Development of a Complex Trauma Group for Women 'Survivors' of Childhood Sexual Abuse

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With thanks to the women who took part in the piloting of the group and the commitment, effort and work that they put into its development.

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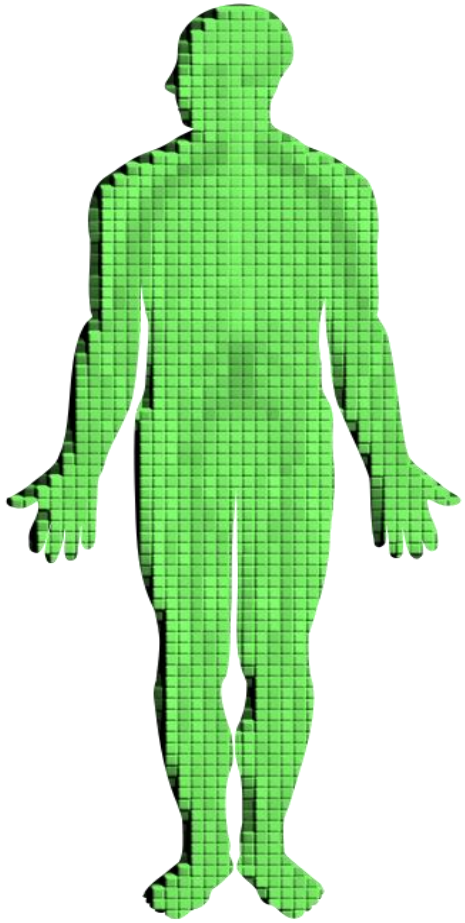
Anxiety physiology

Pathway of anxiety through the Somatic and Autonomic Nervous systems



- Hands, fingers, arms
- Shoulders, upper back
- Neck, head, forehead
- Mouth, jaw, neck
- Chest
- Stomach, abdominal
- Lower back
- Thighs, legs
- Dry Mouth and throat
- Dry Eyes
- Heart pounding and racing
- Cold hands
- Sweating Palms and Underarms
- Blushing
- Shivering

Overview of session

- Background and Context
- Development of the Complex Trauma Group (CTG)
  - Content
  - Processes
- Pilot Study/Evaluation
  - Quantitative
  - Qualitative
  - Anecdotal
- Reflections

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Background

- Collaboration between BCUHB (Clinical Psychology and Amethyst SARC), Rape & Sexual Abuse Support Centre North Wales (RASASC NW), and Stepping Stones North Wales (Stepping Stones NW)
- Group therapy developed to promote ‘Phase 1’ (stabilising and psychoeducation) trauma healing for women presenting with ongoing effects and consequences of complex trauma arising from CSA
- Research funded by the UK Tampon Tax Fund/Welsh Government (2017-2020) and Betsi Cadwaladr University Health Board

Context

Difficulties identified by adults subjected to CSA to accessing suitable interventions, including:

- Not fitting into diagnosis
- Existing services often not recognising relevance or impact of trauma and CSA
- Long waits for accessing therapy, and often being left with little support but emergency/duty
- Scant availability of services to help people prepare for therapy – and a fear of having to talk about trauma leading to disengagement from services
- Frequently receiving the message that they were ‘too complex’
- Paradox – having trauma ignored OR being told that trauma means they are too complex
- Therapy as a ‘fantasy’ – discharged to a waiting list
- “…there may be some helpful aspects to dialectical behaviour therapy (DBT) and mentalization-based therapy (MBT) for us as CSA and SV survivors, (but) because they are contextualised around ‘personality disorder’, many of us have found them to be pathologizing, blaming and harmful.” New Ways of Supporting Child Abuse and Sexual Violence Survivors; Survivors Voices 2022.

Combined factors

- High levels of need combined with limited resources (NHS and Third Sector) to adequately respond to people presenting with chronic CSA histories
- Utility of the Trauma-Informed Approach paradigm as a possible effective alternative to the diagnostic model
- Evidence for the benefits of group therapy for healing from relational trauma and CSA

Based on these identified difficulties and factors, we sought to develop a TIA-based group therapy model that would complement existing services – the Complex Trauma Group

Defining Complex Trauma

- Considered DSM-V PTSD (APA/Kennedy, PJ, Understanding Mental Disorders, 2015)
  - Being exposed to threatened or real death, severe injury, or sexual assault
  - Having at least one of the identified symptoms of *intrusion for more than one month* following the incident
  - Frequent *avoidance of any reminder for more than one month…*
  - At least *two negative changes in beliefs & feelings for more than one month…*
  - At least *two major changes in arousal (being keyed up) and response, etc.*
- Cluster of features and symptoms used to describe Complex Trauma
  - Repetitive/prolonged; experienced in childhood/adolescence; inter-relational context
  - Disorders of Extreme Stress (DES) e.g. alterations in: regulation of affect and impulses; memory, attention and consciousness; somatization; biological self-regulation; self-perceptions; perceptions of perpetrator; relationships with others; systems of meaning *(Mendelsohn, M, Herman JL, Schatzow E, Coco M, Kallivayalil, D, Levitan, J, The Trauma Recovery Group, 2011; Van der Kolk B, Roth S, Pelcovitz D, Sunday S, Spinazzola J, Disorders of Extreme Stress: the empirical foundation of a Complex Adaptation to Trauma, Journal of Stress, Vol 18, No 5, Oct 2005)*

Working definition of complex trauma

- Symptoms of PTSD related to repetitive interpersonal trauma
  - including intrusive memories and disordered arousal
- Symptoms of “disorders of extreme stress not otherwise specified” (DESNOS)
  - Including dissociative disorders
- Relational and other problems associated with Attachment Trauma
  - a form of interpersonal trauma where there is a ‘primary-dependency’ between the child and the perpetrator or where there is disorganised attachment in childhood

CTG Participant Criteria: repeated subjection to abuse - CSA as a principle Component - in early life (up to and including adolescence) - and frequently occurring in a family setting, with the potential underlying Attachment Trauma

Conceptualisation of complex trauma

Recognition of CSA as exceptionally intrusive and damaging relational trauma

CSA leading to profound psychological disturbances and adaptations in early life; generally considered as 'complex trauma'; leading to a range of mental and physical health difficulties in adulthood

(Cloitre M, Courtois CA, Ford JD, Green BL, Alexander P, Briere J, Herman JL, Lanius R, Stolbach BC, Spinazzola J, Van der Kolk, BA, & Van der Hart, 2012, The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults)

TIA PARADIGM de-medicalised approach to addressing childhood trauma

Recognising as normal the neurological adaptive processes that become engaged as the brain seeks to "maintain safety' under intolerable threat

(Evans A and Coccoma P, 2014, Trauma Informed Care: how neuroscience influences practice)

Emphasis on factors that contribute to the person's traumatic experiences and responses including age, circumstances, and relative vulnerability-versus-power dynamics.

Hence the starting point 'it's what happened to you'.

POWER THREAT MEANING FRAMEWORK advances the TIA

Considers the dynamics of power and threat in traumatic experience(s), the meanings ascribed to traumatic events and the normal ways in which humans may respond.

Asks specific questions: HOW HAS POWER OPERATED IN YOUR LIFE? Supplemented with HOW DID IT AFFECT YOU? (What kind of Threats does it pose?) WHAT SENSE DO YOU MAKE OF IT? (What is the Meaning of these experiences to you?) WHAT DID YOU HAVE TO DO TO SURVIVE? (What kinds of Threat Response are you using?)

(Johnstone L & Boyle M, et al, 2018, The Power Threat Meaning Framework…)

Power Threat Meaning Framework (Johnstone and Boyle, 2018)

The main aspects of the Framework are summarised in these questions:

- 'What has happened to you?' (*How is Power operating in your life?*)
- 'How did it affect you?' (*What kind of Threats does this pose?*)
- 'What sense did you make of it?' (*What is the Meaning of these situations and experiences to you?*)
- 'What did you have to do to survive?' (*What kinds of Threat Response are you using?*)

In addition, the two questions below help us to think about what skills and resources people might have, and how we might pull all these ideas and responses together into a personal narrative or story:

- 'What are your strengths?' (*What access to Power resources do you have?*)
- 'What is your story?' (*How does all this fit together?*)

Founding principles

- Linchpin was psychoeducation on the normal responses to CSA, and from this, helping participants to understand the idiosyncratic and often creative and adaptive ways they have developed to deal with its consequences (albeit ways that are often no longer helpful now that the traumatic events have passed).
- Group format provides a safe environment to explore difficulties with others with similar trauma histories/consequences; provides platform to reduce self-isolation, address shame, be compassionate towards others, experience self as normal and potentially 'likeable' (Herman, 1992) and worthy of self-compassion.
- Focussed on present-day difficulties – no requirement to share trauma histories
- In terms of the 3-phase model of recovery, focus on Phase 1, Psychoeducation and Stabilisation, but with a nuanced understanding of the overlap between these phases.
- Power Threat Meaning Framework – as an organising principle
- Utilising expertise and 'healthy' aspect of participants (Group Wisdom)

Principles guiding development and content

- Abuse as a wielding of power
- Education about trauma to normalise trauma responses
- Skills, strategies, ‘things to do’ to regulate trauma responses (e.g. flashbacks, hyperarousal, dissociation, etc.)
- Understanding ‘symptoms’ as more often than not solutions to problems, responses to threat (external and internal) i.e. not the problems themselves.
- Threat response system – anxiety and the autonomic nervous system in a habitual loop
- Creativity
- Mindfulness coupled with Compassion – noticing without judgement
- In the moment – noticing processes as they happen
- Group context – in particular in terms of addressing shame
- Stories, in terms of beliefs about self, others and the world? (Meaning)
- Relationship to ourselves (attachment?) Internal nurture and safety

‘Hoped for’ benefits

- Developing personal safety, self-care and self-compassion
- Promoting empowerment (by understanding the origins of present day problems)
- Supporting development of self-awareness (emotional and physiological)
- Encouraging sense of self-mastery and connection with others in place of helplessness/hopelessness and self-isolation;
- Reclaiming positive self-regard (for psyche and physical body) through normalising (shame-reducing) as opposed to pathologising (shame-invoking) the effects and consequences of the abuse.
- ‘Prerequisite of any processing of trauma is **the strengthening or restoration of daily life competencies’** (Judith Herman, 1992)

Group format

- Initial individual assessment
- 12 two-and-half hour weekly sessions (now 16)
- Closed group
- 6-8 participants
- 2-3 facilitators
- Three pilot groups in 3 regions of North Wales
- Non-NHS premises
- Recruitment from different sources (NHS and Third Sector)

CTG Individual Session Format

Timings	Activity	Content	Exercises	Handouts
30 mins	**Welcome**	Group Check-in	Attendance Sheet; Group Check-in	
30 mins	**Review of last week's topic**	Emotions: Basic & Secondary		
15 mins	**BREAK**			
45 mins	**Topic 5 Trauma & Emotions**	Facilitator-led read-throughs		Why noticing emotions is important (6.4); Mindfulness of Emotions (Ancillary)
15 mins	**Group Exercise**	Triangle of Change	Flip-chart exercise	
15 mins	**Check-out process**	How are people feeling/how is the group? Collaborative – what can we improve on? What will we take away?	Group check-out; Evaluation sheets	

Example from session:

- Group check-in: What did people notice about their emotions? What are their reflections?
- Review: invite group to reflect on previous session, summarise learning, any difficulties/questions.
- Clarify and explain: *emotions are necessary for our survival; basic emotions are unlearned responses that 'pop-up' to alert us to things; secondary emotions are those we may feel in response to a basic emotion.*
- Link to learnt habits: *how we responded to an emotion in the past (e.g. beliefs/pushing away/disconnecting) can be changed when we understand that our present-day response may be a habit.*
- Link to noticing and previous learning: *Clues to our emotions include certain brain and body responses (including anxiety) which we're going to explore now.*

