THIRTEEN WOMEN AND THEIR STORIES: A THEMATIC ANALYSIS OF THE PRE AND POST SELF-NARRATIVES OF FEMALE SURVIVORS OF CHILDHOOD SEXUAL ABUSE WHO UNDERWENT HOSPITAL-BASED GROUP TRAUMA THERAPY

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Abstract

The importance of treating women with histories of childhood abuse has been well established. The efficacy of the Women Recovering from Abuse Program (WRAP) has also been investigated and established. The aim of the current qualitative study was to understand how women with a history of childhood abuse experienced WRAP, an intensive group treatment program based out of Women's College Hospital in Toronto, Ontario. Thirteen women were interviewed pre- and post- treatment using the Self Assessment Interview (SAI). A thematic analysis was conducted on both the pre- and post- interviews that identified theme hierarchies for these two sources of data. These findings deepen our understanding about how participants view their trauma histories, relationships, self-concept, hopes for treatment, symptoms, met or unmet expectations, goal attainment, and impressions of the therapy itself. Theoretical and clinical implications are discussed.

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The current study aims to qualitatively examine the experiences of 13 women who underwent a trauma therapy program at the Women's College Hospital. The Women Recovering from Abuse Program (WRAP), is an intensive 8-week stage one treatment program for women with histories of childhood trauma, that integrates individual sessions and group sessions to directly address stage one trauma work of safety and stabilization. These women all experienced one or more types of trauma in their childhoods and attended WRAP specifically to address these traumas and the symptoms and difficulties they are subsequently experiencing. These women were interviewed both pre- and post-treatment using the Self Assessment Interview (SAI). The current study aims to explore their self-narratives from the perspective of the SAI using the qualitative exploratory approach of a thematic content analysis.

Trauma and its Prevalence

Trauma is defined by the Diagnostic and Statistical Manual – 5th edition, as requiring "actual or threatened death, serious injury, or sexual violence." However, clinically, trauma can be defined as a psychological injury resulting from exposure to an incident or series of events that are emotionally disturbing or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, and/or spiritual well-being. There is a growing volume of literature about the widespread

prevalence of childhood trauma and researchers such as Cicchetti and Barnett (1991) have identified four types of child maltreatment: physical abuse; sexual abuse; psychological abuse; and neglect.

The prevalence of childhood abuse among the general population as measured by the Adverse Childhood Experiences (ACE) Study (1998), found that 11.1% of individuals reported psychological abuse, 10.8% reported physical abuse, and 22.0% reported sexual abuse. The prevalence of childhood abuse among women in the general population as reported in the literature varies. A study conducted by Medrano, Zule, Hatch, & Desmond (1999) found that 60.2% of women participants were sexually abused, 55.2% were physically abused, 45.9% were emotionally abused, 83.4% were emotionally neglected, and 59.7% were physically neglected. Another study performed by McHugo (2005) found that in a sample of 2729 women 62% endorsed a history of childhood sexual abuse, 62% described a history of childhood physical abuse, 60% reported a history of adulthood sexual abuse, and 85% described a history of adulthood physical abuse. Previous researchers have suggested that the variation in reported prevalence is likely due to variation in the definition of abuse, in sampling procedures, and in data-collection methods (Alter-Reid, Gibbs, Lachenmeyer, et. al., 1996). Still, the prevalence in histories of abuse among adult women is impactful.

Reported rates of childhood abuse are even greater in women being treated for psychological illness in outpatient clinics (Bryer, Nelson, Miller, & Kroll, 1987; Hall, Sachs, Rayens, & Lutenbacher, 1993; Muensenmaier, Meyer, Struening, & Ferber, 1993). For example, rates of client reported sexual abuse in outpatient psychiatric clinics are as high as 40%, which is significantly higher than rates in the general population (Finkelhor,

Hotaling, Lewis, & Smith, 1990; Muensenmaier et al., 1993). Overall, within clinical samples of women with psychotic and affective disorders and personality disorders, a history of child abuse is statistically frequent (Cohen, Mannarino, & Rogal, 2001; Darves-Bornoz, Lemperiere, Degiovanni, & Gaillard, 1995; Read, 1997).

The Impact of Childhood Trauma

The high prevalence of single or repeated episodes of abuse and violence is important as these experiences can lead to the development of traumatic symptoms and post-traumatic stress disorder (PTSD). While not all experiences of violence result in trauma, higher rates of violence, repeated violence, and ongoing lack of safety and stability, are more likely to result in trauma and PTSD (Livingston et al., 2020; Roberts et al., 2010) The constellation of symptoms for PTSD includes low mood, suicidality, intrusive distressing memories, anhedonia, nightmares, avoidance of aversive stimuli, difficulty sleeping, difficulty with concentration, dissociation, disruptive flashbacks, panic attacks, and hyper vigilance (American Psychiatric Association, 2013). In addition to acute symptoms, trauma can also have a relational impact on a person's functioning. Individuals with such histories may face obstacles in forming positive therapeutic alliances (Eltz, Shirk, & Sarlin, 1995). They also show greater mistrust of others and may find it difficult to establish feelings of safety or trust (Eltz et al., 1995; Cloitre, Cohen, & Scarvalone, 2002). There can also result a breakdown of consciousness, including emotional, cognitive, and behavioural structures (Moormann et al., 2012) inhibiting integration of information of these structures and inducing disturbances in identity and memory (Moormann et al., 2012). An attachment pattern that is unresolved due to trauma has been associated with increased dissociation (Marcusson-Clavertz, Gušić, Bengtsson,

Jacobsen, & Cardeña, 2017; Pierrehumbert et al., 2009). Similarly, the high incidence of unresolved attachment in individuals with a history of childhood abuse, is associated with severe psychopathology (Bailey,Moran, & Pederson, 2007; Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004; Fonagy et al., 1996; Liotti, 2004; Pearlman & Courtois, 2005). Research suggests that an individual's failure to consolidate memories following an experience of trauma put the person at risk for the development of PTSD, lack of coherent speech, characteristic of unresolved states of mind (Stovall-McClough & Cloitre, 2003). Individuals with unresolved attachment patterns and a history of trauma often have highly dysregulated emotions, dissociative behaviors, and disjointed interactional patterns (Pearlman & Courtois, 2005). It is also postulated that women with a history of childhood abuse have more severe psychopathology, higher rates of psychiatric symptoms, greater chronicity, and worse psychosocial functioning, and, as a result, have more hospitalizations (Amaya-Jackson et al., 1999; Darves-Bornoz et al., 1995; Muensenmaier et al., 1993; Nelson et al., 2002).

Long-term adverse effects of trauma are driven by neurobiological changes in the sympathetic and parasympathetic nervous system including the hypothalamic–pituitary–adrenal (HPA) axis (Agorastos et al., 2018; Heim et al., 2000). Other poor physical health indicators in adulthood are also thought to be related to trauma. These may include increased risk of obesity and metabolic syndromes (Gunstad et al., 2006; Lee et al., 2014), destructive coping mechanisms such as disordered eating and substance abuse (Lotzin et al., 2016; Moulton et al., 2015), a significantly elevated resting heart rate suggestive of heightened autonomic activation, and a significant delay in the time taken to return to resting heart rate (Beilharz, 2020). The ACE study (1994) found a strong

relationship existed between the amount of exposure to abuse during childhood and multiple risk factors for several adult disease conditions including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The findings suggest that the impact of these adverse childhood experiences on adult health status is strong and cumulative. Given the well documented psychosocial and physiological effects of childhood trauma, it is important that clinicians provide effective and accessible treatment.

Treatment for Childhood Abuse and Trauma

Prior research in trauma therapy, such as that by Steigl (2013), has reported that psychotherapy helps individuals shift from a traumatized sense of self to an enduring, positive sense of self, to form meaningful relationships, and to live independently (Saha et al., 2011; Stiegl et al., 2013). These modalities include but are not limited to cognitive behavioral therapy, psychodynamic therapy, emotion focused therapy, narrative therapy, somatic processing, and art therapy. Increased awareness of the high frequency of childhood abuse has led to numerous treatment studies being conducted over the last several years. The majority of these studies focused on examining the efficacy of weekly individual or group trauma therapy. Overall, findings indicate that both individual and group treatments of childhood abuse were generally effective in reducing symptoms. For example, Martsolf and Draucker (2005) reviewed 26 quantitative outcome studies that examined weekly group and individual treatments for survivors of childhood sexual abuse. A meta-analysis conducted by Price, Hilsenroth, Petretic-Jackson, & Bonge, (2001) reported findings that support the efficacy of individual therapy for the treatment of the impacts of childhood sexual abuse. De Jong and Gorey (1996) conducted another

analysis of seven studies of adult group therapy, reporting findings that three quarters of women participants in the groups scored higher on self-esteem and affect measures following treatment. Overall, it has been established in literature that a range of empirically supported and effective therapies exist, that are directive, non-directive, individually and group based (Cohen, Deblinger, Mannarino, & Steer, 2004; Konanur, Muller, Cinamon, Thornback, & Zorzella, 2015; Lawson, 2009). Six month and one-year follow-up studies of these modalities of trauma therapy found that post-therapy PTSD symptom reductions were maintained (Deblinger, Mannarino, Cohen, & Steer, 2006; Konanur et al., 2015). Clinical and school therapists have successfully implemented different models with children ranging from preschool-age to adolescence (Cohen & Mannarino, 1997; Cohen et al., 2006; Feather & Ronan, 2009; Little, Akin-Little, & Gutierriez, 2009).

Research on treatment outcomes specifically among women with histories of childhood trauma often supports a phase-based approach that begins with the implementation of stabilization skills, or “stage one.” Stage two involved processing of traumatic memories, and stage three involves reintegration into life and relationships. A review of data with women who have histories of child abuse described that affect management skill development resulted in favorable recovery and improvement rates (Dorrepaal et al., 2014). Another review demonstrated that affect regulation intervention, done during stage one, for chronically traumatized women with PTSD showed a reduction in PTSD as well as improvement in affect regulation skills (Ford, Steinberg, & Zhang, 2011). A clinician survey on complex PTSD treatment overall recommended a

phase-based, multimodal approach initially focusing on affect regulation, psychoeducation, and stabilization strategies in stage one (Cloitre et al., 2011).

Regarding treatment modality, research in the area of complex trauma has shown that among the therapies available, group intervention is an effective mode of treatment in addressing the long term impact of negative childhood experiences, abuse, and neglect (Cloitre et al., 2002; Muller & Rosenkranz, 2009; Rosenkranz & Muller, 2011; Wolfsdorf & Zlotnick, 2001). Recent years have seen numerous published studies that describe intensive, group-based treatment programs for individuals with a history of childhood abuse. These programs include, but are not limited to, The Homewood Health Center Program for Traumatic Stress Recovery (Wright & Woo, 2000; Wright, Woo, Muller, Fernandes, & Kraftcheck, 20030, The Menninger Clinic Inpatient Program for Trauma-Related Disorders (Allen, Coyne, & Console, 2000), the Women's Safety in Recovery Group (Talbot et al., 1999), The Ross Institute (Ross & Haley, 2004), The Program for Traumatic Stress Recovery (Stalker, Palmer, Wright, & Gebotys, 2005), The Specialized Therapy Unit (Smith, Pearce, Pringle, & Caplan, 1995), The Sanctuary (Bloom, 2000), The Trauma and Dissociation Unit (Middleton & Higson, 2004), and OPAL (Chaikin & Prout, 2004). The data examined within these intensive programs indicate a significant reduction in depression, dissociation, and other trauma symptoms, psychological distress, and physical symptoms following treatment. It is important to note that although these quantitative studies provide important outcome data describing the efficacy of these programs, there is no accompanying qualitative analyses describing process or exploring important contextual experiences of the individuals undergoing treatment.

Successful treatment of childhood abuse survivors has been well documented in stage one group trauma treatments (Talbot et al., 1999; Wolfsdorf & Zlotnick, 2001). Group modalities that are intensive, held over a shorter period of time, with multiple treatment sessions per week, have been reported to be more effective than groups taking place over a longer period of time and less intensive (Lau & Kristensen, 2007). Additionally, in comparison to programs that solely use group sessions, when clients participate in individual sessions as well, greater effects of therapy are found (Ehring et al., 2014). Therapeutic group models enhance awareness and self-regulation, increase a sense of community belonging, and decrease feelings of shame and isolation (Yalom, 2005). Childhood abuse occurs within relationships, and so healing is thought to occur in the context of new adaptive, trusting relationships, especially therapeutic relationships (Zorzella, Muller, & Classen 2014).

Group climate is also a concept that has been widely studied in group psychotherapy. This concept refers to how group members experience aspects of the group environment, and how it impacts goal attainment for group members (Burlingame, MacKenzie, & Strauss, 2003; Johnson, Burlingame, Olsen, Davies, & Gleave, 2005; MacKenzie, 1983; Tschuschke & Greene, 2002). Considering the usefulness and practicality of group therapy for individuals with histories of trauma, it is important to understand the factors that occur within group trauma therapy that might impact an individual's subjective experiences during their time in the program.

The Women Recovering from Abuse Program (WRAP)

The Women Recovering from Abuse Program (WRAP), the focus of the current study, is itself an intensive 8-week, stage one treatment program for women with

histories of trauma. The current research is intended to help clinicians understand qualitative factors contributing to treatment response as described by individual participants in their SAIs.

WRAP is an intensive outpatient group therapy program for women with a history of childhood maltreatment that aims to address the mental health needs of these women. The program, which utilizes a safety-focused treatment approach based on Judith Herman's (1992) stage-one treatment model, was borne out of a collaboration between Women's College Hospital and the Clarke Institute of Psychiatry (now the Centre for Addiction and Mental Health). Women experiencing symptoms related to trauma, such as anxiety, guilt, shame, depression, dissociation, numbing, low self-esteem, relationship difficulties, isolation, or alienation, are well suited to benefit from a time-limited program.

Prospective participants undergo a multi-phase assessment process that begins with a phone screening to exclude participants in immediate crisis. Next, a face-to-face bio-psycho-social assessment follows to assess the client's ability for interpersonal engagement. To prepare for the intensive phase of WRAP, eligible participants are required to have undertaken group- or trauma-therapy relating to their abuse in the past and to complete the Building Resources Group (BRG). The BRG consists of eight 75-minute weekly outpatient groups that assess readiness and provide coping skills and sources for dealing with the impact of early childhood trauma.

