

**Evaluation of the Effectiveness and Acceptability of a Phase-Based Treatment  
for Complex Post-Traumatic Stress Disorder**

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## **Abstract**

Sufferers of Post-Traumatic Stress Disorder (PTSD) caused by repeated or prolonged traumas, such as childhood abuse or intimate partner violence, may have symptoms that go beyond the normal clusters of symptoms seen in PTSD from single-incident traumas. These can include emotional, interpersonal, dissociative and somatic symptoms, and altered beliefs about the self, others and the world. This has been termed Complex Post-Traumatic Stress Disorder (CPTSD). Recent expert guidelines recommend that treatment for CPTSD should consist of several phases, not only individual trauma-focused therapy.

This study is the first evaluation of a new phase-based treatment programme for CPTSD, consisting, sequentially, of a psychoeducation group (Phase 1), Compassionate Resilience group (CRG; Phase 2), and individual trauma-focused therapy (Phase 3). The main research questions were: how effective is the treatment in addressing both PTSD and CPTSD symptoms; and secondly, how acceptable is the treatment to participants?

The study had two components: firstly, a case series analysis of nine participants examining the effectiveness of the treatment, using measures of PTSD, CPTSD and self-compassion. The second component was a thematic analysis of interviews with six participants who had completed treatment, in order to explore the acceptability of the programme.

Results from the case series analysis indicated that the treatment was effective in reducing CPTSD, PTSD symptoms, and self-criticism. As predicted, visual analysis of symptom scores suggested greater symptom improvement during Phase 2

than Phase 1. Surprisingly, PTSD symptoms improved before Phase 3, with three participants showing clinically-significant improvement by the end of Phase 2. The thematic analysis indicated the treatment was highly acceptable to participants, with over-arching themes identified regarding the experience of group format and experience of phase-based treatment.

Overall, this study appeared to support the use of phase-based treatments for CPTSD, and indicated that compassion-focused interventions may be an effective component therein.

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## Chapter 1: Introduction

*“Something was wrong. They put on civilian clothes again and looked to their mothers and wives very much like the young men who had gone to business in the peaceful days before August 1914. But they had not come back the same men. Something had altered in them. They were subject to sudden moods, and queer tempers, fits of profound depression alternating with a restless desire for pleasure. Many were easily moved to passion where they lost control of themselves, many were bitter in their speech, violent in opinion, frightening.”*

(War correspondent Sir Philip Gibbs, ‘Realities of War’, London: Heinemann, 1920)

The psychological impact of experiencing or witnessing a traumatic event such as war, rape, fire or assault is recognised and understood today to a degree that would have been unimaginable a century ago. British soldiers in the First World War suffering ‘shell shock’, a condition initially attributed to nerve damage and later understood as a psychological response to the stresses of war, were often treated with ignominy and in some cases put on trial for cowardice or desertion. The returning soldiers for whom “something had altered” were faced by an almost total lack of understanding of their symptoms or consensus about how to treat them. The term ‘post-traumatic stress disorder’ (PTSD) did not come into use until the 1970s, when the phenomenon was brought to medical attention by US military veterans of the Vietnam War. PTSD was only officially recognised as a psychiatric diagnosis by the American Psychiatric Association in 1980, and included in the International Classification of Diseases (ICD) in 1990.

Today, PTSD is widely recognised as a serious psychological disorder that can result from any kind of trauma, not simply those occurring in war, and for which, happily, effective psychological treatments (most commonly trauma-focused Cognitive Behavioural Therapy (CBT), and Eye Movement Desensitisation and Reprocessing, EMDR) have been developed. However, less widely accepted is the argument that there is a sub-group of people with PTSD for whom the effects of trauma are more far-reaching, and for whom existing PTSD treatments may not be sufficient. For this group, the experience of trauma impacts on the person's sense of self, their capacity to know and accept themselves, to keep themselves safe, and to relate to and trust others. This more complicated reaction to trauma has been termed Complex Post-Traumatic Stress Disorder (CPTSD), and has been linked in particular to the experience of repeated interpersonal traumas such as childhood physical or sexual abuse, intimate partner violence (IPV), human trafficking, slavery or being a prisoner of war.

Academic disagreement over the validity and utility of separating CPTSD from PTSD has meant that the large-scale research studies and evidence-based treatment protocols that are plentiful in the area of PTSD are relatively scarce for CPTSD. This study sought to investigate the effectiveness of one new treatment approach designed to address this gap, and in so doing, contribute to a better understanding of 'what works' for this less well understood, highly traumatised population.

Before describing the current study, we begin with an overview of the research literature, starting with the debate around the diagnostic status of CPTSD, and whether or not CPTSD merits a different treatment approach to PTSD. Arguments for

and against phase-based treatment protocols are then explored, and outcome studies of existing treatment protocols are evaluated. This provides the context for the current study, which evaluated the effectiveness and the acceptability of a new phase-based treatment for CPTSD. Effectiveness was evaluated through a small case series of patient outcome data collected longitudinally throughout treatment. Acceptability was evaluated through interviews with participants at the end of treatment, analysed qualitatively to identify important themes in their experiences of the treatment.

### **Diagnostic Status of CPTSD**

The term CPTSD and its position in relation to the diagnosis of PTSD is highly contested in the clinical and research literature. PTSD diagnostic criteria include: avoidance of reminders or memories of the trauma; re-experiencing symptoms such as dreams or flashbacks, negative cognitions and mood; and arousal symptoms such as hypervigilance to threat and insomnia. The traumatic event must involve direct or indirect exposure (through family or friends) or witnessing: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (Diagnostic and Statistical Manual of Mental Disorders [DSM-V]; American Psychiatric Association, 1994). The most recent criteria also include a ‘dissociative subtype’ of PTSD.

Complex post-traumatic stress disorder (CPTSD) is a term used to describe a constellation of difficulties in addition to the above-mentioned symptoms of PTSD. Authors who support its differentiation from PTSD broadly agree that it is differentiated from the core symptoms of PTSD by five additional symptom domains (Cloître et al., 2012). These include: 1) chronic difficulties with regulating emotions, 2) difficulties with relationships, 3) alterations in consciousness (e.g. dissociation), 4)

adversely affected belief systems including changes in self-concept (e.g. shame, guilt) or loss of previously-valued beliefs; and 5) somatisation of distress in medically unexplained physical symptoms. Those that do not support the differentiation of complex from 'simple' PTSD argue that a diagnosis of CPTSD lacks sufficient discriminant validity, and some also cite a lack of agreement in research about its core features and its precipitating factors (Resick et al., 2012).

The disagreement in academic PTSD research about whether there is sufficient evidence to warrant treating CPTSD as a separate diagnosis to PTSD is reflected in the differing stances taken by the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD). Whilst there is no separate diagnostic category for CPTSD in DSM-V (American Psychiatric Association, 2013), the ICD-10 (World Health Organisation [WHO], 1992) includes a diagnosis of 'personality change after a catastrophic event' which partly reflects the concept of CPTSD. In current proposals for the updated ICD-11 there are two separate diagnoses: PTSD and CPTSD, both of which sit within the spectrum of trauma and stress-related disorders. This proposed diagnosis of CPTSD is comprised of the core elements of PTSD accompanied by enduring disturbances in the domains of affect, self, and interpersonal relationships (Maercker et al., 2013).

### **Origins of CPTSD**

The term 'Complex post-traumatic stress disorder' was first proposed by Judith Herman in 'Trauma and Recovery' (1992). Herman argued that the diagnosis of PTSD does not accurately fit the syndrome seen in survivors of prolonged or repeated traumas. She argued for treating responses to traumas as a 'spectrum of conditions' rather than a single diagnosis, and in particular argued for separate

recognition of a syndrome she called CPTSD that results from ‘a history of subjection to totalitarian control’, ranging from military control, such as being kidnapped, taken hostage, to domestic or sexual control such as chronic child or spousal abuse. Herman claimed that being subject to this type of prolonged traumatising leads to alterations in a number of important domains: affect regulation, consciousness, self-perception, perception of the perpetrator, relations with others, and systems of meaning (Herman, 1992).

Herman proposed that treatment for people with CPTSD ought to consist of three stages, the first of which should focus on regaining personal safety and stability, the second on directly working with the traumatic memories and reconstructing the story, and the third on restoring the connection between the survivor and his or her community, with a view to building a richer post-trauma life.

Although Herman was the first to use the term CPTSD, her research added to ideas that had already been proposed by researchers in areas such as the mental health of refugees (Kroll et al., 1989), childhood traumas (Terr, 1991) and childhood sexual abuse (Finkelhor, 1988), all of whom argued that the standard PTSD diagnosis was inadequate to describe the multiplicity of psychological effects and functional impairments seen in clinical practice in survivors who have experienced prolonged traumas.

As a consequence of this interest in PTSD to repeated traumas, a field trial was conducted for the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) testing the existence of a disorder termed ‘Disorders of stress not otherwise specified’ (DESNOS), which had close similarities to Herman’s proposed CPTSD. The

conclusions of this trial were that DESNOS did not merit a separate diagnosis because most people who met criteria for it also met criteria for PTSD; however, DESNOS was listed amongst ‘associated features’ of PTSD with many of the listed features taken from Herman’s formulation of CPTSD (Weiner, 2003).

The DESNOS diagnosis had six main features: alterations in the regulation of affective impulses, including anger and self-destructive impulses; alterations in attention and consciousness leading to amnesia, dissociative episodes and depersonalisation; alterations in self-perception such as chronic guilt, shame and responsibility; alterations in relationships with others, such as not being able to feel intimate, or trust; somatisation that cannot be medically explained; and alterations in, or loss of, sustaining beliefs (Luxenberg, Spinazzola & Van der Kolk, 2001).

In the recently-published DSM-V, DESNOS was removed and at the same time PTSD was no longer classified as an anxiety disorder but as part of a new diagnostic category of “Trauma and Stressor-Related Disorders” incorporating acute stress disorder, adjustment disorders, and others (American Psychiatric Association, 2013).

### **CPTSD: A Separate Diagnosis?**

During the development of DSM-V the question of whether CPTSD ought to feature separately was revisited in some depth. In order to make recommendations to the committee, Resick et al. (2012) conducted a critical evaluation of all the available research studies of adult samples. They included studies using the terms ‘CPTSD’, ‘complex trauma’, ‘DESNOS’, ‘post-traumatic personality disorder’ and ‘personality change after a catastrophic event’. Evaluating these studies, the authors concluded



that there are several difficulties with establishing CPTSD as a separate diagnosis: firstly, a lack of agreement about the types of traumatic events that precipitate it, and about the core symptoms of the disorder; secondly, that CPTSD lacks discriminant validity by overlapping significantly with PTSD, as well as borderline personality disorder (BPD) and major depressive disorder (MDD). Resick and colleagues did acknowledge that a single diagnosis of PTSD cannot adequately capture the heterogeneity of adaptation and distress that occurs following trauma exposure. However, they concluded that the available evidence does not sufficiently demonstrate the construct validity of CPTSD to justify a new diagnosis (Resick et al., 2012).

There is, however, conflicting evidence regarding the discriminatory validity of a CPTSD diagnosis. An important piece of evidence supporting a separate diagnosis from 'simple' PTSD has been offered by a latent profile analysis of 302 people seeking treatment for interpersonal trauma, including both single incident and chronic trauma, conducted by Cloître, Garvert, Brewin, Bryant and Maercker (2013). Their analysis indicated that there are in fact classes of individuals that are distinguishable according to different PTSD and CPTSD symptom profiles. The 'CPTSD' class identified in the latent profile analysis had high levels of symptoms in PTSD, affect dysregulation, negative self-concept, and interpersonal problems. By contrast the 'PTSD' class had high levels of PTSD symptoms but relatively low levels of symptoms in the three self-organisation domains. The analysis also showed that CPTSD was associated with greater overall impairment than PTSD. Additionally, the analysis indicated that chronic trauma was more strongly predictive of CPTSD than PTSD, whilst single-event trauma was more strongly predictive of PTSD.

Regarding CPTSD and BPD, the overlap between these symptom profiles has been widely noted in research and clinical practice; both incorporate difficulties with relationships, emotional instability, and dissociative symptoms. They are also both theorised to have their origins in traumatic (usually early) experiences. However, Cloître, Garvert, Weiss, Carlson & Bryant (2014) conducted a latent profile analysis which indicated that an independent CPTSD symptom profile can be distinguished from that of both PTSD and BPD. The best fit model identified by their analysis was a four class model which they labelled as ‘low symptoms’, ‘PTSD’, ‘CPTSD’ and ‘BPD’ class. The participants in the CPTSD class were high in self-organisation symptoms and PTSD symptoms, but relatively low in BPD symptoms. The authors noted that some symptoms in the BPD class were not seen in the CPTSD class, such as frantic efforts to avoid abandonment, alternating between extremes of idealisation and devaluation in personal relationships, persistently unstable sense of self, and impulsiveness.

Ford and Courtois (2014) also argue that CPTSD should be treated as a separate diagnosis to BPD. They reviewed the clinical and scientific findings of comorbidity between CPTSD, PTSD and BPD in detail, considering the neuropsychological features of each disorder and drawing on evidence from neuro-imaging studies. Whilst they emphasise the preliminary nature of their findings, the authors conclude that the available research indicates that emotional dysregulation in BPD involves brain alterations associated with deficient self-awareness, intolerance of interpersonal rejection or abandonment, inability to recover from intense negative affect states, and dissociative analgesia. By contrast, PTSD secondary to childhood maltreatment, which is treated as a proxy for CPTSD, seems to involve brain

alterations associated with heightened self-awareness of vulnerability, hypervigilance to safety threats and related threat appraisals, tolerance of chronic negative affect states, and dissociative re-experiencing with alternating states of fear and detachment (Fort & Courtois, 2014). Taken together with the two latent profile analyses of Cloître and colleagues (2013; 2014), there does appear to be a growing body of evidence of the utility of differentiating CPTSD from both PTSD and from BPD.

### **Do People with CPTSD need Different Treatment to People with PTSD?**

At present in the UK there are national clinical guidelines for treatment of PTSD provided by the National Institute for Health and Care Excellence (NICE), which recommend trauma-focused psychological treatment of normally eight to 12 sessions. There are no specific guidelines for treatment of CPTSD. However, the PTSD guidelines do recommend that healthcare professionals should consider extending the duration of treatment beyond 12 sessions if several problems need to be addressed, and particularly after multiple traumatic events. They also recommend that where patients find it very difficult to trust their clinician with details of their trauma(s), treatment should begin with establishing a trusting therapeutic relationship and emotional stabilisation before addressing the traumatic event (NICE, 2005). However, they do not give any more detail about the nature of this treatment, or make specific reference to the treatment of CPTSD.

The absence of a broadly agreed, independent diagnosis of CPTSD is likely to be a major factor in the absence of specific protocols for treatment of CPTSD. As a result, most people with CPTSD symptom profiles are at present receiving treatment that is not specifically designed to tackle the extra symptom dimensions of CPTSD; however, there is a lack of agreement in the literature about whether or not this is

problematic. To date there are only a few studies comparing treatment outcomes for PTSD and CPTSD populations.

There is some limited evidence that suggests that people with prolonged or repeated trauma histories may be effectively treated through stand-alone trauma-focused treatment protocols for PTSD, without specific adjuncts to treat CPTSD symptoms. Resick, Nishith and Griffin (2003) conducted a randomised controlled trial (RCT) of a treatment called cognitive processing therapy (CPT) lasting twelve sessions, which incorporates both cognitive therapy and exposure through writing and reading about the traumatic event. In this trial of treatment of survivors of childhood sexual abuse (CSA) the authors concluded that CPT was effective in treating the symptoms of CPTSD, as measured by the Trauma Symptom Inventory (TSI), as well as PTSD and depression symptoms, with participants showing significant improvements that were maintained over 9 months. Improvements were seen not just in core PTSD and depression symptoms but also in symptoms such as dissociation, impaired self-reference, dysfunctional sexual behaviour, and tension-reduction behaviours. Whilst this indicates that this type of trauma-focused CBT can be effective for some people with CPTSD, it does not preclude the possibility that this population might show greater improvements using another treatment approach, nor has it yet been evidenced in other CPTSD populations. Furthermore, the TSI was not designed to assess CPTSD and therefore does not probe all five additional symptom dimensions.

In contrast, there is research which points to limitations of using PTSD protocols to treat people with CPTSD symptom profiles. In a study by Ford and Kidd (1998) of war veterans receiving inpatient treatment for chronic PTSD, DESNOS

symptom profiles emerged as a consistent and robust predictor of poor inpatient PTSD treatment outcome, independent of the effects of a PTSD diagnosis or of early childhood trauma history. Whereas a PTSD diagnosis predicted an increased likelihood of clinically-meaningful change in this study, DESNOS symptoms predicted a substantially decreased likelihood of clinically meaningful change. Similarly, Ehlers et al. (1998), Ford and Kidd (1998), Tarrier et al. (1999) and van der Kolk et al. (2007) have all published studies that indicate that trauma-focused treatment may be less efficacious and less well tolerated in CPTSD populations.

A specific area of debate is the impact of exposure-only therapy on drop-out rates amongst CPTSD populations. Drop-out rates for exposure-based PTSD treatment can be particularly high amongst CPTSD populations, as demonstrated by a study by McDonagh et al. (2005) of women with histories of CSA. The authors found that women who received a standard CBT protocol for PTSD had a drop-out rate of 41.4 per cent. A further finding was that the drop-out rate was significantly higher for participants receiving exposure therapy than for participants receiving a present-centred problem-solving therapy, which the authors suggest may indicate that women with more complex presentations have difficulty tolerating exposure work due to cognitive and affect-regulation problems (McDonagh et al, 2005). By contrast, however, a meta-analysis by Hembree et al. (2003) of studies of psychological therapies for PTSD found an average drop-out rate of 20.5 per cent in exposure treatments and 26.9 per cent for treatments combining exposure therapy with other CBT techniques, suggesting that it may be in fact be counterproductive to add extra components to exposure treatment protocols, in terms of adherence of treatment.

Whilst there are insufficient robust outcome studies of treatment for CPTSD populations to be able to draw definite conclusions about their efficacy, the research that exists does suggest that the presence of CPTSD symptoms ought to be carefully considered in treatment planning (Weiner, 2003). This research has led to clinicians and researchers looking to adapt standard PTSD protocols and develop new treatment protocols for CPTSD, many of which have taken a phase-based approach.

### **Why Phase-based Treatment?**

In 2012 a Complex Trauma Taskforce made up of PTSD experts, created by the International Society for Traumatic Stress Studies (ISTSS), carried out a survey of 50 expert clinicians working with people with CPTSD. The aim was to survey opinions about the salient symptoms of CPTSD and recommendations for its treatment. As a result of the survey, expert consensus guidelines for the treatment of CPTSD in adults were published (Cloître et al., 2012). The guidelines state that treatment for CPTSD should build functional capacities for self-regulation and psychosocial resources through emotion regulation strategies, anxiety and stress management, and interpersonal skills. Deficits in these areas are a logical first step for intervention since they may interfere not only in daily functioning but also in the therapeutic process itself (Zlotnick et al., 1997). The survey found that 84 per cent of the clinicians surveyed endorsed a phase-based approach to working with this population.

In a recent meta-analysis of psychological treatments for PTSD in adult survivors of child abuse (PTSD related to child abuse is taken as a proxy for PTSD with complex symptoms, in the absence of an agreed diagnosis of CPTSD), Ehring et al. (2014) looked in detail at the eight existing trauma-focused CBT protocols for

individual treatment. They compared the four that were multi-component (Cloître, Koenen, Cohen, & Han, 2002; Chard, 2005; Cloître et al., 2010; Bohus et al., 2013) with the four that were purely trauma focused (McDonagh et al., 2005; Resick et al., 2008 which includes three treatments), and found that effect sizes for the multi-component treatments were larger (from 2.27 to 1.31) than the purely trauma-focused models (1.37 to 0.70), providing support for the utility of phase-based approaches in this population (Cloître, 2015).

A challenge to the ISTSS's conclusions was presented by a recent review of the evidence by de Jongh and colleagues (2016). In this paper the authors point to a lack of studies directly comparing the effectiveness of trauma-focused treatment with phase-based approaches, and to the high drop-out rates that complicate conclusions about intervention effects. They also question whether CPTSD normally entails emotional dysregulation, querying the necessity of stabilisation phases. The authors conclude that there is currently insufficient evidence for the advantages of phase-based treatments over trauma-focused therapy alone, and argue that an over-emphasis on phase-based treatment may unnecessarily delay sufferers' access to treatment.

A response to de Jongh and colleagues by Cloître (2016) argues that although rigorous evidence in favour of phase-based treatments over trauma-focused therapy alone is currently limited, the available studies showing positive outcomes, in combination with there being no evidence of phase-based treatments being harmful to engagement with trauma-focused therapy, provide a good case for continuing to research such treatments. Both de Jongh et al. (2016) and Cloître agree on the need for further, more rigorous research on phase-based treatments for CPTSD.

Even amongst researchers who support the use of phase-based treatments, there is a little consensus about the number of phases, their length, and what they ought to consist of. The treatment structure suggested by the ISTSS guidelines is a three-phase model where the first phase focuses on patient safety and then on building emotional awareness and expression, increasing positive self-concept, addressing feelings of guilt and shame, and increasing interpersonal and social competencies (Cloître et al, 2011). The second suggested phase focuses on processing of trauma memories. The third is a phase in which the clinician supports the patient in making plans for greater engagement in community life through education, employment, social activities or hobbies, in order to support their transition out of therapy. This is strongly reminiscent of Herman's proposed model, in which the third phase of treatment aims to restore the connection between the survivor and his or her community in order to build a richer post-trauma life.

Whilst there was broad agreement amongst the experts in the ISTSS survey on the use of phase-based treatments, there was little agreement on the expected course of treatment or the overall duration of treatment (Cloître et al., 2011). The proposed overall duration of treatment for patients with CPTSD ranged from four months to twelve months. This lack of agreement is attributed by the authors of the guidelines to the paucity of research studies exploring these variables, methodological variations across the studies, differences in samples in trauma background, and differences in measures used, all of which make generalisation difficult. The authors of the guidelines argue for more systematic research into phase-based approaches, evaluation of rates of change, and comparison studies of the individual components of



treatment (Cloître et al., 2012). The few existing studies of phase-based treatments for CPTSD will now be reviewed.

### **Existing Phase-based Treatments for CPTSD**

An early and significant contribution to the field of phase-based treatment research was offered by a randomised clinical trial by Cloître, Koenan, Cohen and Han (2002). In this trial 58 women with PTSD related to childhood abuse were allocated to either a two-phase treatment called ‘STAIR-MPE’, or to a minimal attention wait list. In the treatment condition participants first received eight weekly one-to-one sessions of skills training in affect and interpersonal regulation (STAIR), then a second phase consisting of modified prolonged exposure (MPE) therapy. Although the participants were not assessed on CPTSD or DESNOS criteria, their childhood abuse trauma backgrounds made them more likely to have had symptom profiles consistent with such a diagnosis, and it was therefore used by the authors as a proxy for CPTSD.

The results of Cloître et al.’s (2002) trial indicated two things of significance. Firstly, that the phase-based treatment condition outperformed the wait list condition in reducing PTSD symptoms and interpersonal skill deficits, and improving affect regulation. Secondly, that therapeutic alliance and negative mood regulation skills measured in Phase 1 predicted the success of exposure work in Phase 2 for reducing PTSD symptoms, demonstrating the value of building emotion regulation skills before commencing exposure work for improving the effectiveness of exposure therapy.

A number of other manualised phase-based treatments have been developed, the majority of which adopt a group format for the initial phase. A pilot study by

Dorrepaal et al. (2010) evaluated a manualised stabilising group treatment designed by Wolfsdorf and Zlotnick (2001) for the treatment of CPTSD originating from childhood abuse. The programme begins with psychoeducation about CPTSD before moving onto a cognitive behavioural approach to building skills in emotional regulation, relaxation, assertiveness and anger management, and concludes with work on distrust, guilt and shame. The intervention, lasting 20 weeks, was designed to directly target the extra symptoms of CPTSD, and to then be followed by exposure therapy once tolerance of high affect has been achieved.

Dorrepaal and colleagues' analysis of 36 patients who had symptoms in all domains of CPTSD in this pilot project showed that, after the stabilising treatment, 64 per cent of patients no longer met criteria for CPTSD, as measured by the Structured Clinical Interview for DSM-IV Axis I disorders (SCID-1; First, Spitzer, Gibbon & Williams, 1996) and the Structured Interview for Disorders of Extreme Stress (SIDES; Pelcovitz et al., 1997). After 6 months, this figure rose to 78 per cent. However, there was a drop-out rate of 33 per cent from treatment. Additional support for this intervention has been offered by an adjunctive neuro-imaging study which found that adding the stabilising treatment could be linked to increased selective attention ability and decreased emotional arousal, associated with normalised activation in the dorsal anterior cingulate cortex and anterior insula (Thomaes et al., 2012).

In a later study of the same manualised intervention, Dorrepaal et al. (2013) found that the stabilisation group was well tolerated by participants with comorbid personality disorder symptoms, including both those with socially withdrawn personalities and those with aggressive traits. In fact, those with personality disorder

symptoms appeared to have a lower drop-out rate (10 per cent) than those without personality disorder symptoms (33 per cent), suggesting that stabilisation phases may be more appropriate for some presentations of CPTSD than others.

A pilot of a brief eight-session psychoeducation group programme called ‘Survive and Thrive’ with female offenders with complex trauma history evaluated by Ball, Karatzias, Mahoney, Ferguson and Pate (2013) also showed positive results. The researchers did not directly measure CPTSD symptomology, but did find medium to large treatment effect sizes indicating clinical improvement in general psychological distress as well as traumatic symptomology, as measured by the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) and the PTSD Checklist Civilian version (PCL-C). The manualised programme covered topics including: the physical, emotional and psychological effects of trauma and abuse; coping strategies such as relaxation; developing emotional regulation skills, and dealing with substance misuse. However, there was a 46 per cent drop out before follow-up, some of whom dropped out due to acute problems needing treatment in own right, such as substance abuse.

### **Theoretical Basis of Compassion-focused Interventions for PTSD**

Typically, PTSD treatment protocols have been oriented primarily towards alleviating fear, which is reflected in PTSD’s previous categorisation as an anxiety disorder in DSM-IV. Dominant theories of PTSD such as the Ehlers and Clark cognitive model (2000) have viewed PTSD symptoms as resulting from the fragmented, unprocessed nature of trauma memories combined with negative appraisals of the traumatic event, that together maintain a sense of current threat. The sense of threat leads to maladaptive coping strategies, such as avoidance of the trauma memory, that prevent alterations to the memory or the appraisals. In treatment, the

current sense of threat is therefore targeted through cognitive work that seeks to process the trauma memory, alter the appraisals of the memory, and reduce maladaptive coping strategies. This cognitive, fear-based approach to PTSD provides the theoretical basis for the third phase of the treatment programme being evaluated in the current study.

However, an alternative clinical model of PTSD has been proposed by Lee, Scragg and Turner (2001) which is based on shame and guilt, and this provides the theoretical basis for the second phase of the phase-based intervention, the Compassionate Resilience Group (CRG). Lee, Scragg and Turner argue that, whilst fear is often the primary emotional response to a trauma, other emotional responses, in particular shame and guilt, are also highly significant to the perpetuation of PTSD symptoms (2001). Shame is important because it may present clinically as shame attached to one's actions or responses at the time of the trauma, as well as shame attached to the emotions experienced during therapy, such as intense fear or helplessness (Lee et al., 2001). Therefore, shame may also affect a person's ability to engage in recovery-promoting behaviours, such as disclosing details of the trauma and engaging in exposure-based therapy. Research by Lee has suggested that the emotion of shame may be resistant to traditional cognitive restructuring (Lee, 2009) a technique commonly used in trauma-focused CBT for alleviating fear responses, and therefore requires an alternative therapeutic approach.

Lee advocates working to reduce shame and self-criticism in PTSD sufferers by drawing on a compassion-focused therapy (CFT) approach (Gilbert & Irons, 2005). CFT was originally developed as an adjunct to cognitive therapy by Paul Gilbert (Gilbert, 2000). It seeks to enhance the capacity to self-soothe and to reduce

self-critical maintenance cycles and feelings of shame by developing compassionate self-talk. Academic research into self-compassion has been led by Kristin Neff. Neff's work defines self-compassion as consisting of three components: (a) an attitude of kindness and understanding to one's self, as opposed to harsh judgment; (b) perceiving one's experiences as part of the larger human condition instead of feeling separate and isolated; and (c) being mindfully aware of painful experiences without over-identifying with them (Neff, 2003a). Research has found that higher self-compassion is associated with less depression, anxiety, rumination, and thought suppression, and with greater life satisfaction and social relatedness (Neff, 2003b).