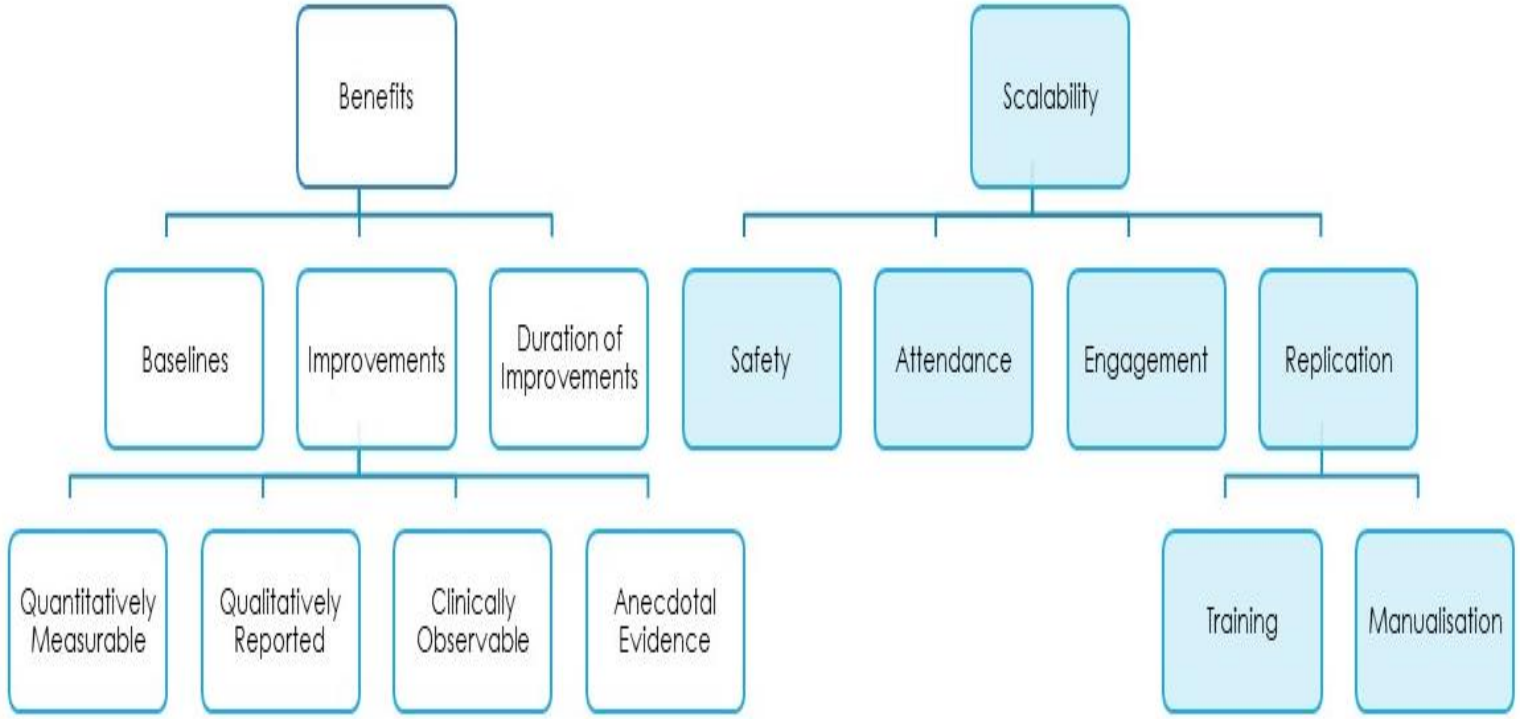
The Participants

- **Initially recruited 22 women into the CTG** (out of a possible 24 participants). Two women were not able to attend the group and one did not consent to the research. Baseline data is therefore available for **21 participants**. The mean age of participants was 41 years (age range between 24 and 67 years).
- All self-reported chronic CSA in childhood and/or adolescence (up to an including 15 years old)
- Across 17 women, (two could not recall start age) the average duration of the abuse was 6.5 years – although 37% reported it continuing over a longer period of 8 to 12 years
- 16 out of 19 reported the CSA starting before their teen years, some as early as 2 or 3 years old
- Primary perpetrators with the exception one case were adults, and all were male. 38% of the women reported either multiple-victimisation (more than abuser) or re-victimisation by others in addition to primary CSA assailants and before the age of 16.
- ACEs showed 86% of women suffered four or more adverse childhood experiences (notably higher that Wales' population norms (14%, Public Health Wales, 2016))

Evaluation

Pilot study aims

- Evaluating ***benefits*** (if any) experienced by participants
- Gauging ***scalability*** for replication



Challenges:

- "Self-report" and disclosure difficulties
- Variations in baseline indicators of psychological distress
- No consensus measure for CSA complex trauma
- Limited study size (maximum 24 people)

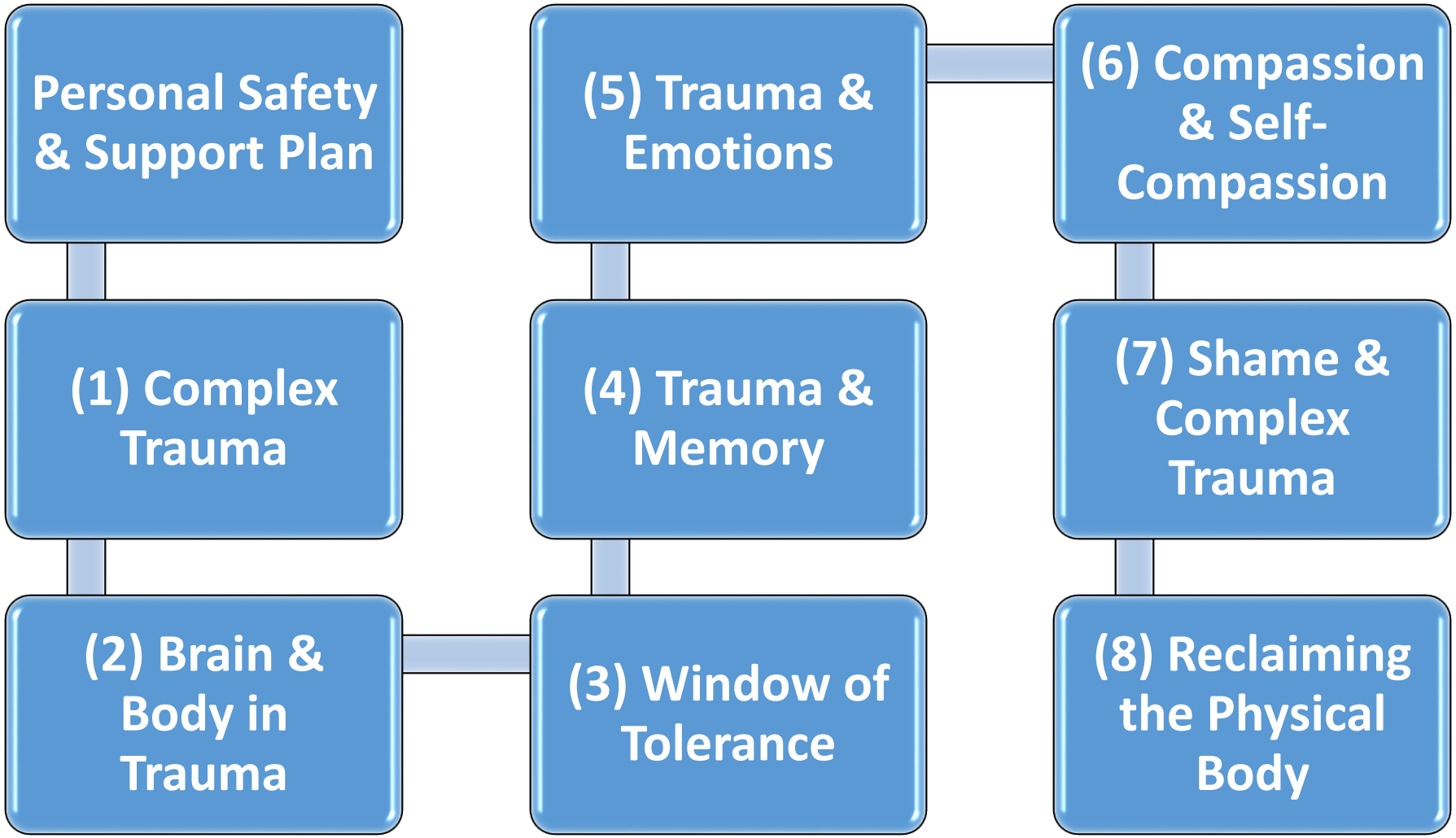
Measures plan

Quantitative Study pre- and post-intervention Measures, combined with **Qualitative Study** post-intervention semi-structured Interviews (thematic framework)

Measure	How utilised	Reference/Authors
World Health Organisation Quality of Life, split in 4 Domains: Physical Health – Psychological – Social Relationships - Environment	**Pre- & post-intervention**	WHO QoL-Bref, WHO, 1996
Adverse Childhood Experiences Questionnaire	**Baseline only**	ACE-Q, Felitti et al, 1998
Somatoform Dissociation Questionnaire	**Baseline only**	SDQ-20, Nijenhuis et al, 1996
PTSD Checklist for DSM-5	**Pre- & post-intervention**	PCL-5, Weathers et al, 2013
Trauma Symptom Checklist	**Pre- & post-intervention**	TSC-40, Briere & Runtz, 1989
Difficulties in Emotional Regulation Scale – Short Form	**Pre- & post-intervention**	DERS-SF, Kaufman et al, 2015
Inventory of Interpersonal Problems	**Pre- & post-intervention**	IIP-32, Barkham, Hardy & Startup, 1996
Dissociative Experiences Scale	**Pre- and post-intervention**	DES-II, Carlson & Putman, 1993
Clinical Outcomes in Routine Evaluation	**Pre- and post-intervention**	CORE-OM, Evans et al, 2000
Clinical Outcomes in Routine Evaluation – 10	**Mid-way intervention point**	CORE-10, Evans et al, 2012

Spectrum of quantitative measures

Psychoeducation: Safety and 8 Topics



Supporting content

Anxiety - retraining mind and body

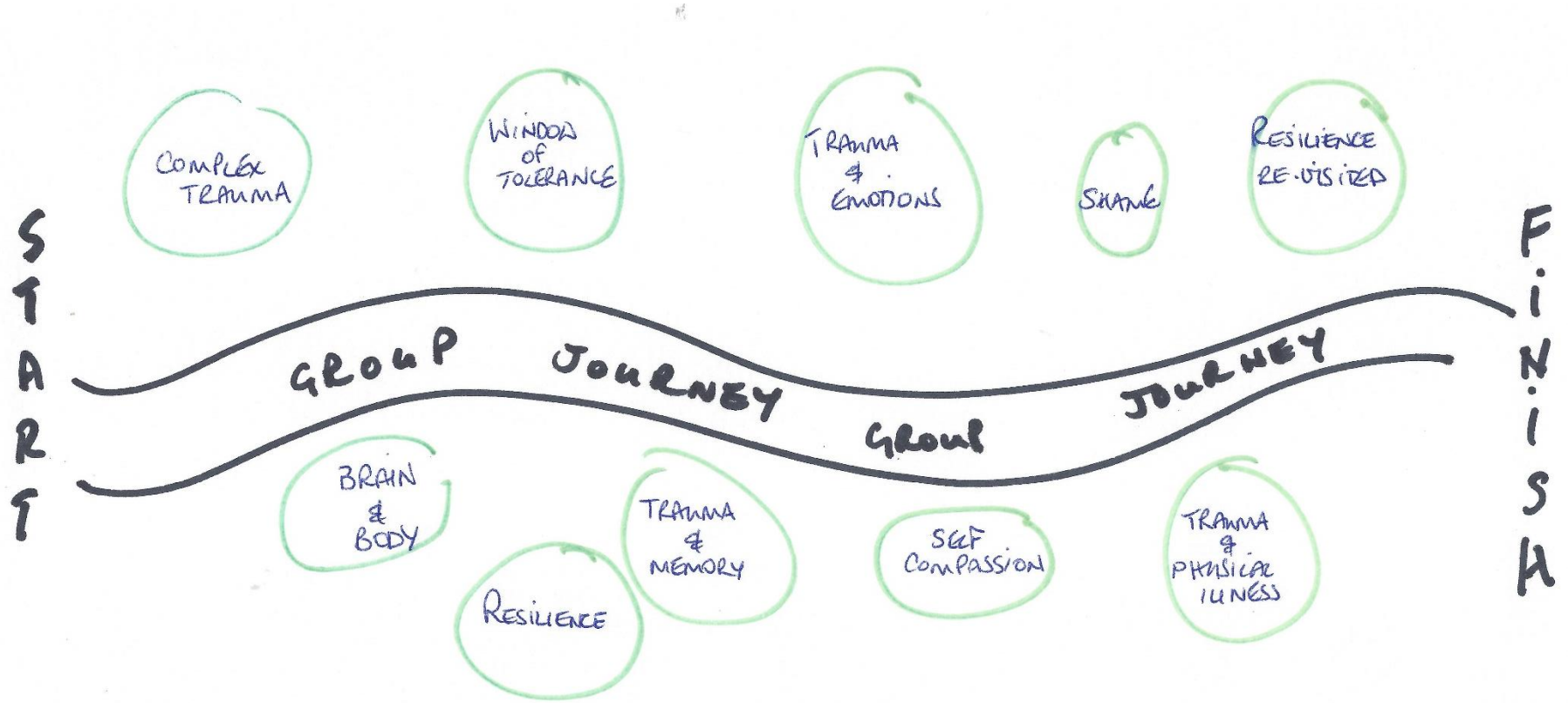
- Regulating anxiety

- ‘Retrains’ the amygdala
- Reduces chronic fluctuations in the autonomic nervous system (accelerator and brake)

- Broadening WOT

- Learning to regulate emotions
- Learning to tolerate stress
- Learning to be mindful in the present

Group journey



Process

- Being attuned and present and mirroring/modelling
- Skilling participants up through exercises and psychoeducation
- Encouraging empowerment
- Normalising people's responses to trauma (away from diagnosing and/or pathologising)
- Encouraging people to notice, connect to emotions in the room
- Improving understanding
- Regulating responses – noticing how these manifest in the room and attending to processes as they occur
- Considering everyday experiences (interested in the past in so far as it is impacting on the present)
- Helping participants to apply psychoeducation and skills to personal experiences in the present
- NOTICING rather than AVOIDING – and attending to these responses as they are mobilised in the group
- Using creative activities to engage right brain activity (as opposed to left brain intellectualisation)

Topic One
Complex nature of CSA trauma (1)

- Event giving rise to extreme stress/distress
- Sexual dimension (extreme form of interpersonal trauma)
- Often repetitive or prolonged
- Developmental vulnerability of child or adolescent
- Inter-relational context (dynamics of power)

Longer term psycho-physiological effects of child sexual abuse:

- Re-experiencing of trauma (visual, emotional, physiological flashbacks)
- Numbing of response
- Hyperarousal
- Avoidance
- Somatic pain and physical illnesses

Trauma injures us

Topic One
Participants' understanding of trauma

Group exercise on the meaning of trauma:

Hell	**Physical, mental, emotional**
Painful memories	**PTSD**
Bad accident	**Combat trauma**
Individual (personal)	**Something that happens to others**
Confusing	**Diverse**
Memory block (and Blocks generally)	**Dissociation**
Amnesia	**Hard to know what's real and what's not**
Strangulation	**Fear**
Suffocating	**Not taken seriously**
To be heard and speak out or not to be heard at all	

Topic One
Complex nature of CSA trauma (2)

Complex Trauma Summary for Participants

- ➔ The term Complex Trauma is used in the group to describe repeated traumas in childhood
- ➔ Its consequences can be wide-ranging and can last for decades
- ➔ Many on-going effects have important survival functions during traumatic experiences
- ➔ These consequences and effects are entirely normal
- ➔ Both psychological and physiological effects of complex trauma can be identified, managed and controlled – even after many years
- ➔ Starting to NOTICE and IDENTIFY them is a first step to managing them more effectively or overcoming them.