Following the completion of the BRG, participants can enroll in WRAP. WRAP is an 8-week outpatient day program that runs for four half-days a week and offers two to three groups a day and weekly individual therapy. WRAP utilizes multiple modalities,

including interpersonal, psycho educational, cognitive-behavioural, psychodynamic, creative, and somatic therapies.

WRAP provides women with seven different therapy modalities all set out to complement each other for good therapeutic outcome. These are: 1) Community Forum; 2)Inside/Outside; 3) CBT Skills; 4) Own Your Power; 5) Trauma Education; 6) Art Therapy; and 7) Leisure group .

The first group is the *Community Forum*, which is structured as an open discussion to help participants develop interpersonal skills. To facilitate interpersonal learning, participants are encouraged to express their thoughts and feelings and reflect on present and past relationships while being mindful of the here-and-now and of prior relational patterns.

Inside/Outside: This group seeks to improve affective and relational skills by using body-oriented and psycho-educational approaches to increase bodily trust and awareness. Adapted from the work of Pat Ogden, Marsha Linehan, Peter Levine and Jon Kabat Zin, this group provides participants with information about internal somatic states to teach them how to self-regulate, self-soothe, and experience pleasure.

CBT Skills: This group uses cognitive behavioural therapy techniques adapted from *Mind Over Mood* by Greenberger and Padesky (1995) to teach participants how to identify and address negative cognition, destructive thinking, and cognitive distortions.

Own Your Power: This group aims to help participants recognize how they become disempowered through trauma, explore alternative ways of relating, and gain skills for self-empowerment by drawing on feminist and empowerment-based literature.

Trauma Education is a psycho educational group that helps participants explore and understand how childhood trauma affects their lives, to gain awareness of their reactions, and actions, in their relationships.

Art Therapy uses a psychodynamic expressive modality. This group encourages participants to implement their spontaneity and creativity to foster reflection and insight while tracking their treatment progress through visual representation.

Leisure Group adopts a relational and experiential treatment approach to support participants in activities of play in a safe and supportive environment while restoring participants' ability to negotiate, assert needs, and express feelings in relationships.

Following WRAP, participants have the opportunity to work one-on-one with a clinician for three 45-minute follow-up sessions to explore issues of termination, plan future goals, consolidate skills, and identify community resources for further support and continuity of treatment.

Importantly, all participants were asked to undergo a pre- and post-treatment interview using an interview protocol called The Self Assessment Interview (SAI) (Angus, L. & Kagan, F., 2013), conducted one-to-one with one of the study's research assistants. The interviews were conducted between the years 2006-2008 and each lasted approximately one to one and half hours. It is these interviews that are the focus of current qualitative study.

Identifying the Gaps

Significant gaps in the literature remain. Most of the studies examining the experiences of women survivors of child abuse have been done using only post-treatment data. For example, Stiegl et al. (2013) interviewed thirteen women after their

participation in an inclusive stabilization group approach. Saha et al. (2011) conducted a retrospective qualitative study of four women with a history of childhood maltreatment who completed a local sexual abuse intervention group. Walker-Williams et al. (2017) examined post traumatic growth among women survivors of child abuse who completed six strengths-based group sessions, however the authors did not conduct interviews pre-treatment. While exploring post-therapeutic perceptions of growth is important, comparisons to women's experiences, feelings, and thoughts prior to therapy would be beneficial to providing important information about these women's full growth experiences over time. The current study draws on pre- and post-therapy qualitative reports of women's anticipated and actual subjective experiences of themselves, how they experienced change, and how they experienced the therapy process.

In addition, it is important to examine mechanisms that promote change and growth among these women. Qualitative analyses of change mechanisms can provide rich, in-depth experiential data. Among studies examining the experiences of women survivors of childhood maltreatment over time, few have taken a qualitative approach. Valerio et al. (2009) analyzed the process of one long-term group from the beginning to the end of therapy. However, the authors based their analysis on questionnaire data, rather than more descriptive interview data from participants.

Of the few studies that have conducted in-depth qualitative interviews, only one has examined interview data before and after an intensive therapy program that combined traditional and complementary individual and group therapy approaches (Sigurdardottir et al., 2016). However, this research was conducted with women who took part in a wellness program rather than a stage one trauma therapy program aimed at reducing post-

traumatic symptoms. Participants in that study presented with more general depression, difficulty working, health problems, and suicidality, rather than directly addressed trauma specific content. Though many of these mood and self-regulation symptoms can be seen in people who experience trauma the aim of this therapy did not directly interact with traumatic content with a trauma focused modality. In the current study, all participants showed significant, acute, and interruptive post-traumatic symptomatology upon entry to the program.

Previous research has been conducted on the WRAP program itself (Classen, Muller, Field, Carrie, & Stern, 2017; Parker, Fourt, Langmuir, Dalton, & Classen 2007; Zorzella, Muller, & Classen 2014; Zorzella, Muller, Cribbie, Bambrah & Classen, 2020). However, most of these studies were either quantitative and or primarily outcome focused. The studies focused on how variables such as mood, PTS symptoms, and anxiety improved, or functioning improved after undergoing the treatment. Classen et.al, (2017) found clinically significant improvements in PTSD symptoms, dissociation, emotion regulation, interpersonal problems, sexual problems, alexithymia, and posttraumatic growth. Zorzella et. Al, (2014) examined the role of attachment styles as impacting participants therapeutic alliance and found that clients' experiences of in-treatment relationships varied as a function of attachment classification over the course of trauma group therapy. Zorzella et. al., (2020) examined the role that alexithymia played in the improvement of PTSD symptoms as improvements in alexithymia throughout therapy were found to be associated with positive outcomes. The only qualitative examination of this study done previously included only the post-therapy interviews in its data. This study used post-treatment interview data from seven women to examine

women's self assessment interview of their experiences in the WRAP program. Only seven participants were used due the SARS outbreak in health institutions that occurred during data collection, and was therefore unable to meet its goal of 10 participants during the timeframe of analysis (Parker et. al., 2007). It identified three primary themes, including "breaking trauma-based patterns", "doing therapy", and "understanding the healing journey as a continuous process" (Parker et al., 2007). The study did not use any of the pre-therapy interview data, nor did it compare data across both interviews. The study identified future goals of study could include assessing a sense of empowerment and interpersonal connection, and changes in trauma-based beliefs.

The Current Study

We know that a significant portion of the general population has experienced some occurrence of childhood abuse. Furthermore, data suggests that women experience and even higher rate of traumatic experience during childhood. Past research has emphasized the negative health impacts the childhood abuse can have on individuals throughout their lifespan. A large body of literature has therefore focussed on detailing the efficacy of various modalities of trauma therapy. Group trauma therapy with a focus in stabilization and regulation has been shown to significantly reduce trauma symptoms. However, gaps in the existing research remain. Literature has yet to focus on the qualitative analyses of therapeutic process factors for women who are undergoing group therapy for childhood trauma. We have yet to examine participants' self-report of their own lived experience across two sets of data points. Zorzella et al (2014) emphasized the importance of needing to examine clients' experiences in groups over the course of WRAP for future research focus. Additionally, Parker et. al., (2007) suggested that future

qualitative research could focus on assessing interpersonal connections and changes in participants' beliefs about their trauma and symptoms.

The Women Recovering from Abuse Program (WRAP), the focus of the current study, is an intensive 8-week stage one treatment program for women with histories of childhood trauma, that integrates individual sessions with group sessions. Considering the aforementioned gaps, it is the aim of the current study to explore the self-narratives of 13 women who completed this program using the SAI's from both pre- and post-treatment interview times.

The current study uses a qualitative approach to explore and describe individuals' subjective narratives of themselves and their experiences as reported in their SAIs before and after completing WRAP, a group program that has already demonstrated good outcomes in symptom reduction. Using thematic content analysis, this study aimed to identify factors that shed light on participants' self-narratives of themselves, their relationships, their trauma, and their symptoms, and how these self-narratives may have shifted or changed after treatment finished.

Research Objectives

1. The current study qualitatively explored themes that emerged in the pre-treatment SAIs: how clients experience and communicate self-narratives surrounding their trauma histories, relationships, self-concepts, hopes for treatment, and current symptoms.
2. The current study qualitatively explored the themes and processes, as experienced and described by clients in the post-treatment SAI. These included, but were not limited to, perceptions of what change they experienced, relationships experienced within the group and program, symptom resolution, negetive or positive processes that occurred during the

group, met or unmet expectations, discussions of goal attainment, and impressions of themselves in therapy.

METHOD

Sample and Sampling

The data from 13 participants used in the current study, were part of a larger investigation conducted by Classen, Muller, Field, Clark, and Stern (2017) looking at 167 women seeking treatment who went through the WRAP program. In this larger study, of the 167 participants, 143 completed the preparatory group (Building Resources Group [BRG]) prior to starting WRAP, and 51 completed the entire course of treatment (i.e., both BRG and WRAP). Previous studies show that these 51 clients experienced significant symptom reduction following treatment, along with the maintenance of treatment gains at follow-up (Zorzella et. Al. 2020). The inclusion criteria for the larger study specified that participants must be at least 18 years old, have a history of childhood trauma, and be considered appropriate for group-based treatment at the time of assessment. This was dependent upon their demonstrated ability to tolerate an intensive interpersonal process, as well as prior therapy experience related to trauma or abuse. Exclusion criteria included medical instability, clinical-level eating disorders, addiction, and suicidal ideation.

In the current study, participants were 13 women seeking treatment with a history of childhood abuse, who completed treatment at the Women Recovering from Abuse Program (WRAP) at Women's College Hospital in Toronto, Canada. These 13 women all participated in a pre-treatment and post-treatment interview called the Self Assessment Interview (SAI), which is the focus of the current study. Participants ranged in age from

31 to 71, with most participants between 31 and 40. All participants endorsed at least one act of both psychological abuse and neglect, 92% reported at least one act of major physical abuse, and 92% endorsed at least one act of sexual abuse.

In the current study, only these 13 clients' SAIs were used as they were the only ones who completed both pre- and post-therapy SAIs, and whose recordings were not corrupted or degraded. Though the entire sample of 51 clients did not complete a pre- and post-interview, the number of participants in the current student is considered high enough to support an exploratory examination of the SAI's. McCrackens (1988) estimated that eight participants can provide an adequate amount of information in qualitative, exploratory studies.

The mean age was 40.26 years (SD = 4.36). The median annual family income was between $20,000- $39,000. Eleven of the participants identified as heterosexual, one participant identified as bisexual, one individual indicated that none of the provided categories applied to their sexuality. Four participants reported having never been married, three participants indicated they were divorced, three indicated they were separated, two individuals indicated they were currently married or in a marriage like relationship, and one person stated they were widowed. One of the thirteen participants identified as Asian, 10.9% identified as Black, 27.3% identified as Filipino, eight identified as White, and four participants identified as Other. Concerning employment status, eight participants stated that they were not currently employed, four people indicated that they were employed on a full-time basis, and one person was employed part-time. Of those that reported being not currently employed, two individuals stated that they were permanently disabled, four individuals reported that they were on medical

leave, two individuals stated they were on a leave of absence, two were looking for work, and one was not currently looking for work as they were a homemaker. See Table 1 for full demographic information.

Data Collection Procedure

Data were collected at the Women's College Hospital in collaboration with the Trauma & Attachment Lab at York University, both located in Toronto, Canada. The pre-therapy SAI was administered prior to treatment (concurrent with Time 1 in the larger study). The post-therapy SAI was administered after the client completed the WRAP program. Participants were eligible to complete the interview approximately six months post-WRAP. The median time elapsed between completion of WRAP and the post-therapy interview was 10 months. The six-month time interval was chosen based on studies by Stalker and Fry (1999) and Bateman and Fonagy (1999) that reported significant improvement of both symptoms and psychosocial functioning after an average of six months post treatment. Regarding the current study, allowing six months after completing the full WRAP program provided time for participants to reflect on, and experience, changes attained from outside the context of the program. These interviews were previously conducted within the context of a larger investigation. The study received ethics approval from York University and Women's College Hospital.

Participants were administered a version of the Narrative Assessment Interview protocol specifically tailored for the WRAP study. Here, it was called the Self-Assessment Interview (SAI) both pre- and post-therapy (Figure 1) (Angus, L. & Kagan, F., 2013). The SAI is a brief semi-structured interview protocol that asks questions such

as: "*How would you describe yourself to someone who wants to get to know who you are? What are your strengths?"*

Questions on the SAI are intended to explore how clients see themselves pre- and post-treatment. The format of the protocol is intended to promote self-exploration without imposing the constraints of forced choices or checklists (Hardtke & Angus, 1998). The instrument does not focus on symptom reduction as an indicator of therapeutic success (Hardtke & Angus, 2004). Instead, it aims to capture how these "self-stories", as windows into their own perception of selves, change during the experience of psychotherapy (Hardtke & Angus, 2004).

All SAIs were audio recorded. Each participant was asked the same protocol of questions both pre- and post- interview. The pre-treatment and post-treatment questions were similar, and post-treatment questions reoriented the participant to the responses that they gave. The intention was to then have the participant reflect on whether their answers remain true post treatment. (Angus, L. & Kagan, F., 2013). See Figure 1 and Figure 2 for the full SAI protocol.

Data Analyses Procedures

Biases and Previous Research Interests

It is important when conducting thematic analyses, or any qualitative research to be aware of and explicit of the existing biases and previous interests the research teams may have. This can help in understanding the lenses in which we looked at the data, and therefore interpreted it. Many of the questions in the Interview Guide were informed by the trauma literature, which describes the major domains affected by trauma view of self, others, and the world; negative affect; problematic behaviours; connection to others; empowerment; and trust (Herman, 1992). We were also explicit in our interest in hearing about more experiential elements of their current stay with WRAP and how this was influenced by their participation in WRAP. The language used in the Interview Guide is part of the common language of WRAP and was familiar to participants. The primary researchers conducting the thematic analysis have a background in the study of Trauma and Attachment. Both are also practicing trauma clinicians, clinicians who assess trauma, and who work frequently with women and children with histories of childhood sexual, psychical, and emotional abuse. The research was conducted out of the Women's College Hospital a hospital known for its advocacy for women, women's medical rights, and women centered health care. The therapy provided by the team at this health center is conducted through a feminist and social justice focussed lens. These backgrounds, foci of clinical practice, and theoretical leanings were important considerations when bracketing the researchers' personal biases

Thematic Content Analysis

The current study utilizes a Thematic Content Analysis to qualitatively explore participants' responses on their pre- and post- therapy SAI. Interviews were recorded and transcribed verbatim and NVivo software was used to organize data coding and to assist with analysis. As described by Braun and Clarke (2006), Thematic Content Analysis requires researchers to suspend beliefs and biases, allowing the analysis to occur organically and inductively from the information obtained (Braun & Clarke, 2006). Inductive reasoning allows researchers to avoid 'forcing' (Glaser, 1992) the data into a pre-existing classification system. Instead, the coding framework is modified based on new information gleaned from the sample at hand, by adding or reorganizing codes or 'fine-tuning' their definitions (Glaser, 1992).

