Acceptability and mechanisms of change associated with group cognitive behavioural therapy using the Recovering from Childhood Abuse Programme among women with CPTSD: a qualitative analysis

Siobhan Hegarty[1,2,4‡] , Kimberly Ehntholt[2], Dorothy Williams[2], Helen Kennerley[3], Jo Billings[1] and Michael Bloomfield[2,4,5]*

[1]Division of Psychiatry, University College London, London, UK, [2]Traumatic Stress Clinic, Camden & Islington NHS Foundation Trust, London, UK, [3]Oxford Cognitive Therapy Centre, Warneford Hospital, Oxford, UK, [4]Translational Psychiatry Research Group, Department of Mental Health Neuroscience, Division of Psychiatry, Institute of Mental Health, University College London, London, UK and [5]National Institute for Health Research University College London Hospitals Biomedical Research Centre, London, UK
*Corresponding author. E-mail: m.bloomfield@ucl.ac.uk

Abstract

Survivors of childhood trauma are at increased risk of complex post-traumatic stress disorder (CPTSD). The Recovering from Child Abuse Programme (RCAP) is a cognitive behavioural therapy (CBT) group promoting adaptive coping strategies which may help overcome CPTSD symptoms in adult survivors of childhood trauma. We sought to explore patient experiences of factors influencing treatment acceptability and potential mechanisms of therapeutic change in a sample of participants in the RCAP programme. As the group was delivered during the COVID-19 pandemic, necessitating a transition to remote therapy, we further aimed to capture experiences of the transition to telehealth delivery of the programme. A naturalistic sample of 10 women with CPTSD attending a specialist out-patient psychological trauma service participated in the study. Therapy sessions were recorded, transcribed verbatim and group members completed written feedback forms following each session. Reflexive thematic analysis was used to analyse the written feedback and transcripts. The RCAP was acceptable to group members and several themes were identified related to the experience of change in the group. Key themes centred on group solidarity; safety in the psychotherapeutic process; schema changes related to the self, others and future catalysed by the shifting of self-blame; increased emotional regulation to feel safer in the present; and increased future optimism. Therapeutic progress continued following the transition to telehealth, although face-to-face delivery was generally preferred. The programme was acceptable and led to cognitive change, enabling increased emotional regulation in the present and improved self-concept, thereby addressing key symptoms of CPTSD.

Key learning aims

(1) To identify potential mechanisms of therapeutic change related to participation in the Recovery from Childhood Abuse group CBT intervention.
(2) To understand factors influencing acceptability of the group intervention among women with CPTSD to childhood sexual abuse.

---

‡First author's current address: Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK.

Introduction

Complex post-traumatic stress disorder (CPTSD), a new diagnosis in the ICD-11 (World Health Organisation, 2018), is a potentially severe and disabling condition. The contemporary view of CPTSD has evolved from previous attempts to capture the more complex symptom profile associated with a history of prolonged, repeated experiences of trauma including abuse occurring during childhood and adolescence (hereafter referred to as developmental trauma), domestic violence, torture and war (Karatzias *et al*., 2019). The CPTSD clinical syndrome comprises the 'core' PTSD symptom triad of re-experiencing, hypervigilance and avoidance, alongside the disturbances of self organisation (DSO) symptom triad of emotional dysregulation, negative self-concept and disturbances in relationships (Karatzias *et al.,* 2017). CPTSD has demonstrated construct validity (Hyland *et al*., 2017). Histories of childhood sexual and physical abuse are associated with a range of adverse outcomes, including high rates of self-harm and risk of suicidal behaviour (van der Kolk *et al*., 1991), and high co-morbidity (Mullen *et al*., 1993). Given the novelty of this formal diagnostic construct, there is a relative dearth of research designed to investigate effective treatments specifically for CPTSD.

Robust empirical support exists for the efficacy of a variety of psychotherapies for the treatment of PTSD, including trauma-focused cognitive behavioural therapy (TF-CBT), exposure therapies, cognitive processing therapy, narrative exposure therapy and eye movement desensitisation and reprocessing (EMDR) (Cusack *et al*., 2016). These therapies involve either imaginal exposure to the trauma memory or *in vivo* exposure to stimuli associated with the memory, to enable reprocessing of the trauma memory. Several interventions designed for the treatment of PTSD have shown promise in their application to developmental trauma. For instance, findings from a recent meta-review support the efficacy of individual treatments: TF-CBT and EMDR, for those with a history of child sexual abuse (CSA) (Niemeyer *et al*., 2022). While promising, there remains a lack of available studies on individuals with established CPTSD diagnosis for review (Niemeyer *et al*., 2022). Additionally, memory reprocessing therapies for PTSD can result in considerable drop-out rates, with estimates of around 30% of patients not completing exposure-based treatments (Cloitre, 2009). Furthermore, a key potential limitation of the application of these therapies to CPTSD is that by focusing on exposure and reprocessing, they may only partially address the symptom profile of CPTSD. There is a need to address the additional DSO symptoms of CPTSD, as a complex symptom profile is associated with poor treatment outcomes using traditional PTSD treatments (McDonagh *et al*., 2005; van der Kolk *et al*., 2007).

CPTSD resulting from a history of developmental trauma can be particularly challenging to treat (Karatzias *et al*., 2019). Developmental trauma has been linked to each of the DSO symptoms of negative self-concept (Pinto-Gouveia and Matos, 2011), interpersonal relationship disturbances (Cyr *et al*., 2010) and affect dysregulation (van der Kolk and Fisler, 1994). In CPTSD, DSO symptoms may occur with greater frequency than intrusive memory symptoms and as such, they represent an important feature distinguishing the CPTSD diagnosis from PTSD (Roth *et al*., 1997). Notably, individuals with a history of developmental trauma may experience less improvement in CPTSD symptoms from traditional psychotherapies (including CBT, exposure and EMDR) than those whose traumatic experiences began in adulthood (Karatzias *et al*., 2019). A recent randomised clinical trial demonstrates the efficacy of tailoring treatments to the specific needs of developmental trauma survivors. Bohus *et al*. (2020) compared the efficacy of a new, phase- based, individual treatment programme, specifically designed to meet the needs of survivors of child abuse with highly complex presentations of PTSD: dialectical behaviour therapy for PTSD (DBT-PTSD), against cognitive processing therapy

(CPT). They found that the DBT-PTSD trial arm had greater treatment retention and produced a greater reduction in PTSD symptoms, intensity of dissociation, and frequency of dysfunctional behaviours, including: self-harm, risky behaviour and drug use. Nevertheless, there remains a need to further explore the mechanisms of therapeutic change in CPTSD related to developmental trauma.

First-line individualised PTSD treatments recommended by the NICE guidelines, e.g. TF-CBT (NICE, 2018), are traditionally delivered using face-to-face sessions between the individual and therapist. As a result, TF-CBT has been shown to be less accessible to those living in rural communities (Shapiro *et al*., 2003). Moreover, once patients have accessed services, they often face long waiting times for individual therapy (Collins *et al*., 2004), which can be associated with clinical deterioration (Reichert and Jacobs, 2018). A lack of evidence-based treatments addressing DSO symptoms in CPTSD, coupled with barriers to accessing traditional PTSD treatments, has created an unmet need among those with CPTSD that has the potential to be redressed by offering group CBT interventions.

