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CLINICAL RESEARCH ARTICLE

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How do men with severe sexual and physical childhood traumatization experience trauma-stabilizing group treatment? A qualitative study

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ABSTRACT

Background: Exposure to potentially traumatizing events, defined as events involving actual or threatened death or serious injury, is associated with an elevated risk of developing enduring physical, psychological and social problems. Complex post-traumatic stress disorder (PTSD) is a disorder that can occur after prolonged and repeated trauma. At least 30% of the sexually abused population is male, but in spite of this fact, treatment research focusing on male victims is virtually non-existent in comparison to research on female victims.

Objective: Trauma-stabilizing group treatment is an increasingly used treatment method for patients with complex PTSD. The aim of the present study was to explore how men participating in a gender-specific trauma-stabilizing intervention experience this treatment approach.

Methods: Five men who participated in a trauma-stabilizing group treatment were interviewed with a semi-structured qualitative interview. The data were analysed using interpretative phenomenological analysis.

Results: The analysis revealed five main themes. The themes highlight the experiences of the participants and describe positive and negative experiences: (1) Group atmosphere, comprising safety, community, emotional openness, anxiety and pressure; (2) Learning, categorized into knowledge and self-understanding; (3) Motivation, which describes both inner and outer motivation; (4) Structure, comprising structure of the meetings, group size and duration of the meetings; and (5) Gender, defined as the experiences of being in an all-male group with female group leaders.

Conclusions: There seem to be a lot of advantages to inviting men to attend gender-specific groups for trauma-stabilizing treatment. The men emphasized the support they received and that participating in a mixed-gender group would have been more difficult. In the future, it may be important to arrange all-male stabilization groups with more focus on male-specific topics.

¿Cómo experimentan el tratamiento de grupo de estabilización del trauma los hombres con traumatización sexual y física severa durante la niñez? Un estudio cualitativo

Antecedentes: La exposición a eventos potencialmente traumatizantes se asocia a un riesgo elevado de desarrollar problemas físicos, psicológicos y sociales duraderos. Al menos 30% de la población abusada son hombres, pero a pesar de este hecho, la investigación enfocada en víctimas de sexo masculino es virtualmente inexistente en comparación a la investigación en víctimas de sexo femenino.

Objetivo: El tratamiento de grupo de estabilización del trauma es un método de tratamiento cada vez más usado para pacientes con TEPT complejo. El objetivo del presente estudio fue explorar cómo experimentan este enfoque de tratamiento los hombres que participan en una intervención de estabilización del trauma género-específica.

Métodos: A cinco hombres que participaron en tratamiento de grupo de estabilización del trauma se les aplicó una entrevista cualitativa semi estructurada. Los datos fueron analizados usando Análisis Fenomenológico Interpretativo.

Resultados: El análisis reveló cinco temas principales. Los temas destacan las experiencias de los participantes y describen experiencias positivas y negativas: i. Atmósfera grupal que comprende seguridad, comunidad, apertura y ansiedad, ii. Aprendizaje categorizado en conocimiento y auto-comprensión, iii. Motivación que describe tanto la motivación interna como externa. Iv. Estructura que comprende la estructura de las sesiones, tamaño del grupo y duración de las sesiones, v. Género definido como las experiencias de estar en un grupo compuesto sólo de hombres liderado por mujeres.

Conclusiones: Parece haber muchas ventajas en invitar a hombres a un grupo género-específico para tratamiento de estabilización del trauma. Los hombres enfatizaron el apoyo que recibieron y que participar en un grupo de género mixto habría sido más difícil. En el futuro puede ser importante organizar grupos de estabilización sólo de hombres con mayor enfoque en temas específicos masculinos.

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Trauma complejo; Abuso sexual; Terapia de grupo; Género; Análisis cualitativo.

关键词
复杂创伤，性虐待，团体治疗，性别，定性分析

HIGHLIGHTS

- There are a lot of advantages to inviting men to attend gender-specific groups for trauma-stabilizing treatment.
- Participating in a mixed-gender group would have been difficult.
- In the future, it is important to arrange all-male stabilization groups with more focus on male-specific topics.
- The men emphasized the support they received in the group.

