



Building ‘a compassionate armour’: The journey to develop strength and self-compassion in a group treatment for complex post-traumatic stress disorder

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Objectives. Complex post-traumatic stress disorder (PTSD) is associated with severe difficulties in emotional regulation, interpersonal relationships, and shame. For individuals with these difficulties, exposure-based treatment for PTSD symptoms is less effective and can even be harmful. This study aimed to investigate the mechanisms of change at an individual and group level for individuals completing treatment for complex PTSD.

Design. Constructivist grounded theory was used to develop an explanatory theoretical model of the change process.

Methods. Semi-structured interviews were conducted with 11 women with a diagnosis of complex PTSD who had completed the group treatment.

Results. The theoretical model captured change as an ongoing journey, which continued after treatment finished. Participants identified three essential aspects of the group that brought about change. The first was the group itself, in which valued relationships were formed. Additionally, participants described two key mechanisms – developing a comprehensive understanding of themselves and their difficulties, and experiencing their emotions and compassion from others.

Conclusions. The key mechanisms of change were the relationships formed within the group and the need for a deeper understanding of the self in order to reduce shame and prepare for exposure-based treatment. Further support is provided for a phase-based approach to complex PTSD treatment. Psychoeducation alone, however, was not sufficient, and it was also crucial that participants could safely access their emotions and experience compassion from others in order for change to come about.

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Practitioner points

- Important aspects of treatment for complex PTSD are emphasised to inform professional practice. In particular, the role of relationships is altering self-perceptions through group therapy.
- Other key elements included participants building an understanding of themselves and their difficulties through psychoeducation, developing compassion for others and themselves, and safely accessing their emotions.
- This study also builds upon the body of evidence for the benefits of phase-based treatment which addresses shame and emotional regulation prior to exposure therapy.

Post-traumatic stress disorder (PTSD) describes the experience of heightened psychological distress following exposure to a threatening or catastrophic event (Diagnostic and Statistical Manual of Mental Disorders 5th edition; DSM-5, APA, 2013). It does not, however, adequately represent individuals who have been exposed to prolonged or repeated traumatic experiences (Cloitre *et al.*, 2012; Courtois, 2004; Herman, 1992), particularly those that have occurred within the context of interpersonal relationships (e.g., childhood sexual/physical abuse and domestic violence) (Cloitre *et al.*, 2012; Courtois, 2004; Rhodes, Spinazzola, & van der Kolk, 2016). The diagnosis of complex PTSD was established to describe additional difficulties in problems in self-regulation across five areas: emotional regulation, relationship difficulties, alterations in attention and consciousness (e.g., dissociation), negatively affected belief systems, and somatic distress. The newest edition of the International Classification of Disease (ICD-11) now recognizes complex PTSD as a formal diagnosis.

There is substantial evidence for the efficacy of a range of approaches for treating PTSD, including the use of exposure therapy, cognitive therapies, eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy (Cusack *et al.*, 2016). All of these focus, at least in part, on exposure to the traumatic memory and related cues, either imaginably or in vivo. The evidence base is, however, limited in its applicability to complex PTSD, as individuals with complex presentations are often excluded from studies (Lonergan, 2014). The difficulties experienced in complex PTSD may also impact on the effectiveness of exposure treatment (Foa, Keane, Friedman & Cohen, 2009).

It is important that clients engage emotionally with exposure for treatment to be effective (Foa *et al.*, 2009). However, if clients become too emotionally aroused they will be unable to process information effectively (Ogden, Minton & Pain, 2006). Thus, there is an 'optimal arousal zone' or 'window of tolerance' (Ogden *et al.*, 2006; Wilbarger & Wilbarger, 1997) in which the traumatic memory can be processed most effectively.

Individuals with complex PTSD may find it more difficult to sustain this 'window of tolerance' for two reasons. Firstly, difficulties regulating emotions can mean that feelings of distress are triggered more easily, escalate more rapidly, and take longer to return to baseline (Cloitre, Cohen & Koenen, 2006; Cloitre *et al.*, 2010). As a result, exposure may be less effective or result in an increase in symptoms (Foa, Riggs, Massie & Yarczower, 1995; McDonagh *et al.*, 2005). Alternatively, to cope with overwhelming emotions, clients may be more likely to draw on existing harmful coping mechanisms (Courtois, 2004).