Gilbert's social mentality theory (2000) suggests that self-compassion may be particularly lacking in people who have often experienced early childhood abuse, as is the case for many people with CPTSD. The theory suggests that how we engage in social roles with our self and others is shaped by our experiences, and that unless a child's processing systems for feeling cared for are stimulated and elaborated through experiences, they will not be available for use in 'self-self' relating (Gilbert & Irons, 2005). This lack of capacity to relate compassionately with the self then results in lower resilience to psychological threats to self-integrity, such as shame and guilt.

### **Evidential Basis for Compassion-focused Interventions in PTSD**

There is a small body of research that indicates links between deficits in self-compassion and PTSD symptoms. Lee's research in the area of CFT for PTSD has found that a significant number of people suffering from PTSD experience shame or are highly self-critical and lack the capacity to self-soothe (Lee, 2012). Cox, MacPherson, Enns and McWilliams (2004) conducted research with a nationally-representative sample of adults who had experienced traumatic events, and found that

higher self-criticism and neuroticism was associated with the presence of PTSD symptoms. Based on this research, Kearney et al. (2013) piloted a 12-week group intervention for veterans with PTSD, using ‘loving-kindness meditation’. This is a practice designed to enhance feelings of kindness and compassion for self and others. The authors found a large effect size ( $-0.89$ ) for PTSD symptoms at 3-month follow-up.

Although there is only limited evidence so far for self-compassion interventions for PTSD, the available evidence suggests that self-compassion may be a helpful approach. It follows that it may be particularly useful for those with the additional symptoms of CPTSD such as alterations in belief systems, which often includes changes in self-concept such as shame, guilt and responsibility beliefs.

Lee’s Compassionate Resilience group intervention (CRG), based on CFT principles, has been developed in order to target CPTSD symptoms. CRG aims to enhance affect regulation, self-soothing, interpersonal functioning, problem-solving and the ability to hold trauma memories with a caring, compassionate mind. It constitutes the second phase of the treatment protocol which is evaluated in the present study, coming after an initial psychoeducation phase about PTSD and its effects (Phase 1), and before a final phase of individual trauma-focused therapy (Phase 3). This phase-based treatment programme is currently the only phase-based treatment for CPTSD to incorporate a discrete phase of compassionate resilience work.

Although no trial has yet tested the effectiveness of compassion-focused therapy in a CPTSD population, CFT has been used successfully as an adjunctive treatment for a range of other psychological disorders, including eating disorders

(Gale, Gilbert, Read & Goss, 2014), psychosis (Braehler et al., 2013), bipolar disorder (Lowens, 2010), personality disorders (Lucre & Corten, 2013) and non-suicidal self-injury in young people (van Vliet & Kalnins, 2011). Given there is some overlap between borderline personality symptoms and CPTSD symptomology, Lucre and Corten's findings of effectiveness of this approach, as well as its acceptability to participants, suggest that compassion-focused interventions may represent a logical adjunct to CPTSD treatment.

That CFT is clinically indicated for CPTSD populations is supported by a qualitative interview study which looked at the process of 'personally-meaningful' recovery from CSA by Chouliara, Karatzias and Gullone (2014). Their analysis of interviews with 22 adult survivors, male and female, identified four factors important to enhancing recovery: 'new meaningful activity', 'formalizing a complaint', 'building inner strength and resources' (consisting of sub-themes of: 'ability to feel positive emotion', 'recognizing own strengths/good mental health', 'self-compassion', 'self as own protector', 'standing up for self') and 'disclosing and shifting blame' (with sub-themes of 'attributing blame to perpetrator', 'end of self-blame', and 'weight off shoulders'). The authors conclude that shame-based and compassion-focused interventions are likely to be very helpful for both building inner strength and shifting self-blame in PTSD sufferers and should be explored in future research.

### **Limitations of Research Literature**

The existing research literature provides some support for phase-based treatments for CPTSD populations. Given the small number of existing studies evaluating phase-based interventions for CPTSD these treatment programmes are still

in developmental stages, with insufficient evidence to favour any one type of stabilising treatment over another. The interventions in the studies described above have largely consisted of psychoeducation about PTSD and emotional regulation components. Some, like STAIR-MPE (Cloître et al., 2002) are one-to-one interventions but most have a group format. At present no direct comparisons exist of outcomes for individual versus group-based stabilisation interventions. There is also no consensus regarding the ideal duration of this stabilisation phase. Furthermore, the existing studies indicate that attrition rates continue to be an issue for these treatments, as for exposure therapies. This suggests that further research is required in order to develop phase-based treatment approaches, including qualitative research to generate a better understanding of what treatment approach is best tolerated by this clinical population.

A further difficulty in interpreting the existing research is that there is a lack of consensus as to the best way to evaluate treatment outcomes for CPTSD, both in terms of how to select research participants, and how to measure CPTSD symptoms, in the absence of purpose-designed diagnostic tools or outcomes measures. Dorrepaal and colleagues (2010; 2013) used the SIDES (Pelcovitz et al., 1997) as an outcome measure, a lengthy purpose-designed measure for assessing the symptoms of DESNOS. Many other authors such as Cloître and colleagues have chosen to use a battery of symptom-specific measures, such as measures of anxiety, emotional regulation, and interpersonal problems, selecting certain items from them in order to tap the complex symptoms of PTSD (e.g. Cloître et al., 2010). With different authors using different batteries of measures, drawing comparisons between studies is difficult.



In terms of research samples, many studies such as Cloître et al. (2002), in the absence of agreement about the diagnostic status of CPTSD, have not made a diagnosis of CPTSD an inclusion criterion, and have instead selected participants based on criteria relating to the nature of their trauma history. A history of child abuse and CSA in particular has often been used as a proxy for diagnosis of CPTSD. However, since not all survivors of child abuse have CPTSD symptoms this means research studies purporting to study CPTSD may include participants who do not have a CPTSD symptom profile. This methodological discrepancy is compounded by a lack of clarity in the CPTSD literature about the precipitating traumatic events that lead to CPTSD, whether it must be prolonged or repeated trauma or can also be caused by a single trauma, and the research literature has not yet established whether complex trauma necessarily and specifically results in CPTSD (Resick et al, 2012). This makes it problematic to compare outcomes of studies with samples selected according to trauma type with studies with samples selected according to CPTSD symptoms.

In addition, existing studies have adopted a range of different exclusion criteria, making it more difficult to compare their findings. A review paper of 34 outcome studies of PTSD interventions by Spinazzola, Blaustien and van der Kolk (2005) found that studies tended to under-report information about exclusion criteria and rates, trauma characteristics, and population data. They found that, where exclusion criteria are listed, they often encompass quite common comorbidities, such as alcohol use issues, as well as other common features such as use of psychotropic medication. The authors argue that, as a result, the external validity of many such

studies is unproven, and therefore drawing conclusions about treatment for CPTSD may be problematic.

A final shortcoming of the evidence base is that the majority of existing CPTSD studies draw on adult populations with historic trauma in childhood. Less is known about the effectiveness of phase-based treatments for CPTSD related to adult-onset trauma, such as torture or intimate partner violence, despite evidence that CPTSD also occurs in these populations (Luxenberg et al., 2001). The ISTSS expert consensus treatment guidelines note this imbalance and recommend that phase-based treatments now be evaluated in populations such as refugees, and others who have experienced repeated or prolonged forms of trauma in adulthood (Cloître et al., 2012). Since approximately 19 per cent of referrals to the Berkshire Traumatic Stress Service consist of adult-onset prolonged traumas such as intimate partner violence, the present study aims to contribute to this neglected area of the research literature.

### **The Case for CPTSD Research**

The high prevalence of repeated and prolonged trauma in the population underlines the importance of research into treatments for people with CPTSD. Findings from the US National Comorbidity Study (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995) indicated that amongst people who reported having been exposed to at least one type of trauma, 64 per cent reported more than one trauma, and 20 per cent of males and 11 per cent of females reported three or more traumatic events. Therefore, amongst those with PTSD, multiple trauma exposures are more common than exposure to a single trauma.

Additionally, childhood abuse is increasingly being recognised as a pervasive traumatic experience with significant, and often severe, psychological consequences. A national survey by the children's charity NSPCC found that one in four children in the UK suffered abuse during childhood (Radford et al., 2011). A large proportion of adults seeking help from mental health services report a history of childhood abuse (Cloître, Cohen, Han, & Edelman, 2001). Therefore, a treatment designed for those with CPTSD, rather than simply PTSD, has the potential for very broad application. A US-based study by van der Kolk, Roth, Pelcovitz, Sunday and Spinazzola (2005) estimated that nearly half of the treatment-seeking population would meet diagnostic criteria for DESNOS.

Secondly, it is important to note that CPTSD may particularly affect populations with cumulative life adversities, such as economically-impooverished people of ethnic minorities, homeless people, victims of political repression, incarcerated individuals and their families, and those with intellectual or physical disabilities, and these cumulative disadvantages may exacerbate the symptoms of CPTSD (Vogt, King & King, 2007). Therefore, developing treatment approaches for individuals with CPTSD means directing research and resources to some of the most disadvantaged members of society (Courtois & Ford, 2009).

### **The Present Study**

The above overview of the research literature has shown that, whilst debate continues in the academic community about the diagnostic status of CPTSD, a growing number of studies are demonstrating the utility of developing treatment protocols that go beyond trauma-focused therapy for people with CPTSD symptom profiles. The ISTSS expert guidelines have indicated that phase-based treatments are

generally seen by experts as a helpful way of stabilising and supporting patients with CPTSD symptoms before they undergo the rigours of trauma-focused therapy. The methodological variation in the research literature has highlighted the need for research that uses CPTSD as an inclusion criterion, and which uses an outcome measure which directly assesses the five additional symptom domains of CPTSD rather than relying solely on measures of PTSD symptoms.

The present study is a service-based evaluation of a new, phase-based treatment for adults with CPTSD being piloted at the Berkshire Traumatic Stress Service (BTSS). The treatment programme was developed in response to the expert consensus treatment guidelines for CPTSD published by the ISTSS (Cloître et al., 2012). The treatment programme consists of three consecutive phases. Phase 1 is a six-week psychoeducational group, in which clients are provided with information about PTSD and strategies for symptom management. Phase 2 is a twelve-week Compassionate Resilience group (CRG) in which clients learn skills of emotional regulation, self-soothing and self-compassion, as informed by Paul Gilbert's Compassion-Focused Therapy (Gilbert, 2010). Phase 3 is the standard treatment for PTSD: either trauma-focused CBT or EMDR over the course of 12-16 individual sessions, but into which learning from the previous phases is interwoven.

This treatment programme is in the piloting stage, and whilst its design is closely based on the research literature reviewed above and ISTSS guidelines, its effectiveness has not yet been established through empirical evidence. This early-stage evaluation of the treatment therefore favoured a small-scale, exploratory research design. The first two phases in particular - Psychoeducation and CRG -

represent a new approach to psychological intervention for CPTSD and therefore merit careful evaluation.

The first aim of this study was to evaluate the effectiveness of the treatment programme through a case series analysis of end-to-end outcome data, looking not only at PTSD symptoms but also the additional symptom domains of CPTSD and levels of self-compassion. In order to do this, the study also piloted a new, brief measure of CPTSD symptoms, the Berkshire Traumatic Stress Service CPTSD measure (Billings & Whalley 2015, *unpublished*), which was designed to be an adjunct to the PTSD Checklist (PCL-5) in order to provide a measure of CPTSD symptoms, which is lacking in the existing CPTSD outcome research.

The second component of the study was to evaluate the acceptability of the treatment programme to service users. Evaluating the acceptability of any new treatment protocol is vital in ensuring its long-term viability, and is perhaps particularly important for this treatment programme in the light of various distinctive features: the division of the treatment into three separate components with gaps in-between, the group-based format of the first and second phases, and the lengthy (30 weeks minimum) commitment demanded of clients. Furthermore, the views of service users are increasingly seen as a necessary component in service evaluation, and since the Health and Social Care Act 2008, all health and social care bodies are obliged to publicly set out how they will ensure they listen to the views of service users and carers (Health and Social Care Act, 2008), with service user and carer involvement now assessed as part of standard CQC monitoring of services.

This naturalistic, service-based study sought to make use of pre-existing service structures for outcome data collection in order to minimise the burden on

participants. Due to an administrative difficulty at the service with updating of measures, at the point of analysis none of the service users who had completed correct measures at assessment had yet completed the third phase of treatment. They therefore met inclusion criteria for the case series analysis but not for the end-of-treatment interview. As a result, whilst the original intention was to use the same sample of participants for both components of the study, instead the second component of the study recruited a separate sample of participants who had completed the whole treatment (but not the up-to-date outcome measures), and who were therefore able to provide important qualitative data about all three phases.

The research questions for the present study were as follows: firstly, how effective is this phase-based approach for treating the symptoms of both PTSD and the five additional symptom domains of CPTSD? Secondly, what symptoms change following each phase of the treatment? It was predicted that no change or only small spontaneous changes in PTSD and CPTSD symptoms would occur over Phase 1, Psychoeducation, which is designed to educate rather than to treat symptoms. It was predicted that differential change would be evident over Phase 2, CRG, with a greater rate of reduction in CPTSD symptoms than in PTSD symptoms, and improvements in self-compassion. In the third phase, consisting of trauma-focused therapy, it was predicted that there would be a greater rate of reduction in PTSD symptoms than in CPTSD symptoms. The third and final research question probed the acceptability of the treatment to service users, and explored participants' views and experiences of the treatment.

## **Chapter 2: Methods**

### **Participants**

The study consists of two components: the first, a case series analysis of outcome data assessing the effectiveness of the treatment; and the second, a qualitative analysis of interviews with clients regarding its acceptability. The sample for the first component was nine, all of whom were women. This reflected the higher rate of female referrals for CPTSD, in combination with the fact that some male service users were waiting for an all-male CRG group to start. The sample for the second component of the study was six, consisting of one man and five women.

All participants were recruited from the Berkshire Traumatic Stress Service (BTSS), a national specialist NHS centre for the treatment of adults with PTSD. The service is pioneering this three-phase treatment protocol for CPTSD.

Inclusion criteria for both components of the study were as follows: over 18 years of age; accepted for treatment at the Berkshire Traumatic Stress Service; meets diagnostic criteria for PTSD with additional CPTSD features; able to complete questionnaires in English; able to understand and participate in an interview conducted in English (second component only). PTSD diagnosis was assessed in accordance with PTSD diagnostic criteria for DSM-V, and CPTSD features assessed in accordance with the ISTSS expert consensus guidelines regarding CPTSD (Cloître et al., 2012). All clinician decisions regarding diagnosis and suitability for treatment were mutually agreed at service team meetings.

There were no exclusion criteria for participation in the study. However, the BTSS has exclusion criteria at screening stage. These are: extreme emotional

instability, acute suicidality or a high level of substance dependence, such that the client would not be stable enough to tolerate treatment.

For the first component of the study, clients who had completed at least the first two phases of treatment as well as regular outcome measures were invited to participate. Of the nine who were invited to participate, all consented to participate.

For the second component of the study, clients who had recently completed all three phases of the treatment, and had agreed to be contacted for research purposes, were invited to be interviewed. Of the six who were invited, all consented to participate.

No incentives were offered for participation; however, participants who travelled in order to participate were reimbursed up to £10 of expenses.

### **Attrition**

Figure 1 indicates how the final case series sample of nine was arrived at, from an original 127 people assessed as having CPTSD at BTSS in 2015. Fifty-one of the 127 did not enrol in the full, three-phase treatment programme, of whom 15 either chose not to do a group treatment, or their clinician judged them unsuitable for a group. Of the 76 who did enrol in the full treatment programme, 16 were discharged before starting treatment. Reasons for discharge included spontaneous recovery, changes in circumstances or no longer wishing to begin therapy. A further five people were discharged after Phase 1, again either due to remission, or due to choosing not to continue. Six people were not eligible for inclusion because they did not do the CRG group, although they stayed in some form of treatment. Thirty-nine people could not be included in the case series analysis because they had not yet completed two phases.



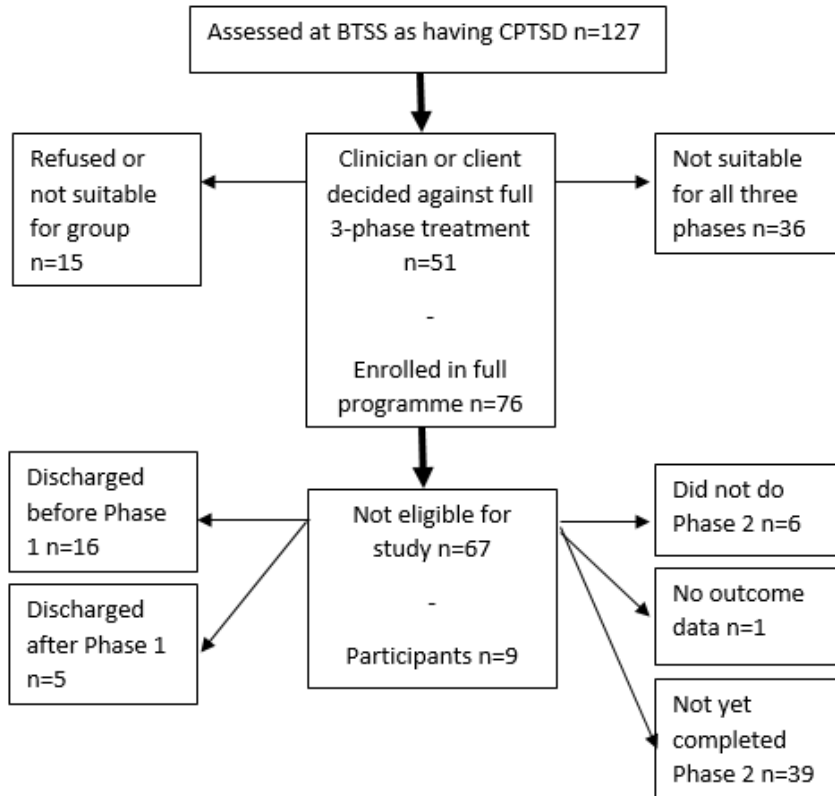


Figure 1: Attrition from Case Series from Point of Assessment

## Ethics

Ethical approval for the study was granted by the Proportionate Review Sub-Committee of the National Research Ethics Service North West – Preston Research Ethics Committee, and the Royal Holloway Departmental Ethics Committee.

Recruitment was approved locally by Berkshire Healthcare NHS Foundation Trust Research and Development department. See Appendices A-D for approval letters.

In consenting to participate, all participants gave permission for the researcher to access their clinical notes at BTSS in order to obtain participant biographical and trauma details, as well as information about any intervening events that may have impacted on their engagement with treatment or their symptom scores.

## **Design**

There were two components to this study. This first consisted of a case series analysis of participant outcome data from measures of PTSD and CPTSD, anxiety, depression, self-compassion and general functioning, all obtained at regular intervals throughout the phase-based treatment. This component sought to answer the first and second research questions pertaining to the effectiveness of the treatment programme and the degree of symptom change observable in each of the phases of the phase-based treatment. The second component of this study consisted of a qualitative analysis of semi-structured interviews with participants who had reached the end of their treatment. This component was designed to respond to the third research question pertaining to the acceptability of the treatment programme to patients. A qualitative, semi-structured interview approach was preferred over a questionnaire approach in order to allow the emergence of a broad range of themes relating to treatment acceptability.

## **Measures**

All participants for the first (case series) component of the study completed the following self-report measures:

**PTSD Checklist for DSM-5 (PCL-5; Weathers, Litz, Keane, Palmieri, Marx, & Schnurr, 2013).** See Appendix E. The PCL-5 is a widely-used 20-item self-report measure that assesses the DSM-5 symptoms of PTSD. Each item is rated 0-4, with a maximum total score of 80. It is a self-report measure that can be interpreted to provide a provisional diagnosis, overall severity score and severity scores linked to DSM-5 diagnostic clusters.

The PCL-5 is an updated version of the PCL for DSM-IV reflecting the revised diagnostic criteria. As a recent revision, psychometric information is not yet available for the PCL-5; however, studies of the psychometric properties of the previous version, the PCL-S for DSM-IV, indicate good reliability and validity. In a sample of 40 road traffic accident and sexual assault victims, Blanchard, Jones-Alexander, Buckley, and Forneris (1996) found an alpha of .94 and an overall correlation between total PCL-S score and CAPS scores of .93. In a study of people who had experienced a variety of traumas, Ventureya, Yao, Cottraux, Note, and Guillard (2002) reported excellent internal consistency (.86) and test-retest reliability (.80) for the total PCL-S score.

**Berkshire Traumatic Stress Service CPTSD measure (BTSS CPTSD; Billings & Whalley 2015, unpublished).** See Appendix F. This additional, brief, purpose-designed measure consists of four self-report items appended to the PCL-5 in order to probe for the four complex PTSD symptom dimensions (difficulties regulating emotions; difficulties in interpersonal relationships; dissociation; somatisation) described by ISTSS guidelines (Cloître et al, 2011) and not already probed by the PCL-5. The fifth CPTSD symptom area (alterations in beliefs) is included in the PCL-5. The response options are the same as those for the PCL-5 (Not at all / A little bit / Moderately / Quite a bit / Extremely), with each item rated 0-4. As with the PCL-5, participants are asked to rate their symptoms in the past month.

**Forms of Criticism and Self-Reassurance Scale (FCSRS; Gilbert, Clarke, Hempel, Miles, and Irons, 2004).** See Appendix G. The FCSRS is a 22-item measure that developed from Gilbert's clinical work concerning self-criticism and the ability to self-reassure. The scale is made up of three factors: Inadequate Self (a sense

of feeling internally put down and inadequately following failure), Hated Self (a sense of self-dislike and aggressive/persecutory desires to hurt the self following failure), and Reassured Self (a sense of encouragement and concern for self when things go wrong). Cronbach's alphas of over .86 for each subscale are reported by the authors.

A study consisting of a clinical sample of 304 people with Axis I and II diagnoses and a nonclinical sample of 381 examined the psychometric qualities of the FCSRS. It found good discriminant validity between Inadequate Self and Reassured Self and between Inadequate Self and Hated Self in the clinical sample. Discriminant validity was less evident between Hated Self and Reassured Self (Castilho, Pinto-Gouveia & Duarte, 2015). In the same study test-retest reliability was good for the subscales Inadequate Self ( $r=0.72$ ), Hated Self ( $r=0.78$ ) and Reassured Self ( $r=0.65$ ). Convergent validity was assessed between FCSRS and self-report measures that evaluate theoretically-related constructs (the Depression Anxiety and Stress Scales, General Health Questionnaire, Levels of Self-Criticism Scale, Self-Compassion Scale, and Life Orientation Questionnaire Test-Revised). Overall, the pattern of correlations found suggested that FCSRS and its subscales have good convergent validity. Additionally, the ability of the FCSRS to discriminate between clinical and non-clinical populations was assessed and revealed significant differences between the clinical and nonclinical samples on all subscales.

**Patient Health Questionnaire-9 (PHQ-9; Kroenke & Spitzer, 2002).** The PHQ-9 is a nine-item questionnaire based on DSM-IV diagnostic criteria for depression, which is widely used in primary care settings. Respondents are asked to rate how they have felt in the last two weeks; each item is scored 0-3 with a maximum total score of 27. It can be used to screen for depression as well as to grade depressive

symptom severity. Two large-scale validation studies have established good criterion and construct validity of the PHQ-9 as both a diagnostic and severity measure (Kroenke & Spitzer, 2002). It has also been shown to be a sensitive measure of change in depression over time, indicating its validity as an outcome measure to evaluate treatment response (Löwe, Kroenke, Herzog & Gräfe, 2004).

**Generalised Anxiety Disorder scale-7 (GAD-7; Spitzer, Kroenke, Williams, Löwe, 2006).** The GAD-7 is a seven-item self-report measure of anxiety that is widely used in primary care settings. Again, respondents are asked to rate how they have felt in the last two weeks; each item is scored 0-3 with a maximum total score of 21. It has been demonstrated to have good reliability, as well as criterion, construct, factorial, and procedural validity and therefore performs well as a screening tool for generalised anxiety disorder and for assessing the severity of anxiety symptoms (Spitzer et al., 2006).

**Work and Social Adjustment Scale (WSAS; Mundt, Marks, Shear & Greist, 2002).** The WSAS is a brief 5-item scale that measures functional impairment attributable to an identified problem or disorder across the domains of home, work, social leisure, private leisure, and relationships. Each item is rated 0-8 according to the extent to which the problem prevents them from carrying out activities in each domain, with a maximum total score of 40. It is used clinically as an outcome measure with depression, anxiety and alcohol misuse populations. There have so far been no studies measuring its validity in measuring impairment in PTSD or Complex PTSD populations, however for depression and anxiety disorders it has good convergent validity with clinically-assessed disorder severity, as well as with clients' global impressions of perceived improvement (Mundt et al., 2002).

**Semi-structured post-treatment interview.** For the second component of the study participants were interviewed individually using a semi-structured interview protocol (see Appendix H). This was designed to probe their experience of the treatment overall and of each individual phase.

The interview schedule evolved over the first few interviews to incorporate feedback and suggestions from participants. Participants were asked to comment on the content of the interview schedule as well as the process and experience of the interview.

### **Procedure**

Participants were invited to participate in the study by their assessing clinician at BTSS, given a participant information sheet (Appendix I), and informed that their decision would not affect their treatment at BTSS in any way. Those who agreed were then asked to sign a consent form (Appendix J) no less than 24 hours later. Participants were informed of their right to withdraw at any time, and of how their confidentiality would be ensured.

For the case series component of the study, participants were asked to complete self-report measures at multiple points throughout treatment. Table 1 shows the time points at which measures were administered. These time points were chosen to be roughly evenly spaced throughout the treatment programme. Whilst maximising the number of data points is preferred in a case series analysis in order to gain an accurate picture of symptom change over time, the number of time points in the current study was limited by a need to mitigate participant burden, particularly since several standardised measures were administered at each data point.

*Table 1: Data Collection Time Points and Measures*

Time point	Treatment stage	Measures
1	Assessment at BTSS	Self-report measures
2	Pre-Psychoeducation	Self-report measures
3	Post-Psychoeducation	Self-report measures
4	Pre-CRG	Self-report measures
5	Mid-CRG	Self-report measures
6	Post-CRG	Self-report measures
7	Pre-Individual treatment	Self-report measures
8	Mid-Individual treatment	Self-report measures
9	Post-Individual treatment	Self-report measures
10	Follow-up (min. 1 week)	Self-report measures & Interviews

For the interview component of the study, interviews were conducted by the researcher either in person (n=5) or by telephone (n=1), according to participant preference. Participants were made aware that the researcher was independent of BTSS, and that their responses would be confidential and not shared with clinicians. Interviews were between 18 and 44 minutes in duration (mean = 32 min) and were audio recorded and then transcribed. Participant personal and trauma details were disguised in the presentation of findings in order to protect confidentiality.

**Case series analysis.** The graphical analysis of case series data was conducted according to guidance offered by Morley and Adams (1991) for clear graphical presentation of single case data in clinical psychology research. The approach to the analysis was informed by the data, in particular the small number of data points per phase, due to the use of standardised rather than idiographic measures.

The trend line fitted to all data was the running median of 2, which is considered most appropriate for 'n < 5' case series designs where 'n' is the number of data points per phase (Morley, in prep.). The measure of central tendency selected was the phase median, again dictated by the small number of data points and as recommended by Morley. Measures of variability within each phase were judged to be unhelpful due to the low number of data points, and likely to complicate the visual analysis, where clarity is highly important (Morley & Adams, 1991).

Relying on visual, graphical analysis of case series data without the addition of statistical analyses is considered acceptable by many case series researchers, and Morley argues that the decision of whether or not to add statistical analysis should be based on the nature of the data being analysed (Morley, 1994). Whilst some case series researchers advocate the use of statistical analysis in order to establish statistically-significant differences between phases, usually through the use of non-overlap statistics (e.g., Kazdin, 2007; Shadish, 2014), the small number of data points per phase in the present study design was judged to render such analyses inappropriate.

**Thematic analysis.** Transcripts were analysed thematically. Thematic analysis is a method of searching across a data set and identifying, analysing and reporting themes within the data. The thematic analysis of the interview transcripts enabled identification of emergent themes regarding clients' experiences of the treatment. The interview transcripts were coded using the software package Atlas.Ti.6 (Cleverbridge).



## Treatment Content

Figure 2 shows the structure of the three-phase treatment programme. The length of time between treatment phases varied according to the individual's pathway through treatment.



*Figure 2: BTSS Treatment Schedule Indicating Duration of Treatment Phases*

Table 2 provides a summary of the content of the three treatment phases. Psychoeducation is a group intervention lasting 6 weeks, with each weekly session lasting 75 minutes. Groups are mixed or single sex according to client preference, with a maximum of ten members. Clients are given a workbook containing teaching materials and between-session tasks, as well as a booklet called ‘Understanding and coping with PTSD’.

Compassionate Resilience group (CRG) is a group intervention lasting 12 weeks, with each session lasting 2 hours. Groups are single-sex and have up to 8 members. There is a one-off pre-group meeting for group members to meet each other and be informed about the nature of the group. Again, clients are given a workbook containing teaching materials and between-session exercises. Skills development, such as soothing rhythm breathing and mindful attention, run throughout the 12 weeks.