"The brain is formed in a 'use-dependent manner'…

neurons that 'fire together, wire together'" *(Bruce Perry, 1995)*

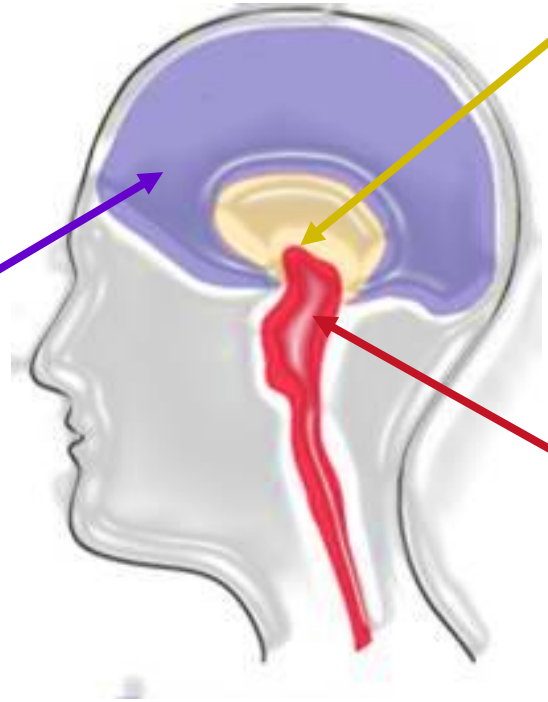
Topic Two: Brain & Body Trauma responses (1)

"The key to healing traumatic symptoms in humans is in our physiology" Peter A. Levine, 1997

- Triune Brain, 3 brains – one mind (Paul Maclean)

The Mammalian Brain – the emotional brain, common to all mammals (mice, cats, deer, tigers). Responsible for emotions, memory and learning.

It is also known as the Limbic System or the Emotional Brain.



The Ape Brain – the thinking brain, common to Great Apes, and most developed in humans. Responsible for complex thinking, social connection, empathy, abstract thought, choosing, planning and language.

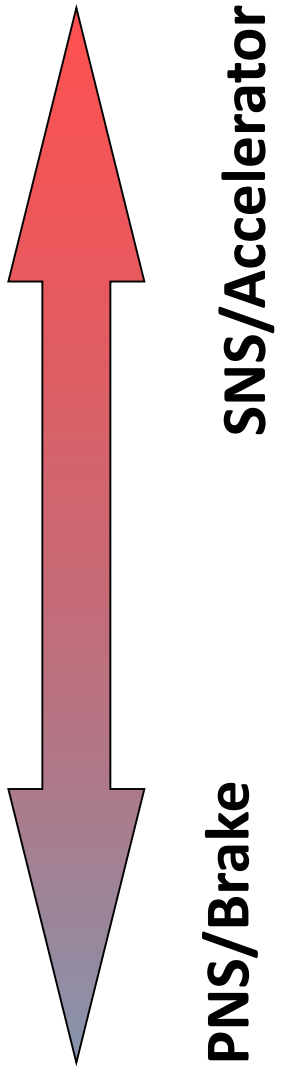
Sometimes called the Neo-cortex or Intellectual Brain.

The Reptilian Brain – the most ancient part of the brain, essential for survival – responsible for heartbeat, breathing, and vital bodily functions, and balance.

It is also known as the Instinctual Brain.

Topic Two: Brain & Body Trauma responses (2)

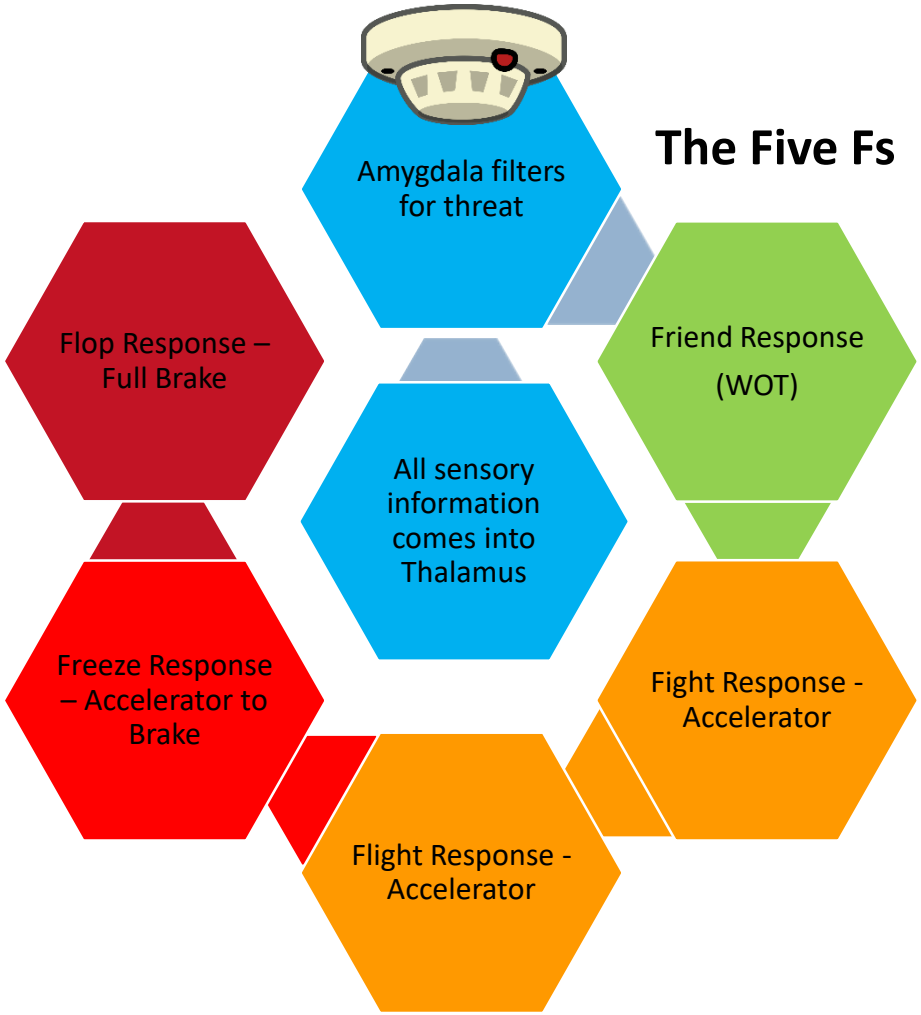
Autonomic Nervous System Pathway of Anxiety

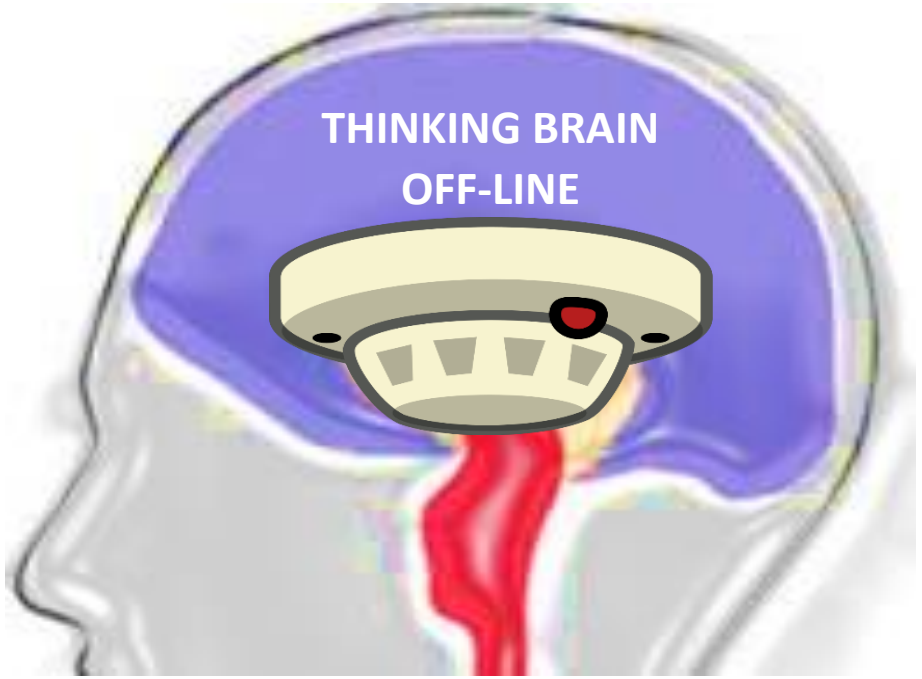


Dry mouth and throat
Dry eyes
Pounding/racing heart
Cold hands
Sweaty palms/underarms
Blushing
Shivering
Lightheaded
Dizzy
Feeling sick
Churning stomach
Urge to pee
Constipation
Diarrhoea
Jelly legs
Racing thoughts
Mind blank
Disoriented
Blurred vision/tunnelvision
Unable to hear well/ringing in ears
Ringing in ears
Hallucinations
Outside self/cut-off from self

Pathway of survival

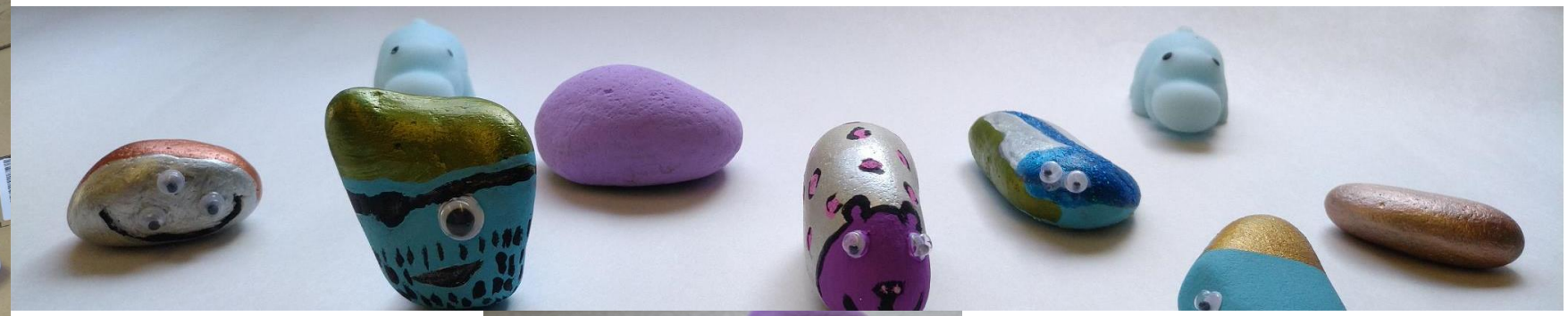
- **Human Survival Responses** **(Zoe Lodrick)**