First, the initial transcripts were analyzed and reviewed by the author and an undergraduate research assistant. The author read and re-reading the interview transcripts to familiarize themselves with the data and to develop initial impressions. Using the constant comparative method, transcripts were reviewed as a whole to separate the data into 'meaning units' and then categorized or coded (Glaser & Strauss 1967, Rennie, Phillips, & Quartaro, 1988). Through a process known as open categorization, codes were then grouped into categories and each unit could be captured by more than one category (Braun & Clarke, 2006). Intuition and self-reflection are used while engaging in this method of analysis, while identifying units of meaning, grouping the units into larger categories, and examining the relationships between categories to synthesize information and establish themes. The analysis involved using NVivo 2 (QSR International Pty Ltd, 2003) to isolate units of meaning, or processes described by the interviewees. In the later

stages of analysis, categories were modified and refined as these codes and categories were constantly compared to the existing data. This iterative grouping process creates categories grouped together according to common themes to derive more abstract, higher-order categories that yield the highest-level broad themes.

The number of codes were large and often overlapped. Due to the need for interaction and collaboration between the author and their research assistant, but also to streamline the sorting of these codes, the author and research assistant used a digitally based pile-sorting technique, inspired by a previous qualitative study done (Parker et. al., 2007). Originally done manually with paper sorting, the current author decided to modify the paper-based technique and instead used a Microsoft Excel sheet to list all of the identified codes and then sort the identified codes into columns that represented the hypothesized overarching thematic umbrellas. Both parties would initially complete this process separately. Agreement on discrepancies between raters is discussed below.

The final stage of analysis involved integrating or synthesizing the categories into themes. The process involved using inductive methods to establish relationships between the categories and reveal the meaning of those categories to determine themes. Categories are compared and contrasted until a pattern becomes identifiable and the meaning of the pattern is revealed. The analysis required researchers to go beyond what is obvious and visible in order to identify the meaning in the data.

To obtain inter-rater reliability two individuals engaged in the thematic analysis process and several validity checks were conducted to ensure the appropriateness of the categories and theme labels established. Several procedures were used to ensure accuracy and trustworthiness of the information in this study. Triangulation involved reviewing

relevant literature in the field to provide support for the findings and themes. Debriefing occurred during bi-weekly meetings between the author, supervisor, and research assistant where sections of information were examined and analyzed and coding decisions were discussed. Discussions centered on emerging themes as the analysis progressed. All levels of codes and themes were compared, and any disagreements were discussed to achieve consensus. Second, a 'reverse coding' technique was used whereby the primary author provided the codes and asked the research assistant to match the code with the appropriate text segment. This process was completed separately for the pre-therapy SAI and post-therapy SAI. Last, the pre- and post-therapy SAI thematic umbrellas were compared together for each participant and explored patterns and themes of growth across the two interviews.

Results

Based on the experiences of 13 women, five main themes emerged in the Pre-Therapy SAI answering the first Research Objective: Exploring how clients experience and communicate self-narratives surrounding their trauma histories, relationships, self-concepts, hopes for treatment, and current symptoms. These themes, under the major thematic umbrella "Hope for Change" were: Improved Relationships, Improved Lifestyle, Improved Sense of Self, Reduction in Symptoms, and Improved Emotional Regulation.

Secondly, four major themes emerged while exploring the post-therapy SAI, answering the second research objective: To qualitatively explore the themes and processes, as experienced and described by clients in the post-treatment SAI. These included, but were not limited to, perceptions of what influenced change they

experienced, therapeutic alliance, relationships experienced within the group, symptom resolution, negative and positive processes that. These themes are: 1)Expressed Goal Achievement; 2)Subjective Expressed Reasons for Goal Achievement; 3)Unexpected Positive Experiences; and 4) Unexpected Difficult Experiences.

Pre-Therapy SAI: "Hope for Change"

Five main thematic umbrellas emerged in the Pre-therapy SAI. The major thematic umbrella that emerged was labelled 'Hope for Change.' This major umbrella is sectioned into two sub-umbrellas, Hope for Change in Outward Presentation and Hope for Change in Internal Self-Experience. External Hope for Change is comprised of two themes: Improved Relationships and Improved Lifestyle. Internal Hope for Change is comprised of three themes: Improved Sense of Self, Reduction in Symptoms, and Improved Emotional Regulation and Expressions. Each of these themes were then composed of sub-themes that are listed and described below. See Figure 3.

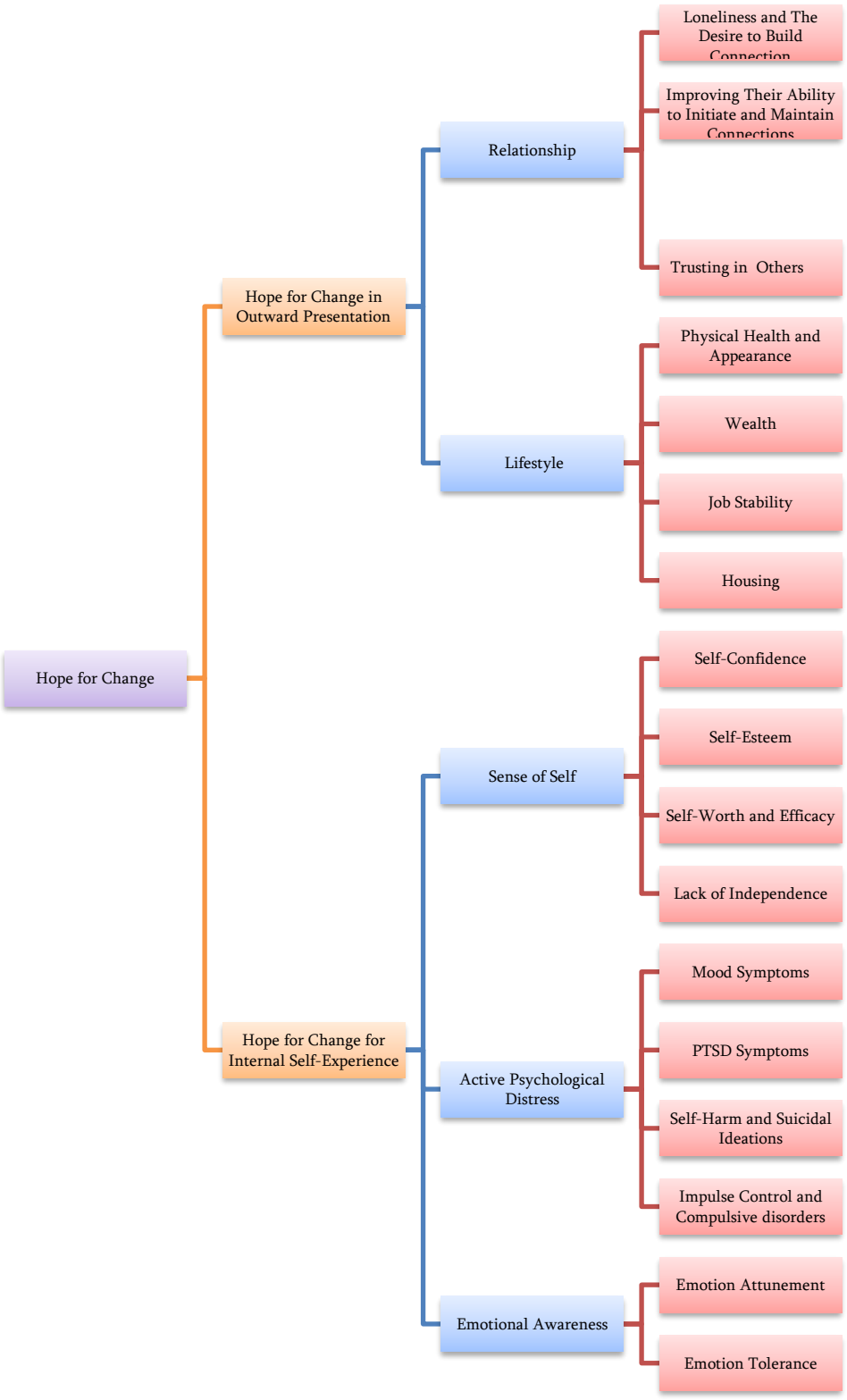

Figure 3: Pre-Therapy SAI Thematic Hierarchy

1. Hope for Change in Outward Self-Presentation

1.1 Relationships. Qualitatively, it appeared that the most frequently discussed theme in the pre-therap**y** SAI was the theme of Relationships and Interpersonal Connections. Most participants focused their discussions regarding hopes for change with topics related to: 1) Loneliness and the Desire for Connections, 2) Starting and Maintaining New Relationships, 3) Trusting in Others. Below the details of each sub-theme is discussed and direct quotations from the qualitative interviews are provided as examples of how the women spoke about these topics.

*1.1.1 Loneliness and the Desire for Connections***.** Many of the participants expressed a yearning for more people in their lives with whom they could experience emotional intimacy and closeness. Many of the participants had one person with whom they felt this closeness, often a romantic partner. However, they expressed a desire to feel this type of closeness with others in different relational contexts. Often this was voiced with the explanation that they enjoyed their close relationship with their romantic partner and wished to experience this type of closeness with different types of platonic relationships as well as to broaden their social support circles.

"*Building relationships. Building solid relationships where I could have – like the relationship I have with my girlfriend, I want to have that with other people… I just want to build relationships, like healthier relationships with people."-P31*

"*I really appreciate my own space- but there's a lot of times when I'm alone and I need something that I'm not getting. I'd love to take some of the walls down." – P144*

"*I can't really connect with the, these wonderful, these wonderful circles that I dreamed, like I almost like I imagined I would be in."-P98*

As is demonstrated by the above quotation, participants expressed a desire for expanding their relational circles beyond that of a romantic partner. The expressed hope for change appeared to focus on learning how to expand and build a circle of support and to be able to welcome more than one person into their lives.

*1.1.2 Starting and Maintaining New Relationships***.** Participants frequently voiced disappointment that they struggle to start and maintain new relationships. They stated these difficulties often led to fears initiating contact due to anxiousness in social contexts, and a lack of self-confidence. Additionally, regarding the maintaining of relationships, participants discussed challenges with increased emotional vulnerability, closeness, and knowing how quickly or slowly to open up to new people.

"*Terror like absolute terror of, like around everything, around school, around ugh going out on the street, around forming friendships."-P98*

"*I can't develop friendship very quickly. I'd like to get to know them faster. Get to know them – have that – I don't know if it's the trust, but not be so alert to try to find something about them that is not right. And to be able to build relationships. I don't have many friends and I choose that because I like to keep people at a distance." -P31*

"*I feel lonely and really want to meet people, but I'm not sure how to do it."-P88*

The above quotation examples described a similar sentiment to the previous point. However, they are classified slightly different in that they seem to express more of a desire to learn how to *initiate* contact or connection rather than the general sentiment of wanting to build circles of relational connection. Their thoughts seemed to especially focus on the difficulties they experienced with fears and anxieties related to meeting new people and initiating conversations. The expressed hope for change appeared to therefore be a desire to learn how to do so.

*1.1.3 Trust in Others***.** Participants spoke frequently of struggling with trusting others. This interfered with starting new relationships as well as with relationships that had already been initiated. They discussed how difficulty trusting people impeded their ability to read social situations, remain emotionally vulnerable, and interpret conversation and body language. They reported this lack of trust often led to a negative interpretation bias of (most likely) benign social signals leading to loneliness and a resultant desire or hope for closeness.

I have other issues, trust issues, I tend not to get very close to people, both men and women, I give very little away…but there is still that, I almost call it a wall. But it's not quite a wall because I'll talk to you, It's not like I won't. I'll ask you a question about you, so I don't have to talk about me." -P144

"*Yeah, ugh learn, be easier about trusting people. I don't trust. I tend to isolate myself and with isolation means that you're not getting any help. I don't have a solid foundation to know that I can for instance go to my friend and be accepted by her, right.*

Can I trust her with what I'm telling her? Is she going to hurt me? And because of that, I'm isolated."-P25

"*I read people before I've even known them. And that's kind of scary for me because if I read them the wrong way it may not turn out the way that I'd like it."-P31*

The thoughts expressed by participants in this sub-category identify an acute challenge with trust and how that difficulty has specifically interfered with their abilities to form connections and maintain intimate connections. The expressed hope for change seemed to focus on learning to trust, to facilitate the improvement of their relationships.

Like the desire for improvement in relationships and connections, in the next theme, participants express a desire for an improvement in how they relate to themselves. These sentiments expressed hope for change in self- confidence, physical appearance, social economic status, and living situations.

1.2 Improved Lifestyle. All participants at some point in their SAI discussed hopes for practical improvement in their physical health and appearance, wealth, job stability and housing.

1.2.1 *Confidence related to physical health and appearance***.** Several Participants cited goals of improved physical fitness, health, and appearance as part of their desired growth during their time in WRAP.

"*[I want to] Get more into shape. I'm trying to eat healthy, build my confidence."*

"... feel beautiful about [myself]. And not feel like I'm ugly. Be able to do things for myself."-P16

"*I have a distorted self-image. My brother loves me but he, you know he thinks, he thinks of that I'm, well his fat sister. I still get the fat sister vibe."-P28*

As seen above, many participants expressed a desire to feel better physically, including having more confidence about their self-image and personal appearance. There were several moments where individuals were other-focussed, in that they would think about how the outside world perceived them and how their own challenges with self-image impacted those predictions. The expressed hope for change seemed to center around increased confidence and self-esteem in their outward appearance.