Phase three consists of a one-to-one trauma-focused therapy in one of two evidence-based models: trauma-focused Cognitive Behavioural Therapy (CBT), or Eye Movement Desensitisation and Reprocessing (EMDR), the decision being made collaboratively between client and clinician.

*Table 2: Treatment Content by Phase*

<b>Content of phases by session</b>		
Phase 1: Psychoeducation group	Phase 2: Compassionate Resilience group (CRG)	Phase 3: Individual therapy
1: PTSD symptoms & formulation	1-4: Psychoeducation about the compassion model: what is threat? What is compassion?	12-16 sessions of trauma-focused Cognitive Behavioural Therapy, or Eye Movement Desensitisation and Reprocessing
2: Threat system & physiology. Relaxation techniques.	5-8: Exploring fears and blocks to developing compassion; shame and self-criticism.	
3: Nature of traumatic memories. Grounding techniques.		
4: Beliefs in trauma. Safe place exercise.	9-12: Compassionate problem-solving and compassionate coaching.	
5: Avoidance. Values-based behavioural activation.	‘You at your best’ and ‘The perfect nurturer’ exercises.	
6: Recap and discuss treatment.		

### Chapter 3: Results of Case Series

Two separate analyses were carried out: a case series analysis and a thematic analysis; findings of the case series analysis are presented first.

Table 3 shows the main characteristics of the sample for the case series analysis. Table 4 provides a clinical summary of case series participants according to standardised measures of PTSD, depression, general anxiety and functioning at pre- and post-treatment, with clinically-significant change indicated by bold text. Since all case series participants were still in treatment at the time of analysis, the table indicates the latest data point available for each participant, which was used for pre/post analyses.

*Table 3: Case Series Participant Characteristics*

ID	Sex	Age	Trauma type
1	F	30	Child sexual and physical abuse
2	F	20	Child sexual abuse and exposure to violence
3	F	45	Childhood exposure to violence, and traumatic childbirth
4	F	38	Adult intimate partner violence
5	F	47	Child sexual and physical abuse, and adult intimate partner violence
6	F	44	Child sexual and physical abuse and adult intimate partner violence
7	F	48	Adult intimate partner violence
8	F	23	Adult intimate partner violence
9	F	43	Child sexual abuse

*Table 4: Clinical Summary of Case Series Participants*

ID	Latest available data point	PCL-5		GAD-7		PHQ-9		WSAS	
		Pre	Post	<sup>a</sup> Pre	Post	Pre	Post	Pre	Post
1	Mid-individual	59	<b>32</b>	20	7	21	14	27	20
2	Mid-individual	69	<b>25</b>	16	<b>5</b>	20	<b>2</b>	20	4
3	Mid-individual	57	<b>24</b>	21	11	22	10	24	17
4	Mid-individual	48	43	12	17	11	11	4	6
5	Pre-individual	36	37	7	6	11	13	14	20
6	Pre-individual	62	63	17	18	21	26	31	34
7	Post-CRG	62	<b>16</b>	16	<b>1</b>	14	<b>1</b>	30	8
8	Post-CRG	66	<b>40</b>	19	<b>8</b>	20	14	16	13
9	Post-CRG	51	37	9	13	15	17	19	22

<sup>a</sup> 'Post' indicates latest available data.

*Note. Bold text indicates clinically significant change calculated using Jacobson's Reliable Change Index (no clinical cut off for WSAS)*

### **Pre-Post Changes in PTSD Symptomology**

Figure 3 shows change on PCL-5 total score for all participants in the case series, comparing scores at assessment with scores at the post-CRG point, and indicating those participants who showed reliable and clinically-significant change. Post-CRG was used as a post-treatment data point for consistency, since that stage of treatment had been achieved by the whole sample, and also because it represents the change in scores after completion of Phases 1 and 2 of the treatment programme. The clinical cut-off score of 44 was based on recommendations of Blanchard et al.'s (1996) study of motor accident and sexual assault survivors. Reliable change was calculated according to Jacobson's Reliable Change Index. The figure indicates that

three of the nine participants showed clinically-significant improvement on the PCL-5 at the post-CRG point.

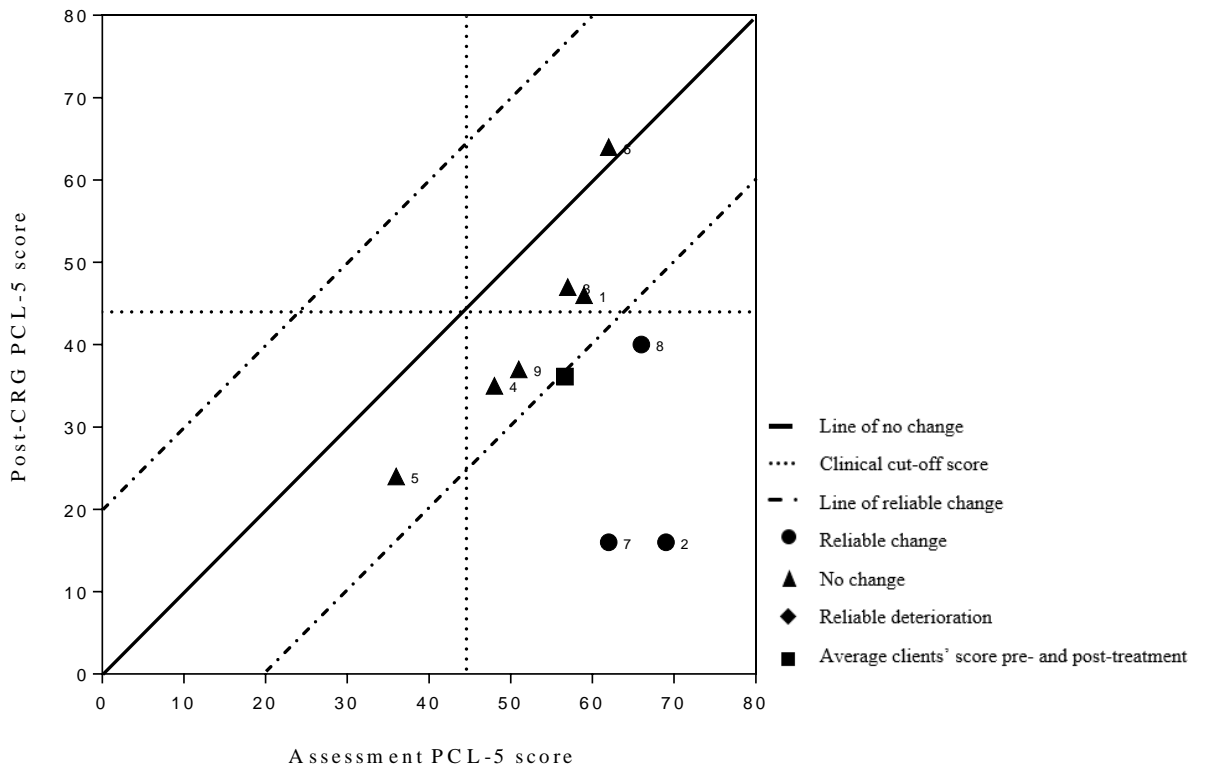


Figure 3: Reliable and Clinical Change for PCL-5 at Post-CRG

Figure 4 shows change on PCL-5 total score from assessment to the latest available data point (indicated in Table 4). For four participants the latest available data was at mid-individual treatment, for two participants it was at pre-individual treatment, and for three participants it was at post-CRG. Therefore, for six of the nine case series participants Figure 4 shows post-treatment data from a later stage in treatment than Figure 3.

Figure 4 shows that at the latest available data point, five of the nine participants showed reliable and clinically-significant improvement on the PCL-5. Comparison of Figure 3 with Figure 4 suggested that overall degree of improvement

in PTSD symptoms, as measured by the PCL-5, was partly a function of participants' stage of progress through the treatment programme.

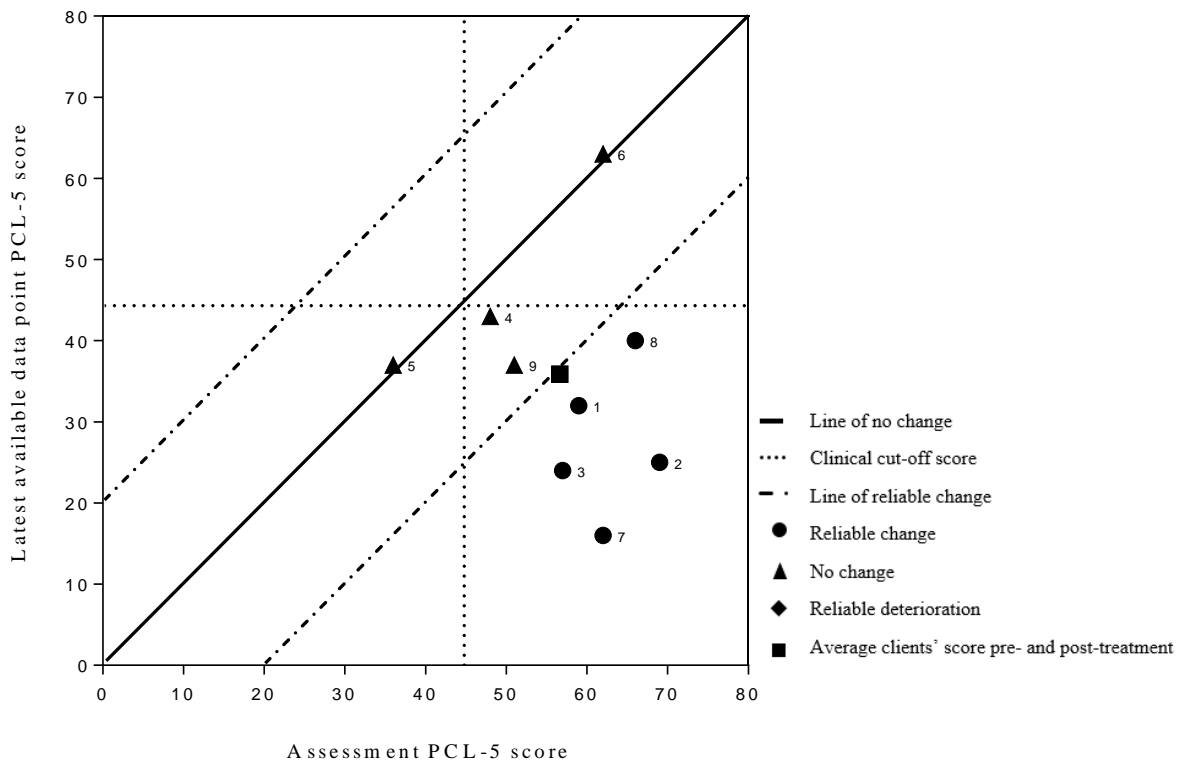


Figure 4: Reliable and Clinical Change for PCL-5 at Latest Available Data Point

Results for each participant of the case series analysis are presented sequentially. Participant background information, obtained from their clinical notes with consent, has been disguised to protect confidentiality. Data points after wait periods are indicated by hollow markers.

### Participant 1

P1 was a thirty-year old woman of White-British origin who experienced repeated emotional, physical and sexual abuse by several adults known to her between the ages of 5 and 16. Her PTSD symptoms started in childhood but were made worse when one of the perpetrators was released from prison shortly before the assessment.

She described suffering frequent nightmares and flashbacks as well as hyperarousal, panic, poor sleep, and dissociative ‘zoning out’. In addition, she described difficulties trusting others and feeling cut off, as well as high levels of self-criticism and shame. She suffered from low mood and was taking an SSRI at the time of assessment. She had attempted suicide in the past and reported recent suicidal ideation but no current intent to harm herself. She also suffered from an unexplained health problem.

P1 did not attend two of the six Psychoeducation sessions and four of the 12 CRG sessions due to ill-health and practical difficulties. At the time of analysis P1 had completed eight sessions of trauma-focused individual treatment (of 12-16 sessions offered).

**Generic measures.** P1’s scores on measures of depression, anxiety and functioning (PHQ-9, GAD-7 and WSAS) are shown in Table 5. As P1 had not finished individual treatment, no scores were available for time points 9-10. The data indicated that from assessment to mid-individual treatment P1’s scores for both the PHQ-9 and GAD-7 improved to a reliable degree. On the WSAS, which is not a diagnostic tool but assesses broader functioning, P1 showed no overall change in score from assessment to mid-individual treatment. Scores in-between indicate some deterioration in functioning during Psychoeducation, returning to the original level over the course of the CRG.

Table 5: P1 PHQ-9, GAD-7 and WSAS scores

	1	2	3	4	5	6	7	8				
	Assess.	Pre-Psych	Post-Psych.	Pre-CRG	Mid-CRG	Post-CRG	Pre-Indiv.	Mid-Indiv.	Pre /Post	RC <sup>a</sup>	CSC <sup>a</sup>	Interpretation
PHQ-9	21	17	22	25	23	11	13	14	-7	Y	N	Severe to moderate
GAD-7	20	14	15	20	20	6	6	7	-13	Y	Improve	Severe to <clinical
WSAS	27	28	38	38	37	26	27	20	-7	N	n/a	n/a

<sup>a</sup>Reliable Change and Clinically-Significant Change calculated using Jacobson's Reliable Change Index

**Graphical analysis.** Results for the PCL-5, Complex PTSD items and FCSRS sub-scale scores are presented graphically in Figures 5, 6 and 7 respectively.

Figure 5 indicates that P1's PCL-5 total score, which was 59 at assessment, decreased overall from assessment to mid-treatment (32). Visual analysis of the graph indicates a slight upward trend in symptom severity during Phase 1 followed by a downwards trend in severity during Phase 2. This suggests that the Psychoeducation group had a negative effect on PTSD symptoms but the CRG had a positive effect. Deterioration is visible after the wait between Phase 1 and 2 (time point 4), however by contrast, symptom improvement during the CRG continued in the wait period after (time point 7). The limited data available for Phase 3 showed continued improvement in PTSD symptoms over the first half of individual treatment.



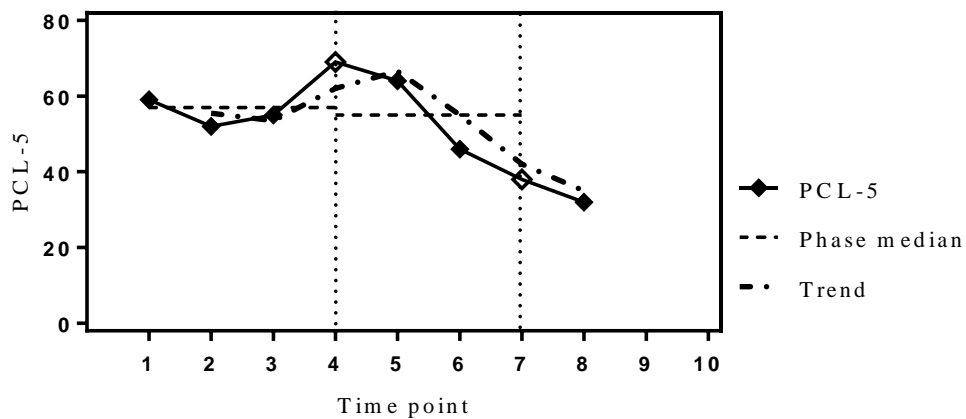


Figure 5: P1 PCL-5 Total Score

Figure 6 shows P1's scores on the five 'Complex' symptom domains of CPTSD, assessed by all four items of the BTSS CPTSD measure (measuring Emotional, Interpersonal, Dissociative and Somatic symptoms), in addition to Item 9 from the PCL-5 probing negative beliefs about self, others or the world. Visual analysis revealed that trends for the five CPTSD symptom items were similar, showing no change or a slight upward trend during Phase 1, followed by a downwards trend in Phase 2. Similar to the trend in PCL-5 total score, this suggests that Psychoeducation was not helpful for alleviating CPTSD symptoms, whereas CRG was helpful. In all cases the improvement during the CRG was sustained in the waiting period after (time point 7). Missing data in Phase 1 made it impossible to draw conclusions about symptom change in the wait period after the Psychoeducation group (time point 4). Data for Phase 3 up to the first half of individual treatment indicated that most CPTSD symptom areas continued to improve, although the Somatic item showed deterioration.

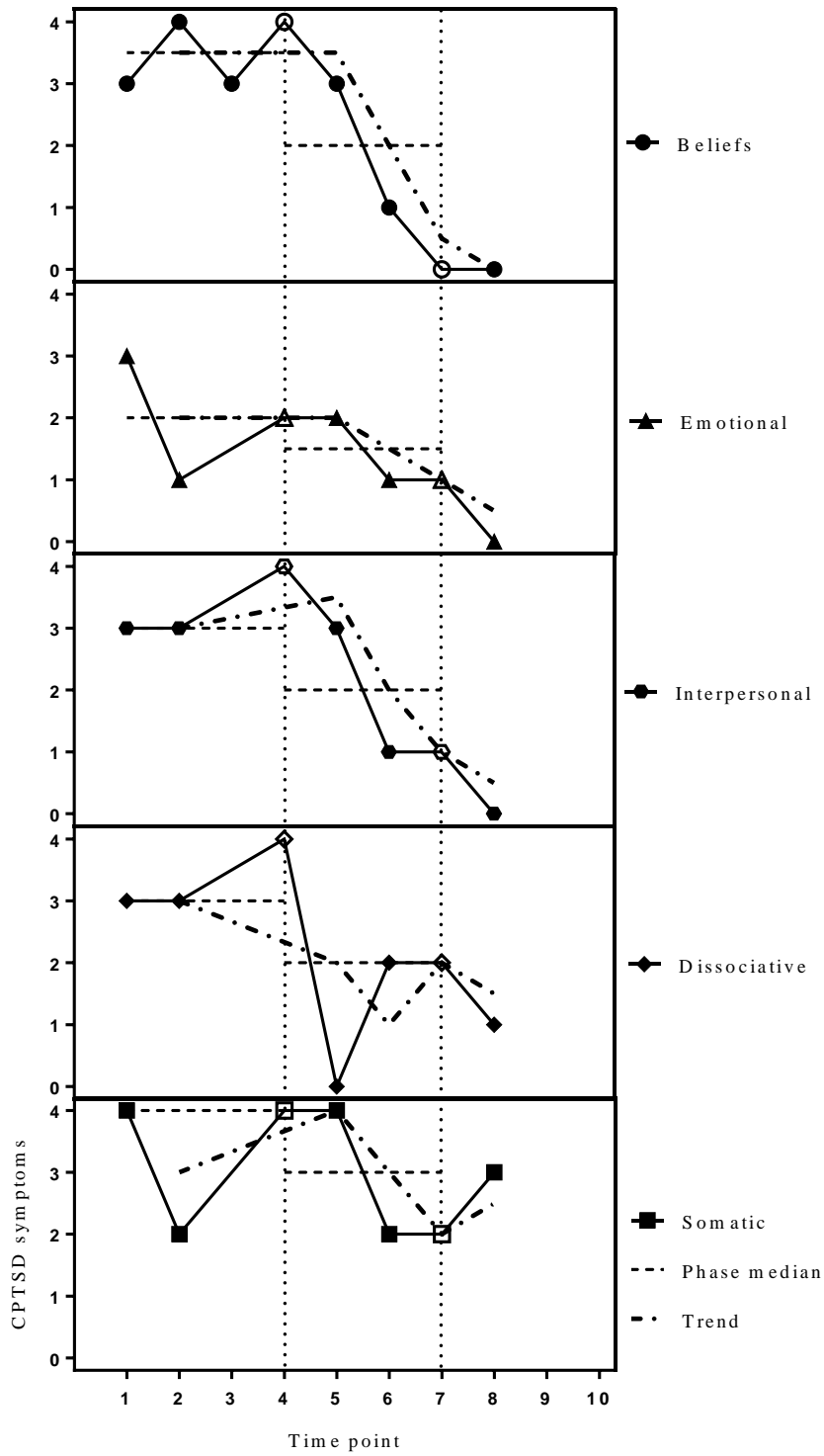


Figure 6: P1 Complex PTSD Symptoms (BTSS CPTSD items & PCL-5 Item 9)

Figure 7 shows P1's scores on the three subscales of the FCSRS. According to visual analysis of the data, the trend on all three subscales of the measure was for no

change or slight deterioration during Phase 1, followed by marked improvement during Phase 2 (decreases in Hated and Inadequate Self, increase in Reassured Self). This suggests that Psychoeducation had little effect, or a negative effect, on self-compassion ratings, whereas the CRG may have been helpful. Gains appear to have continued during the waiting period after the CRG for Hated and Inadequate Self, but not for Reassured Self. In Phase 3, the data suggested some improvement for Inadequate and Reassured Self in the first half of individual treatment, but no change for Hated Self.

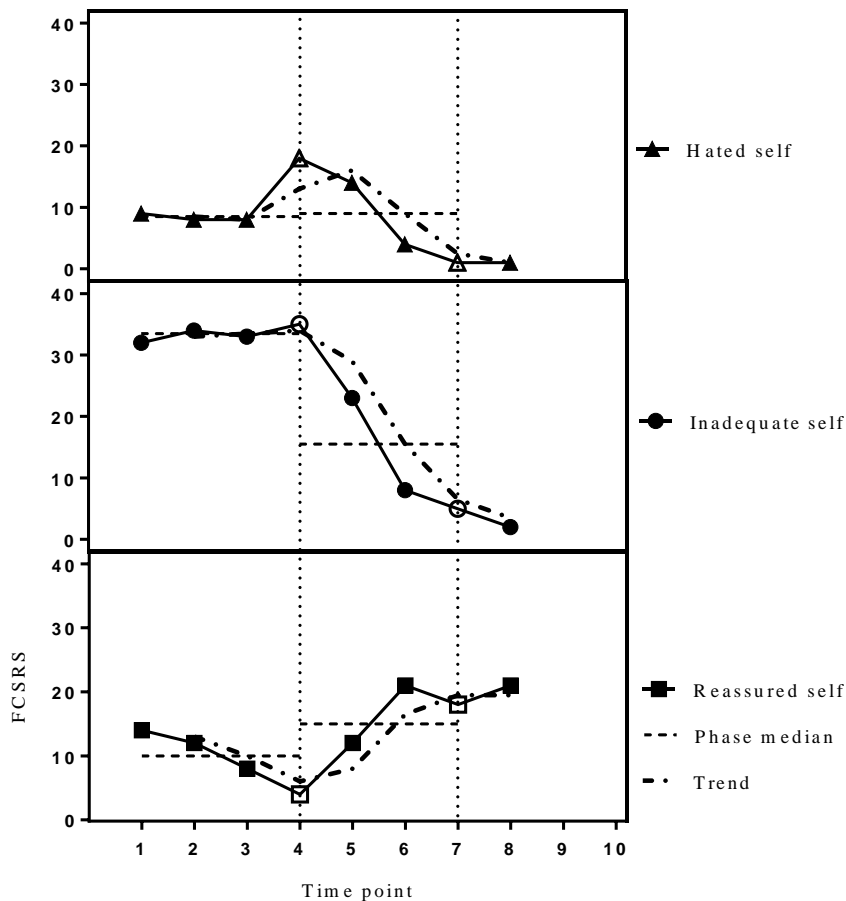


Figure 7: P1 FCSRS Subscales: Hated Self, Inadequate Self, Reassured Self

Overall it appeared that, for P1, Psychoeducation did not have any impact on the generic measures of anxiety, depression and function, nor on PTSD, CPTSD symptoms and self-compassion. However, it is important to note that the participant was not able to attend one third of the sessions that were offered in Psychoeducation. By contrast, the CRG appears to have been helpful for P1 in terms of PTSD, CPTSD and self-compassion, and gains during the CRG were generally sustained in the wait period after. Improvement on all measures appeared to continue in the first part of Phase 3.

## **Participant 2**

P2 was a 20-year-old woman of Irish descent who experienced CSA perpetrated by two cousins and her uncle from the age of 6 to 13. She had not felt able to report the abuse. As a child she also repeatedly witnessed her mother suffer domestic violence perpetrated by her father. At assessment P2 reported distressing visual and olfactory flashbacks on a weekly basis, and nightmares. She struggled with sexual intimacy due to it triggering flashbacks. She had periods of depression and had recent episodes of self-harm, though no suicidal ideation. She held strong negative beliefs about herself which had led to some self-neglect, and she struggled with relationships, experiencing others as rejecting. She also had difficulty managing her anger at times. Prior to assessment at BTSS P2 had had previous mental health services contact and an intervention designed to address features of Borderline Personality Disorder. She was not taking any medication.

P2 attended all sessions of Psychoeducation and the CRG. At the time of analysis she was engaging well with individual treatment and had attended eight sessions.

**Generic measures.** P2's scores on depression, anxiety and functioning measures (PHQ-9, GAD-7 and WSAS) are shown in Table 6. As P2 had not reached the post-individual treatment point, no scores were available for time points 9 or 10. The data indicates that from assessment to mid-individual treatment P2's scores reduced from being in the severe range for both the PHQ-9 and GAD-7, to being below accepted clinical cut-off scores for both (IAPT, 2011). On the WSAS P2 showed marked improvement.

*Table 6: P2 PHQ-9, GAD-7 and WSAS scores*

	1	2	3	4	5	6	7	8				
	Assess.	Pre-Psych.	Post-Psych.	Pre-CRG.	Mid-CRG.	Post-CRG.	Pre-Indiv.	Mid-Indiv.	Pre/Post	RC <sup>a</sup>	CSC <sup>a</sup>	Interpretation
PHQ-9	20	19	15	15	4	0	7	2	-18	Y	Improve	Severe to <clinical
GAD-7	16	17	12	14	2	3	4	5	-11	Y	Improve	Severe to <clinical
WSAS	20	17	24	10	4	4	6	4	-16	Y	n/a	n/a

<sup>a</sup> *Reliable Change and Clinically-Significant Change calculated using Jacobson's Reliable Change Index*

**Graphical analysis.** Results for the PCL-5, Complex PTSD items and FCSRS sub-scales are presented graphically in Figures 8, 9 and 10 respectively.

Figure 8 indicates that P2's PCL-5 total score reduced considerably from assessment (69) to mid-treatment (25). Visual analysis of the graph suggests that, of the two phases for which complete data was available, both appear to have had a positive effect on PTSD symptoms, with the CRG group having the greatest impact. It

was not possible to draw conclusions about Phase 3 from the data points available, though the trend in PCL-5 score for the first half of individual treatment appears to be a continued downward one. Deterioration in symptoms is visible after the wait between Phase 1 and 2 (time point 4) and the wait between Phase 2 and 3 (time point 7).

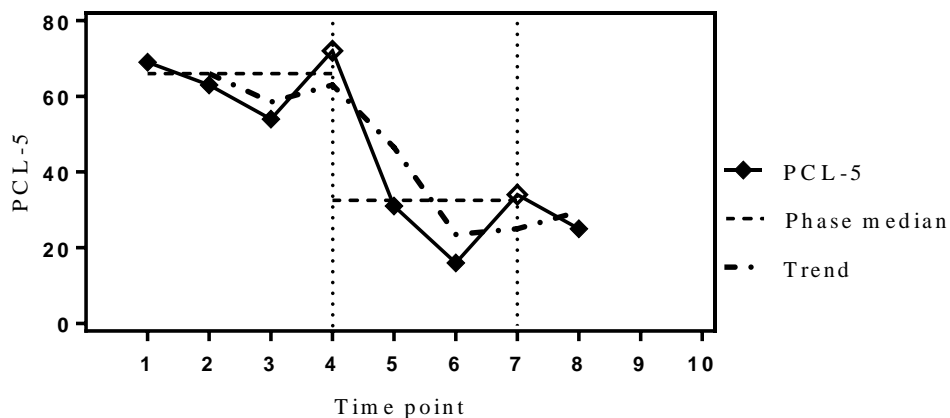


Figure 8: P2 PCL-5 Total Score

Figure 9 shows P2's scores on the five 'Complex' symptom domains of CPTSD. The trends on the five graphs are similar, and show a marked difference between the central tendency for Phase 1 and Phase 2. The trend lines indicated reductions in symptoms across both Phase 1 and Phase 2, as well as deterioration in the wait periods between these phases. The 'Beliefs' domain differed to the other domains by showing no reduction in symptom frequency in Phase 1, but, like the others, showed reductions over Phase 2. Overall, visual analysis of these graphs suggests that Psychoeducation was helpful in reducing most CPTSD symptoms, and CRG was helpful for all CPTSD symptoms. The limited data for Phase 3 suggests either continued improvement or at least maintenance of gains over the first half of individual treatment.

