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Multidisciplinary group therapy for refugee patients with PTSD/CPTSD and psychosomatic comorbidity

Terapia de grupo multidisciplinar para pacientes refugiados con CTEPT/TEPT y comorbilidad psicosomática

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ABSTRACT

In this paper, we present a pilot project for multidisciplinary, time-limited, therapeutic treatment for patients living in exile, severely traumatized by war and/ or torture, suffering from complex post-traumatic stress disorder (PTSD), and psychosomatic comorbidity. The project was developed and conducted at a specialized, public out-patients unit in Gothenburg, Sweden, during February 2022 and June 2023. The authors, a psychologist and a physiotherapist, questioned the dualistic perspective in trauma treatment and aimed to test a new therapeutic model for group setting integrating two clinical approaches, i.e., psychodynamic process-oriented group treatment, and Norwegian psychomotor physiotherapy. The model is characterized by a trauma-informed and culturally sensitive perspective. The background and development of the project is described, along with clinical experience and reflections on the potentialities, and challenges of a co-therapeutic group setting integrating two professions in the treatment of severe psychic trauma.

Keywords: Trauma; Exile; Group-Treatment; Co-therapy; Multidisciplinary.

RESUMEN

En este artículo presentamos un proyecto piloto de tratamiento terapéutico multidisciplinar, de duración limitada, para pacientes que viven en el exilio, gravemente traumatizados por la guerra y/o la tortura, que padecen trastorno de estrés postraumático (TEPT) complejo y comorbilidad psicosomática. El proyecto se desarrolló y llevó a cabo en una unidad ambulatoria pública especializada de Gotemburgo, Suecia, durante febrero de 2022 y junio de 2023. Los autores, un psicólogo y un fisioterapeuta, cuestionaron la perspectiva dualista en el tratamiento del trauma y se propusieron probar un nuevo modelo terapéutico de grupo que integra dos enfoques clínicos, a saber, el tratamiento psicodinámico de grupo orientado al proceso y la fisioterapia psicomotriz noruega. El modelo se caracteriza por una perspectiva informada sobre el trauma y culturalmente sensible. Se describen los antecedentes y el desarrollo del proyecto, junto con la experiencia clínica y las reflexiones sobre las potencialidades y los retos de un grupo coterapéutico que integra dos profesiones en el tratamiento de traumas psíquicos graves.

Palabras clave: Trauma; Exilio; Tratamiento en grupo; Coterapia; Multidisciplinar.

Introduction

The Crisis and Trauma Unit in Gothenburg, Sweden, was founded in 1994 as a public health outpatient service. Our mission is to provide clinical treatment for adult refugees suffering from torture-and-war trauma-related mental health issues. These individuals have endured extreme forms of traumatization, often including dehumanization and violations of their bodies and human rights. While many of our patients are diagnosed with post-traumatic stress disorder (PTSD), complex PTSD (CPTSD) (WHO, 2018), depression, and other anxiety disorders, we recognize that focusing solely on diagnostic terms risks overlooking essential aspects of their suffering, such as forced exile. Moreover, some patients in our care struggle with somatic and/or psychosomatic comorbidities, making their treatment more complex. While our unit primarily offers trauma-informed treatments, particularly individual psychotherapy, we acknowledge the limitations of this approach for refugees from collectivist societies. To address this, we aimed to develop an integrative, culturally sensitive group-based intervention. In our search for existing models and approaches, we found interesting ideas (Bunn et al., 2015; Kira et al.,

2010; Papadopoulos, 2002), but often encountered differences in theoretical frameworks or a lack of implementation of co-therapy, as we envision it—in which two therapists in the same clinical setting integrate their interventions.

Therefore, we embarked on a pilot study to develop and test an innovative integrative group treatment in our regular clinical setting. Our research questions have been: to explore the feasibility of a dual-modality approach to the treatment of complex trauma in a group setting, utilizing co-therapists from two different professions; and to determine whether addressing trauma-related symptoms such as difficulties in emotion regulation, negative self-perceptions, and aspects of interpersonal relationships, while simultaneously exploring how these issues manifest in and through the body, positively affects the patient's well-being.