1.2.2 *Security related to work and finances.* Many clients expressed the desire to use their anticipated new-found knowledge and tools to increase financial and work security.

"*I'd like to have ugh, the money, I'd like to have money and ugh a good income.*

I'd like to be able to help my family, economically and in every other way."-P10

"*I-I think I would change the route I decided to go, you know instead of getting married, going to school instead."-P16*

"*I am working towards working again."P-31*

"*I would be maybe monetarily giving a bit more."-P70*

Many of the participants expressed an explicit wish to be able to improve their financial and employment stability. The conversation seemed equally focussed on money made as well as better employment status. The expressed hope for change appeared to be therefore achieving higher financial stability and better employment.

1.2.3 *Housing.* Last, many of the participants discussed a dissatisfaction and desire for change in their living and housing situations.

"*[I'd like to] get an apartment, get back my own space again…"P10*

"*I would like to change the actual area that I [live in]. I've given a lot of thought about moving back home ugh where I have, I have some options about actually making a fairly large move after, after I get everything finished with as far as my therapy and what have you."-P153*

Many of the participants expressed an explicit wish to be able to improve their living situations. The conversation seemed equally focussed on the area as well as housing. The expressed hope for change appeared to be therefore achieving an improved living arrangement.

2. Hope for Change in Internal Self-Experience

2.1 Sense of Self. Qualitatively it was observed that the next most visited theme was that of the participant's sense of self. Discussion about how they struggle with various feelings and perceptions of who they are and what they were like were frequently visited. Sub themes of these discussions included: 1) self-confidence, 2) self-esteem, 3) worthlessness and helplessness, and, 4) lack of independence. Below, the details of each sub-theme is discussed and direct quotations from the qualitative interviews are provided as examples of how the women spoke about these topics.

"*I'd stop second guessing myself, stop mind reading, stop putting myself down. It's not just the way I look at myself and feel about myself, I'd like to change that."-P122*

*2.1.1 Self Confidence***.** All participants spoke at some point about wishing they could improve their confidence in many domains. This included confidence in themselves, in their role in relationships, at work, and being able to manage their history of abuse and subsequent symptoms.

"*I have been told I have no self-confidence and am very insecure."-P68*

"*I'm…not confident. I may seem strong but I'm not."-P95*

"*Definitely [want to change] my self- confidence. The most important –that's the reason why I want to take this..."-P122*

Many of participants spoke of their lack of self-confidence. For some, as stated in the last quote above, it seemed an integral and central reason for seeking therapy. The lack of confidence seemed to span from body image to relationships, to self-concepts related to their abuse. The expressed hope for change seemed to center around gaining confidence back in various life domains.

*2.1.2 Self-Esteem***.** A second major aspect of "sense of self" that emerged was the participants' desire to feel more secure and have better self-esteem.

On many occasions, participants alluded to their lack of self-esteem and how it impairs their mood, their ability to function, and their relationship to themselves

"*[I have] low self-esteem, I can't handle criticism, I don't like to be pushed to do something when I'm not ready… I don't have talents."-P144*

"[I want to] Be in a good place emotionally for my children. They can sense like, you know, they sense I have low self-esteem. I would like not to feel so many wounds around me all the time, that are still open. I would like to be able to stitch them up and heal them. And feel beautiful about them. And not feel like I'm ugly. I want to better myself, to make myself feel better, to give myself self-esteem."-P16

"*I mean, a lot of it has to do with - you know just you know part of me wanting to do the WRAP is just sort of building up self-esteem…"-P68*

As noted in the quotes above it appears that the concept of self-esteem is another aspect of self that the participants often identified as lacking or missing as they reflected on their internal worlds. It seemed that it both impacted their relationship with themselves, and as pointed out in the second quote above, has even impacted their relationships with others. The expressed hope for change centers around them being able to develop this positive self-esteem.

*2.1.3 Self -Worth and Self-efficacy***.** Another major issue that arose under the theme of Self-Concept were the sub-themes of Self-worth and self-efficacy. This was considered distinct from the sub-theme of self-esteem as it emerged frequently enough during the SAI, and the women often talked about self-esteem, and feeling worthy or helpless, as separate issues.

"*I feel so unhappy with myself-I never felt that I was worthy."-P88*

"*I ruminate a lot. I think about how worthless I am, I think about the past and I get too overwhelmed. I don't go outside, I stay alone."-P122*

"*I want to be more in control of me, whereas I'm not in control of myself now. Maybe one day being able to feel strong enough that I am able to protect my own self."-P70*

"*I feel like… there's something missing. I just want to know why I, why, felt I wasn't worthy to be with a guy? Well, I understand that we're going to be working on ugh, ugh,*

learning techniques to ugh, to deal with the world…learn techniques to ugh not be used and not be a victim, learn how to take control of my life."-P95

As one can observe from the statements made above, the participants focussed on their ideas of their own self-worth frequently enough and separately enough from the idea of self-esteem that they presented as two separate ideas for the women. Again, it seems that the participants felt a lack of worth that felt separate enough from the concept of self-esteem that it was discussed separately and distinctly several times. The expressed hope appears to be an enhancement of worth such that they feel capable and able to be effective agents of their own lives.

2.2 Hope for Change in Active Experiences of Psychological Distress. The second most frequent domain of discussion in the pre-therapy SAI was focused on the current psychological symptoms that the participants were experiencing. Clients talked significantly about wishing for change related to: 1) Mood Symptoms, 2) Post-Traumatic Symptoms, 3) Self-Harm and Suicidal Ideations, 4) Impulse Control and Compulsive Disorders. The details of each sub-theme are discussed and direct quotations from the qualitative interviews are provided as examples of how the women spoke about these topics.

2.2.1 Mood Symptoms. In their pre-therapy SAI participants spoke frequently about their mood symptoms and desire for change in these domains. Mood symptoms frequently discussed included symptoms of depression, anxiety, feeling emotionally overwhelmed and unpredictable mood changes.

"*I've had depression before in my life, but this is a really bad one, so I found out through, I go to psychotherapy and the psychiatrist two days a week and we've changed my medication a lot over time because it just wasn't doing anything."-P28*

"*I'd like to address my depression"-P16*

"*I guess in my late twenties I was getting really overwhelmed by pretty simple things. That really bothers me. Emotionally you just feel completely overwhelmed and the hands go up, and you're like to hell with everything. I'm like – [laughter], I don't want to be that way."-P70*

"*I don't really know if I've had panic attacks because I'm not really sure what a panic attack is. But I do know that I've had different situations where – your breathing is affected and you're just like –You're anxious. You're just – I mean I get anxious quite a bit, and just basically being able to – there's somewhere in my head and I'm not even sure if this is how it works but I kind of feel like if I get, I don't really want to say this, but if I get sort of ripped down and don't back up."-P144*

When discussing what psychological challenges they are managing, many of the participants identified feelings of low mood, anxiety, helplessness, hopelessness, and

inefficacy. The hope for change appeared to center around reducing these negative symptoms and improving mood.

2.2.1 Post-Traumatic Symptoms. In their pre-therapy SAI, participants frequently spoke about hoping to see a reduction in post-traumatic symptoms. These included experiences of flashbacks, nightmares, "triggers', dissociation, repressed memories and intrusive memories. They spoke about how these symptoms were particularly disruptive to their relationships, completion of daily activities, and quality of life.

"*I was driving home and…. I pictured my father coming and picking me up out of my bed and bringing me to his bed."-P98*

"*I need new coping methods for triggers, because there are triggers all around me."-P28*

"*I'm still dealing with it, still recalling parts of the past…Its awful to have this block of 12 years you can't remember."-P10*

"*Since I hit 30, I'm just having all these flashbacks and nightmares, and it's all just sort of coming back."-P16*

Most of the participants identified various Post-traumatic symptoms such as flashbacks, intrusive thoughts, dissociation, nightmares, "triggers", and loss of memory. These significant traumatic sequalae were described in a way where they appeared to be significantly impairing these women's day-to-day function. The hope for change centered

around reduction of frequency and severity in any and all of these difficult to manage symptoms.

2.2.3 Self-harm and Suicidal Ideation. Many of the participants expressed difficulties with continued thoughts of self-harm and suicidal ideation. These challenges included continued and frequent self-mutilation, as well as a history of suicidality and repeated suicide attempts.

"*I am a cutter, you know, so I'd obviously like to address the self-mutilation issues."-P153*

"*There was no sun there was just this and, I didn't care if I lived or died and I seriously contemplated suicide."-P122*

Several of the participants named concerns with symptoms related to self-harm. There was also description of the distracting and difficult nature of having to cope with these particular psychological experiences and the interference they caused in the participants' life and relationships. The hope for change in this domain seemed to center on reducing the frequency and severity of self-harm and suicidal ideation.

2.2.4 Addiction and Impulse Control. Finally, several of the participants spoke about wanting to experience a decrease in their impulse to resort to addictive behaviours such as drug use, alcohol use, eating, gambling, and spending.

"*I'd really like to change the amount that I struggle, like with my addictions right now…I would really like to change the intensity of my cravings. Lessen the frequency of them, the intensity of them."-P68*

"*My best friend would definitely describe me as a very heavy drinker."*

"…most importantly, to help me get to know myself-about re-educating and educating myself on addiction and…give me some good coping mechanisms…I lack the ugh, a lot of coping skills so that's what I think I need the most."-P31

"*I just got out of Toronto General Hospital for an eating disorder, I was diagnosed with an eating disorder not otherwise specified as a result of trauma. And so, I don't know if it's because I wasn't diagnosed with the classic eating disorder, however at the end of the day I had and still struggle with eating."-P122*

As one can observe from the above quotations, many of the participants had both current and historical experiences with addictions and eating disorders. These were in the domains of eating, drinking drug use, spending, and gambling. The participants described these challenges as often life altering. The expressed hope for changed seemed to center around reducing the frequency and severity of the symptoms related to these disorders, as well as increased coping and regulation skills to manage impulse and cravings.

2.3 Hope for change in Emotion Regulation. The next major theme that emerged as the participants discussed their self-narrative, was conversation around emotions, ability to attune to their emotions, regulate emotions and communicate important

emotions. As well they described wanting to be able to integrate their emotional experiences too, so they felt more in control and in power of their emotions, rather than threatened by them. Below, the details of each sub-theme are discussed and direct quotes from the qualitative interviews are provided as examples of how women spoke.

"*I have my emotional weaknesses, you know…moody." -P98*

2.3.1 Emotion attunement acceptance and tolerance. Many of the participants identified a desire to be more aware of, and comfortable with, their emotions, both positive and negative. Participants especially highlighted a lack of comfort with negative or strong emotions.

"*Coping with my dad…maybe being allowed to be angry about it. Being real, being true to my feelings."-P70*

"*I [want] to be like- not so scared of … being lonely."-P95*

"*I'll come to some understanding of and maybe I'll learn about ugh, how to, ugh there's this whole sorrow underneath the surface."-P68*

As noted in the quotations above, many of the participants expressed experiences with strong emotions, especially strong negative emotions. The named concepts such as being "scared of being lonely," being "allowed to be angry", and understanding their own sorrow. This speaks to a desire to attune to and tolerate the emotions that they experience, regardless of the intensity or perceived

negativity. The hope for change expressed seems to center around wanting to be able to better attune to and tolerate these strong emotions.

2.3.2 Emotional communication. Many of the participants also spoke about feeling as though they struggled to communicate emotions. In particular, there was a wish to be better at expressing emotions related to their trauma, relationships, and past wounds

"*Therapy is going to offer me a safe place for me to express the things that I'm afraid to express."-P16*

"*I don't really express my feelings too much."-P10*

In addition to expressing a desire to better attune to and tolerate emotions, the participants also spoke of challenges in talking about, expressing, and communicating emotions. This challenge appeared to apply to both positive and negative feelings. The expressed hope for change seemed to center around becoming for comfortable and practiced at expression feelings to others.

Post-Therapy SAI: Lived Experience of Hoped for Change

Five main themes emerged in the Post-therapy SAI. The highest level thematic umbrella that emerged was labelled 'Lived Experience of Hoped for Change.' This umbrella is sectioned into two sub-umbrellas; 'Change and What was Expected and 'Change and What was Unexpected.' 'Change and What was Expected'is comprised of two themes: Expressed Goal Achievement and Subjective Expressed Reasons for Goal

Achievement. ‘Change and What was Unexpected’ is also comprised of two themes: Unexpected Positive Experiences and Unexpected Difficult Experiences. Each of these themes were then composed of sub-themes that are listed and described below. See figure 4.

