Trauma clients' continuing work on relationships with their self and others after trauma-specific group therapy

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Abstract

In this article we explored how female trauma clients continued to work on their relationship with their self and others after finishing a course of trauma-specific group therapy. We carried out semi-structured qualitative interviews with 13 clients who had completed stabilization group therapy one year previously. A hermeneutic phenomenological approach was used to analyse interview transcripts. The participants' descriptions of important experiential dimensions of their continuing work towards recovery clustered around two main themes and eight sub-themes. The main themes were 1) *Strengthening Constructive Relationship to Self*, encompassing the subthemes *Presence and contact with inner reality, Construction of meaning and understanding, Self-compassion and Self-care*, and 2) *Strengthening Constructive Relationship to Others*, encompassing the subthemes *Breaking old patterns, Assertiveness, Seeking social contact* and *Resilience when therapy is not constructive*. Trauma survivors' continued work on their relationship with themselves and others is clearly an important part of the recovery process. The findings point to the importance of expanding the focus from the individual to the individual in relation to him or herself and others when working with trauma survivors.

Keywords: trauma; post-therapy processes; qualitative interview; recovery; relationship to self; relationship to others

It is well established that the exposure to potentially traumatic experiences, particularly in childhood, is associated with an elevated risk for a range of health problems, including post-traumatic stress disorder (PTSD; see e.g. Darves-Bornoz et al., 2008; Edwards, Holden, Anda, & Felitti, 2003). In the aftermath of trauma often both the survivor's relationships with his or her self and with others are damaged and in need of healing and repair. The diagnostic criteria for PTSD, for example, point to how the disorder can cause significant distress or damage the sufferer's social interactions. A central problem for survivors of trauma is negative alterations in cognition and mood, including a persistent blaming of oneself or others, shame and estrangement from others (American Psychiatric Association, APA, 2013, pp. 271-272). Many trauma survivors have problems with self-care and satisfaction of their basic needs, such as sleep, nutrition and the balance between rest and activity, where self-blame and shame can make trauma survivors feel that they do not deserve to be taken care of. Moreover, the intrusive and intense nature of trauma-specific symptoms compels individuals to focus on handling their often intense and overwhelming emotional reactions in the here-and-now, rather than considering strategies which might be beneficial in the long term. Finally, many trauma survivors have difficulty knowing what they want and need because they are often detached from their inner world, avoiding thoughts, feelings and bodily sensations which might remind them of the trauma (APA, 2013; van der Hart, Nijenhuis, & Steele, 2006). The result is that after exposure to trauma both one's relationship with one's self and relationships with others suffer.

There is, however, little understanding of how survivors reclaim and rebuild relationships with their self and important others. This despite such processes perhaps being fundamental to recovery. Traditional models of recovery and psychotherapy have tended to emphasize the role of the survivor's personal efforts to combat the effects of the trauma as well as the role of psychotherapy and other mental health interventions (Topor et al., 2006; Wampold & Imel, 2015). In doing so they run the risk of overlooking important contextual factors. This includes the role of others and how relationships with others may contribute to healing and growth following formal treatment. When we focus too narrowly on the survivor and neglect the potential contribution of the people with whom he or she has important relationships, we may also be neglecting important dialectics between self and others. This is in line with Benjamin (2004) and Aron's (2006) concept of thirdness as well as Stern's (2004) idea on intersubjectivity in which complex interpersonal situations can only be understood in the context of the relationships involved. What we experience as our 'self' is always articulated, defined and experienced as 'me' in relation to others ('you' or 'them': Buber, 2003; Heard, 1995).