Trauma and the body

The concept of trauma and its aftermaths could be defined from many different perspectives. Here we adhere to psychoanalyst Sverre Varvin (2003, 2017) when he describes the central feature of the post-traumatic condition as the inability to sustain a sense of basic trust, and the loss of the internal empathic other. Traumatic experiences tend to corrode the dialogue with internalized safe others, necessary for developing the capacity for self-reflection and processing. Language falters, often leading to silence and avoidance as mechanisms to cope with anxiety and intrusive memories.

Boulanger (2005) describes the effects of terror and annihilating experiences in adulthood as a collapse of the self as a psychological/symbolic entity. Basic experiences of being an embodied subject and an active agent in life are shattered. The traumatized self's ability to identify, interpret, and self-regulate cracks, along with the empathetic skills to identify feelings and emotions of others, thereby disrupting the intersubjective dimension. The traumatized individual frequently withdraws emotionally from their surroundings, strengthening personal boundaries as a defense against perceived threats, leading to self-centeredness and preoccupation. Trauma must be recognized as a subjective experience affecting individual psychological and physical and collective aspects, including family dynamics, identities, and broader social and cultural issues.

The role the body plays in trauma has been widely explored by experts in the field. Various body-oriented approaches have been developed for the treatment of trauma and post-traumatic disorders. Notable contributors to this field include Peter Levine (1997), Steven Porges (2011), and Bessel van der Kolk (2014).

Methodology

In this work, we integrated trauma-adapted psychodynamic process-oriented group therapy approach, with Norwegian Psychomotor Physiotherapy (NPMP)[1] (Bunkan, 2001; Garland et al., 2002; Garland, 2009; Sandahl et al., 2014). Our model's primary theoretical framework is phenomenology, chosen for its capacity to accommodate our theoretical and practical approaches. We aim to transcend biomedical reductionism by viewing the body as a "bearer of meaning" (Kirkengen & Thornquist, 2012) filled with lived experiences—an approach summarized by the concept of "embodiment". The group began in February 2022, holding weekly 1.5-hour sessions until June 2023, totaling 1,5 year with three holiday breaks of varying durations. In total, there were 59 sessions (60 planned, with one cancelled), and the 1.5-year duration was predetermined. Recruitment was conducted through the routine assessment process at the unit. Inclusion criteria encompassed PTSD or complex PTSD without severe dissociation, along with pain problems or somatoform syndrome. Participants were required to be Swedish speaking, motivated for group treatment, and could be of any gender. Exclusion criteria included untreated orthopedic injuries or organic diseases as primary issues, psychosis, severe dissociation, antisocial personality disorder, and a residence permit duration of less than two years. Our aim was a heterogeneous group, but the final composition was relatively homogeneous, consisting of four women and three men aged 39 to 56. Five participants were from the Balkans, and two were Arabic men, all with war-related traumatic experiences, two from childhood. Two had severe torture experiences

[1] A clinical approach in physiotherapy for mental healthcare, rooted in a phenomenological understanding of the body, focusing on person-centered and process-oriented care. Primarily used for complex clinical conditions with psychosomatic symptoms, including severe psychiatric conditions such as trauma and post-traumatic outcomes, NPMP has been adapted for group and multi-professional settings. Given its compatibility and synergy with psychotherapeutic-psychodynamic approaches, we proposed NPMP as a suitable component for the treatment design.

over 30 years ago. All had prior psychiatric or psychological treatment for posttraumatic reactions, with limited success. Some had received medical or physiotherapeutic care for pain and somatic symptoms.

All had lived in Sweden for many years and were fluent in the language. Treatment outcomes have been assessed using both quantitative and qualitative methods. Quantitative measures include the PTSD Checklist for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (Weathers et al., 2013), the International Trauma Questionnaire (Cloitre et al., 2018), the Kessler Psychological Distress Scale (Kessler et al., 2002), the Comprehensive Body Examination (Friis et al., 2009), the Body Perception Questionnaire-Short Form (Cabrera et al., 2018), and the Group Climate Questionnaire (MacKenzie, 1983). Additionally, qualitative interviews have been conducted by external parties. The project was approved by the Swedish Ethics Authority, and all patients gave informed consent to participate.

