and words choices without introducing clinical terms like 'trauma', 'flash-backs', and so forth. This change in procedure was approved by REK Nord, and an example of a time-line is included in Figure 1.

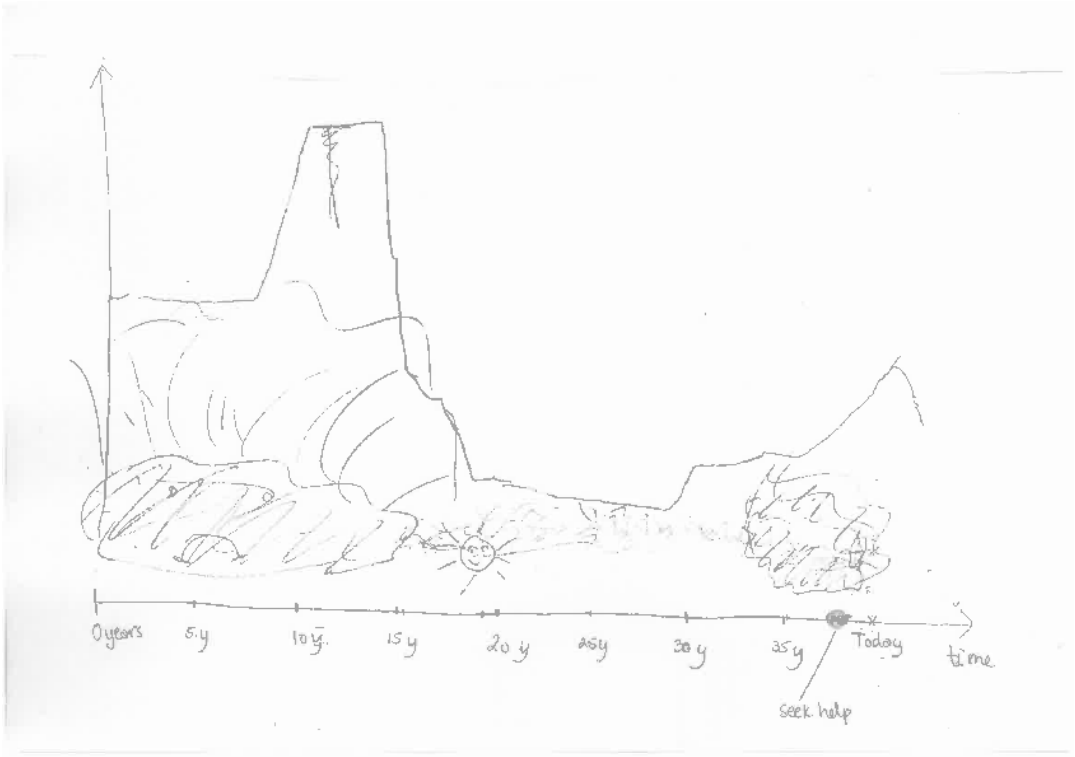


Figure 1. An example of a time-line drawn by a participant during the interview.

I listened to each interview shortly after completion and provided feedback to the two external interviewers to ensure that the data material became sufficiently rich, and that the interviewers were updated on the latest adjustments and developments in the research focus. Feedback both related to the style of interviewing (e.g. encouraging interviewers to probe for more descriptions of concrete situations or experiences) and to

the adjustment of research focus. One example of the latter is the expansion of the focus on the process leading to help seeking following the first interview and the inclusion of the new procedure of having participants draw a time-line to better understand this process.

4.3 Recruitment

Due to the study setting, REK Nord 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 three weeks of their completion of the stabilization group. Those who wanted to participate returned their contact information by post. We then contacted them to arrange a time and place (participants' homes or the clinic) for the interview. All clients who volunteered to participate were enrolled in the study, and all had completed the treatment group. Written consent was obtained at the time of the interviews.

Following the fifth treatment group we had recruited 10 participants to the study, and we were observing converging patterns of meaning in our preliminary analysis of the data. We chose to recruit participants from the sixth treatment group to ensure that we did not exclude important and new perspectives from our analysis. The final sample comprised 13 clients from six treatment groups.[4]

The sampling strategy was purposeful because all potential participants had participated the inclusive stabilization group approach and had relevant experiences to the research questions. The resulting sample was a convenience sample, however, because only 13 out of 31 potential participants volunteered to participate. While representativeness for the purpose of generalization is not the main concern here, a possible selection bias has to be taken into consideration in the data analysis and interpretation, particularly in relation to research question 3. This will be addressed further in sections 6.4.3 and 6.6.

4.4 Participants

In order to maintain participant anonymity in the given study setting it was considered necessary to provide modest amounts of participant-specific information, both in the

[4] 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.

individual papers and in this summary. Reflections on possible implications of this will be presented in section 6.4.2.

The 13 participants were between 18 and 60 years of age (mean age 39 years) and had attended between 60 and 100% of the group meetings. They were all continuing in individual therapy at the time of their interviews. Prior experiences of therapy varied from none to several years. All research participants reported being younger than five 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. They had waited 13–58 years before they sought professional help for their trauma-related problems. 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.

4.5 Data material

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. I transcribed all interviews verbatim shortly after completion, with auditory, non-verbal aspects of the communication, such as emotional tone, indicated by short descriptions added in parentheses. The resulting data material was considered rich and suitable for a meaningful hermeneutical-phenomenological analysis. The 17 interview transcripts therefore comprised the data material used to explore research questions 2–4.

4.6 Data analysis

Analysis was explorative, relying on a hermeneutical-phenomenological approach (Alvesson & Sköldberg, 2000; Laverty, 2003; Smith, 2007). Providing information about the analytic process in a qualitative study, along with the researchers' specific context-dependent starting point for the analytic process, is essential for the evaluation of the quality and the trustworthiness of the presented findings (Angen, 2000; Yardley, 2000). Yet, describing the analytic process accurately is challenging because it is a complex process that starts when the first bits of data (first interview in this case) are encountered and lasts for weeks to months. As data collection proceeds, the more intensive phase of the final

analysis starts. This phase entails a cyclic alternation between periods dominated by a more bottom-up versus top-down approach to the data material. Throughout the process there is a constant alternation between particular parts of the data material (extracts of individual interviews) and the material as a whole (patterns of meaning across interviews), because the quotes and extract cannot be understood without a wider context, and vice versa.

The NVivo 8 software (QSR International, 2008) was used as a technical support for analysing the interview transcripts, allowing easy, updated access to parts of the interview text comprising each sub-theme and theme. NVivo allows a marking of all text relevant to the research question while reading the interview transcripts and to mark each segment of text with a separate label. Segments of text can then be chunked together, forming hierarchies of sub-themes and themes. The program also provides an overview of how many participants have contributed text to each sub-theme or theme, an option used in paper III (Stige, Rosenvinge, & Træen, 2013). Our application of this function in paper III should not be seen as an indication that we were only exploring the main tendencies in the data material.

The first author carried out the primary analysis of the material, and the co-authors and external interviewers contributed to a critical transformation of this initial organisation of data through dialogue. Following the first organization of the data, preliminary interpretations and emerging themes were presented to the external interviewers and the co-authors. The resulting discussions and reflections led to a re-examination of the data and a refinement of the analysis. This process was repeated two or three times with each of the three empirical papers. This ongoing process and negotiation of meaning (i.e. the interviewers' reflections on how the interpretations resonated with their initial understanding of the data material from the interview situations, and the co-authors' reflections, questions, suggestions and comments) facilitated both the analytic process and the process of reflexivity. Considering the clinical history, it was considered too taxing to include participants in this hermeneutic process.

In sum, the hermeneutic process included the following elements:

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 research questions were examined and labelled.
3. All parts of the text expressing different aspects of 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 participants' converging and diverging experiences.
6. Following this first organization of the data, the analysis was critically transformed through dialogue with the external interviewers and dialogue between the authors, as described above.
7. The first author referred back to the overall text to check that all relevant aspects of participants' experiences had been included in the process of analysis.
8. Writing the findings section in the empirical papers constituted the final part of the analytic process.

Using an example from the analysis of help seeking, Table 1 illustrates the process of converging raw text transcripts into units with a shared meaning (Kvale, 1996) and then into sub-themes and themes. The reading and re-reading of all interviews resulted in 309 segments of labelled texts considered relevant to participants' experiences of the process leading to help seeking. This bottom-up processing of the data was then supplemented by a top-down process aiming to collapse and subsume labels with marginal meaning differences relative to the research question. This initial organization of data was followed by the work of converting these labelled segments of text to meaning units.

During this first organization of data, it became obvious that there were two different paths to help seeking in the sample: Self-initiated and other-initiated help seeking. The data were hence organized according to cases of self-initiated and other-initiated first contact with the health care system. The work of abstracting a thematic structure within each of these subgroups of cases then started.

Labelled segment of text	Meaning unit	Sub-theme	Main theme
"When my depression had increased sufficiently, I experienced that the trauma-related symptoms came to the foreground, and I became restless. I had to do something all the time to avoid thinking about the things that had happened. I was very aware that I would not have managed... Well, I had to think about something else! And then the restlessness was there, luckily."	Do something to keep symptoms in check	Keeping trauma history and symptoms at a tolerable distance	Original trauma elicits a strategy of managing on one's own
"I had locked away what happened to me when I was five years old. Because I have known all the time! But I have managed to keep it behind the wall, and the times it has attempted to come forth I have managed to push it back."	Build a mental wall to keep trauma-content from entering consciousness		

Table 1. An example of how raw text translates into meaning units, sub-themes, and themes.

From this point on the interpretative influence of the researchers on the analysis became increasingly stronger, as we needed to step away from the data to look for patterns of meaning, and what concepts or categories could connect the different meaning units, while still incorporate the width of experiences expressed by the participants. There was still a constant alternation between presenting possible ways to organize the data, going back to each interview in detail to see whether the thematic structure accommodated all aspects of help seeking presented by the participants. This closer examination led to an adjustment of the thematic structure. The analytic process of the data relating to help seeking lasted for more than four months.

5. Summary of papers

5.1 Paper I: A stabilization group approach for heterogeneous populations of trauma clients (Stige, 2011)

This paper presents the inclusive stabilization group approach that was developed in response to research question 1. The inclusive stabilization group is an example of a phase one treatment approach adjusted to a Norwegian context with small DPSs. This reflects the understanding of trauma-specific symptoms as an expression of unintegrated aspects of a traumatic experience, and hence the need for phase-oriented trauma treatment (Herman, 1992a; 1992b; van der Hart et al., 2006). The treatment approach can be applied in a wide range of settings and is tailored to include persons who have been exposed to the full range of human-inflicted trauma (either in childhood, adulthood, or both), and who are currently experiencing trauma-specific symptoms.

The paper clarifies how the approach builds on existing trauma theory and empirical studies, and the adjustments that have been made to accommodate a wider range of trauma clients in the same treatment group. The paper also illustrates how key theoretical concepts to the stabilization phase, like 'safety' and 'sense of agency' (Herman, 1992b), are attended to in the practical, therapeutic work in the treatment groups.

The resulting treatment approach suggests a structure with closed, gender-specific groups with a strict focus on stabilization. There is therefore no sharing of individual trauma histories during group meetings. It is recommended that each group is led by two group therapists and consists of no more than seven clients. The approach also suggests 17 weekly group meetings, with each group session lasting 90 minutes. The content of each group meeting is detailed in paper I.

The approach mainly has a here-and-now focus, but the stabilization work is contextualized by focusing on how traumatization in general can lead to the development of trauma-related problems. The focus is thus on enhancing clients' understanding and handling of their trauma-related problems. The group meetings are fairly structured, with an alternation between psycho-education, exchange of experiences between clients and building skills for the efficient regulation of arousal, including grounding exercises (Boon et al., 2011; Najavits, 2002). Trauma-related topics are introduced by psycho-education, and then linked to client experiences. Metaphors are actively used to help clients relate to

the psycho-education, despite the heterogeneous group composition. Client participation is emphasized in the approach, and member-member interaction is encouraged throughout treatment.

5.2 Paper II: The process leading to help seeking following childhood trauma (Stige, Træen, & Rosenvinge, in press)

This paper focuses on the experiences that led participants to seek help. Our analysis revealed that there was a substantial difference between the experiences of participants who had self-initiated their first contact with the health care system, compared with participants where others had initiated this first contact. Other-initiated help seeking led to earlier contact with the health care system. However, participants felt that they did not fully benefit from this early contact because they were not ready to relate to their histories and symptoms.

Eleven of the participants had self-initiated their first contact with the health care system. The analysis of these participants' reported experiences showed that help seeking was initiated after a prolonged period of time. Participants waited between 13 and 58 years from their first exposure to trauma until they sought help. A model for the process leading to help seeking was constructed, and is presented in Figure 2.

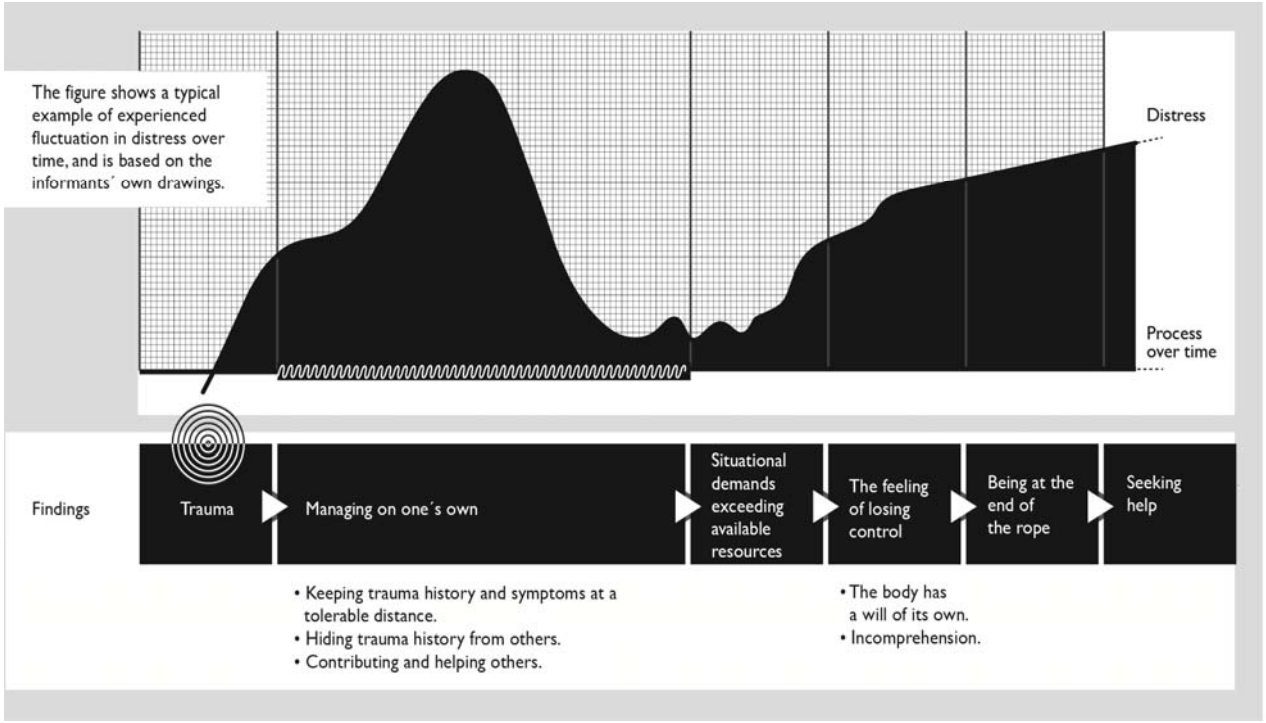


Figure 2. A model of the process leading to help seeking following childhood trauma in this sample.