There is a lack of research into group treatments for CPTSD related to developmental trauma. A recent systematic review and meta-analysis of adults with CPTSD-associated symptoms, found that group treatments using trauma memory processing are more effective for treating core PTSD symptoms, while psychoeducation groups are more effective for treating features of general distress including anxiety and depression (Mahoney *et al*., 2019).

Group treatment contexts can simulate a social microcosm whereby group members display their typical relational patterns (Yalom, 2005). The re-evaluation of negative core beliefs about the self, self-blame and shame can be re-evaluated in a group environment to empower patients to respond to situations with increased self-empathy and flexibility (Yalom, 2005). In practice however, clinicians have cautioned that the use of exposure techniques for individuals in the group setting may trigger distress and re-experiencing symptoms in other group members (Beck and Coffey, 2005). The current study aimed to enhance understanding of factors influencing treatment acceptability and the process of change associated with the Recovering from Childhood Abuse Programme (RCAP; Kennerley *et al*., 2014). This study is part of a wider pilot project seeking to evaluate the potential effectiveness, acceptability and tolerability of the RCAP. The RCAP promotes developing self-conceptualisations and a variety of coping strategies; addressing key issues such as overcoming self-blame, overcoming anger, disclosing trauma to others, overcoming sexual problems, facing loss, and building a new future. We aimed to explore two questions:

(1) What factors influence the acceptability of the RCAP for patients with CPTSD?
(2) What are the potential mechanisms underlying therapeutic change experienced by patients participating in the RCAP?

The present study was affected by the onset of the global COVID-19 pandemic. In March 2020, mid-way through the programme, we transitioned from face-to-face to an online intervention delivery. Therefore, it should be noted that while not an initial aim of the study, we also explored patients' experiences of the group programme being delivered remotely online, during this transition to telehealth.

Method

Design and overview

This study adopts a qualitative, critical realist stance to inquiry. The views and experiences of the group were elicited through the audio-recording of the therapy process, which included time scheduled for group members to provide weekly feedback about each therapy session.

Reflexive thematic analysis was chosen to analyse the therapy process data in this study as it embraces qualitative research values and emphasises the subjective skills the researcher brings to the process (Braun and Clarke, 2020).

Setting

The study took place in a specialist psychological trauma service, in Camden & Islington NHS Trust, an ethnically and socially diverse area of London.

Group members

Group members were 10 female out-patients whose eligibility for the group was determined after an assessment by either a consultant psychiatrist (M.B.) who has formal training in the use of the RCAP, or a senior clinical psychologist (K.E.) with special expertise in working with CPTSD patients. Inclusion criteria for the group were having (a) a confirmed diagnosis of PTSD based on clinical interview, as well as a likely CPTSD diagnosis as based on their ITQ scores (ICD-11; World Health Organisation, 2018) and (b) a history of childhood sexual abuse (CSA). Based on the symptoms and difficulties reported within pre-group assessments, M.B. and K.E. carrying out these assessments concluded that all those individuals being offered the group programme had clinical presentations consistent with that of CPTSD.

Patients were judged inappropriate for participation in the treatment if they met the following exclusion criteria: (a) alcohol/substance abuse/dependence/withdrawal and (b) presence of active suicidal ideation (with intent) or self-injurious behaviour. No restrictions were put on group members undergoing other psychotherapies during the research period. Eleven women were referred to the RCAP, one of whom did not return after the first session due to discomfort in a group setting.

Study procedure

The RCAP group intervention was offered as part of routine clinical treatment. All data collected were therefore part of a routine service evaluation and as such, ethical approval was not required to carry out the current study. Nevertheless, written informed consent was obtained from all group members to participate in the treatment evaluation and to publish its findings, and the study was registered with the NHS Trust R&D audit committee. The discourse contained within transcripts of 21 ninety-minute group therapy sessions served as the primary data source. This included both therapy process data and verbal feedback given by group members in the therapeutic setting at the beginning and end of each session.

To adhere to the principle of collaborative empiricism, feedback on the therapy process and administration was gathered from the group. The provision of all feedback was optional. The first and last five minutes of the therapy session included time scheduled for group discussion on the following: what group members learned, as well as what they found helpful and unhelpful in the previous week's session and that day's session, respectively. This feedback served primarily to allow us, as therapy facilitators, to improve clinical administration of the programme to ensure group members' therapeutic needs were being met. Its secondary function was to promote reflection among group members and provide them with an opportunity to consolidate learning between sessions. A secondary means of data collection involved the use of written feedback forms, consistent with routine CBT practice (Beck, 2011). If group members felt uncomfortable sharing their feedback with the facilitators verbally in the group setting, they were given the option to anonymously share their thoughts on what they had learned, and what was helpful/unhelpful. These forms were given after the therapy session to

be completed immediately and collected before group members left. However, use of written feedback forms was limited and in general, group members preferred to provide verbal feedback.

Treatment procedure

The group sessions were led by a consultant psychiatrist (M.B.) and senior clinical psychologist (K.E.) with the support of two assistant psychologists (S.H. and D.W.). Supervision was provided at monthly intervals by the clinical psychologist who designed the programme (H.K.). The group ran from 13 January to 27 August 2020. After session 10, the group was unable to meet due to the lockdown imposed in response to the COVID-19 pandemic. After a 3-month pause, therapy resumed online using Microsoft Teams. The group restarted with a session to review how people were coping during the pandemic, followed by a reconsolidation session, then proceeded according to the original 18-session programme. A single booster session was provided 3 months after the end of the programme. Attendance was monitored each week and technical support was provided by the team.

Data analysis

The group sessions (21 in total) were audio-recorded, transcribed verbatim, and identifying information removed. Transcripts were pseudo-anonymised and reflexively analysed by the lead author. Reflexive thematic analysis relies on the researcher's transparency to enhance trustworthiness of the analysis, as opposed to reliance on neopositivist approaches aimed at achieving 'objective' or 'unbiased' coding, such as the use of multiple coders to create inter-rater reliability (Braun and Clarke, 2020).

After the first five therapy sessions, the lead author generated a potential list of codes from the reading and re-reading of the first five transcripts. Codes were developed to denote a single unit of meaning, keeping the wording of the codes as close as possible to the original text. These codes were inductively derived from the data according to the research aims of (1) understanding the psychotherapeutic change process as it unfolds among this treatment group and (2) identifying the aspects of the programme that influenced its acceptability to group members. The transcripts were imported into QSR NVivo Pro V12 for Mac along with the initial list of codes.

Following this, analysis of a more interpretive nature was carried out at successively higher levels of abstraction wherein similar codes were combined to explore commonalities between lower-level codes. This iterative process continued each week with the addition of each therapy session transcript. At the end of treatment, the material from all 21 transcripts was refined until the range of themes developed were agreed to adequately fit the data.

Data were analysed considering both the temporal evolution of themes, as well as the variations in group members' perspectives. The final stage of analysis involved conceptual linking of themes which was achieved through discussion with the therapy leads whose expertise in the treatment of CPTSD aided interpretation of the psychotherapeutic process, and the study supervisors, who have expertise in CPTSD and qualitative thematic analysis.

All coding was inductively derived from the data according to the research aims, except for the sections on 'Adapting to telehealth' and 'Feedback at follow up' which were deductively coded to capture (1) how the transition to online therapy delivery influenced group members' experiences of the programme and (2) how the treatment effect was maintained at follow-up, respectively.