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童年经历严重性创伤和身体创伤的男性在创伤稳定团体治疗中的体验：一项定性研究

背景：暴露于潜在的创伤事件与发生持久的身体、心理和社会问题的风险增加有关。尽管至少有30%的受虐待人口是男性，与关注女性受害者群体的研究相比几乎没有关注男性受害者的研究。
目的：创伤稳定组治疗越来越多地用于治疗复杂PTSD。本研究的目的是探讨男性在参与特定性别的稳定创伤干预的治疗体验。
方法：采用半结构化定性访谈对参与创伤稳定团体治疗的5名男性进行访谈。使用解释性现象学分析法处理数据。
结果：分析结果揭示了五个主题，突出了参与者的经验并描述了积极和消极的经历：i. 集体氛围，包括安全、团体、开放和焦虑；ii. 学习，分为知识和自我理解；iii. 内在和外在动机；iv.结构，包括会议结构、团体规模和会议持续时间；v. 性别：在一个男性团体由女性领导。
结论：在特定性别群体中对男性进行创伤稳定治疗似乎有许多优点。参与者强调了他们所获得的支持，并提出如果参加性别混合群体会更困难。在未来，组织纯男性创伤稳定团体并更重视男性特定主题很重要。

1. Introduction

The prevalence of physical non-sexual abuse among children in western societies varies between 4% and 16% in different studies and seems to be evenly distributed among girls and boys. Furthermore, 15–30% of girls and 5–15% of boys have experienced sexual abuse (Gilbert et al., 2009). The actual prevalence in the male population may be even greater, given challenges in defining male sexual abuse and collecting data about it (Pereda, Guilera, Forns, & Gómez-Benito, 2009). Complex post-traumatic stress disorder (PTSD) is caused by human-inflicted, relational and long-lasting traumatic events. Characteristic symptoms include dysregulation of consciousness and affects, somatization and interpersonal functioning (Courtois & Ford, 2009; Ford, Courtois, Steele, Hart, & Nijenhuis, 2005). The traumatic events could be physical or sexual abuse, maltreatment or emotional neglect. The disorder is a result of prolonged and extreme stress, particularly childhood abuse (Van der Hart, Nijenhuis, & Steele, 2006).

Exposure to potentially traumatizing events is associated with an elevated risk of developing enduring physical, psychological and social problems. Gilbert et al. (2009), in a cross-country study of high-income countries, summarize that 25–33% of maltreated children meet the criteria of major depression by their late twenties. Furthermore, they found that 23% of people who were sexually abused, 19% of those physically abused and 17% of those who had been emotionally neglected before the age of 12 had PTSD at the age of 29 years. A meta-analysis of children who have been sexually abused suggests a dose–response effect, with higher risks associated with penetrative sexual abuse than with contact or non-contact abuse (Steine et al., 2017).

Group treatment is now commonly offered to traumatized clients in outpatient services. The rationale for this, in addition to the cost-effectiveness, is the importance of interpersonal learning, and the opportunity for corrective emotional experiences and the instillation of hope (Yalom & Leszcz, 2005). However, few men are attending group treatment. According to Andronico (1996), men's avoidance of psychotherapy generally, and group therapy especially, has to do with the cultural masculine identity. Masculine identity requires men to be both strong and performance oriented, as well as adventurous and emotionally reticent. This may, in group therapy, appear as leadership competition, hierarchical preoccupation, rivalry, and limited interest in expressing and sharing emotional experiences.

To our knowledge, there is only one study examining the effect of group treatment for men with a history of sexual, physical and emotional childhood abuse. Hopton and Huta (2013), in a quantitative study, included 260 men in a group intervention with a focus on both gender role socialization and the creation of a trauma narrative shared with the group. The intervention revealed improvements in both depressive and post-traumatic stress symptoms. The participants referred themselves to treatment on a community level (Hopton & Huta, 2013).

In Norway, a model consisting of a three-phase model for complex trauma treatment has received increasing interest over the past 15 years. This model consists of a first phase (safety) focusing on stabilizing the patients, a second phase (recovery) with a focus on working through the traumatic experiences, and a third phase (reconnection) that aims to rehabilitate and reintegrate the personality (Herman, 1992). A meta-analysis of different group treatment models concludes that despite the widespread clinical use of the three-phase approach, the amount of research is limited (Dorrepaal et al., 2012; Fritch & Lynch, 2008). In Norway, a modified first-phase stabilizing treatment manual from the Netherlands, with psychoeducation, skills training and homework as the three main pillars, is frequently used in the treatment of complex traumas

