Research title: Understanding female survivors of interpersonal trauma experience of Survive & Thrive Course

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Background: Most research has concentrated on individual psychological interventions with a limited focus on the effectiveness of manualised group-based approaches for those presenting with mental health difficulties following trauma. Survive & Thrive is a 10-week psychoeducational course designed for survivors of interpersonal trauma which utilises cognitive behavioural skills training while delivering psychoeducation on how a history of victimisation can impact on the survivors' life. However, relatively little research has been published on the effectiveness of this course.

Aims: This study has been designed to gain an insight into female survivors of interpersonal trauma experiences of attending the Survive & Thrive course and to evaluate this form of psychological intervention.

Method: To gain an understanding of the female survivors of interpersonal trauma experience of the course a qualitative approach has been adopted. Following completion of the Survive & Thrive course patients were invited to take part in this study resulting in a total of 13 females participating in semi-structured interviews. Access to some demographic information of the participants was granted to further inform the qualitative findings regarding their experience. The data was analysed in accordance with the Interpretative Phenomenological Analysis.

Findings: Participants' perceptions about their experience of attending the Survive & Thrive course indicated five superordinate themes: 'sense of connectedness'; 'journey towards recovery'; 'facing the facts & the past'; 'initial apprehension'; and 'sense of being let down'.

Conclusion: The emerging themes indicate that female survivors of interpersonal trauma have benefited from attending the Survive & Thrive course. The participants described this as a journey towards recovery. The findings are further discussed in relation to the implications for patients and the importance of appropriate use of psychoeducational courses, such as Survive & Thrive.

Keywords: interpersonal trauma, psychoeducation, female survivors, group settings

There is an increasing number of individuals being exposed to traumatic life events who are seeking mental health support, which is linked to an increased number of patients being referred to Psychological Services (e.g. Alistic et al., 2014; Hopper et al., 2018). Hannah Gibbons (2016) reviewed referral rates to Tayside Adult Psychological Therapies Services between April and mid-July 2016. Her findings have shown that over half of the patients assessed during this time period had a high level of trauma symptoms that impacted on their psychological functioning. This means that over half of the patients referred to adult psychology in primary care present with some trauma history and would benefit from trauma-based treatment.

Effect of interpersonal trauma on mental health

This study concentrates specifically on interpersonal trauma, which is defined as having a traumatic experience in relation to emotional, physical, and/or sexual abuse in childhood and/or adulthood. Exposure to traumatic events during childhood can substantially influence the child's development which is strongly associated with experiencing mental health issues throughout their lifespan (Hetzel-Riggin & Roby, 2013). A recent meta-analysis by Alistic and colleagues (2014) showed on average 15.9% of posttraumatic stress disorder prevalence across trauma-exposed children and adolescents. Hence surviving interpersonal trauma can influence a number of individuals' functioning abilities, such as their emotional regulation, alterations in attention and consciousness (dissociative symptoms), self-perception (self-blame, guilt), in perception of the perpetrator (acceptance of the perpetrator's belief system), difficulties with both trust and intimacy, impact on their sense of safety (anxiety), and sense of hopelessness (depression) (Courtois, 2008).

Evidence-based treatment for trauma

The majority of the research has concentrated on individual psychological treatment approaches for patients with historical trauma to address the above associated presenting symptoms. Courtois and Ford (2009) argued that at a service level, group therapy is more efficient than individual as it can be offered more broadly. This also provides patients with a sense of normalisation of their symptoms as a response to trauma and with a sense of not being alone; not being the only one who feels this way (Foy et al., 2001; Lukens & McFarlane, 2004). Additionally, it counteracts isolation, provides peer support and observational learning while ameliorating important shame/guilt-based cognitions (Herman, 1992, Lukens & McFarlane, 2004). There is however limited research on the effectiveness of manualised approaches for the mental health difficulties.

Research shows that safety and stabilisation in trauma survivors can be achieved through psychoeducation approaches which emphasise present time, coping strategies/skills,

elimination of self-harming behaviour, control over acute symptoms, and increased self-care (Lubin et al., 1998; Lukens & McFarlane, 2004). Herman's (1992) trauma work provides a conceptual framework which identifies three phases of trauma recovery starting with (1) safety and stabilisation; (2) remembrance and mourning; and (3) reconnection. Thus, psychoeducation is crucial in the initial safety and stabilisation stage as it provides patients with the chance to make connections between trauma history and current difficulties while addressing the origins of current dysfunctional behaviours as attempts to cope with overwhelming stress. It then introduces patients to alternative coping strategies.

Additionally, a systemic review and meta-analysis by Mahoney, Karatzias and Hutton (2019) offers further support for group-based treatment for adults with symptoms of post-traumatic stress disorder. Their study indicated the importance of both trauma memory processing and psychoeducational approaches alone treatment forms. Their meta-analysis further suggests that early interventions that are offered as part of a phased approach in regard to symptoms specific psychoeducational nature are potentially more effective than usual care in improving post-traumatic stress symptoms. Thus, the current evidence-based research highlights the benefits of a group-based treatment as part of the Phase 1 (safety and stabilisation) treatment for trauma prior to patients proceeding towards more individual-based treatment to safely process their trauma memories (Phase 2 – remembrance and mourning).

Psychoeducational course for survivors of interpersonal trauma

To-date there have only been two studies that have looked at evaluating the Survive & Thrive course (Ferguson, 2008). This is a psychoeducational course that was designed for people who have lived through traumatic life experiences such as child abuse or neglect, domestic abuse, stalking or harassment. The course aims to help attendees develop an understanding of the normal range of reactions to trauma and introduce new ways of coping. It is a 10-week course that is structured to utilise cognitive behavioural skills training while delivering psychoeducational information on how a history of victimisation negatively impacts on the lives of trauma survivors. Each week the course runs for 2 hours and covers different topics related to interpersonal trauma such as what is abuse and trauma, what are the effects of both, keeping safe, and addressing common mental health difficulties associated with interpersonal trauma history. The course is facilitated by two clinicians who have qualifications in mental health and have attended the 2 ½ day Survive & Thrive facilitator training.