To enhance validity, the co-facilitators of the therapy group were given the opportunity to read drafts of the evolving analysis to feedback on face validity.

Reflexivity

As the first author of this paper, I am a young woman with an educational background in psychology, who has no personal insight into the experience of developmental trauma.

The authorship contains people who were both clinicians and researchers in this study (S.H., M.B., D.W., K.E.) and people who were not directly clinically involved in this study (J.B., H.K.) to balance the subjective influence on this study. M.B. was the only man involved in the therapy group of women who suffered abuse at the hands of men. All group members had previously indicated at assessment that they were comfortable being treated by a man. M.B's. presence allowed him to model the experience of confiding in a compassionate, emotionally responsive man.

Results

The group membership characteristics are described in Table 1. The group consisted of 10 women of working age ($M=43.9$, $SD=12.7$, $R=26–60$). All met criteria for CPTSD related to CSA. All patients presented with intrusive memories, difficulties in emotional regulation, negative beliefs about the self and feeling cut-off from others following a variety of traumatic life events. The data from one group member – who left treatment after the first session – is excluded from the tables.

Six group members attended 80% or more of the initial face-to-face sessions and five group members attended 80% of the total treatment (see Table 2 for attendance). Three group members dropped out of the therapy, two after four (non-consecutive) sessions towards the beginning of the programme, due to social anxiety and the recurrence of cancer, respectively. The third group member dropped out after nine (non-consecutive) sessions due to difficulties in arranging childcare to enable her to participate in the group. Data from these participants (collected prior to drop-out) has been included in the analysis to present a diverse range of participant experiences, including those who dropped out of the group, as well as those who completed it.

Three core themes influenced treatment acceptability: (1) solidarity of the group context, (2) therapeutic facilitation and (3) adapting to telehealth. Key therapeutic developments were characterised by the themes of shifting self-blame and feeling safe in the present moment and increased optimism for the future. Considerable overlap was found among factors which increased acceptability of the programme and those which catalysed therapeutic change.

Themes are described below, illustrated with quotations from group members and labelled by session number. At first mention, the comments are labelled by session title and all comments are differentiated according to whether they were made during the time dedicated to providing session feedback (indicated by 'FB') or were made during the therapy process (indicated by 'TP'). The inter-relationship between themes is represented in the thematic map in Fig. 1.

Solidarity in the group context and therapeutic facilitation led to the group's readiness for change, underpinned by the mechanisms of shifting self-blame and feeling safer in the present moment, which in turn, led to increased optimism for the future. Figure 1 captures our thematic interpretation of therapeutic change and perceived acceptability of the programme among this sample and is not intended to model the psychotherapeutic change process of women childhood abuse survivors more generally.

Factors influencing treatment acceptability

Solidarity of the group context

This theme encapsulates the sense of support and mutual encouragement that developed in the group setting. Early in therapy, the experience of feeling connected to others with similar past experiences was important.

Table 1. Demographic and clinical characteristics at time of treatment

Demographic characteristic	M (SD)
Age	43.9 (12.7)
	n (%)
Ethnicity	
White British	6 (60%)
White other	1 (10%)
Black Caribbean	1 (10%)
Middle Eastern	1 (10%)
North African	1 (10%)
Marital status	
Single	5 (50%)
Married	1 (10%)
Living with partner	2 (20%)
Widowed	1 (10%)
Separated	1 (10%)
Employed	3 (30%)
Diagnoses (ICD-11)[a]	
CPTSD	10 (100%)
Mixed anxiety and depressive disorder	8 (80%)
Bipolar affective disorder	1 (10%)
Childhood trauma (CTQ)	
Sexual abuse	
None or minimal	1 (10%)
Low to moderate	0 (0%)
Moderate to severe	0 (0%)
Severe to extreme	9 (90%)
Physical abuse	
None or minimal	3 (30%)
Low to moderate	0 (0%)
Moderate to severe	2 (20%)
Severe to extreme	5 (50%)
Emotional abuse	
None or minimal	1 (10%)
Low to moderate	0 (0%)
Moderate to severe	4 (40%)
Severe to extreme	5 (50%)
Physical neglect	
None or minimal	4 (40%)
Low to moderate	1 (10%)
Moderate to severe	4 (40%)
Severe to extreme	1 (10%)
Emotional neglect	
None or minimal	3 (30%)
Low to moderate	2 (20%)
Moderate to severe	4 (40%)
Severe to extreme	1 (10%)
Traumatic life events (LEC)[b]	
Natural disaster	1 (10%)
Transportation accident	3 (30%)
Serious accident at work, home, or during recreational activity	2 (20%)
Exposure to toxic substance	1 (10%)
Assault with a weapon	2 (20%)
Physical assault	8 (80%)
Sexual assault	8 (80%)
Other unwanted or uncomfortable sexual experience	5 (50%)
Captivity	1 (10%)
Life threatening illness or injury	4 (40%)
Severe human suffering	2 (20%)
Sudden violent death	2 (20%)
Sudden unexpected death or someone close to you	6 (60%)
Serious injury, harm, death you caused someone else	1 (10%)
Any other very stressful event or experience	3 (30%)

M, mean; SD, standard deviation; n, number of group members who exhibit a given characteristic; CTQ, Childhood Trauma Questionnaire (Bernstein et al., 2003); LEC, Life Events Checklist (Weathers et al., 2013).
[a]All diagnoses were obtained at initial assessment for treatment suitability, according to ICD-11 criteria.
[b]Data were missing for adult trauma (LEC) for n=1 (10%).

Table 2. Number of sessions attended and completed by group members

Pseudonym	Face-to-face attendance (of 10 sessions)	Online attendance (of 10 sessions)	Sessions completed *n* (%)
Emma	8	8	16 (80%)
Olivia	10	10	20 (100%)
Ava	4	0	4 (20%)*
Isabella	10	10	20 (100%)
Sophia	6	8	14 (70%)
Charlotte	9	8	17 (85%)
Mia	8	1	9 (45%)*
Amelia	10	9	19 (95%)
Grace	7	7	14 (70%)
Chloe	4	0	4 (20%)*

*Individuals who did not complete the therapy group.

> *I'm not alone because you come and everyone is talking about something that happened to them, so it's not just me* [Grace, FB, 4: Understanding your problems, strengths and needs (2)]

As therapy progressed, solidarity in adversity facilitated a supportive culture. The context of being surrounded by others who understood and could empathise, provided the conditions necessary to increase trust. This enabled the group to share beliefs and experiences that they felt compelled to keep secret whilst growing up.

> *I think we have hidden these secrets for all our lives, some of us. So, when it comes to the detail, we feel safe sharing here because the secrets were hidden in ourselves and we don't feel we can leave this room and share the same* [Mia, TP, 7: Understanding the way you think]

Shared experiences of adversity allowed group members to transcend cultural differences. The cultural diversity of the group membership was experienced by two group members – of ethnic minority – as a source of comfort that enabled them to empathise with one another. For them, the group context provided the opportunity to free themselves from oppressive cultural norms that discouraged speaking out about abuse.