Secondly, complex PTSD is associated with high levels of shame and self-hatred (Courtois, 2004). Shame is a negative, self-conscious emotion, characterized by an overwhelming sense of the self as negative and undesirable (Lee, Scragg & Turner, 2001; Lewis, 1971). This gives rise to a sense of current threat to self-integrity, which in turn maintains PTSD symptoms (Harman & Lee, 2010). Shame is highly prevalent in individuals with PTSD (Grey & Holmes, 2008; Harman & Lee, 2010; Holmes, Grey & Young, 2005),

and importantly, it does not habituate through exposure in therapy. Exposure may, in fact, increase feelings of shame (Adshad, 2000) and be harmful to those with complex PTSD (Ford, 1999). Shame has also been consistently associated with non-disclosure in therapy (Hook & Andrews, 2005; Macdonald & Morley, 2001; Swan & Andrews, 2003). This is problematic for exposure therapy in which traumatic memories need to be sufficiently explored and elaborated for treatment to be effective (Ehlers, Clark, Hackman, McManus & Fennell, 2005).

Given the impact of these difficulties on treatment, the UK Psychological Trauma Society (UKPTS, 2017) recommends phase-based treatment, which first supports clients to establish sufficient psychological and environmental resources (Cloitre *et al.*, 2006; Cloitre *et al.*, 2012). Once resources are consolidated, and the individual can sustain the 'window of tolerance' (Ogden *et al.*, 2006), they are more likely to be able to engage fully with, and benefit from, exposure-based treatment.

This has been supported by research by Cloitre and colleagues (Cloitre, Koenen, Cohen & Han, 2002), who found that incorporating a skills-based intervention targeting emotional regulation and interpersonal difficulties predicted greater symptom reduction during exposure treatment. This result has been replicated with an active control group (supportive counselling), and furthermore, dropout rates for the skills group were lower (Cloitre *et al.*, 2010).

Whilst this approach addresses emotional regulation difficulties, it does not address the impact of shame. Compassion-focused therapy (CFT) offers an approach to reduce both emotion regulation difficulties and shame.

Compassion-focused therapy is a cross-diagnostic therapeutic approach that focuses on reducing shame and self-criticism by fostering an internal compassionate relationship (Gilbert, 2009). Emerging evidence suggests that CFT has beneficial effects, specifically, reducing feelings of shame, for clients with a range of difficulties in different clinical settings (Gilbert & Procter, 2006; Herriot-Maitland, Vidal, Ball & Irons, 2014; Laithwaite *et al.*, 2009; Lucre & Corten, 2013; see Leaviss & Uttley, 2014 for a review). Furthermore, developing skills in self-compassion aims to increase capacity for self-soothing in order to manage emotional distress (Gilbert, 2010), thus increasing resources to sustain the 'window of tolerance' for engagement in exposure therapy.

There is tentative support for CFT for PTSD (Bowyer, Wallis & Lee, 2014; Lawrence & Lee, 2013), and this approach has been developed specifically for this population (Lee & James, 2012); however, more research is needed to generalize and establish the reliability of these results. Previous studies have indicated that providing CFT in a group enhanced the therapeutic process (Gilbert & Procter, 2006; Lawrence & Lee, 2013). Notably, clients' qualitative accounts suggest that the group helped normalize their difficulties, created a sense of common humanity, and increased sympathy for their own distress. It is, therefore, important to consider how being in a group affects the therapeutic process.

What is not yet known is *how* CFT addresses difficulties experienced by individuals with complex PTSD, or what the '*active component*' of CFT is (Leaviss & Uttley, 2014, pp. 16). Answering these questions may offer a theory as to how CFT can enhance existing treatments for individuals with complex PTSD.

Study aims

This study aimed to understand the process of change for individuals with complex PTSD who had attended a group treatment based on CFT (Gilbert, 2010; Lee, 2009). This treatment, termed the Compassionate-Resilience group, provided within a specialist

PTSD service and based on Lee and James (2012), utilizes psychoeducation, problem-solving and experiential compassion-based exercises to reduce feelings of shame, and self-blame, in relation to the self and traumatic experiences. Using grounded theory, this study aimed to answer three overarching questions:

- What changes do clients with complex PTSD experience through attending the Compassionate-Resilience group?
- How does this change process occur?
- How does being in a group impact on the treatment process?

Method

Design

The study used constructivist grounded theory (Charmaz, 2014) to develop an explanatory theoretical model of accounts of 11 women, interviewed about their experience of attending the group.

Participants

Participants were recruited from a specialist PTSD service. All participants were assessed as having complex PTSD¹ and had completed the Compassionate-Resilience group therapy (Lee & James, 2012). Apart from one participant, they had not yet started exposure therapy. Participants had to be competent in spoken English. Exclusion criteria mirrored those of the service; clients were excluded only if there were barriers to engagement in treatment. This included experiencing a current acute episode of psychosis or current environmental or psychological stressors, which might undermine their safety.

