

Group-Based STAIR for Complex Trauma in an NHS Specialist Psychotherapy Service: A Service Evaluation

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Abstract

This service evaluation examined the outcomes of an 11-week group-based Skills Training in Affective and Interpersonal Regulation (STAIR) within a tertiary NHS specialist psychotherapy service. STAIR is a phase-based stabilisation intervention designed to enhance emotional regulation and interpersonal functioning in individuals with complex trauma histories. Evidence for group-based STAIR within UK clinical settings remains limited. Using an uncontrolled repeated-measures design, 51 adults with complex trauma histories completed pre- and post-treatment measures of trauma-related symptoms (IES-R), depressive symptoms (PHQ-9), and quality of life (ReQoL-10). Trauma-related symptoms and depressive symptoms significantly decreased, while quality of life significantly increased. Effect sizes were small for quality of life and depressive symptoms, and medium for trauma-related symptoms. The findings offer preliminary support for group-based STAIR as a stabilisation intervention within NHS psychotherapy services. Due to the uncontrolled design, improvements may not be solely attributable to participating in the STAIR group. These results contribute to the growing literature on phase-based interventions for complex trauma populations.

Keywords: Complex trauma; STAIR; stabilisation; PTSD; CPTSD

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Introduction

The Effects of Psychological Trauma

Psychological trauma relates to both traumatising events and their lasting effects on an individual's psychological health (Carlson & Dalenberg, 2000). Adverse experiences are known to negatively impact population health (Felitti et al., 1998) and are costly for the National Health Service (Hughes et al., 2020). Furthermore, they are associated with poor mental and physical health outcomes (McKay et al., 2022; Senaratne et al., 2024), interpersonal difficulties (Karatzias et al., 2017) and revictimisation (Courtois, 2012).

Post-Traumatic Stress Disorder (PTSD) is recognised in both the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR; American Psychiatric Association, 2022) and the International Classification of Diseases, 11th revision (ICD-11; World Health Organization, 2018), whereas Complex PTSD (CPTSD) is recognised as a distinct diagnosis within ICD-11. The ICD-11 distinguishes PTSD from CPTSD by including the core PTSD symptom clusters of re-experiencing, avoidance and a sense of current threat alongside 'disturbances in self-organisation' (DSO): emotional dysregulation, difficulty forming and maintaining interpersonal relationships and negative self-concept. The National Institute for Health and Care Excellence (NICE, 2018) guidance recommends Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) for PTSD. For people with CPTSD or additional needs, NICE acknowledges that further adaptations may be needed to promote safety and engagement in treatment. Meta-analytic evidence indicates that EMDR and TF-CBT remain most effective for PTSD symptoms but have less pronounced effects on the DSO domains in adults with complex trauma (Coventry et al., 2020).

Phase-Based Approaches for Complex Trauma

Phase-based approaches have historically been proposed for complex trauma (Herman, 1992). An ISTSS expert consensus survey supported a phase-based approach to the treatment of complex PTSD (Cloitre et al., 2011). This includes an initial phase-one, stabilising treatment to address DSO symptoms by building emotional and interpersonal resilience prior to trauma processing (Maercker et al., 2022). Although the necessity of stabilisation prior to exposure remains debated (De Jongh et al., 2016; Darby et al., 2023), a recent meta-analysis has shown promising outcomes in those with complex trauma histories (Coventry et al., 2020).

The Specialist Psychotherapy Service

The Specialist Psychotherapy Service (SPS) is a tertiary NHS service that provides psychotherapy to adults with complex emotional difficulties who have commonly experienced complex psychological trauma. While some patients have received multiple diagnoses relating to trauma (e.g., PTSD, CPTSD, Borderline Personality Disorder), many present with comorbidities without formal psychiatric diagnoses. At SPS, patients commonly wait up to 24 months for individual psychotherapy, which may increase the risk of

deterioration during this period (Reichert & Jacobs, 2018). To address this, SPS implemented Skills Training in Affective and Interpersonal Regulation (STAIR) to improve wellbeing and psychological stability in this population.