One of the two studies that looked at the Survive & Thrive course effectiveness concentrated on female offenders' experience of the course (Ball et al., 2013). The study results indicated statistically significant differences between pre- and post-treatment scores, supporting the

effectiveness of psychoeducational group-based treatment for survivors of interpersonal trauma. Unfortunately, the purity of reflecting on the effectiveness of this course has been impacted on by the researchers modifying the structure of those sessions from 10 weeks to 8. Additionally, their study cannot be generalised to the wider population, as it focused only on female offenders with a history of interpersonal trauma.

The second study (Karatzias et al., 2014) concentrated only on survivors of childhood sexual abuse. This was a mixed-method study, the qualitative part of the study was built on a quantitative study that showed no clinically significant change over time in participants presenting problems. Although the results showed no change over time in general distress levels, traumatic symptomatology, depression, anxiety, self-esteem, and life satisfactions, participants were less likely to report self-harm and presented with decreased rates of smoking, alcohol and substance misuse, as well as involvement in illegal and antisocial behaviours at post-treatment and follow-up. The qualitative data also suggested overall satisfaction with the course, despite the high attrition rate of 43% and some apprehension prior to starting it (Karatzias et al., 2014). The participants further identified increased acceptance of the reality of the abuse as a key achievement based on the learning experience they have acquired from the course.

The second study findings have however been based on recruiting both female (89.2%) and male (10.8%) participants while not elaborating on how the female and male survivors of interpersonal trauma experiences may differ. Research has indicated that women report more sexual assaults in adulthood associated with elevated baseline guilt conditions and health related complaints, whereas men reported more baseline anger directed inward (Miller & Cromer, 2015). Therefore, some details have clearly been missed in this mixed design study.

Research aims

There is limited research into the manualised group-based therapy approach for trauma. This study was designed to address the existing gap in the literature and contribute to the understanding of female survivors of interpersonal trauma experience of psychoeducational courses (namely the Survive & Thrive). This research's exploratory structure is inherently phenomenologically oriented. By understanding participants' experience, the course could be further tailored to their needs. Hence it can inform professionals how to adapt the more challenging parts of the course to ensure that future patients further benefit from the course, preventing early disengagement from the treatment.

Methods

Participants

Participants were patients seen within NHS Tayside who have been referred to the Survive & Thrive course run within Tayside Adult Psychology Service. Thirteen female patients, who met the inclusion criteria, have been interviewed about their experience. See Table 1. for additional demographic information regarding each participant.

Inclusion criteria

Women between the ages of 18 - 65 with a history of interpersonal trauma who attended at least 6 out of the 10 sessions of the Survive & Thrive course.

Exclusion criteria

The main exclusion criteria were that the participants were not perpetrators themselves and have not attended a group co-facilitated by the chief investigator.

Procedure

NHS ethical approval was sought prior to the commencement of the research process. Once approval was granted current and past female patients who attended the Survive & Thrive course and met the inclusion criteria were informed of this study by the Survive & Thrive team or course co-facilitators. When they agreed to be contacted by the chief investigator regarding the study, contact was made to provide them with additional information about the study. Consent forms were signed to confirm their understanding of the study and agreeing to part taking. Each participant then attended an approximately 30 minutes semi-structured interview which explored their experience of the Survive & Thrive course, with a particular focus on what parts of it they found beneficial and which were more challenging. Each interview began with a neutral open-ended question, such as: ‘‘What has been your experience of attending the Survive & Thrive course?’’ The conversation developed during the course of the interview into unique interactions typical of the verbatim. The transcript omitted non-verbal signals however it incorporated pauses, overlapping speech and interviewee’s change of intonation. The interview was followed by a 15 minutes off-tape discussion regarding their experience of the interview. Each participant was also provided with a list of contact numbers if they required additional support.

Access was also gained to some demographic information that each patient completed during the Survive & Thrive course as part of Service evaluation. This information was used to further inform the participants’ experience of the course.

Table 1. Participants Demographics

Participant number	Referral source	Age	Employment status	Marital Status	Type of Abuse	Psychiatric Diagnosis (if known)	Previous/ current Psychiatric input	History of Suicide Attempts	Number of attended sessions
1	CMHT	48	Unemployed	Living with partner	Childhood sexual, physical & emotional abuse; childhood physical neglect; harassment in adulthood	Depression, GAD, PTSD	Previous + Current	3	10
2	DAPTS	26	Employed	Single	Childhood sexual abuse; adult sexual abuse; domestic abuse; stalking; harassment, single incident rape in adulthood	None	None	1	10
3	DAPTS	-	-	-	-	-	-	-	7
4	CMHT	26	Employed	Single	Childhood sexual + physical abuse; childhood witness to violence; adult sexual abuse; single incident of rape in adulthood	PTSD	Previous + Current	5+	8
5	DAPTS	62	Unemployed	Widowed	childhood emotional + physical neglect; adult sexual abuse; domestic abuse	Depression, GAD	Previous	0	8
6	CMHT	32	-	Separated	Childhood Sexual abuse, Childhood Physical Abuse, Childhood Emotional Neglect, Childhood witness to violence, Domestic Abuse, Assault in Adulthood	Depression, GAD	Previous + Current	2	9
7	CMHT	31	Employed	Single	Childhood physical abuse, Childhood emotional neglect, Childhood Witness to Violence	Depression, other	Previous	0	10
8	DAPTS	52	Unemployed	Living with partner	Childhood sexual abuse, Childhood Physical Abuse, Childhood Emotional Neglect, Childhood Physical Neglect, Childhood Witness to Violence, Adult Sexual Abuse, Domestic Abuse	Depression, Harmful alcohol use	Previous	2	9
9	CMHT	42	Unemployed	Single	Childhood Sexual Abuse, Childhood Witness to Violence, Domestic Abuse, Single Incident of Rape	Depression	Previous + Current	0	8
10	CMHT	-	-	-	-	-	-	-	8
11	CRHTT	19	-	-	-	-	-	-	7
12	DAPTS	27	Employed	Living with partner	Child Emotional Abuse, Childhood Emotional Neglect, Child Physical Abuse	ASD, PTSD	Previous + Current	0	9
13	DAPTS	45	Employed	Living with partner	Single incident rape	Depression	Previous + Current	0	6