An individual who experiences early, relational trauma learns that other people, often significant others, can intentionally cause him or her harm. In such cases the child is often dependent on the person who causes harm, which is very confusing for the child. Situations in which a single person activates both defensive and attachment systems are difficult for a child to resolve (van der Hart et al., 2006). Moreover, it is consistently reported that women are exposed to relational trauma more often than men (Briere & Elliott, 2003; Tolin & Foa, 2006). Many trauma survivors respond to their ongoing interpersonal problems by relying excessively on self-management, developing innovative ways to handle their symptoms and distress which enable them to function in spite of their difficulties (Sayer et al., 2009; Stige, Træen & Rosenvinge, 2013). While many trauma survivors struggle with interpersonal relationships several studies have suggested that post-trauma social support and social networks play a significant role in recovery processes (Charuvastra & Cloitre, 2008; Ozer, Best, Lipsey & Weiss, 2003). Research on the experiences of trauma survivors suggests that a supportive social context seems to be vital to recovery (Banyard & Williams, 2007; Hobfoll, Jackson, Hobfoll, Pierce & Young, 2002).

The field of trauma treatment is complex, encompassing a wide variety of approaches that partly differ in what they understand and emphasize

as important aspects of treatment (see e.g. Shannon, 2011). Emphasizing the significance of post-trauma difficulties with inter- and intra-personal relationships, phase-oriented trauma treatment focuses on restoration of more constructive relationships with others and a stronger, more secure relationship with one's self (Herman, 1992; van der Hart et al., 2006; Stige, 2011). In the first phase in particular, treatment focuses on helping clients to develop strategies for keeping safe and taking better care of themselves; these may include setting of appropriate boundaries and increasing contact with inner feelings and thoughts (Herman, 1992; Stige, 2011). Our research on female trauma clients' perceptions of post-stabilization group (phase one trauma treatment) recovery processes indicated that they regarded better relationships with others and a better self-relationship as central to the recovery process (Stige, Binder, Rosenvinge & Træen, 2013).

Given that inter- and intra-personal problems are common sequelae to trauma and that interpersonal relationships are an important factor in mental health and in recovery processes in general, we wanted to explore how such relationships develop after phase-oriented trauma treatment. As women are overrepresented in the population of those exposed to relational trauma it is particularly interesting to explore how women work on their relationships with others and with their self during the recovery process. In this study we asked how female trauma clients continued to work on relationships with their self and others after completing a trauma-specific group treatment.

Methods

Study Setting

The study took place in a remote area of Northern Norway and was based around an outpatient clinic at a Community Mental Health Centre. All participants had attended a stabilization group (phase one trauma treatment) at the outpatient clinic one year earlier. Stabilization group therapy consists of a series of 17 weekly meetings, focusing on increasing patients' understanding and ability to manage trauma-related symptoms and problems. All group meetings involve a mixture of psycho-education, arousal regulation training and exchanges of experiences between clients. Informed by humanistic and person-centered psychology, and building on Herman's (1992) work on trauma treatment, the approach emphasizes safety, restoration of control, empowerment, skill building and the establishment of new relationships (Stige, 2011). This therapy is currently offered in single-gender groups.

Design and Methodological Approach

In order to obtain rich narrative data from our participants we chose to use semi-structured, in-depth interviews. Participants were interviewed twice: upon completion of stabilization group therapy (T1) and one year later (T2). Here we report on the interviews from T2.

We wanted to explore the participants' lived experiences (phenomenology) while at the same time acknowledging the inevitable influence of our own experiences and perspectives on the way we understand and interpret research data (hermeneutics; Finlay, 2005). A hermeneutic phenomenological approach was therefore chosen to integrate these perspectives (Alvesson & Sköldberg, 2000; Angen, 2000; Laverty, 2003). The meanings derived from hermeneutic phenomenological analyses are considered to represent a fusion of the analysts' and participants' experiential horizons. A dialogical view of reflexivity was, therefore, central to the research process (Alvesson & Sköldberg, 2000).

Recruitment and Participants

At the end of the group treatment all 31 clients from the six women's treatment groups received a written invitation to participate in the research project. Thirteen women volunteered to participate in the project and all completed both interviews. This enabled us to compare the two interviews and track changes occurring in the year after the women had completed stabilization group therapy.