Participants were recruited from three consecutive cohorts of the group. Of 13 participants who expressed an interest in taking part, 11 completed the study. The two who did not take part were unable to attend interviews due to family commitments.

Procedure

The study received full NHS Ethical and R&D Approval (HRA reference 15/SC/0401 granted on 24/07/2015; Berkshire Healthcare NHS Foundation Trust R&D reference 2015/24 granted 26/08/2015). Recruitment was via the group therapy sessions, all service users who completed the group were provided with an information sheet from the group facilitators, and those interested in participating consented to be contacted. Participants were interviewed in the NHS clinic where their treatment was delivered, and informed consent was given at the time of the interview. In line with the grounded theory model, analysis took place as close to data collection as possible. As a minimum, an audio review of each interview was conducted immediately afterwards and notes were recorded in the form of memos and reflections. This identified areas of the model requiring further development, and the interview schedule was updated accordingly. All transcription and coding were completed by the first author, with supervision of this undertaken by the second author and a grounded theory consultant.

¹ Participants diagnosed by clinicians at assessment when accessing the service.

Analysis

The analysis process followed that of constructivist grounded theory (Charmaz, 2014). After each interview, transcription was completed and coding was initiated.

The coding process involved initial line-by-line coding of transcripts through close analysis of the data, breaking it down into its smallest component parts, and defining the messages within the data (Charmaz, 2014). After initial coding, focused coding was completed to form preliminary ideas, and subsequently, tentative analytic categories. These categories formed the building blocks for the theoretical model and were revisited, elaborated, and adjusted throughout the analysis process. Alongside the above, memos and diagrams were used to record interpretations and ideas about the emerging theory (Charmaz, 2014). This informed theoretical sampling – the decision-making process to determine which areas of the model had not yet been sufficiently developed and how the interview schedule should be updated.

A constant comparative method was followed (Charmaz, 2014). Accordingly, all interviews were compared with previous interview data, and initial codes were checked against tentative categories to determine where they elaborated these, or where they formed new categories. As the model formed, earlier interviews were revisited to compare them against developments.

After 11 interviews, the model had developed and was sufficiently elaborated. Through discussion of the model and its component categories in supervision, it was agreed that data saturation had been reached.

Reflexivity and credibility checks

Constructivist grounded theory (Charmaz, 2014) takes a social constructionist position, which recognizes the subjectivity of the research process and the influence of the researcher's personal and professional experiences. The following credibility checks were, therefore, incorporated into the study:

- Reflexive interviews with other qualitative researchers and a reflective diary;
- A constant comparative method was employed in which the data were repeatedly checked and compared with the developing model;
- Formal and peer supervision and consultation regarding the raw data, codes and categories, and the developing model;
- Theoretical sampling was used to ensure that underdeveloped areas of the model were addressed in later interviews;
- The developing model was shared with facilitators and service users who had attended the group, through a group discussion of the themes and processes arising from the analysis. They confirmed that the model was consistent with their experiences.

Measures

Demographic details were collected using a short questionnaire and the broad category of trauma for each participant was obtained from their clinical records, with consent. A semi-structured interview schedule was developed in line with the research questions and in liaison with two service users who had previously completed the group. This was modified and updated to allow for development of the model.

Results

Participant demographics

Eleven participants took part in the study. All participants were female and were aged between 22 and 62 years (mean age = 44.09). The majority of participants identified as white ($n = 10$) and one of mixed race. All had experienced multiple, prolonged, or repeated traumatic events of an interpersonal nature, such as domestic violence and/or childhood sexual, physical, or emotional abuse.

The journey of change model

The process of change was described as an ongoing journey, from before the group started and which continued after the group finished. The model presented in Figure 1 captures this journey.

Experiences prior to attending the group

Participants described experiencing what participant 6 called '*deep set self-hatred*' and self-blame prior to starting the group. Most participants reported a belief that they were to blame for their traumatic experience and subsequent difficulties. For example, when asked what she thought about herself prior to the group, participant 8 said:

I deserved all that happened to me, so everything that's happened I absolutely deserved it, that I'm pathetic, I'm a failure, that I'm weak. . .and everything that's happened is pretty much my fault. . .it was the bottom line, you know it was, I deserved it, everything. P8

Participants also described feeling stigmatized about their distress prior to the group, as they, and others, could not understand their difficulties. This in turn left them isolated in their struggles:

I just thought I was really weird. . .and it was like. . .I just wish I could flick a switch and be strong and I wish I could get on with it, that's all I want to do is get on with it but I couldn't, so that made me feel really weird and because of that I think I was very hard on myself. P11