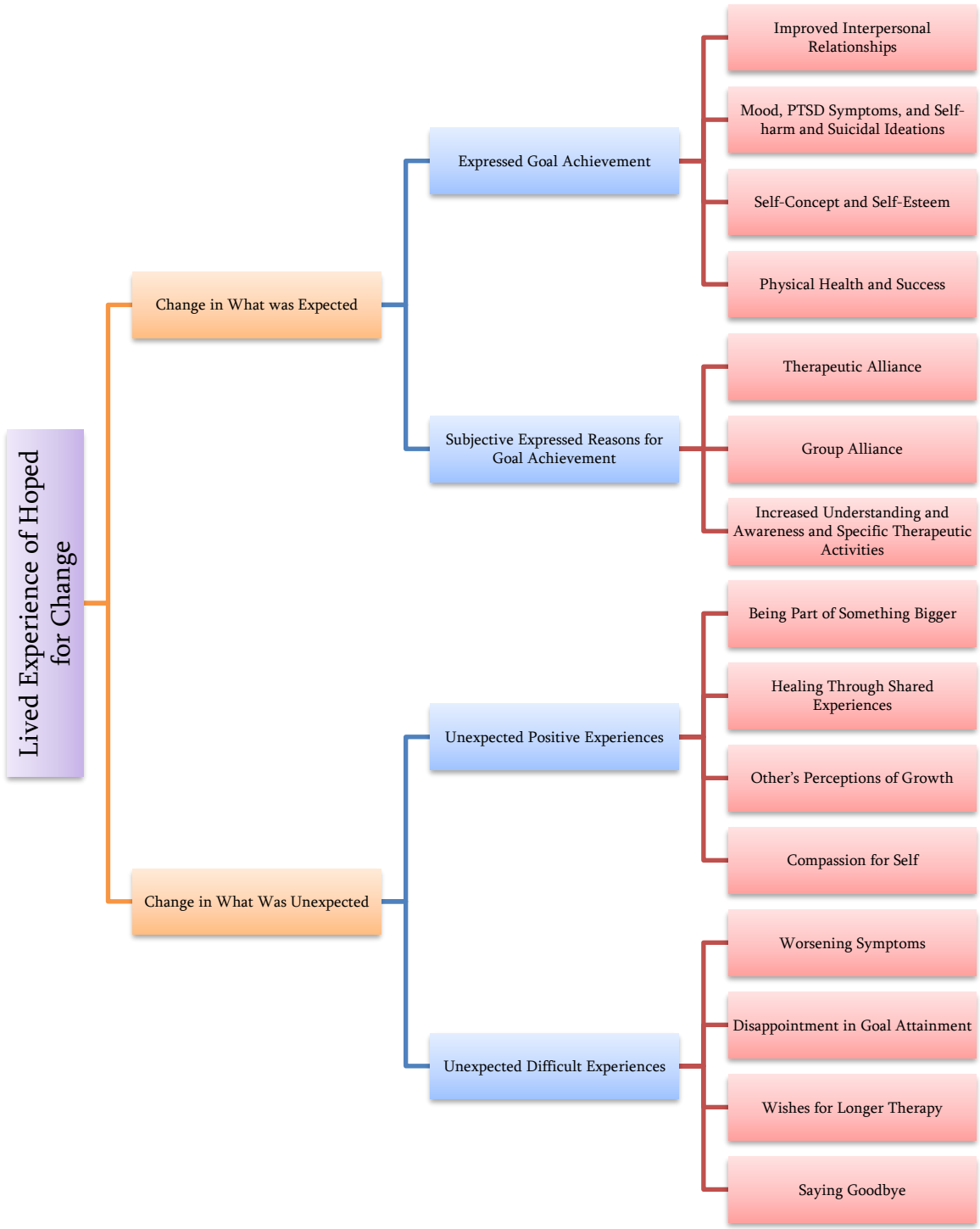

Figure 2: Post Therapy SAI Thematic Hierarchy

1. Change in What Was Expected

1.1 Expressed Goal Achievement

In this thematic umbrella we discuss the sub themes of goal attainment, positive shifts, and noted self-improvement that were hoped for or anticipated by participants. All participants were asked to reflect on answers they gave in the pre-therapy interviews regarding the goals that they had stated, and whether they felt that they had experienced a shift or change in the areas they identified. Overall, many participants reported that they experienced positives shifts related to the sub-themes of: 1) Improved Interpersonal Relationships; 2) Mood, Post-Traumatic Symptoms, and Self-harm and Suicidal Ideations; 3) Self-Concept; 4) Physical Health and Success; and 5) Self-Compassion. Below the details of each sub-theme are discussed and direct quotations from the qualitative interviews are provided as examples of how the women spoke about these topics.

1.1.1 *Improved Interpersonal Relationships***.** During the pre-therapy interviews most participants expressed a desire to see improvements that fell under the theme of interpersonal relationships and experiences. Interestingly, during the post interview, most participants expressed some level of improvement related to this sub-theme. In fact, this was the improvement most commonly reported when asked to reflect on where they see positive shifts.

"Big difference. I find that there is a big difference…Building relationships, definitely. I've built relationships with some of the women in the program, and we've

stayed connected, and we've talked. We call each other, we've seen each other and that for me is a total change."-P31

"I'm more friendlier with people. I find that building connections again – maybe my husband laughs at me, people call me and I actually talk to them."-P122

"Since I've left WRAP, I have been in touch with three of the women, that's a difference, that's a change."-P98

"It was good. It was really good. One of the people that annoyed me the most and I didn't understand the most, I mean I did understand her in some ways but in other ways she made me really uncomfortable and I remember thinking to myself, "alright, you know, after being in group with her and yeah, I get a lot of what she said but we could never be friends. We could never be friends outside here." And in the end, she was the first one that I spent most of my breaks with. She's the person I talk to the most and I think I ended up being the person she cared about the most in the group. And I really believe that we're gonna be friends once she's done."-P25

As you can see in the quotes above, numerous participants described positive growth in the time during treatment. They describe making friends with other clients, some connections were even unexpected and surprising to the participants. Participants also described feeling improvements in their connections people in their external social world. They describe increased openness and friendliness to others. They also describe positive changes in their ability to continue to stay connected with these new friends. The

increased connection and new relationships seem to have been interpreted as positive change directly related to their expressed hope for change in personal relationships.

1.1.2 *Mood and Post Traumatic Symptoms and Self-harm and Suicidal Ideation.* During pre-interviews participants frequently endorsed goals related to improving symptoms such as low mood, anxiety, post traumatic symptoms, and decreasing self harm behaviours and suicidality. During the post-therapy interviews, participants frequently noted that they experienced noticeable improvement related to this sub-theme.

"My goal was, you know, to not use and to finish the program and I think this was first goal that I've reached successfully in my life [starts to cry]."-P153

"My (Seroquel) decreased because of the program. I'm going to say it's because the program. Because I was just better, not so manic, and twitchy and all this other stuff."-P144

'I think (the reduction in medication) was because of my (learning to cope with) flashbacks. Because the way I coped with my flashbacks was more of a- I'm recovering from alcohol, so I also have an addiction problem. So, I think- I'm not sure but, it was just something probably registered in that area of my brain where I didn't really need to, you know. I had a tool that I could use."-P122

"I still have a problem without using, like being around people and, but it's getting easier for me. Like I'm not feeling the need to use."-P16

"Like I do have my depressed moments, but it's not as bad as it was. But there are days where it is bad, but I'm able to get through it. I'm able to manage more."-P98

"It's, my, well, for example, when I wake up in the morning, ugh, I'm not in state of anxiety. I don't feel fear for the day or for my life and I ugh, I feel kind of normal in the morning when I wake."-P31

As you can see in the quotes above, numerous participants described positive improvement in their PTS and mood symptoms. They described feeling less anxiety, less fear, reduced low mood, less flash backs, improved concentration, lowered hypervigilance, and less frequent mood lability. Additionally, they seem to describe feeling more capable and able to cope with the everyday challenges that they are faced with. The changes in their symptoms interpreted as positive change directly related to their expressed hope for change in PTS and mood symptoms.

1.1.3 *Self-Concept and Self-Esteem***.** During pre-therapy interviews many participants expressed a desire to feel better about themselves, improve their self-esteem and shift their self-concept to include more positive self-perception. Throughout the post-therapy interviews, participants noted shifts in this thematic area, and spoke about shifts in how they viewed themselves and the quality of their self-esteem.

"I feel more accepted. I feel more dignified. I feel ugh, hhmmm, maybe more control now."-P16

"Yeah, I think (they were positive shifts). In that department, I still can't fit into certain clothes, but that's not so important to me."-P144

"It's just a wave of feeling about myself. Maybe it's more self-respect, maybe it's the beginnings of it because I think it's something I've lacked all my life."-P122

"I have, even though there's still those things in myself, I also see potential, I still have this hopelessness but I'm hopeful too."-P25

"And I think that, that this program has indeed helped me change my self esteem, ugh self care and my path that I'm taking and it's integrated a, about a self esteem for me that I really can't place right now."-P28

The above quotations outline an increase of concepts such as "self-respect," "self-esteem," "dignity," and "acceptance." The participants also seem to convey a feeling of hopefulness for increased growth and development for continued improvement, using words such as "potential" and "hopeful." The increased in self-esteem and self-acceptance appear to have been interpreted as positive change directly related to their expressed hope for change in self-concept.

1.1.4 *Physical Health and Material Success***.** As noted in the pre-interviews, many of the participants expressed goals related to the theme of more security related to physical health and material success such as work success, housing, income, education, and financial security. During the post-therapy interviews participants reported improvements in this thematic umbrella. These improvements included efforts to enroll in more education programs, acquiring housing security, and seeing increased income and job performance.

"I've made slight improvements. Uh my income's improving and I've just taken some steps to try and learn a new way of making an extra income."-P98

"Uh well first off, I'm in my own apartment and have been- I see it as a sense of independence. I have a stronger support system in place.-Yeah, you can say, as well as the shelter, the housing department at the shelter."-P144

"I've got stronger support system in place still. I'm aiming for more and my next step actually is to ugh, to attend Seneca. I think the enrolment is July, I think the 16th or 23rd." -P25

"Yes, I do, although I wanna continue to seek further forms of education. Opportunities that have come my way, I guess.- (that's) How things have shifted. I see that as it's going to open some doors, though I don't what the doors are."-P95

Many of the participants outline various ways their financial and housing situations have improved. They listed changes included increased income, returning to school, living independently, and better support systems. The participants largely view their financial and housing situations as more positive, independent. Further, many state predictions for increased improvement in the future. The increased financial and living situations seem to have been interpreted as positive change directly related to their expressed hope for change in their financial and housing stability.

1.1.5 *Compassion For Self***.** While participants discussed shifts that were perceived within themselves as treatment progressed, many reported that they became aware of a lack of self-compassion as they engaged in treatment. Furthermore, these

participants noted that by the end of treatment their ability to be kind and compassionate with themselves had positively shifted and they were noticing a softening in their own self- judgment.

"Yes. By helping me see how I am hard on myself."-P28

"I have to save my family now and myself, you know. -I think I'm think I was putting myself down. very bright. -I think that was extreme -I've got more compassion for myself. I'm accepting myself m-more."-P16

"I'm, ugh less hard on myself. I'm still hard on myself. I still demand a lot of myself but I'm less hard."-P25

"So many changes but I'm thinking one that really stands out in my mind is a group member saying get off the cross (), and for me that was really symbolic. I'm very much a Catholic, and I'm not God, I'm not perfect, and give myself that break. I don't have to suffer like God did. I'm not God – just get off that cross. That to me was very significant. That to me was very significant. And that really helped me to kind of open-up in the beginning."-P31

"I get down on myself a lot and I feel like, I don't so much feel like I should be ahead of the game a lot more. But I need to be kind to myself and realize that these changes are incredibly large. And not to minimize them, and (that's) my old brain pattern's way of thinking, trying to destroy and sabotage things for myself and-so WRAP has given me some hope that, you know, there's room for change here."-P144

The participants often reported that with the increase in self-awareness, and understanding of their trauma and trauma symptoms, a corresponding self-compassion also increased. They described feeling a softer sense of kindness for themselves and the difficulties they have had due to their traumas. They also seem to be better able to be aware of when they are being self-critical or judgmental as this self-compassion increases.

1.2 Subjective Experienced Reason for Goal Achievement

After discussing the shifts and improvements in the thematic umbrella of Goal Attainment, many participants reflected on what they felt contributed to their experienced goal achievement. This next thematic umbrella encompasses the reasons to which participants attribute their improvements and goal attainment. During these discussions, individuals most commonly named perceived improvements as being related to A) Therapeutic Alliance, B) Group Alliance, C) Increased Understanding and Awareness, and D) Specific Therapeutic Activities. Below, the details of each sub-theme are discussed and direct quotes are provided.

1.2.1 *Therapeutic Alliance.* Participants reflected on positive shifts, goal attainment, and positive experiences in therapy. During these qualitative reflections, all participants noted that their alliance with both their group facilitators and their assigned individual therapists were significantly positive, and decidedly impactful. All participants agreed that at least a portion of their positive experiences and growth was attributable to the sub theme of positive alliance with their therapist.

"Because they, the facilitators it was a constant- it was taken care; they were taking care of me…Yeah, and I like that feeling. I've never experienced that before."-P98

"My one-on-one therapist [therapist's name], she was amazing and made me realize that taking care of me and holding me, and what would it be like to hold me? To think about actually myself. to kind of put my needs before. Like if I'm feeling a certain way I should express it and just be able to take care of me."-P122

"I think she's a marvellous counsellor and you know, she, it's almost like she's, she's been in a sense, mothering me. And this (helped). I think she's younger than me too but ugh she ugh, she's worked with me for a year and she's taught me, she's taught me things that a mother should've taught me."-P144

"*She, [name of therapist], the way she- she listened. You know, there wasn't necessarily anything that was said. Or you know- but then she would say something to reinforce what I'm thinking. like kind of putting it into more words…"-P31*

"She has strong feelings that I played a role in the group. And she made me feel really important, special. She did…It was genuine too, I don't know."-P70

"...but also ugh, these trained facilitators who were able ugh to keep on an even keel, really. I felt I was in a safe place to express what I felt about something that was said."-P88

Interestingly, many of the participants described a unique connection experience with their therapists and the trained facilitators. The described feeling understood, regulated, reinforcing, listed to, and cared for. Even more interesting the participants used words like “nurturing”, “holding”, “mothering” and “taken care of.” These concepts convey an air of maternal or parental transference that the client felt was positive, supportive, gentle, and helpful. The participants spoke of these alliances with their facilitators as corrective and therapeutic.

1.2.2 Group Alliance. In addition to the above noted impact of therapeutic alliance with the group facilitators and individual therapists, all participants spoke about their connection and relationship to the group. This sub-theme captures the explicit positive and close relationships that participants felt they developed within the group, as well as the significant impact they felt the group had on the previously noted thematic umbrella of goal attainment.

“I found a group that, ugh, that I didn’t feel, that I didn’t feel like an ugly duckling with, that I could, I could relate to on a lot of different levels.”-P88

“Oh yeah definitely. There was a lot of imprinting and bonding with other members, and awareness and recognitions that were brought on with other members that I think will always, always be there for me. And they were very important.” -P122

"And I felt, this is the place to do- I feel safe, feels like I'm in good hands, nurturing hands."-P31

"Oh yeah. I felt like I was a little bit more together when I was here. It just felt like a family. I guess, you know, I think because as always my biggest problem is family. So, I'm constantly seeking out family." -P95

"Because, uh in the space of the group, (it was) a safe place with women who shared experiences, the same experiences."-P70

Like the above parent-like connections that the participants described feeling with their therapists, the participants also conveyed feeling strong intimate connections with their fellow group members. They also used words like "safe," "family," "imprinting," "bonding," "nurturing," and "important." The participants clearly felt a significant and important connections with members of their groups and expressed sentiments that they felt a deep and trusting bond with the other women. The also appeared to express an attunement and understanding of the other participants that felt strongly reciprocated.