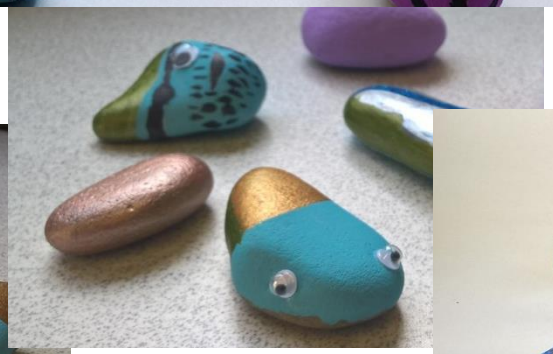




Amygdala Brain Domination

Amygdala Pet Exercise

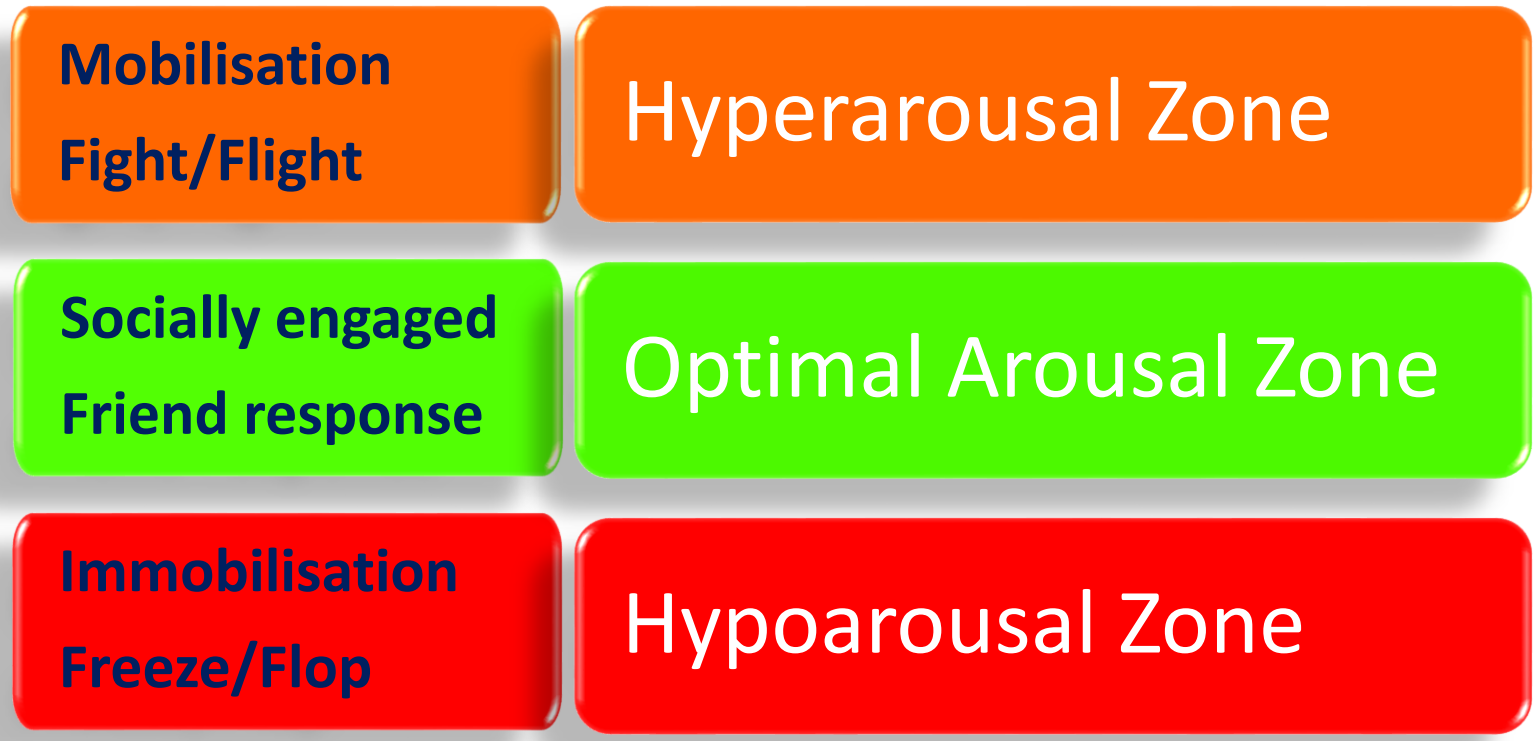




From Guard Dog to Pet…

Topic Three: Window of Tolerance

"a psychological and physiological setting in which we are able/ capable of 'cooling down' after being activated by a stressor" (K.L. Kain and S. J. Terrell, 2018)



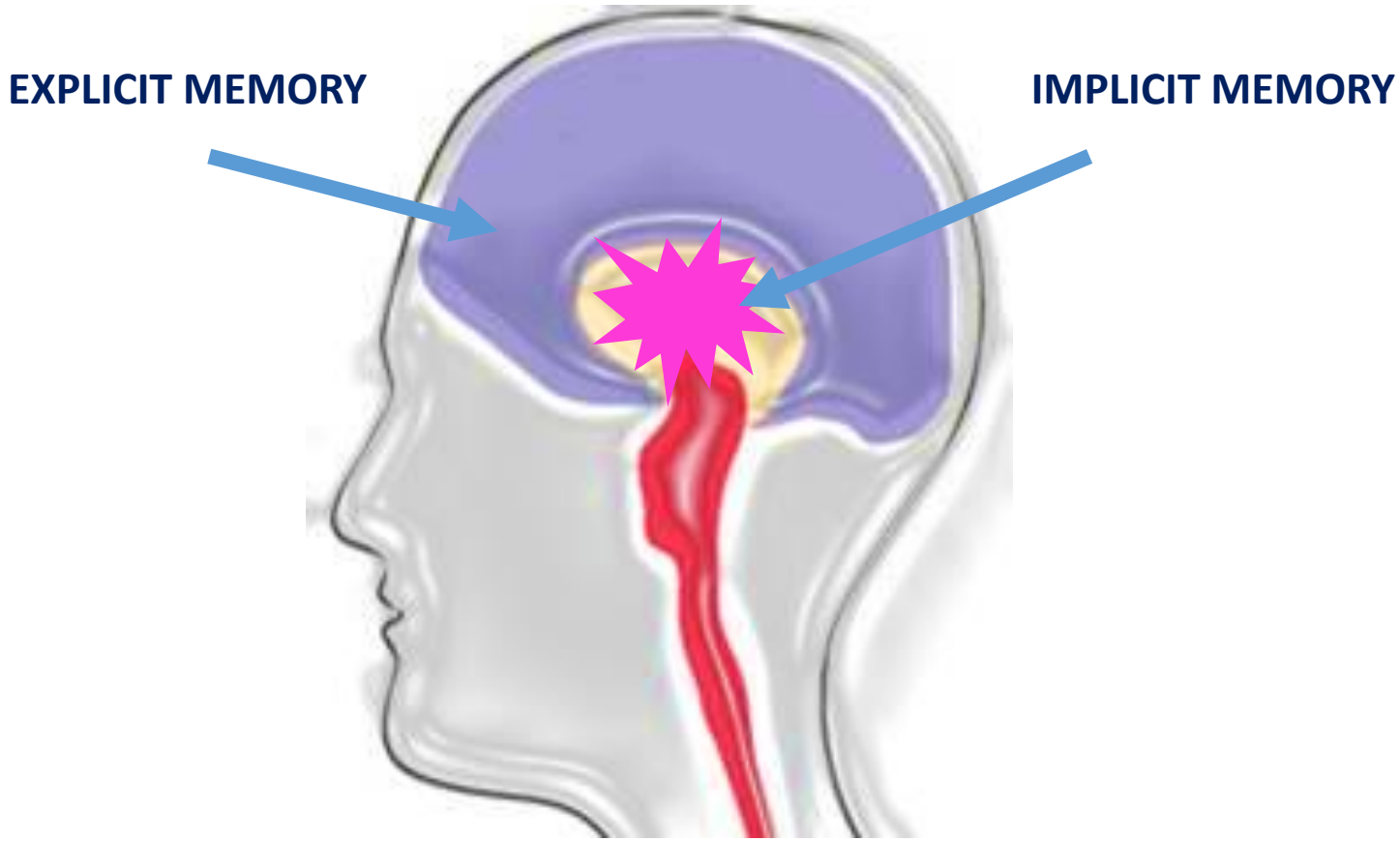
Disorganised cognitive processing
Emotionally reactive
Hypervigilant

Able to think and tolerate emotions simultaneously

Disabled cognitive processing
Numbing of affect
Absence of sensation

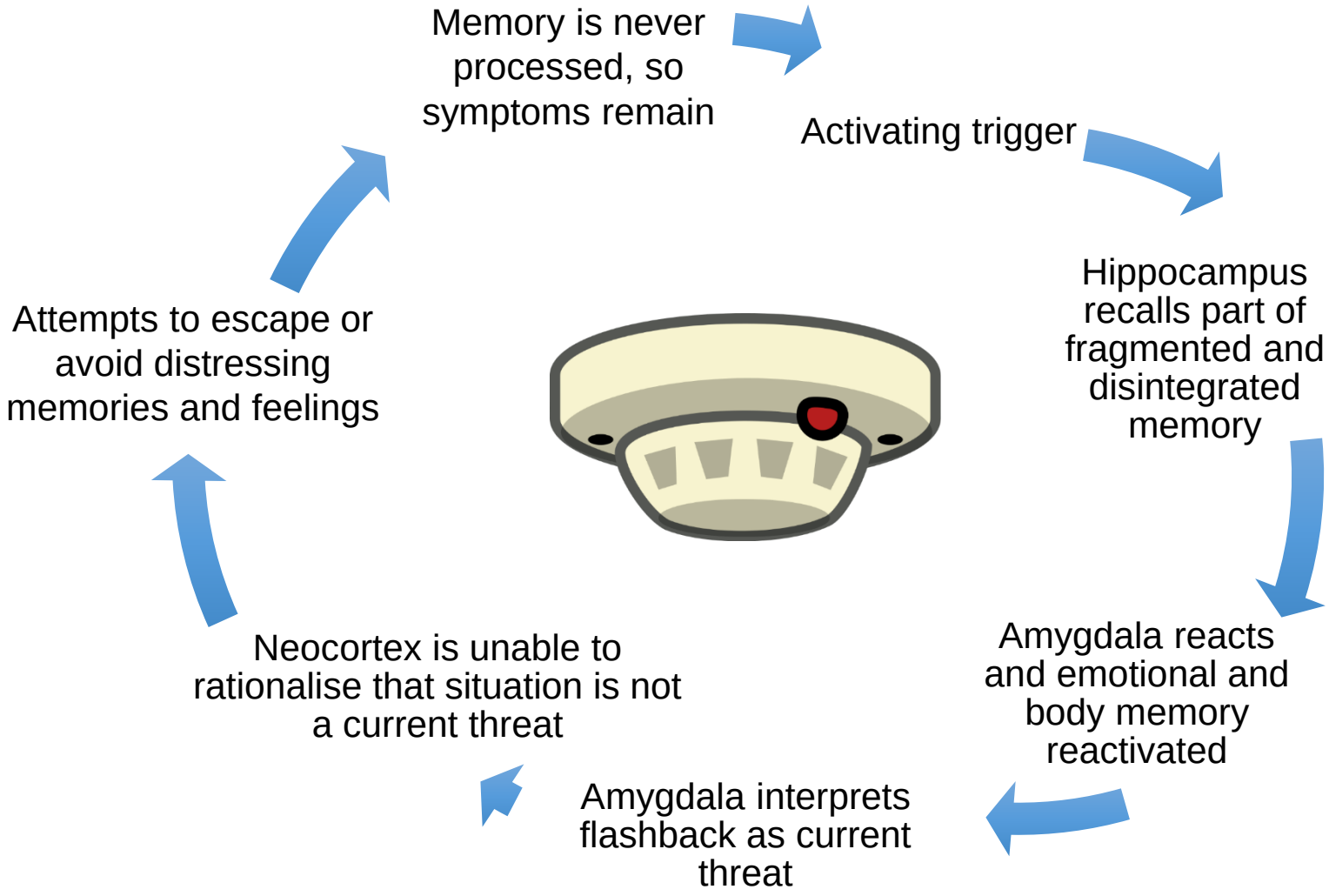
Topic Four: Trauma and Memory

- Trauma memories different to ‘normal’ memories
- ‘Thinking brain’ offline – so memories encoded differently
- Fragmented memories – sensations



Topic Four: Trauma and Memory

Flashback and memory 'loop'



Noticing and tracking

What helps?

- Name the experience as a flashback
- Remember that it's a common and normal response to trauma
- Recognise that the flashback is not an event that is happening now
- Remember that you are safe now
- Remember to breathe (calmly and slowly)
- Actively use your five senses to reorient yourself
- Sooth yourself, be kind to yourself, perhaps seek support of a trusted other, after the flashback has occurred.

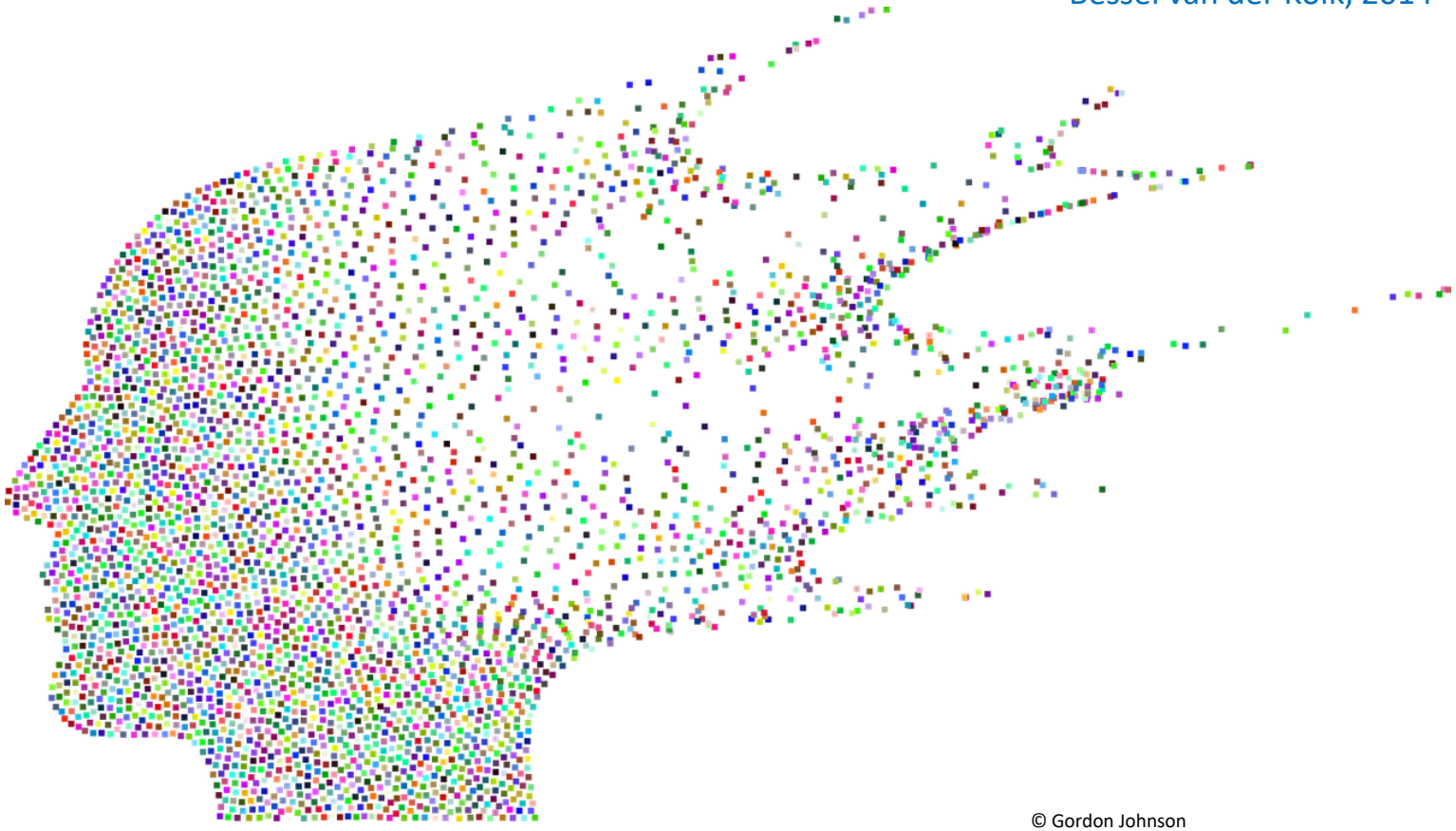
Be curious!