Thirdly, participants reported various relationship struggles denoted by a difficulty connecting with others or not being able to assert their own needs:

Before I'd never say boo to a goose. . .I'd always sit there going yeah, yeah, sort of thing, and just agree. . .I'd never disagree, 'cause I don't like confrontation. P1

Overcoming barriers and readiness for change

Many participants reported experiencing apprehension and/or fear about attending group therapy, in particular for the reasons described by participant 2:

People judging you. . .and also me hearing anything that happened to other people and whether it would. . .trigger, thoughts and memories and cause more flashbacks really. P2

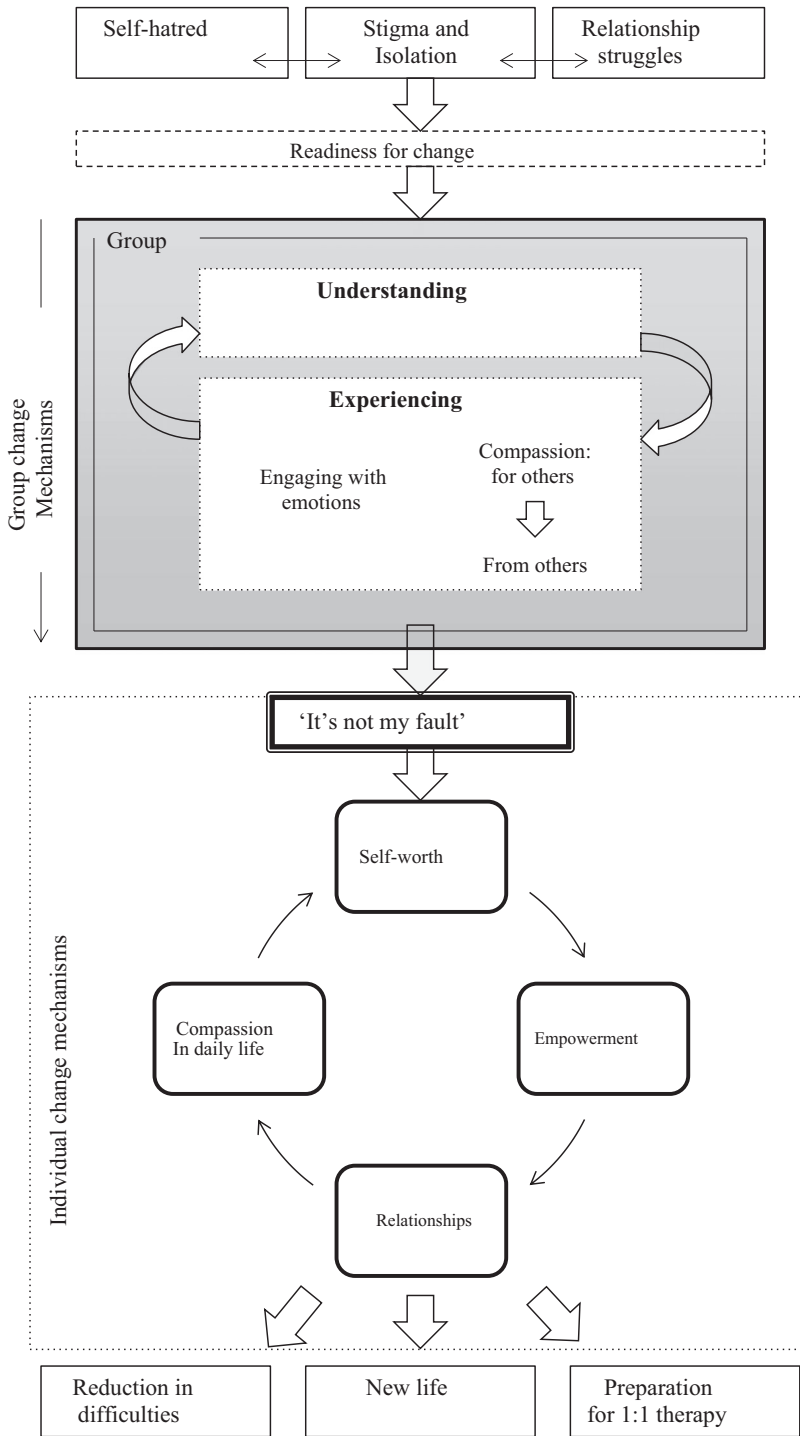


Figure 1. The 'Journey of Change' model for individuals completing the Compassionate-Resilience group.