Design and analysis

A qualitative approach has been adopted as it looks for socially constructed meanings that cannot be assessed by numerical data. Further, it is more sensitive to multiple interpretations that individuals may make of their experiences in the process of meaning making (Smith, 1996). The data were explored using Interpretative Phenomenological Analysis (IPA), a method that has particular resonance for psychologists within qualitative research (Smith, 1996). The approach provides participants with space to voice their experience, and the meaning they assign to these. IPA is an established, systemic and phenomenological-focused approach that allows for the interpretation of first-person accounts in a meaning-focused qualitative method (Smith, 1996).

The data analysis involved five separate stages, as part the IPA methodology.

1. Meaning constructions – transcribed verbatim and was analysed in accordance with an idiographic and iterative approach;
2. Identification of key emerging themes and coding of these – transcript was read several times;
3. Coded themes comprised of constituent themes were clustered into superordinate themes – relating those to the overarching dimensions of the interview narratives;
4. Data was interrogated nomothetically; and
5. The identified themes within each transcript were inputted into a table of exemplary quotes, constituent themes, and superordinate themes (Smith, 1996).

Findings

As outlined in the introduction, previous literature focused on the individual psychological treatment option omitting the importance of group-based interventions. During the interviews many patients indicated to have been struggling prior to accessing the Survive & Thrive course. The demographics table above has also summarised the number of interviewees' attempts on their life, highlighting what some of them reported during the interviews, such as a sense of helplessness regarding their future. The main theme that came up was believing themselves to be the only one's feeling this way. Five superordinate themes emerged through the analytical process. The interviews offered rich and varied individual expressions of these themes, and consistent commonalities allowed some insight into the effectiveness of the manualised group-based psychological intervention. It highlighted the meaning patients have taken from this experience and the process by which this may occur. See Table 2 for a summary of the superordinate and subordinate themes along with example quotations from the interviews.

Table 2. Master table of super-ordinate and sub-ordinate themes: example quotations.

Superordinate theme	Sub-theme	Example quotes
1. Sense of connectedness	1.1. I am not alone	"...having everybody together and talking about their own experiences it's just creates sense of like community, like you're not the only one." "And that's what I liked the most about that sense of community. " "...when I've been through what I've been through, I was kind of quite reclusive. So attending the group and stuff has allowed me to sort of meet other people who went through similar experiences." "But it was also helpful having other people, knowing there are other people going through similar stuff as well."
	1.2. Shared understanding	"...I know a lot of the women there as well say that it was good that interaction with other people. And towards the end we have actually looked forward to coming to see each other and see how we were progressing." "You would kind of support each other." "You could talk about it, you didn't feel odd."
	1.3. Safe environment /space	"It was just a nice place to go." "You didn't feel, oh I can't say that because they're gonna think what is she talking about. So that helped." "And that's what I liked about it. That personal touch, if you'd like. You felt like an individual. Even though we have all felt the same and we were there all for the similar reasons, I still felt that my individual needs were being met."
2. Journey towards recovery	2.1. It gets harder before it gets better	"...I suppose you feel worse before you get better." "So now, yeah it does bring up a lot of bad memories and I still get triggered to this day. That I will be all my life but that's the downside. But the good side is that I've dealt wit it. And accept it. And try to move on."
	2.2. Life changing experience	"They helped me to belief that maybe I am not an evil person." "Well it has changed my life. It's literally changed me." " I would I would recommend it for anyone having a hard time' it was invaluable for me at that time."
	2.3. Sense of empowerment	"I decided that I had to and try do something for myself that was not for anybody else. Because that's what I really learned in the group. You have to do for yourself is really important." "So it was good in the aspect that I got out and it got me, it kind of help the process of meeting other people who went through similar experiences to mine." "And it also made me realise that I had to help me."
	2.4. Long way to go	"So ultimately it does make you feel better and it's sort of like not instant thing but something that happens slowly quite early on." "Some days when you don't feel as good as you do on other days, there were like resources and stuff, booklets we've got to look at." "Well it started with Survive & Thrive and it's basically been since then. It's gradual. And as I said, it's still a long way to go." "Ehm but building it in it took a couple of months for me to notice and start to step out."
3. Facing the facts & triggers	3.1. Facing denial & triggers	"But sometimes it is difficult to take yourself out of that dark place when you are constantly reminded and constantly working through your problems."