Skills Training in Affective and Interpersonal Regulation (STAIR)

STAIR is a phase-based stabilisation programme that aims to strengthen emotional regulation and interpersonal skills in individuals affected by complex trauma (Cloitre et al., 2020). This approach is based on the theory that trauma survivors experience losses in social, emotional, and environmental resources (Cloitre et al., 2020).

Although evidence is still emerging, recent systematic reviews have indicated that STAIR is associated with significant pre- to post-treatment reductions in trauma-related symptoms and interpersonal difficulties among individuals with complex trauma histories (Lorbeer et al., 2023; Amilhau et al., 2025). However, randomised trials have found no additional benefit from adding STAIR before trauma-focused processing compared with immediate trauma-focused treatment (Oprel et al., 2021; van Vliet et al., 2021).

Group-based Treatments and Stabilisation

There is increasing evidence of promising outcomes for traumatised populations from delivering STAIR in a group format (Gudiño et al., 2016; Jackson et al., 2019). Group-based stabilisation has been shown to improve emotional regulation, interpersonal functioning, and PTSD symptoms in survivors of childhood trauma (MacIntosh et al., 2018). Other studies have discussed important qualitative themes such as psychological safety, group solidarity (Hegarty et al., 2022), and coping skills (Willis et al., 2023). A meta-analysis on individuals with symptoms associated with CPTSD found that trauma-focused group treatments were most effective at reducing PTSD symptoms, while psychoeducational, stabilisation groups were most effective in reducing general psychological distress (Mahoney et al., 2019).

Research on group-based STAIR interventions in UK NHS settings remains limited. This study aimed to evaluate the clinical usefulness of group-based STAIR for people with complex trauma histories within the Specialist Psychotherapy Service.

Method

Design

This study utilised an uncontrolled repeated-measures approach to assess quantitative outcomes both before and after the intervention.

Inclusion criteria

Screening was conducted prior to the start of each group, whereby STAIR group facilitators contacted potential group members via telephone. The inclusion criteria were as follows:

- Clinical presentations consistent with PTSD or CPTSD were identified by clinicians during the initial assessment, although formal diagnosis was not required.

- Comfortable in a group setting and willing to engage with the course material and home practice, ascertained through the screening phone call.
- Awaiting individual psychotherapy within the Specialist Psychotherapy Service.

Participants

The participants' ages ranged from 23 to 72 years. All were routine patients at SPS within the Sheffield Health Partnership University NHS Foundation Trust. The service works with adults with mental health difficulties who have previously engaged with psychological interventions and require further treatment due to persistent difficulties. The STAIR group was offered to patients awaiting trauma processing, who reported difficulties consistent with PTSD or complex PTSD as a primary cause of concern during their assessment, although this was not formally diagnosed. The assessment process includes approximately two hours with a qualified clinician (e.g., psychotherapist, psychologist), the use of the Nine-Item Patient Health Questionnaire-9 (PHQ-9; Kroenke & Spitzer, 2002), Recovering Quality of Life-10 (ReQoL-10; Keetharuth et al., 2018) and Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1997) measures, and a multidisciplinary team discussion. Participants commonly presented with multiple complexities such as comorbid personality disorders, mood disorders, and neurodiversity.

A total of 95 patients were screened for participation in the STAIR group. One patient did not provide consent for their outcome data to be included in the service evaluation and was therefore excluded from all analyses and attrition calculations. Of the remaining 94 patients, 18 did not attend any sessions. In total, 76 participants attended at least one session, of whom 25 did not complete the intervention. Consequently, quantitative analyses were conducted on data from 51 participants (11 males and 40 females) who completed the STAIR group.

This study includes quantitative data from eight completed STAIR groups, each consisting of seven to 11 initial participants. Of these groups, five were all-female, one was all-male and two were mixed-gender. The mean attendance across all participants in this study who completed STAIR was 85.5%. Attrition among participants who attended at least one session was 32.9% (25/76).

Procedure

The STAIR groups included in this investigation were delivered at SPS from September 2023 to December 2025 as a phase-one intervention to individuals awaiting individual psychotherapy.

There were a total of five qualified CBT therapists involved in delivering the groups. Therapists rotated, typically with two facilitators leading each session.

All therapists completed STAIR training prior to delivering sessions, and received ongoing clinical and peer supervision. An additional staff member supported the therapists in six of the groups.