(Boon, Steele, & van der Hart, 2011; Michalopoulos, 2012). Stige, Binder, Rosenvinge, and Træen (2013) included 13 females with unspecified traumas in a qualitative study, using a modified version of this treatment manual. They found five interrelated, but distinct main themes: finding new ways to understand one's emotions and actions, moving from numbness towards vital contact, becoming an advocate of one's own needs, experiencing an increased sense of agency, and staying with difficult feelings and choices. However, the manual describes symptoms and techniques mainly from a feminine perspective (e.g. use your favourite perfume). This is of importance as many men struggle with psychological, social and somatic consequences of traumatic events, and should be offered treatment adjusted to their needs. In spite of the fact that a large number of men are survivors of sexual abuse (Gonsiorek, Bera, & LeTourneau, 1994), treatment research focusing on male victims is virtually non-existent in comparison to research on female victims. There could be several reasons for the lack of treatment studies including male victims. First, it could be due to the nature of the men's abuse experiences (Fisher, Goodwin, & Patton, 2009). Secondly, male victims often reveal a symptom picture that is difficult to understand. Thirdly, the men's shame and alexithymia may be a hindrance to seeking help (Levant, Hall, Williams, & Hasan, 2009). Consequently, it is important to evaluate how men experience recommended trauma treatment. To our knowledge, no previous studies of this intervention have included male victims and focused on the gender perspective.

The main aim of the present study was to examine how male victims experience trauma-stabilizing group treatment in a group with only male participants.

2. Material and methods

The study has a qualitative explorative approach and was conducted in a natural setting, based on data from semi-structured interviews (Smith, Larkin, & Flowers, 2009). This method is especially suitable for use in a field for which there is a lack of knowledge. Moreover, it is important to examine in detail how people make sense of their experiences, in their own terms, without attempting to fix experience in predefined or overly abstract categories.

2.1. Participants

The study is based on five out of six men who attended a stabilizing trauma group from April to November 2013. Before inclusion, they were thoroughly interviewed with an emphasis on their trauma history, their relation to the offenders, PTSD symptoms, dissociation, interpersonal difficulties, affect regulation problems and somatic symptoms. One of the participants refused to consent to the present study because the qualitative interview had to be recorded. The men were aged between 29 and 64 years, and all were ethnic Norwegian. Only one of the men was working. All had low incomes and were on state benefits. One had a history of substance addiction, one of substance abuse and one of alcohol addiction. All five men were single, and none had children. Most of them had a long history in the mental health care services, ranging from 2 to 45 years of treatment. Their previous diagnoses were social anxiety, depression, substance abuse and substance addiction. Their present diagnosis was complex PTSD, and all had experienced multiple traumas from childhood (sexual abuse, physical abuse, emotional abuse or neglect, or most often combinations of these). Two of the men had had female offenders, three male offenders, and one both male and female offenders.

2.2. Recruitment

Patients with a history of trauma consecutively referred to Mortensrud outpatient clinic in Oslo, Norway, were screened for inclusion in the study, and if eligible, referred to the group unit for stabilizing treatment. Patients eligible for the group intervention were given oral and written information about the study. Patients in the study were evaluated with standard clinical instruments at the outpatient clinic: the Circumplex of Interpersonal Problems (CIP) and Symptom Checklist-90 (SCL-90). In addition, patients in the study were screened for PTSD with the Traumatic Experiences Checklist (TEC) and the Impact of Event Scale – Revised (IES-R). If a PTSD diagnosis was confirmed, the participants were further evaluated for complex trauma with the Dissociative Experiences Scale (DES) and Strengths and Difficulties Questionnaire (SDQ). If DES revealed excessive dissociation, the patients were interviewed with the Interview for Dissociative Disorders and Trauma related Symptoms (IDDTS) to assess the type and level of dissociative symptoms. Patients who fulfilled the criteria for complex PTSD were included in the study. All participants provided written informed consent, but one treatment participant refused participation in the study when he was informed that the interviews had to be recorded.

2.3. The intervention

Our intervention is in accordance with the psychoeducational manual from the Netherlands (Boon et al., 2011). The duration of the intervention was 22 weeks, with one meeting each week. Every meeting lasted for

2 hours. There were two female group leaders. According to the manual, one psychoeducational topic relevant to the men's diagnosis was presented each session. As homework, the participants were asked to read and relate the topic to their own symptoms and practise exercises to reduce their trauma symptoms.

2.4. Ethical aspects

The study was approved by the Regional Committee for Medical and Health Research Ethics (2014/423094).

2.5. Data collection

Data were collected by interviewing one participant at a time, through a semi-structured interview. The interviews were conducted by an experienced clinical psychologist. She did not know the patients and had never met them before. The qualitative interview comprised open and expansive questions. The interview included both descriptive and more evaluative sequences. The main theme in the guide was how the participants experienced the treatment, expressed as freely as possible. The focus was on their expectations and experience of change, and their own ideas about the reasons for change. The interviews were digitally recorded, and transcribed in a slightly modified verbatim mode by the first author.

