TREATMENT FOR SURVIVORS OF TRAUMA

A Stabilization Group Approach for Heterogeneous Populations of Trauma Clients

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High prevalence and long-lasting implications of human-inflicted trauma call for effective treatment approaches reaching clients in need of trauma-specific treatment. Numerous approaches exist, but often with limited empirical support. There is also a tendency toward segregating treatment approaches depending on type of exposure history and presenting symptoms. This might exclude clients in need of trauma-specific treatment; therefore, treatment approaches that can reach more heterogeneous groups of clients are needed. In this article, a group-based treatment approach adjusted to include clients with a wide range of trauma-related problems and traumatic experiences will be presented. A brief outline of the approach is presented, together with the theoretical and empirical background, to facilitate implementation by practitioners and empirical testing.

KEYWORDS *group, heterogeneous populations, stabilization, trauma, treatment*

The high prevalence of potentially traumatizing experiences in the general population (Finkelhor, Ormrod, & Turner, 2007; Giaconia et al., 1995; Putnam, 2003), as well as the increased risk of developing long-lasting and

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far-reaching problems following these experiences (Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006; Jacobson & Herald, 1990; Kessler, Chiu, Demier, Merikangas, & Walters, 2005), is becoming ever clearer. For several decades, clinicians and researchers have pursued knowledge on how to best help people recover after devastating traumatic experiences. As the field has developed, several important differentiations have emerged concerning the characteristics of both traumatic exposure and trauma-related symptoms.

A particularly important differentiation was pointed out by Herman (1992b) nearly 20 years ago, drawing attention to the different characteristics of single versus long-lasting trauma, and the special and stage-dependent therapeutic needs in designing treatment with survivors of long-lasting trauma (Herman, 1992b; Steele & van der Hart, 2009). The first phase (stabilization) is considered necessary when trauma exposure has resulted in the development of trauma-related symptoms, such as intrusions, avoidance, and dissociation, and where problems with affect regulation and efficient handling of symptoms interfere with daily functioning. The core concept of the stabilization phase is the reestablishment of safety (Herman, 1992b). Other key elements include efficient regulation of arousal, social engagement, increasing sense of agency or the degree to which you feel like an agent regarding your own life, expanding action repertoires, and enhancing body awareness (Fisher & Ogden, 2009; Herman, 1992a; Ogden, Minton, & Pain, 2006; Steele & van der Hart, 2009; van der Hart, Nijenhuis, & Steele, 2006).

When combined, the elements in the stabilization phase aim at preparing the client to work more directly with trauma content in the second phase, called *integration*. In this second phase, the aim is to integrate traumatic memories without getting overwhelmed. The third phase, according to Herman (1992b), focuses on reconnection with other people and everyday life, and creating a future. The theory of structural dissociation (van der Hart et al., 2006), which more explicitly addresses dissociation following traumatization, puts emphasis on the integration of the personality and rehabilitation in the third phase. In addition, this theory stresses the importance of “realization” in the healing process following traumatization. Realization means “to distinguish the present moment in time and space; to tell the difference between the past, present and future” (van der Hart et al., 2006, p. 161). Key elements to realization are *personification* (It happened to me) and *presentification* (It happened then, but is not happening now). Although operating with different phases of trauma treatment, the previously mentioned way of conceptualizing trauma treatment must not be conceived as a linear model. Stabilization work remains an important and integrated part of trauma treatment, also in the second and third phases. Other treatment models, such as eye movement desensitization and reprocessing (EMDR; Shapiro, 2005), incorporate stages including “client preparation” to the reprocessing of traumatic memories. Elements like “resource development and

installation" (Dworkin, 2005, p. 79) bear many similarities to stabilization, as conceptualized earlier, while "reprocessing" bears similarities to phase two work (integration).

In the preceding years, the shortcomings of existing diagnostic categories to encompass the full spectrum of symptoms following prolonged traumatization have also been pointed out, and suggestions of including new diagnostic categories, like Complex PTSD, have been made (Herman, 1992a, 1992b). Focus has also been drawn to clients with dissociative disorders and how these disorders dictate pace, content, and form of assessment and treatment (Steele & van der Hart, 2009; van der Hart et al., 2006). In addition, the focus on the body and the mind when treating survivors of trauma has been strengthened and recognized, where concepts like increased body awareness, grounding exercises, and bodily memories are vital (Fisher & Ogden, 2009; Ogden et al., 2006).