		"...it was sort of triggering off things in me but the staff were really looking out for us the staff were brilliant, you know."
	3.2. Eye opening moments	"But it does kind of put things in a perspective when you hear other people's stories and how they have dealt with tem, you know. It kind of does put your own, maybe, maybe just challenges the way you think about them a little bit." That kind of first time when I felt kind of maybe I am not guilty of something. Maybe I should not be ashamed, you know."
	3.3. Acceptance and greater understanding	"I have piece of mind. And I understand a lot of things. A lot more now." "...because you're accepting it and when you accept it you can move on do you know what I mean, that's the part of healing too..."
4. Initial apprehension	4.1. Sense of helplessness	"I couldn't even sit in my own house. I was scared there. And I wasn't worried about me, so what am I scared of, I don't know. So that's how it started." "I was suicidal. I did not want to be alive. I was lost. I was very lost. Felt I've had everything ripped. Well I did have everything ripped underneath my feet. And felt alone."
	4.2. Readiness for change	"Yeah, I can imagine that it can be overwhelming for some people, unfortunately our group has dropped out in numbers. Some of these things are just huge and maybe some women just couldn't cope."
	4.3. Fear of the unknown	"...I wouldn't have thoughts in the past that it would be something that would've benefited me." "...a bit of fear that my expectations are far too you know, that unrealistic but expectations but I mean that was far out weight by the excitement of learning you know and finding out what it's about and you know." "...it definitely became a lot easier going because I know what to expect."
5. Sense of being let down	5.1. Challenging personalities	"But one time there was like 5, I just found it. You could see that people were opening up more in the smaller group than in the larger group." "Whereas in the bigger group there was like a bunch of people and maybe somebody dominated more than another person who was quieter." "I would maybe try and group different personalities together more. Ehm or just kinda be a bit more thoughtful of if this person is going to be disruptive or is this person going cos we did have one person who every opportunity they get they would just speak about their own traumatic experience."
	5.2. Repetitiveness of questionnaires	"There was a lot of questionnaires. I understood why we were doing it, was just a big strain cos I'm really dyslexic." "I can understand why they do it, they want to see how you are getting on in the group, but trying to read like the same questions every 2nd week your like, oh my god another one."
	5.3. Need for additional support	"I would prefer for it to go on for longer. But that's maybe you know, that obviously can't happen." "And I think it was mainly because of the fact that it was in my routine, that was what I did." "Place where you can go, when the course ends. Like a place where you can have a contact."

Further elaboration of the themes, accompanied by verbatim illustrative data excerpts, is provided below.

Theme 1: Sense of connectedness

This superordinate theme developed as the participants reflected on their experience of self while attending the Survive & Thrive course and three subordinate themes emerged that contributed to understanding this experience. Diagram 1 shows the chief investigator's interpretation of how the superordinate and respective subordinate themes occurred during the interviews. Despite each interview being very individualistic, a pattern has been identified in how the participants understood their experience of the Survive & Thrive course and the overlaps of the stages which they went through.

1.1. I am not alone

As a consequence of what victims of an interpersonal trauma experience, they can feel alone. Often, they can internalise what has happened to them as being their fault, engaging in self-blame. Thus, as highlighted in a number of quote examples below, the most valuable aspect of the Survive & Thrive course was the sense of connectedness and not being alone, which was also highlighted by some prior literature (e.g. Foy et al., 2001; Lukens & McFarlane, 2004).

> *"...you realise that people are in the same boat as you and before that I've never thought of that." (Participant5)*

Or:

> *"...there was people my age and there was also people who were older and retired. And I was just like this is really interesting like it's all ages not just like young people and it made you realise that this happens to a lot of people and it was quite helpful to know that there was other people going through what you I've experienced.." (Participant11)*

And:

> *"I'm sitting here crying cos I am really relieved that I got somewhere and someone I fitted in. I actually it was like all my life I felt different and didn't feel emotional look at people and think, you know. And I used to think different and react differently and think differently, no one really got a sense of me...." (Participant8)*

As well as:

> *"I found the experience more ehm beneficial being with others and I was quite surprised about that about being in a group, I thought I would be quiet*