2.6. Data analysis

Data were analysed by interpretative phenomenological analysis (IPA) (Smith et al., 2009). IPA is a qualitative research method with analytic attention on the participant's attempts to make sense of their experiences. In this method, phenomenological and hermeneutical principles are supported. This means an emphasis on the mutual co-creative and interpretative nature of the meaning that the participants and the interviewer, and in the next stage the researchers, are ascribing to their experiences. The first author transcribed the interviews verbatim. The text was then read and reread several times by all three authors. The content was coded into categories that best represented the meaning stated. An independent reading of the interviews, and an ongoing dialogue and discussion of a relevant and meaningful categorization, have been implemented in line with this understanding. The first author was both one of the group leaders and a researcher.

The process is described in six steps (Smith et al., 2009): (1) reading and rereading the original data; (2) initial noting, close, line-by-line analysis of the experiential claims, concerns and understanding of each participant; (3) identification of emergent patterns within the material, and then a dialogue between the researchers about what these concerns might mean for participants, leading to a more interpretative account; (4) development of a structure, frame or gestalt which illustrates relationships between themes; (5) moving to the next case; and (6) looking for patterns across cases, to establish recurrent themes.

The understandings of the recurring themes were also discussed in the qualitative research network at the Research and Education Department at Oslo University Hospital.

3. Results

The analysis of the interviews revealed five main themes. The themes highlight the experiences of the five male group members and describe both positive and negative experiences: (1) Group atmosphere, comprising safety, community, emotional openness, anxiety and pressure; (2) Learning, categorized into knowledge and self-understanding; (3) Motivation, divided into inner and outer motivation; (4) Structure, comprising the structure of the meetings, group size and duration of the meetings; and (5) Gender, defined as the experiences of being in an all-male group with female group leaders. For examples of the ways in which the five themes were addressed by participants, see Table 1.

3.1. Group atmosphere

The group atmosphere is the emotional climate in the group, consisting of both positive and negative emotions which arise in the interpersonal interactions in the group. We have gathered and then divided this theme into five meaning units.

3.1.1. Safety

All participants referred to safety as an utterly important prerequisite for their attendance in the group.

> It is all about trust. What you tell in the group stays in the group. You are not being judged by the others.

Thus, for these men, it seems as though trust and acceptance are the most important factors in the feeling of being safe.

3.1.2. Community

All participants described the experience of being together and sharing common feelings as the most beneficial experience in the group. This was made possible because they felt safe and accepted by the others. One participant expressed the importance of community as follows:

Table 1. Important reflections from patients in the group treatment.

Theme	Meaning units	Quotations from patients
Group atmosphere	Safety	It was a safe environment in the group. I was not judged by the others … It was important to me.
	Community	In the beginning it was a bit scary to sit together with the others. When we got to know each other better it was easier.
	Emotional openness	You get a lot of support from the others in the group.
		Excellent! All have same ideas and thoughts … or very similar ideas and thoughts.
		I think that men would find it easier to open up when it is only men in the group.
		It is perhaps a good thing for us to open up to talk about things, and it is perhaps not so easy for a man.
	Anxiety	I recognized that the others were stressed by me. Maybe they thought: 'What is it with this guy?' I was shivering and tried to find something to look at when someone asked: How do you feel like being here now? I said: 'Just terrible, I just want to go home'.
		If I had a bad day it was hard to be there. I just wanted to leave. I felt it was too hard. We talked about traumas, and my own trauma history became too close and strong.
Learning	Knowledge	Something as simple as if I get a panic attack when I am outside, I can inflict a slight pain on myself, not to disappear. Like pinch my arm, put the nails in my hands, something like that. To find an anchor …
	Self-understanding	And then I remembered that they said, in particular one thing that actually helps me a little bit: 'You are here, it is now, and all is good'. Sayings like that actually help when you are having a bad time.
		And if I can understand it, I can come through it, I think. There have been many occasions where I have understood things, or had these little 'aha' understandings, during this period. Understanding what is anxiety, for example. How to deal with it.
		So it is important to be conscious about it, what's going on up in the computer? (brain).
Motivation		If I had not been psychologically ready for the course, I would have certainly dropped out. I just wanted to change, have a better life and stuff like that. So, it has been very important to me.
		It's not always that you want to participate in the group. Then I often pushed myself to attend.
Structure	Meeting structure	I feel that the order of things has been good. … In part one it was not much I haven't heard before … but in part two there was much that I had not worked with before. So I feel that it has been a very good inclination. Get the most difficult thing in the end, in a way.
	Group size	I just feel that when the group was full there was very little time for each of us. When the group was smaller it was more appropriate.
	Duration	I think it was OK: Of course, it was advancing very fast, but it had to be like that. Thus, you can't hold on for several years with such a course. So, you can take this course and I think it is OK, but the important thing is that you use it further, because otherwise I think you forget it, and then I think you don't get anything out of it.
Gender		Because of my traumatic history, I have always had problems relating to women. It is easier to relate to other men.
		If women attended the group something would be lost, something that you don't dare to say. Men talk differently to other men than to women. It is easier sometimes to have a man-to-man talk. I noticed sometimes that when we talked as men only, then we suddenly agreed very quickly. It was like that when we talked about feelings of weakness. I noticed that all the others agreed quickly and said: 'yes … yes … yes'.
		You get the same perspective as you have yourself. I felt that very many of the men felt they had not filled the male role, in a way. We did basically agree on that. If there had been women in the group, I don't quite know how it would have been.
		It was important to me to see that other men have also experienced trauma. It was not said what kind of trauma and stuff like that then, but … I think it has been OK. For I have understood that everyone has recognized what we have been working with. It was quite obvious.