Over the years, the field of psychological trauma has seen rapid advancements. Today there is an array of both individual (Ogden et al., 2006; van der Hart et al., 2006) and group stabilization approaches (Najavits, 2002), and combinations of individual and group approaches (Chard, 2005; Wolfson & Zlotnick, 2001). There are also examples of attempts to integrate stabilization and integration in the same treatment approach (Lubin, Loris, Burt, & Johnson, 1998). Despite the large number of available group approaches and their wide application in the treatment of trauma-related problems, there is a relatively small body of empirical studies systematizing experiences and testing the effect and efficacy of these approaches (Ford, 2009; Fritch & Lynch, 2008). The empirically tested approaches are, however, generally found to be equally effective in reducing symptoms (Alexander, Neimeyer, Follette, Moore, & Harter, 1989; Classen, Koopman, Nevillmann, & Spiegel, 2001; Dorrepaal et al., 2010; Ford, 2009; Fritch & Lynch, 2008; Lubin et al., 1998; Schnurr et al., 2003).

In the quest to find the most potent treatment in this complex field and to make research results easier to interpret, there has been a movement toward creating homogeneous samples based on exposure characteristics; for example, treatment for women with a history of childhood sexual abuse (Chard, 2005; Wolfson & Zlotnick, 2001), adults exposed to domestic violence (Tutty, Bidgood, & Rothery, 1993), or rape victims (Resick & Schnicke, 1992). Only a few approaches open up to a wider horizon of traumatic exposure and comorbid psychiatric disorders in the same group (Lubin et al., 1998; Najavits, 2002).

This development toward more specialized treatment approaches potentially helps researchers and clinicians understand more of this complex field. It has been argued, though, that the empirically tested group approaches are too often poorly or vaguely described, making replication difficult (Fritch & Lynch, 2008). Additionally, their inclusion criteria are often too narrow, making generalization to clinical populations difficult, where

multiple trauma and comorbidity are common (Fritch & Lynch, 2008). Given the current knowledge, informed choices on treatment of survivors of trauma in clinical settings are difficult to make.

Providing separate treatment for clients based on exposure history or symptom picture might not always be possible as a result of low population density, varied and complex client populations, or the need to provide treatment quickly after referral. More inclusive treatment approaches that can capture a greater range of clients when it comes to exposure characteristics and symptom picture (Fritch & Lynch, 2008) are therefore needed as an addition to the specialized approaches. The approach in this study represents an attempt to move in this direction.

The following section provides a brief outline of an inclusive treatment approach, notably in terms of the overall structure, the inclusion criteria, the assessment process, and the structure of group sessions. The content of the approach is then described in more detail. Finally, illustrations of how theoretical concepts important in stabilization work are incorporated into the approach are presented. From this information, replication of the approach should be possible so that the approach can lend itself to future research and clinical work.

OUTLINE OF THE TREATMENT APPROACH

The primary goal of the approach is to reduce fear of, encourage exploration of, and enhance understanding and handling of trauma-related symptoms. Building on Herman's (1992b) work, the approach emphasizes safety, restoration of control, empowerment, skill building, and establishment of new social connections. The approach hence focuses on stabilization in a strict sense, with no sharing of trauma histories. Similar to some existing approaches, the clients receive concurrent group and individual treatment (Chard, 2005; Wolfson & Zlotnick, 2001). However, unlike existing approaches, this approach is open to clients with a variety of traumatic experiences ranging from childhood sexual abuse, exposure to domestic violence in adulthood, and rape, to assault. Clients with a range of trauma-related problems, ranging from posttraumatic stress disorder (PTSD) to dissociative identity disorder, are also included in the same treatment group.

The approach was developed in a rural context with low population size and population density. It is also applicable in urban settings as a way of providing trauma-specific treatment quickly after referral. The approach is offered at an outpatient facility where an external referral is needed in addition to an appraisal of the client's fulfillment of the Norwegian government's criteria for receiving help from the specialized health services. If the client is already receiving therapy at the outpatient facility, his or her therapist can refer the client to the group. The approach has been applied in

six treatment groups for women exposed to “human-inflicted trauma” such as child sexual abuse, emotional neglect, physical abuse, rape, battering, and so on. A total of 35 clients, aged 19 to 60 years, were enrolled in the program. The dropout rate has been 13.3% ($n = 4$). Also, the approach has been applied in one stabilization group for men exposed to human-inflicted trauma. Six men were accepted for the program, but only three started, and all three completed the program.