The substantial reported delays in help seeking were interpreted as a consequence of heavy reliance on a strategy of managing on one's own (i.e. self-management). Important components of this strategy were to keep their trauma histories and symptoms at a tolerable distance, hide their trauma histories from others and contribute and help others. At some point in time participants reported encountering new situational demands that exceeded their available resources. This needed not be negative life-experiences, but resulted in participants experiencing loss of control over intrusive symptoms and incomprehension, coupled with experiences of exhaustion. Help seeking was initiated when participants felt they had no other option, often due to a perceived negative influence on significant others.

The reported delay in help seeking (Fikretoglu et al., 2010; Wang, Berglund et al., 2005) and reliance on self-management prior to seeking help (Kessler et al., 2001; Koenen et al., 2003; Sayer et al., 2009; Wang, 2006) is in line with existing research. However, participants' stories and experiences nuance the conceptualization of self-management as a mere barrier to help seeking. Participants experienced that they were sufficiently on top of things for a long time prior to seeking help, and the strategy of self-management provided them with important experiences of coping and meaning. The findings also show how help seeking might represent a substantial change to survivors of childhood trauma and illustrate the importance of paying attention to the experiences that led to help seeking when planning and initiating trauma-specific treatment.

5.3 Paper III: A meaningful struggle: Trauma clients' experiences with an inclusive stabilization group approach (Stige, Rosenvinge, & Træen, 2013)

This paper addresses clients' perspectives on participation in an inclusive stabilization group approach. The analysis resulted in five main themes, and showed how treatment participation was experienced as demanding but rewarding, as a meaningful struggle. The main themes were: *Dreading and hoping – preparing for participation; Tuning in and staying put; Meeting other trauma survivors; Acquiring a stabilizing ballast;* and *Being receptive to change*.

Deciding to participate in the stabilization group was challenging for all the participants. They were attracted to the group by a hope that participation would give them tools to improve their everyday lives, but they also feared the implications of group

commitment. Turning up for the first group meeting was thus the most difficult part of the stabilization group for many of the participants. Even after this initial barrier was overcome, many participants experienced ambivalence regarding their continued participation in the group due to group participation being experienced as demanding. They had to get used to the different elements of the group treatment, finding their way of being in the group and dealing with treatment-related processes of change.

Although it required great effort, group participation was experienced as worthwhile for all participants. This related at large to the opportunity to meet other trauma survivors: to experience that they were not alone and to have a chance to exchange experiences with others who could relate to their own experiences and difficulties. Group participation rendered the participants feeling more robust and better prepared to face whatever came their way — they had acquired a stabilizing ballast. However, participants underlined the active role they had taken to benefit from the group treatment and the importance of being receptive to change when receiving such treatment.

Participants' experiences with treatment participation, i.e. ambiguity related to group participation, having to figure out how group therapy worked, experiencing group participation as providing new, helpful ways to view themselves and relate to the people around them and the importance of being ready to change in order to benefit from treatment, are in line with findings presented by Parker and colleagues (2007).

The findings also extend previous knowledge by shedding light on how trauma clients might experience ambivalence throughout treatment due to experiencing demanding processes of vulnerability, adjustment to treatment participation, and treatment-related change. This might be true even if participants are completers of treatment, experiencing treatment as beneficial. Moreover, the findings provide concrete examples of what trauma clients might find useful in therapy. In particular the opportunity for exchanging experiences and meeting other trauma survivors were emphasized, along with the significance of acquiring knowledge and skills that contributed to participants' experiences of being more robust in facing their life situations and potential future challenges.

The findings hence support the perspective of clients' active role in healing (e.g. Bohart & Tallman, 1999; Knight et al., 2012). In fact, participants recognized and

emphasized the active role they played in benefitting from treatment, and reflected upon the importance of clients being receptive to change, open to new experiences and perspectives and willing to give things time, in order to benefit from treatment.

5.4 Paper IV: Stories from the road of recovery– How adult, female survivors of childhood trauma experience ways to positive change (Stige, Binder, Rosenvinge, & Træen, 2013)

In this paper we explored participants' experiences of the road of recovery and ways to positive change. Experiences of positive change were not restricted to the period of attending the inclusive stabilization group, and the results should not be seen as a treatment-specific outcome. The analysis resulted in five distinct, but interrelated main themes, namely: *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*.

Participants were experiencing different roads of recovery, but they shared the experience that once a substantial positive change had happened, this often led to more positive change. We conceptualized this as a loop of positive change. The way participants entered this loop varied. While some participants entered it through encountering information that helped them find new and better ways to understand their experiences and reactions, others entered the loop through a change in behaviour or increased bodily contact. The importance of a strengthened sense of agency and opportunities for new meaning-making stood out among participants' experiences. The latter was also closely connected to increased emotional contact, and the strength of this relationship, together with the independent value of increased emotional contact in the process of recovery, was something we did not fully anticipate.

The road of recovery was not only associated with a decrease in distress and increase in positive experiences, however. Symptom elimination was hardly mentioned in participants' stories, and several participants actually experienced the process of recovery involving either no change in the level of distress or even an increase in symptoms. The way participants experienced and related to their distress changed, however, so that they still experienced being on the road of recovery. Some participants felt more robust in

staying with difficult feelings; others experienced the increase in symptoms as bearing meaning because they had been so numbed for years.

The findings in paper IV thus conceptualize recovery as a demanding process that unfolds over time and requires personal effort. Opportunities for new meaning-making, increased emotional and bodily contact, and a strengthened sense of agency were important ways to positive change. While symptom elimination was a possible part of recovery, it was not a necessary part of this process. In these respects the findings support existing research on the first-person perspective of trauma recovery (e.g. Adler, 2012, Banyard & Williams, 2007; Borg & Davidson, 2008; Davidson & Roe, 2007; Draucker et al., 2009; Thomas & Hall, 2008).

In addition to this confirmation of previous knowledge, the findings point to how difficult and challenging experiences might be perceived as meaningful and worthwhile and part of the recovery process. The experience of having found something to navigate after was emphasized in this respect. Moreover, the findings contribute to the field by illustrating how the process of recovery can be experienced as a loop of positive change, with a mutual influence of the various aspects of the recovery process, and where there might be many different ways of entering the road of recovery.

6. Overall discussion of findings

This thesis focuses on a trauma-specific treatment group approach that can be applied in a wider range of settings such as small DPSs where homogenous trauma groups cannot be offered. Moreover, it explores clients' perspectives on (a) the experiences leading to help seeking; (b) participation in the new treatment approach; (c) the process of recovery.

Looking at the findings across papers, new aspects appear that were not obvious when looking at the individual papers in isolation. It seems that the participants' ways of understanding themselves and their situation (i.e. their meaning-making processes), and their experiences of being able to influence their own situation (i.e. their sense of agency) have been distinctly different at various points in time (e.g. prior to seeking help as compared to the time they seek help). These differences further seem to be related to variations in participants' experienced state of health and well-being (e.g. *Incomprehension* and *Losing control* related to an experienced deterioration in health). Taken together the findings thus point to the double roles meaning-making processes and a sense of agency played in the aftermath of childhood trauma for these participants, as both potential catalysts for help seeking and important components in the process of recovery. I will therefore use the opportunity provided by the present format to integrate the findings from the four papers, using meaning-making processes and sense of agency in the aftermath of childhood trauma as focal points.

The specific findings have been summed up in Chapter 5 and discussed more thoroughly in the individual papers. However, a brief overview of how the findings are related to each other and how they confirm and extend available literature will be presented. The findings' relations to participants' meaning-making processes and sense of agency will then be discussed. Reflections on the trustworthiness of the study and the transferability of the findings will then be presented, along with limitations and implications for future research. Finally, a more detailed section on the clinical implications will be included, as the research project was carried out within a context of standard treatment and explores clients' perspectives on a treatment approach developed in response to challenges linked to the homogeneous organization of the Norwegian mental health care system, despite diverse conditions.

6.1 A précis of the findings

Taken together, the findings presented in this thesis indicate that including clients with a wide range of different trauma histories and trauma-related symptoms in the same treatment group may be a meaningful way to organize trauma-specific treatment in contexts where homogeneous trauma groups cannot be offered. Most participants experienced the strict focus on stabilization and the non-sharing of trauma histories as beneficial. Trauma stabilization was experienced as relevant to participants even though many years had passed since their first traumatic exposure at the time of treatment. Indeed, the non-sharing helped them focus on their current problems and how to handle these.

The focus on how to understand and handle trauma-related symptoms rendered the participants feeling more robust in staying with difficult feelings and approaching their symptoms and bodily experiences, rather than avoiding them. This might indicate that an inclusive stabilization group approach might contribute to counteract one of the core symptoms in PTSD, namely avoidance of trauma-related stimuli (APA, 2000). In addition, participants' experiences with meeting other trauma survivors underline the importance of finding ways to offer group-based trauma treatment in a wider range of settings. The applicability and adoptability of a phase-oriented approach to trauma treatment (Herman, 1992b; van der Hart et al., 2006) as a possible means to offer trauma treatment in a wider range of settings is therefore supported by the presented findings.

Participants' perspectives offer important and powerful examples of how the studied phenomena can be experienced. The findings thus offer new understandings that complement and extend on existing knowledge. Through the participants' stories the multiple functions of self-management were illustrated, along with the decisive role experiences of exhaustion and losing control over intrusive and bodily symptoms might have on the decision to seek help following childhood trauma.

Participants' stories also expand on existing knowledge by providing concrete examples of how treatment participation might be experienced as challenging throughout the course of treatment. This related both to demanding, although welcomed, processes of change, and a prolonged sense of vulnerability linked to participating in a trauma-specific treatment group. One way to understand this experienced sense of vulnerability is to examine how group participation differed from participants' previous coping strategies.

Prior to seeking help, participants reported actively hiding their trauma histories from others as one important aspect of their strategy of managing on their own (i.e. self-management; paper II). When participants contemplated join the inclusive stabilization group, they reported feeling very vulnerable. This related largely to sensitive information that could be inferred from their participation in a trauma-specific treatment group that few, if any, knew about — namely that they had been exposed to trauma and were struggling with the consequences of this exposure (paper III). Even though their individual trauma histories were not explored during group meetings (i.e. non-sharing; paper I), this was a very different type of non-sharing than participants had relied on previously when actively hiding their trauma histories from others. The findings thus shed light on how participation in an inclusive stabilization group can represent a non-sharing that is also a non-hiding, thus eliciting strong feelings of vulnerability.

The findings also complement existing knowledge by provide concrete examples of helpful components of the inclusive stabilization group approach, such as its strict focus on stabilization and the opportunity to meet other trauma survivors, exchange experiences and find new ways to understand and relate to oneself, one's history and symptoms (paper III). Participants' experiences from their roads of recovery also pointed to the many different ways to enter the loop of positive change, the mutual influence of the various elements of the recovery process and the independent value of increased bodily awareness in the process of recovery (paper IV).

The findings are also consistent with existing research in many respects. The reported delays in help seeking and heavy reliance on self-management prior to help seeking are in line with existing research on delays (e.g. Fikretoglu et al., 2010; Wang, Berglund et al., 2005) and barriers to seeking help (e.g. Kessler et al., 2001; Koenen et al., 2003; Sayer et al., 2009; Wang, 2006). The participants' experiences of ambiguity related to group participation despite treatment providing new and helpful experiences and their emphasis of being ready to change in order to benefit from treatment also support existing research (i.e. Parker et al., 2007). The presented findings further support a view of trauma recovery as a demanding process that requires personal effort (e.g. Banyard & Williams, 2007; Davidson & Roe, 2007; Draucker et al., 2009; Thomas & Hall, 2008), where symptom elimination is a possible but not necessary part of recovery (Borg & Davidson, 2008).

6.2 Processes of meaning-making in the aftermath of childhood trauma

Participants' reported ways of relating to themselves and the outside world prior to seeking help and at present are strikingly different. From relying on self-management and avoiding trauma-related content, they reported approaching their symptoms, trying to understand them and improved relationships with significant others. Looking at the findings across papers it therefore seems that participants' ways of being in the world reflect different understandings of the world at different points in time, i.e. different meaning systems. A 'meaning system' is here understood as core meaning structures resulting from meaning-making processes that inform a person's understanding of the world (Gillies & Neimeyer, 2006, p. 54) parallel to Janoff-Bulman's (1992) concept 'assumptive world'.

The strategy of self-management allowed participants to function reasonably well prior to seeking help despite their traumatic experiences and experiences of distress (see Figure 2). Moreover, it provided them with important experiences of coping and positive feedback. Participants thus relied on this strategy for years without considering help seeking an option.

However, self-management was experienced as a lonely journey. Participants believed that no one would come to their rescue and were therefore hiding their trauma histories from others. Moreover, many participants used a significant amount of energy to control their surroundings and their own reactions so they would not be overwhelmed by their trauma histories and symptoms; as a result, they had to ignore and avoid many of their innermost feelings. More importantly, their perceptions of their opportunities seem to have been rather rigid. They felt that they had to manage on their own, no matter what, that they had to help others even if they did not feel like it. Many attributed experiences of trauma-related symptoms to their personal weakness and felt responsibility for preventing new traumatic experiences, both for themselves and others (paper II).

Based on knowledge of the effect childhood trauma can have on development (e.g. Cook et al., 2005) and the characteristics of traumatic experiences (Saporta & van der Kolk, 1992) it seems reasonable to assume that the strategy of self-management reflects post-trauma meaning-making processes. One way of interpreting the one-sided reliance on self-management reported by the participants, then, is to view it as indicative of a successful re-creation of a coherent, but rather negative understanding of the world, other people

and themselves. It seems the participants were managing, but not thriving. They were merely hanging in there.