> *I feel like I'm being subjugated by* [my] *culture, it's killing me* [. . .] *In settings like this, you understand me, but if I speak to people from my culture, they will judge me* [. . .] *In my culture we don't talk about abuse, you cannot find it on TV or internet it's like they are suffocating you* [Grace, TP, 5: Preparing and planning for changes in your life]

> *Same thing with my culture* [. . .] *All my life they told me: shut up, it's shameful! That's your family; you don't speak about your family like that, but people that were born here* [in the UK] *say no, you go to the police, you get help* [Charlotte, TP, 5]

Having a safe space to speak out about the abuse, helped many members to normalise the experience of their trauma symptoms. At the end of treatment, several felt that this was one of the most valuable things offered by the programme.

> *I feel so much less alone now, before I was like: oh, this is just me feeling like this, no one else feels like this . . . but other people have talked about their experiences and they've been similar to mine and they've dealt with it in the same ways I have* [. . .] *It's been really nice knowing that I'm not alone* [Isabella, FB, 20: Ending therapy but continuing the work]
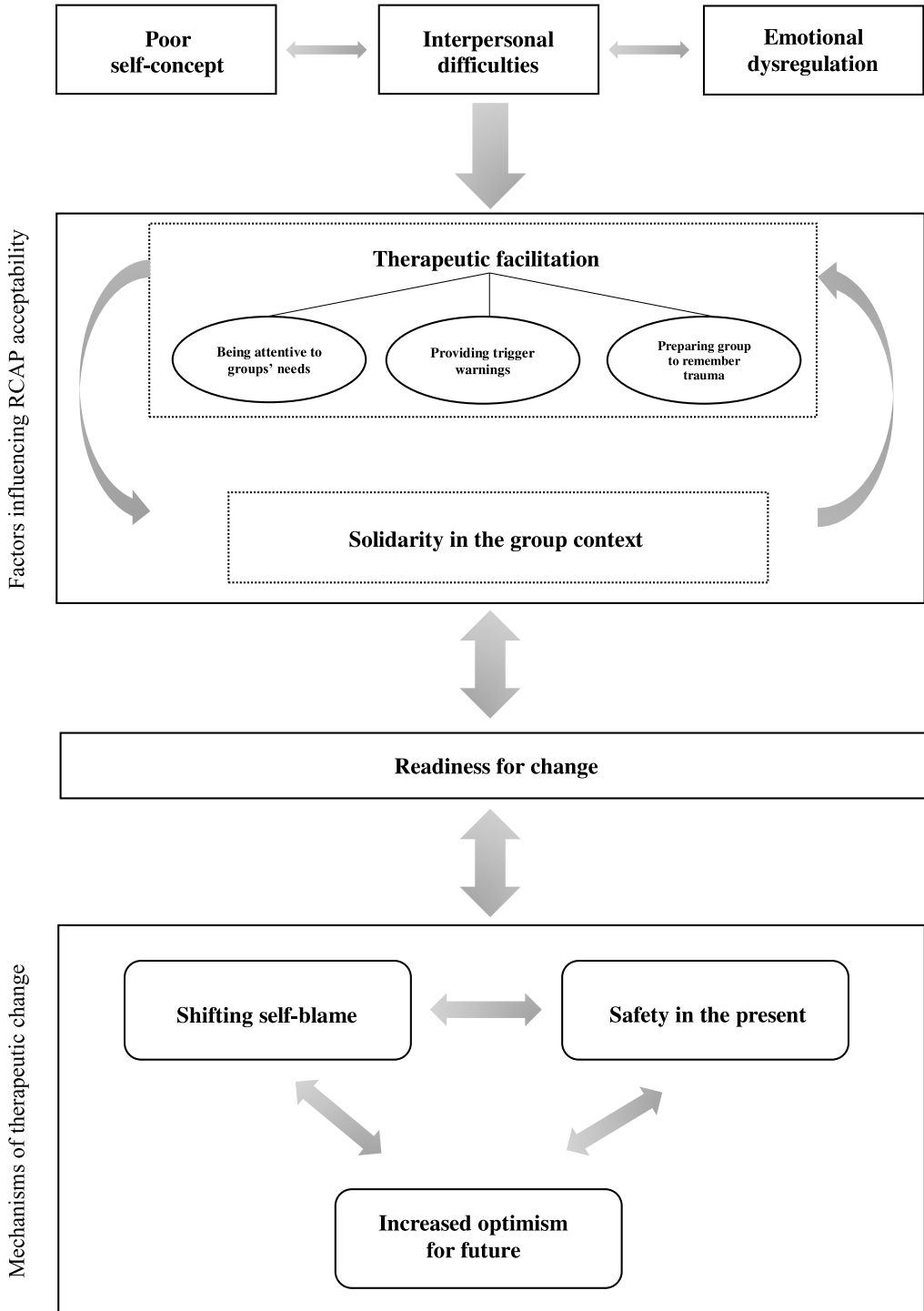
Factors influencing RCAP acceptability

Mechanisms of therapeutic change

| Poor self-concept | Interpersonal difficulties | Emotional dysregulation |

Therapeutic facilitation

Being attentive to groups' needs

Providing trigger warnings

Preparing group to remember trauma

Solidarity in the group context

Readiness for change

Shifting self-blame

Safety in the present

Increased optimism for future

Figure 1. Thematic map displaying the inter-relationships between themes.

Therapeutic facilitation: creating safety in the group environment

This theme encapsulates factors which influenced perceived safety of the therapeutic environment, including the composition of the group, as well as situations in which the therapeutic handling of the group by facilitators helped to overcome challenges created in the group dynamic, captured by the subthemes 'Attentive facilitation' and 'Triggered by disclosure; the importance of giving warning'. It also includes situations in which therapeutic facilitation threatened acceptability, captured by the subtheme 'Being prepared to remember'.

Apart from one of the lead therapists (a male psychiatrist), the composition of the group and facilitators was all female. Early on, the predominantly female context enabled group members to express themselves more freely: '*I found it good to be in a female group where you can share things that you can't with guys*' (Charlotte, FB, 2: Developing coping strategies and skills to help you recover). At the conclusion of therapy, two group members reflected that in hindsight, the inclusion of a male therapist had helped them to experience a compassionate and supportive male presence. For instance, Emma felt it helped her to overcome the feeling that all men are inherently threatening.

> It sort of makes you feel like, 'do you know what? Not all men are terrible human beings. Some of them are helpful and kind', and it has helped to sort of desensitise the fear of being vulnerable around men [FB, 20]

Attentive facilitation

Initially, the group was split in opinion regarding the degree to which group members should be allowed to share their personal experiences of CSA. While the majority expressed that the sharer was entitled to feel listened to by stating they were '*Very valid in expressing how they feel and what happened to them*' (Amelia, FB, 2); two of the younger group members stated that they resented that this came at the expense of deepening their learning. For instance, following session 4 which aimed to help group members understand their problems, strengths and needs using the CBT maintenance model, Isabella expressed frustration that her psychoeducation was disrupted by disclosure: '*I'm not sure if this group is for learning or sharing our troubles. I don't want to hear other traumas. I want to learn*' (Isabella, FB, 4). Therapeutic facilitation was judged to be optimal when disclosure was considered well managed. For instance, following a period of dissociation in response to hearing someone recount a traumatic experience, Isabella found that '*Being asked if I was ok was helpful, it helped me to pay more attention and contribute more*' (FB, 5).