Inclusion and Exclusion Criteria

Clients at the outpatient facility can be assessed for the group approach, if they (a) have been exposed to human-inflicted trauma either in childhood, adulthood, or both; and (b) have active trauma-related problems. Human-inflicted trauma is defined as experiences where the intentional aspect is central, be it childhood abuse or neglect, intimate partner violence, or experiences with rape, assault, or robbery. It is thus a wider concept than “complex trauma” (Courtois & Ford, 2009; van der Hart et al., 2006), which requires the trauma to be long-lasting and relational in nature. Active trauma-related problems are defined as having symptoms of simple PTSD (Diagnostic Code F43.1 in the *International Classification of Diseases* [10th ed.; ICD-10]; World Health Organization, 1993), complex PTSD (Herman, 1992a), or symptoms or disorders of dissociation (Diagnostic Code F44.x, ICD-10).

Exclusion criteria are (a) severe and ongoing substance abuse that interferes with the client’s ability to meet regularly and on time, (b) a current psychosis or manic episode or major depressive disorder that interferes with cognitive functioning, or (c) severe suicidal ideation. Hence, clients with substance abuse can be included, provided they are not under the influence during group meetings, and are able to meet regularly. Inclusion of clients with substance abuse issues often happens with the help of their individual therapist. Clients experiencing ongoing threats are also assessed for the program and may be included as long as they are not currently living with the person posing the threat. If so, the stabilization phase is offered in individual treatment alone as group-based stabilization is not considered beneficial.

Assessment

To determine if the clients fit the inclusion criteria of the group, they are assessed using several self-report measures. The Post Traumatic Symptom Scale 16 (PTSS-16; Mollica, Caspi Yavin, Bollini, & Truong, 1992) and Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979) are used to assess symptoms of PTSD. The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) is used to assess symptoms of depression, and the Somatic Dissociation Questionnaire-5 (SDQ-5; Nijenhuis, Spinhoven, van

Dyck, van der Hart, & Vanderlinden, 1997) and Dissociation Experiences Scale (DES; Bernstein & Putnam, 1987) are used as indicators of dissociative symptoms. The Traumatic Experience Checklist (TEC; Nijenhuis, van der Hart, & Kruger, 2002) is used to map traumatic exposure. Potential candidates are then interviewed by the group therapists, at which point the final assessment is made. In this final assessment, the client's expectations of the treatment are explored and information about the treatment is provided. When a client is included in the program, the group therapists attend a session together with the individual therapist and the client. During this time, the organization and cooperation between the two parts of treatment is discussed openly and sorted out. The frequency of individual sessions is determined case by case depending on the client's needs and wishes.

Key Features of the Approach

The approach is semistructured and eclectic in nature. It consists of 17 weekly sessions, as clinical experience has illustrated that it takes time for clients to feel safe in the group and for group cohesion to develop. Two therapists lead the group and each session lasts for 90 min without a break. The groups are closed, with a maximum of seven clients in each group. Clinical experience has shown that a low number of clients is a necessity when working with such heterogeneous client groups to attend to all clients in a satisfactory way. The low number of clients in each group also ensures enough time for interaction between clients and the exchange of experiences during group sessions.

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. This is done to enhance clients' understanding, and control of, their trauma-related problems. Because it is important to keep emotional intensity at a moderate level when including clients with dissociative disorders in trauma groups (Ford, 2009), trauma histories are *not* explored or shared in these heterogeneous groups. If someone starts to talk about trauma history, the discussion will be closed gently but quickly. The client will then be encouraged and supported in talking with his or her individual therapist about this issue. The approach thus diverges from approaches like the one presented by Lubin et al. (1998), where trauma history is shared in the final phase of the treatment.

Structure of the Sessions

Each group session has the same structure, but the content varies. The group members and group therapists are seated on mattresses and pillows, forming a circle, with a centerpiece including a candle in the middle. The rationale for the seating arrangement is to help the clients stay more present by actively

having to use their bodies while sitting, thereby counteracting dissociation and drifting off.

Every group session starts with a music-listening exercise constructed to enhance body awareness and strengthen the ability to express differences in opinion. A different piece of music, with a steady rhythm and no sudden changes in tempo or volume, is played every session. The clients are asked to listen to the music and notice, without changing anything, what it is like to sit and listen to this piece of music. After listening to the music, the therapists help the clients explore how their breath and bodily experiences changed while listening. By sharing their experiences with listening to the music, and how this experience might differ from the others' experiences, the clients get to practice expression of differences in opinion over a safe topic—music. Differences in opinion regarding music are generally accepted, and the clients express that this forms a safe topic, where they can practice expressing their opinions.