Participants' descriptions of their current experiences related to treatment participation (paper III) and ways to positive change (paper IV) are strikingly different. Participants described how they now related to their inner feelings, significant others and existential issues in a new and more flexible manner. This increased contact with their inner feelings and bodies was reported as meaningful, although difficult and sometimes even painful. Heather, for example, shared how being more in touch with her feelings exacerbated her symptoms. This actually made her feel more alive and made life more worth living. An important part of the recovery process for these participants was, therefore, to arrive at new meaning structures that made it meaningful to invest their energy in working on improving their own situations, even when this meant facing difficult and painful experiences (paper IV).

Participants also experienced that their new meaning systems reduced guilt through changing their understanding of their part in their symptoms and the traumas they had endured. This helped many look at themselves, their current life situations and their histories in a new and more positive light. Finding new ways of understanding as part of treatment participation and recovery thus rendered participants feeling more robust in facing their life situations, symptoms, and future challenges.

The work presented in this thesis rests on a hermeneutical-phenomenological approach to knowledge production, thus emphasizing the constructivist and interpretive character of meaning and knowledge (Alvesson & Sköldberg, 2000). In this sense, meaning-making processes are always influencing us, and they are something we cannot escape. The way we make sense of things is therefore not static, but something that always changes as we encounter new experiences and new perspectives. The presented findings illustrate these ongoing processes of meaning-making, as participants' experiences seem to reflect different, but coherent meaning systems both prior to seeking help and at present.

Participants' descriptions of their experiences around the time they sought help (i.e. *The feeling of losing control* and *Being at the end of the rope*), on the other hand, can be understood as expressing a collapse in their old meaning systems. Encountering life situations that knocked them off balance, participants reported experiencing an

uncontrollable increase in intrusive systems, coupled with incomprehension. The perceived impact these experiences had on significant others often led to participants' decision to seek help (paper II). The catalyst function of incomprehension for help seeking in this sample can be understood, then, as illustrating the potential stabilizing effect of a coherent meaning system that facilitates navigation through life (i.e. self-management), even when this meaning system is based on a rather negative view of oneself, others, and the world.

In fact, the importance of a coherent meaning system for subjective well-being and health has been emphasized in salutogenesis (e.g. the theory of SOC), with such coherent meaning systems considered protective in the face of adversity and promoters of a movement towards the healthy end of the health ease/dis-ease continuum (Antonovsky, 1987). Furthermore, trauma-specific theories (e.g. theory of shattered assumptions; Janoff-Bulman, 1992) and models focusing on meaning-making (e.g. Gillies & Neimeyer, 2006) point to how the negative effects of traumatic experiences can be attributed to trauma's devastating effects on a person's meaning system. For example, the theory of shattered assumptions relates trauma-specific symptoms to a shattering of basic assumptions such as the world as benevolent and meaningful and the self as worthy (Janoff-Bulman, 1992). Gillies and Neimeyer (2006) have proposed a model for traumatic loss where the degree of congruence between the traumatic experience and existing meaning system is regarded as decisive in understanding levels of distress following traumatic loss.

Participants' experiences around the time they sought help can be seen as illustrating this de-stabilizing effect of a crumbling meaning system. The described experiences strongly resemble descriptions of processes elicited by trauma-related shattering of assumptions (Janoff-Bulman, 1992), or reactions to traumatic experiences being incongruent with existing meaning systems (Gillies & Neimeyer, 2006).For the majority of participants, however, the collapse of their old meaning systems prior to seeking help was not elicited by a new or a repetition of old traumas. Even positive life events, like getting married and experiencing that one was not alone, could destabilize one's level of functioning (paper II).

One way to understand this finding, then, is to explore the new situational demands as either being congruent or incongruent with participants' existing meaning systems (Gillies & Neimeyer, 2006). Applying this perspective to the findings, one

interpretation would be that post-trauma meaning systems that result in a rigid reliance on self-management and avoidance of trauma-related stimuli can become instable and crumble when confronted with unexpected, incongruent experiences. This might be true even for positive and willed events, such as getting married. Experiencing that one is not alone (e.g. getting married, meeting other trauma survivors) or being confronted with new perspectives (e.g. toward help seeking, or views on childhood trauma) might then be so incongruent with existing meaning systems that it leads to a collapse of these meaning systems, eliciting trauma-like reactions. In this respect the findings extend existing literature on post-trauma meaning-making processes.

While the discussion above has shed light on the importance of having a coherent meaning system, the findings also point to the differential effects of coherent meaning systems (i.e. self-management versus recovery), depending on the opportunities these meaning systems provide for a positive and flexible way of understanding and relating to oneself, others, and one's life situation. The *way* experiences are interpreted and made sense of therefore seems to be related to experiences of health and well-being.

This point is emphasized in the literature on post-traumatic growth, where meaning-making processes elicited by trauma are seen as having the potential to improve one's situation through the development of new and more helpful meaning systems (Nelson, 2011). Cognitive approaches to treating mental health problems (e.g. Segal, Williams, & Teasdale, 2002) also emphasize the importance our interpretation of the events we encounter has for experiences of well-being and health.

From this perspective, the assumed collapse of existing meaning systems preceding help seeking in this sample can be understood as having the potential to activate healing processes. One way to understand the findings is that the scary and confusing experiences leading to help seeking, thus an abandonment of self-management, provided participants with opportunities for developing new and more helpful meaning systems. This view is supported by the way participants' experiences of treatment participation and recovery resembles described processes in trauma recovery, such as rebuilding the assumptive world (Janoff-Bulman, 1992) and acquiring new perspectives that make it easier to understand oneself, one's history and symptoms (Herman, 1992b). Help-seeking behaviour in this sample might therefore be interpreted as indicative of a transitional phase where new more helpful meaning-making processes might be facilitated.

Taken together, then, the findings can be interpreted as an expression of a process where the participants gradually reconstructed new, and more helpful meaning systems, which enabled them to view themselves, their ability to influence their own situation, and what the future holds, from a new perspective. From being experts on how to avoid exposure to overwhelming trauma-related stimuli, participants met the world in a more flexible manner, feeling they could handle whatever came their way without having to control the stimuli they encounter. Moreover, the potential opportunities a collapse in existing meaning systems provides for recovery has been explored, along with the idea of help seeking as an indicator of opportunities for new and more helpful meaning systems to develop. The findings also show how non-traumatic events can function as catalysts for new and helpful meaning-making processes in the aftermath of childhood trauma.

The findings thus both illustrate participants' abilities to utilize available resources and grasp opportunities for new meaning-making processes, and the importance of exploring meaning-making processes to understand the movement on the health ease/dis-ease continuum following childhood trauma (Antonovsky, 1987).

6.3 Sense of agency in the aftermath of childhood trauma

Looking at participants' descriptions from their roads of recovery, the concept of 'sense of agency', here defined as the experience of being able to influence one's own situation (e.g. Herman, 1992b), was one of five key components. Participants reported concrete changes in how they lived their lives, related to a strengthened sense of being able to do something to influence and improve their own situation. They took charge of their own situations, particularly in response to negative situations and symptoms.

A strengthened sense of agency as a key component of trauma recovery has also been reported by previous narrative research (Harvey et al., 2000; Phillips & Daniluk, 2004). Moreover, opportunities for a strengthened sense of agency are emphasized in trauma theory and treatment (e.g. Fallott & Harris, 2002; Herman, 1992b; van der Hart et al., 2006), and the inclusive stabilization group approach included several structural elements, such as psycho-education, practicing skills for efficient regulation of arousal during group meetings and emphasizing the opportunity for member-member interaction, aiming at facilitating the strengthening of clients' sense of agency (Stige, 2011).

One way to understand the important role a strengthened sense of agency seems to play in trauma treatment and recovery is to contrast it to characteristics of trauma (e.g.

Saporta & van der Kolk, 1992) and trauma-specific health problems (APA, 2000; Courtois & Ford, 2009). A strengthened sense of agency can therefore be seen as an antidote to the experiences of losing control, failing in all attempts to escape, and not knowing how to understand or stop what is happening.

Although being present in article IV, the participants' experiences of an increased sense of agency was not the focal point of the discussion, possibly due to the way it concurs with existing trauma theory (e.g. Herman, 1992b) and research on trauma recovery (e.g. Harvey et al., 2000). However, looking at the findings across papers, the significance of this concept in understanding the presented findings stands out.

From this perspective, participants' reliance on self-management prior to seeking help (paper II) can be interpreted as an expression of their ability to re-create a sense of agency in the aftermath of childhood trauma. Although leading to delays in help seeking, the strategy provided the participants with important experiences of coping and positive feed-back. Participants found their own ways of handling their life situations and symptoms (i.e. keeping them at a tolerable distance), providing them with an available action repertoire, and thus the experience of being able to do something to influence their situation.

The concept also seems relevant to participants' experiences of treatment participation (paper III). Attending the inclusive stabilization group in response to self-initiated help seeking was experienced as beneficial. Participants reported experiences that seem to have strengthened their sense of agency (i.e. *Meeting other trauma* survivors and *Acquiring a stabilizing ballast)*. Many participants developed new ideas of how to handle their own symptoms by meeting other trauma survivors and exchanging experiences during group meetings. Listening to the experiences of others also seems to have helped participants sort out what they were in the position to change, giving them faith that they could do something to influence their own situation.

Participants' experiences of group participation and ways to positive change differ significantly from their stories from around the time they sought help. Participants' experiences from this period were characterized by losing control and exhaustion. They were overwhelmed by their symptoms and did not know how to understand them or how to handle them. This can be interpreted as an indication of a significantly weakened sense of agency.

Taken together, then, the double roles of a sense of agency in the presented findings stand out. In this sample, participants' sense of agency functioned as both a catalyst for seeking help and an important promoter of recovery following childhood trauma.

The findings also point to some of the dilemmas of health-promotion efforts and in assuming 'the-sooner-the-better' in treating mental health problems. Even though participants experienced treatment participation as beneficial, they emphasized the importance of being receptive to help in order to benefit from treatment (paper III). This reminds us of the importance of respecting the individual's post-trauma processes when planning and initiating treatment. A push for earlier treatment contact (i.e. health-promotion efforts to shorten delay in help seeking; Jané-Llopis & Anderson, 2006) would possibly have imposed an external perspective of viewing the person as incapable of resolving her problems. Given the influence external characterization (i.e. victim versus survivor) can have on clients' sense of agency (Phillips & Daniluk, 2004), overriding individuals' processes of seeking help would possibly weaken the participants' sense of agency, rather than strengthen it. This would be unfortunate given the significance a strengthened sense of agency seems to play in trauma recovery.

Returning to trauma theory, the theory of structural dissociation of the personality (van der Hart et al., 2006) builds on the work of Janet and relates the sense of agency to the process of 'personification'. Personification involves the capacity to take ownership of one's experiences, and is regarded one of two key aspects of trauma recovery:

> We become consciously aware that a particular event happens to us, that we have done or felt something, that an experience will affect our lives and we change our own actions accordingly (Janet, 1935a). Personification thus connects our sense of self with past, present, and future events, and with our own mental and behavioral actions, giving us a sense of agency (van der Hart et al., 2006, p. 153).

Pacherie (2008) also emphasizes the importance of a connection between past, present and future experiences in the sense of agency:

> A second important distinction is between long-term sense of agency and an occurrent sense of agency. The former may be thought to include both a sense of oneself as an agent apart from any particular action, i.e., a sense of one's capacity

> for action over time, and a form of self-narrative where one's past actions and projected future actions are given a general coherence and unified through a set of overarching goals, motivations, projects and general lines of conduct. The latter is the sense of agency one experiences at the time one is preparing or preforming a particular action (Pacherie, 2008, p. 195).

Applying these perspectives of sense of agency (i.e. Pacherie, 2008; van der Hart et al., 2006), with their emphasis on a connection between the self and past, present and future experiences, provides a new understanding of the findings and their interrelation. The difference between the sense of agency that can be inferred from participants' reliance on self-management and their experiences of an increased sense of agency as part of the recovery process becomes obvious. The sense of agency seems, then, to move both along a dimension of strength (i.e. strong-weak feeling of being able to do something to influence one's situation) and flexibility (i.e. flexible-rigid perception of available actions and opportunities for influencing one's situation).

While self-management seems to have provided participants with important experiences of coping and ways to influence their situations, participants were actively trying to keep trauma-related content at a distance. In different ways the participants were actively avoiding and ignoring inner feelings, bodily sensations and symptoms. Some were cutting away their trauma histories from their (self-) narratives others put their trauma histories behind a mental wall to remain somewhat disconnected from them (paper II).

A movement from numbness toward vital contact was, then, an essential component in participants' experiences of trauma recovery. On their roads of recovery participants experienced increased contact with their bodies, approaching and relating to their symptoms and improving their relations with others (paper IV). The theme *Experiencing a strengthened sense of agency* must therefore be understood within this context of interrelated experiences of positive change.

One interpretation is, therefore, that self-management provided experiences of being able to influence one's situation that proved vital within an extreme context of early and multiple traumas. However, self-management also limited participants' possibilities for developing a flexible and strong sense of agency through their lack of awareness and contact with their bodies, feelings and histories. Participants were therefore left without a

coherent self-narrative including their past, present and future mental and behavioural actions (c.f. van der Hart et al., 2006; Pacherie, 2008). The sense of agency inferred from self-management seems, then, to be based on a rather rigid and narrow scope of actions and opportunities to influence one's situation, where the sense of agency largely related to the degree participants succeeded in controlling their surroundings and inner feelings so trauma content was kept at a tolerable distance.

Against this background, participants' experiences from their roads of recovery stand out as significantly different. Parallel to their experiences of increasingly being able to influence their own situations (i.e. sense of agency) they approached themselves, their bodily sensations, feelings, histories and other people, rather than numbing or avoiding them. Moreover, they reported feeling more robust in facing their life situations, feelings, symptoms, and future challenges (paper III) and had found new ways to understand themselves, their symptoms, and histories (paper IV). Participants' experiences of an increased sense of agency as part of the recovery process therefore seem to reflect a long-term sense of agency (Pacherie, 2008), with increased flexibility and range of actions and possible ways to influence their situations. Participants seemed to have acquired a general sense of capacity for action. They felt ready to handle whatever came their way.

This perspective on the sense of agency seems to emphasize the interrelatedness of different elements in the recovery process. Participants' experiences of an increased sense of agency thus seems to be facilitated by their experiences of other positive changes, such as finding new ways to understand their emotions and actions, moving from numbness toward vital contact, and increased robustness in staying with difficult feelings. This underlines the importance of adopting a broad approach to trauma recovery.

The interplay between self-narrative and a long-term sense of agency is also emphasized by Pacherie (2008), possibly supporting a view of adopting a broad approach to trauma recovery. Also van der Hart and colleagues (2006, p. 154) clearly describe the connection between explicitly formulating our experiences and a strengthened sense of agency: 'We strengthen our sense of ownership of our mental and behavioral actions when we give ourself (and sometimes others) an account of them. We formulate beliefs about what is happening to us and within us.'