> I am not alone in it, somehow. It has helped. That you sit there with a group of people who have experienced the same as yourself.

This participant is contrasting the feeling of community in the group to feelings of loneliness and the feeling of being different from others outside the group.

Another participant highlights recognition and equality as important:

> I recognized myself in the others, and I felt a sort of equality with the others.

3.1.3. Emotional openness

All of the participants mentioned emotional openness as a goal in itself, not only as a prerequisite for being able to share experiences. Openness in this regard is a feeling of being emotionally free to express feelings and thoughts. All of them mentioned a longing for this freedom, and had more or less the feeling of being able to open up:

> I've been more open, and, it was fine […] especially at the end, I noticed that people became more open.

> I have always had trouble with opening up in front of other people. Some things are easier to talk about now, but there is still a lot that I can't talk about.

3.1.4. Anxiety

The participants described two types of anxiety in the group and between the sessions: social anxiety due to the attention from the other group members (performance anxiety or shame reactions) and anxiety from activating traumatic memories (flashbacks and dissociations).

Traumatic anxiety reactions such as flashbacks, somatic hyperactivation or emotional arousal were mentioned as a reaction to stories or emotions told by others in the group, or as reactions to the content in the learning material. Symptoms such as dissociation were described:

> I have had many other symptoms than flashbacks. I have dissociated a lot.

3.2. Learning

The participants described learning as a very important part of their experience, but with very different meanings. The answers ranged from the learning of specific techniques, to general insight, knowledge about the disorder, understanding of themselves, their own feelings and relations to others, and personal growth. It seems that the understanding and accepting of their victimized situation was a shared experience and highly valued by everyone, while the specific techniques they used to master their symptoms were more individual.

3.2.1. Knowledge

Everyone said that they had learned techniques to master their symptoms:

> I learned a lot of different techniques. This was mainly about being present in the moment and being more relaxed. To take a deep breath is the easiest for me.

Some appreciated concrete knowledge:

> To learn about amygdala and stuff like that, was very interesting. I've never heard about this before …

3.2.2. Self-understanding

The participants appreciated achieving a new understanding of themselves and their symptoms:

> It is important to understand. It is all right to get to know why things are as they are. When you are able to understand, when you know why things are as they are, then it is possible to go a bit further.

Others emphasized information about the diagnosis and how this information influences self-image and feelings of shame:

> Yes, earlier I thought that it's something wrong with me, but it is not, it is the things I have experienced that are wrong. This is a huge difference. If there is something wrong with me, it is easier to hide.

3.3. Motivation

The motivational factor was mentioned by everyone as an important prerequisite in their struggle to overcome their hindrances and be able to learn and relate in new ways. Some of the participants experienced this as an outer pressure from the therapists:

> I think it is very good that they push us to be more open.

while another could not see the usefulness of this pressure:

> I did not see the meaning in being pushed.

However, most of the men experienced this pressure as their own inner motivation. This inner motivation was something they either felt they had or felt they were missing:

> You must be in a process, something pushing you, working all the time. This is essential.

3.4. Structure

In this category, we have collected the most important organizing factors that were experienced as building a secure frame in the treatment group: the meeting structure, the group size and the duration of the meetings.