The thirteen participants were aged between 19 and 61 years old at T2. Ten participants reported that they had children, and eight participants reported that they were working or studying at T2. All

participants reported that they had been less 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.

Data Collection Procedures

The study received ethical approval from the Regional Committee for Medical and Health Research Ethics, North Region (REK North) and from the Norwegian Social Sciences Agency. The first author was one of two group therapists in five of the six stabilization groups. A team of three interviewers conducted the interviews so that none of the participants was interviewed by her former therapist. This was important to ensure free consent and to avoid the possibility that the power relationship between therapist and client would influence the dynamics of the interviews and the data emerging from them. Interviews at T2 were conducted 12–15 months after the last meeting of the stabilization group. The interviews lasted between 70 and 140 minutes (mean = 95 minutes). Interviews were audio-recorded and transcribed verbatim.

Data Management and Analysis

NVivo 9 software (QSR International, 2010) was used as technical support for the analysis. Analysis began with all three authors reading and analysing the data separately, guided by the analytical question 'How do clients consolidate and continue to use the helpful processes initiated in therapy?'. During this preliminary analysis it became clear that experiences related to participants' relationships with their self and others were central to the accounts of continuing recovery which were given in the second interviews. As these factors had also played an important role in participants' perceptions of their recovery process one year previously (Stige, Binder, Rosenvinge & Træen, 2013) further analysis focused on how participants had continued to work on their relationships with their self and others in the year following completion of stabilization group therapy.

Over the course of a series of meetings the authors deepened the analysis, and reached consensus on the thematic structure. The first author transferred the initial analysis into NVivo, which was then used as a support in the process of seeking consensus on the thematic structure.

Findings

Our analysis of the participants' reported experiences clustered around two main themes and eight sub-themes. All participants reported experiences relating to both main themes. The main themes were 1) *Strengthening Constructive Relationship to Self*, encompassing the subthemes *Presence and contact with inner reality, Construction of meaning and understanding, Self-compassion* and *Self-care*, and 2) *Strengthening Constructive Relationship to Others*, encompassing the subthemes *Breaking old patterns, Assertiveness, Seeking social contact* and *Resilience when therapy is not constructive*. These will be presented in more detail below.

Strengthening Constructive Relationship with Self

The first main theme identified through our analysis focused on how participants had continued to strengthen and develop a healthy relationship with themselves following the group therapy. When interviewed at T1 participants stated that the process of recovery had brought with it new understanding, increased contact with their bodies, and increased sense of agency (Stige, Binder, Rosenvinge & Træen, 2013). In the interviews at T2 most participants emphasized that one of the important benefits of the group therapy was the way in which it had helped them change the way they looked at themselves and also the way they treated themselves, especially in painful and difficult situations. This main theme had four sub themes: *Presence and contact with inner reality, Construction of meaning and understanding, Self-compassion* and *Self-care*.

Presence and contact with inner reality. Many participants described feeling more present after participating in the stabilization group. This was both experienced as an increased bodily and relational

presence. For some participants this meant that they were able to let go of ruminations about the past, as they were more able to take in what was happening in the present:

> I start to, instead of relating to everything that has been, I relate to the way it is now. To do those things that are important – to take care of myself, and maybe also being more present. And thus, magically, my problems dissolve. They just turn, and become... So I feel that absolutely everything has improved.

This sense of being more present was also described in emotional terms, as the ability to stay in contact with inner reality, even when feelings were strong and painful:

> Fear, well earlier I haven't felt it. And in the beginning, when I started talking about fear I was like: 'Ha! Fear is shit!' Fear, just the word fear made me want to get it out and jump on it. Because it annoyed me. Fear is something we kick in the trash. Because I have met it throughout... It has been a tragedy all those times fear has been there. To start to accept that feeling has been a tough process for me. To start to put words to my feelings and learn to feel them in my body. I'm still working on it.