Participants' sense of agency seems, then, to undergo important changes over time, closely related to the processes of meaning making described in 6.2. One interpretation is

therefore that participants' one-sided reliance on self-management prior to seeking help reflected functional, but rather rigid, meaning systems and sense of agency that helped participants go about their lives in an extreme context of childhood trauma. Although functional, the participants' meaning systems and sense of agency were fragile when confronted with unexpected stimuli, due to their rigid reliance on controlling internal and external stimuli to avoid being overwhelmed by trauma-related stimuli. Around the time participants sought help, they experienced their meaning systems and sense of agency crumbling. These scary experiences, leading to the abandonment of self-management, made it possible to construct new and more helpful meaning systems and acquire more flexible ways to cope with their life situations. These changes were accompanied by an increased contact with bodily sensations, inner feelings, personal histories and significant others. Participants thus felt more robust and confident they could face whatever came their way.

Taken together, the findings show why adopting an explicit focus on processes of meaning making and the sense of agency can be important to understand post-trauma coping, help seeking, treatment participation and recovery.

6.4 Reflections on the trustworthiness of the study

The issue of 'trustworthiness' or goodness (Angen, 2000) of a piece of research is important, regardless of the method or methodological approach applied and necessitates standards that the research can be evaluated by. However, the issue of evaluating the quality of qualitative research is controversial and has resulted in a vast amount of diverging literature.

While most researchers agree that there needs to be some way of distinguishing high from poor quality in qualitative research, it has proven hard to agree upon how this evaluation ought to happen. This partly reflects a history where qualitative research has been evaluated by inappropriate criteria developed in response to quantitative research. These criteria often relied on a more positivistic ontology and epistemology, resulting in qualitative research being characterized as 'unscientific', 'sloppy', or 'biased' (Angen, 2000). The controversy surrounding the evaluation of quality in qualitative research also relates to the great variety of research approaches that are categorized as 'qualitative research'. Moreover, it reflects different attitudes towards the application of terms originally used to

evaluate quantitative research, such as 'reliability', 'validity', and 'rigor' (e.g. Angen, 2000; Morrow, 2005).

Several concrete but diverging suggestions for how qualitative research could be evaluated have been presented. Some suggestions involve relatively rigorous criteria, or even checklists, for evaluating qualitative research (British Medical Journal, 2013; Parker, 2004). Other suggestions aim to formulate more general and flexible guidelines and agendas that attempt to incorporate the variety of different approaches to qualitative research, while maintaining a focus on what distinguishes high quality from poor quality (qualitative) research (e.g. Angen, 2000; Elliott, Fischer, & Rennie, 1999; Stige et al., 2009; Yardley, 2000).

The work in this thesis relies on the latter approaches to the evaluation of qualitative research. The trustworthiness of a study is thus seen as related both to the way research is carried out and presented, as well as the utility and relevance of the research (Angen, 2000; Stige et al., 2009; Yardley, 2000). Important aspects therefore involve the way researchers manage to situate themselves and their research. It is thus vital to convey information about the study context, research participants, theoretical orientations of the researchers and the research process. This information will then make it possible for the reader to evaluate the trustworthiness of the presented research.

While the evaluation of the trustworthiness of the work presented in this thesis will be informed by future research, the local community, participants, clinicians and the wider community of researchers, I regard it as an important responsibility for a researcher to be attuned to the issues of trustworthiness throughout the research process. If a study fails to fulfil the standards for good (enough) research, it becomes an unethical endeavour. This relates both to research participants, who have dedicated time and efforts sharing personal and sometimes painful experiences, and to the misuse of society's resources (i.e. time and money spent on the research project). In the following sections, I will therefore present my reflections on the trustworthiness of the work presented in this thesis.

6.4.1 Engagement and processes of reflexivity

The work presented in this thesis is in different ways grounded in a prolonged and deep interest in and commitment to the field of psychological trauma. This commitment is also reflected by my multiple roles as treatment developer, group therapist and researcher. This prolonged engagement with trauma theory, trauma treatment literature and the work of

developing and running the inclusive stabilization group approach both contributed to my sensitivity to the context (i.e. sociocultural, theoretical, organizational) and commitment with the phenomena and the situation under study — both believed to be important in facilitating trustworthiness of qualitative studies (Stige et al., 2009; Yardley, 2000). This has given me a solid background for understanding participants' examples and experiences, thus representing an advantage in interpreting the interview texts.

However, such prolonged and broad engagement also implies a deeply rooted preunderstanding that potentially can weaken the trustworthiness of the research if not attended to in a reflexive manner (i.e. 'processing', 'interpretation', and 'self-critique'; Stige et al., 2009). This necessitated a continuous focus on reflexivity and how our pre-understanding and position in the context we were studying were influencing the emerging research processes. Several processes and elements of the present research design were helpful in this respect.

Having a team of three conducting interviews had multiple benefits in the given research setting, including providing opportunities for richer data than would have otherwise been possible. Moreover, the perspectives of the external interviewers facilitated reflexivity by increasing awareness of how our own preunderstandings influenced the emerging research processes.

Writing paper I similarly facilitated an awareness of my preunderstandings, and how they influenced the emerging research processes, e.g. my expectation of successful stabilization work resulting in a decrease in trauma-specific symptoms.

The inclusion of co-authors in the process of analysis and writing also facilitated reflexivity, particularly because the team of researchers had experiences with a range of different types of clinical work and research, as well as different theoretical orientations. The inclusion of several researchers in the processes of data analysis and writing was thus a particular help in detecting blind spots acquired by my prolonged engagement with the field and topic under study.

6.4.2 Balancing the need to protect participant identity with the need to situate and contextualize the findings

The presented research was conducted in a rather narrow setting where all potential research participants were receiving treatment at a small DPS and had participated in an inclusive stabilization group due to their exposure to human-inflicted trauma and current

trauma-specific symptoms. Identification of persons based on different pieces of information is more probable in a rural context, because of the increased transparency about a person's actions and experiences in such a context. Also, because research question 3 focuses on clients' experiences with the inclusive stabilization group, several persons from each treatment group were included in the study. This can potentially lead to group members identifying each other in the presented findings, and thus gaining access to new and sensitive information about other group members.

The study setting thus presented some challenges in maintaining participant anonymity that needed to be addressed. Ensuring participant anonymity is an important ethical principle in all research, but is particularly important in qualitative studies, where participants share their inner thoughts and experiences (NEM, 2009). To meet these challenges, then, we had to think carefully about the types of information that were shared regarding the research participants (i.e. details on trauma exposure, coupled with participant-specific information, such as age and employment status). As a result, relatively sparse amounts of participant-specific information were presented, both in this summary and in the individual papers. There is, for example, no information about age, type of traumatization or current life situation provided with the quotes.

While the chosen solution is believed to ensure the anonymity of research participants, proper contextualization of qualitative data is also essential to ensure the research is of high quality. In fact, the explicit communication of the situatedness of findings is necessary, both to evaluate qualitative research and to help develop and extend our knowledge base (Angen, 2000; Davies & Dodd, 2002; Stige et al., 2009; Yardley, 2000). The fact that findings in this thesis were presented with less contextualization and participant-specific information than ideal therefore potentially weakens the trustworthiness of the findings.

Although the study setting necessitated the sub-optimal contextualization of data in order to ensure participant anonymity, other means were available to help situate the study. For example, findings were presented with many and rich quotes (i.e. 'grounding in example'; Elliott et al., 1999). We also provided as much information as possible regarding the study setting, the inclusive stabilization group approach, the theoretical and empirical context of the study, my multiple roles, and the chosen research design to achieve transparency regarding the research process (Angen, 2000; Davies & Dodd, 2002; Yardley,

2000). While these processes required careful attention and reflection throughout the research process, the information provided in the individual papers and in this summary is believed to reflect a balance between the need to protect the identity of the participants within the given study setting and the need to situate the study and researchers, and to contextualize the data.

6.4.3 Conducting research in a setting of standard treatment

The fact that the study was conducted in a context of standard treatment within the public mental health care system potentially strengthens the trustworthiness of the findings. The need for more research shedding light on clients' perspective of standard treatment is also illustrated by the fact that treatment outcomes in these settings are substantially poorer than in clinical trials (Lambert & Shimokawa, 2011). Moreover, the research project and the resulting treatment approach were developed in response to concrete challenges in the provision of trauma-specific treatment within the current organization of the Norwegian mental health care system. The presented findings confirm and extend on existing research, trauma theory, and clinical practice, further supporting the potential usefulness and practical impacts of the findings, thus their trustworthiness (Angen, 2000; Stige et al., 2009; Yardley, 2000).

However, because all potential participants were clients who had fulfilled the Norwegian government's requirements for receiving specialist mental health care, and because I had been the group therapist for many of the potential participants, the study setting was also associated with important ethical challenges. In particular the issues of informed consent and voluntary participation, two of the most fundamental principles in research ethics (Johansson & Lynøe, 2008), were actualized in the given setting. The research design therefore had to reflect these ethical issues to ensure that clients did not feel pressured to participate in the study, either due to treatment dependency or fear of losing treatment options.

To meet these challenges the chosen research design relied on a purposeful convenience sample, with no information about participants versus non-participants. Information about the research project was only provided in written after completion of treatment. The data used to answer the research questions were therefore retrospective and collected at one point in time. Moreover, interviews were conducted by a team of

three to avoid a situation in which a participant was interviewed by a former therapist (for more information, see section 4.2).

Although appropriately addressing the issue of informed consent and voluntary participation, the chosen research design limits interpretation of the emerging data material. This relates particularly to research question 3, as we have no available information about how research participants are similar and different from non-participants who have also participated in the inclusive stabilization group approach. This concern is not related to the representativeness of the sample, but rather the need to situate the sample properly (Elliott et al., 1999) in order to interpret the emerging data and contextualize the presented findings.

Moreover, relying solely on retrospective data when studying processes that unfold over time (i.e. the process leading to help seeking and the process of recovery) can be a disadvantage because the chosen design does not allow us to access and track changes in the studied phenomena over time. The retrospective nature of the data could then represent an obstacle to producing rich and substantive accounts. While the collected data were considered rich and suitable for a meaningful hermeneutical-phenomenological analysis, the sole reliance on retrospective data is a potential limitation that should be addressed in future research.

Taken together, we therefore see that the work presented in this thesis has had to overcome several challenges and dilemmas linked to trustworthiness throughout the research process. These challenges related particularly to the study setting and my prolonged engagement with the topic under study. While some of these challenges represents limitations to the work presented in this thesis I would argue the chosen research design and research process attend to both issues of ethics and issues of quality of the presented research in a satisfactory way. This claim is also supported by REK Nord's approval of the study, and by the fact that all four papers in the thesis are published or accepted for publication in peer-reviewed journals.

6.5 Reflections on the transferability of the findings

'Transferability' in this thesis is understood as the extent to which the reader experiences the presented findings as relevant and informative in a context different from the one under study (Morrow, 2005). In this sense, transferability is linked to trustworthiness through the concepts of usefulness, or practical impact, and relevance, or theoretical

importance (Stige et al., 2009; Yardley, 2000). Transferability is also linked to the situatedness of a piece of research (Davies & Dodd, 2002), and is achieved when the researcher provides sufficient information about the self (researcher-as-instrument) and the research context, processes, participants, and researcher-participant relationships to enable the reader to decide how the findings may transfer to a different context (Morrow, 2005).

The researcher can, nonetheless, make an 'analytic generalization' (Kvale, 1996, p. 161) which involves a well-founded evaluation of how the findings might be used as guidance for what will happen in a different situation. It is vital, though, that the researcher allows the reader to judge the validity of these generalizations by providing explicit information about the evidence and arguments that underpin them. In the following paragraphs I will therefore present my reflections on the transferability of the findings.

The findings presented in this thesis rely on in-depth interviews with 13 research participants at one point in time. Moreover, all participants had participated in an inclusive stabilization group approach, and were recruited from a relatively narrow context in rural parts of Northern Norway. The chosen study design thus provides good opportunities for studying converging and diverging experiences with help seeking, treatment participation and recovery within a clearly defined study setting. In fact, because all participants had participated in a clearly defined treatment approach, the study provides a wanted opportunity to explore what constitutes a good outcome within a specific treatment approach (e.g. Binder et al., 2010).

Based on this, one could argue that the participants' experiences related to treatment participation are probably transferable to a wider range of settings, as they are linked to a specific treatment approach that can be offered in a range of different settings. This assumption is also supported by the way the findings regarding treatment participation both confirm and extend on existing research (i.e. Parker et al., 2007). Given the rural context of the study, it is likely, though, that the findings related to treatment preparation (i.e. *Dreading and hoping – preparing for participation*) are most relevant in a rural setting where there is a risk of meeting group members in non-clinical settings. This particular aspect of treatment participation might then also transfer to experiences of participation in other types of group treatment in a rural setting.

Based on the way the findings on help seeking confirm existing research on delays and barriers to help seeking, it is probable that the findings on the process leading to help seeking in this sample is transferable to a wider range of contexts. However, given the rural context of the study, where trauma-specific treatment has not been available prior to the inclusive stabilization group approach, it is uncertain how the post-trauma coping reported by this sample transfers to an urban context where trauma-specific treatments have been available and have been established as treatment options.

In addition, the findings related to the process of recovery support existing research and theory on trauma recovery (e.g. Banyard & Williams, 2007; Davidson et al., 2010; Thomas & Hall, 2008) and are probably transferable to a wider range of contexts. However, the participants in this study had all eventually self-initiated contact with the mental health care system and all participated in trauma-specific group treatment. This has implications for transferability. The presented findings will therefore not necessarily transfer to samples of trauma survivors who have recovered without any treatment, or who have recovered with the help of other-initiated contact with the health care system.

It is also possible that the context for the process leading to help seeking in this sample influenced participants' experiences of recovery. Future research from a wider range of settings is therefore needed to explore how aspects of presented findings might or might not be transferable to other contexts. However, in the end it will be the readers' evaluations of the presented findings as relevant and informative in a context different from the one under study that will determine their transferability (c.f. Morrow, 2005).

6.6 Limitations

The limitations of the present study have been presented in the individual papers, and methodological reflections on issues relating to trustworthiness and the transferability of the findings have been addressed above. There are, however, a few clear limitations of this study that warrant attention. I will therefore briefly highlight these limitations below.

The study setting made it necessary to rely on a convenience sample with no information about how research participants differed from non-participants. This represents a limitation, particularly relating to research question 3, as such information potentially would have influenced our interpretations of the data material. Given the rather demanding recruitment procedures, the findings should therefore be understood as

a possible expression of the perspectives of the best-functioning individuals from the treatment groups.