The process

In the initial phase, patients expressed their expectations and agreed to follow the group's rules. The therapy room provided ample space for movement, with participants seated in a circle. Body activities were incorporated into each session, including sitting, lying on mats (in a circle), standing, or moving around the room. Each session adhered to a predetermined structure, starting with 10 to 20 minutes of body activities led by the physiotherapist. During this time, the psychologist primarily observed, occasionally providing verbal input or actively participating in the activities.

Following the initial body activities, the psychologist assumed a more active role as a facilitator, encouraging communication and managing the group's dynamics. Initially, we had planned to end each session with a 5- to 10-minute body activity aimed at integrating body and mind dimensions. However, it quickly became apparent that transitioning from verbal to physical interventions was challenging and may not have been meaningful. As a result, this physiotherapy intervention was kept more flexible and less structured than the opening activities.

The exercises and body activities throughout the process were developed based on the physiotherapist's expertise and collaborative reflections among the co-therapists during session briefings and debriefings. Through joint reflection on the group's dynamics and individual participants' progress, we determined interventions that could effectively support, nurture, or challenge the group during different phases of therapy. This approach allowed us to focus on specific aspects that the group collectively addressed during the therapeutic process.

For instance, in the initial phase, exercises focused on stabilization and enhancing body self-awareness in sitting or standing positions, emphasizing shared experiences and fostering a sense of togetherness without extensive movement or direct physical interaction among participants. As the group progressed to an intermediate phase and began opening to intimacy and personal narratives, exercises in a supine position were introduced to challenge participants' ability to let go and facilitate contact with feelings of sorrow and mourning for their traumatic experiences. Additionally, the titration technique, alternating tension and relaxation of muscles, was utilized to explore and expand the window of tolerance for both individuals and the group as a whole. In the later phase nearing the conclusion of the process, exercises involving amplitude movements such as standing, moving, and interacting at different levels were introduced to challenge rigid nonverbal unconscious communication patterns.

A central theme that we, as group leaders rooted in different professions, have struggled with during the whole process was the administration of verbal and nonverbal therapeutic interventions and modalities, as well as the switch between a more directive and a listening approach. This patient group had experienced traumatic events, some of which were extremely life-threatening and dehumanizing. The effects of trauma tended sometimes to place the group, including therapists, in a field ruled by a fragmented, uncontained, and unthinking system (Stubley, J., personal communication).

In this context, projections and unconscious communication through the body are common. The ability to verbalize mental representations and emotions is compromised, challenging group cohesion, especially when facing primal annihilation anxiety related to traumatic experiences (Hopper, 2003). We will share three clinical vignettes to highlight key methodological challenges and therapeutic breakthroughs encountered during the process.

Clinical vignette 1

We begin with an excerpt from the third session, still in the early phase, in which the focus was on safety and initial interpersonal connections. Both patients and therapists were exploring the group's communication style. In this session, therapists aimed to introduce a new approach to understanding the patients' experiences. The session started with a

directive body-oriented intervention—a simple 1-2-3 rhythmic tapping—to encourage coordination, focus, playfulness, and synchronization to a shared rhythm.

Afterward, there was a moment of silence, during which the psychologist looked inquiringly at the physiotherapist, who asked:

> *If the body could speak, what would it say right now?*

Silence followed, but then group members began to share:

> P5: *Uncomfortable*.
> P6: *I would like to lie down, I feel destroyed…*
> P3: *It would scream!*
> P3 cries and points at her chest: *I have pain everywhere… I feel shame for not being able to work… I also want to lie down on the floor*.
> P4: *I'm tired, I haven't slept for several days…I'm in pain everywhere…*

We observe that some individuals refer to the body as "I", while others refer to it as "it". The body is experienced both as a subject and an object, as flesh and metaphor, and it's given a voice. Through this, various forms of suffering emerge: a desire to resign, to surrender, to cry out, to complain, and to be acknowledged and recognized—an experience shared by the entire group. We note that, in a later phase of the process, the group was encouraged to lie on mats on the floor, which reactivated this material, allowing for further exploration and processing.