Triggered by disclosure; the importance of giving warning

Initially, when some group members spoke about details of their abuse, others reported that they found it distressing and unhelpful.

> I found some parts a bit triggering when people recounted their personal experiences. I felt quite frozen and couldn't speak. I found it harder to concentrate and felt myself go into a darker place when discussing suicide [Amelia, FB, 2]

This represented a barrier to engagement early in the programme. Isabella characterised such disclosure as '*over-sharing*' but felt conflicted about interjecting, as she didn't wish to invalidate the other group member's experience: '*It triggered me but I felt bad stopping them from talking*' (TP, 2). The group agreed upon a strategy suggested by one of the lead therapists of providing a '*trigger warning*' before stating something potentially distressing.

As the sessions progressed, this became a part of the therapeutic work itself, helping group members to normalise their experiences.

> *I might be triggered, but I like it when people share. Like this is one of the most useful things that I'm gaining from this therapy, I'm starting to feel normal* [Olivia, TP, 7]

Compliance with this new ground rule served to enhance acceptability of hearing distressing material by helping group members learn to self-regulate emotionally by bracing for stress. For instance, Amelia noted during session 9 (on understanding that you were not to blame) that the group was coping well with the discussion of a lot of 'triggering' content. When asked what this said about her and other group members, Amelia responded:

> *I guess we're taking on board some of the coping mechanisms aren't we, and starting to use them and even if it's a subconscious thing, it's yeah, we're growing in strength, bit by bit* [FB, 9: Understanding that you were not to blame (1)]

Being prepared to remember

This theme captures the importance of allowing group members to prepare themselves to approach traumatic memories in the therapeutic context. Many initially avoided their trauma memories, as evidenced by group-wide refusal to participate in the 'choosing to remember' exercise, which involved writing down personal experiences of historical abuse in the therapy workbook. Mia stated that she avoided writing down her traumatic memories as she felt this was akin to 'reliving it' (FB, 8: Remembering the past and dealing with flashbacks).

> *Even if we had been prepared, I can't remember if you said it at the beginning of the session, but it would just be helpful to say later on, if you want to or not, we'll be asking you to recall memories, it's up to yourselves* [Amelia, FB, 8]

Importantly, as treatment progressed, readiness to overcome avoidance of traumatic memories increased in most individuals. This process was encouraged by vicarious learning.

> *I didn't fill mine in* ['Choosing to Remember' exercise] *because I didn't want to think about it but after hearing you guys speak it, I actually feel like I can write it down* [Isabella, FB, 12: Understanding that you were not to blame (3)]

Potential mechanisms of therapeutic change

Shifting blame

This theme reflects the process through which group members shifted self-blame for past trauma onto their abusers. In session 9, group members were asked to create a list to assign responsibility to individuals/organisations involved in their abuse. Group members were instructed initially to exclude themselves from the list. Following facilitated discussion about the abusers' responsibility, the group then ordered this list from most to least responsible and were asked if/where they would place themselves on the list. Initially, self-blame for past abuse was pervasive: '*that would be my initial thought, it would be you* [points at herself], *you were at fault*' (Mia, TP, 9). Only one group member denied identification with a feeling of self- blame: '*I didn't feel like it was my blame. I've never felt that*' (Charlotte TP, 12). The process of shifting self-blame began as group members shared reflections on their thought processes as children.

[. . .] *as a child you are trying to come up with reasons why it's happening and that's where the feelings of self-blame start to grow because you are trying to work out why this person – who should be trying to protect me – is hurting me* [Amelia, TP, 9]

Group members worked together to counter the self-blaming beliefs they had internalised in childhood. Isabella challenged her tendency to self-blame for not disclosing her abuse by acknowledging that her family had deterred her disclosure: '*when I was older and I realised it* [the abuse] *was wrong, I tried to tell but my family told me to deny it*' (TP, 9). Similarly, Mia and Emma challenged their beliefs that the way they looked justified their abuse: '*It shouldn't matter what you are wearing because you are a child at the end of the day*' (Emma, TP 9).

Hearing others' experiences of self-blame was a profound moment of realisation for several group members: '*usually I'd have said me* [who was to blame] *and by not doing that, I've grown in the last half hour*' (Mia, TP, 9). This was echoed by the entire group, all of whom denounced self-blame for their abuse during the session: '*I was gonna put myself on the list* [of people to blame for the abuse] *and then, in the end, I was like no*' (Emma, TP, 9).

Feeling safe in the present

This theme captures the self-reflective process that group members engaged with, to overcome negative automatic thoughts and deeply held beliefs, to feel safer emotionally, in the present moment.

It's being able to take yourself out, to sit down, to breathe and realise that your thought is extreme but there's a whole gradient of other options and thoughts and choices you could go through [Emma, TP, 8]

Feeling safe in the moment was seen to require continuous active commitment to thought testing.

You've planted a seed and if you nourish it, it will get better [. . .] *It is not like a magic thing, like boom! No, it takes time. You have to put it in your head and nourish it and try and use it. Someday we'll have very dark days and maybe that seed will get neglected, but you'll get out of it, so the seed won't die* [Grace, FB, 8]

This reflects a belief shared by many of the membership: creating lasting therapeutic change takes time and requires perseverance. For instance, Emma described her difficulty in challenging her fear that everyone in her life will eventually let her down.

I understand logically, but from an emotional standpoint immediately I get push back [. . .] *every single human being has the potential to turn* [TP, 16: Dealing with intimacy]

Several group members described the continued activation of fear in certain situations, despite progress made in treatment. In Emma's case, despite continued difficulty with interpersonal relationships, she acknowledged that overall, she had made progress: '*I am not just a victim to my thought process anymore. I am a lot more in control*' (TP, 19: Coping in the long term and managing relapse). Similarly, Isabella reported that the strategies she had learned to examine her thinking patterns more objectively, enabled her to overcome negative emotions.

[...] *now when I am triggered, I am like ok, what exactly happened? Why am I feeling like this? Is this actually true? So, I think that has been useful because my understanding of where my emotions are coming from, it makes me process them, so I can calm myself more easily* [TP, 19]

Increased optimism for the future

Self-development throughout the programme led to optimism for the future. For Isabella, this manifested as increased ambition: '*I'm a lot more motivated and I feel like I can do a lot more things now, so I am even more excited for the future*' (TP, 18: Grieving and mourning: facing loss). Similarly, Amelia expressed increased confidence to demonstrate assertiveness in the face of potential threat.

I think moving forward, when there are people that remind me of [abuser], *I will actually be able to stand up for myself, rather than freeze and not be able to speak* [FB, 20]

Olivia described a profound perspective shift since the beginning of the programme, in recognising the potential for goodness in other people.

You [to the group] *just treat me really well and like – I have never had that before in my life, so it has made a really big change to how I see the world and I feel that I could meet some good people now. There could be some good people on this Earth* ... [FB, 19]

Group members also expressed an increased belief in their resilience. Several stated that they would continue to take a step back from their negative thoughts, to come to a more objective, non-judgmental stance, i.e. decentre.

You have reinstated and reinforced again: to think about your thoughts; to be self- aware, that sort of stuff; to constantly be looking for new self- management and self- care techniques, and that will follow me forever and I feel so much better now. Obviously, I still have my issues, but I feel so much better [Emma, FB, 20]

This highlights that despite continued emergence of challenges, actively engaging with the therapeutic techniques learned, helped group members to reach a more positive outlook.