For some participants this also meant that they were able to accept a broader range of emotional states, and 'listen' to feelings in productive ways:

> I have to feel what it evokes in me, of sorrow or sadness, of disappointment that I maybe haven't been able to stand to feel earlier. The feelings are there now. I manage to be more present in my feelings. I think something has happened there – I have come down from my head into...[my body].

This emotional and bodily presence also paved the way for a sense of increased vitality, and for sometimes also feelings of joy:

> After that [the group therapy] I started to feel that sometimes I am laughing from the heart. It is not just anxiety-laughter, like it has often been before – laughing just to reduce tension. I don't do that anymore. I laugh when I feel like it. [...] So I cry when I am touched, those feelings also are coming. It just feels wonderful to feel in that way.

Construction of meaning and understanding. At T1 the participants had emphasized the significance of receiving psycho-education and finding new ways of understanding their emotions and actions (Stige, Binder, Rosenvinge & Træen, 2013; Stige, Rosenvinge & Træen, 2013). In the second interview many participants said that they now felt they could understand their own reactions. They felt they could relate their feelings and reactions to their history of trauma or to their current situation. After therapy ended they continued to try to make sense of their own experiences in this way and thus their reactions became more manageable. A year later they reported that they now found it easier to take constructive action:

> I open up to my feelings, but it's also that I manage to make a clearer division between what are feelings and what are facts: 'Ok, this feels like it is the end of the world, but the fact is that it isn't. Ok, I just have to live with this feeling.' That also makes it easier to see if my feeling is exaggerated, if it is really related to what happened back then, or if it is just because I have been feeling down, or things like that.

Some of the participants had also been involved in a larger search for meaning after therapy ended and explored their own history to strengthen their sense of identity:

> I see myself better [now]. In a way I know myself better, that is, who I am. Before I was so mixed up with my childhood and all that chaos and what I had inside me. And I can see better how tough things have been for me.

Some participants took a very active role in seeking input that would help them understand more of themselves, their own histories, and their reactions. They sought information from others, such as family members, to get a better grasp of their life history:

> I have tried to do research on my own history when I have been at home and met my family. I try to understand what has happened, how things were, based on what I see today. Things fall into place more. I feel that, somehow.

Self-compassion. Several participants told how they had originally blamed themselves heavily for their reactions to the trauma they had experienced, but that they were now able to support themselves emotionally and to recognize their reactions as normal:

> I was very ashamed and embarrassed for finding myself in such a situation. But I learnt from it too. I can see that, ok, what I have experienced makes me vulnerable to ending up

in such situations.

Part of being able to take a compassionate approach to oneself when it comes to painful trauma reactions was being able to see the universal aspects of one's situation. Experiences in group therapy had helped participants to understand that their own reactions were normal; they had learned that other people in similar situations suffered in the same way. This also helped them to stop blaming themselves for their pain:

> And I thought, 'My God! It is not only me! She also feels that way, so maybe it has to do with things you carry with you.' And you become a bit kinder to yourself, because you get to the point where you can say 'In fact it's ok, because this is not only about me being like this as a person, it has to do with my life situation and what has happened to me in my life.' So, you get a better understanding of yourself and others.

Self-care. To look after yourself, to care for yourself only becomes possible when one is able to see oneself as a person with value, someone worth caring for. Participants described how the work they had done in the group on developing a new view of themselves had helped them take care of themselves. The quote below illustrates what it can mean to look at oneself in a new way, and how this can facilitate quite specific behavioral changes:

> It is not only that I feel I manage things better. It is also, like, when I stand in front of the mirror, it doesn't become like (gasps). I don't puke anymore, put it like that. I don't just hurry away from the mirror. It has been five years I haven't bothered to put on make-up. All those things are a bit easier, ordinary things.

The improvements in self-care were manifest first and foremost in the details of daily life, in good routines which would ensure a healthy physiological balance. Participants used their awareness of the potential domino effect of stress and physiological imbalance to make sure they got sufficient sleep and rest:

> I am very conscious that I mustn't take on too much, that I need to set boundaries before I get too stressed. Because if not, that influences everything. Then I start to sleep poorly, and I don't manage to eat properly, and everything escalates.