Change was highlighted by participants as challenging, given the long-standing nature of many of their difficulties. Indeed, for some, they described their difficulties as being part of their 'hard-wiring' (P2). Participants also recalled perceiving change as taking a leap into the unknown, eliciting feelings of fear or apprehension.

It's like you're frightened to come out of your own little bubble because you don't know what's going to be on the other side, so it's safer to stay in your own little bubble and if you call yourself names then so be it, you call yourself names. P5

For some, they also experienced scepticism about self-compassion:

I'm a compassionate person towards others but compassion towards me is a sign of weakness so I was very much, it's not for me, so it's for others and I can give it, but I don't want it, I don't want it from myself and I don't want it from others. P8

In order to overcome the fear of attending a group, and initial scepticism about compassion, participants reported needing to be ready for change. This comprised a motivation to attend and a willingness to engage with the material:

There was a bit of anxiety there to start with but I was like, no I really want to go because I really want to get the help that I need, I really want to work this out. P10

The change process

Three elements of the group brought about change for the participants. The first was the group itself, which was both the context for change and also integral to the change process. Within this context, participants described two mechanisms of change: *understanding* themselves and their difficulties, and *experiencing* their emotions and a compassionate relationship with others. Via these processes, participants were able to engage with, and for some, begin to accept, the idea that what happened to them, and their subsequent difficulties were not their fault. This realization appeared to be crucial for developing self-worth and engaging with the ongoing change process.

The group

Four key features of the context, created by the group, interacted with the mechanisms described above to bring about change. The first was psychological safeness – the sense that threat and distress were reduced in the group, through clear group rules and boundaries, and a relaxed and friendly atmosphere:

The validation and the warmth from everybody is so soothing...but also gave me such courage that...even though I was struggling, I was able to keep coming, I guess, because I knew when I got there that I would be understood, that I wouldn't be judged. P8

Secondly, group facilitators provided a contained and compassionate space in which individuals felt able to share as much or as little as they wanted to. Participants described the facilitators as caring, but also knowledgeable and credible, which supported engagement with the material:

You sit there and you think, you can't know how I'm feeling. . .but because of how they do it and how they word it and you've got the slides on the board and absolutely everything you find yourself, even if you're cynical. . .you're looking round the room and everybody's nodding and you're thinking there is something in this. P6

Thirdly, participants described their relationships with other members as highly valued. Participants described a sense of belonging and identification – or connectedness, which reduced feelings of isolation and stigma:

It has a big impact in terms of recognising that. . .you're not on your own and hearing other people, it means a lot to me in a way that I've managed to share that with them and if I did see any of them again, I feel quite a lot of warmth towards them. P4

The group also played an increasingly important role in providing strength, hope, and inspiration for making changes and in motivating participants to attend:

It did feel like we were a little bunch of warriors, which really kind of, it amped me up, it gave me the strength that I needed to push through that kind of big brick wall of denial. P7

You kind of watch each week as everyone progresses and it encouraged you to progress. . .you kind of went, if they can do it, I can do it. P10

Finally, the structure and organization used repetition and a range of methods to support participants to engage with the group material:

I think it was the layout of all the talks as we went through each session that we had they sort of build on each other. . .it just progressed really well that you could kind of progress each week and then we had homework to come home with which helped continue it on for the week. P10

Mechanism 1 – Understanding

The psychoeducation aspect of the group reportedly helped participants make sense of difficulties and understand why they were feeling and acting as they were. They described feeling understood by the facilitators and other members, which reduced their feelings of shame about their experiences:

I really liked the sort of clinical psychology aspect of it. . .explaining to us how our brain works because then you don't feel like it's such a personal problem, it's like, well all humans have the same brains and this is why my brain's done that and you don't feel alone you think oh I'm part of the human race then and this is how we all work. P9

Participants described how hearing others' experiences also enhanced this understanding process:

I think it was just listening to everybody else and seeing how upset and their little prisons that they were in and it was like a reflection of me, is this what I'm like? Because I wouldn't want that for that person, and yet I'm doing it for me. P3

Mechanism 2 – Experiencing

The second mechanism was experiencing, which comprised two processes. Firstly, participants described safely connecting with their emotions, having previously avoided their emotions or felt overwhelmed by them:

I've always prided myself on not showing emotion and keeping it buttoned down and now I realise that's something really quite negative to do to yourself, and I remember. . . I just burst out crying and couldn't stop and she [other group member] gave me a really big hug and it made me cry more but that was what was important and going back in to tackle the rest of that week. . . meant that I was emotionally raw and receptive and I think that's why I got such a strong epiphany as, 'cause I was already kind of open and I wouldn't have necessarily had that if I'd dissociated and shut everything down. P7

Alongside this was experiencing genuinely compassionate relationships with the other group members and with facilitators. Participants firstly reported experiencing compassion *for* others, which most participants found relatively easy:

You just knew that we all had the same feeling for each other, that none of us wanted the other person to feel any more pain and if we could take it away we would because we know what it feels like. P3

The second, which was more challenging for some, was experiencing and accepting compassion *from* others. This appeared to be an important step for becoming receptive to developing self-compassion.