Adapting to telehealth

This theme details group members' experiences of adapting to remote treatment delivery. There was initial resistance towards moving therapy online. However, group members overcame their reservations and reflected that continuing online was acceptable to them.

It's not a bad thing, doing it virtually [laughs]. *I think when we all discussed it back in March* [during the last session before the pause in treatment due to COVID-19], *I was very much against it* [due to reservations about sharing freely in the home] *but it has not been too bad* [Amelia, FB, 11: Consolidation session following break in therapy, due to COVID]

For Charlotte, the transition to telehealth improved her ability to access the treatment: '*to tell the truth, I prefer it because it is easier to talk at home than it is to get to the hospital to be there in person*' (FB, 8).

However, most of the group expressed that face-to-face therapy was preferable. Olivia described how the transition to telehealth had created complacency for her around the treatment.

I used to prepare ahead of time. The night before I used to do the homework and then I'd read the material on the tube on the way to class [. . .] now the folder sits beside me and I do nothing about it [. . .] everything was better when it was more interactive, but this is better than nothing, of course [Olivia, FB, 17: Dealing with sexual difficulties]

Feedback at follow-up

Several participants shared during the 3-month follow-up session that they had continued to derive benefit from the lessons they learned within the group: '*I feel like this is the first time in years that I've got control over what happens in my life and that I can make decisions for myself*' (Charlotte, TP, 21: Booster session). The most prominent reflection shared by the group membership reiterated how the sense of connectedness they felt within the group was deeply valued.

I just wanted to say to everyone that you are beautiful, strong, resilient and fantastic people who I have connected to – probably the most I've ever connected to people when dealing with this stuff and I just wanted to thank you for giving me the strength, the positivity and the ability to look forward and the optimism and for helping me to feel normal and not alone anymore [Amelia, TP, 21]

Discussion

We sought to explore treatment acceptability as well as the potential mechanisms of change associated with participation in the RCAP in a group of women with CPTSD. We found the programme was acceptable to most of the group. We identified shifting self-blame and feeling safe in the present moment as being potential mechanisms of therapeutic change leading to increased optimism for the future.

The process of guided discovery (Beck and Dozois, 2011) began early in therapy, wherein group members were asked questions to help them define their problems and identify the thoughts and beliefs underlying their emotions. The group became accustomed to considering both supportive and contradictory evidence surrounding their own and others' thoughts and were encouraged to practise this self-analysis in the homework tasks. As therapy progressed, group members increasingly began to initiate thought testing and were active in working with the facilitators to establish the common goals of shifting self-blame and feeling safer in the present. This is consistent with the finding that collaborative empiricism is a key predictor of therapeutic success in CBT (Dattilio and Hanna, 2012).

Hearing detailed accounts of traumatic events was distressing to several group members and thus, such detail was discouraged in the group. The introduction of a trigger warning system served to curtail the degree of traumatic detail described and helped the group to brace for upsetting content. This strategy increased resilience to trauma references by enabling the group to overcome avoidance and learn that emotional self-regulation is possible in response to 'triggering' experiences. This supports the argument that promoting safe and appropriate disclosure is paramount to the trauma recovery process (Chouliara *et al.*, 2014). However, it is important to distinguish the utility of *facilitated limited disclosure* from exposure techniques used in memory reprocessing, which may cause secondary traumatisation in the group setting and were not used in the present study (Resick *et al.*, 2008).

For all group members, the experience of being understood by others with similar histories of CSA served as a powerful normalising experience and is likely to have been important in reducing shame and increasing self-worth. This is consistent with the type of therapeutic process described to unfold in compassion-focused therapy groups with victims of CSA (Ashfield *et al.*, 2020; Lawrence and Lee, 2014). In the current study, group members indicated that hearing others'

experiences helped them to accept that the blame belonged with the abusers. This is noteworthy as shared experiences are absent in the context of individual psychotherapy.

A recent qualitative study exploring patient experiences of individualised trauma treatments (Imagery re-processing and EMDR) for the treatment of PTSD related to developmental trauma, suggested that 'going back to the source' to reprocess the trauma memory, was necessary to change perspectives and beliefs around the experience and move forward (de Haan *et al.*, 2021). However, our findings suggest that in a group context, direct reprocessing is not necessary to produce subjective therapeutic change for child abuse survivors in the 'here and now'. Rather, we found the compassion expressed between group members enabled them to shift self-blame by helping one another to assign responsibility to their abusers for their traumas (Gilbert and Procter, 2006). Moreover, our group membership disengaged when directly asked to write down memories of their abuse in the 'Choosing to remember' exercise. This optional component of the programme in session 8 was the most akin to the exposure element of TF-CBT. Our findings suggest that connecting self-blaming beliefs to past abuse may be a more tolerable strategy of promoting cognitive restructuring than memory exposure in group treatment of CPTSD.

Later in treatment, some group members verbally engaged with trauma memories in session (to acknowledge how the abuse contributed to their present symptoms). It may be that group members found this to be more helpful than privately recording abuse experiences as it gave them the opportunity to contextualise and normalise distress related to the abuse memories. It appeared that witnessing others eventually 'choose to remember' in this way was helpful to reduce shame and avoidance in the wider group. It should be noted that this verbal disclosure retained 'here and now' focus and was not of comparable depth or detail to memory exposure techniques. Considering recent meta-analytic evidence suggesting that psychoeducational groups are preferable to address general distress symptoms related to CPTSD, while trauma memory processing groups are preferable to address core PTSD symptoms (Mahoney *et al.*, 2019), the RCAP may be suited to individuals with CPTSD who are not yet ready for memory exposure.

As treatment progressed, group members expressed that they felt better able to regulate their emotional responses, consistent with findings documenting the recovery process in stabilisation groups for survivors of developmental trauma (Stige *et al.*, 2013). We found that feeling safe in the present moment was underpinned by increased self-reflection. The group also began to help each other to both identify and challenge negative automatic thoughts. This supports Hope and Heimberg's (1993) assertion that the group environment enables group members to act as therapists for one another (as cited in Westbrook *et al.*, 2011). Finally, group members in this study reported at 3-month follow-up that continued engagement with thought testing and emotional regulation strategies learned in the group, helped them to feel more socially connected and have a greater sense of control over their lives.

Importantly, the transition from face-to-face to online therapy delivery did not seem to deter group members from sharing their experiences. By contrast, therapeutic observation suggests that the bonds between group members continued to grow after this transition, despite the popular group opinion that telehealth was sub-optimal compared with face-to-face therapy. Given potential barriers to accessing in-person treatment, the potential for this programme to be adapted for online delivery is promising.

Strengths and limitations

A key strength of this study is our exploration of the dynamic change processes as they unfold during therapy, which extends previous research that has relied on patients' post hoc recall of therapy experiences, using single time point interviews (Ashfield *et al.*, 2020; Lawrence and Lee, 2014; Stige *et al.*, 2013). Secondly, the group membership was diverse, varying in age,

ethnicity, cultural background, and prior experience of therapy. Thirdly, we captured a transition in treatment delivery from face-to-face to telehealth.