Another important part of self-care is recognizing that an activity that is generally beneficial can, sometimes, be too much, and taking action accordingly: *[You have] to remind yourself all the time that you shouldn't train too much or too hard,* as one of the participants said. Another aspect of self-care is ensuring that one maintains an emotional balance through one's choice of activities. The participants described being aware that certain activities might have a positive impact on their emotional well-being, and caring for themselves in choosing to do them:

> Self-care is, above all, taking care of myself, doing things that do me good. Or that I feel are good. It can be as simple as to clean, because if it is dirty around me I don't thrive. Things like going to the movies, reading a good book. The things that give me positive experiences.

One of the challenging aspects of self-care is that one sometimes has to prioritize one's own needs above those of others. This was a theme in the stabilization groups, as many participants had a habit of subordinating themselves to other people's needs. Participants described making structures and routines in daily life that allowed them sometimes to prioritize their own need for rest and recuperation:

> To be a bit selfish at times, to only think about yourself sometimes. Going to a cafe, or having a long bath, watching a good movie, and not just focusing on everybody else. Because we focused on that in the stabilization group. That everyone needs to care for themselves at times.

Prioritizing one's own needs might quite simply mean ensuring that one's schedule allows time for one self, to do with as one wishes:

> I guess it is a bit like a *good girl syndrome*. I am not going to hurt anyone and I'll do as I am told. I tell myself 'Ok, but you cannot satisfy everybody. You have to take care of yourself as well.' So I have booked a set time, in the middle of the day, and I have told people 'I don't want visits in this time.' Because that is my time. How I spend it varies, I might sit and think or write, or sit at the computer, or knit, but it is my time. I can do whatever I want. And that has been wonderful!

Strengthening Constructive Relationships with Others

The second main theme identified through our analysis focused on how the participants continued to work on their relationships with others after

completing the stabilization group therapy. This main theme consisted of four sub themes: *Breaking old patterns, Assertiveness, Seeking social contact* and *Resilience when therapy is not constructive*.

Breaking old patterns. During therapy many participants had discovered that the way they interacted with other people was not constructive and subsequently they focused on breaking old interaction patterns. They reported that they had managed to stop themselves responding to triggers for old patterns and were choosing more constructive reactions instead. Said one of the participants: *Well, I try to, instead of saying 'Get the hell out of here, I cannot take anymore!' I sit down and I say 'Listen, we have to figure this out.'*

Another participant reported that she had started to notice how her short fuse and irritation influenced her son – that he had started to tip-toe around her. She managed to use her child's reaction as an opportunity to stop and reflect upon how her problems affected her son, and what she could do to turn this around:

> My boy didn't get a choice [about participating in a session with the individual therapist]. *Interviewer: Ok? So you just decided that he had to come along?* Yes. Because I had noticed that he was changing. I noticed that it felt like he was tip-toeing around me. Even if I tried to talk to him, I realized that he didn't understand. So I spoke to my therapist and arranged an appointment for him. After that things changed a bit. He dared to speak his mind. He understood that I don't get worse if he gets mad at me when I say something unreasonable.

Another participant shared her experience of learning to manage difficult social situations more constructively:

> I have started to learn to handle those situations. I have started to understand. For example, at work there is a person who has an aggressive style. Now I understand that there is no point fighting every battle. I wouldn't have understood that earlier, and probably would have been traumatized and sad. But I don't feel like that now.