1.2.3 Understanding and Awareness. As clients discussed their experiences of shifts, positive improvements and goal attainment, a sub-theme of Increased Understanding and Awareness emerged. Many of the participants noted that they felt they are more aware of and better understand their trauma and the impact their trauma was having on various life domains. Many participants reported that this general improvement in understanding and increased awareness of trauma and how it impacts them contributed

significantly to why they felt they experienced improvements in symptoms, life function, and their ability to use the tools that they were being taught.

"I still fall back, I still go to crisis, but I'm more aware of what they mean now."-P10

"Well, a lot of it had to do with the program that I was in. WRAP was such an eye-opener for me. It's opened-up a lot for me since, and how I was, how I behaved, how trauma impacted me – it's just more clear to me how I've been. Whereas before, like I said, I was totally in the dark. I didn't know why I was getting flashbacks, I didn't know why I was like dreaming things. So, it was definitely an eye-opener for me and it helped me a lot."-P16

"I understand why I was food restricting before, I never realized that it was because I've, it was the only thing that I could control."-P122

"Well until I ugh started examining ugh my ugh reactions on a daily basis and ugh how I felt, without, with the help of new outlook, meaning that I have a- Post Traumatic Stress disorder. Before that, I-I was interested ugh, I was interested in Freudian and (Reichian) and ugh therapy and I and transactional analysis and all those different things but they never gave me a real understanding of what was wrong with me and this, this uh diagnosis is the most useful."-P98

"There's been a shift, yeah, there's absolutely been a shift. I think, I think mainly it's just the program in whole made me realize that my way of thinking was not so much

distorted but it was a pattern, it was a brain pattern…I was needing to, I was needing to understand that there are other resolutions, there are other options."-P88

"*I'm, I was made aware of things I do ugh, ways I cope that maybe aren't so good and it was ugh sometimes a revelation for me. I was able to ugh start standing up for myself in the gr- and this was a big one." -P25*

Many of the participants conveyed a new sense of clarity and understanding of their trauma post-treatment. They also stated feeling more awareness about and understanding of their mood and PTS symptoms. Some participants indicated that this awareness and clarity helped them gain a greater understanding of maladaptive patterns that they had been engaging in. Furthermore, this clarity has then allowed them to make positive shifts in their behavioral and cognitive patterns.

1.2.4 Therapeutic Activities. Last, clients related their experiences of positive improvements in the thematic umbrella of Goal Attainment to the therapeutic activities that they participated in during the therapy program. These included specific tools such as grounding, self-soothing, and self-regulation activities, as well as the group program, and individual therapy in general.

"I've empowered myself with these courses and these classes. And knowledge is another strength."-P68

"*(Grounding) is a very important tool that I've never had before. Because I would just go with my emotions, and (cry). I don't really remember, I do know that I've had*

moments of crisis, but this particular grounding tool just did it for me. It made all the difference."

"*Because I feel that the program, getting back to changing the way of my thinking with respect to the cognitive therapy, I felt that that has been the most help for me and I've been practicing that at, at the house."-P31*

"I learned in WRAP, I put the elastic band around my wrist and that was a lot better for me instead of randomly cutting myself."-P122

I think it was facilitators talking about trauma and just different communication styles. I'm more aware of it now. Facilitators have helped me and also group members. Because they've been able to give me feedback and it's like wow, I guess I'm not the only one. And that kind of helped – not kind of, it did help."-P95

The participants were able to name specific therapeutic tool and activities they found particularly helpful during the course of treatment. Tools for emotion regulation, self-harm reduction, cognitive-behavioral skills, communication skills, and other psycho-education were named as especially important. The participants explicitly stated that they felt these tools directly helped them improve and they continue to practice a lot of these skills even after finishing treatment.

2. Change in Ways That Were Unexpected

2.1 Unexpected Positive Experiences

During discussion about shifts, changes, positive experiences, the thematic umbrella of Unexpected Positive and Experiences emerged. This thematic umbrella encompassed positive improvements or changes that the participants experienced but did not initially expect or name when considering program goals and completion targets. Related to this thematic umbrella, individuals most commonly noted sub-themes of 1) Healing Through Shared Experiences, 2) Other's Perceptions of Growth, 3) Compassion for self, and 4) being part of something bigger. Below the details of each sub-theme are discussed and direct quotes are provided.

2.1.1 The Power of Shared Experience. Every participant in the current study mentions at some point during their interview an experience of recognizing shared experiences within the other group members. These experiences were presented as important to the participants. There was a sense that this awareness of shared experience was soothing, helped normalize their thoughts and feelings, and instilled a sense of belonging.

"Because I, the other women. Because I saw that I was not the only one going through this and I always thought I was"-P144

"I just felt like, you know, I know you, I get you…Yeah. You know, it may not be the same, it may not be anything like that, but we have something similar. And that's what made the huge difference."-P10

"I'm still absorbing a lot right now -but I think that being amongst the women and knowing that they have the same thoughts that I did, ugh, they've also shared experiences and I think that there's strength in numbers. And I feel that at this point, just my whole thought process has shifted."-P88

"Okay, well, I feel that when we did the group ugh, sessions, when people would ugh start checking in or and what would come up collectively and individually was uh would s-, would bring up emotions and memories in me and in other people but I'll talk about myself. Somebody would share something and I would feel ugh, it would, my trigger, a memory of my own, a thought, and then an intuition, a sudden understanding, a sudden awareness of-of wha- of that feeling or that experience that I had in the past."-P70

As seen above, many of the participants expressed surprise at how many of the other group members shared similar thoughts and experiences to them. This seemed to connect the group members to each other in an unexpectedly deep and intimate way. They expressed experiencing reciprocated feelings of belonging, understanding, and connection. Many of the women seemed to feel that their shared traumas, though different in content, shared similar emotions, and had similar impacts. This knowing seemed to help the women connect and bond.

2.1.3 Others Noticing and Validating Personal Perceptions of Growth. Almost all participants reflected that important people in their lives have noticed and verbally mentioned positive shifts and changes in the participants since completing the WRAP

program. These observations seemed important and impactful to the participants who received this feedback.

"Well, you know, I can see, ugh, a change in how people are perceiving me and uh, but uh in the living place, uh, I mean maybe it's natural after a year for people to be friendlier but I see that I'm relating better and that people are relating better to me."- P88

"Well they see a softer side of me. They see me smile a lot more. My friends have told me they have seen a lot of shifts in me. I'm just more open to people. Being able to communicate better, as opposed to being closed and quiet." -P70

"Yeah, my boyfriend told me that, like, you know, he started seeing the changes and things, But I think some of the people in the group noticed a big change in me. I was told that I dealt with everything in a very mature way, when there was any confrontation in the group, that I took a mature and very responsible attitude to it. And that I've slowed things down, I seem more, like, present. And less like zoned out, you know, like dead." -P68

"The person in my life right now. He's said, "I've noticed a change in you, I've noticed some changes in the way you are, the way you're seeing and talking, and the way you're acting". -P122

"Yes, ugh, my brother-in-law, my sister and my addiction counsellor and..-they've noticed, they've noticed some motivation, mainly the motivation to get better. -It's been difficult. I'm not used to praise. I'm not used to positive feedback." -P10

Many of the participants expressed some surprise that the changes that they were noticing in themselves were also being noticed by other people in their lives. The had numerous accounts of where a family member or friend has pointed out differences in the participants' words, actions, and demeanors. They seem to feel that theyre being more positively perceived by those around them and use descriptions such as "softer," "more mature, more responsible," "not zoned out," " more present," "being more open," and as smiling more.

2.1.5 Being Part of Something Bigger. Many of the participants reported that being part of the WRAP program and study led to an unexpected feeling of contribution, pride, and satisfaction. These women mentioned feeling as though their decision to take part in the study felt "important," "significant," and "impactful." Last, there was an observed quality of community belonging and a sense that these women felt that their contributions made a difference to other women like themselves.

"*Well, it made me feel that I was doing something that was important. Not necessarily, see, not necessarily for me but for others, because this is relatively new from what I understand. And this is near the hospital that takes, that does this. And so, I felt like I was part of something. So again, I did something that was, I wasn't really thinking about me." -P122*

"to feel like a part of something that was kind of like… Bigger than me… It felt, I needed to contribute. Every day that I needed to come in, I needed to be honest, I needed to be real, I needed to express how I felt- what, and still be diplomatic in some cases."

R: So you felt like you were participating in something much bigger than you. And that sounds like that was important for you.

P: Right. So I was going to be true to myself and true to everyone else."-P144

As described, many of the participants in the current study spoke about feeling a larger, community health oriented draw to completing the research. In fact, several of the participants reported that knowing that their questionnaires and therapeutic experiences were being used for research motivated them to be dedicated, open, and committed to the therapy itself. The drive to contribute to a greater cause even extended to feeling the need to engage more honestly and actively in therapy.

2.2 Unexpected Difficult Experiences

During the interview many participants spoke about various themes of unexpected difficult experiences. These included having difficulty in relationships during WRAP, challenging events such as therapy ending, and having to endure worsening symptoms at times as therapy ebbed and flowed. During these discussions individuals most commonly named perceived challenging experiences as being related to A) Worsening symptoms, B) Disappointment in Goal Attainment, C) Wishes for longer Therapy, and D) Saying Goodbye. Below the details of each sub-theme are discussed and direct quotes are provided.

*2.2.1 Worsening Symptoms***.** Despite an overall subjective report of improving symptoms, many of the participants did note that they experienced an increase in some symptoms at some point during the treatment process. Many of these noted experiences

related these increases in symptoms to increased vulnerability, emotional fatigue, and increased awareness of their internal world.

"I felt, like, old- exhausted and tired physically, but I think I've got a little bit more vulnerable for a long time. I felt way more vulnerable (I know) the feeling for me and sense it, and it made me feel like, you know. But then there was a shift, and I kind of regressed back."-P16

"I think I'm more, I think that, that the program has increased my flashbacks and it's increased, some, ugh, suppressed memories and that's why I have to go on this (resperin). Ugh, they're very intrusive, it's not something that I enjoy nor did I realize what was happening to me because I've been drugged up., I never really realized how much this program was going to bring to the surface for me and, and it's extraordinary what the brain can do."-P31

"I'm not sure, it might, ugh, I, I, I think it might make me trust more than I ought to in certain situations, so I'm not sure that's a-yes or no. I'm still practicing so I almost feel a bit vulnerable."-P88

"The eating disorder is a thing. I remember during the program it was really rough for me and I started making myself purge all the time. And I managed to get a handle on it. I think being in that program – like it was just so intense, the after feeling of after you purge is that good feeling."-p153

"I'm thinking cuz there might have be-, there might be. my psoriasis isn't any better [laughs]. It, sometimes it's worse."-P98

As you can see many of the women described an intensifying of certain symptoms such as their flashbacks and eating disorders as they addressed their trauma and trauma symptoms. They described feeling an increase in some of the more difficult and intense memories and material related to their trauma. They frequently used the word "vulnerable' and "vulnerability" as a consequence of spending so much time and energy on focusing on that difficult material. This increased vulnerability, heightened sense of sensitivity and intensity seemed to draw them to engage in some of their less adaptive coping skills and they attempted to manage this intensification.

2.2.2 Disappointment in Goal Attainment. Several of the participants expressed directly their disappointment in not reaching one or more goals that they had voiced in the pre-therapy interviews. Many spoke about these missed goals as being related to their increased awareness of how the process of therapeutic healing can be slow and lifelong.

"Even though there's a lot of, you know, I've already listed a lot of good things that came out of this, lots of positive changes and shifts, there's still this part that really sees how slow things are."-P122

"And nothing just clicked, or nothing just changed in (general) . I don't- I feel I completed it I felt like (a war [laugher in unison] or I had just been through a war) and I'm going home. WRAP, the whole thing was- when I say intense, it was intense."-P70

"Yeah, I had, I had some difficulties with some of the diagrams, specifically, the hyper- and the hypo-arousal chart." -P28

"I don't know, I'm still pretty isolated outside of the group."-P153

Many of the women did note that the improvement wasn't as quick or as complete as they had wished. Some of them expressed disappointment in how there were domains in their functioning that they continue to feel that they struggle in. Some of the women as detailed difficulties in the material that they were trying to learn and felt less improvement because of these challenges at times.

2.2.3 Wishes for Longer Therapy Duration. Related to the material presented above, many of the women expressed a sincere desire for a longer therapeutic program, about feeling overwhelmed by the amount of work it took to begin the therapeutic process and how that, combined with the short intense timeline, led to them falling short of their goals. Still, rather than wishing they hadn't begun the process, they wished they could experience it for longer.

"And it was a loss, because I (wasn't going to be with these women anymore). And I wasn't going to be with you know, my facilitators anymore. They were there like as a, help, you know? A rock. So I couldn't really intake the information. At least (partly/part way) through the WRAP- time, I started to associate myself with everybody (getting messed up) and everybody- preparing myself [cut off]." -P16

"Not enough time, and not enough work on my part. You know, I just feel like I can't develop those skills overnight." -P88

"I think again it was the failure- I can't do this, you know I need more skills, I need more training. Yeah, because eight weeks really is not enough. Yeah it's a start and it was gruelling. But it's not enough, like I mean it needs to be a constant part of life. You know, WRAP needs to be a constant part of life." -P95

Many of the women expressed a wish that the program could have lasted longer or continued on. Because of the domains discussed above in which some participants felt they didn't improve, there was an expressed wish that they could continue in order to continue to see improvements in these areas. Additionally, some conveyed they wished there was a way to make WRAP and "constant", and interwoven in their day to day life. There was many who felt the eight-week length was too short and that they felt they had more to learn.

2.2.4 The Grief and Loss of Program's End. Most of the women reported during their post-interview that the process of having to complete the goodbye ritual was upsetting and felt like a loss. Though the ritual was meant to symbolize closure and endings, many of the participants reflected that the experience created a great deal of sadness, feelings of loss, and grief. The participants mentioned having past difficulties with loss and grief, which were triggered for them during this ceremony.