Symptoms of trauma-related dissociation

"Dissociation is the essence of trauma"

Bessel van der Kolk, 2014

- Amnesia
- Depersonalisation
- Derealisation
- Identity confusion
- Identity alteration
- Hearing voices



Grounding techniques

What helps?

- Mental Grounding Techniques
- Reorientation Grounding Techniques
- Sensory Grounding Techniques
- Movement Grounding Techniques
- Making a Grounding Box
- Flashback Halting Protocol

How and why it helps?

Consequences of CSA complex trauma

- **Changes to amygdala function**
  - Lower threshold
  - Increased intensity
- **Physiology**
  - Tuned to danger
  - No sense of SAFETY
- **Corrupted Memory**
  - Trauma still present in re-lived experiences
  - Gaps in recollection
- **Impaired ‘friend’ response**
  - Damaged social engagement
  - Poor self-regulation of arousal and emotions

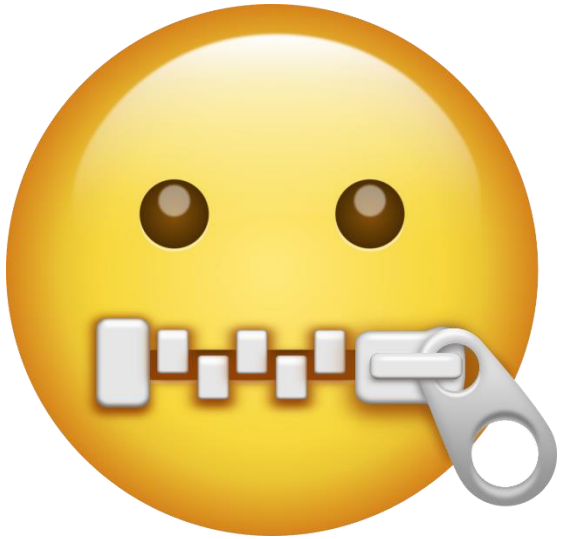
Topic Five: Emotions and trauma

"[A] primary challenge for most complex trauma survivors involves recognizing, accepting, modulating, communicating about, and even embracing their emotions'"

Christiane A. Courtois, 2014

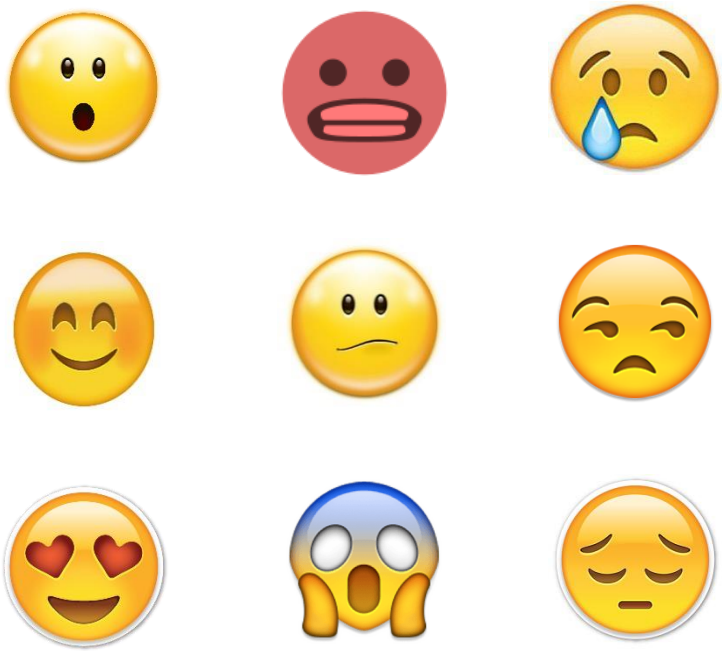
- **Dissociation**
  - Avoidance
  - No sense of human connection

- **Alexithymia**
  - No words for feelings (Greek)
  - Estrangement from self, emotional deadness



Topic Five: Physiology of emotions

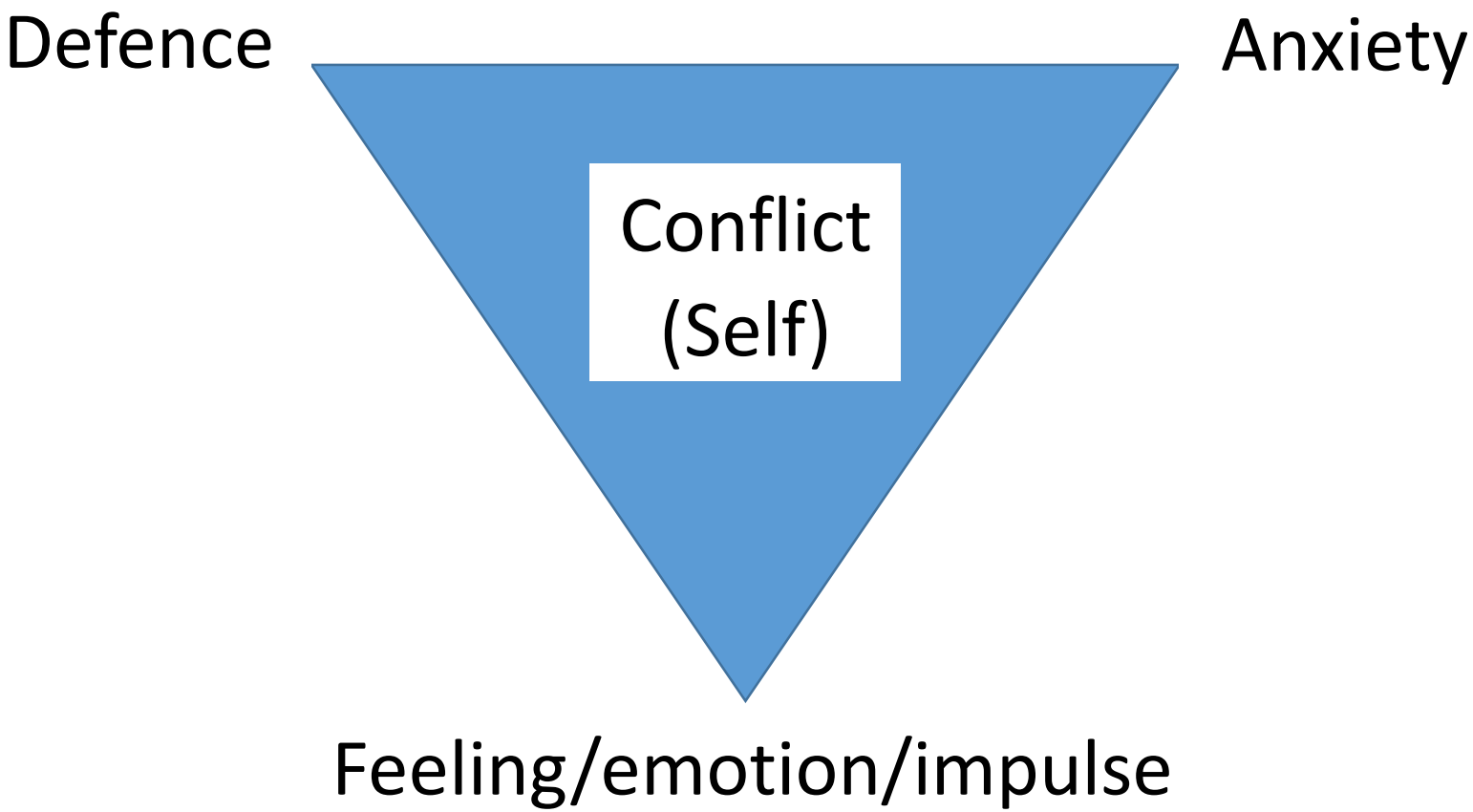
Emotions Are Pop-Up Messages



Key points

- Emotions are adaptive and necessary for survival
- They are shared by all humans
- Emotions are neutral; they are ‘pop-up’ messages or ‘guides’
- Basic emotions are instinctive responses
- Secondary emotions are often learned reactions to primary emotions
- Particularly fear, anger and disgust can help to protect us
- Emotions cause physical effects
- We need our emotions.

Triangle of Conflict – understanding emotions



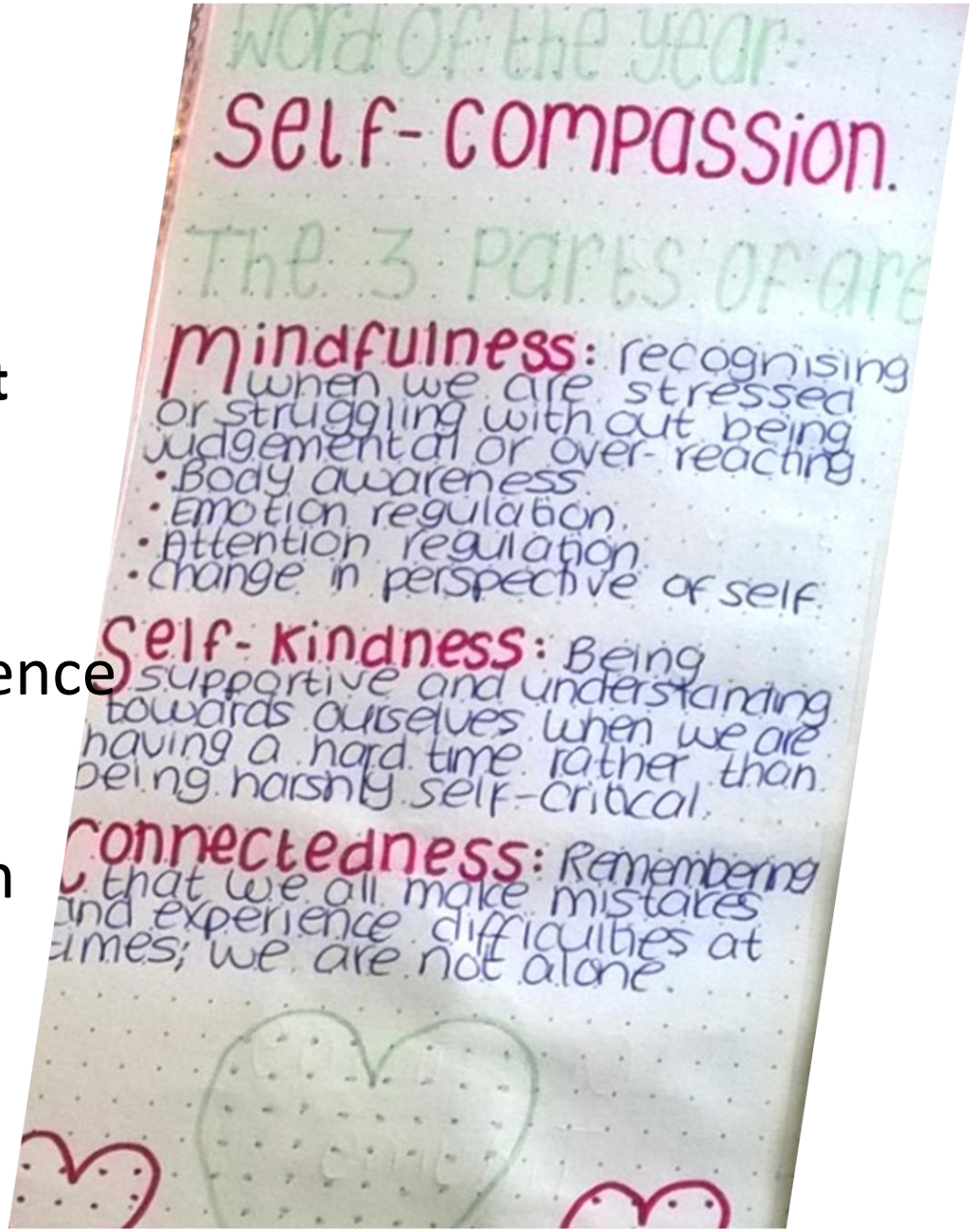
Topic Six: Self-compassion

What it is

- Self-kindness (versus self-judgement
- Common humanity (versus isolation)
- Mindfulness (versus over-identification)

What it isn't

- Self-pity
- Self-indulgence
- Self-esteem

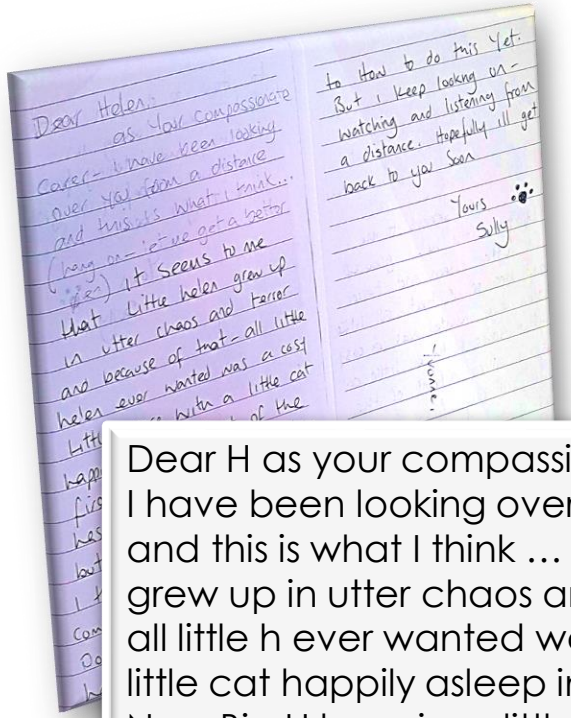


Topic Six: Developing self-compassion

What helps?