Clients are then asked to share experiences from homework of the previous week and voice pressing issues that need attention. The topic of the day is then introduced with psychoeducation, presented in an interactive and easy-to-grasp way. Metaphors are used actively to provide room for reflections on both a concrete and more abstract level. The clients are also continuously encouraged to link their own experiences to the topic of the day. The psychoeducation also has an important function in structuring the sessions and focusing the interaction between the clients. Throughout the session, there are alternations between psychoeducation, skill building, and practicing of efficient regulation of arousal, and exchange of experiences between clients. These alternations are important in helping clients regulate arousal and stay focused during the session. At the end of the session, the therapists help clients formulate take-home messages and assign the clients homework, for which the clients are asked to practice the new skills acquired during the session.

In the first session the clients are also given a small notebook where they can make notes from the psychoeducation and from their homework. This log helps them stay focused during group sessions, while providing continuity between sessions and after the treatment is completed.

THE CONTENT OF THE TREATMENT APPROACH

The topics introduced by the therapists in each session are outlined next. The focus is always on involving the clients and having them link their own experiences to the topics and share their experiences with the group. The overview of session content that follows must therefore be read with the general structure of the sessions in mind. The order of the sessions is also changed if necessary, for example, if a client struggles with a

particular symptom, like severe sleep problems leading to a drop in level of functioning. However, when possible the therapists should follow the presented order.

Session 1—Getting Started

Lead presentation round and make nametags. Present information about the framework of the treatment (number of sessions, reason for sitting on mattresses, why there will be no sharing of trauma history in the group, and that everybody has an individual therapist). Work on “guidelines for interaction.” Go through issues of confidentiality and have all clients sign confidentiality contract. Explore participants’ expectations and thoughts on important topics and link this to information about common symptoms after trauma. Describe trauma treatment and its phases briefly. Establish consensus on the work to be done in the stabilization group and topics to be covered. Homework: Continue to work on what is needed to feel safe in the group.

Session 2—Safety

Continue to work on guidelines for interaction. Present psychoeducation on the importance of safety for recovery (Herman, 1992b). Work on establishing the notion of “safe place,” as mental representation of feeling safe that can be used to help the body relax (Dworkin, 2005; Parnell, 2008). Briefly describe how the body reacts to perceived danger. Introduce the metaphor of “the BRIO®-train” as a picture of trauma treatment, and how traumatic memories are encoded and stored differently from other memories (van der Kolk, 1994, 1996). The wagons in the BRIO®-train, held together by little magnets, illustrate the autobiographical memory. The traumatic memories are wagons that have not found their place in the BRIO®-train yet. When the trauma wagons come too close to other wagons, they crash into the train and make chaos. This is a parallel to having a flashback or an emotional reaction to a trigger, and so on. The goal of the trauma treatment then, is to help the little trauma wagons find their places in the train so they can settle and be integrated in the autobiographical memory. Stress the importance of helping the body and mind to orient to the present moment, the here and now. Work on how to separate the here and now from past experiences, “back-then.” Introduce and practice grounding exercises (Najavits, 2002; Ogden et al., 2006), and show how they are resources to stay in the here and now. Homework: Continue developing the safe place and practice using it every day.

Session 3—Triggers and Reactions to Danger

Complete the guidelines for interaction. Give more in-depth psychoeducation on the body’s reaction to danger, automatic responses to danger that

have not adapted to the current context (van der Hart et al., 2006), and the importance of safety. Introduce the metaphor of the “inner wall” (van der Weele, 2006; van der Weele & With, 2008), which illustrates the separation of the here and now from the past. When the wall is very thin or absent, one is either easily flooded by intrusive memories, or one doesn’t relate to events that have occurred, one dissociates. The goal is to get a thick, solid wall with a door—to be present in the here and now while acknowledging that there have been horrible things in the past, without being overwhelmed or dissociated. Link the metaphor to information on triggers and how struggling with trauma-related problems can make the body “confused in time,” where the body reacts to intrusions as if it happens now. Homework: Continue to use safe place and start the work of mapping triggers.

Session 4—Regulation of Arousal

Present psychoeducation on hypo- and hyperarousal and their function, the “window of tolerance” (Ogden et al., 2006)—the variance in arousal that one can tolerate while still functioning well—and efficient regulation of arousal. Link psychoeducation back to the topic of bodily reactions to danger and automatic responses to danger. Go through how one can help the body regulate arousal, by the use of grounding exercises. Homework: Continue to use safe place, and practice using grounding exercises at least once a day.