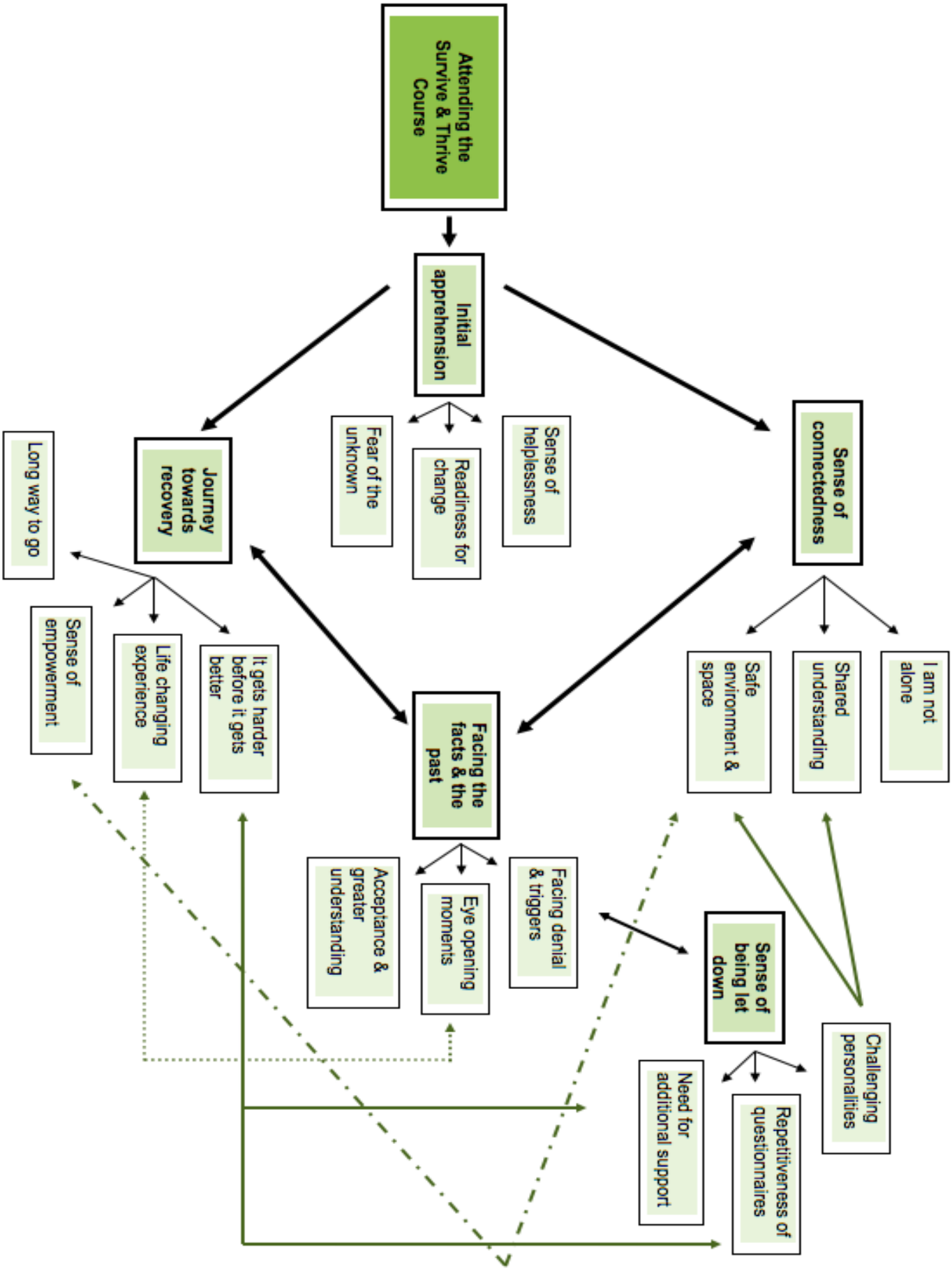

Diagram 1. Representation of superordinate and subordinate themes as they occurred during the interviews.

but I felt I was wanting to be more supportive towards the other people in the group...'' (Participant9)

1.2 Shared understanding

The participants then mainly spoke of benefiting from the shared understanding and being understood without needing to go into detail about what they have went through.
For example:

''It was like the other girls were talking for me... & ...So eh I lot of identify identity with other people that I'd never had, I never had, I never had the feeling that someone really understood because I didn't even understand myself....'' (Participant8)

Or:

''...even though speaking to other people about it, I wasn't amongst people that had also been through it and I think just having that connection of you know, not knowing what the specifics were, but having the connection of , you know nobody really deserves to be in an abusive situation and you know sort of you are strong enough to get through it....'' (Participant9)

And:

''Ehm there's something different about the course to just one-on-one therapy, you do your own therapy and you go and you learn more among other people who have been through similar experiences to you or at least they just understand what it's like to have had a difficult past.'' (Participant12)

1.3 Safe environment/space

Given the history of interpersonal trauma, going to new places and building up trust can be challenging (e.g. Foy et al., 2001). Therefore, creating a safe environment where the patients felt safe to talk amongst each other was important to them, such as:

''It felt very safe because I knew that the other women that were there, were there for the same reasons as me. And it has given me a bit more confidence to speak up in a group because we were there all for the same reason.'' (Participant2)

And:

''Just how it made you feel. It was just really nice and it was a relaxing environment as well. And it was safe. No judgement or you know it wasn't

too personal either because it was a group thing. It was good. Really good.'' (Participant6)

Theme 2: Journey towards recovery

The participants captured their experience of the Survive & Thrive as a 'journey towards recovery' with the subsequent themes.

2.1. It gets harder before it gets better

As expected for any psychological treatment, in order to overcome mental health difficulties it means having to open up about difficult life experiences or engage in behavioural change. This often gets more challenging before patients can start noticing a change (e.g. Beck, 1997; Tasca et al., 2017). Similar experience has been captured by the participants, such as:

''I think the first couple of weeks were the easy weeks. And then it sort of got harder the more in depth it tended to go. And I found it harder the sort of last the last three sessions were really tuff. But they were also helpful as well.'' (Participant4)

Or

''It's therapy, isn't it. So it brings out the bad. Because you have to bring it all up to understand it now as an adult because everything I have seen as a child made no sense to me.'' (Participant6)

And

''There was things that was really hard to cope, plus it's brining up stuff you don't really want to think about, like I know that I was going there to think about it, to get used to it, to get over it sort of thing. But it was still really, really hard to go cos every time I went I was like I was really reliving it, sounds so sad. (laughs).'' (Participant11)

2.2 Life changing experiences

Once participants went through the difficult part of the course and started to move towards noticing the change, they described this as 'life changing'. By gaining a better understanding of the normal range of emotional response to what they have been through, it has allowed them to move away from self-blame while understanding their emotions better. For example:

''That it made me understand that. That it is not a flaw in me, it is because of the lack of learning and caring as a child... But I went through most of my adulthood not understanding that and being very ehm scared of people and not wanting to take part in things. And being very sensitive and being upset

very easily. And I did not know all of these things until I have went along to the Survive & Thrive'' (Participant2)

And

''It just gave me a new perspective. Like another way to think about things rather than the way I was thinking about things. Because I was in like quite a bad way. Yeah but I found it amazing, life changing.'' (Participant6)

Or

''I'm still here because of that course, I was very bad very depressed very suicidal...'' (Participant7)

2.3 Sense of empowerment

By understanding what they have been through, learning from each other and not being alone in this process, participants reported having a sense of empowerment, such as:

''But when you realise there were good people and you were kind of willing to open up in the group and stuff. So that kind of helped a bit, with well it helped me with getting out and being with people again. Because usually I just have locked myself away after what had happen.'' (Participant3)