Furthermore, the research design relied exclusively on retrospective data from one point in time to explore experiences with processes unfolding over time, such as help seeking and recovery. This represents a potential limitation to the study.

Finally, the study setting necessitated the limited availability of participants-specific information and a sub-optimal contextualization of the presented findings in order to maintain participant anonymity. Because such information could have facilitated the reader's opportunities to evaluate the trustworthiness and the transferability of the findings it represents a limitation to this study that should be addressed in future research.

6.7 Implications for future research

The presented findings provided information about clients' perspective of an inclusive stabilization group approach in a rather narrow context and suggested the potential for such an approach to trauma treatment. Even though findings were encouraging, the lack of information about non-participants meant that we have to assume the presented findings might reflect the perspectives of the highest functioning group members. This underlines the importance of future research being conducted in a wider range of study settings that allow more flexibility regarding research design (i.e. prospective studies including all group members) and the presentation of findings (i.e. opportunities to include more participant-specific information and more contextualization of the presented findings).

Moreover, the present study provided no information about the effectiveness and efficacy of the treatment approach. This should be addressed in future studies. More research is therefore needed to establish the possibilities for applying more inclusive stabilization groups as a means to reach more trauma clients in need of treatment.

Also, all participants in the present study eventually self-initiated contact with the mental health care system and participated in an inclusive stabilization group. Future research should explore the phenomena of post-trauma coping and trauma recovery among trauma survivors who recover without any formal treatment, or recover with the help of other-initiated contact with the health care system.

It is also interesting to explore relationships between the age of participants and their reported delay in help seeking. Because all participants happened to have

experienced PTE before the age of five, and because all had sought help relatively recently, it was the oldest participants in our sample that reported the most extensive delays in help seeking. One may speculate whether the new way of organizing mental health care services in Norway, with increased availability of mental health services locally, may have contributed to a lowering of treatment barriers in the younger generations, hence shortening the delay in help seeking for this group. This could be important to explore empirically, as the results would have important implications for the organization of mental health care services.

6.8 Implications for clinical practice

6.8.1 Recognizing the client's continued efforts during treatment and recovery

An important clinical implication from the presented findings is the importance of recognizing the continuous efforts trauma survivors invest in their treatment participation and recovery processes. Participants' experiences with the inclusive stabilization group show how trauma clients might experience ambivalence throughout their treatment due to the significant effort such participation requires. This might be the case even among clients who experience treatment as beneficial and who do not drop out of treatment. Moreover, participants emphasized the active role they had to take in order to benefit from treatment, and the challenging, though rewarding, road of recovery. Acknowledging clients' active role in treatment and recovery might potentially facilitate recovery-promoting processes, such as strengthening their sense of agency and facilitating new meaning-making processes. Sensitivity to clients' active role in treatment and recovery might also facilitate a better match between individual readiness to accept help and the type of treatment offered.

6.8.2 Benefits of a multimodal focus in trauma treatment

The potential benefit of focusing on body awareness as part of phase-one trauma treatment was supported by participants' experiences. In addition, the findings show how increased contact with experiences and bodily sensations might have an independent value for trauma clients. Body awareness was also important for meaning-making processes in this sample. Focusing on body awareness as a part of trauma treatment might

therefore have dual benefits in facilitating progress in both trauma treatment and functioning in everyday life.

However, the findings also show the many different ways to enter the loop of positive change and how these ways are interrelated. The findings thus indicate the potential benefits of actively using 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), when working therapeutically with survivors of childhood trauma.

6.8.3 The multiple meanings of self-management, help seeking, and symptom load

Through our analysis the multiple functions of self-management, as both a source to positive experiences of coping and a barrier to help seeking, became evident. Similarly, the action of seeking help can be understood as both an expression of a breakdown in participants' meaning-making and sense of agency, as well as indication of opportunities for new and more helpful meaning systems to develop in this sample. Help seeking also represented a substantial change in itself to the participants. Awareness of the multiple meanings of self-management and help seeking could be important in a clinical setting. By exploring the experiences leading to help seeking and its meaning, a clinician might get access to important information regarding a client's resources and potentials for change that could be valuable in the therapeutic work.

The potential clinical value of openly exploring clients' experiences of increases in symptoms was also illustrated by the findings. While it is often assumed that a decrease in reported symptoms is the desired result of clinical work, participants' experiences of ways to positive change illustrated the importance of exploring the subjective meaning attached to an increase or decrease in symptoms. For a person who has previously numbed her/his feelings, an increase in symptoms might be experienced as important and even contributing to meaningfulness. The findings thus imply that clinicians need to adopt a wider focus than symptom elimination in order to support clients in their efforts on the road of recovery.

6.8.4 Opportunities for facilitating participation in trauma-specific treatment

The participants experienced the preparatory phase of group treatment as demanding, and several participants experienced the support from their individual therapists as vital in

facilitating participation in the inclusive stabilization group. The findings thus point to the importance of pre-treatment motivation and preparation work in supporting clients, who are about to start in an inclusive stabilization group.

Even in groups with no focus on the clients' trauma histories, clients can feel that they either directly or indirectly will reveal sensitive personal information just by participating in the group (c.f. non-sharing as non-hiding). Participants thus reported experiences of ambivalence throughout group participation due to the significant effort such participation required. Awareness of these processes might be helpful in a clinical setting, allowing clinicians to attend to clients' readiness to enter different types of treatment (e.g. individual versus group treatment, or general group therapy versus trauma-specific group treatment) and needs for support to continue 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.

6.8.5 Possible implications for the provision of trauma treatment

The presented findings are based on interviews of 13 participants in a rather narrow context. Yet, their experiences with treatment participation might point to possibilities regarding provision of trauma treatment. In the following sections I will therefore make explicit some of the implications for treatment suggested by the findings (i.e. analytic generalization; Kvale, 1996).

Taken together, the findings indicated that inclusive stabilization groups can be conducted even in smaller, rural settings, and that it might be particularly important to meet other trauma survivors in such settings. In this sample such encounters seem to have facilitated processes of new meaning-making and strengthening clients' sense of agency. The findings thus point to the importance of continuing to explore ways to offer group-based trauma treatment in a wider range of settings.

Based on participants' experiences with the inclusive stabilization group it seems that the development of key group therapeutic factors, such as group cohesion (Yalom & Leszcz, 2005) might be facilitated in such an approach by having relatively small, closed groups, with a strict focus on stabilization (i.e. no direct focus on the clients' individual trauma histories). An alternation between psycho-education, the exchange of experiences and the practicing of efficient arousal regulation may also be important to allow a range of

different trauma-specific symptoms to be addressed, compared, and differentiated. Emphasizing within-group confidentiality and providing written information about the treatment, as well as written guidelines addressing concerns about confidentiality, might help clients prepare for stabilization group participation.

Participants' experiences of the major difference between self-initiated and other-initiated contact with the health care system further imply that previous unsuccessful treatment should not automatically disqualify people from receiving new treatment. Moreover, it should not be interpreted as an indication for a poor prognosis, without thoroughly exploring each individual case.

7. Conclusion

This thesis has presented a new treatment approach, i.e. an inclusive stabilization group, which can be applied in a wider range of contexts, including small DPSs. Thirteen participants, all of whom had completed the new treatment approach, were interviewed, exploring the first-person perspective of (a) help seeking; (b) treatment participation; (c) ways to positive change.

The data analysis revealed how the strategy of self-management played an important role in understanding delays in help seeking, with a collapse in existing meaning systems and sense of agency functioning as a catalyst for help seeking in this sample. Moreover, the findings underlined the multiple functions of self-management. Treatment participation was experienced as a meaningful struggle, requiring continuous effort, but rendering participants feeling more robust in handling their life situations and future challenges. The importance of meeting other trauma survivors was emphasized by the findings. Participants' experiences of ways to positive change illustrated the significance of new meaning-making processes, increased emotional contact and a strengthened sense of agency in processes of trauma recovery. The interrelatedness of different recovery-promoting components and the multiple entries to the road of recovery were emphasized. Important clinical implications were the active role trauma clients play in their processes of treatment participation and recovery and the importance of having a multimodal focus when working clinically with trauma survivors.

Taken together, the findings indicate a potential for more inclusive stabilization groups as a way to offer trauma-specific treatment in a wider range of settings. This should encourage more research to examine clients' perspectives on this approach in a wider range of study settings, as well as its effectiveness and efficacy, to establish the possibilities for applying more inclusive stabilization groups as a means to reach more trauma clients in need of treatment. The double roles that meaning-making processes and the sense of agency can play in the aftermath of childhood trauma, i.e. catalysts for help seeking and key components of trauma recovery, were illustrated by the participants' experiences. The findings also shed light on the differential influence of meaning systems and the sense of agency depending on the opportunities provided for positive and flexible ways of coping, understanding and relating to oneself, others and one's life situation. An explicit focus on

processes of meaning-making and the sense of agency might, then, facilitate a better understanding of post-trauma coping, help seeking, treatment participation, and recovery.

8. References

Adler, J. M. (2012). Living into the story: Agency and coherence in a longitudinal study of narrative identity development and mental health over the course of psychotherapy. *Journal of Personality and Social Psychology, 102*(2), 367–389. doi: 10.1037/a0025289

Afifi, T. O., & Macmillan, H. L. (2011). Resilience following child maltreatment: A review of protective factors. *Canadian Journal of Psychiatry, 56*(5), 266–272.

Alexander, P. C., Neimeyer, R. A., Follette, V. M., Moore, M. K., & Harter, S. (1989). A comparison of group treatments of women sexually abused as children. *Journal of Consulting and Clinical Psychology, 57*(4), 479–483. doi: 10.1037/0022-006X.57.4.479

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

Amstadter, A. B., Aggen, S. H., Knudsen, G. P., Reichborn-Kjennerud, T., & Kendler, K. S. (2012). Potentially traumatic event exposure, posttraumatic stress disorder, and Axis I and II comorbidity in a population-based study of Norwegian young adults. *Social Psychiatry and Psychiatric Epidemiology*, 1–9. doi: 10.1007/s00127-012-0537-2

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., . . . Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry: Clinical Neuroscience, 256*(3), 174–186. doi: 10.1007/s00406-005-0624-4

Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research, 10*(3), 378–395. doi: 10.1177/104973230001000308

Antonovsky, A. (1987). *Unraveling the mystery of health. How people manage stress and stay well*. San Francisco, CA: Jossey-Bass Inc. Publishers.

APA. (2004). Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Arlington, VA: American Psychiatric Association Practice Guidelines.

APA (Ed.). (2000). *Diagnostic and statistical manual of mental disorders* (Fourth Edition, Text Revision ed.). Washington, DC: American Psychiatric Association.

Axelsen, E. D. (2009). *Symptomet som ressurs; psykiske problemer og psykoterapi (The*

symptom as a resource; mental health problems and psychotherapy). Oslo: Pax forlag.

Banyard, V. L., & Williams, L. M. (2007). Women's voices on recovery: A multi-method study of the complexity of recovery from child sexual abuse. *Child Abuse & Neglect, 31*(3), 275–290. doi: 10.1016/j.chiabu.2006.02.016

Barrett, B. J., & St Pierre, M. (2011). Variations in women's help seeking in response to intimate partner violence: Findings from a Canadian population-based study. *Violence Against Women, 17*(1), 47–70. doi: 10.1177/1077801210394273

Binder, P. E., Holgersen, H., & Nielsen, G. H. (2010). What is a "good outcome" in psychotherapy? A qualitative exploration of former patients' point of view. *Psychotherapy Research, 20*(3), 285–294. doi: 10.1080/10503300903376338

Bisson, J. I., & Andrew, M. (2007). Psychological treatment of post-traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews* (3), CD003388. doi: 10.1002/14651858.CD003388.pub3

Bisson, J. I., Ehlers, A., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). Psychological treatments for chronic post-traumatic stress disorder. Systematic review and meta-analysis. *British Journal of Psychiatry, 190*, 97–104. doi: 10.1192/bjp.bp.106.021402

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, NY: W. W. Norton & Company.

Borg, M., & Davidson, L. (2008). The nature of recovery as lived in everyday experience. *Journal of Mental Health, 17*(2), 129–140. doi: 10.1080/09638230701498382

Bowman, M. L., & Yehuda, R. (2004). Risk factors and the adversity-stress model. In G. M. Rosen (Ed.), *Posttraumatic Stressdisorder: Issues and controversies* (pp. 15–38). Chichester, UK: John Wiley & Sons, Ltd.

Brand, B. L., Lanius, R., Vermetten, E., Loewenstein, R. J., & Spiegel, D. (2012). Where are we going? An update on assessment, treatment, and neurobiological research in dissociative disorders as we move toward the DSM-5. *Journal of Trauma & Dissociation, 13*(1), 9–31. doi: 10.1080/15299732.2011.620687

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

Briggs-Gowan, M. J., Carter, A. S., Clark, R., Augustyn, M., McCarthy, K. J., & Ford, J. D. (2010). Exposure to potentially traumatic events in early childhood: Differential links to emergent psychopathology. *Journal of Child Psychology & Psychiatry, 5*(10), 1132–1140. doi: 10.1111/j.1469-7610.2010.02256.x.

Briggs-Gowan, M. J., Ford, J. D., Fraleigh, L., McCarthy, K., & Carter, A. S. (2010). Prevalence of exposure to potentially traumatic events in a healthy birth cohort of very young children in the Northeastern United States. *Journal of Traumatic Stress, 23*(6), 725–733. doi: 10.1002/jts.20593

British Medical Journal (2013). Qualitative research checklist. Retrieved 07.05.2013, from http://www.bmj.com/about-bmj/resources-authors/article-types/research/editors-checklists

Bromberg, P. M. (2003). Something wicked this way comes: Trauma, dissociation, and conflict: The space where psychoanalysis, cognitive science, and neuroscience overlap. *Psychoanalytic Psychology, 20*(3), 558–574. doi: 10.1037/0736-9735.20.3.558

Burgess-Proctor, A. (2012). Pathways of victimisation and resistance: Toward a feminist theory of battered women's help-seeking. *Justice Quarterly, 29*(3), 309–346. doi: 10.1080/07418825.2011.553727

Carey, P. D., Stein, D. J., Zungu-Dirwayi, N., & Seedat, S. (2003). Trauma and posttraumatic stress disorder in an urban Xhosa primary care population: prevalence, comorbidity, and service use patterns. *Journal of Nervous and Mental Disease, 191*(4), 230–236. doi: 10.1097/01.nmd.0000061143.66146.a8

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders, 82*(2), 217–225. doi: http://dx.doi.org/10.1016/j.jad.2003.12.013

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*(5), 965–971. doi: 10.1037/0022-006x.73.5.965

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., . . . Zirakzadeh, A. (2010). Sexual abuse and lifetime diagnosis of pychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings, 85*(7), 618–629. doi: 10.4065/mcp.2009.0583

Classen, C., Koopman, C., Nevillmanning, K., & Spiegel, D. (2001). A preliminary report comparing trauma-focused and present-focused group therapy against a wait-listed condition among childhood sexual abuse survivors with PTSD. *Journal of Aggression, Maltreatment & Trauma, 4*(2), 265–288. doi: 10.1300/J146v04n02_12

Cloitre, M., & Koenen, K. C. (2001). The impact of borderline personality disorder on process group outcome among women with posttraumatic stress disorder related to childhood abuse. *International Journal of Group Psychotherapy, 51*(3), 379–398. doi: 10.1521/ijgp.51.3.379.49886

Cook, A., Spinazzola, J., Ford, J. D., Lanktree, C., Blaustein, M., Cloitre, M., . . . van der Kolk, B. A. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390–398. Retrieved from: http://nursebuddha.files.wordpress.com/2011/12/complex-trauma-in-children.pdf

Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archieves of General Psychiatry, 64*, 577–584.

Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma: Theory, Research, Practice, and Policy, S*(1), 86–100. doi: 10.1037/1942-9681.S.1.86

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

Darves-Bornoz, J.-M., Alonso, J., de Girolamo, G., de Graaf, R., Haro, J.-M., Kovess-Masfety, V., . . . Gasquet, I. (2008). Main traumatic events in Europe: PTSD in the European Study of the Epidemiology of Mental Disorders Survey. *Journal of Traumatic Stress, 21*(5), 455–462. doi: 10.1002/jts.20357

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health, 16*(4), 459–470. doi: 10.1080/09638230701482394

Davidson, L., Strauss, J. S., & Rakfeldt, J. (2010). *The roots of the recovery movement in psychiatry: Lessons learned*. Chichester, UK: Wiley-Blackwell.

Davies, D., & Dodd, J. (2002). Qualitative research and the question of rigor. *Qualitative Health Research, 12*(2), 279–289. doi: 10.1177/104973230201200211

de Girolamo, G., Dagani, J., Purcell, R., Cocchi, A., & McGorry, P. D. (2012). Age of onset of mental disorders and use of mental health services: needs, opportunities and

obstacles. *Epidemiology and Psychiatric Sciences, 21*(1), 47–57. doi: 10.1017/S2045796011000746

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J. P., . . . Chatterji, S. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *The Journal of the American Medical Association (JAMA), 291*(21), 2581–2590. doi: 10.1001/jama.291.21.2581

Dorrepaal, E., Thomaes, K., Smit, J. H., van Balkom, A. J., van Dyck, R., Veltman, D. J., & Draijer, N. (2010). Stabilizing group treatment for complex posttraumatic stress disorder related to childhood abuse based on psycho-education and cognitive behavioral therapy: A pilot study. *Child Abuse & Neglect, 34*(4), 284–288. doi: 10.1016/j.chiabu.2009.07.003

Draucker, C. B., Martsolf, D. S., Ross, R., Cook, C. B., Stidham, A. W., & Mweemba, P. (2009). The essence of healing from sexual violence: a qualitative metasynthesis. *Research in Nursing & Health, 32*(4), 366–378. doi: 10.1002/nur.20333

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*. San Francisco, CA: Jossey-Bass.

Elliott, D. M. (1997). Traumatic events: Prevalence and delayed recall in the general population. *Journal of Consulting and Clinical Psychology, 65*(5), 811–820. doi: 10.1037/0022-006x.65.5.811

Elliott, R., Fischer, C. T., Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*(3), 215–229. Retrieved from: http://www.wider-mind.com/research/elliott_fischer_rennie_1999.pdf

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

Fallot, R. D., & Harris, M. (2002). The trauma recovery and empowerment model (TREM): Conceptual and practical issues in a group intervention for women. *Community Mental Health Journal, 38*(6), 475–485. doi: 10.1023/A:1020880101769

Fanslow, J. L., & Robinson, E. M. (2010). Help-seeking behaviors and reasons for help seeking reported by a representative sample of women victims of intimate partner violence in New Zealand. *Journal of Interpersonal Violence, 25*(5), 929–951. doi: 10.1177/0886260509336963

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245–258.

Fikretoglu, D., Liu, A., Pedlar, D., & Brunet, A. (2010). Patterns and predictors of treatment delay for mental disorders in a nationally representative, active Canadian military sample. *Medical Care, 48*(1), 10–17. doi: 10.1097/MLR.0b013e3181bd4bf9

Finkelhor, D. (1994). The international epidemiology of child sexual abuse. *Child Abuse & Neglect, 18*(5), 409–417. doi: 10.1016/0145-2134(94)90026-4

Finkelhor, D., Omrod, R. K., & Turner, H. A. (2009). Lifetime assessment of poly-victimization in a national sample of children and youth. *Child Abuse & Neglect, 33*, 403–411. doi: 10.1016/j.chiabu.2008.09.012

Fisher, J., & Ogden, P. (2009). Sensorimotor psychotherapy. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorder: An evidence-based guide* (pp. 312–328). New York: NY: The Guilford Press.

Foa, E. B., Keane, T. M., & Friedman, M. J. (Eds.). (2000). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York, NY: Guilford.

Foa, E. B., Zoellner, L. A., Feeny, N. C., Hembree, E. A., & Alvarez-Conrad, J. (2002). Does imaginal exposure exacerbate PTSD symptoms? *Journal of Consulting and Clinical Psychology, 70*(4), 1022–1028. doi: 10.1037/0022-006X.70.4.1022

Foote, B., Smolin, Y., Kaplan, M., Legatt, M. E., & Lipschitz, D. (2006). Prevalence of dissociative disorders in psychiatric outpatients. *The American Journal of Psychiatry, 163*(4), 623–629.

Fosse, R., & Dersyd, A. K. (2007). Forekomsten av traumeutsatte pasienter ved distriktspsykiatriske sentre i spesialisthelsetjenesten (Prevalence of trauma exposed clients in distric psychiatric centres in spezialist health services) Oslo: RVTS/Ø.

Foy, D. W., Glynn, S. M., Schnurr, P. P., Jankowski, M. K., Wattenberg, M. S., Weiss, D. S., . . . Gusman, F. D. (2000). Group therapy. In E. B. Foa, T. M. Keane & M. J. Friedman (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (pp. 155–175). New York, NY: Guilford.

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

Gavrilovic, J. J., Schutzwohl, M., Fazel, M., & Priebe, S. (2005). Who seeks treatment after a traumatic event and who does not? A review of findings on mental health service utilization. *Journal of Traumatic Stress, 18*(6), 595–605. doi: 10.1002/jts.20068

Gillies, J., & Neimeyer, R. A. (2006). Loss, grief, and the search for significance: Toward a model of meaning reconstruction in bereavement. *Journal of Constructivist Psychology, 19*(1), 31–65. doi: 10.1080/10720530500311182

Gillies, D., Taylor, F., Gray, C., O'Brien, L., & D'Abrew, N. (2012). Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. *Cochrane Database of Systematic Reviews, 12*, CD006726. doi: 10.1002/14651858.CD006726.pub2

Gjertsen, A. (2007). Åpenhet og helhet ti år etter (Openness and wholeness ten years on.). *Tidsskrift for Norsk Psykologforening, 44*(6), 755–760.

Glass, D. C., & Singer, J. E. (1972). *Urban stress: Experiments on noise and social stressors*. New York, NY: Academic Press.

Haavet, O. R., Straand, J., Hjortdahl, P., & Saugstad, O. D. (2005). Do negative life experiences predict the health-care-seeking of adolescents? A study of 10th-year students in Oslo, Norway. *Journal of Adolescent Health, 37*(2), 128–134. doi: 10.1016/j.jadohealth.2004.08.031

Hansen, V., & Øiesvold, T. (2004). Community psychiatry in the Sub-Arctic. Experiences with the shift from hospital-based to community-based psychiatric services in Northern Norway. *Epidemiologia e Psichiatria Sociale, 13*, 73–77.

Harvey, M. R., Mishler, E. G., Koenen, K., & Harney, P. A. (2000). In the aftermath of sexual abuse: Making and remaking meaning in narratives of trauma and recovery. *Narrative Inquiry, 10*(2), 291–311. doi: 10.1075/ni.10.2.02har

Hepp, U., Gamma, A., Milos, G., Eich, D., Ajdacic-Gross, V., Rössler, W., . . . Schnyder, U. (2006). Prevalence of exposure to potentially traumatic events and PTSD. The Zürich Cohort Study. *European Archives of Psychiatry: Clinical Neuroscience, 256*, 151–158. doi: 10.1007/s00406-005-0621-7

Herman, J. L. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377–391.

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

Hjemmen, A., Dalgard, O. S., & Graff-Iversen, S. (2002). Volden som rammer kvinner og volden som rammer menn - to ulike verdener? (Violence affecting women and violence affecting men - two different worlds?). *Norsk Epidemiologi, 12*(3), 275–280.

Hodgetts, A., & Wright, J. (2007). Researching clients' experiences: A review of qualitative studies. *Clinical Psychology & Psychotherapy, 14*(3), 157–163. doi: 10.1002/cpp.527

Horvath, A. O., Del Re, A., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationship that work. Evidence-based responsiveness* (2nd ed., pp. 25–69). New York, NY: Oxford University Press.

Hyman, B., & Williams, L. (2001). Resilience among women survivors of child sexual abuse. *Affilia, 16*(2), 198–219. doi: 10.1177/08861090122094226

Jané-Llopis, E., & Anderson, P. (Eds.). (2006). *Mental health promotion and mental disorder prevention across European Member States: A collection of country stories*. Luxembourg: European Communities.

Janoff-Bulman, R. (1992). *Shattered assumptions* New York, NY: The Free Press.

Janoff-Bulman, R., & Frieze, I. H. (1983). A theoretical perspective for understanding reactions to victimization. *The Journal of Social Issues, 39*(2), 1–17.

Johansson, I., & Lynøe, N. (2008). *Medicine & philosophy. A twenty-first century introduction*. Heusenstamm: Ontos Verlag.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 593–602. doi: 10.1001/archpsyc.62.6.593

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., . . . Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research, 36*(6 Pt 1), 987–1007.

Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617–627. doi: 10.1001/archpsyc.62.6.617

Knight, T. A., Richert, A. J., & Brownfield, C. R. (2012). Conceiving change: Lay accounts of the human change process. *Journal of Psychotherapy Integration, 22*(3), 229–254. doi: 10.1037/a0028871

Knox, S., & Burkard, A. W. (2009). Qualitative research interviews. *Psychotherapy Research, 19*(4-5), 566–575. doi: 10.1080/10503300802702105

Koenen, K. C., Goodwin, R., Struening, E., Hellman, F., & Guardino, M. (2003). Posttraumatic stress disorder and treatment seeking in a national screening sample. *Journal of Traumatic Stress, 16*(1), 5–16. doi: 10.1023/a:1022051009330

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

Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. In J. C. Norcross (Ed.), *Psychotherapy relationship that work. Evidence-based responsiveness* (2nd ed., pp. 203–223). New York, NY: Oxford University Press.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3), 21–35.

Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research, 14*(5), 726–735. doi: 10.1177/1049732304263638

Lubin, H., Loris, M., Burt, J., & Johnson, D. R. (1998). Efficacy of psychoeducational group therapy in reducing symptoms of posttraumatic stress disorder among multiply traumatized women. *American Journal of Psychiatry, 155*(9), 1172–1177.

Lukasse, M., Schei, B., Vangen, S., & Øian, P. (2009). Childhood abuse and common complaints in pregnancy. *Birth, 36*(3), 190–199. doi: 10.1111/j.1523-536X.2009.00323.x

Luthra, R., Abramovitz, R., Greenberg, R., Schoor, A., Newcorn, J., Schmeidler, J., . . . Chemtob, C. M. (2009). Relationship between type of trauma exposure and posttraumatic stress disorder among urban children and adolescents. *Journal of Interpersonal Violence, 24*(11), 1919–1927. doi: 10.1177/0886260508325494

Macy, R. J., Nurius, P. S., Kernic, M. A., & Holt, V. L. (2005). Battered women's profiles associated with service help-seeking efforts: Illuminating opportunities for intervention. *Social Work Research, 29*(3), 137–150. doi: 10.1093/swr/29.3.137

McGloin, J. M., & Widom, C. S. (2001). Resilience among abused and neglected children grown up. *Developmental Psychopathology, 13*(4), 1021–1038.

McNally, R. J. (2004). Conceptual problems with the DSM-IV criteria for posttraumatic stress disorder. In G. M. Rosen (Ed.), *Posttraumatic stress disorder: Issues and controversies* (pp. 1–14). Chichester: John Wiley & Sons, Ltd.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250–260. doi: 10.1037/0022-0167.52.2.250

Mulvihill, D. (2005). The health impact of childhood trauma: An interdisciplinary review, 1997-2003. *Issues in Comprehensive Pediatric Nursing, 28*, 115–136.

Murphy, S. B., Moynihan, M. M., & Banyard, V. L. (2009). Moving within the spiral: The process of surviving. *Affilia: Journal of Women and Social Work, 24*(2), 152–164. doi: 10.1177/0886109909331702

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

Nelson, S. D. (2011). The posttraumatic growth path: An emerging model for prevention and treatment of trauma-related behavioral health conditions. *Journal of Psychotherapy Integration, 21*(1), 1–42. doi: 10.1037/a0022908

NEM. (2009). Veiledning for forskningsetisk og vitenskapelig vurdering av kvalitative forskningsprosjekt innen medisin og helsefag (Guide for assessing the ethical and scientific standards of qualitative research projects within medicine and health sciences.) Retrieved from: http://www.etikkom.no/Forskningsetikk/Etiske-retningslinjer/Medisin-og-helse/Kvalitativ-forskning/

Nilsson, D., Gustafsson, P. E., & Svedin, C. G. (2010). Self-reported potentially traumatic life events and symptoms of post-traumatic stress and dissociation. *Nordic Journal of Psychiatry, 64*, 19–26.

Norwegian Board of Health Supervision (Statens helsetilsyn). (2001). *Distriktpsykiatriske sentre - organisering og arbeidsområder*. (1-2001). Oslo, Norway: Statens helsetilsyn Retrieved from http://www.helsetilsynet.no/upload/Publikasjoner/veiledningsserien/distriktspsykiatriske_sentra_ik-2738.pdf.

Norwegian Directorate for Health and Social Affairs (Sosial- og helsedirektoratet). (2006). *Psykisk helsevern for voksne. Distriktpsykiatriske sentre - med blikket vendt mot kommunene og spesialiserte sykehusfunksjoner i ryggen (Community mental health centers)*. Oslo, Norway: Sosial- og helsedirektoratet.