3.4.1. Meeting structure

The structure, rhythm and repetition of the meetings were things that all participants appreciated and mentioned as important in their experience of a secure frame, repeating a certain pattern every time:

> We came, we logged on, as we called it, said hello to each other … chatted a little about what we had done at home last week … So it just went that way, and it was very good.

3.4.2. Group size

This theme was mentioned by only one participant. He had severe social anxiety, and appreciated the safety of being in a small group:

> I've had social anxiety too, so it has also been good to have a small group to deal with.

At the same time, he reflected that it is difficult to hide in a little group:

> … although it was also a bit scary.

3.4.3. Duration

Both the length of each meeting and the total duration of the course were experienced as being too short for most of the participants. One felt that he did not get enough attention and time:

> At the start I felt there was too little time on each individual in a way. […] I feel the sessions could have been longer. When you talked about what you consider as important things, three of the other participants interrupted you and told things important to them. So, it was too little time for each of us perhaps.

3.5. Gender

The participants saw it as an advantage that the group included only men, both the men who had experienced mixed treatment groups before, and those who had no prior experience. They mentioned the male gender role as common ground, and the need to share their thoughts and feelings about this topic. Two of the participants had been traumatized by women, and they felt it safer to be with men. One participant felt that the comradeship between men was a facilitator in opening and sharing experiences:

> You feel like buddies in the group … if it is a mix, then you may not show the feelings, maybe.

Some of the men mentioned that the gender role makes it more difficult to be open and honest with women in the group:

> … I think it is easier to open up when it is a men only group and stop to think: 'What will she think about me when I say this?'

Most of the men felt that the masculine way of talking was easier in the all-male group. Some of them also said that it is easy to think that women are experts on feelings, and that their own feelings are not important or the right ones. One of the participants mentioned that experiencing that other men too could have traumatic experiences was important. One of the participants mentioned the shame reduction as important in the meeting with other men:

> … you get confirmed that: 'Hey, you are not as crazy as you think!'

None of the participants mentioned the fact that the two group leaders were women, but when asked about this, they said that they were professional, elderly women and therefore not in the relevant category. When the interviewer questioned them further on this topic, three of the participants reasoned that it perhaps would have been easier to feel understood and to identify with the therapists if at least one of them had been a man.

4. Discussion

The present study identified five themes concerning how men with complex PTSD experience group treatment: Group atmosphere, Learning, Motivation, Structure and Gender. In the following, we will discuss the findings as a frame for understanding the relations between the men's experiences and their needs as victimized men.

4.1. Group atmosphere

We were surprised that the group atmosphere was so important to the men, as reported in the interviews, as they did not give signals in that direction during the group sessions. The men were not very talkative and seemed shy. This was also apparent during the breaks, when they walked around alone, looked at things and often fidgeted with their mobiles. This general lack of expression of feelings and thoughts in the group may be linked to the common 'gender role alexithymia' described by Levant et al. (2009), or we may think of it as a specific expression of the supposedly higher shame level that follows being a man and victim of abuse (Aakvaag, 2016). However, in spite of this silence, they individually described both pleasant and unpleasant feelings and thoughts about the atmosphere in the group. In other studies of group therapy with men, it is common to use different concepts to describe the positive group factors, such as cohesiveness and freedom of emotional expression (Beech & Hamilton-Giachritsis, 2005), holding, support and safety (Drožđek, Kamperman, Bolwerk, Tol, & Kleber, 2012). For the men in our

study, who had been traumatized by violence and sexual abuse in childhood, the need to be seen and accepted as one of many in a supporting group may be of paramount importance. To what extent this differs from groups with only females is difficult to interpret. It could be speculated that the group atmosphere is more important for men than women. Men with complex traumas seem to be more socially isolated than women and have seldom established their own families. This is to some extent in line with a study from Canada including 260 men with a history of physical or emotional traumas, where the rates of marriage and employment status were lower than in the general population (Hopton & Huta, 2013). In a study by Stige et al. (2013) including 13 females, 10 had children and four were working. In the present study, only one man was working and none of the men had a cohabitant or children. Consequently, it could be that the group setting for men is important as a training area for establishing new relationships.

4.1.1. Safety

The group members described the feeling of being safe first and foremost as a feeling of trust and acceptance. These men had their triggers in the interpersonal field, not in the outer world. They emphasized the confidentiality in the group more than their physical security. In trauma theory, lack of safety reflects the trauma experience, and the topic is dealt with in areas reflecting the kind of traumatic threat: physical, emotional and relational safety (Herman, 1992). In accordance with this, it might be expected that safety for the group members, who had experienced violence and sexual abuse in close relationships, would mean physical, emotional and relational safety. But for these men, safety means first and foremost freedom from people's judgement. This can be understood as it not being the trauma itself, but the interpersonal and intrapsychic dooming and shaming, that is the core of the anxiety. This also corresponds to other findings which state that safety is particularly crucial in all-male groups, reflecting that men only will open up to vulnerable feelings when they are certain that they will not be shamed or blamed (Joliff & Horne, 1996).

