ARE TRAUMA STABILISATION GROUPS SAFE AND EFFECTIVE?

Trauma Stabilisation groups have grown in popularity but have mixed outcomes in our general adult mental health setting. We share some of our service data, and results from a literature review, to support the development of best practice guidelines for trauma stabilisation delivered in group format.

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Introduction

Trauma stabilisation as an essential phase of trauma recovery was highlighted by Judith Herman in 1992 and is in the first phase of many treatment models for PTSD/CPTSD and other interventions within a trauma-informed framework.

Trauma stabilisation helps understand and legitimise a person's emotional and physical response to trauma, and views behaviour/ emotions as a legitimate response to trauma rather than evidence of 'disorder'.

Trauma stabilisation as a standalone intervention is relatively new and popular with many MH services.

However, concerns have been raised about the lack of evidence for the need for discrete stabilisation 'treatment'.

Objective

Our Part One Psychological Therapies Service (POPS) had many requests for trauma stabilisation groups. We wanted to know if they were safe and effective.

Methodology

We looked at the clinical outcomes for the groups: Were they well attended (acceptability)? Did they support recovery?; Did they reduce episodes of care?; Were they good value for money?

We also reviewed the literature that looked at trauma stabilisation delivered in a group format

Results

No consensus on the effectiveness of TS in a group format. Improving evidence for trauma stabilisation as effective in reducing C/PTSD symptoms (even without processing); others suggest unhelpful and unnecessary.

Drop out rates for TS groups were high, and outcomes mixed.

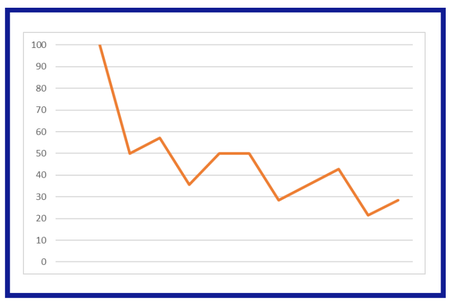
Analysis

Seven key components for group interventions: Introduction; Psychoeducation; Understanding how to manage trauma symptoms; Grounding; Interpersonal functioning; Cognitive techniques; Practise and feedback.

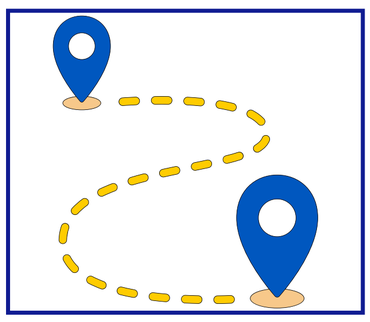
Completion rates for group were low - around 28% of those who had opted in, attended session 10.

29% of people attended at least 70% of sessions.

Attendance



Run chart: percentage attendance over 10 weeks for trauma stabilisation group - by week 9 attendance is 21%.
Only 50% of those who opted in attended week 1



All clients who completed group (>70%) went on for 1:1 therapy.
Those who dropped out were at increased risk of discharge from the service.

Conclusion

Trauma stabilisation groups can be effective but need responsive and thoughtful management to address acceptability and ensure not extending episodes of care. We will:

- Implement clearer inclusion criteria
- Provide an introductory session
- Reduce psychoed, increase skill practice and experience sharing
- Improve structure to provide balance
- Provide supplementary materials and homework to encourage skill uptake
- Encourage experience sharing, while avoiding trauma confrontation directly
- Person centre modules – After introduction, change modules to reflect priorities and need

We will further analyse our data after making changes.

RELATED LITERATURE

Herman (1992) Trauma and Recovery
Pendrey, Bowes and Maybury (in press). Why do people drop out of group therapies?
Dorrepaal et al., (2012) Stabilising group treatment for CPTSD.
De Jong et al., (2016) Critical analysis of the current treatment guidelines for CPTSD.