Assertiveness. Many participants felt that the group therapy had strengthened their ability to say 'no' and to set healthy boundaries. A continued focus on assertiveness therefore proved important to many participants. They found that being assertive got easier over time, and that the guilt that used to haunt them when they said 'no' or put their own needs first, was no longer bothering them: *I used to be really afraid of hurting someone if I said 'no'. I have become better at saying no. Saying 'You know, I cannot do this'. And I don't feel as bad afterwards, I have noticed.*

Some participants noticed that their increased presence and contact with inner reality meant their own and others' pain and strong emotions took their toll on them and hence that they had to set boundaries. One of the participants had, for example, always been there for everyone around her, never sharing her difficulties with others. She had, however, also been completely detached from her own emotions. As she got more in touch with her inner reality, she realized both how pleased she was with her ability to help others, and the necessity of looking out for herself in order to help others:

> I have always been there for others. And now I have had to say 'no'. I have a friend. Her husband found someone else and left her. You know? I didn't think that would get to me like it did. Not what she went through, but I was dealing with her feelings. I was exhausted. My heart was racing, I couldn't breathe. I just had to say that 'I can't deal with this. I don't have room for that as well'. It was really difficult. I really wanted to support her. She had hit rock bottom. But then I thought 'I have to set limits!'

Seeking social contact. Many participants had previously been very rigidly self-reliant in coping with their difficulties (Stige, Træen & Rosenvinge, 2013). An important therapy-related change that participants experienced was that social contact now made them feel better, and with an improved ability to reach out and seek social contact, when they needed it:

> *Interviewer: What do you do now to handle your problems?* Participant: I use the people I have around me. [...] Being with others feels good. [...] It is maybe just little things I do. I spend time with people, talk to people about different things. People know how I am feeling.

Another participant realized that she needed feedback from a fellow human being in her search of

her own identity. After the group therapy she actively used her friends to get feedback on her history and herself as a person:

> Because this is what I have experienced and learnt: Neither of my parents have said anything to me, and showing care and empathy wasn't among their strengths. *Interviewer: And you didn't have anybody else either?* Participant: No, I didn't have anybody else. I had myself. And now I have started, in a way, to find myself. To strengthen myself and find myself. That has been a job for me. I read a poem that was really good. By Hans Børli. It is called 'Mirror'. It goes like this: 'He does not know what he looks like, the one who has not seen himself reflected in the clear, exploring gaze of a fellow human being.' That fits how I have felt. [...] I have written my trauma narrative. And I have a few friends that have read it, so they could give me feedback on myself. [This was important] because I haven't had anyone who has seen me [that way].

Resilience When Therapy is Not Constructive

A few participants reported that their experience of therapies following the stabilization group had not been constructive. Negative therapy experiences are a well-documented phenomenon that we have to take into account when talking to clients, and it has to be recognized that some therapists, intentionally or otherwise, harm their clients (see e.g. Linden, 2013). Clients exposed to relational trauma are considered a vulnerable group because of their experience of very negative, destructive relationships in which there is considerable power imbalance. The therapeutic relationship can be highly significant and can be a foundation for positive change; however, it is also a highly asymmetric relationship. The participants whose subsequent therapy had not been constructive had, nevertheless, managed to remain in a position of agency, staying true to what was important to them and expressing this in their meetings with the therapist.

One participant reported that she, for the first time in a very long time, had managed to stay in touch with her inner feelings, thoughts and needs. She was still struggling with strong anxiety but did not want to take medication on a daily basis, fearing to lose the fragile contact with herself that she had established:

> I have chosen to manage without antidepressants, and don't use medication. Now I have asked if I could have something I can use when the anxiety is... Just something to have in the cupboard, something prophylactic. I don't want to use something I have to use every day. I just want something, as a prevention. Maybe it helps just to have it in the cupboard? But that was not received positively [by the therapist], because they wanted to give me something I could take every day. And again I'm feeling, 'do I have to stand on the table screaming out what I want?' Because, I don't want to be swallowing medication every day, letting something else take control over my life again. Now I have managed to get in contact with myself, and I want to walk that road, make my own path. And I want to feel that I am in control of my life. Not the opposite.