Or

''Profoundly it enabled me to help myself that's what it enabled me to do. To identify and help myself I haven't come out as Wonder Woman, I'm not saying that cos you know life aint easy, you know. Ehm but a greater insight into the way I think...'' (Participant8)

And

''It's like the, the group gives you this extra bit of strength and courage just the way it's set up and the way they teach and the way that they do things, it just it works really well.'' (Participant12)

2.4 Long way to go

Most participants reported noticing the benefit of the Survive & Thrive not until couple of months after the course came to an end. This has been highlighted in previous literature regarding the need for time to consolidate newly acquired skills while having a chance to put these into practice (e.g. Pacual et al., 2015). Some have also spoken of the importance of handouts they have been given and being able to go back to them. For example:

''Probably it wouldn't be until couple of months after it. And then I started going back over the sheets and stuff. And because it wasn't as intense and

you weren't in a room with strangers. I was going through things and understand it sort of better and how to apply it and use it.'' (Participant4)

Recognising the newly acquired skills set that not everyone has:

''Even though you maybe not thinking it is helping as much at the time, it is when you actually reflect back on it when you think, well look these are skills I can take away with me. They are not something everybody knows, and that's for one.'' (Participant1)

Acknowledging the course is not a 'cure' it is a guide to making improvement in one's quality of life (e.g. Tasca et al., 2017):

''Like even now, there's things I know I don't understand everything, I get things wrong. I am human. Yeah. It is an ongoing thing. It's life. You're continuingly learning, you're continuingly discovering.'' (Participant6)

Or

''Now Survive & Thrive it's not a curing thing, it's not a click fingers and done, but it gives you tools, it gives you the tools to kinda face life and to just keep going, which I needed at that time.'' (Participant7)

Theme 3: Facing the facts & the past

The participants described the hardest part of the course being facing the facts and having the co-facilitators describe what abuse is and the effects of it on one's mental health. Most of the participants have also been recognising the benefits of having to sit through more challenging discussions during the course, as it allowed them to gain a better understanding of their current mental health (e.g. Hundt et al., 2017; Tasca et al., 2017). The themes below captured the process of what the participants explained as having experienced.

3.1. Facing denial & triggers

This theme that arose from the interviews is a common reflection of psychological treatment that has been captured by prior publications (e.g. Hundt et al., 2017; Tasca et al., 2017). Patients tend to avoid remembering the past as they are unsure how to process the associated emotions with these memories. Thus, many participants described this part of the course as triggering and emotionally challenging, such as:

''The issue with it is that it's so every single time you go it's that whole session and you are bombarded with all of this. In a positive, not bombarded in a negative way. But you think about it and you think about it some more and you go over, over, and over it again. So that honestly I would seem both as a positive and negative because I take it for me

personally if I am thinking about it all the time and working through every little bit it holds you in the past..'' (Participant1)

Or

''A lot of it, some of it triggered things that I was feeling inside and some of the stories were. When the group started sharing stuff, sometimes I would leave and be going home and I've been physically exhausted. It was like I have been in a boxing match.'' (Participant3)

3.2 Eye opening moments

A majority of the participants have spoken of the 'wow' effect, when they came to a self-realisation. They have realised that topics they did not identify with initially have actually been relevant to them. The main topic from the course that participants described as a big eye opener was not realising that repressing anger contributes to some of their unhealthy coping strategies, such as:

''There were certain ones beforehand that I though I won't be able to identify with that because for example the week on anger. That won't be really me. But as has went on, ehm they discussed too much anger and also too little anger so it was a really really interesting one because you feel you can identify with every part of it in a certain way...'' (Participant1)

Or

''Just because I feel guilty about something does not mean that I've cause it. And being able to share my guilt and the shame you have about the abuse has been massive. And that itself has helped you so much. It's like nobody has ever said to me, it is not your guilt. The guilt belongs to the abuser. They were the one who were guilty. But they have left you carrying their guilt. Nobody has ever said that to me and it was like, WOW.'' (Participant2)

3.3 Acceptance and greater understanding

The participants expressed how the course allowed them to put the group process into perspective (e.g. Hogan et al., 2006). They spoke of the different levels of processing the information; being this written or verbal which enabled them to synthesise and consolidate their past experience and newly acquired knowledge to understand better their current mental health struggles; such as:

''I started to gain more understanding and awareness into what I feel and why I feel the way I do. Just the way they teach, they just give you an

insight into why you are going through what you are going through and they make sure you don't feel like you are alone." (Participant12)

Or

"I found it quite good cos there was like different like methods of like talking like they read from the PowerPoint but they also like did things on a flip-chart as well like that was really good and like it was quite interactive, they were like we will all write something down on a post it note and they could." (Participant11)

And

"...but now through the group I can sort of say – oh well I do understand now why my body reacts this way and it's just a panic attack or it's just a low mood and it's gonna pass." (Participant4)

Theme 4: Initial apprehension

There has been some initial apprehension from some of the participants prior to starting the course. Some spoke of having no hope that anything could help them along with the fear of the unknown.

4.1 Sense of helplessness

Participants described having a sense of helplessness prior to starting the Survive & Thrive course. They spoke of the struggle of not receiving the right help and feeling stuck in life.