The STAIR group protocol was extended from the original eight-week programme (Cloitre et al., 2020) to 11 weeks, comprised of the following weekly sessions lasting 90–120 minutes each:

1. Introductory session
2. Psychoeducation of PTSD
3. Emotional awareness
4. Emotion regulation through the three channels: The body channel
5. Emotion regulation through the three channels: The thought channel
6. Emotion regulation through the three channels: The behaviour channel
7. Distress tolerance
8. Understanding relationship patterns
9. Changing relationship patterns part 1
10. Changing relationship patterns part 2
11. Self-compassion and group review

An introductory session was added to support psychological safety and promote group rapport. In addition, ‘the three channels’ content (body, thought and behaviour) was delivered across three separate sessions to allow more time for patients to consolidate their learning and skills. The core STAIR model was maintained by retaining the original framework and ensuring a focus on psychoeducation and skills training.

Materials

Participant attendance was collected alongside completed pre- and post-treatment patient-reported outcome measures of:

Recovering Quality of Life-10 (ReQoL-10)

The ReQoL-10 is a 10-item self-report measure used to assess quality of life over the last seven days. Respondents used a five-point Likert scale to indicate the extent they felt able to engage in various thoughts, feelings and activities, with scores ranging from zero to 40. Higher scores indicate greater quality of life.

Impact of Event Scale-Revised (IES-R)

The IES-R is a 22-item self-report measure used to assess the subjective distress caused by a traumatic event(s) over the last seven days. Respondents rate how affected they were by various items corresponding to the DSM-IV symptoms of PTSD, using a five-point Likert scale. Total scores range from zero to 88, with higher scores indicating greater levels of distress. A total score of 33 has been used as a screening threshold associated with probable PTSD (Creamer et al., 2003).

Nine-Item Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 is a nine-item, self-report measure used to assess depression symptom severity over the previous two weeks. Respondents used a four-point Likert scale to indicate how

affected they were by symptoms, with scores ranging from zero to 27. Higher scores indicate greater depression severity.

Quantitative Analysis

Shapiro–Wilk tests were used to assess the normality of the difference scores. Neither ReQoL-10 $W(50) = .96$, $p = .067$ nor PHQ-9 difference scores significantly deviated from normality, $W(51) = .98$, $p = .492$, supporting the use of paired-samples t-tests for these measures.

The IES-R difference scores violated the assumption of normality, as indicated by the Shapiro–Wilk test, $W(45) = .92$, $p = .004$, with visual inspection of box-and-whisker plots revealing three scores which exceeded $1.5 \times \text{IQR}$ beyond Q1 or Q3. These extreme values were retained as they reflected large but clinically plausible changes in the scores, rather than errors. Accordingly, a Wilcoxon signed-rank test was conducted with all 45 cases to compare the pre- and post-treatment scores.

Effect sizes were calculated using Cohen's d for paired-samples t-tests and a rank-biserial correlation (r) for the Wilcoxon signed-rank test. Cohen's d was calculated by Jamovi as the mean difference between pre- and post-treatment scores divided by the standard deviation of the difference scores. Cohen's d values of 0.2, 0.5 and 0.8 were interpreted as small, medium and large effects, respectively. Rank-biserial correlations of 0.1, 0.3 and 0.5 were interpreted as small, medium and large effects.

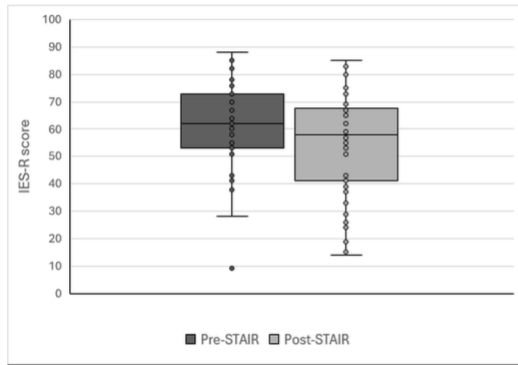
All statistical tests were two-tailed, with statistical significance defined as $p < 0.05$. No adjustments were applied for multiple comparisons, therefore, the analyses should be considered exploratory.