- Safe place imagery
- **Developing ideal compassionate helper**
- Compassionate letter writing
- Empathy for inner critic

Developing an Ideal Compassionate Helper



Dear H as your compassionate carer
I have been looking over you from a distance,
and this is what I think … It seems to me that little h grew up in utter chaos and terror and because of that all little h ever wanted was a cosy little space with a little cat happily asleep in front of the fire – all cosy.
Now Big H has given little h this but Big H needs more.
I think Big H needs love, companionship and to be big!
Doing grow up stuff. I haven't yet got a solution as to how to do this yet. But I keep looking on – watching listening from a distance. Hopefully I'll get back to you soon. Yours, Sully.

Exercise for building an 'ideal and compassionate' helper that is BIGGER, STRONGER, WISER and reflects qualities of compassion:

- **Wisdom**
- **Strength**
- **Warmth**
- **Acceptance**
- **Non-Judgemental Attitude**

Adapted from Paul Gilbert, *Psychotherapy and Counselling for Depression*, 3e, Sage Publications Ltd, 2007, and www.get.gg/compassion.htm

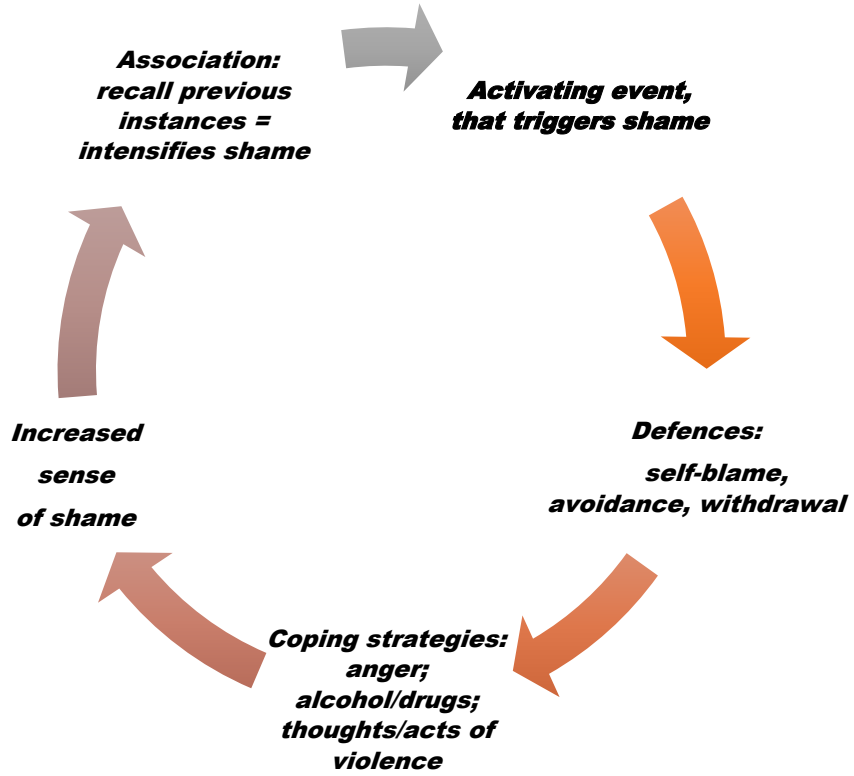
Topic Seven: The experience of shame

"Shame is a complex interaction between feelings, thoughts and behaviours which are inextricably linked in an endless cycle…"

Christiane Sanderson, 2015

3 aspects of shame

- Physiological responses
- Cognitive processes
- Behaviour



Topic Seven: Guilt versus shame

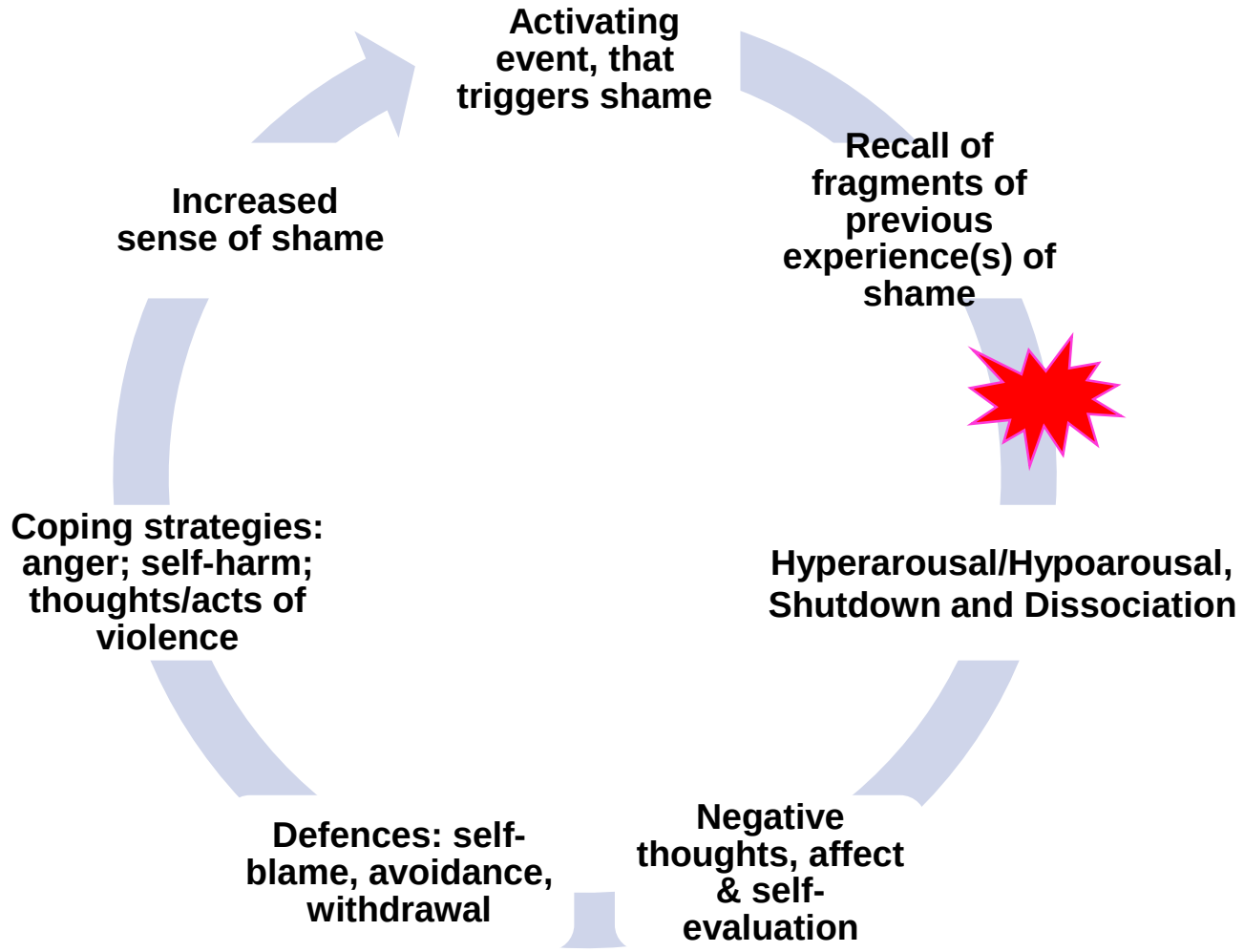
Guilt

- I did something bad
- I regret my actions
- In conscious awareness
- Focus is on transgression
- Motivates restitution, apology
- Doesn't affect core identity
- May be fearful of punishment
- Can be discharged through making amends

Shame

- I am bad
- Essence of existence feels shameful
- Not always conscious
- Focus on self as inadequate/failure
- Often silent, lacks channel for discharge
- Is induced/reinforced by others
- Makes me feel paralysed
- Have to make amends for whole self

Topic Seven: Cycle of shame and CSA



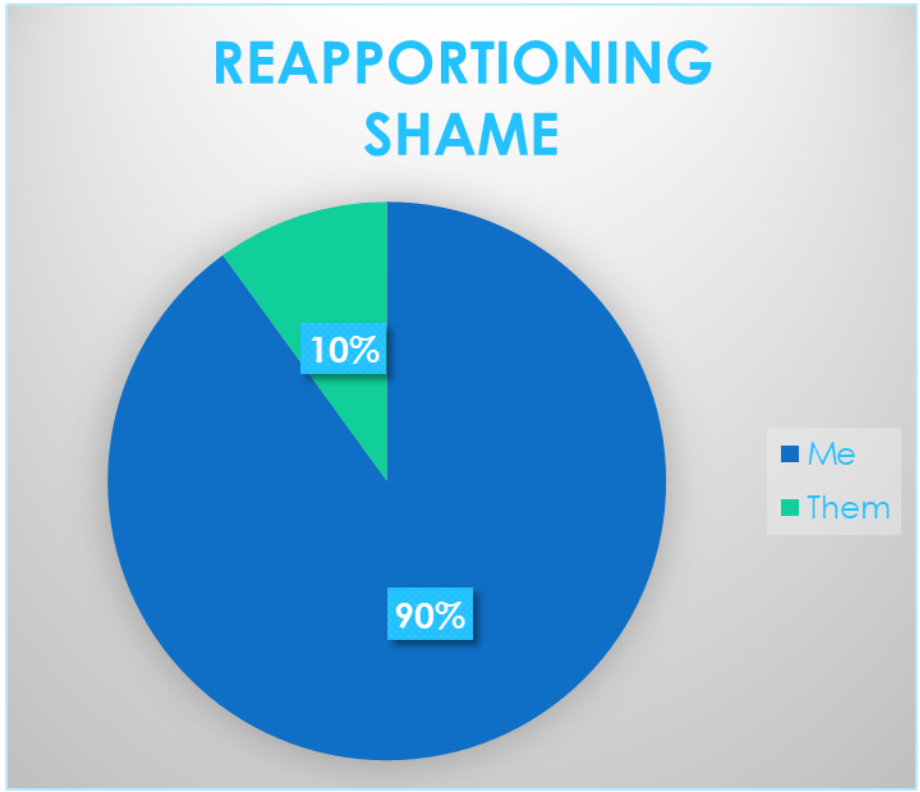
Starting to overcome shame

"the best antidote to shame is through human contact. Being accepted, understood and valued by someone in a non-judgemental way will enable you to release your shame … to come out of hiding and become more visible"

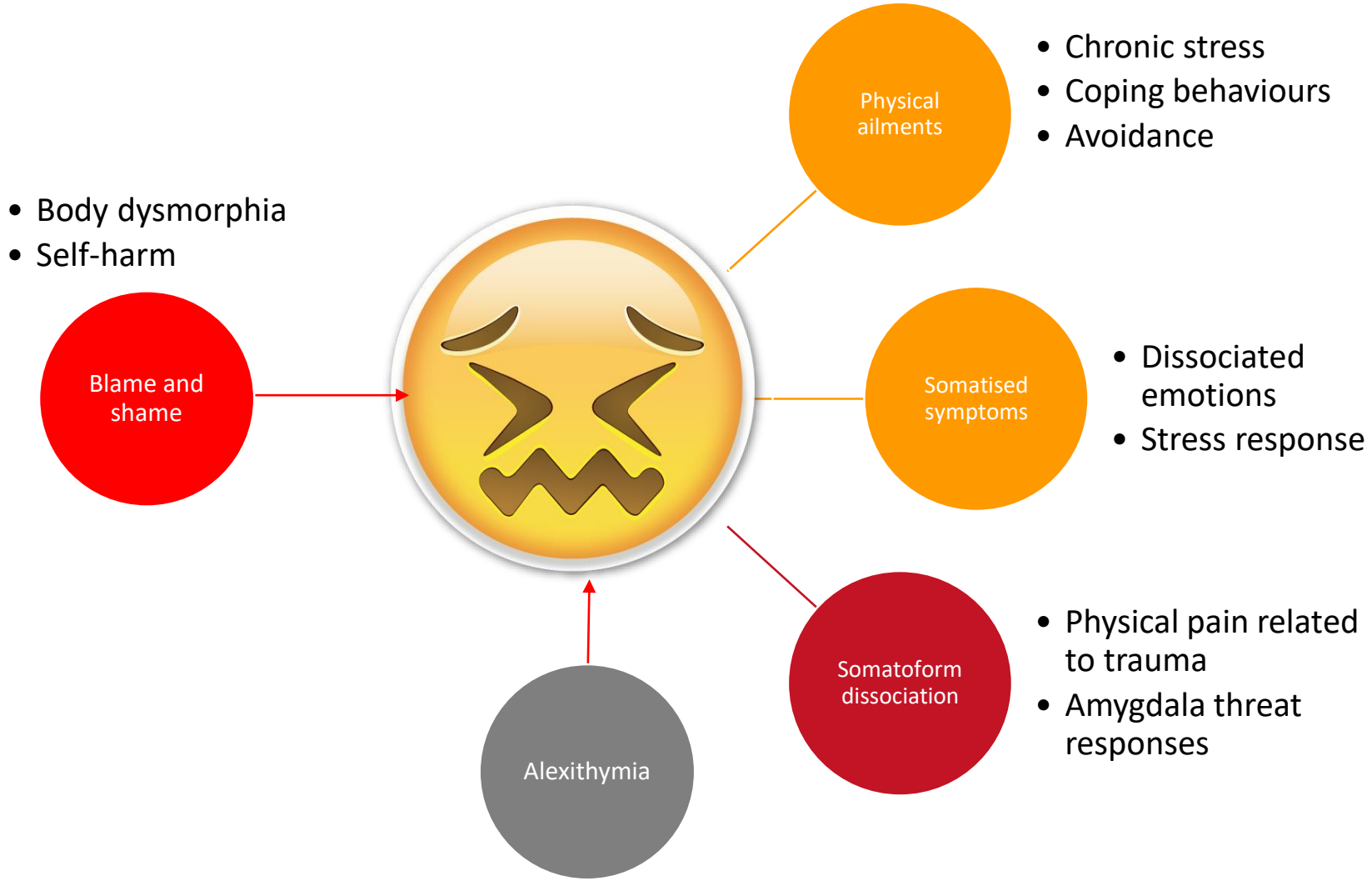
Christiane Sanderson, 2014

What helps?