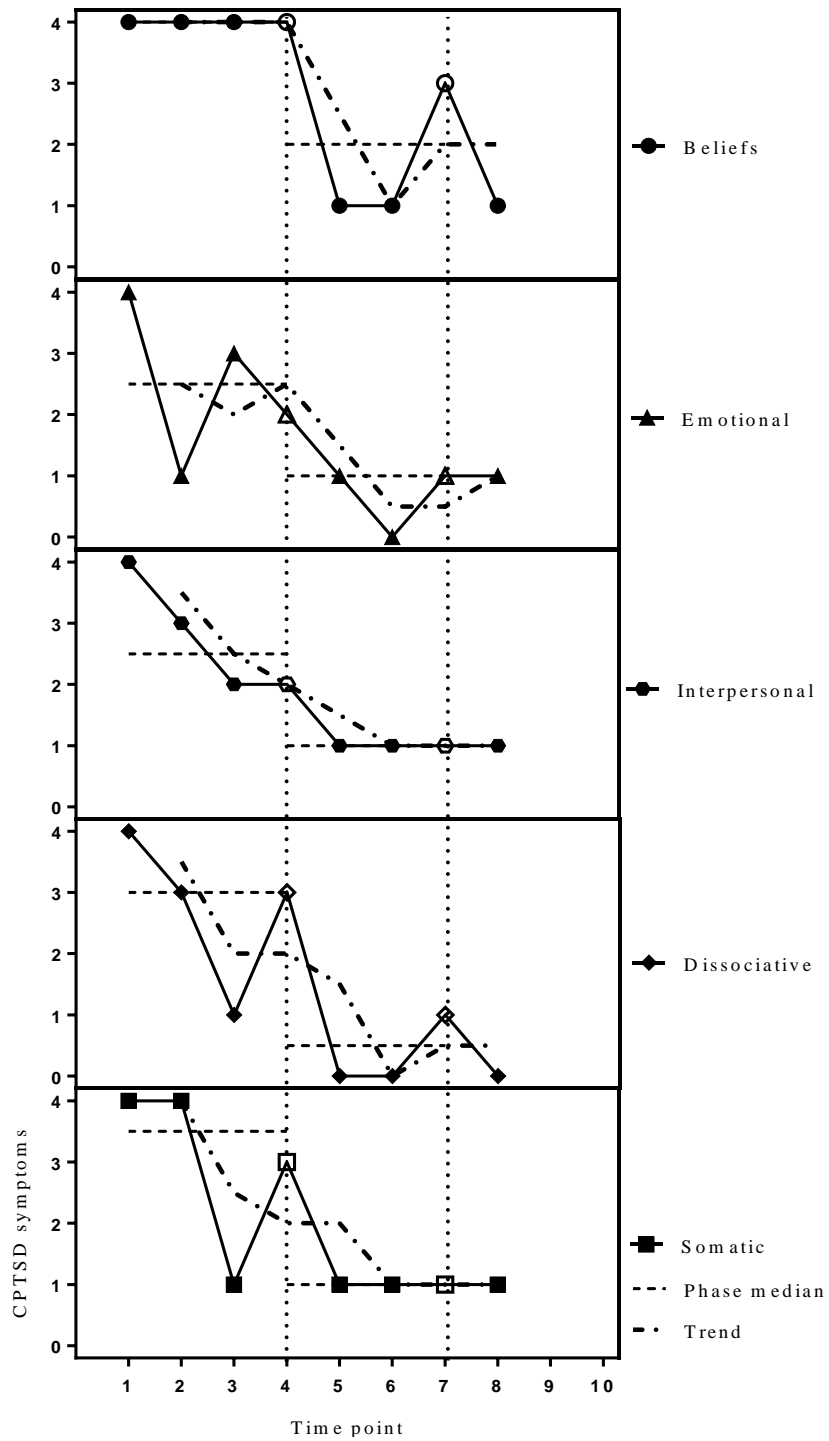


Figure 9: P2 Complex PTSD Symptoms (BTSS CPTSD items & PCL-5 Item 9)

Figure 10 shows P2's scores on the three subscales of the FCSRS. The trend on all three subscales was for improvement (reductions in Hated Self and Inadequate

Self; an increase in Reassured Self) in Phases 1 and 2, according to visual analysis of the data. For Hated Self the trend appears similar across Phase 1 and 2, suggesting they were equally helpful. Inadequate Self, which was rated very highly at assessment, showed the steepest improvements in Phase 2. Reassured Self also showed the steepest improvement in Phase 2. This suggests that although both Psychoeducation and CRG appear to show improvements on the FCSRS, the CRG was the most effective phase of treatment for P2 in reducing self-criticism and increasing the capacity to self-reassure. The limited data available for Phase 3 indicates little change on any of the FCSRS subscales in the first half of individual treatment.

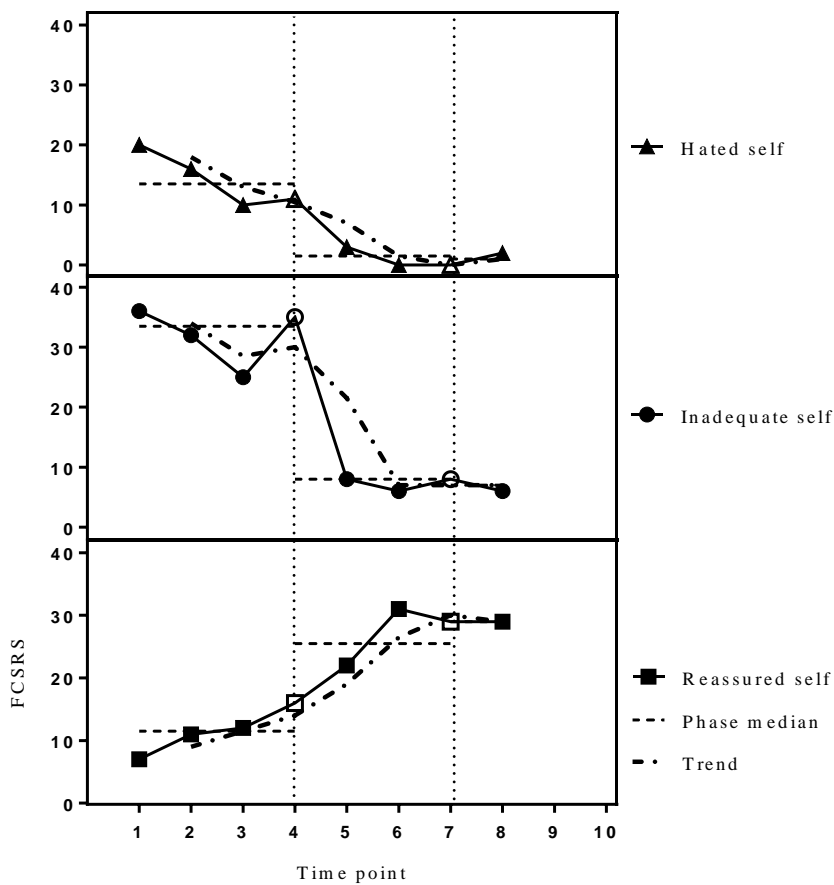


Figure 10: P2 FCSRS Subscales: Hated Self, Inadequate Self, Reassured Self



Overall, for P2, it appeared that both Psychoeducation and CRG may have been instrumental in improving PTSD and some CPTSD symptoms. With only two data points for Phase 3 it was difficult to draw conclusions about the impact of individual treatment on scores; however the trend appeared to show that improvements on the PCL-5 continued in the first half of individual treatment whereas improvements on CPTSD items and FCSRS slowed down. This reflected the explicit emphasis of Phase 3 on reducing PTSD symptoms, rather than targeting CPTSD symptoms or self-compassion.

### **Participant 3**

P3 was a 45-year-old woman of White British background who suffered emotional abuse from her father as a child, and witnessed domestic violence towards her mother. As an adult she experienced a traumatic childbirth. She had a number of PTSD symptoms at assessment including flashbacks, intrusive memories, difficulty sleeping, dissociation, poor concentration and medically-unexplained pain. It was not clear which symptoms were related to which trauma. She described strong feelings of shame and embarrassment, and negative beliefs about herself such as ‘I deserve to be punished’. She held beliefs about the dangerousness of the world, described feeling cut off from others and was low in mood. Prior to treatment at BTSS P3 had been admitted to hospital for an acute stress reaction triggered by family difficulties. She was taking beta blockers, sleeping tablets and an SSRI.

P3 attended all Psychoeducation sessions. She was unable to attend three of the CRG sessions due to a bereavement. At the time of analysis P3 had attended seven sessions of individual therapy.

**Generic measures.** P3's scores on measures of depression, anxiety and functioning are shown in Table 7. As P3 had not reached the end of individual treatment, no scores were available for time points 9-10. The data indicates that from assessment to mid-individual treatment P3's scores reduced from being in the severe range to being in the moderate range for both depression and anxiety (IAPT, 2011), although the improvements did not meet criteria for CSC. On the WSAS there was no assessment score due to missing data, and no reliable change overall.

*Table 7: P3 PHQ-9, GAD-7 and WSAS scores*

	1	2	3	4	5	6	7	8				
	Assess.	Pre-Psych.	Post-Psych.	Pre-CRG	Mid-CRG	Post-CRG	Pre-Indiv.	Mid- Indiv.	Pre /Post	RC <sup>a</sup>	CSC <sup>a</sup>	Interpretation
PHQ-9	22	24	21	15	27	9	12	10	-12	Improve	N	Severe to moderate
GAD-7	21	21	21	20	21	11	13	11	-10	Improve	N	Severe to moderate
WSAS	-	24	28	26	23	19	18	17	-7	N	n/a	n/a

<sup>a</sup> *Reliable Change and Clinically-Significant Change calculated using Jacobson's Reliable Change Index*

**Graphical analysis.** Results for the PCL-5, Complex PTSD items and FCSRS sub-scale scores are presented graphically in Figures 11, 12 and 13 respectively.

Figure 11 illustrates that P3's PCL-5 total score improved reliably overall from assessment (57) to mid-individual treatment (24). Visual analysis of the trend line indicated that P3's PCL-5 score increased over Phase 1 and decreased over Phase 2, suggesting that Psychoeducation increase symptoms whereas the CRG reduced symptoms. The gains in Phase 2 were partly lost in the wait period after (time point 7). The available data for Phase 3 indicated that PTSD scores reduced markedly over the first half of individual treatment.

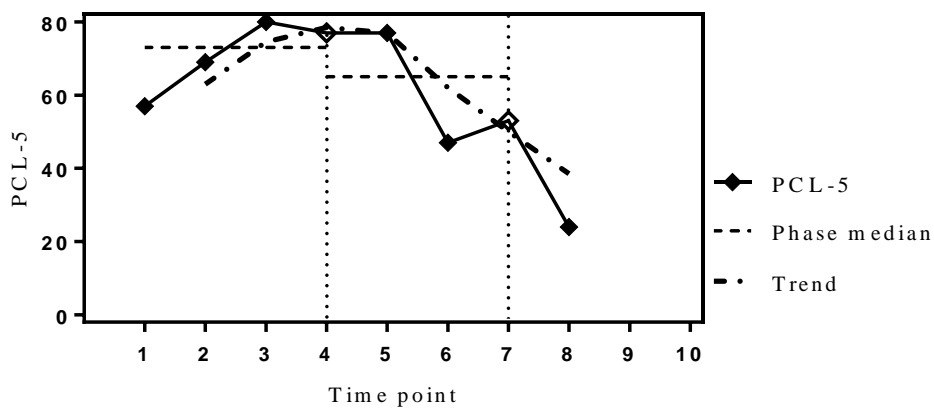


Figure 11: P3 PCL-5 Total Score

Figure 12 shows P3's scores on the five 'Complex' symptom domains of CPTSD. The lines of central tendency for most items indicate very little change between Phase 1 and Phase 2. However, this statistic obscures changes that did occur. The trend lines indicate that all CPTSD items except Beliefs showed some slight improvement during Psychoeducation (time point 3) although gains were lost in the waiting period after. Additionally, all symptoms showed improvements during the CRG, particularly the second half (time point 6), although, again, for several symptoms gains were partly lost in the waiting period after.

Overall, visual analysis of P3'S CPTSD scores indicated that Psychoeducation may have been somewhat helpful in alleviating symptoms but gains were not

sustained, whereas the CRG appeared to show a sustained positive impact on all CPTSD symptoms except Somatic. For Phase 3, data for the first half of individual treatment showed improvements on all five items, suggesting that individual treatment may have had a positive impact on CPTSD symptoms.

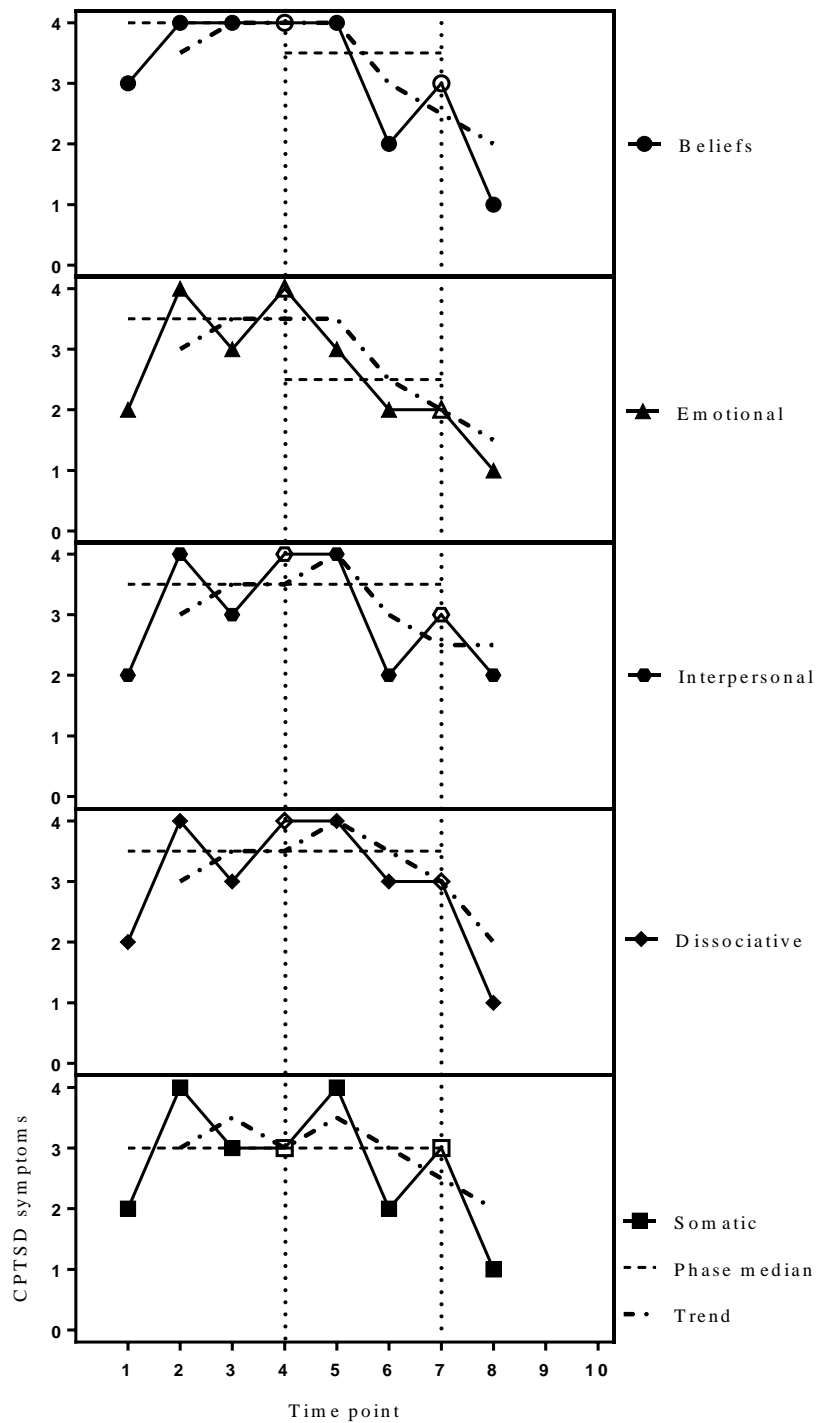


Figure 12: P3 Complex PTSD Symptoms (BTSS CPTSD items & PCL-5 Item 9)

Figure 13 shows P3's scores on the three subscales of the FCSRS. Visual analysis indicated deterioration in self-compassion (increase in Hated and Inadequate Self; decrease in Reassured Self) on all FCSRS dimensions across Phase 1. In Phase 2 there was a trend of reduction in scores for Hated and Inadequate Self, and no change for Reassured Self. This suggests that Psychoeducation was not helpful but CRG did have a moderate effect in reducing self-criticism, although it did not appear to impact on P3's capacity for self-reassurance. For Phase 3, the available data showed some improvement on Inadequate Self and Reassured Self but an increase in score for Hated Self.

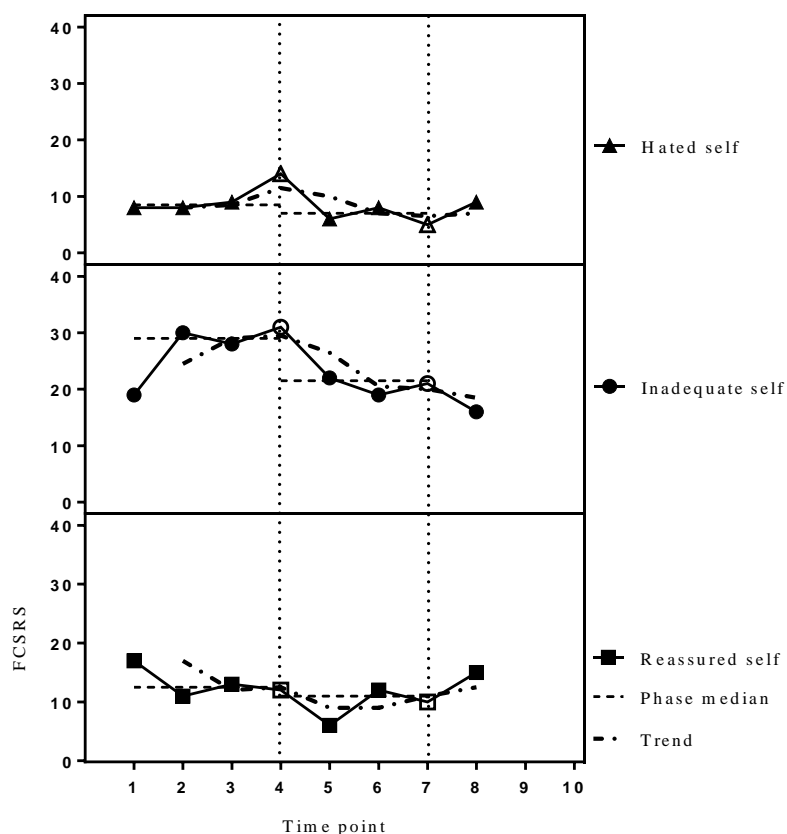


Figure 13: P3 FCSRS Subscales: Hated Self, Inadequate Self, Reassured Self

Overall for P3, Psychoeducation appeared to have had a negative effect on PTSD, CPTSD symptoms and FCSRS ratings, whereas CRG appear to show positive effects on all these measures, despite a bereavement and several missed sessions, and these gains were generally partly sustained in the wait period after the CRG. Individual treatment, based on data for the first half only, appeared to be associated with a reduction in both PTSD and CPTSD symptoms.

#### **Participant 4**

P4 was a 38-year-old mixed-race woman who experienced a sexually abusive and controlling relationship culminating in a serious physical assault two years prior to assessment at BTSS. Although the relationship ended, there was ongoing threat from her ex-partner, including stalking and harassment. The main difficulties she described were frequent nightmares and visceral daytime flashbacks of the abuse. She reported feeling anxious and hypervigilant, and having poor memory and concentration. She also described high levels of guilt and self-blame for not leaving the relationship sooner.

Due to work commitments P4 was unable to attend the Psychoeducation group, held during working hours, and instead covered the same material in two individual sessions. She was subsequently able to join the CRG group and attended all sessions. The end of the CRG coincided with the start of a court case concerning her ex-partner. At the time of analysis P4 had completed 7 sessions of individual treatment.

**Generic measures.** P4's scores on measures of depression, anxiety and functioning are shown in Table 8. Due to the participant not returning measures, no

scores were available for time points 2 or 3. Additionally, since P4 had not yet finished individual treatment, no scores were available for time points 9-10.

Pre-post comparison of assessment and mid-individual PHQ-9 scores indicated that P4’s score did not change reliably. Scores on the GAD-7 showed deterioration, with scores increasing from the moderate to severely anxious range (IAPT, 2011). On the WSAS P4 showed no reliable change. Across all three measures there appeared to be marked deterioration in the waiting period between the CRG and pre-individual treatment (time point 6 to 7).

*Table 8: P4 PHQ-9, GAD-7 and WSAS scores*

	1	2	3	4	5	6	7	8				
	Assess.	Pre-Psych.	Post-Psych.	Pre-CRG	Mid-CRG	Post-CRG	Pre-Indiv.	Mid- Indiv.	Pre/Post	RC <sup>a</sup>	CSC <sup>a</sup>	Interpretation
PHQ-9	11	-	-	15	10	5	15	11	0	N	N	Moderate
GAD-7	12	-	-	13	9	8	19	17	+5	N	N	Moderate to severe
WSAS	4	-	-	3	13	5	9	6	+2	N	n/a	n/a

<sup>a</sup> *Reliable Change and Clinically-Significant Change calculated using Jacobson’s Reliable Change Index*

**Graphical analysis.** Results for the PCL-5, Complex PTSD items and FCSRS sub-scales scores are presented graphically in Figures 14, 15 and 16 respectively.

Figure 14 shows P4’s PCL-5 total score, which was 48 at assessment and 43 at the mid-individual treatment point, indicating minimal overall change in PTSD symptoms from assessment to the mid-individual point. Due to missing data it was

not possible to draw conclusions about the effect of Phase 1. For Phase 2 the trend line suggests moderate improvement during the CRG; however, these gains were lost in the wait period after (time point 7). There was insufficient data for Phase 3 to draw conclusions; however, the available data for the first half of individual treatment suggested slight improvement in PTSD symptoms.

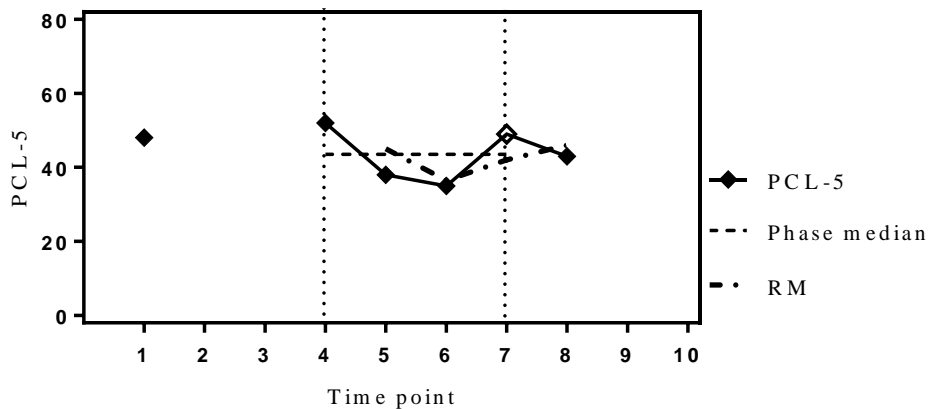


Figure 14: P4 PCL-5 Total Score

Figure 15 shows P4’s scores on the five ‘Complex’ symptom domains of CPTSD. Again, missing data made it impossible to draw conclusions about the effects of Phase 1. Visual analysis of Phase 2 indicated overall worsening on the Emotional, Dissociative and Somatic items, and some improvement for Beliefs and Interpersonal symptoms. This suggested that CRG had a minimal impact on CPTSD symptoms. All items except Beliefs showed deterioration in the wait period between Phase 2 and Phase 3. Four of the five items showed no change in the first half of individual treatment. The Somatic item, by contrast, showed improvement. Therefore, the first half of individual treatment largely did not appear to impact CPTSD symptoms.



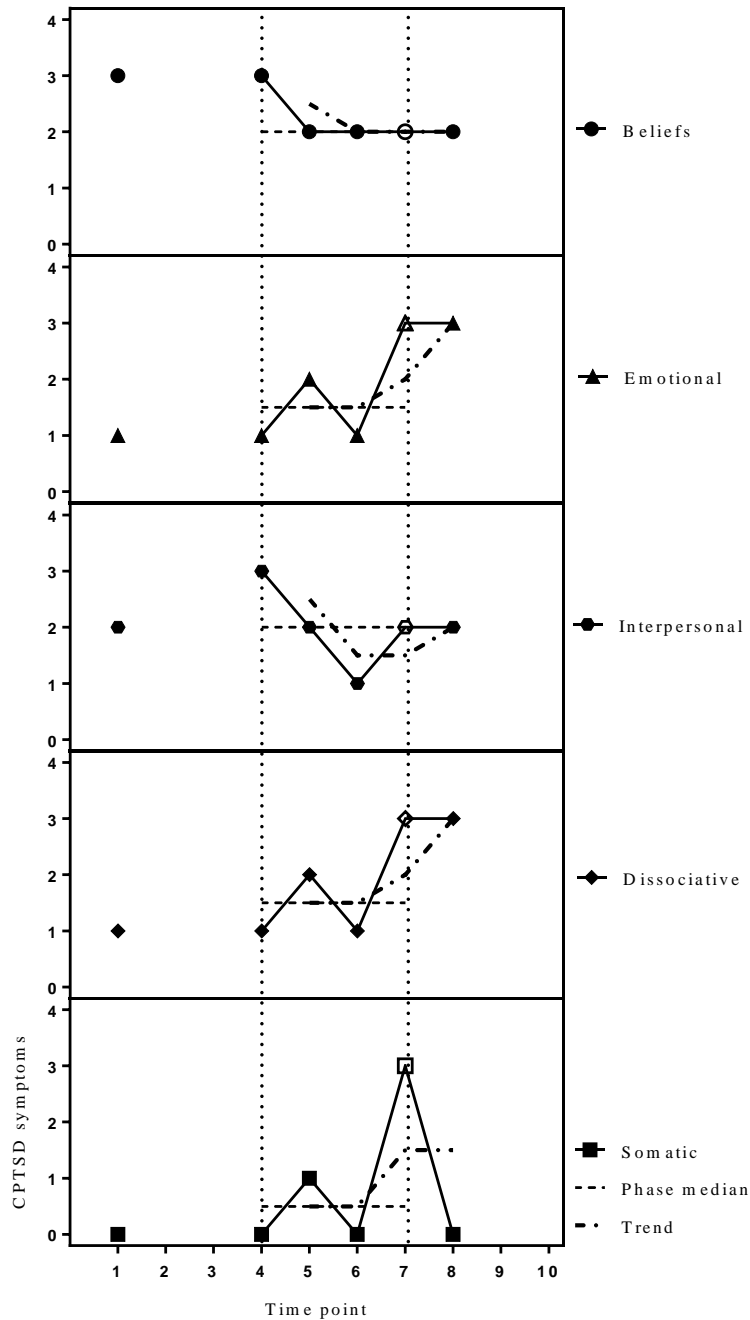


Figure 15: P4 Complex PTSD symptoms (BTSS CPTSD items & PCL-5 Item 9)

Figure 16 shows P4's scores on the three subscales of the FCSRS. Overall there appeared to be no change in scores on Hated Self, Inadequate Self or Reassured Self from assessment to mid-individual treatment. No conclusions could be drawn about Phase 1 from the available data. Visual analysis of the trend for Phase 2 indicated an improvement (reduction) in both Hated Self and Inadequate Self, but

only very slight change on Reassured Self. Gains made during the CRG were partly lost in the wait period afterwards. The available data for Phase 3 indicated scores continued to deteriorate and therefore gains made in Phase 2 were lost in the first half of individual treatment. Therefore, for P4, the CRG appeared to be helpful for reducing self-criticism, whereas individual treatment was not.