Clinical vignette 2

In the 17th session, the group had established a safe environment in which members could dynamically respond to each other and shift emotionally. The session began with a standing exercise led by the physiotherapist, followed by a brief psycho-pedagogical explanation to stimulate anchoring, balance, grounding, and contact with the leg muscles. Participants actively engaged without much resistance. During the verbal part of the session, group interaction centered on topics related to bodily limitations and pain, with a focus on one patient experiencing depressive helplessness. Some members adopted a positive stance, encouraging acceptance and hope, but struggled to connect. Another patient discussed her experience with cancer and pain, questioning the silence surrounding trauma and the purpose of group therapy:

> P4: *But we're not here to discuss our physical illnesses*.
> P6 to P4: *You seem frustrated about this for a while…*
> Physiotherapist to P4: *Do you feel irritated?*
> P4: *No, I'm not irritated… It's mostly about my need to seek help and express what we all carry inside*.
> P3: *That's right…*

The group engaged in a dynamic discussion about the therapy's goals, personal and collective purposes for attending therapy, and personal responsibility:

> Psychologist: *It seems the group is beating around the bush and has ambivalence about discussing the war and its lingering effects*.
> P6: *I'm very afraid to speak… I'm afraid of breaking down and not being able to go home afterwards… Is there enough time and space for all of us?*
> Psychologist: *Some of you have openly expressed that there are things that cannot be named*.
> P1: *There are things I'll never be able to talk about… things that are beastly, that humans can do to each other*.
> P7: *I understand what you're saying from my experience in the Concentration Camp… I've been thinking about you all week and I want to share something important. Although I'm carrying a lot, I'm hesitant to discuss, I've been feeling better lately and haven't had attacks in a long time. Perhaps it's because of the group… the 'elephant'… [referring to the heavy feeling on his chest]. I'll continue attending and want to support everyone. It's difficult to discuss awful issues, but I testified in Le Hague and, although I couldn't share everything, it was helpful*.
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This passage reveals the group's profound struggle with conflict and ambivalence surrounding shame and the fear of both physical and mental breakdown. They began to recognize how discussions about somatic conditions might impede other forms of communication, yet at times, it was the only language they could use to express their suffering. Members started to reflect on each other and confront each other's resistances more openly.

Clinical vignette 3

The final passage we share aims to underscore the challenges and possibilities of co-therapy as we envision it:

The monopolizing overwhelmed and overwhelming patient

In session 34, a patient becomes deeply overwhelmed, speaking in a manic-like manner and sharing brutal trauma-related material. He monopolizes a significant portion of the session, while the group listens without apparent reactions. However, both co-therapists are strongly emotionally affected. The psychologist feels compelled to intervene actively to stabilize the patient and protect the group from potential re-traumatization, while the physiotherapist remains passive and silent.

This dynamic between co-therapists recurred in various critical moments throughout the therapeutic process. One therapist ended up speaking more than intended, while the other became more silent and inhibited. This pattern reflects their characters and personality traits, which exacerbated when exposed to distressing material, creating a rigid dynamic and leading to splitting and frustration, reducing their capacity to lead the group effectively. In this

session, the patient's overwhelming behavior dominated, putting their interplay as co-therapists at risk. Despite the dense group climate, the environment remained nurturing, although the time for body-oriented intervention at the session's end was minimal. At this critical moment nearing the end of the session, the physiotherapist intervened spontaneously and intuitively, leading the group in a closing act. Everyone was invited to stand together in silence for just 1 minute in a circle.

This allowed the group to become aware of the timeframes, and the session was concluded. During the debriefing, we as co-therapists found ourselves unable to communicate openly and comprehend the session's dynamics. Feelings of frustration, confusion, and misunderstanding emerged, and initially, we avoided addressing them. It took some time for us to fully regain our "capacity to think" (Garland, 1998) and mentalize, allowing us to develop an intersubjective understanding of what occurred during the session. Navigating these ruptures as a co-therapy couple and exploring the underlying unconscious dynamics through supervision helped us realize that our initial struggles with verbal and nonverbal interventions, our level of activity, and specific methodological issues were less significant. This realization enabled us to adopt a more dynamic stance, contributing to a safer and more cohesive group-matrix (Hopper, 2003).