Just the suggestion sort of intellectually of being nice to yourself is all very well but when they did the meditation, that actual example, of somebody being so nice to you when you haven't experienced that for as long as you can remember it does sort of provoke a very strong emotional reaction. P9

It's not my fault

Better understanding of their difficulties, connecting with their emotions, and fully experiencing compassion brought about a realization amongst participants, described by some as a number of 'light bulb moments' (P2, P7) in which they began to see that their experiences and difficulties were not their fault:

I had to realise that it's not my fault. . . it was the other, the person who was in an adult mind and I was a child and so the blame is with them, it was nothing to do with me, I think that was one of the biggest moments, I mean, so much helped but that was one of the biggest ones to see I didn't have to blame myself anymore. P11

The ability to make this shift was integral to the change process. Being able to challenge the idea that the trauma was their fault, or at least cast some doubt on this idea, freed participants up to create a different, more compassionate, relationship with the self.

Self-compassion cycle

Participants described how developing self-compassion was a gradual and challenging process that required practice, and continued after the group finished (represented by the cycle at the bottom of the model in Figure 1):

I still feel like there's a lot of change to come with me. . .because I do feel like the full benefit of the course hasn't come to fruition at all I just feel like this is the tip of the iceberg. P7

Participants reported that within the context of the group relationships, realising that their difficulties were not their fault allowed them to develop the belief that they were worthy of compassion and of addressing their difficulties. This formed the category of 'self-worth'.

I'm so much more confident in myself so much more happier in myself, I can make decisions now for myself where before I thought I couldn't. . .I just feel like I've really started to heal and especially, especially knowing and seeing and learning it's not my fault, what has happened to me is not my fault has in a way set me free to be myself. P11

This also came with a sense of empowerment, feeling stronger, and consequently being more assertive about their own needs:

It's made me feel like I've put on like a compassionate armour where y'know I'm able to handle each day better and I feel like I've got a security armour on and I'm able to just be compassionate with all aspects of my life. . .it makes me feel stronger and feel more empowered. P10

It's taught me to be a lot stronger and to say no, if I don't want to do something, I have a right to say no instead of, oh they might not like it if I say no. . .and there have been a couple of times where I was quite proud that I actually turned round and said, I don't want to do that so I was really pleased that I've been able to do that. P5

There was a sense that as a result of the group, participants experienced changes in their relationships. For some, this was positive, as they felt better able to understand others, worried less about social interactions, and felt able to make connections:

It's massively improved my relationship with friends. . .trying to make new friends was something I was terrified of before. . .I have less anxiety about that now because I feel confident in my ability to handle it and I feel confident that I'm perhaps someone that someone might want to know which before was just I had very little faith in people finding me interesting. P7

For others, they reported that it made some relationships challenging because they were changing but those around them were not necessarily changing or accepting of the change:

I still feel a little bit like I'm shifting and some other people in my life are not. . .it's what happened afterwards 'cause I've been the way I am for such a long time that starting to come back to myself, it's going to be hard for other people and I'm not sure where they're going to fit in in my life at the moment. P9

Feeling deserving of self-care and the sense of empowerment to accept and fulfil their own needs allowed participants to engage in compassion in daily life. Using the techniques taught in the group:

When I'm being negative towards myself. . . I do my breathing and I imagine me at my best and then through doing that. . . I'm just able to talk myself down from it. . . where I'm going, oh you know you're really crap and you, I don't like you and it just becomes do you know what, you're not crap and you do like yourself, you're just having a really tough moment but that's fine, we can get through it and it's just handling myself better. P10

Engaging with self-compassion, for some, also meant an increase in their ability to self-soothe and to take care of themselves more:

Cause I'd have been doing this and that and just constantly keep going, whereas now I can say to myself, no actually, you can go to bed early. You want to go to bed early 'cause you're tired, you can go to bed early. . . or if you want to do this or you want to do that it's fine. P2

Actually taking more time for myself to try and relax more and in very small ways to put myself first now and again. P4

Participants reported that this process was simultaneously positive and challenging. At times, being more self-compassionate resulted in an increase in self-critical thinking. Increased self-worth was, therefore, key in sustaining motivation to continue to try to be self-compassionate:

I didn't expect that the kind of negative voice would get a lot stronger as the positive compassionate voice was growing. . . there's like two warring sides as one is kind of beginning to challenge it, the other side has fought even stronger to kind of cling on to those things. P7

Personal changes

For some participants, the symptoms of PTSD were reduced, including a reduction in hypervigilance and flashbacks:

I'm not in that hyper, hyper alert anymore, it's not like I'm looking over my shoulder or if there's a noise out in the car park or there's a noise out in my hallway I'm not jumping, so that has had a big effect, I'm not, I'm just being more comfortable with me. P3

Additionally, some participants said they experienced a new lease of life as a result of the group:

Because of what had happened to me in the past years, sort of thing, I was rather more, I wasn't neglected, I was sort of, not allowed to do things. . . and being with the group, it's started me wanting to live again, if that makes sense. P1

I think I'm. . . almost at the beginning of being able to enjoy my life. . . in some ways that's quite sad, but in other ways its quite exciting. . . it's just like as if I've got a whole life ahead of me now, I'm going to live it and no one's going to stop me. P2

Finally, participants reported that they felt more prepared to move onto exposure therapy for PTSD symptoms. There were two reasons participants felt they were better prepared. Firstly, they reported having increased resources to manage difficult emotions:

It's given me a step to try and... understand these things that I'm going through and the way I feel and it's given me options of what I can do to get myself out of those feelings. P3

Secondly, for some they felt that the shame and threat associated with their trauma memory were somewhat reduced, making it easier to consider processing it:

I do feel that I'm now ready because when I took the sort of guilt and the blame out of it, it makes the whole situation I went through not seem so scary I guess a part of the fear for me, was how could I have let that happen to myself and 'cause I didn't want to think about it... now I can stand outside and look at it with the eyes of a more balanced person rather than the person that went into it, I think I would have more empathy with that person. P9

Discussion

The present study indicates that the Compassionate-Resilience group brought about some subjective change for all participants, to a greater or lesser extent for different individuals. The theoretical model represents the mechanisms and stages participants had to go through for change to occur, and there were various outcomes described by participants:

- Improvements in self-worth and assertiveness;
- Changes in relationships, both positive and challenging;
- Increased self-compassion and self-care;
- Reduction in PTSD symptoms;
- Feeling more prepared for processing the trauma memory in exposure therapy.

Support was provided for the use of phase-based treatment for complex PTSD, given participants' perception that the Compassionate-Resilience group helped them feel more prepared for exposure therapy. In line with previous research (Cloitre *et al.*, 2006; Cloitre *et al.*, 2012; Cloitre *et al.*, 2002; Cloitre *et al.*, 2010), the increase in resources to manage emotional distress was important for being able to contemplate exposure therapy.

The group context was fundamental to the change process, mirroring past findings that group relationships enhance therapeutic progress in CFT (Gilbert & Procter, 2006; Lawrence & Lee, 2013). Particularly important in this study was 'connectedness' between group members, which comprised a close bond and sense of identification. This is similar to the description of '*common humanity*' (Lawrence & Lee, 2013, p. 502), and theoretical ideas pertaining to the importance of universality in group therapy (Yalom & Leszcz, 2005) that propose that being in treatment with others with similar difficulties helps reduce shame, self-stigma, and feelings of social isolation. This is of particular relevance for complex PTSD, given the high prevalence of shame, self-hatred, and interpersonal difficulties (Cloitre *et al.*, 2012; Courtois, 2004; Harman & Lee, 2010). Furthermore, this study endorses the idea that groups can provide inspiration and hope (Yalom & Leszcz, 2005).

The results indicate that the intervention addressed participants' shame and self-blame, particularly for those able to challenge the belief that the trauma was their fault. This is compatible with previous studies, which have observed reductions in shame

following CFT (Gilbert & Procter, 2006; Herriot-Maitland et al., 2014; Laithwaite *et al.*, 2009). As in previous studies, developing an in-depth understanding of how the brain works in relation to trauma and distress played a key role in the reduction in shame (Lucre & Corten, 2013). It was clear, however, that understanding alone was not sufficient to reduce self-blame. Participants reported needing to experience compassion from others, before self-blame could reduce. This supports clinical observations and research literature indicating that emotional change, or the ability to '*feel* different' in therapy (Gilbert, 2010; p. 6; Lee, 2009), is more challenging for individuals high in shame and self-criticism.