- Connection with others
- Group therapy
- Cognitive processing: making a 'responsibility pie'
- Self-compassion



Physical health problems



Reclaiming the body

What helps?

- Befriending our bodies
- Extending self-compassion to our physical selves
- Forgiving our bodies
- Group wisdom: ACTIVE JOY
  - Fire dancing with poys
  - Cycling
  - Dancing (shake it off)

Summary

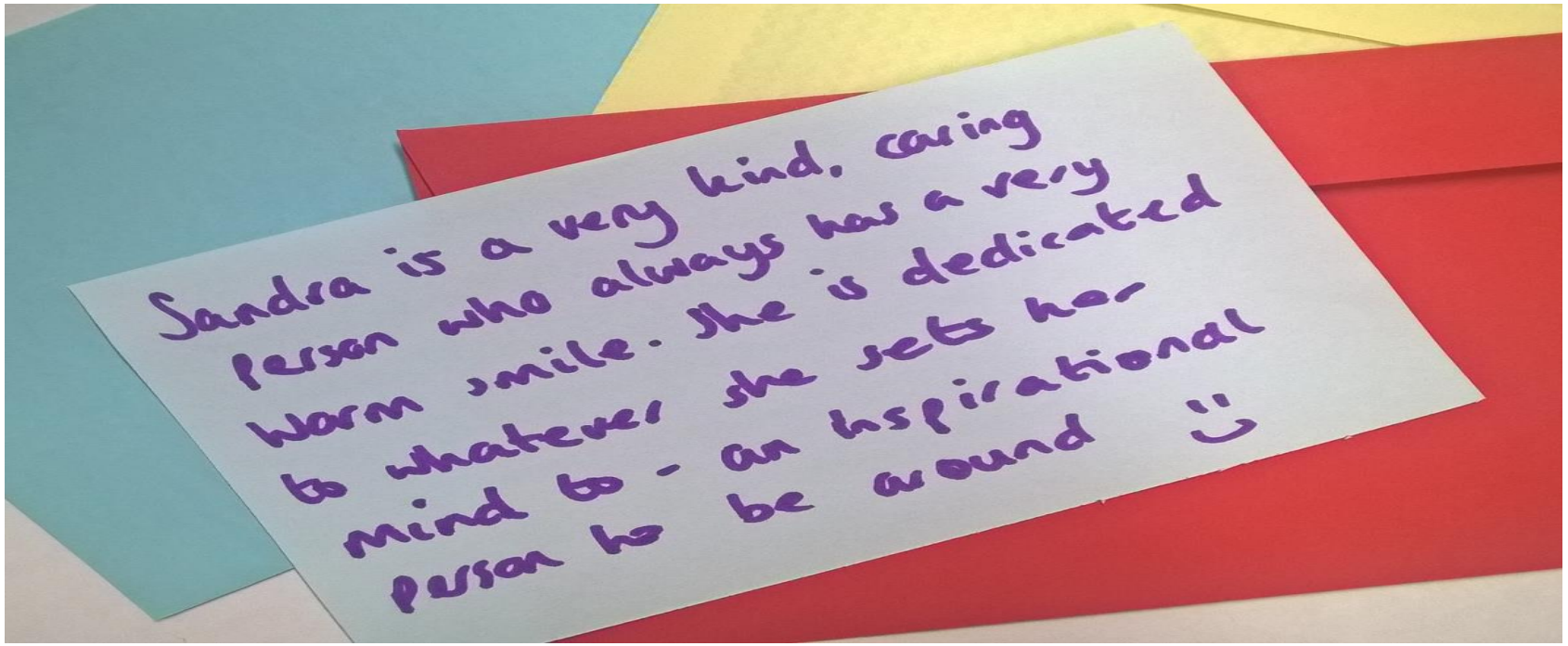
What helps?

- ➔ Becoming curious
- ➔ Noticing anxiety
- ➔ Being non-judgemental
- ➔ Developing self-awareness, including emotions
- ➔ Learning self-compassion
- ➔ Befriending physical body

Exploring how it helps

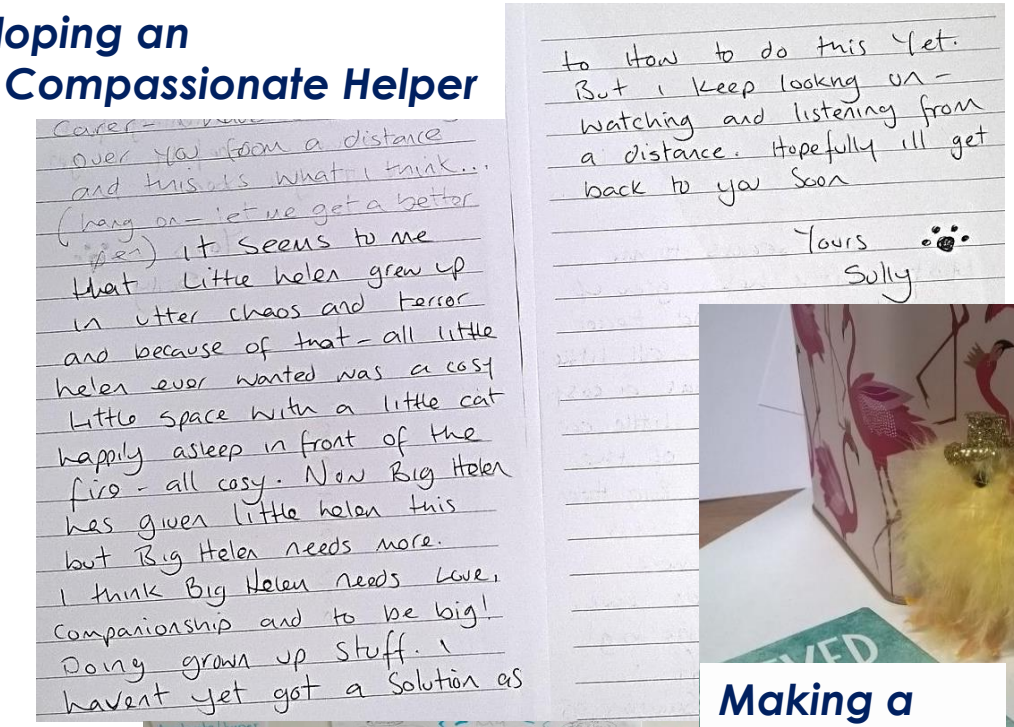
Closing exercise

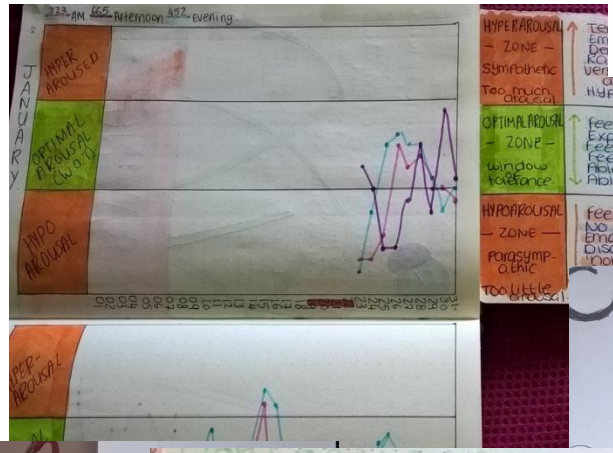
Gifting of positive sentiments and thanks by each group member to each other …