"My emotional state and my mental state was quite bad at that time. I was working. I was just kind of surviving." (Participant6)

Or

"Before I took part in the course, I was quite frustrated because I had been working quite hard to make a difference in my life and I needed that extra help." (Participant12)

4.2 Readiness to change

Some of the participants captured the importance of when the course was offered to them. Given the above explained emotional state and sense of helplessness, they have spoken of needing to be in the right place in life when they were ready to make changes and engage with the treatment (e.g. Cook et al., 2017; McMurran, 2012). For example:

"I was really in the right place at the right time wanting it, you know..." (Participant8)

Or

‘‘I mean you have to change, you have to be willing to change I think so.’’ (Participant12)

4.3 Fear of the unknown

Many patients fear attending a group-based treatment because of the unknown factor of who is going to be in the group. From what the participants described the extra step taken by the course co-facilitators who have met with them before hand and showed them the room where the course is run made a significant difference for them with regards to them attending the initial session; such as:

‘‘Ehm not knowing what to expect. I did meet CLINICIAN once before so I knew I would one person I would recognise her face. Because the thought of a group of people that I do not know, group of strangers, very scary.’’ (Participant2)

Or

‘‘I was like really scared because I didn’t know what to expect. And I just didn’t know what the other people are going to be like or joining the group. And there was a lot of anxiety and stuff. But the staff really helped like showing me the room that it’s gonna be in and that.’’ (Participant4)

Theme 5: Sense of being let down

Despite the above captured positives, the participants have found some challenges with the course too. Most of these challenges are areas that are difficult to control for and some provided insightful points to take forward in terms of delivering this course regarding the best way to support the patients.

5.1. Challenging personalities

One of the main difficulties among a group-based treatment is the mixture of personalities. As captured by the participants despite the co-facilitators’ best efforts, there have been some individuals who did not respect some of the course boundaries. Despite the benefits of having a group of individuals who share similar experience, as captured above offering the ‘sense of connectedness’, some patients used the group to over share their personal experience of the trauma which others have found triggering. For example:

‘‘It was actually the individuals. It was jus that some of the trauma that they have experienced had triggered some of the stuff in me. And that was quite hard to deal with.’’ (Participant3)

Or

‘‘...there were few annoyances but that was more to do with group members and that. But that’s going to happen whenever you put a group together and teach them a lesson, it’s personalities clash.’’ (Participant7)

5.2 Repetitiveness of questionnaires

The participants struggled with the number of questionnaires they had to complete each week as part of the service evaluation. Not only did they find the process of this ‘repetitive’ and ‘boring’, but for some it was highlighting the lack of progress they have been making on a weekly basis, which has been triggering some participants’ low self-worth.

‘‘One thing that I found a bit boring but I know that they had to do it was the questionnaires. Sometimes because I felt, I felt for a long time the same.’’ (Participant5)

Or

‘‘...it tends to be just adminy stuff to start with I kinda found that quite boring and quite annoying... the introductions make me want to push it way, so I found those a bit difficult... ’’ (Participant7)

5.3 Need for additional support

The general feedback was that participants enjoyed the course so much that they did not want it to end. Given it allowed them to increase their social levels and sense of connectedness this was the most difficult part for them. Some spoke of the loss of contact, as they would not get to see each other again:

‘‘I think when we were kind of put in the group for the 10 sessions and then we were kind of given coping skill and stuff and then we have opened up about stuff that has happened to us and then all of the sudden it just ended. And we have no where to turn to and. A lot of the, the couple of the women were like this is it then, we are not going to see each other again. ’’ (Participant3)

Some participants stated despite having the co-facilitators available during the break and after the course, they would have liked to receive additional support in between appointments. This might be linked to the range of individuals attending the course with different needs and from different services (e.g. Primary Care Psychology versus Community Mental Health Team settings), where different levels of support are provided. For example:

‘‘...if I found the session quite hard. I’d like to speak to someone in a like an appointment just to talk about it one on one, something like that....’’ (Participant11)

One of the disadvantages of a psychoeducational course is the lack of opportunity to go over sessions patients did not attend. There are two follow up sessions that allow for some summary, but this would not cover in full the session someone has missed, such as:

> *''...since people are also missing some it would be good to have a kind of revision also in the middle maybe or towards you know the end...''*
> *(Participant13)*

Discussion

These findings demonstrate that the Survive & Thrive course is not a 'cure' for patients with a history of interpersonal trauma, however it provides them with new strategies and skills to move forward in their life. One of the key themes identified by the participants was the 'sense of connectedness'. A sense of belonging and not being alone was described by the participants as the main factor contributing to benefiting from completing the Survive & Thrive course. Given the tendency for isolation, vulnerability and difficulties around trust that survivors of interpersonal trauma experience, being in an environment where their social connectedness levels were addressed has helped to improve their overall well-being (e.g. Foy et al., 2011; Lukens & McFarlane, 2004). Additionally, having one's feelings validated by others is important to all individuals, however this is particularly important for survivors of interpersonal trauma, who's emotions have often been invalidated and neglected contributing to their fear of expressing their feelings (Courtois & Ford, 2009).

The Survive & Thrive course facilitated the participants ability to create connections with other group members, thereby helping them to combat isolation and alienation. Participants described how sharing their experiences helped to normalise their reactions, which also contributed to shame reduction. Similar findings have been captured by other studies mainly relating to survivors of complex trauma (e.g. Hopper et al., 2018). The participants also described having a 'sense of empowerment' as a result of the course, which helped with their confidence and increase in social levels by starting to establish healthy boundaries in their relationships. Thus, based on these findings, the aim of future studies should be on how to increase the uptake of patient's engagement in inclusive stabilisation groups, while exploring how to reduce the burden of participation along with the 'fear of the unknown'. Further research in this area is important not only due to this study's findings but also other literature identifying social support (sense of connectedness) as a mediating factor between suicidal ideation and history of neglect in survivors of childhood trauma (e.g. Yong-Chun et al., 2017).