Session 5—Intrusions and Dissociation

Present psychoeducation on traumatic intrusions (Ogden et al., 2006; van der Hart et al., 2006). Clarify that the goal is to accept the intrusions as expressions for something that has happened earlier, at the same time helping oneself stay oriented in the here and now without getting overwhelmed. Repeat strategies for separating the here and now and back then. Repeat information about grounding exercises. Homework: Continue to practice the use of grounding exercises, if possible, in situations where one is outside the window of tolerance.

Session 6—Intrusion and Avoidance

Continue psychoeducation on traumatic intrusions. Introduce the metaphor of the “tired 3-year-old,” where avoidance of one’s own past and symptoms is compared to the effect of not responding to the needs of a tired 3-year old. The metaphor illustrates the importance of both acknowledging what has happened in the past, and calming oneself and orienting oneself to the present. Encourage clients to reflect on the effect of avoidance (van der Hart et al., 2006). Elaborate on grounding exercises and link back to the metaphor

of the inner wall. Homework: Use grounding exercises when being hyper- or hypoaroused, or when experiencing mild traumatic intrusions.

Session 7—Sleeping Problems

Present psychoeducation on sleep, sleeping problems, and sleep hygiene (Stepanski & Wyatt, 2003). Focus on how to increase the probability of getting a good night's sleep. All participants make their own evening routine. Homework: Continue to work on grounding exercises and use the evening routine every evening.

Session 8—Nightmares

Continue to work on sleep hygiene, and expand on the topic by focusing on nightmares, and the handling and prevention of recurring nightmares (Kellner, Neidhardt, Krakow, & Pathak, 1992; Krakow et al., 2001). Link back to the psychoeducation on traumatic intrusions and the metaphor of the inner wall. Homework: Make a new ending to a recurring nightmare and write it down. Think about the new ending once or twice a day. Continue to use the evening routine and use grounding exercises when waking from nightmares.

Session 9—Expansion of “Life Space”

Introduce the metaphor of the “butterfly woman” (van der Weele, 2006; van der Weele & With, 2008), illustrated in Figure 1. The dark clouds (which make up the wings of the butterfly) press on from the past and the future, representing the traumatic memories and the worries for the future. The life-space in the here and now thus gets very small. By using the feelers, one can stretch out for good memories and hopes for the future, thus expanding the life-space. Focus on the potential resource represented by wilfully steering the focus toward good memories and hopes for the future as a counterweight to the intrusive memories and worries about the future. Have clients focus on one good memory, write it down, and share it in the group. Explore what happens in the clients' bodies as they focus on and share their good memories. Homework: Work on focusing on good memories and hopes for the future. Write them down while focusing on sensations—the smells, the temperature, the sounds, and tactile feelings.

Session 10—Self-Care and Resource Building

Lead brainstorming and reflections on examples of self-care and why self-care is important. Homework: Do one good thing for yourself every day and

FIGURE 1 An illustration of how the butterfly metaphor can be visualized.

write it down in a calendar. Spend a minimum of 30 min on physical activity a day.

Session 11—Self-Care

Continue the work on self-care and why it can be difficult to prioritize own needs and wishes when struggling with trauma-related problems. Homework: Continue to focus on self-care every day.

Session 12—Cognitive Implications of Trauma

Explore how the clients relate to future events and their expectations when preparing for something new, such as joining the group. Encourage the clients to reflect on how our expectations, assumptions, and attribution influence how we meet and perceive new situations and people. Link these experiences to the “theory of shattered assumptions” (Janoff-Bulman, 1989, 1992), and how basic assumptions regarding ourselves, other people, and the world are affected by trauma. Homework: Continue to focus on self-care, and write down thoughts or questions activated by today’s topic.

Session 13—Cognitive Implications of Trauma

Continue with the topic of cognitive implications of trauma. Address questions and thoughts from the clients. Repeat the theory of shattered assumptions. Homework: Continue to focus on self-care and write down thoughts or questions activated by the day’s topic.

Session 14—Cognitive Restructuring

Present information on how one can handle intrusive, negative thoughts and incorrect trauma-related notions of oneself and others that feel true today, even if they are not. Link today's topic to the previous two sessions and the session on traumatic intrusions. Work on pinpointing negative, intrusive thoughts that clients struggle with, such as "I am helpless." Find "counter sentences" that *feel* true to the clients today. Teach the clients the "butterfly hug," an adaptation of Dworkin's (2005) resource development and installation. Arms crossed with hands resting on the upper arms, the counter sentence is said out loud, followed by a deep breath. While exhaling, one taps lightly on one's arms. Briefly address that treatment is coming to an end and mention ways of relating and reacting to termination. Map what the clients feel they need to take away from the last three sessions. Homework: Use the butterfly hug to counteract intrusive, negative thoughts.