Two participants also felt that their therapists wanted to end their therapy before they felt ready. In the interviews they described how they stood up for their ability to continue therapy, even when this was difficult:

> I have been in treatment for one and a half years now. And now we are supposed to end therapy. And that has influenced me. I am not at all ready for that! [...] We will have a meeting next week, and I am going to say it the way it is. I feel I don't have a choice. I have come so far. I am usually very agreeable, doing what people ask of me, for everybody else. But this I am doing for me. I have to continue therapy until I am through. If not it is a waste. So I am going to address it.

Overall Discussion

The processes of strengthening a constructive relationship with oneself and with others are closely related (Figure 1). A person's experiences of who he or she is take form and are fully articulated in his or her relationships to others. That which is most deeply personal is arrived at through interaction and dialogue, within the sphere of a person's intimate relational world (Wachtel, 2014). At the same time, the person's relationship with him or herself will also determine how he or she allows others into her life, and the ways in which he or she relates to others. Thus relationships with oneself and others are deeply and inevitably embedded in each other.
Detachment from inner reality is a life-restricting problem for trauma survivors (van der Hart et al., 2006). Participants' continued efforts to reinforce and utilize their new capacity for presence and contact with their inner world thus appear to be an

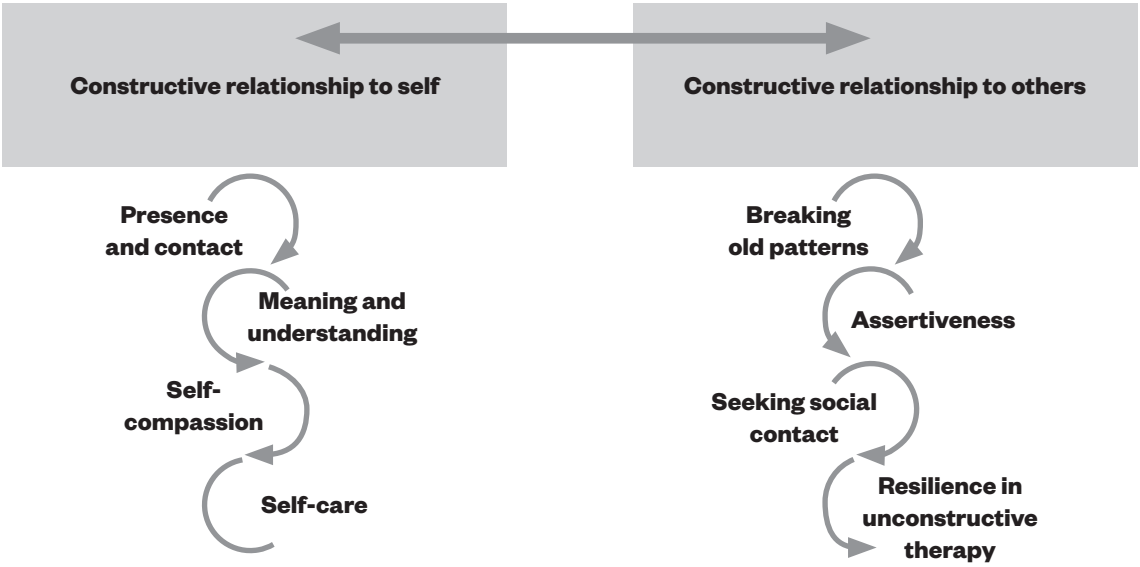
important part of the recovery process. Participants described how their greater contact with their inner world gave them more flexibility and emotional freedom and opened up new ways of understanding their histories and their emotional reactions. Their new ways of understanding themselves were much more friendly, attuned and accepting than previously. The inner harshness that dominated in the aftermath of trauma did not take up that much space any more; instead the participants had established a more caring and compassionate stance toward themselves.