Norwegian Ministry of Health and Social Affairs (Sosial- og helsedepartementet). (1997-1998). *Opptrappingsplanen for psykisk helse 1999–2006 (The plan for strengthening mental health care 1999–2006)*. (Stortingsproposisjon 63). Oslo: Sosial- og helsedepartementet Retrieved from: http://www.regjeringen.no/nb/dep/hod/dok/regpubl/stprp/19971998/stprp-nr-63-1997-98-.html?id=201915.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body. A sensorimotor approach to psychotherapy*. New York, NY: W. W. Norton & Company.

Olafson, E. (2011). Child sexual abuse: Demography, impact, and interventions. *Journal of Child & Adolescent Trauma, 4*(1), 8–21. doi: 10.1080/19361521.2011.545811

Pacherie, E. (2008). The phenomenology of action: A conceptual framework. *Cognition, 107*, 179–217. doi: 10.1016/j.cognition.2007.09.003

Paras, M. L., Murad, M. H., Chen, L. P., Goranson, E. N., Sattler, A. L., Colbenson, K. M., . . . Zirakzadeh, A. (2009). Sexual abuse and lifetime diagnosis of somatic disorders: A systematic review and meta-analysis. *The Journal of the American Medical Association (JAMA), 302*(5), 550–561. doi: 10.1001/jama.2009.1091

Parker, A., Fourt, A., Langmuir, J. I., Dalton, E. J., & Classen, 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

Parker, I. (2004). Criteria for qualitative research in psychology. *Qualitative Research in Psychology, 1*, 95–106. doi: 10.1191/1478088704qp010oa

Pedersen, P. B., & Bremnes, R. (2011). *Distriktpsykiatriske tjenester 2010. Driftsindikatorer for distriktpsykiatriske sentre (District psychiatric services 2010. Service indicators for district psychiatric centers.)*. (IS-1926). Trondheim, Norway: Helsedirektoratet.

Phanichrat, T., & Townshend, J. M. (2010). Coping strategies used by survivors of childhood sexual abuse on the journey to recovery. *Journal of Child Sexual Abuse, 19*(1), 62–78. doi: 10.1080/10538710903485617

Phillips, A., & Daniluk, J. C. (2004). Beyond "survivor": How childhood sexual abuse informs the identity of adult women at the end of the therapeutic process. *Journal of Counseling & Development, 82*(2), 177–184. doi: 10.1002/j.1556-6678.2004.tb00299.x

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

Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*(5), 748–756. doi: 10.1037/0022-006X.60.5.748

Resnick, H. S., Kilpatrick, D. G., Dansky, B. S., Saunders, B. E., & Best, C. L. (1993). Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *Journal of Consulting and Clinical Psychology 61*(6), 984–991. doi: 10.1037/0022-006X.61.6.984

Roman, M. W., Hall, J. M., & Bolton, K. S. (2008). Nurturing natural resources: the ecology of interpersonal relationships in women who have thrived despite childhood maltreatment. *Advances in Nursing Science, 31*(3), 184–197. doi: 10.1097/01.ans.0000334282.96601.82

Rothbaum, B. O., Foa, E. B., Riggs, D. S., Murdock, T., & Walsh, W. (1992). A prospective examination of post-traumatic stress disorder in rape victims. *Journal of Traumatic Stress, 5*(3), 455–475. doi: 10.1007/BF00977239

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, UK: Cambridge University Press.

Sayer, N. A., Friedmann-Sanchez, G., Spoont, M., Murdoch, M., Parker, L. E., Chiros, C., & Rosenheck, R. (2009). A qualitative study of determinants of PTSD treatment initiation in veterans. *Psychiatry, 72*(3), 238–255.

Schnurr, P. P., Friedman, M. J., Foy, D. W., Shea, M. T., Hsieh, F. Y., Lavori, P. W., . . . Bernardy, N. C. (2003). Randomized trial of trauma-focused group therapy for posttraumatic stress disorder: results from a department of veterans affairs cooperative study. *Archives of General Psychiatry, 60*(5), 481–489. doi: 10.1001/archpsyc.60.5.481

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*: Guilford Publications, Incorporated.

Seidler, G. H., & Wagner, F. E. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: a meta-analytic study. *Psychological Medicine, 36*(11), 1515–1522. doi: 10.1017/s0033291706007963

Sloan, D. M., Feinstein, B. A., Gallagher, M. W., Beck, J. G., & Keane, T. M. (2011). Efficacy of group treatment for posttraumatic stress disorder symptoms: A meta-analysis. *Psychological Trauma: Theory, Research, Practice, and Policy, Nov*. doi: 10.1037/a0026291

Smith, D. W., Letourneau, E. J., Saunders, B. E., Kilpatrick, D. G., Resnick, H. S., & Best, C. L. (2000). Delay in disclosure of childhood rape: results from a national survey. *Child Abuse & Neglect, 24*(2), 273–287. doi: 10.1016/S0145-2134(99)00130-1

Smith, J. A. (2007). Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well-being, 2*(1), 3–11. doi: doi:10.1080/17482620601016120

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research*. London: SAGE Publications.

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

Steine, I. M., Milde, A. M., Bjorvatn, B., Grønli, J., Nordhus, I. H., Mjrdalj, J., & Pallesen, S. (2012). Forekomsten av seksuelle overgrep i et representativt befolkningsutvalg i Norge (The prevalence of sexual abuse in a Norwegian representative population sample.). *Tidsskrift for Norsk Psykologforening, 49*, 950–957.

Stige, B., Malterud, K., & Midtgarden, T. (2009). Toward an agenda for evaluation of qualitative research. *Qualitative Health Research, 19*(10), 1504–1516. doi: 10.1177/1049732309348501

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

Stige, S. H., Binder, P. E., Rosenvinge, J. H., & Træen, B. (2013). Stories from the road of recovery – How adult, female survivors of childhood trauma experience ways to positive change. *Nordic Psychology,* doi: 10.1080/19012276.2013.796083.

Stige, S. H., Rosenvinge, J. H., Træen, B. (2013). A meaningful struggle: Trauma clients' experiences with an inclusive stabilization group approach. *Psychotherapy Research,* doi: 10.1080/10503307.2013.778437

Stige, S. H., Træen, B., & Rosenvinge, J. H. (in press). The process leading to help seeking following childhood trauma. *Qualitative Health Research.*

Summerfield, D. (2004). Cross-cultural perspectives on the medicalization of human suffering. In G. M. Rosen (Ed.), *Posttraumatic Stress Disorder. Issues and controversies* (pp. 233–245). Chichester, UK: John Wiley & Sons Ltd.

Taylor, T. L., & Chemtob, C. M. (2004). Efficacy of treatment for child and adolescent traumatic stress. *Archives of Pediatrics & Adolescent Medicine, 158*(8), 786–791. doi: 10.1001/archpedi.158.8.786

Thomas, S. P., & Hall, J. M. (2008). Life trajectories of female child abuse survivors thriving in adulthood. *Qualitative Health Research, 18*(2), 149–166. doi: 10.1177/1049732307312201

Tjalden, P., & Thoennes, N. (2000) Full report of the prevalence, incidence, and consequences of violence against women: Findings from the national violence against women survey. Washington, DC: Department of Justice, Office of Justice Programs.

Tolin, D. F., & Foa, E. B. (2006). Sex differences in trauma and posttraumatic stress disorder: A quantitative review of 25 years of research. *Psychological Bulletin, 132*(6), 959–992. doi: 10.1037/0033-2909.132.6.959

Tutty, L. M., Bidgood, B. A., & Rothery, M. A. (1993). Support groups for battered women: Research on their efficacy. *Journal of Family Violence, 8*(4), 325–343. doi: 10.1007/BF00978097

van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. London: W. W. Norton & Company.

van der Kolk, B. A. (1996). The complexity of adaptation to trauma: Self-regulation, stimulus discrimination, and characterological development. In B. A. van der Kolk, A. C. McFarlane & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experiences on mind, body, and society* (pp. 182–213). New York, NY: Guilford.

van Roode, T., Dickson, N., Herbison, P., & Paul, C. (2009). Child sexual abuse and persistence of risky sexual behaviors and negative sexual outcomes over adulthood: Findings from a birth cohort. *Child Abuse & Neglect, 33*(3), 161–172. doi: 10.1016/j.chiabu.2008.09.006

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*(5), 258–259. doi: 10.3109/10398569609080498

Walby, S., & Allen, J. (2004). *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey* London, UK: Research, Development and Statistics Directorate.

Wang, J. (2006). Perceived barriers to mental health service use among individuals with mental disorders in the Canadian general population. *Medical Care, 44*(2), 192–195.

Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 603–613. doi: 10.1001/archpsyc.62.6.603

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 629–640. doi: 10.1001/archpsyc.62.6.629

Weiss, J. M. (1968). Effects of coping responses on stress. *Journal of Comparative and Physiological Psychology, 65*(2), 251–260. doi: 10.1037/h0025562

Weiss, J. M. (1970). Somatic effects of predictable and unpredictable shock. *Psychosomatic Medicine, 32*(4), 397–408.

WHO (Ed.). (1993). *The ICD-10 classification of mental and behavioural disorders: Diagnostic criteria for research*. 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*(2), 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, NY: Basic books.

Yardley, L. (2000). Dilemmas sin qualitative health research. *Psychology & Health, 15*(2), 215–228. doi: 10.1080/08870440008400302

Paper I

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

Paper II

Stige, S. H., Træen, B., & Rosenvinge, J. H. (2013). The process leading to help seeking following childhood trauma. Qualitative Health Research, in press.

Paper III

Stige, S. H., Rosenvinge, J. H., Træen, B. (2013). A meaningful struggle: Trauma clients' experiences with an inclusive stabilization group approach. Psychotherapy Research, doi: 10.1080/10503307.2013.778437

Paper IV

Stige, S. H., Binder, P. E., Rosenvinge, J. H., & Træen, B. (2013). Stories from the road of recovery – How adult, female survivors of childhood trauma experience ways to positive change. Nordic Psychology, doi: 10.1080/19012276.2013.796083.

Appendices

Appendix 1- Information letter (Norwegian)

Appendix 2 - Consent form (Norwegian)

Appendix 3 - Interview guide (Norwegian)

Appendix 4 - Approval letters by NSD & REK

APPENDIX 1

Spørsmål om deltagelse i forskingsprosjekt knyttet til klienters opplevelse av endring og deltagelse i stabiliseringsgruppe.

I januar 2008 startet vi opp et nytt, gruppebasert behandlingstilbud ved Dagavdelingen i Alta, som du har tatt del i. Som du vet, er tilbudet rettet mot kvinner som har opplevd at noen har gjort dem så vondt at de fremdeles har psykiske plager knytt til dette. Eksempel på slike traumer er fysisk, psykisk og seksuell vold, overgrep og forsømmelse. Gruppen er rettet mot dere som har opplevd noe av dette, og som i dag sliter med plager som mareritt, plutselige påtrengende minner, nummenhet, på-vakt-følelse, bli-borte-følelse m.m.

I forbindelse med at vi har startet opp denne typen gruppe, ønsker vi å gjennomføre et prosjekt. Målet er å få mer kunnskap om hvordan dere som deltagere har opplevd egen endring over tid, og hvordan dere har opplevd behandlingen (positive og negative erfaringer). *Vi ønsker å bruke denne informasjonen fra dere til å lære mer om hvordan vi kan forbedre behandlingstilbudet for personer som har opplevd traumer, og som har plager knyttet til dette.*

Hvis du sier ja til å være med på prosjektet, vil vi møte deg to ganger etter endt gruppebehandling. *En gang rett etter gruppa er ferdig, og en gang ca 1 år etter gruppa. Intervjuene vil bli gjennomført av Kristin Dahn eller Ragnhild Dalvik. Vi vil i tillegg be om tillatelse til å gå inn i journalen din og hente ut, og avidentifisere skårene på skjemaene som ble brukt til inntak og ved avslutning av gruppebehandlingen, slik at disse avidentifiserte skårene kan brukes sammen med materialet fra intervjuene dine.*

I tillegg til at dere som klienter blir intervjuet, vil individualbehandlerne på VPP bli spurt om å delta i et gruppeintervju der man fokuserer på behandlerne sine erfaringer med å ha en stabiliseringsgruppe som del av behandlingstilbudet. Man vil ikke fokusere på enkeltpersoner, men med erfaringer på systemnivå. Dette for å få et så fullstendig bilde som mulig av de erfaringene som finns knyttet til stabiliseringsgruppa.

Begge intervjuene vil bli tatt opp, og prosjektleder (Signe Stige) vil være ansvarlig for at lydopptakene og transkripsjonene blir forsvarlig oppbevart. Transkripsjon av intervjuene vil skje fortløpende, og lydopptakene vil så bli slettet. Alle innhentede data vil bli behandlet konfidensielt og vil bli avidentifisert. Hver person registreres med et nummer som viser til en navneliste. Det kun prosjektleder som har adgang til navnelisten og som kan finne tilbake til deg. Dette slik at vi kan kontakte deg i forbindelse med intervjuet 1 år etter gruppa. Ingen enkeltpersoner vil kunne gjenkjennes i endelige rapporter / publikasjoner.

Selvutfyllingsskjemaene vil ligge i journalen din som del av behandlingsinformasjonen. Det øvrige datamaterialet vil makuleres ved prosjektets slutt i 2012. Prosjektet er godkjent av Etisk Komité og Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS. Deltagelse er frivillig og kan trekkes tilbake når som helst uten at det får konsekvenser for deg som klient. Du kan også be om at intervjudata blir slettet dersom du velger å trekke deg fra prosjektet.

Dersom du ønsker å delta i prosjektet kan du ta kontakt med Signe Stige, eller bruke vedlagt svarslipp, så vil vi avtale tidspunkt for det første intervjuet.

Kontaktinformasjon:

Prosjektansvarlig:
Signe Stige
Psykolog, Dagavdeling Alta – Gruppeterapeutisk Team
Tlf. 78 48 39 71
signe.stige@helse-finnmark.no

Intervjuansvarlig:
Kristin Jakoba Dahn
Psykologspesialist, VPP Alta
Tlf. 78 48 38 00

Svarslipp

Jeg _____ønsker å delta i forskningsprosjektet ”Førstefase traumebehandling – Stabiliseringsgruppe for kvinner utsatt for relasjonstraumer”, og samtykker til å bli kontaktet for å avtale tidspunkt for intervju.

Kontaktinformasjonen min er:

Adresse:

Telefon:

_____ _____

Sted / dato Underskrift

Svarslippen kan sendes i vedlagt svarkonvolutt, som er ferdig frankert.