4.1.2. Community

In this psychoeducational intervention, every person has their own goal. The communications in the group focused on the participants' skills training and trigger handling. In line with the treatment method, we had told the participants to avoid sharing trauma histories in the group, to prevent too much involvement and retraumatization. Despite this, the factor 'community' was mentioned as the most beneficial experience in the qualitative interviews. Community recalls Yalom's factors 'universality' and 'group cohesiveness' (Yalom & Leszcz, 2005). According to Yalom, the patients, 'after hearing other members disclose concerns similar to their own, report feeling more in touch with the world and describe the process as a "welcome to the human race" experience'. In open therapy groups, where disclosure is a significant part, many studies report this theme as most beneficial, and the patients who reported themselves improved were significantly more likely to have felt accepted by the other members (Yalom & Leszcz, 2005). In psychoeducational courses, where disclosure of self is not a part of the intervention, it is less obvious that the feeling of acceptance and community is being emphasized by the participants. However, Stige et al. (2013) found the same positive effect of community and self-acceptance as in our study. They explain this by the common focus in the current trauma-related symptoms that they experienced and shared in the group. The participants were helped to recognize themselves in the others in the here and now, without being overwhelmed by trauma histories.

4.1.3. Emotional openness

Emotional openness was a personal goal for the participants. This was an unexpected finding in so far as openness was never a goal in the intervention and was not in their individual treatment goals. Emotional openness was never verbalized during the sessions, but during the interviews all participants revealed their longing for openness. According to Aakvaag (2016), trauma-related shame is a specific and common affect in victims of childhood abuse, and we speculate that victimized men are more prone to feeling double shame: the shame of being a victim and the shame of being a weak man. The feeling of being seen and accepted is the most 'anti-shaming' factor, and emotional openness is necessary to reach this goal. In an open long-term group with men, Seager and Thümmel (2009) conclude that the gender-specific setting is more suited to men with severe and complex psychological needs, and that the need to find another way of being male is facilitated by the experience of tenderness in the group. This facilitates the need to open up to the other, to be vulnerable, and is dependent on sufficient trust.

4.1.4. Anxiety

The participants in the present study reported severe anxiety, consisting of both social anxiety and trauma reactions. Many constantly re-experienced the trauma while they were participating in the intervention. This was to some degree surprising as, except for one strong emotional reaction with tears, the group was mostly silent and showed few emotional reactions. Social anxiety is a common factor in all group treatment. The trauma reactions, on the other hand, are specific to the traumatized victims. Together, these create a high level of anxiety in the group, and we can

understand the participants' situation like fighting on two fronts: the anxiety arising in the here-and–now experiences in the group, and the anxiety with roots in the past, the trauma reactions.

In a qualitative Norwegian study on women attending a similar course, the participants mention more symptoms arising during the first period of the intervention (Stige & Binder, 2017). In psychodynamic theory, this phenomenon is seen as a sign of starting change, and as a result defence mechanisms increase. The result is an inner motivational conflict between the wish to change and the wish to stay in the known, and the conflict is expressed in a feeling of anxiety. However, after 3 months, the participants who had previously felt numb and out of touch with their experiences remarked that increased symptoms were experienced as part of the recovery process (Stige & Binder, 2017). They described this as an increased ability to stay with their own experiences, and find hope and meaning in their lives. In contrast, participants in the present study were interviewed only immediately after the intervention. It would have been interesting to explore whether the anxiety level among the participants in the present study levelled off after the intervention as a sign of recovery.

4.2. Learning

Increased insight, self-understanding and the ability to handle symptoms seem to differ among the participants in our study. This may reflect their differences in personality and coping style with regard to inner and outer motivation. The need for insight and understanding may be an acceptance of oneself or an attempt to reduce the feeling of shame. To achieve control of their own reactions and relations, people need to handle their symptoms in an optimal way. This theme is frequently reported in both quantitative and qualitative studies (Briere, 2010; Zlotnick et al., 1994). Some studies also mention corrective emotional learning as a result of the positive experiences in the group as a precondition for being able to use the knowledge in their own life (Boon et al., 2011). This is probably of importance also in mixed-gender groups and groups with only females. In our group, the experiences of being met and seen with acceptance can be seen as a corrective emotional learning to the expected judging or attacking response.