Session 15—Pausing and Orienting

Attend to group processes related to termination of the treatment (Yalom & Leszcz, 2005). Help the clients pause to see what their situation is like today, how this is different from six months ago, and where they picture themselves in a year from now. Use the metaphor of the inner wall actively. Focus on what they need the last two sessions. Homework: Continue to focus on self-care and the butterfly hug.

Session 16—Noticing and Understanding Variation

Explore variations in symptoms and levels of function. Have clients reflect on what they are already doing that helps them, and have clients explore what makes their symptoms worse. Link the clients' experiences to the metaphor of the inner wall and the topic of self-care. Explore what the clients will need in the future. Repeat psychoeducation based on the clients' wishes. Homework: Explore what makes it possible and what makes it challenging to create the room one needs for future self-care.

Session 17—Connecting the Dots

Repeat psychoeducation based on the clients' wishes. Sum up the work of the group, share changes noticed by the therapists, and have the clients express their experiences with the group. Focus on what the clients take with them from the treatment, as well as what they need in the future to continue their process.

TRANSFORMING THEORY INTO THERAPY

A brief description of the approach has been given. For replication and empirical testing to be possible, more details are needed (Fritch & Lynch, 2008). A brief presentation of how core concepts in stabilization theory are incorporated into the approach follows. The elements addressed are establishment of safety, social engagement and exchange of experiences between clients, efficient regulation of arousal, increasing sense of agency, expanding action repertoires, and enhancing body awareness (Fisher & Ogden, 2009; Herman, 1992a; Ogden et al., 2006; Steele & van der Hart, 2009; van der Hart et al., 2006).

Safety is considered a key concept in stabilization work (Herman, 1992b; Steele & van der Hart, 2009). Both human-inflicted trauma and trauma-related problems are dominated by the feelings of fear, insecurity, and unpredictability. The trauma survivor has experienced the world as unsafe, knows that other people might inflict hurt, and often trusts no one, including himself or herself. To (re)establish the feelings of safety, agency and control are some of the main goals in the stabilization phase (Herman, 1992b). Even though they are all closely related, the feeling of safety is at the very core of stabilization work.

The group therapists have a continuous focus on how the assessment process, structure of the sessions, and their interventions can enhance the clients' feelings of safety. During sessions, the therapists focus on group processes and the development of group cohesion (Yalom & Leszcz, 2005), while probing for clients' own experiences. The clients' experiences are then linked together and related to the psychoeducation to avoid group segregation. The therapists consequently work hard to facilitate the establishment of the group as a safe place where the clients can be part of the group while still opening up at their own pace. The securing of minimal participation by all clients in all group meetings contributes to this, and also prevents insecurity from developing as a result of some group members not actively taking part in the group. It also helps the most apprehensive participants to take part, thus avoiding the feeling of isolation and failure. The focus on client interaction and securing of minimal participation also ensures the presence of social engagement (Herman, 1992b), another key feature of stabilization work. Whereas the psychoeducation provides the necessary structure to ensure the group is doing stabilization work, the social interaction between clients provides opportunities for having restorative social experiences in the group.

The therapists work very hard to ensure the clients feel that they can share everything in the group, and that no experience, feeling, or reaction is too much for the therapists to handle. The therapists also monitor the clients' arousal levels and body language closely during group sessions, which will help the clients stay with their feelings and experiences, while helping them

regulate arousal. This, along with the use of grounding exercises (Najavits, 2002; Ogden et al., 2006), is used to work on establishing the feeling of safety. The grounding exercises also serve the purpose of increasing efficient regulation of arousal (Ogden et al., 2006; van der Hart et al., 2006). Concrete techniques for regulating arousal, such as grounding exercises practiced in a safe group setting, could facilitate the experience that efficient regulation of arousal is possible and that one can achieve this by oneself, possibly even at home. This strengthens the clients' sense of agency, another key element in the stabilization phase (Herman, 1992b), as well as expanding their action repertoires.