The present study has several limitations. Firstly, we acknowledge the study's exploratory nature. No conclusions can be drawn regarding the treatment's effectiveness at reducing CPTSD symptoms based on quantitative measures. The findings reflect the views and experiences of a small sample of CSA survivors with CPTSD. The all-female heterosexual group limits transferability of the findings to people of other genders and sexual identities. Suitability for the group setting needs to be carefully considered at assessment as one group member dropped out after the first session. In total, four group members dropped out of the programme. However, we did not aim to explore the issue of treatment tolerability. It may have been valuable for the group members to have been offered individual interviews at the end of the programme with someone not directly involved in clinical administration of the group, to enable free expression of negative experiences within the group. Additionally, it is possible that our collection of feedback during sessions, within the group space, precluded group members from freely expressing negative experiences of each session due to group influence. Finally, the dual role of the first author posed a challenge to reflexivity in conducting the thematic analysis. Despite steps taken to manage this, the distance between patient and researcher was unavoidably reduced.

Clinical implications and directions for future research

Our findings suggest that a group intervention focused on cognitive restructuring through CBT mechanisms shows promise in facilitating therapeutic change among women with CPTSD. Specifically, this treatment appeared helpful for the management of DSO symptoms among this group. We found the inclusion of a man as co (lead) therapist helped patients to unlearn associations of threat associated with gender that had developed following early abuse perpetrated by men. Thus, female patients in this group with CPTSD to CSA perpetrated by men appeared to benefit from the opportunity to establish a trusting relationship with an empathic male co-therapist, in the safety of a female dominant setting.

Furthermore, the findings suggest that the safety measures taken enabled successful management of disclosure. Thus, the potential therapeutic benefit of facilitated limited disclosure in a group setting should not be dismissed clinically.

Future quantitative research is needed to investigate RCAP treatment effectiveness on symptom reduction, using larger, more representative samples. Research is needed to determine whether the RCAP is best suited as an adjunct to, as a preparatory intervention for, or following, individualised trauma focused work. Future studies should investigate whether some patients require a shorter duration of individual therapy following this intervention. Triangulation of the current findings with data recording symptom changes over time may be useful to consolidate which processes are associated with maintenance of treatment change for this population. Finally, the field would benefit from future research exploring patient experiences of an entirely online administration of the RCAP. This would help to establish whether initial face-to-face contact is necessary for positive outcomes. Our findings suggest that telehealth delivery of this programme should be as interactive as possible, to minimise patient disengagement.

Conclusion

Our study illustrates that a therapeutic focus on cognitive restructuring to overcome self-blame, enabled group members to develop meta-cognitive skills through learning to de-centre from and reappraise negatively biased thoughts about themselves, the world, and the future. Group members additionally improved their emotional regulation skills which increased their

confidence in being able to cope with future challenging situations. Therefore, the RCAP shows promise in addressing the DSO symptoms of CPTSD, and furthermore, shows potential as an online intervention.

Key practice points

(1) The RCAP promotes development of emotional regulation and targets trust difficulties.
(2) The RCAP was helpful to adult female survivors of childhood trauma with CPTSD.
(3) Faciliated limited disclosure of experiences of trauma in the group promoted group bonding and normalised distress.
(4) Overcoming self-blame was experienced as a key marker of therapeutic progress.
(5) Group cohesion was maintained through both face-to-face and online delivery.

Further reading

Ashfield, E., Chan, C., & Lee, D. (2020). Building 'a compassionate armour': the journey to develop strength and self-compassion in a group treatment for complex post-traumatic stress disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, *94*, 286–303. https://doi.org/10.1111/papt.12275

Mahoney, A., Karatzias, T., & Hutton, P. (2019). A systematic review and meta-analysis of group treatments for adults with symptoms associated with complex post-traumatic stress disorder. *Journal of Affective Disorders*, *243*, 305–321. https://doi.org/10.1016/j.jad.2018.09.05

Author contributions. Siobhan Hegarty: Data curation (supporting), Formal analysis (lead), Methodology (equal), Project administration (equal), Writing – original draft (lead), Writing – review & editing (lead); **Kim Ehntholt:** Data curation (lead), Project administration (lead), Writing – review & editing (supporting); **Dorothy Williams:** Data curation (supporting), Project administration (supporting), Writing – review & editing (supporting); **Helen Kennerley:** Resources (lead), Supervision (lead), Writing – review & editing (supporting); **Jo Billings:** Formal analysis (supporting), Methodology (supporting), Supervision (supporting), Writing – review & editing (supporting); **Michael Bloomfield:** Conceptualization (lead), Formal analysis (supporting), Funding acquisition (lead), Methodology (supporting), Project administration (lead), Supervision (lead), Writing – review & editing (supporting).

References

Ashfield, E., Chan, C., & Lee, D. (2020). Building 'a compassionate armour': the journey to develop strength and self-compassion in a group treatment for complex post-traumatic stress disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, *94*, 286–303. https://doi.org/10.1111/papt.12275

Beck, J. S. (2011). *Cognitive Behavior Therapy: Basics and Beyond* (2nd edn). New York, USA: Guilford Press.

Beck, J., & Coffey, S. (2005). Group cognitive behavioral treatment for PTSD: treatment of motor vehicle accident survivors. *Cognitive and Behavioral Practice*, *12*, 267–277. doi: 10.1016/s1077-7229(05)80049-5

Beck, A., & Dozois, D. (2011). Cognitive therapy: current status and future directions. *Annual Review of Medicine*, *62*, 397–409. doi: 10.1146/annurev-med-052209-100032

Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., Stokes, J., Handelsman, L., Medrano, M., Desmond, D., & Zule, W. (2003). Development and validation of a brief screening version of the Childhood Trauma Questionnaire. *Child Abuse and Neglect*, *27*, 169–190. https://doi.org/10.1016/S0145-2134(02)00541-0

Bohus, M., Kleindienst, N., Hahn, C., Müller-Engelmann, M., Ludäscher, P., & Steil, R., . . . & Priebe, K. (2020). Dialectical behavior therapy for posttraumatic stress disorder (DBT-PTSD) compared with cognitive processing therapy (CPT) in complex presentations of PTSD in women survivors of childhood abuse. *JAMA Psychiatry*, *77*, 1235. https://doi.org/10.1001/jamapsychiatry.2020.2148

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*, 328–352. https://doi.org/10.1080/14780887.2020.1769238

Chouliara, Z., Karatzias, T., & Gullone, A. (2014). Recovering from childhood sexual abuse: A theoretical framework for practice and research. *Journal of Psychiatric and Mental Health Nursing*, *21*(1), 69–78

Cloitre M. (2009). Effective psychotherapies for posttraumatic stress disorder: a review and critique. *CNS Spectrums*, *14* (suppl 1), 32–43. Retrieved from: http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=emed11&NEWS=N&AN=354315516

Collins, K. A., Westra, H. A., Dozois, D. J. A., & Burns, D. D. (2004). Gaps in accessing treatment for anxiety and depression: challenges for the delivery of care. *Clinical Psychology Review*, *24*, 583–616. https://doi.org/10.1016/j.cpr.2004.06.001