This strengthened contact with emotional reality, as well as the new ways of understanding and caring for themselves, also showed itself in the way participants actively broke old maladaptive patterns in their relationships with others. They now had a better understanding of what they needed in their relationships and also demonstrated greater flexibility and willingness to experiment with new types of actions. This resulted in more assertive behavior, but also in more active seeking of necessary social contact and support. In line with previous research (Charuvastra et al., 2008; Ozer et al., 2003) we therefore concluded that relationships with others played a crucial role in the participants' recovery. Everyday life takes place in the context of relationships with family and friends (Topor et al., 2006), and it was in relation to their husbands and children, parents and siblings, neighbors and colleagues that participants were able to build new and meaningful lives.

For many participants, their work in the stabilization group was only one part of their journey towards recovery from trauma; however what they had learned in this group therapy often helped them in individual therapy, even when the therapy, or aspects of it, proved unconstructive. Participants' newly won ability to stand up for themselves was manifest in their ability to express their opinions and needs to their therapists under these challenging circumstances.

One way of interpreting our findings is to consider them from the perspective of the theory of cyclical psychodynamics (Wachtel, 2014); old vicious circles of self-defeating behavior are replaced with

Figure 1: The relationship between the two main themes and the eight subthemes resulting from our analysis of the data material.



constructive experimentation with new patterns. This, in turn, allows for new types of experiences with others, facilitating further recovery as the old dramas are replaced with new adventures. For our participants the breaking of old patterns was not restricted to relationship with others, it also extended to their beliefs about themselves. Their continued work on constructing meaning and understanding gave rise to new self-representations. The participants seemed to acquire enough sense of security to put their pathogenic beliefs about self and others to the test in their relationships (Silberschatz, 2012). This allowed them to let go of rigid and dysfunctional representations of self and opened up the possibility of finding healthier and more functional ways of relating to and interacting with others, which in turn pave way for more self-definition, more assertiveness and better satisfaction of attachment needs through contact with significant others. The most striking point is the extent to which the participants became active agents in their own lives during the period after group therapy; group therapy was certainly only the start of their personal journeys. An important implication of our findings is thus the importance of adopting a broad focus on relationships when working with trauma survivors, including a focus on how clients work on their relationships with themselves and with others, and the dialectics between these processes.

Scope and Limitations

In this study we explored how female trauma clients continued to work on their relationships with themselves and others after having attended a stabilization group. Interviewing the participants twice, on completion of stabilization group therapy and again one year later, enabled us to explore how clients continued to work on their relationships with themselves and others over time. This design allowed us to explore the first-person perspective on the phenomenon of interest, shedding light on how clients work with therapy-related processes after completion of therapy; however our qualitative approach means that our findings cannot be generalized to the wider population of trauma survivors. We do not know, for example, how the participants differed from non-participants who had attended the stabilization group. In addition, because many of the participants continued in individual therapy after completing stabilization group therapy it is difficult to differentiate the influence of the group therapy from that of continued individual therapy. Because all participants followed the same treatment program our findings do not shed light on whether the reported changes in relationships with self and others are specific to phase-oriented trauma treatment, or occur in response to other forms of trauma-specific treatment. Finally, the fact that all three authors are clinical psychologists with an interest in processes of psychotherapy may have made us vulnerable to overestimating the significance of therapy in facilitating the changes reported in this article. Future research should explore how different types of trauma-specific treatment influence trauma survivors' relationships with themselves and others and attempt to distinguish between the effects of individual and group therapy on these processes.

Conclusion

Trauma survivors continue to work on their relationship with themselves and their relationships with others after attending trauma-specific group treatment, and this continued work is clearly an important part of the recovery process. In this study we found that survivors' continued work on their relationship with themselves centered around increased presence, active ways of creating meaning and giving themselves compassion and care. Their continued work with others centered on breaking old relational patterns, being more assertive when necessary and actively seeking social contact. Trauma survivors are often in need of extended psychotherapy; our participants' resilience in the unfortunate cases where therapy did not prove constructive may represent an important outcome of continued work on relationships with other. The findings point to the importance of extending the focus beyond the therapist–client relationship when working with trauma survivors.

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