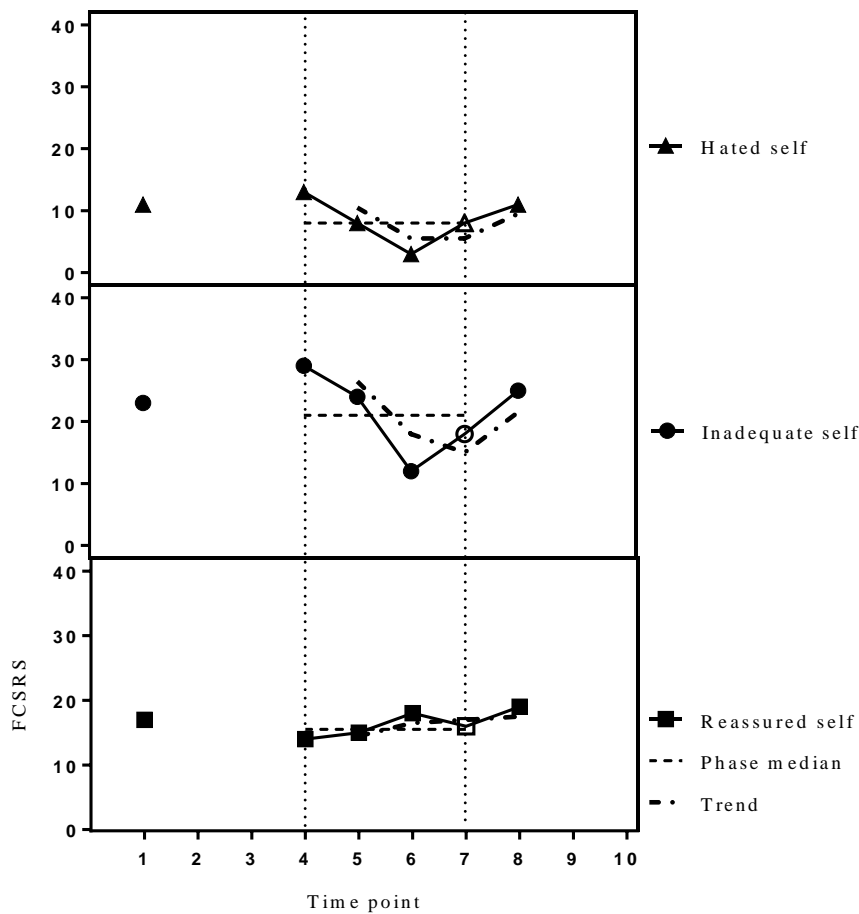


Figure 16: P4 FCSRS Subscales: Hated Self, Inadequate Self, Reassured Self

Overall, visual analysis of P4's data showed little or no overall improvement from assessment to mid-treatment on the generic measures, PTSD and CPTSD measures or FCSRS ratings. However, the trend did indicate improvement during CRG for PTSD symptoms, as measured by PCL5, and for self-criticism, as measured

by the FCSRS. Nevertheless, these gains were partly or largely lost during the wait period after. It may be important in interpreting these results to note that the post-CRG period was one of high stress for the participant due to a court case and continued threat from her ex-partner, which may have impacted on symptom scores.

### **Participant 5**

P5 was a 47-year-old White European woman who was physically and sexually abused by her step-father from age 5 to 10. She also witnessed her step-father being physically and sexually abusive to her mother. In her mid-twenties P5 experienced a physically and sexually abusive relationship lasting two years. P5 described suffering intrusive memories, flashbacks and nightmares linked to both the childhood abuse and abuse in adulthood. She had difficulties with relationships and avoided sexual intimacy. She described periods of shutting off from others, as well as feeling out of touch with her own sense of self. She struggled with regulating her emotions, experiencing periods of low mood and angry outbursts. She also described considerable self-hatred, self-blame and self-criticism. She had recently been prescribed a tricyclic antidepressant to treat insomnia.

P5 engaged well with Psychoeducation and CRG. When starting individual treatment, it became apparent that circumstances at home had made it difficult for her to practice the techniques learned in the CRG since finishing it, and also made it difficult for her to start individual treatment immediately. After a delay, she commenced individual treatment and had had four sessions at the time of analysis.

**Generic measures.** P5's scores on measures of depression, anxiety and functioning are shown in Table 9. As she had not reached the mid-point of individual

treatment, no scores were available for time points 8-10. The data indicates that there was no reliable change in depression, anxiety or overall functioning scores.

*Table 9: P5 PHQ-9, GAD-7 and WSAS scores*

	1	2	3	4	5	6	7				
	Assess.	Pre-Psych.	Post-Psych.	Pre-CRG	Mid-CRG	Post-CRG	Pre-Indiv.	Pre /Post	RC <sup>a</sup>	CSC <sup>a</sup>	Interpretation
PHQ-9	11	18	14	13	17	9	13	+2	N	N	Moderate to moderate
GAD-7	7	12	10	10	10	2	6	-1	N	N	Mild to mild
WSAS	14	24	17	23	25	13	20	+6	N	N	n/a

<sup>a</sup> *Reliable Change and Clinically-Significant Change calculated using Jacobson's Reliable Change Index*

**Graphical analysis.** Results for the PCL-5, Complex PTSD items and FCSRS sub-scales are presented graphically in Figures 17, 18 and 19 respectively.

Figure 17 indicates that P5's PCL-5 total score, which was 36 at assessment, did not change overall to pre-individual treatment (37). Visual analysis of the trend line indicated a slight increase in symptoms during Phase 1 followed by a reduction of symptoms in Phase 2, suggesting that the CRG had an effect on PTSD symptoms but Psychoeducation did not. Deterioration in symptoms was visible in the wait period after the CRG (time point 7).

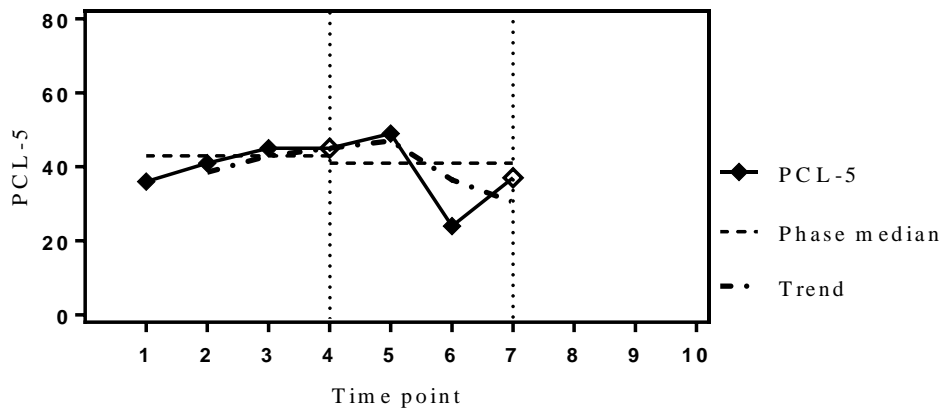


Figure 17: P5 PCL-5 total score

Figure 18 shows P5’s scores on the five ‘Complex’ symptom domains of CPTSD. Visual analysis of the five items reveals similar changes on all five items. Whilst the lines of central tendency suggest little change between Phase 1 and Phase 2, the trend lines show deterioration in Phase 1 followed by improvement in Phase 2 in all five domains. This suggests that Psychoeducation had no positive effect on CPTSD symptoms and may even have had a negative impact, whereas the CRG appeared to have a positive impact. However, gains in the CRG were partly or wholly lost in the waiting period after (time point 7) for Beliefs, Somatic and Dissociative symptoms.

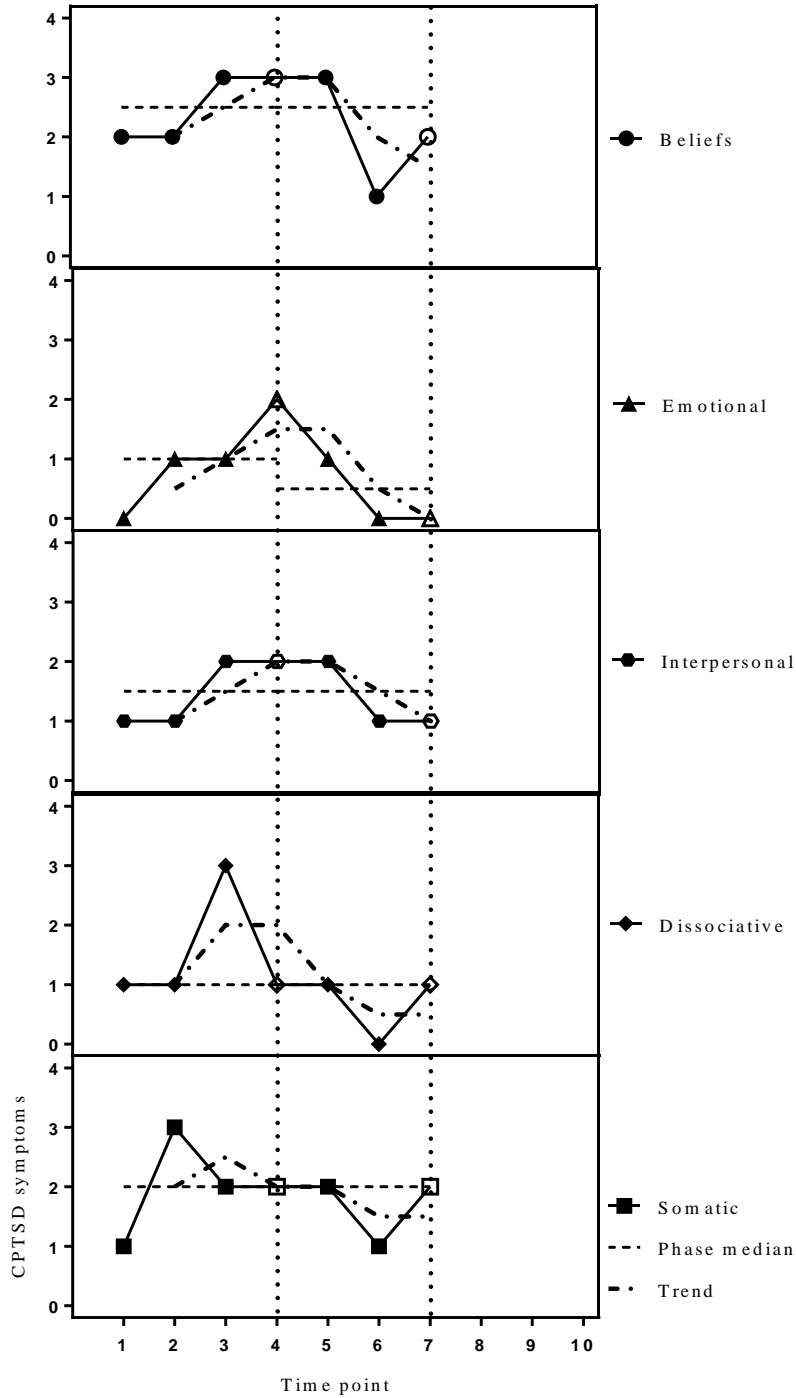


Figure 18: P5 Complex PTSD symptoms (BTSS CPTSD items & PCL-5 Item 9)

Figure 19 shows P5's scores on the three subscales of the FCSRS. The trend on all three subscales was for little change in Phase 1 followed by moderate improvement during Phase 2 (reductions in Hated Self and Inadequate Self; increase

in Reassured Self), with the most improvement visible in Inadequate Self, which was the highest-scored subscale of the FCSRS at assessment. For Hated and Inadequate Self the improvements appear to continue through the waiting period after the CRG, but not for Reassured Self. This visual analysis suggests that Psychoeducation did not have an impact on P5's self-compassion as measured by the FCSRS, whereas CRG did appear to have a moderate positive impact.

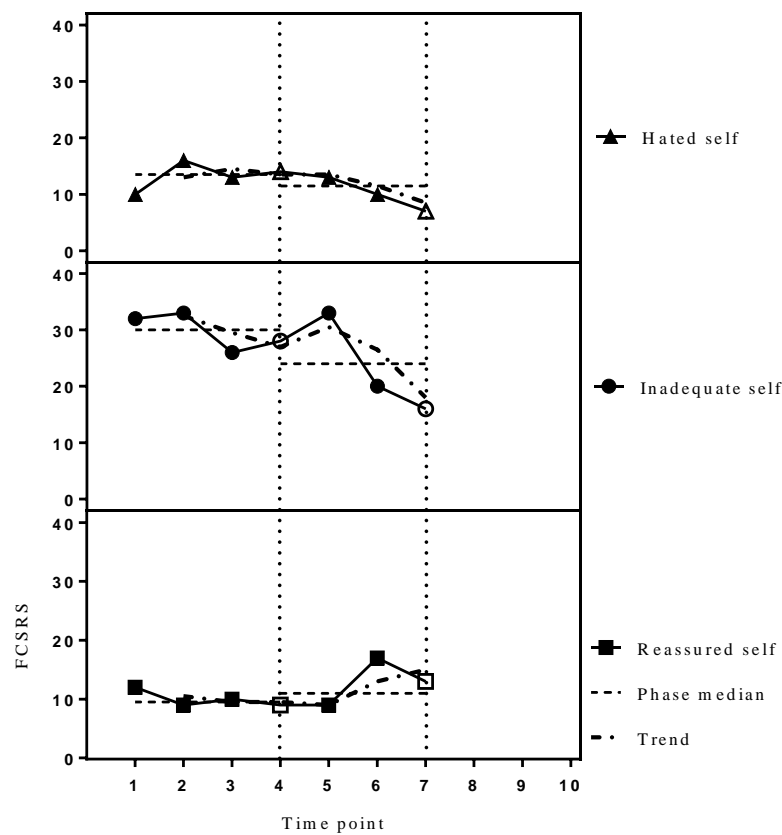


Figure 19: P5 FCSRS Subscales: Hated Self, Inadequate Self, Reassured Self

Overall for P5, the generic measures indicated that neither Psychoeducation nor CRG were associated with improved symptoms of depression, anxiety or overall functioning. Visual analysis of the PTSD, CPTSD and FCSRS scores suggested that

Psychoeducation also had little impact on these measures. However, the CRG did appear to have a moderate positive impact on PTSD, CPTSD symptoms and FCSRS scores. The delay that P5 experienced in starting individual treatment may have contributed to the deterioration in PTSD and CPTSD symptoms visible in that wait period.

### **Participant 6**

P6 was a 44-year-old woman who experienced physical, emotional and sexual abuse as a child, and was later in a relationship with a violent partner for 20 years. Her PTSD symptoms began in childhood but worsened following the murder of a friend ten years prior to assessment. She was suffering flashbacks, intrusive memories and nightmares, daily dissociative episodes, poor sleep and hypervigilance. She had some Obsessive Compulsive behaviours, generalised anxiety and depression, and unexplained joint pain. She was also having difficulties with relationships with others. She held herself responsible for some of the traumatic events and as a result she experienced guilt and held beliefs about being deserving of punishment and hatred. The participant had made suicide attempts in the past but had no current self-harm or suicidal ideation. Prior to treatment at BTSS she had had psychological therapy which did not focus on PTSD.

P6 engaged well with the Psychoeducation and CRG, although there were ongoing difficulties with housing and finances over this period. At the time of analysis she had had six sessions of individual therapy.

**Generic measures.** P6's scores on depression, anxiety and functioning measures are shown in Table 10. As P6 had not reached the mid-point of individual



treatment, no scores were available for time points 8-10. The data indicates that for the PHQ-9, GAD- 7 and WSAS P6’s scores did not reliably change from assessment to pre-individual treatment, indicating no overall improvement in general anxiety, depression or general functioning.

*Table 10: P6 PHQ-9, GAD-7 and WSAS scores*

	1	2	3	4	5	6	7				
	Assess	Pre-Psych	Post-Psych	Pre-CRG	Mid-CRG	Post-CRG	Pre-Indiv	Pre /Post	RC <sup>a</sup>	CSC <sup>a</sup>	Interpretation
PHQ-9	21	18	16	19	17	21	26	+5	N	N	Severe to severe
GAD-7	17	17	17	18	18	17	18	+1	N	N	Severe to severe
WSAS	31	32	29	33	32	28	34	+3	N	n/a	n/a

<sup>a</sup> *Reliable Change and Clinically-Significant Change calculated using Jacobson’s Reliable Change Index*

**Graphical analysis.** Results for the PCL-5, Complex PTSD items and FCSRS sub-scales scores are presented graphically in Figures 20, 21 and 22 respectively.

Figure 20 indicates that P6’s PCL-5 total score, which was 62 at assessment, did not improve overall, with the latest score at pre-individual treatment of 63. Visual analysis of the graph shows a very slight downwards trend during Psychoeducation, however these gains were lost during the wait period after (time point 4) and there was no change in trend during Phase 2. The lines of central tendency for Phase 1 and Phase 2 were very similar. It was not possible to draw conclusions about Phase 3 in the absence of any data beyond the start of individual treatment. Visual analysis of

this data suggests that Psychoeducation had a very slight effect on PTSD symptoms whereas the CRG had no effect, as measured by the PCL-5.

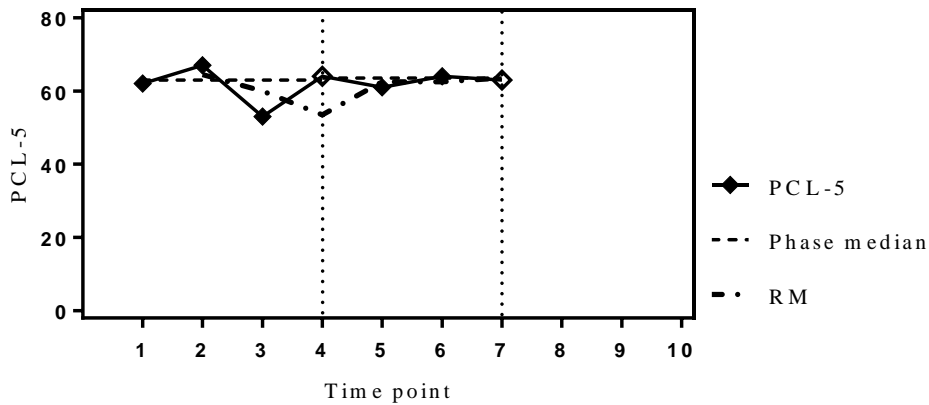


Figure 20: P6 PCL-5 Total Score

Figure 21 shows P6’s scores on the five ‘Complex’ symptom domains of CPTSD, most of which she rated highly throughout. The items measuring Beliefs, Emotional and Somatic symptoms showed a slight downwards trend (improvement) in symptom severity during Phase 1, followed by a stable or upwards trend (deterioration) during Phase 2. The phase lines and central tendency for Dissociative and Interpersonal symptom items showed that these symptoms stayed stable across both Phase 1 and Phase 2. Overall, visual analysis of P6’s data suggests that Psychoeducation may have been helpful for CPTSD symptoms, but the CRG did not appear to have any effect on symptom scores.

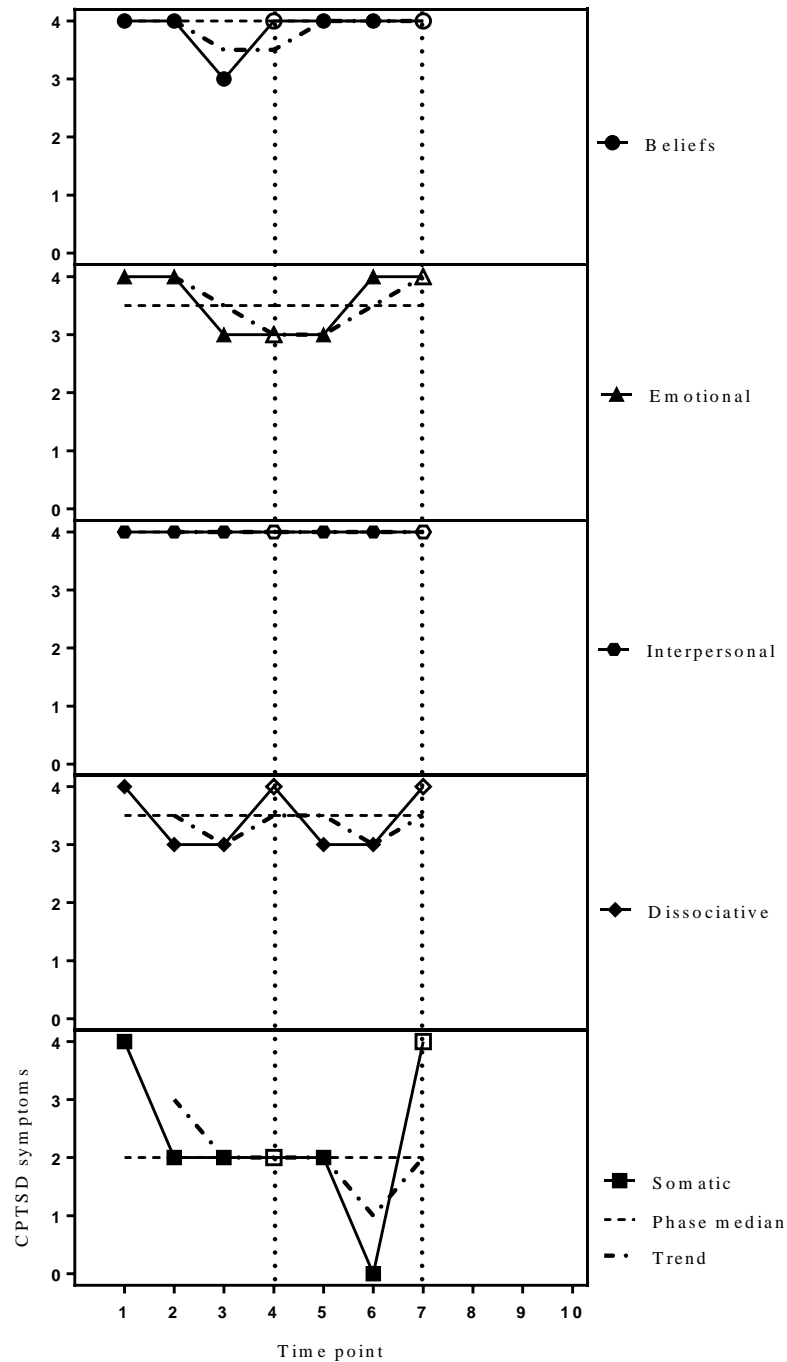


Figure 21: P6 Complex PTSD Symptoms (BTSS CPTSD items & PCL-5 Item 9)

Figure 22 shows P6's scores on the three subscales of the FCSRS. Visual analysis suggests there was little change in these scores across treatment phases, as indicated by the similar central tendency in Phase 1 and Phase 2 for all three subscales. The phase lines do indicate a very slight decrease in Hated and Inadequate

Self and increase in Reassured Self during Phase 1; however, these small gains were lost during the waiting period after Psychoeducation and before CRG (point 4). The trend line for Reassured Self also indicates a slight increase during Phase 2, although again the gains appear to have been lost in the waiting period after (point 7). This data provides limited support for the effectiveness of the Psychoeducation group and no support for the CRG building self-compassion and self-reassurance, despite the explicit emphasis of the CRG on building these capacities.

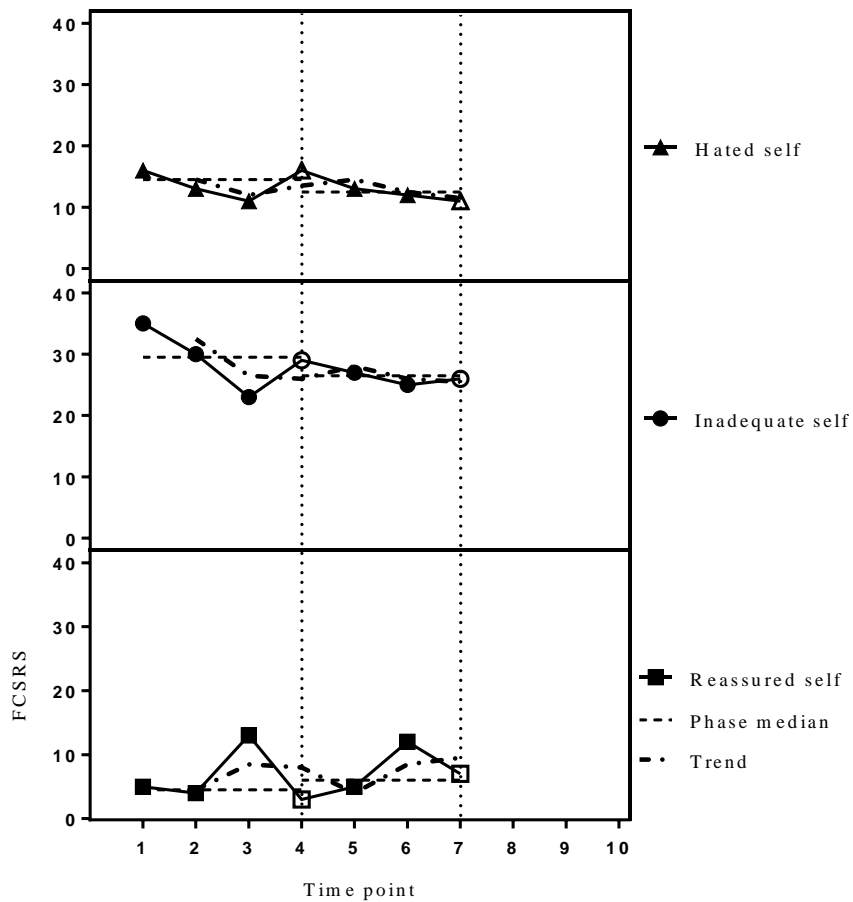


Figure 22: P6 FCSRS subscales: Hated Self, Inadequate Self, Reassured Self

Overall, P6's scores showed no change on generic measures or on PTSD symptoms. Little overall change was perceptible in the graphical analyses on any measures. Some very slight improvements in CPTSD and FCSRS ratings during Phase 1 may suggest that Psychoeducation was helpful; however, in many cases these gains were lost in the wait period after. There was little support for the effectiveness of the CRG on any measures. According to these results, P6 did not appear to have benefited significantly from the treatment programme at the latest available data point, although her scores may have been impacted by external stressors (housing, finances) that she was experiencing.

### **Participant 7**

P7 was a 48-year-old White British woman who experienced an emotionally, physically and sexually abusive relationship lasting four years, which involved threats to rape and kill. She suffered injuries and attempted suicide before managing to leave the relationship 18 months prior to assessment at BTSS. Her PTSD symptoms included hypervigilance, panic, dissociative episodes and a heightened sense of threat. She had had episodes of low mood and periods of being unable to work. She also described difficulty trusting others and feeling cut-off from others, as well as somatic complaints. She held negative views of herself, with high levels of shame and self-criticism. At the time of the assessment a court case regarding her ex-partner was pending.

For P7, Psychoeducation and CRG coincided with her ex-partner's trial and sentencing, and as a result she missed a couple of sessions of both treatment groups. At the time of analysis she was due to begin individual treatment.

**Generic measures.** P7's scores on measures of depression, anxiety and functioning are shown in Table 11. As P7 had not reached the pre-individual treatment point, no scores were available for time points 7-10. The data indicates that from assessment to post-CRG P7's depression and anxiety scores showed clinically-significant improvement, and on the WSAS, P7 showed reliable improvement.

*Table 11: P7 PHQ-9, GAD-7 and WSAS scores*

	1	2	3	4	5	6				
	Assess	Pre-Psych.	Post-Psych.	Pre-CRG	Mid-CRG	Post-CRG	Pre /Post	RC <sup>a</sup>	CSC <sup>a</sup>	Interpretation
PHQ-9	14	20	12	7	11	1	-13	Improve	Y	Moderate to <clinical
GAD-7	16	19	18	8	13	1	-15	Improve	Y	Severe to <clinical
WSAS	30	30	20	20	24	8	-22	Y	n/a	n/a

<sup>a</sup> *Reliable Change and Clinically-Significant Change calculated using Jacobson's Reliable Change Index*

**Graphical analysis.** Results for the PCL-5, Complex PTSD items and FCSRS sub-scale scores are presented graphically in Figures 23, 24 and 25 respectively.

Figure 23 shows P7's PCL-5 total score, which was 62 at assessment and reduced considerably to 16 at post-CRG. Visual analysis of Figure 23 indicated that this reduction occurred over both Phases 1 and 2, suggesting that both Psychoeducation and CRG were helpful in alleviating PTSD symptoms. Some deterioration in symptoms was visible after the wait between Phases 1 and 2 (time point 4).

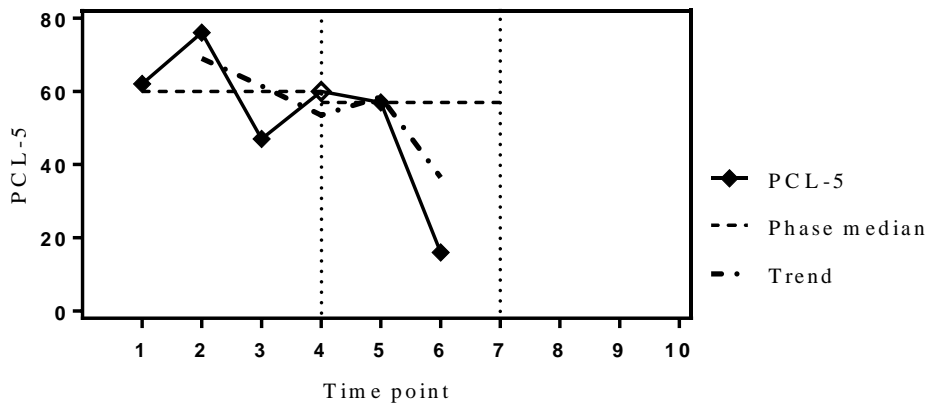


Figure 23: P7 PCL-5 Total Score

Figure 24 shows P7’s scores on the five ‘Complex’ symptom domains of CPTSD. In Phase 1 visual analysis revealed a trend of improvement in Beliefs, Emotional and Interpersonal symptoms. For Dissociative and Somatic symptoms there was overall deterioration in Phase 1, however the graph indicated that this was attributable to deterioration in the wait between assessment and Psychoeducation (time point 2), and in fact the Dissociative item did show improvement during Psychoeducation. All five symptoms showed reductions in Phase 2, suggesting that the CRG had a positive impact on CPTSD symptoms.