"My goodbye to them was the most difficult... It was a very sad goodbye, got really attached." -P122

"I was (not) especially happy to say goodbye to her. Yeah, a loss. It was almost ridiculous because, you know. Yeah. So, I grew really attached."-P153

"And it was a loss, because I wasn't going to be with these women anymore. And I wasn't going to be with you know, my facilitators anymore. They were there like as a, help, you know? A rock." -P16

"The goodbye ceremony- we have a ceremony when we leave. It's pretty intense for me, but I've always had trouble when other people were leaving the ceremony? But I was able to do the whole thing, and say goodbye, and still be like, okay."-P25

Participants noted a feeling of loss and grief as the program ended. The described a deep feeling of attachment to both their facilitators as well as their group members. This attachment, understandably, became important and meaningful, and the process of saying goodbye during the goodbye ceremony was discussed as difficult, intense, and sad. This feeling of loss for the supports they built was strongly felt and expressed by many of the participants.

Discussion

This study qualitatively explored women's experiences in a short-term group trauma therapy program using information gathered pre- and post-intervention by means of a semi-structured interview, the SAI. Using thematic analysis, we aimed to examine

how participants reflected on and reported their perceptions of themselves, their relationships, their symptoms, and the change they both anticipated and experienced both before and after the intervention.

Research objectives included qualitatively exploring themes that emerged in the pre-interviews: how the clients experience and communicate their perception of their relationships, their sense of self, their treatment goals, and their current symptoms. We explored themes and processes, as experienced and described by the women in the post interview that occurred following WRAP. These included, but were not limited to, perceptions of what influenced change, therapeutic alliance, relationships experienced within the group, symptom resolution, negative and positive processes that occurred during the group, met or unmet expectations, discussions of goal attainment, and impressions of the therapy itself.

Pre-therapy SAI Thematic Hierarchy

The content of the narratives during the pre-therapy interviews spanned topics of current relationships, current sense of self-identity, current symptoms, lifestyle, goals, and hopes for the program. Specifically, themes that emerged largely focused on participant's hopes for improvement in the area of symptoms, emotion regulation, relationships, physical lifestyle, and self-concept.

Hope for Change in Outward Presentation

Interestingly, this thematic umbrella, which includes Improved Relationships and Improved Lifestyle, aligns with what other research is reporting on how individuals *actually* experience change and growth. The participants widely communicated a desire to build better quality relationships, learn to trust those with whom they are in a

relationship, and become more confident in initiating and maintaining relationships. The reported hope for improved relationships aligns closely with what other research tells us has actually occurred in post-traumatic growth. Zięba, Wiecheć, Biegańska-Banaś, & Mieleszczenko-Kowszewicz, (2019) found that individuals frequently reported high rates of post-traumatic growth in the area of "Relating to others." Similarly, Blanchard (2013) also wrote about the widely experienced improvement in relationships with others after receiving therapy for trauma.

It is understandable that the participants voiced a desire for improved relationships. Past research has shown us that individuals with histories of abuse show greater mistrust of others, as well as a greater unwillingness to take part in the relationship (Eltz et al., 1995). If the trauma occurred within the context of a known or personal relationship, individuals may find it extremely difficult to establish feelings of safety or trust with anyone (Eltz et al., 1995; Cloitre, Cohen, & Scarvalone, 2002).

A robust body of research supports the idea that an individual needs intimate, healthy, and supportive social relationships. Research in the area of resilience has shown that individuals with close, supportive, and meaningful relationships are more likely to tolerate external pressures such as negative life events, work stressors, loss, grief, and failure (Beckett, 2011). People with healthy social support have been shown to recover faster from physical ailments, have lower rates of mood and stress difficulties, and tend to perform better in work, school, and life (Petrov, 2012)

It appears that, in agreement with this body of knowledge, instinctually the participants recognized the importance of healthy and fulfilling relationships and were able to clearly communicate this desire while speaking about their hopes for post-therapy

improvement. Qualitatively they expressed a need that aligned with what previous quantitative research has shown: 1. individuals with trauma histories experience difficulty with forming and maintaining relationships, and 2. individuals feel more fulfilled, healthy, and supported when they have supportive relationships.

Hope for Change in Internal Self-Experience

Discussion in the area of Internal Change is comprised of three themes; Improved Sense of Self, Reduction in Symptoms, and Improved Emotional Regulation and Expressions. Participants expressed a great deal of hopefulness and goal-oriented attitudes that related to these themes.

Reduction in Symptoms. The participants were experiencing significant and impairing symptoms such as suicidality, episodes of flashbacks and dissociation, nightmares, drug and alcohol abuse, self-harm, poor self-esteem, poor emotion regulation, and clinically significant anxiety. All participants met criteria for, at minimum, PTSD, and others also met criteria for Major Depressive Disorder, an Anxiety disorder, and/or alcohol/drug addiction. These difficulties were interfering with the participants ability to work, parent, manage relationships, and perform day-to-day tasks. Participants were experiencing significant impairment and lower quality of life due to these experiences and it is therefore understandable that they would wish to see improvements in these areas.

Self Concept. Participants commonly reported low self-esteem, low self-worth, low self-confidence, and poor self-concept. Many participants anecdotally described these issues with self-esteem as also affecting their ability to start and maintain

relationships, complete work-related tasks, socialize, leave their homes, parent, and feel worthy. Once again, the impacts of these self-perceptions were having a significant impact on their daily lives, and it was therefore understandable that the participants identified this theme, and subsequent sub-themes, as being important components of their hope for change.

Emotions. Last, in the theme of Emotions, participants frequently expressed a wish to be better able to attune to, express, understand, and tolerate their emotions. Participants spoke about wishing to be able to face their emotions, as they were experiencing discomfort and suffocation, with 'being unable to touch their sorrow' as one client eloquently expressed. Many of the participants seemed to voice a desire to be able to feel safe with their own emotions and feel more in control of their strong emotional experiences. From the SAI data it appeared that many women entered WRAP speaking about their emotion with almost a sense of fear and lack of power. It therefore makes sense that they would want to gain a feeling of strength when managing and regulating their emotional experiences. One can imagine that having such intense emotional experiences post-trauma, and feeling helpless about these experiences, would be in itself distressing and challenging. It therefore follows that these women would express a hope to be able to feel more in control and at the helm of their emotional changes.

Post-therapy SAI Thematic Hierarchy

The content of the narratives during the post-therapy interviews fell under the major identified theme umbrella of Lived Experience of Change. Sub-umbrellas spanned topics of achieved goals, subjective views of what contributed to goal attainment,

unexpected positive experiences, and unexpected negative experiences. Specifically, themes that emerged largely focused on where participants had noticed they changed in ways they expected, ways they didn't expect, and reasons why they believed these changes occurred.

Achievement of Goals

We found that most participants reported subjectively experiencing growth in the areas of symptom reduction, lifestyle improvement, improved relationships, and improved self-concept.

Improved Relationships. Participants reported feeling that they were able to better connect with friends and family, were able to experience more trust within their relationships, feel more secure relationally, and set healthier relational boundaries (as discussed in the theme umbrella of unexpected positive changes). In fact, many of the participants spoke about new and important friendships they had established with other group members of the WRAP program, and the meaning those relationships held for them.

Reduction of Symptoms. Participants also reported noticeable reductions in anxiety, improvement in mood, less suicidality, fewer instances of self-harm, fewer flashbacks and dissociation, and less mood lability. Numerous participants also reported being able to reduce some of their prescription psychotropic medications. Some of the participants who had entered the program struggling with drug and alcohol use reported subjective improvements in these substance use behaviours. Some participants who entered the program with disordered eating also reported improvement in behaviours such as restricting, binging, purging, and compensation.

Improved Self Concept. Participants noted feeling a higher sense of self-worth. They expressed an increased sense of self-respect, dignity, and value. Participants reported feeling higher degrees of self-acceptance. Some participants indicated that they felt a renewed sense of potential and hopefulness about their future. Last, several participants noted that their increased sense of self-esteem and self-worth has led to increased efforts to practice acts of self-care.

Under the theme umbrella of Unexpected Positive Growth, participants also spoke in length about improvements in their own self-compassion. Many of them described have great difficulty with being hard on themselves, "beating themselves up," and feeling as though their "bad" qualities overshadowed their good qualities. Post-therapy, participants described being able to be softer with themselves, more realistic in their expectations, and were learning how to forgive themselves.

Also, under the theme umbrella of Unexpected Positive Growth, participants discussed how they have noticed that *others* have identified seeing growth and differences in the participants from beginning to end of the WRAP program. Participants reported that partners, siblings, friends, and children had directly noted changes that the participants were experiencing.

Improved Lifestyle. Participants described improvements in several areas of their day-to-day living. Several participants spoke about feeling an impetus to seek out further education after WRAP finished, and successfully enrolling in post-secondary programs. Several participants who had been living in a shelter when they had entered WRAP had managed to find secure permanent housing. Several women noted that they had increased their income or had received a raise at their present job either during the program or after

WRAP had finished, and they attributed these improvements to things learned during therapy.

Subjective Reasoning for Goal Attainment

Most participants reported subjectively experiencing growth in the areas of symptom reduction, lifestyle improvement, improved relationships, and improved self-concept. Within the discussion of goal attainment and experiences of change, participants expressed some of their beliefs as to why they perceived they experienced these positive changes. Participants most frequently expressed believing that the factors that led to their successes were their relationship with their therapists and group facilitators, their relationships with other group members, increased awareness and understanding of their symptoms and trauma, and the effectiveness of the different therapy activities and tools.

Therapeutic Alliance. First and foremost, participants attributed their change, growth, and goal attainment to the therapy relationships they built during the program. These relationships included those built with their individual therapists and group facilitators. Participants described feeling cared for, listened to, valued, understood, and supported by the various clinicians they interacted with throughout the program. Participants expressed that they felt their therapists were genuine, caring, nurturing, consistent, present, and soothing.

Interestingly, the majority of the participants described a feeling of nurturance, care, and consistency, and reassurance from their therapists. This experience led to participants reporting that they felt important, cared for, and safe. This qualitative self-report of feeling nurtured and safe in this way can be conceptualized as the participants' attachment systems being activated during a corrective attachment experience. Childhood

abuse is thought to disturb attachment and consequently compromise an individual's capacity to relate to others in adaptive and healthy ways (Muller & Rosenkranz, 2009; Herman, 1992; Pearlman & Courtois, 2005). As attachment theory proposes, early interactions with caregivers influence how individuals form connections. Childhood abuse almost always occurs within the context of important relationships. As therapy occurs in the context of trusting relationships, it is important to understand how clients are perceiving and interacting with the therapeutic relationship. In this study, participants frequently reported childhood abuse and neglect. If the therapist facilitates a safe and nurturing environment, clients may experience this as a corrective and positive emotional experience, as the client learns to trust, sit safely in a space of vulnerability, and allow the secure relationship between client and therapist to develop.

These positive qualitative experiences expressed by the participants align closely with the large body of research clinicians have gathered related to the importance of therapeutic alliance. The client's ability to form a safe and secure therapeutic relationship with their therapist is viewed as central to positive therapy outcome (Horvath & Luborsky, 1993). The necessity of a strong alliance in group therapy has also been demonstrated (MacKenzie, 1983; Piper, Ogrodniczuk, Lamarche, Hilscher, & Joyce, 2005), and, Mallinckrodt, Coble, & Gantt, (1995) postulate that therapeutic alliance may be as integral to experiences in group based therapy as in individual work.

Zorzella, Muller, & Classen (2014) described quantitative findings that empirically corroborated the perceived alliance experiences that the participants described. This study, conducted within the larger WRAP research project, found that group participants formed close attachments to their group facilitators and therapists early

on, and that then increased over time, even though the clients demonstrated both dismissive and unresolved attachment styles (Zorzella, Muller, & Classen, 2014).

Group Alliance. Participants next spoke about their connection and relationship to the group. This sub-theme captures the explicit positive and close relationships that participants felt they developed within the group, as well as the significant impact they felt the group relationships had on their goal attainment and growth. Participants described feeling welcome, connected, and safe within the group. They described feeling connected to the other women through the similar experiences they described. Participants relayed a sense of belonging and feeling accepted when speaking about their group. The participants explicitly described feeling that these connections were partially responsible for aspects of the change and growth they experienced.

Interestingly, parallel to the above discussed nurturing and sometimes maternal transference to their therapists: “I think she’s a marvellous counsellor and you know, she, it’s almost like she’s, she’s been in a sense, mothering me. And this (helped). I think she’s younger than me too but ugh she ugh, she’s worked with me for a year and she’s taught me, she’s taught me things that a mother should’ve taught me.”-P144

Further to this, participants also voiced a familial transference to the group as well. For example; “*Oh yeah. I felt like I was a little bit more together when I was here. It just felt like a family. I guess, you know, I think because as always my biggest problem is family. So, I'm constantly seeking out family.”*

These parallel processes of transference are enlightening in how clients perceived and experienced the support of the group and why they felt the group played a role in their positive shifts and changes. In contrast to their potentially experiencing simply a

relationship of friendship or collegiality to other group members, the classification of "family" suggests a deeper, more connected, and more significant relationship.

Indeed, past research has suggested that the multilevel interactions within a therapeutic group require equal consideration when exploring the concept of therapeutic alliance (MacKenzie, 1997; Muran & Barber, 2010; Yalom, 2005). Past research postulated that it is equally important to examine how group members experience group dynamics that unfold in the group context as it is to consider therapeutic alliance with clinicians (MacKenzie, 1983). In relation to the previously mentioned concept of attachment, it has also been suggested that group cohesion weakens the effects of members' attachment anxiety during group tasks (Zorzella, Muller, & Classen, 2014). That is, a sense of security within the group relationships is associated with a reduction of activating strategies in an anxious group member (Zorzella, Muller, & Classen, 2014). Taking this into consideration, if the participant is feeling a sense of relief, they are then freer cognitively and emotionally to take part in the therapeutic activities being presented at the time.

Viewing the group as family sheds light on the level of importance and regard held by participants for fellow group members. It is understandable that they would attribute these relationships to being integral to the goals they had attained and growth they previously described.

Understanding and Awareness. As clients discussed their experiences of shifts, positive improvements and goal attainment, a sub-theme of increased understanding and awareness emerged. Many of the participants noted that they felt they are more aware of and understand better their trauma and the impact their trauma was having on various life

domains. Many participants reported that this general improvement in understanding and increased awareness of trauma, what it is, the symptoms, and the way it impacts them in different domains of life, contributed significantly to why they felt they experienced improvements in symptoms, life function, and the ability to use the tools that they were being taught.