Cusack, K., Jonas, D. E., Forneris, C. A., Wines, C., Sonis, J., Middleton, J. C., Feltner, C., Brownley, K. A., Omsted, K. R., Greenblatt, A., Weil, A., & Gaynes, B. N. (2016). Psychological treatments for adults with posttraumatic stress disorder: a systematic review and meta-analysis. *Clinical Psychology Review*, *43*, 128–141. https://doi.org/10.1016/j.cpr.2015.10.003

Cyr, C., Euser, E. M., Bakermans-Kranenburg, M. J., & Van Ijzendoorn, M. H. (2010). Attachment security and disorganization in maltreating and high-risk families: a series of meta-analyses. *Development and Psychopathology*, *22*, 87–108. https://doi.org/10.1017/S0954579409990289

Dattilio, F., & Hanna, M. (2012). Collaboration in cognitive-behavioral therapy. *Journal of Clinical Psychology*, *68*, 146–158. doi: 10.1002/jclp.21831

de Haan, K. L. B., Lee, C., Correia, H., Menninga, S., Fassbinder, E., Köehne, S., & Arntz, A. (2021). Patient and therapist perspectives on treatment for adults with PTSD from childhood trauma. *Journal of Clinical Medicine*, *10*, 954. https://doi.org/10.3390/jcm10050954

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: overview and pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy*, *13*, 353–379. https://doi.org/10.1002/cpp.507

Hyland, P., Shevlin, M., Brewin, C., Cloitre, M., Downes, A., & Jumbe, S. Karatzias, T. Bisson, J. I. & Roberts, N. P. (2017). Validation of post-traumatic stress disorder (PTSD) and complex PTSD using the International Trauma Questionnaire. *Acta Psychiatrica Scandinavica*, *136*, 313–322. https://doi.org/10.1111/acps.12771

Hope, D. A., & Heimberg, R. G. (1993). Social phobia and social anxiety. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (pp. 99–136). The Guilford Press.

Karatzias, T., Murphy, P., Cloitre, M., Bisson, J., Roberts, N., Shevlin, M., Hyland, P., Maercker, A., Ben-Ezra, M., Coventry, P., Mason-Roberts, S., Bradley, A., & Hutton, P. (2019). Psychological interventions for ICD-11 complex PTSD symptoms: systematic review and meta-analysis. *Psychological Medicine*, *49*, 1761–1775. https://doi.org/10.1017/S0033291719000436

Karatzias, T., Shevlin, M., Fyvie, C., Hyland, P., Efthymiadou, E., Wilson, D., Roberts, N., Bisson, J. I., Brewin, C. R., & Cloitre, M. (2017). Evidence of distinct profiles of posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder (CPTSD) based on the new ICD-11 trauma questionnaire (ICD-TQ). *Journal of Affective Disorders*, *207*, 181–187. https://doi.org/10.1016/j.jad.2016.09.032

Kennerley, H., Whitehead, L., Butler, G., & Norris, R. (2014). *Recovering from Childhood Abuse Therapy Workbook*. Oxford, UK: Oxford Cognitive Therapy Centre.

Lawrence, V. A., & Lee, D. (2014). An exploration of people's experiences of compassion-focused therapy for trauma, using interpretative phenomenological analysis. *Clinical Psychology and Psychotherapy*, *21*, 495–507. https://doi.org/10.1002/cpp.1854

Mahoney, A., Karatzias, T., & Hutton, P. (2019). A systematic review and meta-analysis of group treatments for adults with symptoms associated with complex post-traumatic stress disorder. *Journal of Affective Disorders*, *243*, 305–321. https://doi.org/10.1016/j.jad.2018.09.059

McDonagh, A., McHugo, G., Sengupta, A., Demment, C. C., Schnurr, P. P., Friedman, M., Ford, J., Mueser, K., Fournier, D., & Descamps, M. (2005). Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. *Journal of Consulting and Clinical Psychology*, *73*, 515–524. https://doi.org/10.1037/0022-006X.73.3.515

Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1993). Childhood sexual abuse and mental health in adult life. *British Journal of Psychiatry*, *163*, 721–732. doi: 10.1192/bjp.163.6.721

Niemeyer, H., Lorbeer, N., Mohr, J., Baer, E., & Knaevelsrud, C. (2022). Evidence-based individual psychotherapy for complex posttraumatic stress disorder and at-risk groups for complex traumatization: a meta-review. *Journal of Affective Disorders*, 299, 610–619. https://doi.org/10.1016/j.jad.2021.12.056

Pinto-Gouveia, J., & Matos, M. (2011). Can shame memories become a key to identity? The centrality of shame memories predicts psychopathology. *Applied Cognitive Psychology*, 25, 281–290. https://doi.org/10.1002/acp.1689

NICE (2018). Recommendations | Post-traumatic stress disorder | Guidance. Retrieved from: https://www.nice.org.uk/guidance/ng116/chapter/recommendations (accessed 3 August 2020).

Reichert, A., & Jacobs, R. (2018). The impact of waiting time on patient outcomes: evidence from early intervention in psychosis services in England. *Health Economics*, 27, 1772–1787. doi: 10.1002/hec.3800

Resick, P. A., Monson, C. M., & Chard, K. M. (2008). *Cognitive Processing Therapy Veteran/Military Version*. Washington, DC, USA: Department of Veterans' Affairs.

Roth, S., Newman, E., Pelcovitz, D., van der Kolk, B., & Mandel, F. S. (1997). Complex PTSD in victims exposed to sexual and physical abuse: results from the DSM-IV field trial for posttraumatic stress disorder. *Journal of Traumatic Stress*, 10, 539–555. https://doi.org/10.1002/jts.2490100403

Shapiro, D. A., Cavanagh, K., & Lomas, H. (2003). Geographic inequity in the availability of cognitive behavioural therapy in England and Wales. *Behavioural and Cognitive Psychotherapy*, 31, 185–192. https://doi.org/10.1017/S1352465803002066

Stige, S. H., Binder, P.-E., Rosenvinge, J. H., & Traeen, B. (2013). Nordic psychology stories from the road of recovery: how adult, female survivors of childhood trauma experience ways to positive change. *Nordic Psychology*, 65, 3–18. https://doi.org/10.1080/19012276.2013.796083

van der Kolk, B. A., & Fisler, R. E. (1994). Childhood abuse and neglect and loss of self-regulation. *Bulletin of the Menninger Clinic*, 58, 145–168.

van der Kolk, B. A., Perry, J. C., & Herman, J. L. (1991). Childhood origins of self-destructive behavior. *American Journal of Psychiatry*, 148, 1665–1671. https://doi.org/10.1176/ajp.148.12.1665

van der Kolk, B. A., Spinazzola, J., Blaustein, M. E., Hopper, J. W., Hopper, E. K., Korn, D. L., & Simpson, W. B. (2007). A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 68, 37–46. https://doi.org/10.4088/JCP.v68n0105

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The Life Events Checklist for DSM-5 (LEC-5)*. Retrieved from: https://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp

Westbrook, D., Kennerley, H., & Kirk, J. (2011). *An Introduction to Cognitive Behaviour Therapy: Skills and Applications* (2nd edn). Sage Publications Ltd.

World Health Organisation (2018). ICD-11 – Mortality and Morbidity Statistics. Retrieved from: https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/585833559 (accessed 3 August 2020).

Yalom, I. (2005). *The Theory and Practice of Group Psychotherapy* (5th edn). New York, USA: Basic Books.