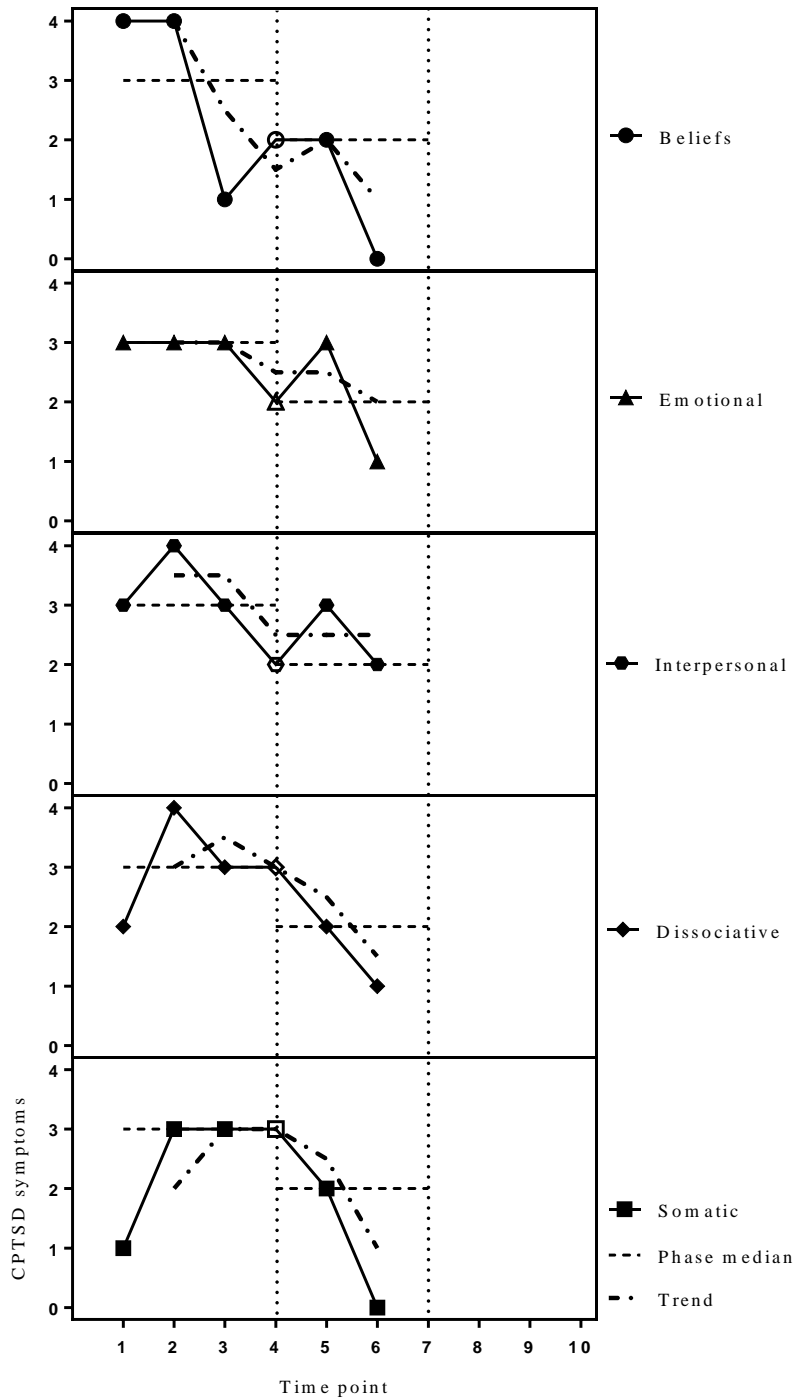


Figure 24: P7 Complex PTSD Symptoms (BTSS CPTSD items & PCL-5 Item 9)

Figure 25 shows P7's scores on the three subscales of the FCSRS. The trend lines on all three subscales have similar trajectories showing slight improvement (reductions in Hated Self and Inadequate Self; increase in Reassured Self) in Phase 1, and steeper improvement during Phase 2. This suggested that both Psychoeducation



and CRG were helpful, but the CRG was most effective for P7 in reducing self-criticism and increasing self-reassurance.

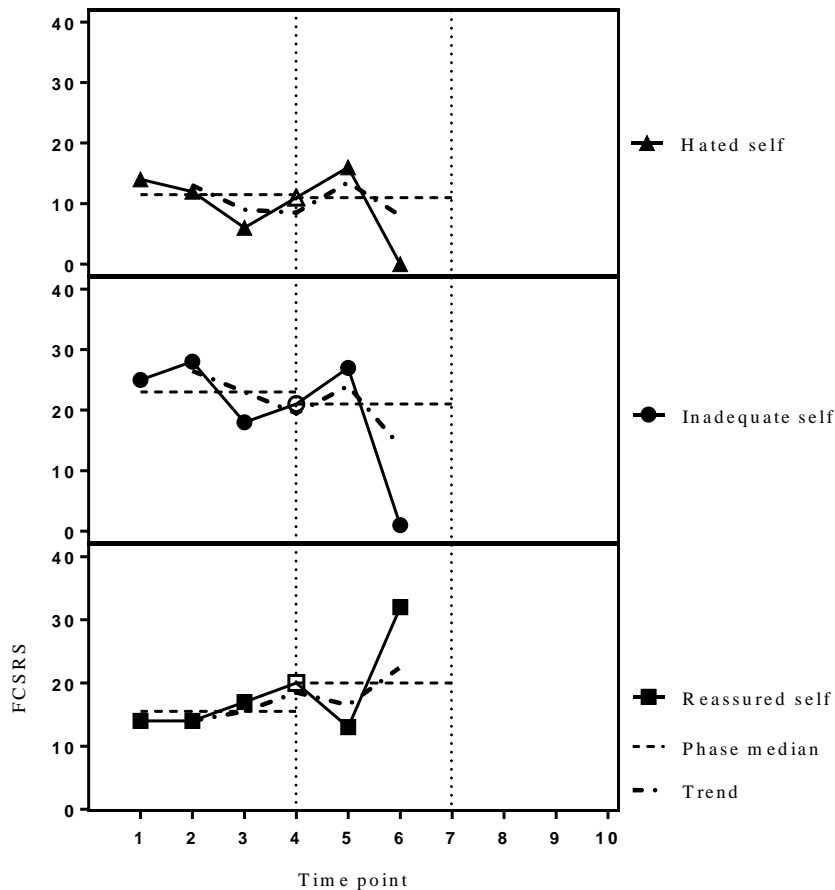


Figure 25: P7 FCSRS Subscales: Hated Self, Inadequate Self, Reassured Self

Overall, both Psychoeducation and CRG appeared to be associated with reductions in P7's PTSD, CPTSD and self-criticism / self-compassion scores, with the CRG phase showing the most marked changes in self-criticism and self-compassion, which is consistent with its explicit focus on building self-compassion. There was no data available beyond time point 6 therefore it was not possible to judge whether gains made during the CRG were lost or sustained in the wait period after.

## **Participant 8**

P8 was a 23-year-old woman who was sexually assaulted as a teenager, and subsequently suffered a controlling and physically abusive relationship for 5 years. After separating from her partner she experienced continued harassment by him. P8 was suffering from frequent nightmares about the abuse, intrusive thoughts and feeling anxious and hypervigilant. There was also considerable self-criticism and self-blame for not leaving the relationship sooner, and the potential impact of the relationship on her child.

P8 attended all sessions of the Psychoeducation group and of the CRG. She was obliged to have contact with her abusive ex-partner during this period and legal processes were ongoing, which was a source of additional stress. At the time of analysis P8 was due to begin individual treatment.

**Generic measures.** P8's scores on depression, anxiety and functioning measures are shown in Table 12. As P8 had not reached the pre-individual treatment point, no scores were available for time points 7-10. The data indicates that P8's scores for depression and anxiety showed reliable change, whereas the WSAS did not show reliable change in functioning.

Table 12: P8 PHQ-9, GAD-7 and WSAS scores

	1	2	3	4	5	6				
	Assess.	Pre-Psych.	Post-Psych.	Pre-CRG	Mid-CRG	Post-CRG	Pre /Post	RC <sup>a</sup>	CSC <sup>a</sup>	Interpretation
PHQ-9	20	15	16	19	13	14	-6	Improve	N	Severe to moderate
GAD-7	19	14	13	15	10	8	-11	Improve	Y	Severe to mild
WSAS	16	19	17	20	13	13	-3	N	n/a	n/a

<sup>a</sup> *Reliable Change and Clinically-Significant Change calculated using Jacobson's Reliable Change Index*

**Graphical analysis.** Results for the PCL-5, Complex PTSD items and FCSRS sub-scale scores are presented graphically in Figures 26, 27 and 28 respectively.

Figure 26 shows that P8's PCL-5 total score reduced from 66 at assessment to 40 at post-CRG. Visual analysis of the trend showed a gentle decrease in PCL-5 score in both Phase 1 and 2, although the Phase 1 gains are offset by deterioration during the wait between Phase 1 and 2 (time point 4). There was not yet data available at time point 7 to judge whether Phase 2 gains were lost or sustained in the wait period after. Overall both Psychoeducation and CRG appear to have had a moderate positive impact on PTSD symptoms.

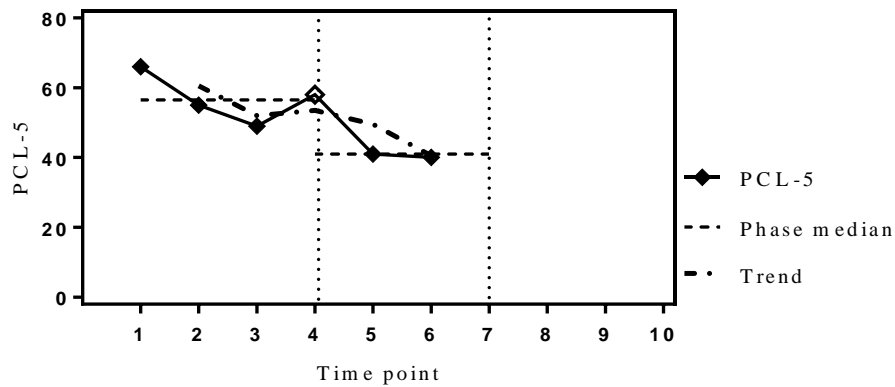


Figure 26: P8 PCL-5 Total Score

Figure 27 shows P8's scores on the five 'Complex' symptom domains of CPTSD. Visual analysis of the five symptom items revealed different patterns of change. Emotional, Interpersonal and Dissociative symptoms all showed improvement from Phase 1 to Phase 2 indicated by lower lines of central tendency in Phase 2 than Phase 1. For these symptoms the trend lines indicate there was no symptom reduction in Phase 1 but there was in Phase 2. Beliefs and Somatic symptoms showed overall deterioration from Phase 1 to 2, according to the line of central tendency, with the trend lines revealing that most deterioration occurred in the wait period after Psychoeducation. Therefore, for P8 Psychoeducation appeared to be helpful only for Beliefs, and CRG appeared to be helpful for Emotional, Interpersonal and Dissociative symptoms.

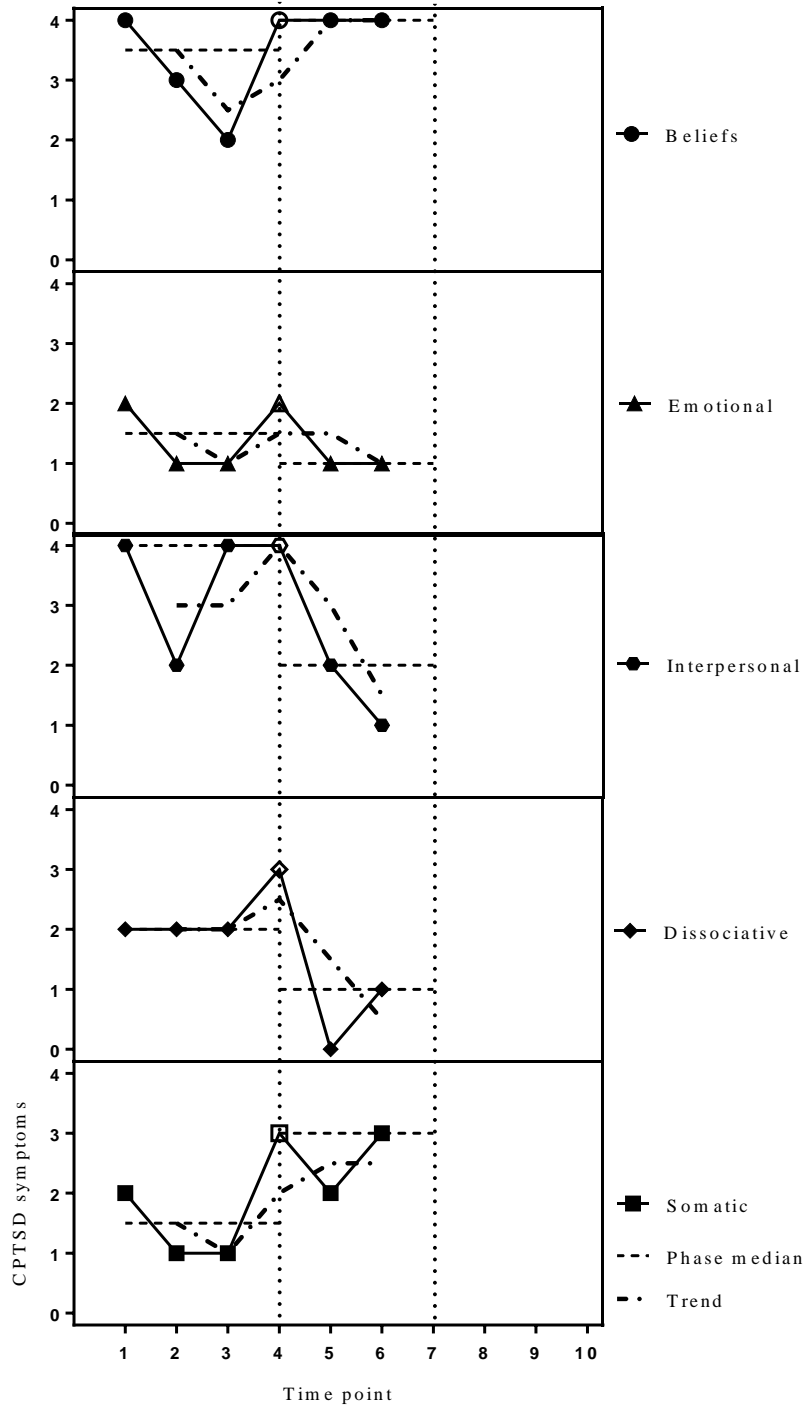


Figure 27: P8 Complex PTSD Symptoms (BTSS CPTSD items & PCL-5 Item 9)

Figure 28 shows P8's scores on the three subscales of the FCSRS. Visual analysis of the graphs suggested little change across Phase 1 and 2, with no change in the lines of central tendency. The trend lines indicate a very slight, negative direction

of change (increases in Hated and Inadequate Self, decreases in Reassured Self) in Phase 1, and a slight positive trend in Phase 2. Overall, P8's data offered little evidence for the effectiveness of Psychoeducation in reducing self-criticism or increasing self-reassurance, but some limited evidence for the effectiveness of the CRG.

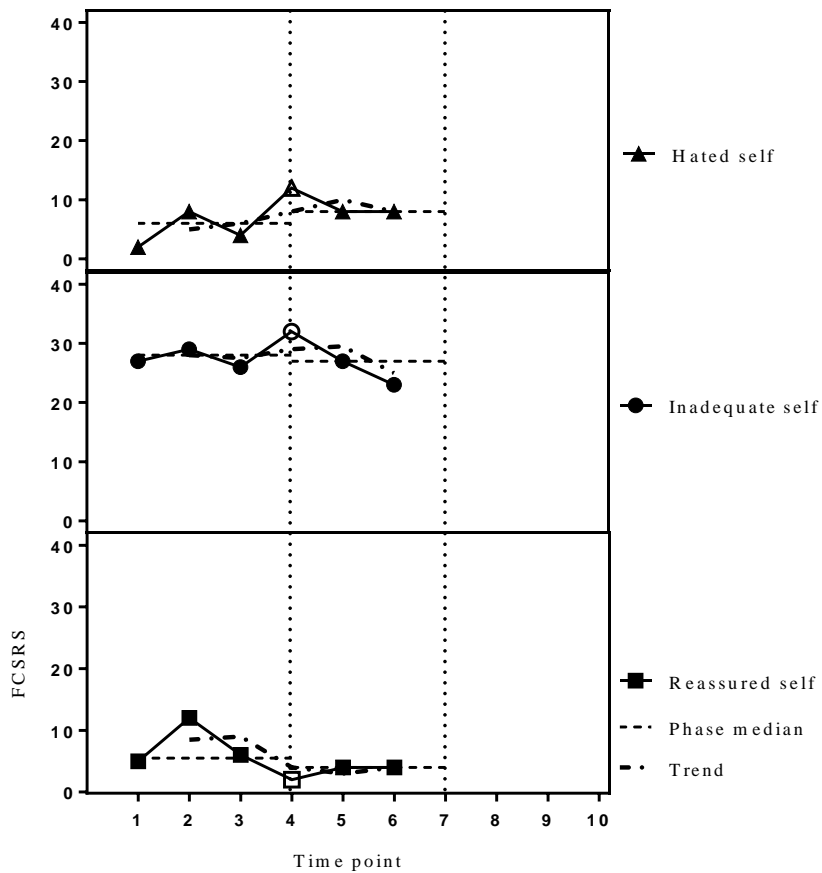


Figure 28: P8 FCSRS Subscales: Hated Self, Inadequate Self, Reassured Self

Overall for P8 it appeared that Psychoeducation may have been helpful for alleviating PTSD symptoms, but not for CPTSD or self-compassion. CRG appeared to be helpful for PTSD and some CPTSD symptoms as well as for increasing self-

compassion. There was no data available beyond time point 6 so it was not possible to say whether improvements in the CRG would be sustained in the wait period after.

### **Participant 9**

P9 was a 43-year-old White British woman who experienced sexual abuse between the ages of 10 and 14, and as an adult was subjected to an emotionally and physically abusive relationship lasting 21 years. Additionally, four years prior to assessment at the BTSS she also suffered a violent attack resulting in permanent injury. She was suffering with intrusions to this attack, to the domestic abuse, and to the sexual abuse in childhood. She was struggling with low mood and described herself as shutting herself away from the world. She felt lacking in confidence, had self-critical thoughts and said she had lost a sense of “who I am”. P9 had a history of self-harm and a suicide attempt, as well as a recent incident of self-harm. She was taking an SSRI, a tricyclic antidepressant and pain medication. She was experiencing ongoing difficulties with housing at the time of assessment.

At the time of analysis P9 had completed both Psychoeducation and CRG with only one session of each missed, and was awaiting individual treatment.

**Generic measures.** P9’s scores on depression, anxiety and functioning measures are shown in Table 13. As P9 had not reached the pre-individual treatment point, no scores were available for time points 7-10. Due to incomplete questionnaires there was only partial data at the pre-Psychoeducation point and no data at the pre-CRG point. The data available indicates that overall, P9’s scores for depression, anxiety and functioning did not change reliably.

Table 13: P9 PHQ-9, GAD-7 and WSAS scores

	1	2	3	4	5	6				
	Assess.	Pre-Psych.	Post-Psych.	Pre-CRG	Mid-CRG	Post-CRG	Pre /Post	RC <sup>a</sup>	CSC <sup>a</sup>	Interpretation
PHQ-9	15	16	12	-	11	17	+2	N	N	Mod. severe to mod. severe
GAD-7	9	16	7	-	8	13	+4	N	N	Mild to moderate
WSAS	19	22	22	-	17	22	+3	N	n/a	n/a

<sup>a</sup> *Reliable Change and Clinically-Significant Change calculated using Jacobson's Reliable Change Index*

**Graphical analysis.** Results for the PCL-5, Complex PTSD items and FCSRS sub-scales are presented graphically in Figures 29, 30 and 31 respectively.

Figure 29 indicates that P9's PCL-5 total score reduced from 51 at assessment to 37 at post-CRG, and the line of central tendency indicates lower scores in Phase 2 than Phase 1. However, missing data at both pre-Psychoeducation and the pre-CRG point means caution must be applied in interpreting the relative impact of the two treatment groups. From the available data it appears that there was an improvement in PTSD score from assessment to post-psychoeducation, and that there was deterioration in PTSD symptoms during the second half of the CRG, but there was no data for the first half.



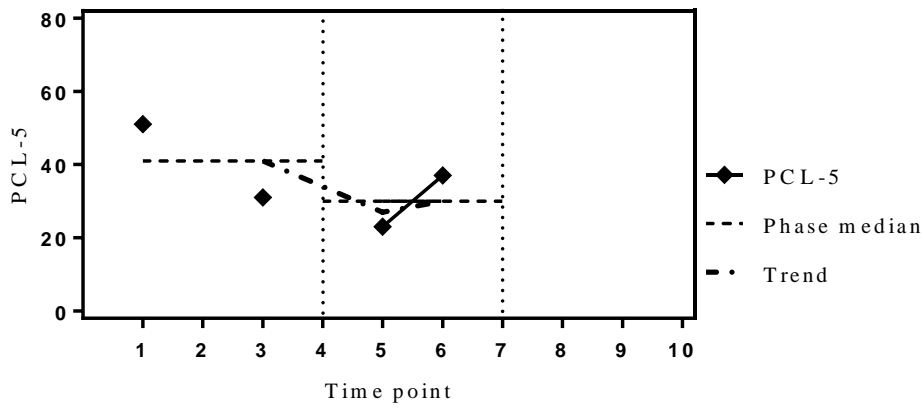


Figure 29: P9 PCL-5 Total Score

Figure 30 shows P9’s scores on the five ‘Complex’ symptom domains of CPTSD. Again, caution must be applied in interpreting the graphs due to missing data. Comparisons of the assessment and post-CRG point indicate that the first two phases of treatment overall produced a slight reduction in Beliefs and Somatic symptoms, no overall change in Interpersonal and Dissociative symptoms, and a worsening in Emotional symptoms.

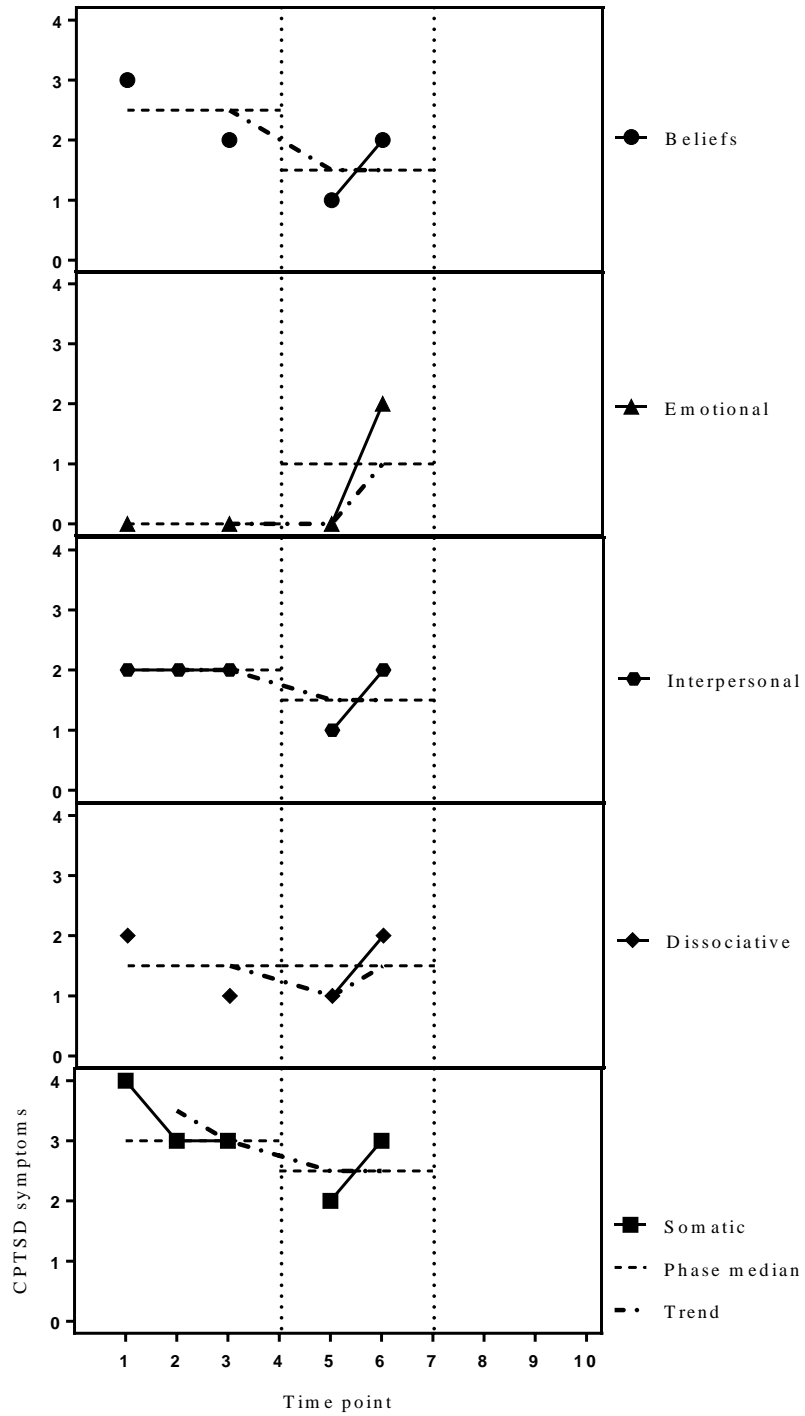


Figure 30: P9 Complex PTSD Symptoms (BTSS CPTSD items & PCL-5 Item 9)

Figure 31 shows P9's scores on the three subscales of the FCSRS. All three subscales show little change from Phase 1 and 2 according to the lines of central tendency, and the trend lines too show minimal change. The available data for P9 is

insufficient to provide evidence for the effectiveness for Psychoeducation or CRG in improving self-compassion.

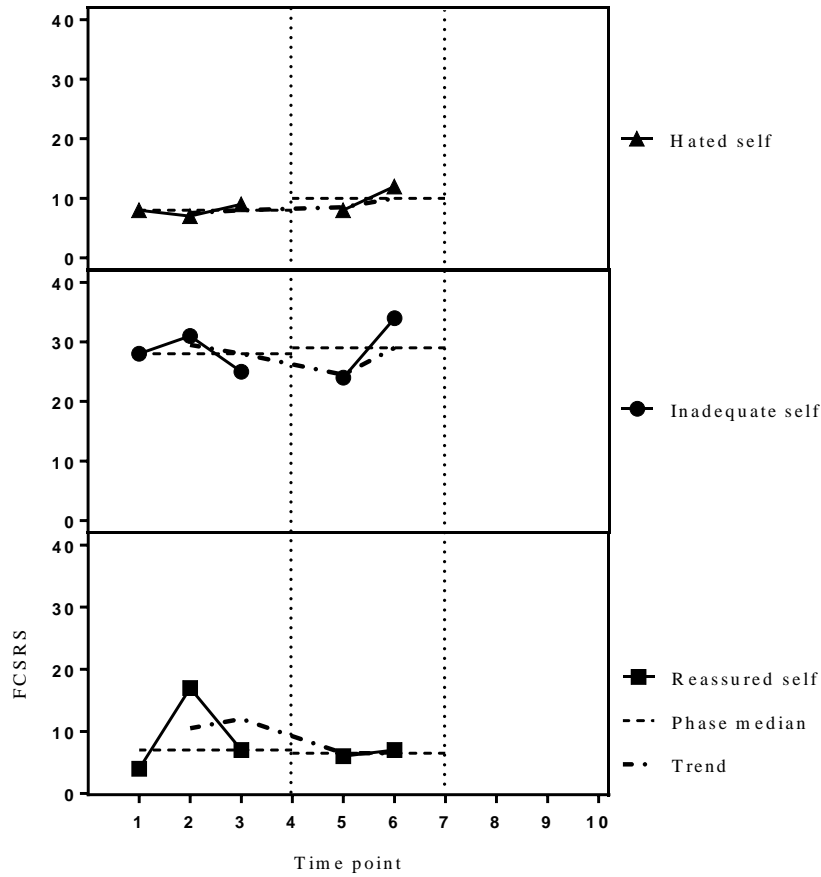


Figure 31: P9 FCSRS Subscales: Hated Self, Inadequate Self, Reassured Self

Overall the available data for P9 indicated that the two phases, Psychoeducation and CRG, taken together, did not have much of a positive impact on generic measures or on CPTSD or FCSRS scores, but they were associated with moderate improvements in PTSD symptoms. Missing data made it impossible to extrapolate any differences in impact of Psychoeducation and the CRG.

**Summary.** The findings of the case series illustrated the differential responses of nine participants undergoing the same treatment programme. The majority of participants showed some areas of improvement over the course of treatment, with P6 the only non-responder in any phase on the PCL-5 and the generic measures, though she did show some improvement in self-compassion. It may be relevant to note the considerable co-morbidity that this participant presented with (OCD and generalised anxiety symptoms additionally to CPTSD), as well as the extreme chronicity of her traumatic experiences, which included abuse in childhood, IPV spanning twenty years in adulthood, and a traumatic bereavement.