4.3. Motivation

Motivation was experienced in two different ways. Some of the men experienced the homework tasks or the therapists' questioning in the group as outer push and pressure to perform. These men had high levels of performance anxiety and were occupied with questions of existential meaning, social shame and shortcomings. The participants who experienced the pressure as an inner motivation were more task oriented, and had the belief that it was up to them to succeed or not. They wanted to control the situation through mastery, and perhaps to avoid the victimization position. The importance of motivation is also strongly stressed in the study by Stige and Binder (2017). It could be speculated that patients with a strong passive victim orientation, and a symptomatology characterized by ruminating and existential problems, might profit more from a treatment focused on sharing and communications as in a traditional group therapy model, rather than an exposure and mastery-oriented psychoeducational model.

4.4. Structure

Our findings suggest that the participants experienced the rigid structure in the trauma-stabilizing group as important for improvement. This is in line with a study from Michalopoulos (2012), who showed that traumatized patients who participated in traditional process-oriented open group settings did not manage to be present in the here-and-now situation. Their trauma reactions made them dissociate and feel out of contact in an unpredictable and less structured group setting. The importance of structure points to the importance of having the group rules and rituals in mind when constructing the schedule for the courses. Even though the intervention emphasized the prevention of sharing trauma stories, the men were nonetheless under great influence from the group. Their vulnerability needed protection in the form of continuity and stability, to help them to stay in the 'tolerance window' (Briere, 1996), which means to be optimally emotionally, physiologically and cognitively present.

4.5. Gender

The participants in this study were all men, and the therapists were women. In spite of this, the participants described it as being safe to relate to the men in the group, and that the leaders were professionals and not first and foremost women. When asked, none of them agreed that the group leaders also should have been men. However, two participants wondered whether it would have been better if one leader had been a man and the other a woman, thinking that it would be easier to identify with a male group leader. The results of the present study could be influenced by the fact that there were two female group leaders. It could be that the 'gender blindness' failed to recognize the signals of the

patients' anxiety and their wordless communication taking place in the group. It could also be that the men were too polite to speak freely about their wish to have male group leaders. The advantages of gender-specific groups for men have also been shown in previous studies. They highlight the verbal and non-verbal support and the emotional freedom of using their own language, leading to more self-understanding and acceptance (Reimer & Mathieu, 2006; Seager & Thümmel, 2009). Other studies describe men's difficulties with female participants, such as men trying to flirt, competing for attention and using a lot of energy to engage with the women in the group (Joliff & Horne, 1996). Consequently, it seems important to offer gender-specific group treatment when it comes to traumatized men.

4.6. Frame of relationship between themes: shame

Shame seems to be an overarching issue in every theme. Shame can be the most disturbing and dominating feeling in the men's lives, making them try to avoid being seen, not looking at other people, protecting their bodies in sheltering postures and clothes, avoiding talking or making noises, and if possible placing themselves at a distance from other people. Shame seems to be a hindrance to showing who they really are, and to participating in the community that they long for. When they experience the positive force in the group, they become attracted to the community and comradeship, but the price they pay is having to reveal themselves and let the others see the shame-awakening self. This threatens the shameful person's assumptions about other people – that they are not to be trusted, are evil and make you lose – and awakens their anxiety and inner pressure. They experience an inner conflict and feel this to be very tough. However, it seems that the present intervention, with its psychoeducational approach and an accepting group atmosphere, helped the men to accept themselves and their traumatic history of abuse, and thus reduce their feeling of shame.

5. Conclusions

There seem to be a lot of advantages to inviting men to gender-specific groups for trauma-stabilizing treatment. All of them emphasized the support they received in the group and that participating in a mixed-gender group would have been more difficult. In the future, it may therefore be important to arrange all-male stabilization groups with more focus on male-specific topics. Further research should focus on how men experience the intersection between the traditional male role, the cultural delusions about male victimization and the experience of being a male victim. Furthermore, studies aiming to examine the effect of this intervention (e.g. randomized controlled trials) are warranted.

6. Limitations

The results of the present study must be considered as preliminary. As this was a qualitative study with few informants, our findings may not be valid for all patients. The first author was both the group leader and the researcher. This may have influenced the results, but the research group made a deliberate effort to bracket preconceptions in all phases of the study. Still, it is possible that other researchers with a different theoretical framework might have identified and classified themes differently than has been done in the present study.

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