Results

Throughout the process, all participants showed good attendance and compliance. One patient ended treatment after six months, and another after a year. Both, the youngest in the group, had childhood war trauma. They left the group orderly, feeling significantly recovered and no longer in need of therapy, anchoring their decisions with the group.

In general terms, when assessing PTSD symptom severity after treatment, it was found that three out of seven patients exhibited notable improvement. Meanwhile, two patients showed no change, and two experienced a slight worsening of symptoms. As for changes in somatic symptoms, they align with results above, with some patients exhibiting chronic conditions and others with clear improvement.

An independent qualitative study conducted by two psychology students from the University of Gothenburg (Hensner & Mattson, 2023) revealed that all participants expressed satisfaction with the treatment, regardless of changes in symptom severity. This outcome merits further consideration and exploration. Several patients noted positive effects of the treatment, including reduced feelings of loneliness and shame, newfound perspectives on themselves and their traumatic experiences, and a deeper understanding of the connection between somatic and psychological aspects. Being part of a group, in which they could both influence and be influenced by others, was described as a positive and transformative experience, aligning with key elements of effective group therapy processes (Yalom & Leszcz, 1970-2020). The study also identifies areas for potential improvement in future treatments. It emphasizes the significance of patients' prior experiences, expectations, and hopes for treatment outcomes. While these factors can positively influence treatment effectiveness, overly high expectations can lead to disappointment. Additionally, patients' existing understanding of the body-mind connection can impact their level of resistance, acceptance, and compliance with physiotherapeutic interventions.

Discussion

To summarize, clearer communication about treatment expectations and assumptions is needed. Providing additional psychoeducation on body-mind dynamics and incorporating more body-oriented activities could be beneficial. However, spending too much time explaining the treatment rationale risks becoming overly didactic.

Additionally, it is important to consider that resistance may stem from avoidance rather than solely a lack of cognitive understanding. Exposing traumatic material in group settings remains a delicate question and a challenge. In the study by Hensner and Mattson (2023), some patients expressed their struggle and ambivalence regarding discussing and listening to others trauma narratives. Verbal and non-verbal interventions addressing traumatic material may inadvertently pressure individuals to speak up, which can be challenging. A potential treatment model could include individual trauma-focused therapy alongside the group intervention, providing a space for targeted exposure work as necessary. Participants' overall satisfaction with treatment, regardless of symptom reduction, prompts consideration of alternative measures to assess progress, particularly for patients with chronic and complex PTSD.

Conclusions

Integrating two therapeutic approaches effectively required structured collaboration between co-therapists. Pre- and post-session briefings and debriefings were essential for reflection and alignment before each session, fostering a cohesive working dynamic.

Embracing differences in co-therapy was crucial to avoid excluding valuable perspectives and hindering the therapeutic process. Throughout the process, we refined our therapeutic styles, transitioning between directive and observant leadership to accommodate the group's dynamics. The goal was to address the dilemma of trauma between compulsive speaking and silence. Despite its challenges, the co-therapy process was rewarding, requiring dedication, openness to differences, curiosity, and mutual respect, resulting in a more holistic approach to trauma treatment.

Conflicts of interest

Nothing to declare.

Disclaimer

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Authors' contributions

Conceptualization: Cabrejas M and Daverio G; **Data Curation:** Cabrejas M and Daverio G; **Funding Acquisition:** Cabrejas M and Daverio G; **Investigation:** Cabrejas M and Daverio G; **Methodology:** Cabrejas M and Daverio G; **Project Administration:** Cabrejas M and Daverio G; **Writing/original draft:** Cabrejas M and Daverio G; **Writing – Review & editing:** Cabrejas M and Daverio G ; **Final approval:** Cabrejas M.

Availability of data and material

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