Although all other participants showed improvement on at least some measures, pre-post analysis of PTSD symptoms indicated that some participants (P1, P2, P3, P7, P8) made reliable, clinically-significant improvement while others did not (P4, P5, P6, P9). There did not appear to be any specific trauma background characteristics that marked out the higher responders from the lower responders. Longitudinal data presented graphically revealed that participants experienced differential changes in symptoms in differing phases of treatment. These differences, which are apparent at an idiographic level, would risk being obscured at a group-wise level of analysis.

## Chapter 4: Results of Thematic Analysis

A second, qualitative analysis was carried out consisting of a thematic analysis of interviews with a further six participants, all of whom had completed all three phases of the treatment programme. See Table 14 for participant characteristics. Participants were between 22 and 52 years old (mean = 41.5) and had completed the treatment between one week and five months prior to the interview (mean = 8 weeks).

*Table 14: Thematic Analysis Participant Characteristics*

ID	Sex	Age	Trauma type	Time since completing treatment
10	F	48	Child physical and emotional abuse. Violent sexual attack in adulthood in context of intimate partner violence.	1 week
11	F	22	Child physical abuse and witnessed violence. Sexual assault 2 years ago by multiple perpetrators.	5 months
12	F	52	Child sexual, physical abuse and torture by multiple perpetrators.	1 week
13	F	50	Two sexual assaults by same perpetrator, 3 years ago.	4 weeks
14	F	35	Sexual assault at age 13 and intimate partner violence in adulthood in several relationships, one occasion resulting in miscarriage.	6 weeks
15	M	42	Child sexual, emotional and physical abuse from age 2.	3 months

Complete transcripts of all six interviews were included in the thematic analysis. The analysis was conducted according to the six-phase procedure set out by

Braun and Clarke (2006) for thematic analysis, and adhering to the 15-point checklist of criteria that the authors propose for good thematic analysis. The data were transcribed using a simple orthographic notation which is recommended for thematic analysis since it does not require the same level of detail in the transcript as discourse or narrative analysis (Braun and Clarke, 2006). Immersion in the data began during transcription and with repeated readings of the data corpus. Coding and recoding was facilitated by using the qualitative analysis software package Atlas Ti.6. Within Atlas Ti.6 each interview transcript was assigned to a separate primary document within the hermeneutic unit. See Appendices K and L for samples of coded transcripts.

The analytic process was theoretically-driven, meaning that the researcher was reading for interesting meanings and patterns specifically relating to the acceptability of the treatment programme. This approach to thematic analysis is recommended for answering a specific research question and providing a detailed account of a specific aspect of the data corpus, rather than an inductive approach which aims to code freely without any pre-existing coding frame or theoretical stance (Braun and Clarke, 2006). The analysis was semantic, in that, unlike, discourse analysis, the analysis did not seek to theorise about underlying conceptualisations or ideologies; language was assumed to straightforwardly reflect participants' meaning and experience.

The data corpus was actively read, searching for interesting meanings and patterns relating to participants' experience of treatment, and was coded in a systematic fashion, collating codes into candidate themes. These themes were checked across the data set and refined until they were considered an accurate reflection of the meanings evident in the entire data set.

The analysis yielded two main, overarching themes in the data relating to the acceptability of the treatment programme: ‘Experience of group treatment’ and ‘Experience of phase-based treatment’. These themes and their sub-themes are described and illustrated using extracts from interview transcripts.

### **Experience of Group Treatment**

All participants talked about their experience of treatment delivered in a group format. Participants tended not to distinguish between the experience of being in a group for Psychoeducation and the experience of being in a group for the CRG. Within this theme the following three sub-themes were identified: ‘Group as “the biggest anxiety”’, ‘Group as “helping each other out”’, and ‘Group “makes you feel normal”’.

**‘Group as “the biggest anxiety”’.** This sub-theme was identified in participant’s descriptions of their expectations and fears before starting the treatment programme, and related to the group format being, for many participants, an off-putting element to the treatment; for some, the most off-putting element. In all cases, however, it was described as an anticipatory worry which did not materialise. This sub-theme is illustrated by the following extracts from interview transcripts:

*“I think it’s fair to say that we were all really scared, to say the least, in walking in and all sort of sitting around each other” (P11, para. 22)*

*“I mean I was, in the beginning I was really quite apprehensive about that, you know, other people being there, but no, it worked well for [phase] one and two I think.” (P13, para.65)*

For many participants the anxiety about being in a group was related to a fear of judgement from other group members, as in the following extract:

*“I had concerns about opening up, and um worrying about what I would have to talk about, what had happened to me, or how I felt, and about people judging me, both the consultants and the other people being in the group, so I think the biggest anxiety was meeting the other people in the group and what they would think, but actually when you meet the people in the group you’re not talking about yourselves at all” (P12, para. 9)*

The risk of judgment for most participants, like P12, was rooted in a fear of being judged negatively by other group members for features of their personal lives or trauma history. For one participant with a history of intimate partner violence, the fear of being judged also related to being judged as non-deserving of the treatment:

*“I thought oh crap, here we go again, everyone’s going to go ‘you’re a bloody fraud, you could have just walked away, why didn’t you do this’, and you know that, that was a big fear that someone was going to turn round and almost tell me off for being there. R: And did anything like that happen? P14: No, no! [laughs]” (P14, para.43)*

The same participant later described how this anxiety about disclosing her trauma history to other group members was overcome with time:

*“We didn’t need to go into anything specific, um, I think some of us did occasionally, very broadly speaking we went into things, but again I started to get over that fear of people judging me as much, and started to actually open up a little bit about it in the group, and yeah I mean, the other women all seemed to jump on the*



*bandwagon of going 'no, of course you deserve to be here' and stuff like that which helped massively." (P14, para. 73)*

Several participants, as for P12 and P14 above, talked about how their pre-treatment fears of being judged by others in the group did not materialise partly because personal disclosure of trauma history in the group was restricted by pre-agreed group boundaries and managed carefully by facilitators; the importance of this was illustrated in the following two extracts:

*"There was still confidentiality there as well, because as much as we all got really close we all actually didn't know exactly what that other person went through, so that was still quite nice because you didn't know what they were going to think about you if you were going to be embarrassed over it or anything" (P11, para.35)*

*"I think once we established like from the very very first moment we established that we're not actually there to talk about anything that's happened to us, that made it a lot easier." (P14, line 19)*

In addition to fear of judgement from others, another concern about the group format mentioned by some participants was the potential negative impact of having to hear others' disclosures, as in the following extract. Again, this issue was seemingly managed by limiting disclosure about traumatic experiences within the group.

*"I think it's just the anxiety of realising, uh, worrying what other people think and I think it will be that that stops people going to it, because you're going to a group and you're thinking that you're going to be there hearing about other peoples' awful stories and you won't cope with listening to that... and you don't know what to do because you're not a practitioner so you can't support them or give them any help,*

*but it's absolutely nothing like that... because if you're listening to other peoples' stories and you're already weighed down with what's happened to you, you could then, um, it could tip the balance with you because you're not able to do anything to help them.” (P12, para.13)*

This theme highlights how anxiety-provoking the group format can be for clients before starting treatment, and illustrates some specific concerns that clients may have. However, it also indicates that most of the concerns raised by the participants about group treatment were adequately addressed through the careful setting up and facilitation of the group in relation to self-disclosure.

**‘Group as “helping each other out”’.** This second sub-theme relates to participants’ descriptions of how members of the group would help each other, both within sessions and outside of sessions. Some participants talked of being helped by others in the group, some of helping others, and some of both. Two of the ways in which participants described being helped by others in the group in a co-therapist type of role was by generating new ideas and more compassionate perspectives for each other, as in the following two extracts:

*“And the fact it was done in a group, you helped each other in different situations because you all have gone through different things but you can all sympathise and have empathy, and maybe see around, a way that somebody can probably do something different. And I think that that was the biggest thing in the group, for me.... again it was helping each other out in situations that arose in everybody's week”. (P10, para. 9)*

*“It started me on the path of trying... to stop listening to that negative voice and to try and get a more positive one in my head. It started that process. And even though it wasn't my voice I could hear the voices of the other girls in the room telling me that I was, you know, that I wasn't allowed to speak to myself in that way and stuff, so, it did help in that regard, it gave me a different internal dialogue even though it wasn't mine!” (P14, para.79)*

These examples illustrate an advantage of group format over individual format, in that it offers more peoples' perspectives than individual therapy can. Another participant spoke of being helped by the presence of others in the group because they, by having some commonality of experience, were able to give a voice to some of her own, more difficult to articulate, thoughts:

*“As the weeks went on and we got to know one another, um, things that other people were saying, you know, I may have been thinking that, and wanting to speak, but didn't want to speak, and then somebody else would say it for me, and I would think ‘well, I was going, I wanted to say that’ but my mouth wouldn't open and the words wouldn't come out. So, yeah, they were, we were all on the same wave band and thinking more or less the same things.” (P13, para.33)*

Another participant talked about the way in which group members would offer each other comfort during difficult sessions, an experience which she described as simultaneously ‘horrible’ and working ‘really, really well’.

*“It was horrible sitting back and watching somebody that you have grown close with getting really upset, but at the same time you were kind of happy that you were there so that when they were going through that, getting their flashbacks or*

*anything, that you were comforting them. I think they also really wanted that comfort as well. So all in all it worked really, really well.” (P11, para.24)*

This extract points to the fact that helping others in the group was positive overall but could also be experienced as a responsibility. Whilst the above extracts are examples of group members helping each other within sessions, several participants also described the group members helping each other by providing support outside of treatment sessions, as illustrated by the following two extracts:

*“Um, and being in a group as I said on the weeks that we couldn’t have a session we were all meeting up and trying to be there for each other as much as we could, and no, I think that made a massive difference, it made us have that sort of camaraderie between us a bit which was good.” (P14, para. 73)*

*“We all used to go out to a coffee shop afterwards and sit and have coffee together and just, laugh it off you know, especially if it was a really upsetting session then we’d all have a nice hot chocolate and just sit and try and giggle it all off.” (P11, para. 35)*

It appears that for Participant 11 the social element offered by the group acted as a sort of cathartic ‘bridge’ between the emotional intensity of the treatment sessions and the outside world. The social aspect of the group was clearly important to several participants. As the following extract indicates, this tended to develop gradually over a few sessions:

*“We all got on pretty well and it, you know, after a few weeks we all started to talk and chat and before we went in you know the class we would be chatting outside, so it was quite nice having other people in the group.” (P13, para.65)*

This sub-theme therefore demonstrates the varied ways in which participants experienced the group as helpful, inside and outside of sessions, both in terms of therapeutic support, and in terms of providing social relationships that are sometimes lacking for people with CPTSD.

**‘Group “makes you feel normal”’.** This sub-theme related to the ways in which participants said being part of a group helped to change their view of themselves, their emotions or their symptoms, in a normalising way. The following extract illustrates how the other group members made one participant feel differently about his own emotions, and that this in turn changed how he saw himself:

*“R: What do you think made the groups a bit more helpful for you than individual work? P15: Um, sharing each other’s emotions and their troubles, because you feel so isolated, you honestly feel that you are the only one on this planet with all these problems, you know, that’s how it makes you feel, you know, and when you hear other people’s stories, and see how angry and emotional they are, you know, it makes you feel, you know, it’s difficult for you to understand, but, it kind of makes you feel normal. You know, it makes you feel like, I’m not going crazy, I’m not an alien, you know, I’m not the only one in the world with this, you know.” (P15, para. 105)*

This participant points to both the emotional dysregulation and negative beliefs about the self that are characteristic of CPTSD, but also the isolating experience of having mental health problems, and how a group can alleviate this isolation and make you feel more ‘normal’. Another participant talked about the importance of being treated with respect by other group members, as well as the experience of having her own emotions validated by others:

*“I think we all had that same respect because we all came here knowing that we’ve all suffered and that it’s hard. So just that respect that was shown, not just through the facilitators but everybody involved. So the respect and validating your emotions was good.” (P10, para.27)*

The significance to P10 of being treated with respect by other group members perhaps points to previous experiences of not feeling respected by others, or not feeling worthy of respect. This may be related to having experienced abusive relationships, or to the societal stigma that people with chronic mental health difficulties often experience. The following participant talked about how meeting other people who had similar struggles with mental health helped her to feel less ashamed of her own difficulties, after a lifetime of stigmatisation:

*“And yeah, just having the reassurance that there were other people going through it as well, that you’re not on your own, because everything prior to that point had always been very hushed up, and you know, I’m nearly [age] for god’s sake and I started in mental health when I was twelve, you know, and it was the dirty family secret, you know. And this just made it open, and the fact that there were other people sat there with me and, you know, some of them were my age, some of them were younger than me, but I think we’d all to some extent experienced that ‘oh it’s a dirty secret and you’re on your own and you’ve got to cope with it on your own and you’ve got to be silent about it’. (P11, para.29)*

The same participant went on to talk about how being amongst others who had had similar experiences allowed her to be freely herself in a way she couldn’t with people outside of the group without fear of being seen as mad:

*“It was something to actually really look forward to because in our own heads, you know, especially with our family and friends who are closest to us that knew us all thought to a certain extent that we were a bit cuckoo, and uh, [laughs], having that one time a week where we could actually thoroughly be ourselves was probably the highlight of everyone’s week.” (P11, para.35)*

This sub-theme therefore demonstrates how powerful the experience of being in a group could be, perhaps particularly for those who carried strong negative beliefs about themselves or about their mental health, and how being enabled to feel more ‘normal’ and acceptable was an important part of the treatment in its own right.

### **Experience of Phase-based Treatment**

This theme described participants’ experiences of the structure of the treatment programme as a whole, the sequential design, and the relationships between the three phases. Two sub-themes were identified: firstly, ‘Phases “work as a package”’, and secondly, “Whipping off the band-aid” – the difficulty of wait periods’.

**Phases ‘work as a package’.** This theme related to participants’ perceptions that all three stages of the treatment were complementary, or that there was a sense of progression across the phases and that this made sense to them. Several participants expressed the view that they didn’t feel the treatment would work without all three phases, as in the following two extracts:

*“R: And, overall, with the three phases, do you have a sense of which one was the most useful for you? P15: No, I wouldn’t just pick one because I think it works as*

*a package. If you took one out, I don't think it would work. I think you kind of need all of that, to make it work." (P15, para.157)*

*"I don't think you could recover in the way that I recovered, and I have really recovered, you know, I don't have any nightmares any more, I don't suffer from anxiety in the way I did, you know, I just don't have the symptoms I had before. So, that wouldn't have worked if I hadn't done all three phases.... Each phase was very different to the other, so there was a little bit of similarity or understanding the second phase with the first phase, you'd think 'Oh I learnt that, I understand that now' but I can't imagine how you could do it any other way. It was very, very thorough, and very, very effective." (P12, para.48)*

This sense of each phase offering something different was echoed in the following extract, where a participant articulated very clearly what she felt each phase had uniquely offered:

*"R: And do you think any of the phases were more helpful than the others, would you say? P13: Um, well for me personally the first one because the understanding of an illness was helpful. And the second, yeah, all of it the same I suppose, yeah the second one was helpful because I learned not to blame myself for what happened, and the third one because I spoke out and said something that I really needed to say. So to me they all, yeah there was something in each of them that did help me." (P13, para.96)*

Many participants talked about the sequential nature of the phases of treatment, whereby they felt that the order of the phases was appropriate and meaningful. In the following extract the participant compares this to learning to read by learning the



alphabet first, giving a strong sense of the treatment as building in complexity across the phases:

*“The first phase, you couldn’t have done any of it without doing it, you had to do the first phase to do the second phase to get to, to get what you needed to out of the second phase, um. I can’t remember any of it in detail, but just one automatically went onto the other. It’s like learning to read and write without learning the alphabet, you couldn’t do it” (P12, para.19)*

In the following extract P14 describes how the first phase of treatment, Psychoeducation, helped her in the second and third phases by helping her to identify new ways of coping with traumatic memories, and to reduce less helpful coping strategies:

*“But definitely me understanding my symptoms more helped me protect myself a bit more when it did come to the second stage and the third phase when I actually started bringing up a lot more old memories and stuff like that, having that protection of understanding ‘well yeah, if I wear pyjamas in bed I’m going to feel safe’, ‘if I do this I’m going to feel better’, and um, you know. And it helped me make a decision as well that, during that period I went ‘right, I’m going to take my drinking in hand because obviously this isn’t making it any better’ ... yeah it definitely helped quite a lot I think because it sort of set down the foundations for me being able to then go to the next point. (P14, para.55)*

A number of participants talked about the treatment being sequential specifically in terms of how the earlier two phases had helped them in preparing for Phase 3, individual trauma-focused therapy, by developing the resilience necessary

for getting through what was often perceived as the most difficult phase of treatment. In the following extract, P11 talks about having built up both ‘tools to cope’ and confidence in the first two phases that helped her with the third phase.

*“P11: You felt like going into that final third phase you had enough tools to be able to cope with whatever was going to hit you, as such... R: How do you feel it worked having the treatment in three different phases? P11: I thought it was brilliant. Because as much as they were all sort of very very different, they all pieced together quite well, and I think going through the third and final stage which was the hardest stage um, having the group therapies to begin with helps build your confidence for when going into that third phase” (P11, para.45)*

In the following extract, the participant sees Phases 1 and 2 as necessary not just for building coping skills but also in reducing the risk of triggering self-harm, and in building the trust necessary to engage in Phase 3:

*“R: Did you find any of the phases particularly more helpful or less helpful than the others? P12: They were all crucial, but the final phase was the final recovery, doing those stories. But I couldn’t have done those stories if I hadn’t, if the trust hadn’t built up. R: So it would be difficult doing phase 3 without having done phases one and two? P12: You wouldn’t be able to do it. It would be too dangerous. And those might be stupid words to say! But it would have been too dangerous really. You wouldn’t have been able to attempt that, I think you could end up having people walking out and actually, reliving something like that, you could end up with people being suicidal I think, or attempting suicide.” (P12, para.55)*

Whilst many participants did not identify one phase as more helpful than the others, those who did largely identified the third phase as the most useful to them overall. However, they also talked of how difficult it might have been to do the individual trauma-focused work without doing the other phases first, as in the following extracts. These participants perceived the first two phases as primarily designed to help with coping in Phase 3 of the treatment.

*“[Phase] three I think really helped me more than the other two. Because it enabled me to gain control. Whereas the other two was just learning about how to deal with this third phase. But the third was, ‘you’re taking control of your life now, you’ve done the prep for it, we’ve put everything in place.’” (P10, para.95)*

*“I would say the third phase made the most difference, but if I hadn’t gone through the first two I wouldn’t have been able to just even have coped with the third phase. I think we would still be there now, going over the same memories, you know, hashing through it over and over again, and I wouldn’t be moving anywhere with it, I’d still be stuck on repeat where I had been for the last twenty-two years before I started this process, you know.” (P14, para.91)*

This sub-theme therefore illustrates the broad perception amongst the participants that the three phases of the treatment worked together in a complementary fashion, and were all helpful towards recovery. Further, that the order of the phases had an underlying logic, and this underlying logic was often perceived as being to help participants to engage with trauma-focused therapy in Phase 3, which these participants felt it had done.

**“Whipping off the band-aid” – the difficulty of wait periods’.** This sub-theme reflects participants’ experiences of the two wait periods between the three phases of treatment. The theme takes its name from the following extract where a participant talked about the anxiety she experienced waiting between one and two months after Phase 2 (CRG) to start Phase 3 (individual trauma-focused therapy):

*“P14: I mean it was getting towards being a bit long but it wasn’t too bad, you know. I think, you know, if you get to that point where it’s been more than a month you start going ‘ooh, do I really want to do this?’ Because also you’ve got that fear and the knowledge that you know, you know that you’re about to have to go through everything, and yeah. R: Mm, so there’s something about getting onto it quickly? P14: Mm. Whipping off the band-aid, yeah!” (P14, para.103)*

The expression ‘whipping off the band-aid’ captures a sense of trying to minimise pain by moving quickly onto the third phase, and the pain in question seems to be the anxious dread of trauma-focused therapy. Other participants also spoke of finding this wait between CRG and individual therapy particularly difficult.

*“P11: I think there was a bit, yeah there was a bit of a wait in going from um the second phase to the third phase. R: How did you find that? P11: It was, it was a little bit distressing as such, because I felt like I had done so well, and accomplished so much in the first phase and the second phase that I was so ready to go onto the third one, and that wait in between I felt like yeah I had a certain amount of tools to cope, but I wasn’t quite there yet, and it was still affecting my everyday life and the things that I did, that I just so badly wanted it over” (P11, para.48)*

The participant refers to the waiting period before Phase 3 as ‘distressing’ and seems to refer to the third phase of treatment when she talks of wanting it ‘over’. For other participants, the difficulty of wait periods wasn’t merely caused by anxious anticipation of Phase 3, but also having to cope without any therapeutic contact, having become accustomed to weekly contact in Phases 1 and 2:

*“R: How were those breaks for you? P13: Um, I panicked a bit because um, it’s like, not seeing anybody to say how I’m feeling, you know the questions that you’re asked in the class, um, about your feelings and how you felt inside and stuff, to the weeks that I didn’t see anybody for that it was a bit unnerving, like ‘how am I going to cope until my next meeting?’ But then if it was quite a long break as the weeks went on it did get easier, um. R: But it was tricky? P13: Yeah, because I didn’t have no one there.” (P13, para.87)*

It is not clear whether the participant is referring to the loss of the group facilitator or the other members of the group; it seems that what is important is simply contact with someone who is interested in her wellbeing.

For other participants, what made the idea of longer wait periods anxiety-inducing was the fear that the progress they had made in treatment so far might be compromised, as in the following extract:

*“I think there was, you always had that fear there was going to be a big break in between each phase, uh, because there was always that possibility. I think I was quite lucky in the fact that that didn’t really happen to me. But if there had been too big a break you feel like you might have stepped backwards before you’d managed to get up onto the next level, you know.” (P14, para.99)*

The following participant expresses this fear of losing what she has gained by forgetting the previous ‘course’, as well as echoing some of the same concerns as above about managing anxiety about Phase 3:

*“P10: Between the first and the second that wasn’t too bad. But then second and the third it was scary, because it’s like ‘what are you going to have to go through? What’s it going to be like?’ And I think the three to four weeks was quick. The fact that I’ve done these three courses in less than a year and the fact that they were open to me that quick, that saved me another year of suffering. R: So you were glad to move on reasonably quickly? P10: Yeah because then you don’t forget the previous course.” (P10, para.91).*

It is notable that P10, as for P14 above, spoke about a hypothetical scenario of having a long wait period, and how that would be difficult, whilst saying that the wait periods she herself experienced were manageable in length. This suggests that the wait periods between treatment phases, which are self-evidently not the main focus of the treatment design, are nonetheless a psychologically-significant element of the phase-based structure, even for those who have short wait periods, because of the feelings of isolation or worry that they may provoke. Further, the analysis suggests that longer waits between Phase 2 and 3 in particular may be difficult due to the anxiety attached to starting trauma-focused therapy.

**Summary.** The themes and sub-themes of the thematic analysis indicated that both the group format of Phases 1 and 2 and the phase-based structure of the treatment were acceptable to the interviewees, who described various ways in which they helped in their recovery. However, it also demonstrated the ways in which both could be cause for anxiety: anticipatory anxiety of attending a group for the first time,

or anxiety about the wait periods between the treatment phases. The ‘Group as “the biggest anxiety”’ sub-theme also demonstrated the importance of careful management of disclosure within the group by the facilitators, which the participants in this analysis appeared to feel had been achieved.

The theme ‘Experience of phase-based treatment’ also provided some insight about how the third phase was experienced by participants: for several participants it was the most helpful phase of the treatment, as well as the most difficult. This offered a perspective on the third phase of the treatment for which there was less data in the case series analysis. Although the samples for the two analyses were different, they were triangulated to provide some evidence for both the effectiveness of the treatment for the majority of participants in terms of symptom reduction, and the acceptability of the treatment programme.

## **Chapter 5: Discussion**

This study sought to evaluate a new phase-based treatment for CPTSD through two separate analyses: a case series analysis of outcome data to evaluate effectiveness, and a thematic analysis of qualitative interview data to evaluate acceptability. The case series broadly demonstrated that the treatment was effective for most participants, but patterns of change differed between participants. The thematic analysis suggested that participants experienced the treatment programme as highly acceptable and appropriate to their needs, although it was associated with anticipatory anxiety, particularly around the group format of Phases 1 and 2.

### **Effectiveness of the Treatment Programme**

The case series analysis provided detailed, longitudinal data for nine participants from assessment to end of Phase 2 or later, using measures of PTSD symptoms, CPTSD symptoms, and levels of self-compassion. All nine participants had CPTSD from either childhood abuse or adult intimate partner violence, in some cases both, and several had ongoing stressors at the time of treatment, such as court cases.

Whereas eight of the nine participants were above a clinical cut-off of score of 44 on the PCL-5 at Assessment, only three participants were still above the cut-off at Post-CRG, falling to one at the latest available data point. Of the six participants below clinical cut-off at Post-CRG, three also met criteria for reliable, clinically-significance change. This indicated that the treatment programme was effective in treating PTSD symptoms; further, that the first two phases were effective for some participants, without any trauma-focused therapy. Additionally, since using the latest available data for pre-post analyses resulted in higher rates of remittance than at Post-



CRG, it is possible that, had the analysis been able to follow all participants to the end of treatment, symptoms would have further improved.

The rate of improvement in PTSD symptoms at the latest available data point, with eight participants being in the sub-clinical range for PTSD, compares favourably with existing phase-based treatments for CPTSD. In the evaluation of STAIR followed by prolonged exposure (STAIR-PE; Cloître et al., 2002), 77 per cent of participants who received the STAIR-PE condition, did not meet criteria for PTSD at post-treatment.

Pre-post analysis of PCL-5 scores at post-CRG, which found that six participants were below clinical cut-off and three had made reliable, clinically-significant improvement, provided a comparison point with other stabilising interventions evaluated in isolation, such as Dorrepaal and colleagues' pilot study (Dorrepaal et al., 2010). This was a 20-week stabilising group intervention comprising of psychoeducation and CBT principles, designed to treat CPTSD related to childhood abuse. The authors found that 22 per cent of participants who received the stabilisation intervention alone, without subsequent trauma-focused therapy, no longer met criteria for PTSD at post-intervention, as measured by SCID-1, rising to 35 per cent at follow-up. The first two phases of the present treatment programme therefore compare favourably to Dorrepaal's stabilising intervention, as measured by changes in PTSD symptoms.

Despite this overall positive picture of improvement, which suggests that the treatment is effective at reducing PTSD symptoms, graphical analysis revealed considerable heterogeneity in patterns of change between participants and between

measures. These will be considered in further detail for each phase, in relation to the specific hypotheses of this study.

### **Phase 1: Psychoeducation**

It was hypothesised that no change or only small spontaneous changes in PTSD and CPTSD symptoms would occur over Phase 1, Psychoeducation, since its aim is to educate rather than to treat symptoms. This hypothesis was partly confirmed by visual analysis of case series data, although the heterogeneity of the data made drawing conclusions about Psychoeducation from this sample difficult.

Psychoeducation appeared to have helped some participants, but not all. Of the seven participants for whom there was discrete Phase 1 data, four participants appeared to show reductions in PTSD severity during Psychoeducation; however, for three of these, gains made during Psychoeducation were partly or wholly lost in the wait period afterwards. There was a similar picture for CPTSD symptoms. Three of the seven participants showed improvement on at least three of the five CPTSD symptom items during Psychoeducation, however, only one participant maintained these gains during the wait period after.

The case series findings therefore provided only limited evidence for the effectiveness of Psychoeducation in reducing PTSD or CPTSD symptom scores. Whilst this may call into question the utility or necessity of the intervention, it is possible that Psychoeducation may perform a function that is not assessed by the outcome measures used here. In a study of a 10-week psychoeducation group intervention for survivors of CSA, Karatzias et al. (2014) found no changes in PTSD symptomology, depression, anxiety or self-esteem, as measured by outcome measures; they did however find lower rates of self-harm, decreased rates of smoking,

alcohol and substance misuse, as well as lower involvement in illegal and antisocial behaviours at post-treatment and follow-up. This suggests that psychoeducation interventions may offer positive aspects of stabilisation that are more difficult to capture through standardised measures, or may be less immediate, and therefore not seen in Phase 1 scores.

Additionally, although the sample of participants was different for the two analyses, it is relevant to note that the findings of the thematic analysis indicated that participants found all three phases of the treatment programme helpful, and that they worked together as a package, in a logical, sequential fashion. Some participants described Phase 1 as giving them an essential level of understanding about their difficulties, and said that they didn't feel the treatment would have worked as well as it did if any of the three phases had been removed.