Results

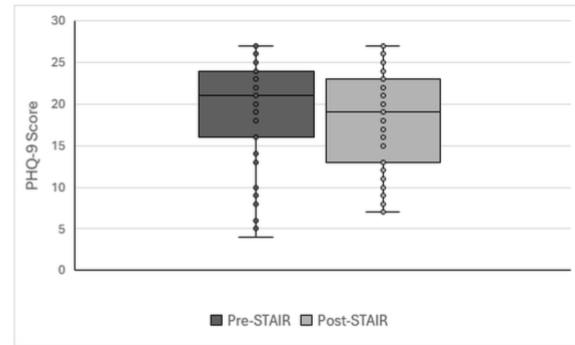
Analysis

Sample sizes varied across the outcome measures due to missing data (IES-R $n = 45$, PHQ-9 $n = 51$, ReQoL-10 $n = 50$). All three measures showed significant differences between pre- and post-treatment scores (Figure 1).

a) Comparison of trauma scores;
Pre and Post STAIR group



b) Comparison of depression scores;
Pre and Post STAIR group



c) Comparison of quality of life scores;
Pre and Post STAIR group

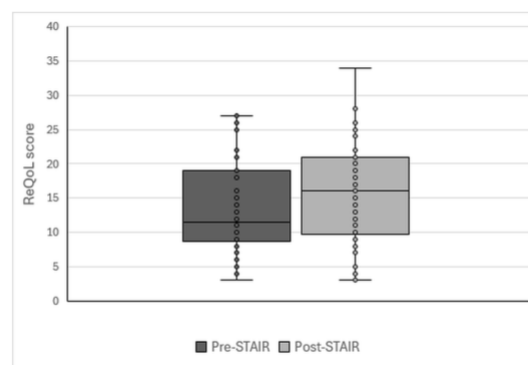


Figure 1. Distribution of service outcome measures. (a) IES-R (b) PHQ-9 (c) ReQoL-10. Boxplots show the interquartile range with the median indicated by the horizontal line, whiskers extend to $1.5 \times \text{IQR}$.

Note. IES-R = Impact of Event Scale–Revised; PHQ-9 = Patient Health Questionnaire–9; ReQoL-10 = Recovering Quality of Life–10.

The results of two paired-samples t-tests and one Wilcoxon signed-rank test investigating differences between pre- and post-treatment measures are displayed in Table 1. Paired-samples t-tests found a significant increase in ReQoL-10 scores between the pre-STAIR and post-STAIR measures, $t(49) = 2.91$, $p = .005$. There was also a significant decrease in PHQ-9 scores between pre and post-treatment measures, $t(50) = 2.06$, $p = .044$. A Wilcoxon signed-rank test indicated a significant decrease in IES-R scores, $W = 724$, $p = .008$.

Table 1

Descriptive and inferential statistics for outcome measures at pre- and post-treatment. Paired t-tests were used for PHQ-9 and ReQoL-10; Wilcoxon signed-rank test was used for IES-R.

	Pre-treatment	Post-treatment	Test statistic	p	Effect size
IES-R	Mdn = 62 (IQR = 20)	Mdn = 58 (IQR = 26)	$W = 724$	.008	$r = 0.40$
PHQ-9	$M = 19.14$ (6.06)	$M = 17.69$ (5.86)	$t(50) = 2.06$	.044	$d = 0.29$

	Pre-treatment	Post-treatment	Test statistic	p	Effect size
ReQoL-10	M = 13.34 (6.49)	M = 15.56 (7.23)	t(49) = 2.91	.005	d = 0.41

Note. Values are presented as means (SD) for PHQ-9 and ReQoL-10 and medians (interquartile range) for the IES-R due to non-normal distribution. Paired-samples t-tests were used for PHQ-9 and ReQoL-10 and the Wilcoxon signed-rank test was used for IES-R. Effect sizes are reported as Cohen's d for t-tests and as rank-biserial correlation (r) for the Wilcoxon signed-rank test. IES-R = Impact of Event Scale–Revised; PHQ-9 = Patient Health Questionnaire–9; ReQoL-10 = Recovering Quality of Life–10.