Previous research shows that psychoeducation, increasing an individual's understanding and awareness of their difficulties, is helpful in managing symptoms. One study, with patients with Bipolar Disorder, showed that programs focused on individual and family psycho education were efficacious in enhancing and supporting mood stability of the client, and led to better coping skills and less reports of burden on caregivers (Colom & Lam, 2005). Previous research in trauma therapy also emphasizes the importance of psycho education in supporting awareness and understanding in the individual. Trauma Focused Cognitive Behavioral Therapy names psycho education as one of its core therapeutic components (Zayfert & Becker, 2007). Even methods that lean more psychodynamically such as play therapy suggest psycho education as being an important part of trauma informed care (Waycott & Carbis, 2019).

Like previous research has demonstrated, improved awareness and understanding about one's own emotions, reactions, instincts, and behaviours, from a trauma informed and psychologically oriented context is therapeutic in its own right. The current study, through the participants' own reports corroborates and supports this understanding. Participants spoke about this process of therapeutic psycho education using words such as “revelation”, “relief,” “clarity,” and “eye-opener.” They described experiences that illustrate that if an individual can begin to understand the processes behind what they are

experiencing, that simple understanding can help reduce distress, increase meaning making, and initiate shifts.

Therapeutic Activities. The last area that participants reported as having significant impact on their perceived goal attainment and growth was related to the specific therapeutic tools and activities used during both group and individual sessions. Several of the participants named specific behavioural tools (e.g., snapping a rubber band for managing self-harm urges) as grounding tools that were significant and impactful.

Overall participants reported that they experienced goal attainment and positive growth. They largely attributed this growth to their relationships with their therapist, their relationships within the group, increased understanding and awareness of trauma and post traumatic symptoms and mechanisms, and the usefulness of the tools and mechanisms themselves. In fact, through the interview discussions, women spoke about their growth experiences in themes that very closely adhere to what we know theoretically through empirical study describing why and how people undergoing therapy "do better."

Unexpected Positive Growth

Being Part of Something Bigger. Many of the participants reported that being part of the WRAP program and study led to unexpected feelings of contribution, pride, and satisfaction. These women mentioned feeling as though their decision to take part in the study felt "important," "significant," and "impactful." They described that they felt moved to continue the program, even though at times the work was exhausting. As well, there was an observed quality of community belonging and a sense that these women felt that their contributions made a significant difference to other women like themselves.

Interestingly, these experiences have been reported in previous studies examining people's motivations for taking part in clinical research. One study explored why dementia patients and their caregivers chose to take part in focus groups for dementia research (Law, Russ & Connelly, 2013). Participants reported that the feeling of "being part of something bigger" was intrinsically motivating enough to want to take part (Law, Russ & Connelly, 2013). In fact, research participants identified that they would have chosen to take part in the study regardless of any tangible personal benefits. Additionally, all participants further noted that, "They would not have been put off by any of the costs." (Law, Russ & Connelly, 2013). Minogue *et al* (2005) found that medical service users involved in research found the experience to be valuable and even enjoyable. The study authors suggested that the numbers participating in research increased because of their direct involvement in the medical program.

As described, many of the participants in the current study spoke about feeling a draw to complete the research, as it was benefitting the larger community. Furthermore, we know that several of the participants reported that knowing that their questionnaires and therapeutic experiences were being used for research motivated them to be dedicated, open, and committed to the therapy itself.

Unexpected Negative Experiences.

Many participants spoke about various themes of unexpected negative experiences. These included negative experiences of others, negative events, and negative changes in self. During these discussions, individuals named perceived negative experiences related to Worsening Symptoms, and Saying Goodbye.

Worsening Symptoms. Overall, participants subjectively reported that they experienced reduced symptoms. And the Classen et al. (2017) study on the WRAP program found that the women did experience significant symptomatic improvement. But many of the participants noted that they experienced an increase in some symptoms at some point during the treatment process, especially near the beginning. Many relate these increases in symptoms to increased vulnerability, emotional fatigue, and increased awareness of their internal world. Additionally, many of the participants noted increases in flashbacks, dissociation, addiction behaviours, disordered eating, and anxiety. The women understandably reported some frustration and unease around the time of these increases in symptomatology.

It may be reasonable to expect a transient symptomatic increase when clients face new therapeutic challenges. In starting treatment, initial increases in vulnerability, newness to the therapeutic relationship, and newness to the use of coping tools can be overwhelming for many. It may be prudent for clinicians to help clients anticipate such transient periods of difficulty as they embark upon challenging trauma work. Such preparation takes advantage of the above discussed tenets of psycho education and awareness as therapeutic factors. If the client is aware of this possibility, distress may decrease and they can better prepare for, notice, and attune to this increase in symptoms with their therapist in an open and informed manner.

The Loss of Saying Goodbye. Many of the clients spoke with emotion and grief as they contemplated the ritual of the goodbye ceremony that all clients attend. Some clients reported that they did not anticipate the level of grief they would feel having to

leave their group members. Other participants noted that they could sense early on that saying goodbye would be intense and challenging. In fact, they reported that they purposefully did not engage as openly or as intimately with their fellow group mates due to the fear of the impending loss. As previously mentioned, participants deeply valued their connections to their group members and attributed much of their program experience and positive growth to these other individuals, going through the same processes.

Bowlby (1979) previously wrote about the way in which individuals tend to manage the concepts of separation and loss. His work on attachment and relationships can help shed light on some reactions displayed by clients facing impending termination. Anxiously attached individuals tend to rely on activating strategies (e.g., intense distress and effort to receive comfort), and avoidant attached individuals seem to resort to deactivating strategies (e.g., denial of loss and grief and the devaluation of relationships) to cope with loss in group therapy (Hammond & Marmarosh, 2011). Relatedly, one study showed that perception of alliance sometimes negatively declined towards the end of therapy termination for individuals with dismissing attachment styles who are undergoing trauma group therapy (Kanninen, Salo, & Punamäki, 2000).

Participants talked directly as they expressed acute awareness that their experience of termination was challenging, laden with loss and grief, and also destabilizing. Considering the value they placed on group members, perhaps this should not be surprising. Clinicians might take this into consideration by extending discussion of

termination to several weeks earlier, following the psychotherapy adage that processing of “the end” starts at the beginning.

Future Research and Limitations

First, it is unknown whether there are differences in the individuals who agreed to participate in the larger WRAP research project in comparison to those who chose not to take part. Second, of the 54 women who completed the full program and research study, only 12 had available data for this study. This occurred because not all women completed the second interview, and of those who did, some had corrupted audio files and missing data. A brief analysis did not show a significant demographic difference between those who completed both interviews and those who did not, and so we determined that participants in the current sample were representative of the larger sample, and as previously mentioned, a sample size of 12 is considered above threshold in qualitative research like this. Still, 12 participants may be considered by many to be a rather small sample, and this may raise concerns regarding the study’s external validity. Third, the program’s continuous slow-open intake model resulted in a lack of control over the dynamics of the group, and we were not able to determine whether the relationships among fluctuating group members impacted their Self Assessment Interview. Finally, this study did not address the extent to which clients’ subjective experiences and perception of their time in WRAP might have been coloured by such factors as gender, culture, and sexuality. Further research on whether these variables impact the way individuals navigate and experience trauma therapy is suggested.

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Figures

Figure 1

PRE-TREATMENT SELF ASSESSMENT INTERVIEW

INTERVIEW GUIDELINES

2. Introduction of interviewer and role with research team.

We would like to spend a few minutes with you now and ask a few questions about you before beginning the group treatment program. We think that you are in fact the best expert on you, and as such is very helpful for us to understand as much as possible about how you see yourself, how others see you and what if anything, you might like to change about yourself, at this point in time. This interview will be audio-taped so that after the completion of the WRAP program, we can meet again and review this tape. We will be very interested in understanding your experiences of change over the course of the WRAP treatment program and also what you found to be of help or hindrance in the treatment program. Anything you disclose to me as part of this interview will remain confidential to the research team and used for research purposes.

Question #1: " How would you describe yourself to someone who wants to get to know who you are?

"What are your strengths?"

If the participant describes herself according to a role (e.g., I am a mother), the interviewer would then ask "What kind of mother are you?" The participant might respond with a description such as, "I am a loving mother."

Following each description, the interviewer prompts the participant to provide a recent example from his/her life that illustrates the description that she/he has provided. The participant is then asked to provide an autobiographical memory narrative that illustrates this descriptor of self. If the participant uses an adjective (e.g., "I am very caring"), he/she is subsequently asked to provide the interviewer with an autobiographical memory narrative to illustrate the descriptor in terms of lived experiences. Participants are encouraged to take their time and generate as many descriptions as they can.

The purpose of question #1 is to explore how clients see themselves prior to treatment – positively or negatively, externally or internally-oriented in terms of singular or multiple perspectives. Examples, or stories of clients' lived experience that illustrate views of self are requested to assess the degree to which views of self are grounded in the client's own life experiences rather than reflecting acquired beliefs about the self that are congruent with others views of self or cultural norms.

Question #2: "How would someone who knows you very well and cares about you describe you?"

"How much do you agree with that description of you?"

The purpose of this question is to assess the way in which a client perceives others' view of him/herself and explore the possible implications of discrepancies between a person's view of himself or herself versus how s/he feels others view him or her. In other words, "do I see myself as I feel others see me or do I feel others see me differently than I see myself?"

Question #3: "If you could change or make a difference in yourself, what would that be?"

"If you could make a change or difference in your life, what would that be?" what would that look like?

The purpose of this question is to gain an understanding, early in treatment, what - if anything - the client hopes to change about himself/herself. The responses to this question also provide a concrete pre-treatment reference point to reflect upon and from which to compare each participant's own conceptualization of change at therapy outcome.

Question #4 : What do you think is the most important concern for you to address in the WRAP/ Group Treatment program (specific)?

How do you think that participation in the treatment program will address your most important concerns?

Figure 2

POST-THERAPY SELF ASSESSMENT INTERVIEW

INTERVIEW GUIDELINES

In today's interview I am going to ask you some questions about your experience in WRAP. When I mention WRAP, feel free to consider of any aspect of the program. This can include the group sessions in general, any of the specific groups, the group therapists, your individual therapist, the other group members, the time spent at lunch or breaks, the types of information or materials you received, the environment and any other direct or indirect aspect of the program that was part of your experience.

STEP ONE. Changes in Self and Life.

Present the Self Assessment Summary Sheet to the client.

A) "In the brief interview that you completed before treatment began, you indicated that if you could make a difference in you it might be _____.

Is there a difference in _____?

If the answer is no:

What do you think got in the way of that happening?

Proceed to Step 2.

If the answer is yes:

Probes

a. what has changed or is different in you.

b. is this difference in you helpful for you?

is this difference in you unhelpful for you?

c. what do you attribute this change in you to?

did therapy contribute to this change or difference?

d. recent example of how this change in _____ has made a difference in your life?

e. has it had an impact on your relationships with others?

have others noticed/commented on changes in you?

B) “In the brief interview that you completed before group treatment began, you indicated that if you could change or make a difference in your life it might be _____.

Have you noticed a difference in _____?

If the answer is no:

What do you think got in the way of that happening?

Proceed to Step 2.

Probes

If the answer is yes:

a. describe what has changed or is different in your life.

b. is this difference in your life helpful for you?

is this difference in your life unhelpful for you?

c. what do you attribute that difference in your life to?

d. a recent example of how this change in _____ has made a difference in your life?

e. has it had an impact on your relationships with others?

have others noticed/commented on changes in you? Example?

STEP TWO. Other Changes.

A) Have you made or noticed any changes or differences in how you experience yourself as a result of being in WRAP?

If the client is unsure how to respond, you may prompt them, with the following:

“If you could think back to when you came into therapy and how you are now, do you feel any differently?”

If the answer is no, go to Question B

Probes:

If the answer is yes:

a. describe what has changed or feels different in your life.

b. is this change helpful for you? How?

is this change unhelpful for you? How?

c. What helped make these differences in your life?

d. a recent example of how this change in _____ has made a difference in your life?

e. How has it had an impact on your relationships with others?

Have others noticed/commented on changes in you?

STEP THREE. Focus on the Experience of Therapy

Next, we would like to ask you some questions about a therapist you have worked with while involved in WRAP. When we say "therapist," we invite you to think about

the one clinician who has made the greatest impression on you, regardless of what that impression is. Try to have that person in mind when we ask you about your "therapist."

a. Do you think your therapist contributed to these changes occurring in your life? If so, how?

b. Do you think other group members contributed to this change happening in therapy? If so, how?

c. Can you think of any critical incidents, specific moments or events in your therapy sessions in which the changes you have mentioned occurred?

Please describe what happened.

. For each moment (ask if they do not tell you spontaneously):

What was different or changed?

How did the change come about?

Why is this significant?

e. Are there any (other) moments in the WRAP that stood out for you?

Please describe.

If no, proceed to Step 5.

If yes, ask the following questions.

For each moment ask:

What stood out for you?

What was different or important about this event/moment for you?

How was this significant for you?

STEP FOUR. Impact of Experiences Outside of Therapy

During the past 16-20 weeks has anything happened outside of therapy that contributed to these changes? (For example, things you are doing, or your life in general.)

STEP FIVE. Returning to the Self Assessment Summary Sheet and Views of Self.

A. In the pre therapy interview you indicated that you viewed yourself as _____.

Do you still view yourself foremost in this way?

Has that shifted or changed for you? If so, how? Can you provide a recent example from your life?

B. You also stated that your strengths were _____.

Do you still view yourself foremost in this way?

Has that shifted or changed for you? If so, how? Can you provide a recent example from your life?

STEP SIX. Self Assessment Summary Sheet and Others Views of Self.

You also described that a person who knows you well and cared about you would describe you as _____.

A. Would that person still describe you in the same way?

If yes, is there a recent example in your life which demonstrates this?

B. If you feel others' view of you has changed, in which ways has it changed?

and how did you become aware of this?

a. Could you describe an event in which you became aware of this change in others' view of you?

b. Could you elaborate on how this change or lack of change of others' views of you makes an impact on you?