In order to '*feel*' different, and alleviate shame, the relationships formed in the group were key. As a result of interpersonal trauma, relationships can be experienced as threatening (Fowler, Allen, Oldham & Frueh, 2013; Gilbert, 1998; van der Kolk, 2014). Additionally, individuals high in shame experience the self as unacceptable or disgusting, and consequently, expect that others will reject them (van der Kolk, 2014). In this study, participants reported feeling accepted and valued by other members even when the group was aware of the shaming aspects about them, namely the trauma and subsequent distress. This perhaps served to directly challenge the fear of rejection.

The role of relationships in recovery from trauma has been well-established, as having a good support network and re-connecting with attachment figures (e.g., parents or intimate partners) following traumatic experiences is important in reducing feelings of threat (van der Kolk, 2014). This is captured by participants' description of the group providing '*psychological safeness*' in which they felt safe to be vulnerable. Furthermore, it was this safety that allowed emotional, which again was essential to the change process. This is important as emotions are inextricably linked with trauma memories (van der Kolk, 2014). Consequently, individuals may need to be gradually exposed to emotions to learn to access and manage difficult feelings within a safe environment.

This study also explored the processes of change, indicating that participants needed to be prepared and motivated to engage in the Compassionate-Resilience group. Similar processes have been described in theoretical models that explain the pre-conditions for change in therapy (e.g., Prochaska & DiClemente, 1982). As in the trans-theoretical model of change, participants who were able to overcome their initial reluctance to attend the group reported having positive expectations and being highly motivated to engage in treatment. Additionally, the processes of '*understanding*' and '*experiencing*' are similar to processes described by Prochaska and DiClemente (1982). Specifically, that change in therapy may initially take place through increasing the awareness of difficulties, and later, through expressing blocked emotions. Importantly, this study highlighted that for individuals with complex PTSD, change means letting go of coping strategies that they feel are fundamental to keeping them safe and therefore presents a significant challenge. This should be validated in clinical practice, and clients should be supported to make an informed decision about whether they are ready to engage in treatment.

Limitations

It could be argued that the research design, and therefore, small sample size, does not lend itself to generalizability of the findings. As Carminati (2018) argues, however, this depends on the definition of generalizability that is adopted. The grounded theory model aims to construct a theory from the data in order to draw analytic or theoretical generalization, as opposed to statistical generalization (Carminati, 2018). Through the process of data saturation, all themes and aspects of experience are incorporated until no new themes are

identified, with the aim of establishing general themes from specific experience (Carminati, 2018; Morse, Barrett, Mayan, Olson & Spiers, 2002).

To establish the efficacy of the treatment approach, however, and test the model proposed in this study, further research is needed. Additionally, this study did not capture the experience of individuals who dropped out of the group. Exploring this further would help establish the acceptability of the treatment.

Finally, all participants were women and there was little diversity in the race of the sample. Future research should consider exploring experiences of individuals from minority, or disadvantaged groups (such as minority ethnic groups, refugees, or LGBTQ individuals) as experiences of stigma and shame may be particularly pertinent to individuals who are marginalized within society (Meyer, 2003).

Research implications

This study provides rationale to further explore the impact of CFT group interventions for this client group. Of particular importance is establishing the efficacy of this approach through randomized-controlled trials (RCTs). Where possible, comparing the treatment with an active control condition, to assess whether the mechanisms identified in the journey of change model can account for improvements in shame, emotional regulation, and relationships as indicated by this study.

It would also be beneficial to assess whether the addition of this treatment enhances engagement with and effectiveness of exposure treatment. Finally, this study indicates that change was an ongoing process, and therefore, studies would benefit from including longer-term follow-up measures to capture continuing change.

Clinical implications

Whilst additional research is needed, the present study offers support for targeting shame and self-blame within interventions for complex PTSD. For individuals with high levels of shame and self-criticism, integrating compassionate mind training (Gilbert, 2010; Lee & James, 2012) into treatment may enhance the application of existing treatments, particularly if provided in a group format. The journey to self-compassion required an immersive experience of feeling compassion for others and receiving compassion from others. It is important, therefore, that groups are well-facilitated, so clients feel safe and are able to build genuine and supportive relationships with one another. It is clear that relationships with others, including therapeutic relationships, play an important role in influencing the relationship with the self.

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Conflicts of interest

All authors declare no conflict of interest.

Author contributions

Emily Ashfield (Conceptualization; Data curation; Formal analysis; Methodology; Writing – original draft) Carmen Chan (Conceptualization; Formal analysis; Investigation; Methodology; Supervision; Validation; Writing – original draft; Writing – review & editing) Deborah Lee (Conceptualization; Methodology; Supervision; Validation; Writing – review & editing).

Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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