Discussion

This investigation offers one of the first evaluations of group-based STAIR, delivered in a UK NHS tertiary psychotherapy service. The findings from this evaluation support STAIR's core aim of re-establishing resources diminished by trauma through targeted skills training (Cloitre et al., 2020). Participation in the 11-week STAIR group was associated with significant improvements in self-reported trauma-related distress, depressive symptoms, and quality of life, consistent with previous research (Lorbeer et al., 2023; Amilhau et al., 2025). Using the rank-biserial correlation, a medium effect was observed for trauma-related symptoms ($r = .40$). Using Cohen's d, a small effect was observed for depressive symptoms ($d = .29$) while quality of life showed a small-to-medium effect ($d = .41$). These findings are partially consistent with Mahoney et al. (2019), who found that group-based stabilisation and psychoeducational interventions were associated with reductions in psychological distress. However, in contrast to these findings, the current study found the greatest effect on trauma-related distress (Mahoney et al., 2019).

Implications

These findings indicate that group-based STAIR is a feasible intervention used within a tertiary NHS psychotherapy setting, offering meaningful improvements in trauma-related distress and wellbeing during extended waiting periods for treatment. Group-based STAIR may be valuable as a phase-one stabilisation intervention to manage patient wellbeing and distress, irrespective of whether patients subsequently access trauma processing. These findings are particularly relevant for services with limited resources and lengthy waiting lists, highlighting STAIR's potential as a brief, structured resource-efficient intervention.

Limitations and Future Directions

This evaluation has several limitations. Firstly, the uncontrolled design means that it is not possible to determine whether improvements were exclusively due to participation in the STAIR group or could be attributed to other factors. Further research using a controlled design with a larger sample would be valuable to establish the specific mechanisms of change within STAIR.

The use of completer-only analysis may have introduced selection bias. Those who completed the STAIR group may systematically differ from those who discontinued, potentially leading to an overestimation of treatment effects. The overall attrition rate was 32.9%, while not dissimilar from rates reported in comparable CBT interventions, including

group-based treatments (Fernandez et al., 2015), the outcomes of participants who did not complete STAIR remain unknown.

Additionally, follow-up data were not collected, meaning the longitudinal impact of the STAIR group is unknown, including the potential impact on subsequent trauma processing. Further studies should investigate whether improvements are sustained over time and whether there is an optimal point to receive STAIR within the trauma treatment pathway.

As the outcome measures used in this evaluation did not directly measure aspects of CPTSD, the specific impact of STAIR on these areas cannot be determined within the scope of this evaluation. Further research should consider CPTSD-specific measures and qualitative methods.

The absence of formal diagnostic inclusion criteria likely resulted in a heterogeneous sample, including individuals with overlapping features of CPTSD, PTSD, and Borderline Personality Disorder. While this limits conclusions on the effects of STAIR for specific diagnostic groups, it likely enhances ecological validity by reflecting the diagnostic diversity and complexity typical of NHS psychotherapy services, where people with multiple diagnoses are often treated within the same clinical pathway.

Finally, attendance varied considerably between participants (55%–100%). Future research should explore whether attendance and engagement are associated with improved outcomes.

Conclusion

Group-based STAIR appears to be a feasible phase-one stabilisation intervention for adults with complex trauma histories in an NHS setting. Participation was associated with significant reductions in depressive and trauma-related symptoms, as well as improvements in quality of life. These findings suggest that STAIR may provide improvements during the waiting period for psychotherapy. Overall, this study contributes to the growing evidence base for STAIR and underscores its potential value as a resource-efficient intervention in NHS psychotherapy services.

Declarations

Ethics statement

Formal ethical approval was not required for this service evaluation, however, NIHR Good Clinical Practice guidance was followed, including the use of a participant information sheet and consent form. The project was registered with the Sheffield Health Partnership University NHS Foundation Trust Clinical Effectiveness Team and was approved to meet the quality and ethical standards required by the Trust.

AI-use statement

Generative AI tools were not used to write this manuscript.

Conflict of interest

The authors declare that there is no conflict of interest.

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This work received no external funding.

Data availability

Anonymised datasets were generated for this service evaluation but are not publicly available due to service governance and confidentiality considerations.

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