Group Exercises

Developing an Ideal Compassionate Helper

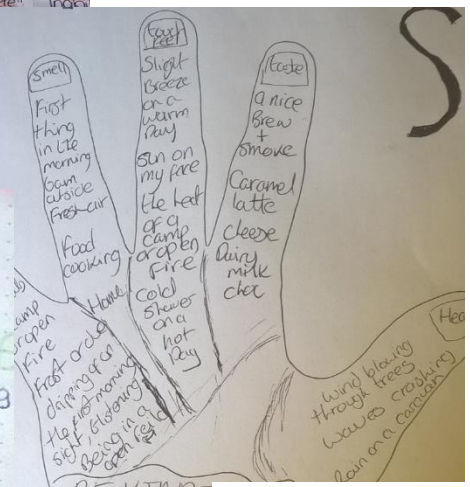




Tracking Window of Tolerance /Hyperarousal/Hypoarousal

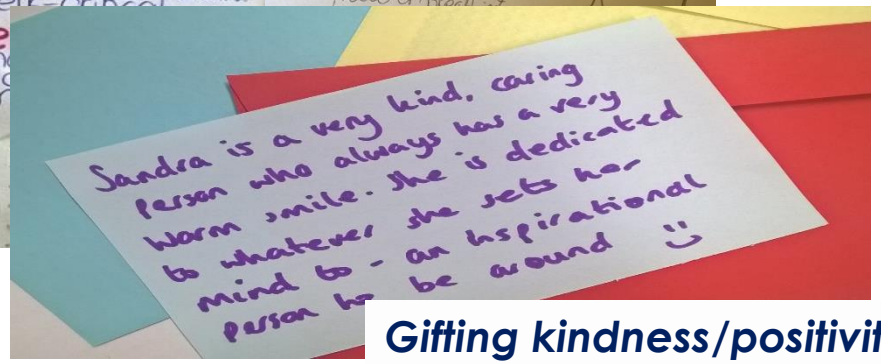
Making a Calming Box

Interpreting Self-Compassion



Calming Hand/ Five Senses

Personal map of understanding



Gifting kindness/positivity

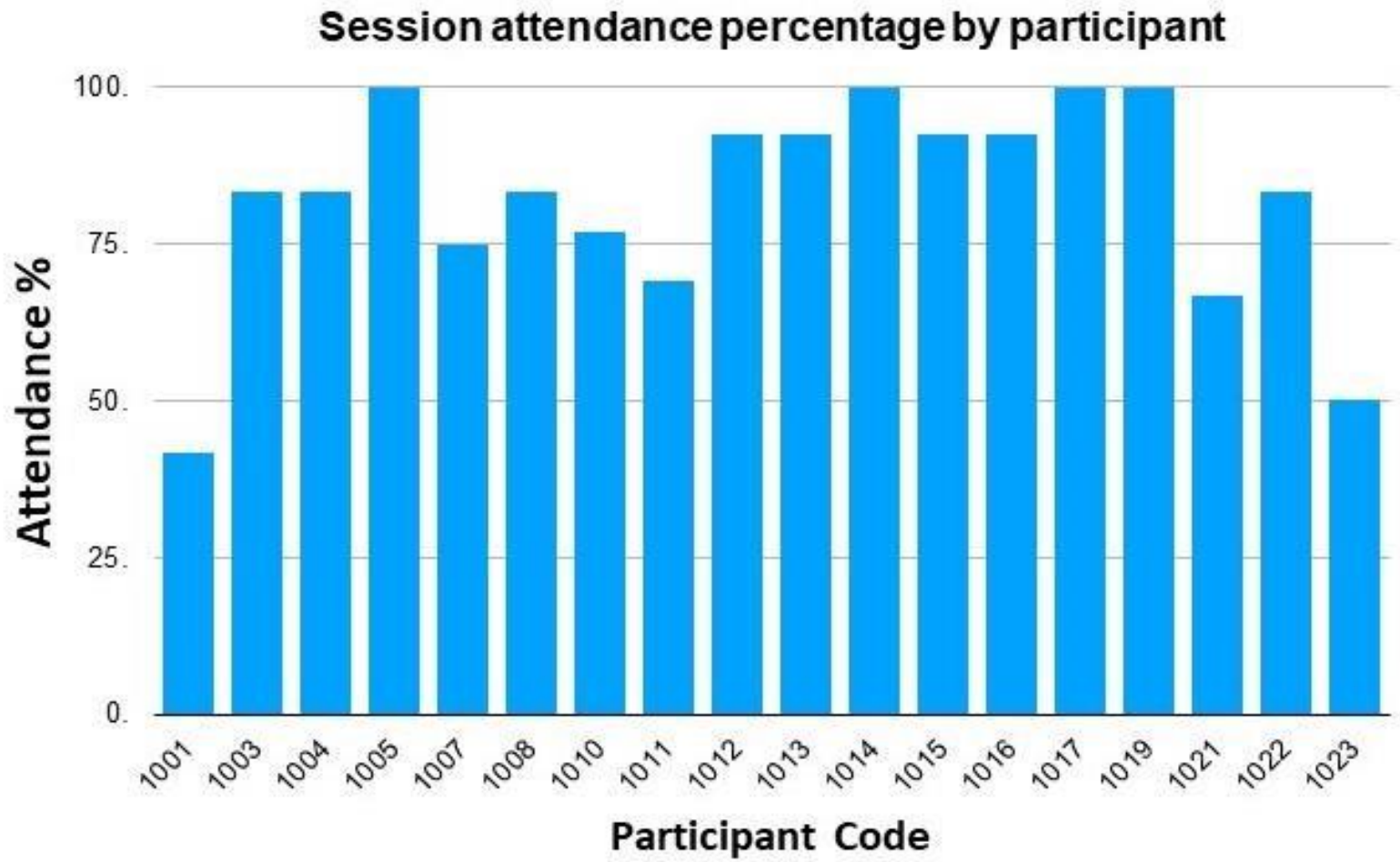
Evaluation results

Quantitative Study	Qualitative Study	Observations/Anecdotal

Quantitative research spectrum

Measure	How utilised	Reference/Authors
World Health Organisation Quality of Life, split in 4 Domains: Physical Health – Psychological – Social Relationships - Environment	**Pre- & post-intervention**	WHO QoL-Bref, WHO, 1996
Adverse Childhood Experiences Questionnaire	**Baseline only**	ACE-Q, Felitti et al, 1998
Somatoform Dissociation Questionnaire	**Baseline only**	SDQ-20, Nijenhuis et al, 1996
PTSD Checklist for DSM-5	**Pre- & post-intervention**	PCL-5, Weathers et al, 2013
Trauma Symptom Checklist	**Pre- & post-intervention**	TSC-40, Briere & Runtz, 1989
Difficulties in Emotional Regulation Scale – Short Form	**Pre- & post-intervention**	DERS-SF, Kaufman et al, 2015
Inventory of Interpersonal Problems	**Pre- & post-intervention**	IIP-32, Barkham, Hardy & Startup, 1996
Dissociative Experiences Scale	**Pre- and post-intervention**	DES-II, Carlson & Putman, 1993
Clinical Outcomes in Routine Evaluation	**Pre- and post-intervention**	CORE-OM, Evans et al, 2000
Clinical Outcomes in Routine Evaluation – 10	**Mid-way intervention point**	CORE-10, Evans et al, 2012

Attendance


Session attendance percentage by participant
Attendance %
100.
75.
50.
25.
0.
1001
1003
1004
1005
1007
1008
1010
1011
1012
1013
1014
1015
1016
1017
1019
1021
1022
1023
Participant Code

Quantitative Study Headlines

- Data analysis led by Stuart Ivory, Assistant Psychologist, BCUHB
- **Baseline pre-intervention** symptomology showed a range of complex difficulties - often exceeding the cut-offs that indicate a variety of dissociative and trauma-related disorders e.g. scores on DES II and PCL5. Despite their Chronic CSA and ACEs histories, only 11 women had received any prior care for their complex trauma from mental health services.
- **Post-intervention results** indicated positive benefits from the intervention:
  - Statistically significant improvement in WHO QoL in Domain of Environment: health & social care, home environment, freedom – physical safety & security
  - Positive trend (though not reaching statistical significance) in measures of PTSD symptomology, interpersonal difficulties, emotion regulation, general mental health and quality of life
  - Exception: DES-II measure of dissociative experiences. Baseline pre-intervention mean score was 37 (SD=16.48); 17/21 participants scored above the threshold of 20. Mean scores post-intervention, based on 5/13 participants, increased to 40.42 (SD=20.32)

Qualitative Study Structure

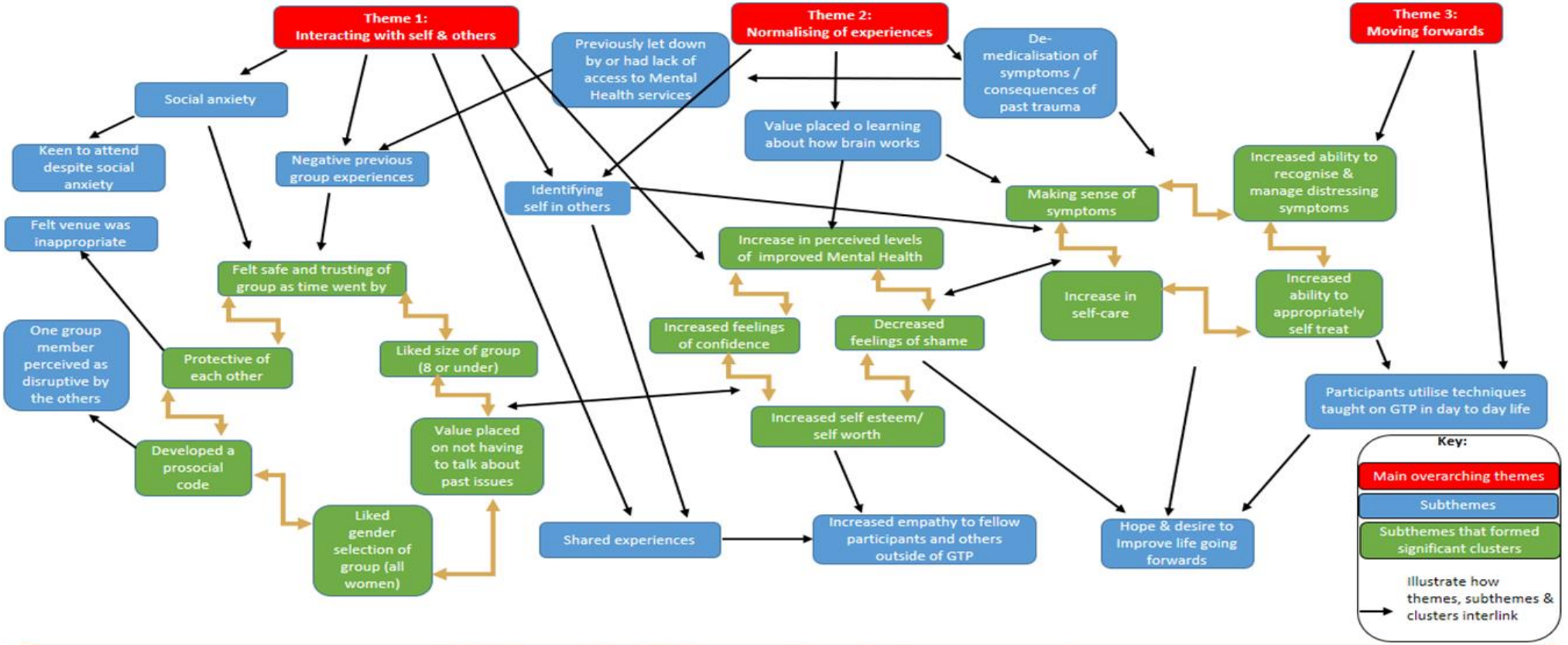
- Interviews lasted up to one hour, using a semi-structured format including the following nine open questions:

1. **HOW DID YOU FIRST HEAR ABOUT THE GROUP?**
2. **WHAT WAS IT LIKE TAKING PART?**
3. **HAS TAKING PART MADE ANY DIFFERENCE TO HOW YOU SEE OR FEEL ABOUT YOURSELF?**
4. **DO YOU FEEL TAKING PART HAS HAD ANY IMPACT ON YOUR DAY-TO-DAY LIFE?**
5. **DO YOU FEEL TAKING PART HAS HAD ANY IMPACT ON HOW YOU FEEL ABOUT YOUR LIFE GOING FORWARDS?**
6. **WHICH ASPECTS OF THE GROUP WERE MOST HELPFUL/VALUABLE/POSITIVE/GOOD AND WHY?**
7. **WHICH ASPECTS WERE NOT AS HELPFUL/VALUABLE/POSITIVE AND WHY?**
8. **DO YOU THINK THE GROUP WOULD BE HELPFUL TO OTHERS WITH A SIMILAR PAST?**
9. **IS THERE ANYTHING YOU WOULD LIKE TO TELL ME?**

Qualitative Study Headlines

- Led by Sarah Davies, Research Midwife/Officer, (BCUHB) and Aaron Pritchard, Independent Research Methodology & Data Analyst
- All 19 women who attended the CTG were invited to take part in the Qualitative Study. 12 responded and 9 eventually took part.
- Analysis revealed three clear overarching themes (with sub-themes) that came up repeatedly both individual recollections and across the set of data:
  1. Interactions with self and others (at individual and group levels)
  2. Normalising of experiences (sub-theme: de-medicalisation)
  3. Moving forwards (with a new sense: hope)

Thematic Framework Analysis Diagram



Subthemes identified as sustained outcomes over time

- Improved relationships with family & friends (especially own children)
- Decrease in feelings of isolation from others and society
- Increased ability to think about/ make hopeful plans for future
- Increased feelings of overall safety
- Participants recommend group to others
- Long held negative beliefs introduced by others are challenged

Interactions with Self and Others

"Well, at first I must admit, I was scared because I don't do well em…like I say outside of my home environment and, and, I think I was a bit scared of you know sort of speaking up or saying very much at all but em… everybody here was very, very friendly and very supportive. And I found after a couple of times going I relaxed and could take part better"

Participant 1008

Normalising of experiences

“I used to think I was going mad…even before my flashbacks…But now I understand it’s all because of the trauma I had before. I understand, I understand because before I used to think I was going mad, I’d say to my husband, the men in white jackets are coming for me – he’d say what are you on about”

Participant 1014

Moving Forwards

"You can see there is a life, there is a future and that was really good…there are people a bit further on than I was and as much as yes, they are still having their bad times, they are less; but actually they're striving, and because I've got my own strive, then I want to have a good life, don't want my life to be controlled by what happened…She [other participant] almost shows me that you can, you can."

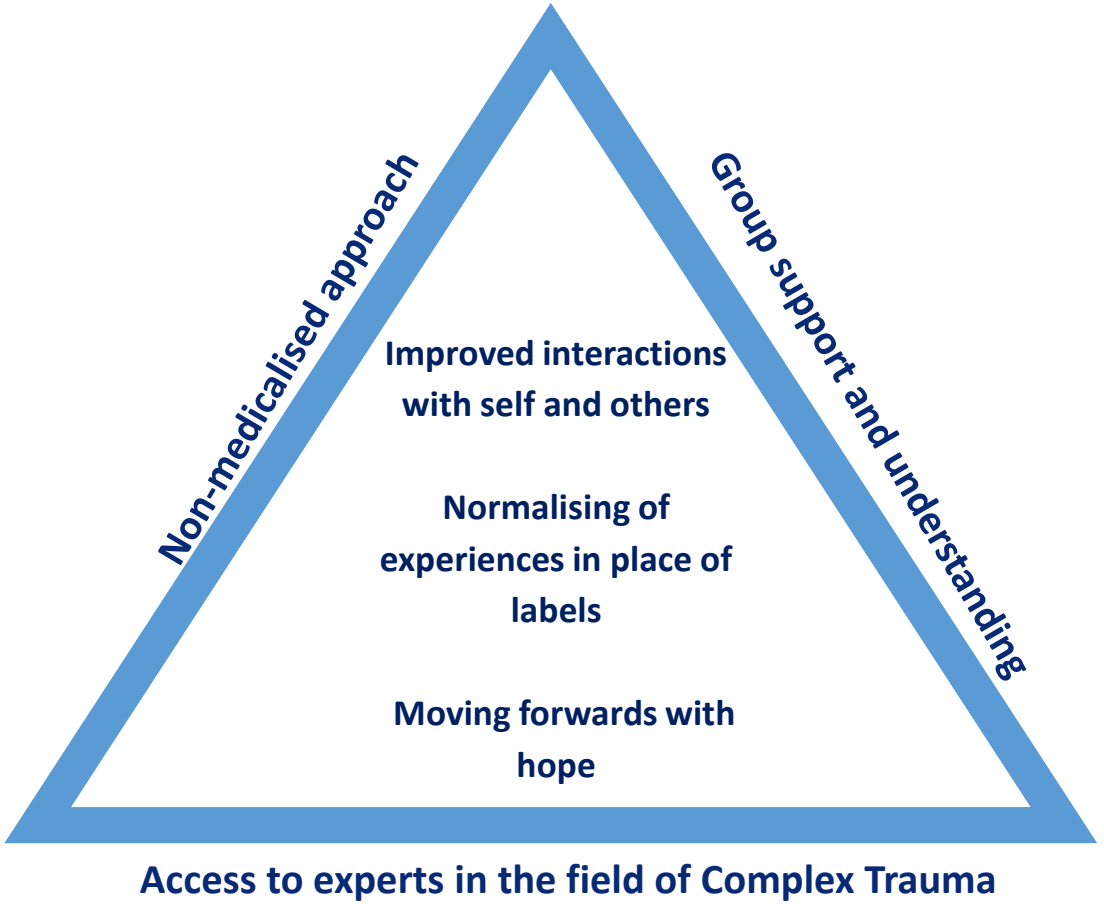
Participant 1017

Changes that we saw or were told about

- What stories did we hear?
- Relationships with others
- Relationships with self
- How do we measure what’s meaningful?

Benefits (1)

Key elements of themes and sub-themes that distinguish benefits identified in Quantitative Study



Benefits (2)

Specific benefits identified in Qualitative Study

- De-isolation at an individual level
- Acquisition of new skills as positive coping mechanisms
- Normalising of effects (symptoms)/consequences
- Knowledge translating into ‘power’
- Safety and re-socialising
- Ability to envisage a future with hope

Specific areas for improvement identified in Qualitative Study

- Challenges with language/concepts of psychoeducation
- Review location for potential triggers
- Managing conflicts in the group
- Post-group support (and additional support generally)

Reflections