The concept of expanding action repertoires is important in stabilization work as trauma-related symptoms can be seen as repeated attempts at coping that fail to adjust to the current situation. The symptoms are fixed ideas, as elaborated on in the theory of structural dissociation (van der Hart et al., 2006). The clients therefore need to get experience with both engaging and shifting between different action systems (Ogden et al., 2006; van der Hart et al., 2006) in addition to acquiring new skills. This might be facilitated by the structure of the group sessions, with alternation between different forms of learning.

The focus on enhancing the action repertoire is also closely linked to enhanced body awareness (Fisher & Ogden, 2009; Ogden et al., 2006), another important concept in stabilization work. Being in touch with bodily sensations can feel threatening to survivors of trauma, as their overwhelming feelings are linked to painful bodily memories and experiences (Ogden et al., 2006). Many clients with trauma-related problems therefore avoid being fully in touch with their bodily experiences (Steele & van der Hart, 2009). It is therefore important to facilitate a gradual increase in body awareness, where one steps carefully to avoid the clients being overwhelmed by bodily experiences. This represents a challenge in a group setting and especially when the group consists of participants with a range of trauma-related problems and experiences.

Both the seating arrangement, which is mildly uncomfortable, and the music-listening exercise facilitate an increase in body awareness. Having clients sit on mattresses encourages them to feel their own bodies, notice when it gets uncomfortable, and then express their need for a shift in activity. The music-listening exercise is, in many ways, closely linked to mindfulness (Segal, Williams, & Teasdale, 2002), but serves additional purposes. Many survivors of trauma find it extremely difficult to express differences of opinion or to clearly express their experiences, thereby becoming visible yet vulnerable. Originally, in the trauma situation, this strategy might have been crucial to immediate coping, but it is counteractive in the group setting. It is relatively accepted to have different tastes in music and there are no right or wrong answers to how a piece of music should affect you (Ruud, 1998). Music thus forms a perfect training ground for starting to explore and

express how one experiences something and how this differs from others' experiences.

The given examples are not exhaustive of how core concepts in stabilization are incorporated into this approach. They do, however, illustrate how theory has been transformed to therapy in the presented approach, and give additional information on how the heterogeneous stabilization groups are run. Together, the information provided in this article can provide a rather clear picture of this approach, and represents a response to some of the existing critique of group-based trauma treatments (Fritch & Lynch, 2008).

CONCLUSION

The approach presented here represents an option for stabilization work when working with clients with a wide range of trauma-related symptoms and trauma histories. The approach might be especially useful in settings with low population size and density, and as a way of providing first-phase trauma treatment quickly after referral when working in urban areas. The approach emphasizes the adjustment of the content and form of the psychoeducation, as well as having an alternation between psychoeducation, skill building, and sharing of experiences when working with heterogeneous stabilization groups. The approach has so far been applied in six treatment groups for women and one group for men exposed to human-inflicted traumas. Even though the description of this approach illustrates one attempt to help survivors of trauma, further development of treatment approaches that can reach more heterogeneous groups of clients when it comes to trauma-related symptoms and trauma history is needed. There is also a need for future research and empirical testing of stabilization group approaches before one can reach informed choices on trauma treatment in complex, clinical populations.

REFERENCES

- 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.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory–II*. San Antonio, TX: Psychological Corporation.
- Bernstein, E., & Putnam, F. W. (1987). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, 174(12), 727–735.
- 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.

- 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.
- Courtois, C. A., & Ford, J. D. (Eds.). (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. London: Guilford.
- Dorrepaal, E., Thomaes, K., Smit, J. H., van Balkom, A. J. L. M., van Dyck, R., Veltman, D. J., et al. (2010). Stabilizing group treatment for Complex Posttraumatic Stress Disorder related to childhood abuse based on psychoeducation and cognitive behavioral therapy: A pilot study. *Child Abuse and Neglect*, 34(4), 284–288.
- Dworkin, M. (2005). *EMDR and the relational imperative: The therapeutic relationship in EMDR treatment*. New York: Routledge.
- Finkelhor, D., Ormrod, R., & Turner, H. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse and Neglect*, 31(1), 7–26.
- Fisher, J., & Ogden, P. (2009). Sensorimotor psychotherapy. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 312–328). London: Guilford.
- Foote, B., Smolin, Y., Kaplan, M., Legatt, M. E., & Lipschitz, D. (2006). Prevalence of dissociative disorders in psychiatric outpatients. *American Journal of Psychiatry*, 163(4), 623–629.
- Ford, J. D. (2009). Group therapy. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 415–440). London: Guilford.
- Fritch, A. M., & Lynch, S. M. (2008). Group treatment for adult survivors of interpersonal trauma. *Journal of Psychological Trauma*, 7(3), 145–169.
- Giaconia, R. M., Reinherz, H. Z., Silverman, A. B., Pakiz, B., Frost, A. K., & Cohen, E. (1995). Traumas and posttraumatic stress disorder in a community population of older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(10), 1369–1380.
- 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: Basic Books.
- Horowitz, M. J., Wilner, N. R., & Alvarez, M. W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine*, 41(3), 209–218.
- Jacobson, A., & Herald, C. (1990). The relevance of childhood sexual abuse to adult psychiatric inpatient care. *Hospital & Community Psychiatry*, 41(2), 154–158.
- Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. *Social Cognition*, 7(2), 113–136.
- Janoff-Bulman, R. (1992). *Shattered assumptions*. New York: The Free Press.
- Kellner, R., Neidhardt, J., Krakow, B., & Pathak, D. (1992). Changes in chronic nightmares after one session of desensitization or rehearsal instructions. *The American Journal of Psychiatry*, 149(5), 659–663.
- Kessler, R. C., Chiu, W., Demier, O., Merikangas, K., & Walters, 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.