The additional superordinate and subordinate themes that occurred as a result of the interviews are in accordance with general knowledge about the vulnerability, ambivalence, and trauma-based treatment approach, which are characteristic of the initial phases of any group-based treatment (Yalom & Leszcz, 2005). The study has also offered some insight to participants' experience of the course; in particular Diagram 1 has highlighted the sequences of the participants' experience of the captured themes and the times when additional support might have been required. Although boundaries have been set to avoid sharing specific trauma experiences, the participants were reminded of specifics through example scenarios or by some patients over sharing details regarding their trauma experience. An important clinical implication is that course co-facilitators need to focus on patients' readiness to engage with more triggering aspects of the course while providing additional support to help those who might also be experiencing additional difficulties, such as co-morbid social phobia. As highlighted by the quotes, this requirement could be met by being shown the clinical room as well as getting to meet one of the co-facilitators prior to commencing the course. Those who find the material triggering could be offered one-to-one review appointments on an individual basis at set stages of the course.

Furthermore, the study has highlighted the importance of time to understand the traumatic experience as well as to practice the newly acquired skills throughout the course. This was captured by the participants as a 'journey towards recovery' with the subordinate theme of 'long way to go'. Despite its inherent stressors, as would be expected of any trauma-based psychological treatment, all the participants spent most of the interviews drawing on the positive aspects of attending the Survive & Thrive course. The way participants described how the course has helped them was mainly in line with acceptance and understanding the distressing emotions while acknowledging that these will pass. It has not made these difficulties completely resolved. Additionally, most of the participants spoke of the need for consolidation time which enabled participants to put the newly acquired techniques into practice while having additional time for self-reflection (e.g. Pascual et al., 2015). Those who were interviewed one or two years after completing the Survive & Thrive course reported more changes in comparison to those who completed the course between 2-4 months prior to the interview. A longitudinal study would be required in order to capture the exact time-line of patients progress throughout and after completion of the psychoeducational course.

Overall, this study offers a rich insight into the female survivors of interpersonal trauma experience, adding to the previous two studies that focused namely on the effectiveness of the Survive & Thrive course. Increasing the insight of the participants' experience of the course might assist clinicians and mental health services in adapting this course to their patient population needs and encourage wider use of this manualised psychoeducational

course. Findings from this qualitative study should be encouraging for services in regard to recognising the identified benefits participants experienced as a result of completing the Survive & Thrive course.

Clinical implications

Given the above captured benefits a group-based manualised psychoeducational course can have for female survivors of interpersonal trauma, some of the barriers to engagement with this treatment option should be further explored. The findings from the current study suggest that receiving additional support both before and throughout the course has been vital. Thus, the clinicians who screen suitable patients for this treatment should ensure that they explore potential barriers to attending the course and arrange a viewing of the clinic room in advance or a meeting with a course co-facilitator.

Given the lack of control over the range of personalities within a group, one of the aspects that mental health services might require to focus more on is exploring screening measures for readiness to engage with such a treatment option. Despite this study not capturing the reasons for disengagement from treatment, some of the participants feedback was around readiness and willingness to change. Cook and colleagues (2017) identified patient's readiness to consist of three components: psychological and psychiatric stability, general readiness to change, and specific skills to manage trauma-focused evidence-based treatments (e.g. distress tolerance, affect regulation skills). Their study highlighted some of the current difficulties in the screening process for predicting who is actually ready to engage. It has emphasised along with other literature that there is not a specific scale that allows mental health services to define ''readiness'' and this mainly depends on clinicians' individual judgement (e.g. Couineau & Forbes, 2011; Zubkoff et al., 2015). Thus, this area might require more exploration in order to identify a uniform measure that can be adapted by clinicians across different services.

Strengths, limitations, and future directions

Given the number of patients with a history of interpersonal trauma being seen within Psychology Services (e.g. Gibbons, 2016) with new initiatives promoting mental health well-being, there has been an increased focus on the evaluation of different types of trauma-based psychological interventions. This study therefore offers a rich insight into female survivors of interpersonal trauma experience of the Survive & Thrive course, and the factors moderating this experience.

The primary limitation of this study is its restricted access to Tayside area population only. Thus, to assess effectiveness of this course more broadly and to generalise the findings, this study needs to be replicated throughout Scotland to assess for other factors, such as deprivation index and/or access to other means of support. Additionally, the participants interviewed for this research ranged in terms of time since completion of the course from only a few weeks up to two years. To allow for a greater insight into the changes captured overtime, future studies could only interview participants a set number of months post completion of the course. The highlighted quotes from the interviews have already shown some differences among the participants who might have completed the course two years ago in comparison to those who completed a month ago. Thus, all of these are additional variables of how much time after the course individuals had to consolidate their newly acquired skills/learning.

Furthermore, a chief investigator (first author of the study) conducted this study and carried out the data analysis, meaning that potential limitations arise in using IPA. This approach draws on the researcher interpreting their understanding of the interviews with prior knowledge of the researched topic (Smith, 1996). Moustakas (1994) suggested a technique called 'bracketing' allowing the researcher to set aside their experiences and take a fresh perspective. It should however be noted that it is impossible to bracket one's biases completely (e.g. Allen-Collinson, 2009).

Conclusion

The findings of this study highlight that a manualised group-based intervention can be equally as effective as some individual psychological interventions, based on the participants comments. The study has demonstrated that survivors of interpersonal trauma have benefited from being able to identify that they are not the only ones feeling that way and having the opportunity to learn from each other, which would not be facilitated through individual psychotherapeutic treatment. Thus the 'sense of connectedness' should be further researched as a potential contributing factor to greater outcome from psychological interventions. This research invites mental health professionals and services to evaluate the prevalence of individual psychological treatment that is being offered to patients with history of interpersonal trauma over group-based psychoeducational treatment, such as the Survive & Thrive course.

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