Du kan også levere svarslippen i ekspedisjonen på VPP Alta, eller ta kontakt med Signe Stige på telefon eller e-post, dersom du ønsker å delta i prosjektet.

APPENDIX 2

SAMTYKKEERKLÆRING

Jeg har lest informasjonen om prosjektet *Førstefase traumebehandling - Stabiliseringsgruppe for kvinner utsett for relasjonstraume*, gitt i informasjonsskrivet til deltakerne, og jeg har fått muntlig informasjon om prosjektet.

Jeg er klar over at det er frivillig å delta, og at jeg når som helst kan trekke meg uten å oppgi noen grunn.

JA	NEI	
☐	☐	Jeg samtykker til å delta i de to intervjuene
☐	☐	Jeg samtykker til at data som foreligger fra tiden før intervjuene, som behandlers observasjoner fra gruppa og skåre på skjemaene jeg fylte ut som del av behandlingen, kan anonymiseres og brukes i prosjektet

……. ……..……..

Sted, Dato Navn

APPENDIX 3

"Velkommen hit! Jeg heter _____ og jobber ved Voksenpsykiatrisk Poliklinikk. Det er jeg som kommer til å intervjue deg, både nå, og om et år. Signe Hjelen Stige, som du kjenner fra stabiliseringsgruppa, er prosjektleder for dette forskingsprosjektet, men vil altså ikke ta del i intervjuene.

Du har jo deltatt i ei stabiliseringsgruppe som nettopp er avslutta, og som du vet er dette bakgrunnen for dette intervjuet. Som det stod i informasjonsbrevet er det dine opplevelser av og erfaringer med å gå i denne gruppa, samt din opplevelse av endring over tid, vi er opptatt av – det finnes ingen rette eller gale svar, men vi ber om at du svarer så utfyllende og ærlig som mulig på de spørsmålene jeg stiller deg. Det er jo sånn at når jeg stiller spørsmål så kan det være noen spørsmål som du synes er vanskelig å svare på. Da har du selvsagt lov til å si at du ikke ønsker å svare på dette. Men hvis jeg opplever at du snakker om noe annet, så vender jeg tilbake til spørsmålet til du har svart meg, eller direkte har sagt at det kan eller vil du ikke svare på. (Dette gjør jeg fordi jeg vet at mange av oss forsøker å komme unna vanskelige ting, ved å snakke om noe helt annet – og det er Ok i hverdagssituasjoner – men ikke i forhold til forskingsintervju) Høres det greit ut?

Som du vet vil intervjuet bli tatt opp, og intervjuet vil så bli anonymisert og systematisert. Dersom det er ting du lurer på, eller som er uklart underveis i intervjuet må du bare spørre, ok? Jeg kommer også til å undersøke underveis om jeg har forstått deg rett, ved å oppsummere noe av det du har sagt. Har du noen spørsmål før vi starter?"

Fint. Da må jeg først be deg skrive under på denne samtykkeerklæringen – for å sikre at dere som deltagere i prosjektet er med frivillig og har forstått hva dere sier ja til"
(Ta fram samtykkeerklæring, og få klienten til å krysse av, og så skrive under.)

Fint. Da starter vi selve intervjuet:
Først; kan du fortelle meg, så utfyllende som mulig, og med dine egne ord, hvordan du har opplevd det å gå i stabiliseringsgruppa? (NB! Bruk mykje tid på dette spørsmålet, og følg opp og få utdjupa aspekta klienten kjem inn på)

Aktuelle oppfølgingsspørsmål:
- *Kan du si litt mer om det? / Kan du utdype det?*
- *Kan du fortelle om en situasjon som illustrerer det?/ Har du noen eksempel på det?*
- *Hvordan opplevde du det å være med i ei gruppe, der alle hadde lignende plager som deg?*
- *Hvordan opplevde du det at det var så strenge rammer ifht at man ikke skulle snakke om det man har opplevd?*
- *Hvordan opplevde du "undervisningsbiten" av gruppa – det at gruppeleder kom med informasjon og undervisning ifht traumer og posttraumatiske symptom?*

Livslinja

(Til intervjuer: NB! Legg merke til plassar der kurva endrar retning, både oppover og nedover, og få fram spontane narrativ knytt til opplevd endring – både forverring og forbedring i plager, og kva meistringsstrategiar ein har brukt.)

Her har jeg et ark, som representerer livslinja di. Her ble du født, og her er du i dag. Tid er derfor bortover her.
Kan du først markere på arket de periodene i livet der de vonde tingene skjedde? Du skal ikke fortelle om det, eller gå inn i det, men bare tegn en mørk sky over de aktuelle periodene…

Fint. Kan du markere på tidsaksen første gang du søkte hjelp?
Kan du fortelle litt om hva som skjedde i denne perioden som førte til at du søkte hjelp?
Kan du markere de periodene du har mottatt hjelp?
Og kan du markere den perioden du gikk i stabiliseringsgruppa?

Fint. Oppover her er styrken på de plagene som du har opplevd å ha på de forskjellige tidspunktene. Hvordan ville det nå sett ut dersom du skulle tegnet styrken i de plagene du har hatt og variasjonen i disse, fra tidspunktet det vonde skjedde og fram til i dag?

Aktuelle oppfølgingsspørsmål:

- *Kan du si litt mer om det?/ Kan du utdype det?*
- *Kan du fortelle om en situasjon som illustrerer det?/ Har du noen eksempel på det?*

Når du ser på grafen nå, så har det variert litt over tid. Er det de samme plagene som har vært tydelige / som du har opplevd hele tiden?

Aktuelle oppfølgingsspørsmål:

- *Hvilke plager har vært mest fremtredene på ulike tidspunkt?*
- *Kan du si litt mer om det?/ Kan du utdype det?*
- *Kan du fortelle om en situasjon som illustrerer det?/ Har du noen eksempel på det?*

Kan du fortelle meg hvordan du har merket variasjonen i plagene?

Hva tror du har bidratt til endring på de ulike tidspunktene?

Aktuelle oppfølgingsspørsmål:

- *Hva skjedde rundt den tiden som gjorde det verre?*
- *Hva skjedde rundt den tiden som gjorde det bedre?*

Hva har du gjort på de forskjellige tidspunktene for å håndtere de plagene du har hatt?

Aktuelle oppfølgingsspørsmål:

- *Har det som har hjulpet deg endret seg over tid, og på hvilken måte?*
- *Hva gjorde du da, for å håndtere de plagene du hadde?*

(Sjå fortsatt på livslinja og still dei tre neste spørsmåla):

Du har jo tegnet perioden du gikk i stabiliseringsgruppa her, men hvis du nå snur arket, og tenker deg at vi blåser opp tidsaksen for den perioden du gikk i stabiliseringsgruppa, slik at det halvåret gikk herifra til hit; Hvordan ville det da se ut?

Fint. Når du ser på grafen du har tegnet, hva har skjedd i løpet av det halvåret du gikk i stabiliseringsgruppa ifht de traumerelaterte plagene?

Aktuelle oppfølgingsspørsmål:

- *Kan du si litt mer om det?/ Kan du utdype det?*
- *Kan du fortelle om en situasjon som illustrerer det?/ Har du noen eksempel på det?*
- *Hvordan har du det nå ifht de plagene du hadde da du startet i stabiliseringsgruppa?*
- *Har opplevelsen din av disse plagene endra seg over tid, og eventuelt på hvilken måte?*
- *Hva tenker du har bidratt til denne endringa?*

Når du ser på grafen nå, hvordan vil du beskrive den prosessen du har vært igjennom ved å gå i stabiliseringsgruppa?

Aktuelle oppfølgingsspørsmål:

- *Kan du si litt mer om det?/ Kan du utdype det?*
- *Kan du fortelle om en situasjon som illustrerer det?/ Har du noen eksempel på det?*
- *Hva har skjedd med deg i løpet av gruppeopplegget, og hvilke endringer har du lagt merke til?*
- *Hvordan har gruppa vært til hjelp for deg i din prosess?*

Hvis du ser på grafen igjen, hvordan tror du at de traumerelaterte plagene kommer til å være det neste året? Kan du tegne det inn i grafen?

(Få henne til å tegne det inn på begge sider av arket – både der tidsasken er blåst opp, og på den vanlige livslinja)

(Snu arket slik at dere ser på den fullstendige livslinja, peik på aktuelle punkt på linja)

Hvis vi ser på grafen du har tegnet, søkte du hjelp første gang her, og så gikk du i stabiliseringsgruppa her.

Når du ser tilbake, når hadde det vært mest nyttig for deg å få tilbud om stabiliseringsgruppa, slik du tenker nå?

Kan du markere det på tegningen?

Kan du si litt om hva det er som gjør at du tenker at å få gå i stabiliseringsgruppa nettopp på det tidspunktet hadde vært mest nyttig for deg?

Hva kunne de rundt deg ha sett etter som ville fortalt dem at akkurat da hadde det vært nyttig for deg med stabiliseringsgruppe?

Når du ser tilbake på den prosessen du har begynt på i stabiliseringsgruppa, hva vil du trenge i tida framover for å holde frem med denne prosessen?

Aktuelle oppfølgingsspørsmål:

- *Kan du si litt mer om det?/ Kan du utdype det?*
- *Kan du fortelle om en situasjon som illustrerer det?/ Har du noen eksempel på det?*
- *Hva anser du som den største utfordringen ifht dette i tida framover?*

Hvis vi nå fokuserer på selve gruppeopplegget, hva hadde du håpet å få ut av behandlingsopplegget før gruppa startet?

Aktuelle oppfølgingsspørsmål:

- *Kan du si noe mer om det?/ Kan du utdype det?*
- *Hvordan står du ifht dette i dag?*

”Når man har vært i ei gruppe, er det vanlig at det er noe som oppleves som bra, noe er mindre bra, og det kan være ting som frustrerer en, eller irriterer en. Og det kan være noe som du syns er totalt likegyldig. Jeg vil gjerne ha alle dine erfaringer, for kun på den måten kan vi gjøre tilbudet enda bedre for andre klienter...”

Du har jo sagt en del om det allerede, men hvis du skulle gi tilbakemelding ifht selve gruppeopplegget, hva opplevde du som nyttig, hva var mindre nyttig, og var det noe du savnet?

Aktuelle oppfølgingsspørsmål:

- *På hvilken måte opplevde du det som nyttig/mindre nyttig?*
- *Hva føler du at du har fått ut av gruppa?*
- *Hvordan føler du at du har bidratt i gruppa?*
- *Hva har vært det vanskeligste med å være med i gruppa?*
- *Hvordan har du likt strukturen i gruppeopplegget?*

Kan du fortelle om en episode som viser noe du syns var positivt med å gå i stabiliseringsgruppa?

Aktuelle oppfølgingsspørsmål:

- *Kan du si litt mer om det?/ Kan du utdype det?*

Kan du fortelle om en episode som viser noe du syns var vanskelig eller negativt med å gå i stabiliseringsgruppa?

Aktuelle oppfølgingsspørsmål:

- *Kan du si litt mer om det?/ Kan du utdype det?*

Hvis din beste venn skulle starta i ei tilsvarende gruppe, hva ville du fortalt henne / han?

Aktuelle oppfølgingsspørsmål:

- *Hvordan ville du beskrevet stabiliseringsgruppa?*
- *Hvilke forventninger skulle han / hun hatt?*
- *Er det noe som det er viktig at hun eller han hadde visst før de starta i stabiliseringsgruppa?*

Hvilken kontakt har du hatt med andre deler av hjelpeapparatet mens du gikk i gruppa, og hvordan har du opplevd denne kombinasjonen?

Aktuelle oppfølgningsspørsmål:

- *Hvem har du hatt kontakt med?*
- *Hvor ofte har du møtt kontaktpersonen din?*
- *I hvilken grad har kontaktpersonen vært viktig for deg i denne tida (mens du gikk i gruppa)?*

Hvilken oppfølging har du nå? Fra VPP, 1.linje etc?

Er det noe mer du har lyst å tilføye om dine opplevelser knytt til å være med i stabiliseringsgruppa?

APPENDIX 4

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Signe Stige
DPS Vest-Finnmark, VPP Alta
Postboks 1294
9505 ALTA

Vår dato: 01.02.2008 Vår ref: 18071 / 2 / SF Deres dato: Deres ref:

TILRÅDING AV BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 04.12.2007. Meldingen gjelder prosjektet:

18071	*Førstefase traumebehandling - Stabiliseringsgruppe for kvinner utsett for relasjonstraume*
Behandlingsansvarlig	*Helse Finnmark HF, ved institusjonens øverste leder*
Daglig ansvarlig	*Signe Stige*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://www.nsd.uib.no/personvern/prosjektoversikt.jsp.

Personvernombudet vil ved prosjektets avslutning, 31.12.2012, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Bjørn Henrichsen

Sølve Fauskevåg

Kontaktperson: Sølve Fauskevåg tlf: 55 58 25 83
Vedlegg: Prosjektvurdering

Stige Signe
DPS Vest -Finnmark
Dagavdeling Alta
Postboks 1294
9505 ALTA

Deres ref.: Vår ref.: 200802135-6/MRO/400 Dato: 23.06.2008

P REK NORD 68/2008 FØRSTEFASE TRAUMEBEHANDLING - STABILISERINGSGRUPPE FOR KVINNER UTSETT FOR RELASJONSTRAUME - PROSJEKTET GODKJENNES

Vi viser til prosjektleders brev av 04.06 og 05.06 vedlagt revidert informasjonsskriv og samtykkeerklæring.

Prosjektleders tilbakemelding på komiteens merknader til prosjektet i møte 15.05.2008 tas til etterretning.

Etter fullmakt har komiteens leder fattet slikt

vedtak: *prosjektet godkjennes.*

Det forutsettes at prosjektet er godkjent av andre aktuelle instanser før det settes i gang. Prosjektet må forelegges komiteen på nytt, dersom det under gjennomføringen skjer komplikasjoner eller endringer i de forutsetninger komiteen har basert sin avgjørelse på. Komiteen ber om å få melding dersom prosjektet ikke blir sluttført.

Vedtaket kan påklages av en part eller annen med rettslig klageinteresse i saken jf. fvl. §28. Klagefristen er tre uker fra det tidspunkt underretning om vedtaket er kommet fram til vedkommende part, jf. fvl. § 29. Klageinstans er Den nasjonale forskningsetiske komité for medisin og helsefag, men en eventuell klage skal rettes til Regional komité for medisinsk og helsefaglig forskningsetikk, Nord Norge. Det følger av fvl. § 18 at en part har rett til å gjøre seg kjent med sakens dokumenter, med mindre annet følger av de unntak loven oppstiller i §§ 18 og 19. Se også http://www.etikkom.no/REK/klage.

Vennlig hilsen

May Britt Rossvoll
rådgiver
77644876

ISBN xxx-xx-xxxx-xxx-x