- Krakow, B., Hollifield, M., Johnston, L., Koss, M., Schrader, R., Warner, T. D., et al. (2001). Imagery rehearsal therapy for chronic nightmares in sexual assault survivors with posttraumatic stress disorder: A randomized controlled trial. *Journal of American Medical Association*, 286(5), 537–545.
- 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.
- Mollica, R. F., Caspi Yavin, Y., Bollini, P., & Truong, T. (1992). The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *Journal of Nervous and Mental Disease*, 180(2), 111–116.
- Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: Guilford.
- Nijenhuis, E. R. S., Spinhoven, P., van Dyck, R., van der Hart, O., & Vanderlinden, J. (1997). The development of the Somatoform Dissociation Questionnaire (SDQ-5) as a screening instrument for dissociative disorders. *Acta Psychiatrica Scandinavica*, 96(5), 311–318.
- Nijenhuis, E. R. S., van der Hart, O., & Kruger, K. (2002). The psychometric characteristics of the Traumatic Experiences Questionnaire (TEC): First findings among psychiatric outpatients. *Clinical Psychology and Psychotherapy*, 9(3), 200–210.
- Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body. A sensorimotor approach to psychotherapy*. New York: Norton.
- Parnell, L. (2008). *Tapping in: A step-by-step guide to activating your healing resources through bilateral stimulation*. Boulder, CO: Sounds True.
- Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(3), 269–278.
- Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology*, 60(5), 748–756.
- Ruud, E. (1998). *Music therapy: Improvisation, communication, and culture*. Gilsum, NH: Barcelona.
- Schnurr, P. P., Friedman, M. J., Foy, D. W., Shea, M. T., Hsieh, F. Y., Lavori, P. W., et al. (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.
- Segal, Z. V., Williams, M., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford.
- Shapiro, R. (Ed.). (2005). *EMDR solutions: Pathways to healing*. New York: Norton.
- Steele, K., & van der Hart, O. (2009). Treating dissociation. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 145–165). London: Guilford.
- Stepanski, E. J., & Wyatt, J. K. (2003). Use of sleep hygiene in the treatment of insomnia. *Sleep Medicine Reviews*, 7(3), 215–225.
- 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.

- van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. London: Norton.
- van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry*, 1(5), 253–265.
- van der Kolk, B. A. (1996). Trauma and memory. In B. A. van der Kolk, A. C. McFarlane, & L. Weisæth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 279–302). New York: Guilford.
- van der Weele, J. (2006). Styrk den indre veggen: Arbeid med stabilisering og kontroll av gjenopplevelser [Strengthen the inner wall: Work with stabilization and controlling intrusions]. In T. Anstorp, K. Benum, & M. Jakobsen (Eds.), *Dissosiasjon og relasjonstraumer: Integrering av det splittede jeg* [Dissociation and relational trauma: Integration of the fragmented self] (pp. 138–154). Oslo, Norway: Universitetsforlaget.
- van der Weele, J., & With, A. (2008). *Sommerfuglkvinnen: Kurshefte for kvinner som lever vanskelige liv* [The butterfly woman: Booklet for women who live difficult lives]. Oslo, Norway: Alternativ til vold.
- 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.
- World Health Organization. (Ed.). (1993). *The ICD–10 classification of mental and behavioural disorders*. Geneva, Switzerland: Author.
- Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.