## **Phase 2: Compassionate Resilience Group**

The second hypothesis of this study was that differential change would be evident over Phase 2, the Compassionate Resilience group (CRG), with a greater rate of reduction in CPTSD symptoms than in PTSD symptoms, as well as improvements in self-compassion. This was predicted because CRG is a non-trauma-focused intervention designed to target the 'complex' items of CPTSD, such as emotional dysregulation, interpersonal difficulties and negative beliefs, by building self-compassion and reducing shame, rather than targeting core PTSD symptoms.

**Changes in PTSD and CPTSD symptoms.** Of the eight participants for whom there was discrete Phase 2 data, visual analysis indicated that seven participants showed improvements on some or all measures over Phase 2, indicating

that the CRG was helpful for almost all participants. Of the eight participants, six showed improvements on at least three of the five CPTSD items. Whilst not all participants showed improvement on all five items, decreases were visible for all five items – beliefs, emotional, interpersonal, dissociative and somatic – across the nine participants during Phase 2, indicating that the CRG may be effective for the range of additional ‘complex’ symptoms that are believed to make up CPTSD.

Contrary to the hypothesis, however, there was no evidence for a greater rate of reduction in CPTSD symptoms than in PTSD symptoms in Phase 2. Of the six participants who showed improvements in CPTSD symptoms during Phase 2, all six also showed improvements in PTSD symptoms, as measured by the PCL-5. One participant did not show improvement on CPTSD items but did show improvement on the PCL-5.

Therefore, the evidence suggested that the CRG was effective in reducing CPTSD symptoms for six of the nine participants. It also, contrary to the hypothesis, showed similar benefits for reducing PTSD symptoms. This was not predicted, given that the CRG targets self-compassion rather than core PTSD symptoms and it does not involve trauma-processing, which is the NICE- recommended component of evidence-based treatments for PTSD.

This finding lends tentative support to arguments that shame and deficits in self-compassion serve to maintain PTSD symptoms, and that, therefore, improvements in self-compassion may reduce PTSD symptoms (Lee, Scragg and Turner, 2001). This is consistent with a recently published study of within-person processes of 65 participants undergoing exposure-based cognitive therapy for PTSD by Hoffart, Økstedalen and Langkaas (2015), where PTSD symptoms and self-

compassion were measured weekly. The authors found that the self-compassion components of self-kindness, self-judgment, isolation, and over-identification had a within-person effect on subsequent PTSD symptoms, with reduction in self-judgement particularly significant. By contrast, they found few indications that within-person variations in PTSD symptoms predicted subsequent self-compassion.

**Changes in self-compassion.** The second part of the hypothesis was that Phase 2 would show improvements in self-compassion, as measured by the FCSRS. This was predicted because the explicit focus of the CRG is on building self-compassion and reducing shame. This hypothesis was supported by visual analysis of the data, which showed that seven of the eight participants for whom there was discrete Phase 2 data experienced improvement on at least two of the three subscales of the FCSRS.

For those participants who showed improvements on the FCSRS in Phase 2, most showed the steepest apparent improvement on the Inadequate Self subscale, with five participants showing marked improvement on this subscale. The case series data therefore appeared to provide evidence for the CRG as an intervention that effectively addresses self-criticism.

### **Phase 3: Individual Trauma-Focused Therapy**

Finally, it was predicted that in Phase 3, individual trauma-focused therapy, there would be a greater rate of reduction in PTSD symptoms than in CPTSD symptoms, since Phase 3 consists of evidence-based treatments for PTSD which do not necessarily target CPTSD symptoms. It was not possible to draw firm conclusions

regarding this hypothesis due to most participants not having finished Phase 3 at the time of analysis.

Of the four participants for whom there was data for the first half of individual treatment, all showed improvement on the PCL-5. However, there was no data for the second half of treatment, which may have shown a different pattern of change. Of these four participants, two also showed improvements in CPTSD symptoms and self-compassion for this first half of individual treatment, but the other two did not. One participant showed some deterioration in FCSRS scores in the first half of individual treatment, indicating decreased levels of self-compassion. The findings from this part of the analysis suggested that Phase 3 may be more effective in reducing PTSD symptoms, as measured on the PCL-5, than CPTSD symptoms, supporting the hypothesis. However, more data is needed for the latter part of Phase 3 in order to fully explicate the changes that occur during this phase of the treatment.

The finding that the first half of individual treatment appeared to be effective in reducing PTSD symptoms but less effective for CPTSD symptoms is important. If the same pattern of differential change continues in the second half of individual treatment and can be replicated in a larger sample, this would add weight to arguments that phase-based approaches are superior to individual trauma-focused therapy for people with CPTSD, as they are more able to address the extra ‘complex’ symptoms. This would provide empirical support for the ISTSS task force recommendations (Cloître et al., 2012) that individual trauma-focused therapy may not adequately address CPTSD symptoms. This contrasts with the position taken by de Jongh et al. (2016) in their recent critical analysis of the ISTSS guidelines, which is that phase-based treatments may not be necessary for this population.

The thematic analysis from this study lends weight to the arguments in favour of phase-based treatment. While several participants described the third phase as the most effective, a sub-theme of the data was that participants felt that all three phases were necessary. Further, several participants felt that Phase 3 was also the hardest phase, and that they would not have been able to cope with it had they not already done Phase 1 and Phase 2. Participants spoke about finding new coping strategies or reducing harmful behaviours, such as drinking, during these first two phases, which then enabled them to cope with moving on to addressing their traumas in the final phase. Importantly, Phases 1 and 2 were also group-based, and a significant theme of the qualitative analysis was that the participants felt the group format itself offered benefits above individual treatment. A treatment consisting of individual trauma-focused therapy only, as proposed by de Jongh et al. (2016), would therefore lack these advantages.

### **Group Format**

The thematic analysis identified a range of perceived benefits from undergoing treatment in a group format. Participants spoke of group members providing additional support during sessions, in terms of comfort or encouragement, as well as social support outside and between sessions. They also spoke about how powerful the experience of being amongst people with shared experience of CPTSD could be; that it normalised their own symptoms and emotions, which in turn helped them to feel more ‘normal’ and less stigmatised. Therefore, treatment in a group appears to help to reduce the shame and stigma that are often features of PTSD (Lee, 2012). This suggests that phase-based treatments for CPTSD may benefit from incorporating at

least one group phase, unlike the individual format of the stabilization intervention STAIR-PE (Cloître et al., 2002).

However, another sub-theme of the thematic analysis was that the group format of the treatment was, for some participants, the main cause of anxiety prior to starting treatment. This is significant because it suggests that the format may impact on treatment uptake, despite the positive experiences that participants reported once they had actually started the group. This finding is consistent with a study of acceptability of group treatment for people with panic disorder and agoraphobia (Sharp, Power & Swanson, 2004), where participants were given a choice between the two formats for equivalent CBT treatment at the end of a waiting list period. The study found that 95 per cent chose individual treatment over a group format. The authors then randomly allocated participants to either condition and found that outcomes were the same for participants in the two groups, suggesting the unpopularity of group treatment was not due to inferiority. In the current study, 15 of the 127 clients referred with CPTSD were judged at assessment to be unsuitable for the treatment programme because either they preferred not to be in a group, or their clinician considered them unsuitable for a group. This supports the possibility that a group format of treatment may somewhat reduce uptake of treatment.

### **Strengths of Study**

This study used a mixed methods approach consisting of two analyses, a quantitative case series analysis and a qualitative thematic analysis. These were able to address two different research questions, the first about the effectiveness of the treatment and the second about its acceptability to service users. The findings of the case series suggested that the treatment was effective in reducing PTSD and CPTSD



symptoms, and the thematic analysis indicated that most participants experienced the treatment programme to be helpful and relevant to their difficulties. Whilst most existing studies of phase-based treatments have focused on effectiveness, a treatment with low acceptability may have implications for treatment uptake and adherence. The mixed-methods approach therefore allowed a triangulation of evidence that would not be possible with one method of analysis alone. Evaluating the treatment programme from the perspective of the service-user also reflects a growing recognition in UK health legislation of the importance of service-user feedback and involvement in the shaping of services and evaluation of care quality (Health and Social Care Act, 2008).

The value of mixed method research in evaluating treatment interventions is increasingly being recognised. Dattilio, Edwards and Fishman (2010) argue that whilst Randomised Controlled Trials (RCTs) are generally seen as the gold standard of treatment effectiveness studies, case study designs and qualitative approaches offer a level of rich, contextual information as well as a degree of ecological validity that RCTs cannot. They propose that evaluations of psychotherapeutic treatments ought to always employ mixed methods, comprising qualitative interview-based explorations of the implementation of the treatment, as well as systematic case studies, and RCTs.

The limitations of RCTs are inherent in their need for homogeneity in samples, which leads to exclusion of people with comorbid conditions, as well as the need for complete data which leads to exclusion of people with less reliable attendance. People with CPTSD often struggle with somatic conditions, emotional and interpersonal instability in their lives that may affect attendance. Additionally, they often have co-morbidities such as personality disorders, substance-use or self-harm which are often used as exclusion criteria for RCTs. For example, one of the

few existing RCTs of phase-based treatment for CPTSD, conducted by Cloître et al. (2002), excluded people with any of the following: dissociative disorder, Bipolar I disorder, borderline personality disorder, or the presence of a suicide attempt or psychiatric hospitalisation within the last three months. Criteria such as these mean that clinically-representative CPTSD populations may be under-represented in large-scale, controlled research, whereas small n designs potentially allow a more inclusive analysis with greater applicability to naturalistic clinical settings. The present study included participants with recent risk, recent psychiatric hospitalization and a participant with a diagnosis of BPD.

Additionally, using an idiographic approach to analysis meant that differences between participants were made visible that would have been lost through the ‘averaging out’ of scores that occurs in a group level of analysis, thereby identifying some participants who experienced very great changes in symptoms, and a few who showed much less. Using repeated measures at a single case level also enabled a more detailed examination of change across phases that would not be possible with a large sample.

### **Limitations**

The strengths of a small n, mixed methods design must also be weighed against the disadvantages of these approaches.

**Sampling.** Most importantly, the findings of this study are not generalizable to the CPTSD population as a whole, and, as such, the case series can only describe the effectiveness of the treatment for the nine individual participants. In this case, the nine individuals were all female, predominantly White British, and middle-aged. The

sample of six for the thematic analysis was also predominantly female. That the participants for both analyses were mainly female reflected the higher numbers of female referrals for CPTSD at BTSS, and the fact that some male clients were waiting for an all-male CRG.

Secondly, it is important to note the selection bias inherent in selecting to study the acceptability of the treatment to people who have completed the full programme. Since people who are unsatisfied with their treatment are less likely to complete it, the findings of the thematic analysis may be skewed towards presenting a positive picture of clients' experiences of the treatment programme. A useful follow-up study would be to interview clients who withdrew from treatment before completion, and analyse their responses in the same manner.

The same selection bias affects the case series component of the study. Information about attrition from the point of assessment, presented in Chapter 2, revealed that some people who were assessed as having CPTSD decided not to do the full three-phase treatment, or refused treatment in a group format and were offered an individual alternative. Therefore, the final samples, both for the case series and the thematic analysis, consisting only of those who were enrolled in the full treatment, selects out those who did not do all three phases, and who might potentially have been less likely to benefit from the treatment, or less likely to find the treatment or group format acceptable if interviewed, than those who chose to do the full treatment. This may have skewed the outcome results toward successful outcomes. Further, all participants had to be available to do the full treatment which included groups held during working hours, which would have excluded some people with full-time jobs or caring commitments, and perhaps also those less-motivated for treatment.

**Incomplete data.** The analyses that were carried out were not as planned in the original study design. Due to difficulties at the service in distributing correct measures, there was a limited sample of participants eligible for the case series, none of whom had completed treatment by the time of analysis. As a result, there were different samples for the case series and the thematic analysis, which meant that the findings of the case series could not be directly related to the findings of the thematic analysis. Using the same sample for both would have made it possible to use the interview data to understand more about possible reasons that specific participants benefited more in terms of symptom reduction than others. It could have also have enabled exploring whether those who showed little improvement on outcome measures found anything in the treatment that was beneficial to them.

The same difficulty of case series participants not having completed treatment meant that there was incomplete Phase 3 data for four participants, no data Phase 3 for the majority, and no follow-up data. This meant that conclusions about the effects of individual trauma-focused therapy in the context of the treatment programme were highly tentative. However, Phase 3 comprises trauma-focused CBT or EMDR, both of which are well-evidenced for treating PTSD, whereas Phases 1 and 2 are innovative group interventions that have not been researched extensively, and therefore were of arguably greater importance to the evaluation.

**Case series design.** This study was a service-based evaluation and therefore the design of the case series analysis was directed by pre-existing service structures regarding administration of outcome measures. As a result, the design fell short of ‘Design standards’ for case series research which have been published by a panel of experts in single-case designs (Kratochwill et al., 2010). The main area of limitation

was the number of time points at which questionnaire measures were administered. This was partly due to the use of several full standardised measures such as the PCL-5, PHQ-9 and GAD-7 at every data point, which meant that further increasing the number of data points would have put undue burden on participants.

A particular issue was that there were only two pre-treatment data points, whereas the guidelines argue for a minimum of three per phase, including three before treatment in order to establish a baseline of symptoms. A good baseline phase in single case design acts as a 'within-participant control' in order to distinguish the possible effect of time on recovery from the effect of the intervention. Some experimental studies with control groups have found that a proportion of participants recover spontaneously while waiting for treatment, for example, McDonagh et al.'s (2005) study of CSA survivors reported that 17.4 per cent of wait list controls no longer met PTSD criteria after 14 weeks. Conversely, other studies of CPTSD or CSA populations have found no improvement in wait list conditions (e.g. Resick & Schnicke, 1992; Cloître, et al., 2002). Whilst it is problematic to make comparisons between findings from the current, small n study and larger studies, the rate of reliable, clinically-significant change in the current study greatly exceeds McDonagh's reported 17.4 per cent rate of spontaneous recovery, making it less likely that all improvements in PCL-5 scores over the course of treatment in this study were attributable to spontaneous recovery.

A second design limitation was that there were only two data points for Phase 1, pre- and post-, whereas a minimum of three is again expected according to expert design standards. A consequence of having fewer data points was that the more sophisticated tools of visual analysis, for example, projecting from one phase to the

next, were inappropriate, as was the use of non-overlap statistics, which is advocated by some proponents of statistical analysis in case series designs (e.g., Kazdin, 2007; Shadish, 2014). Relying on visual analysis of CPTSD and FCSRS without the addition of statistical analysis is considered acceptable and indeed preferred by some researchers (Morley, 1994); however it makes it difficult to identify reliable, significant change. Therefore, this study's conclusions about the impact of the treatment on CPTSD symptoms or self-compassion are necessarily tentative.

Had the study been designed without pre-existing service constraints, one solution would have been to use the full, standardised measures for pre-post analyses only, and to use a single target measure more frequently, as well as brief process variables, such as visual analogue scales, administered every session, providing more data points but each having a lower burden on participants (Morley, 1996).

**Measurement.** A new measure, BTSS CPTSD (Billings & Whalley, *Unpublished*), was trialled in this study, consisting of four additional items in the format of the PCL-5, and intended to assess the additional CPTSD domains (emotional dysregulation, interpersonal difficulties, dissociation and somatic symptoms) that are not assessed by the PCL-5. This was necessitated by the absence of any purpose-designed, validated measure of CPTSD, which may be due to the current lack of formal diagnostic criteria for CPTSD.

The Structured Interview of Disorders of Extreme Stress (SIDES; Pelcovitz et al., 1997) is the only purpose-designed measure for assessing DESNOS symptoms and has a self-report measure version, the SIDES-SR. The SIDES and SIDES-SR have therefore been used by a few researchers (e.g. Dorrepaal et al., 2010; Maack, 2012) to assess Complex PTSD. However, it is a long, 45-item measure which, as a

treatment outcome measure adds considerably to the burden on participants, and was therefore judged to be inappropriate for a repeated-measures design. Furthermore, to date, the SIDES has not been widely used, perhaps because DESNOS no longer exists as a diagnostic category since the introduction of DSM V, and as a result there is minimal evidence regarding its psychometric properties.

Other researchers (e.g., Cloître et al, 2010) have used a combination of items from other measures to tap into the various constructs associated with Complex PTSD, using measures of depression, anxiety, and anger. However, this too has drawbacks: the measures are not designed for the purpose and therefore their validity for measuring CPTSD is unestablished. Additionally, using scores on several different measures in sum as an indicator of CPTSD makes it less straightforward to identify cut-offs or norms, and again adds considerably to the burden on participants.

The CPTSD BTSS measure was therefore employed as an economical solution to the problem of measuring CPTSD symptoms in the absence of a purpose-designed and well-validated measure of complex PTSD. However, further research is required to explore the statistical properties of the measure. Additionally, the five-point response scale, which was adopted for consistency with the PCL-5, arguably makes the individual items less sensitive to change, and more liable to be affected by floor and ceiling effects, and therefore less suitable for individual analysis.

The lack of an agreed, formal diagnosis of CPTSD was also a difficulty for the application of the inclusion criteria for this study. Clinicians who assessed clients for PTSD with CPTSD features were doing so based on expert consensus guidelines regarding CPTSD, rather than on clear diagnostic criteria, which represents a threat to validity. Furthermore, due to service constraints it was not possible to have

participants assessed separately by two clinicians in order to establish whether or not there was agreement, indicating inter-rater reliability. Therefore, this method of determining CPTSD in the sample does not have demonstrable validity or reliability.

Finally, in regards to measuring PTSD, the use of the PCL-5 to establish severity and diagnostic status is reliant on participants' self-report of symptoms, whereas the gold-standard for PTSD diagnosis is the Clinician Administered PTSD Scale (CAPS-V), a structured interview. However, this was judged not to be feasible as an outcome measure for a repeated measures design due to the considerable added burden to participants.

### **Future Research**

This was the first evaluation of this new, phase-based treatment programme, drawing on an exploratory, pragmatic research design using a small sample. Given that the findings have suggested a good level of effectiveness of the treatment programme for treatment of PTSD, some impact on CPTSD symptoms, as well as the acceptability of the treatment programme to service-users, there is now a good basis for continued clinical use of the treatment programme to treat people with CPTSD, coupled with further research. A logical first step would be to continue the current study to follow participants to post-treatment and through a follow-up period to investigate whether gains, particularly in CPTSD symptoms and self-compassion, about which very little is known, are consolidated or lost after the end of treatment.

To build on this study, a useful next step would be to utilise an experimental design, where phases are administered in different orders, to explore whether the order has any impact on effectiveness. The structure of the current programme departs



somewhat from the ISTSS expert consensus recommendations. The ISTSS recommendation is for a three-phase model where Phase 1 consists of establishing safety, strengthening the individual's capacities for emotional regulation and reducing shame, Phase 2 consists of trauma-focused therapy, and Phase 3 consists of interventions designed to consolidate the gains in emotional, social and relational competencies, and to aid the transition out of therapy to greater engagement in community life (Cloître et al., 2012). However, these are guidelines and have not yet been tested empirically. It would therefore be important to investigate whether the order of the phases in this phase-based treatment programme has any impact on effectiveness or acceptability of the treatment.

A further experimental manipulation that may be important is that of dose, since there is no research in this area to date and therefore the length of the treatment phases does not have an empirical basis. Since many participants showed deterioration in symptoms during the wait period between Phase 1 and 2, it would be interesting to manipulate the length of Phase 1 to see if this improves consolidation of gains. The ISTSS survey found that the majority of experts considered a combined treatment duration of 9 to 12 months for the first two phases to be suitable, which is longer than the current study, and longer than other existing phase-based treatments such as STAIR-PE, which consists of sixteen sessions in total (Cloître et al., 2002).

Future research in this area will benefit greatly from a reliable, validated measure of CPTSD, and therefore more research is needed to establish the statistical properties of BTSS-CPTSD. A pre-requisite of larger-scale research will be the identification of sufficiently sensitive, validated measure(s) with which to measure change in CPTSD symptoms, as well as sufficient numbers of people who have

completed the full treatment for recruitment. Once these have been achieved, there would be a strong case for an RCT in order to provide evidence of the efficacy of the treatment programme.

An RCT to evaluate the treatment programme would benefit from a comparison group of participants who only do Phase 3, individual trauma-focused therapy, in order to directly compare the efficacy of these two approaches, and thereby address the main concern of de Jongh et al. (2016), that the need for phase-based treatment above single-phase treatment is still unproven. This larger scale of research can also explore factors that may mediate the efficacy of the treatment, such as category of trauma, chronicity of trauma and demographic variables, in order to be able to make recommendations as to whom the treatment is most likely work for.

### **Clinical Implications**

The current study clearly has a high level of relevance to clinicians working in the areas of PTSD and CPTSD. With further quantitative research to establish the efficacy of the treatment programme, the protocol for this phase-based treatment programme may be shared with other services in order broaden the availability of this treatment for people presenting to services with CPTSD.

The findings of the thematic analysis have raised a couple of areas for clinicians to consider in the development of this treatment programme. Firstly, the anticipatory anxiety generated by group format treatments is significant, and may result in lower uptake of treatment. The potential risk of reducing uptake must of course be balanced against the service-level benefits of offering group-format treatments, by enabling more service users to access treatment sooner. In order to

mitigate the risk of the group format reducing uptake, particular care will need to be given to communicating to clients the advantages of group format treatment over individual treatment, as richly demonstrated by the thematic analysis. It will also be worth emphasising to potential clients the clear boundaries put around personal disclosure within the groups. There is also, however, a need for an alternative to group treatments for those who cannot be convinced, and would otherwise not access treatment at all.

Secondly, the thematic analysis indicated that wait periods between treatment phases were an important issue to participants, with shorter waits described as better, as they were seen as reducing the risk of forgetting earlier treatments, as well as limiting the build-up of anxiety for the next phase, particularly in relation to the wait for trauma-focused therapy. Where services are unable to offer shorter wait periods, there may need to be consideration given to optional 'holding groups' for those who are between phases, in the same way that some services offer holding groups for waiting list clients.

## **Conclusion**

This study has explored the effectiveness and the acceptability of a new, phase-based treatment programme for CPTSD, which incorporates a unique compassion-focused group component, in addition to psychoeducation, as a form of stabilisation prior to individual trauma-focused therapy. This ambitious programme seeks to address the needs of people who present with a broader spectrum of difficulties than is typically seen in sufferers of PTSD to single-incident traumas,

some of which may interfere with help-seeking or adherence to treatment. This study, whilst tentative in its findings, tends to support the ISTSS expert guidelines which argue that the phase-based approach may have advantages for this population that go beyond the benefits of individual trauma-focused therapy.

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## Appendices

### Appendix A: REC Conditional approval



#### NRES Committee North West - Preston

Barlow House  
3rd Floor  
4 Minshull Street  
Manchester  
M1 3DZ

Telephone: 0161 625 7818  
Fax: 0161 625 7299

30 June 2015

Ms Jennifer Readings  
Doctorate in Clinical Psychology  
Royal Holloway  
Egham  
TW20 0EX

Dear Ms Readings

**Study title:** Evaluation of a phase-based treatment for complex PTSD  
**REC reference:** 15/NW/0563  
**IRAS project ID:** 174621

The Proportionate Review Sub-committee of the NRES Committee North West - Preston reviewed the above application on 26 June 2015.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager Mrs Carol Ebenezer, [nrescommittee.northwest-preston@nhs.net](mailto:nrescommittee.northwest-preston@nhs.net). Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

#### Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

## Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

- a. The Committee would like to see the Participant Information Sheet revised to
  - i) Include the information that the interviews will be recorded
  - ii) Include the information that the recording can be stopped at any time and words deleted or replaced
  - iii) Include under confidentiality "if you disclose a risk of harm to yourself or others, or a criminal offence, this will have to be reported to the relevant authority"
- b. The Committee would like to see the Consent Form revised to
  - i) Give each point a separate number and box to initial
  - ii) Include a further point "I understand that relevant sections of my medical notes and data collected for the study may be looked at by regulatory authorities or by persons from the Trust where it is relevant to my taking part in this study. I give permission for these individuals to have access to this information"
  - iii) Include a further point at the end "I agree to take part in this study"

**You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.**

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

*Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### **Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion").

#### **Approved documents**

The documents reviewed and approved were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Policy certificate]		01 August 2014
Interview schedules or topic guides for participants [Interview schedule]	1	28 May 2015
Other [ CV Academic supervisor]	1	23 June 2015
REC Application Form [REC_Form_22062015]		22 June 2015
Referee's report or other scientific critique report [RHUL research subcommittee approval]		16 January 2015
Referee's report or other scientific critique report [CI's response to RHUL research subcommittee's provisional approval]		14 January 2015
Referee's report or other scientific critique report [RHUL research subcommittee provisional approval]		03 December 2014
Research protocol or project proposal [Protocol version 1]	1	28 May 2015
Summary CV for Chief Investigator (CI) [CV - J Readings ]	1	28 May 2015
Summary CV for supervisor (student research) [CV - Dr Jo Billings]	1	28 May 2015
Validated questionnaire [PTSD Checklist for DSM-5]		19 June 2015
Validated questionnaire [Life Events Checklist for DSM-5]		19 June 2015

Validated questionnaire [Work and Social Adjustment Scale]		19 June 2015
Validated questionnaire [Forms of Criticism and Self-Reassurance Scale ]		19 June 2015
Validated questionnaire [Patient Health Questionnaire-9 and Generalised Anxiety Disorder scale-7]		19 June 2015
Validated questionnaire [BTSS C-PTSD scale]		19 June 2015

### **Membership of the Proportionate Review Sub-Committee**

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### **After ethical review**

#### Reporting requirements |

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

### **User Feedback**

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/qualityassurance/>

### **HRA Training**

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



**Dr Patricia Wilkinson Chair**

Email: nrescommittee.northwest-preston@nhs.net

☐

*Enclosures: List of names and professions of members who took part in the review*

*"After ethical review – guidance for researchers"*

*Copy to: Ms Sharon Clutterbuck  
Mr Stephen Zingwe| Berkshire Healthcare NHS Foundation Trust*

☐

**NRES Committee North West - Preston**

**Attendance at PRS Sub-Committee of the REC meeting on 26 June 2015**

**Committee Members:**

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Mrs Hannah Chambers	Lay Member	Yes	
Dr Rob Monks	Senior Lecturer Department of Nursing	Yes	
Dr Patricia Wilkinson	General Practitioner/ Chair	Yes	

**Also in attendance:**

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Carol Ebenezer	REC Manager

## Appendix B: REC Approval confirmation



### NRES Committee North West - Preston

Barlow House  
3rd Floor  
4 Minsbüll Street  
Manchester  
M1 3DZ

Telephone: 0161 625 7818  
Fax: 0161 625 7299

15 July 2015

Ms Jennifer Readings  
Doctorate in Clinical Psychology  
Royal Holloway  
Egham  
TW20 0EX

Dear Ms Readings

**Study title:** Evaluation of a phase-based treatment for complex PTSD  
**REC reference:** 15/NW/0563  
**IRAS project ID:** 174621

Thank you for your email of 15 July 2015. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 30 June 2015

#### Documents received

The documents received were as follows:

Document	Version	Date
Participant consent form	2	02 July 2015
Participant information sheet (PIS)	2	02 July 2015

#### Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Policy certificate]		01 August 2014
Interview schedules or topic guides for participants [Interview schedule]	1	28 May 2015
Other [ CV Academic supervisor]	1	23 June 2015
Participant consent form	2	02 July 2015

Page 2

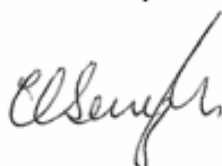
Participant information sheet (PIS)	2	02 July 2015
REC Application Form [REC_Form_22062015]		22 June 2015
Referee's report or other scientific critique report [RHUL research subcommittee approval]		16 January 2015
Referee's report or other scientific critique report [CI's response to RHUL research subcommittee's provisional approval]		14 January 2015
Referee's report or other scientific critique report [RHUL research subcommittee provisional approval]		03 December 2014
Research protocol or project proposal [Protocol version 1]	1	28 May 2015
Summary CV for Chief Investigator (CI) [CV - J Readings ]	1	28 May 2015
Summary CV for supervisor (student research) [CV - Dr Jo Billings]	1	28 May 2015
Validated questionnaire [PTSD Checklist for DSM-5]		19 June 2015
Validated questionnaire [Life Events Checklist for DSM-5]		19 June 2015
Validated questionnaire [Work and Social Adjustment Scale]		19 June 2015
Validated questionnaire [Forms of Criticism and Self-Reassurance Scale ]		19 June 2015
Validated questionnaire [Patient Health Questionnaire-9 and Generalised Anxiety Disorder scale-7]		19 June 2015
Validated questionnaire [BTSS C-PTSD scale]		19 June 2015

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

**15/NW/0563**

**Please quote this number on all correspondence**

Yours sincerely



**Carol Ebenezer REC Manager**

E-mail: [nrescommittee.northwest-preston@nhs.net](mailto:nrescommittee.northwest-preston@nhs.net)



## Appendix C: Berkshire NHS R&D approval

**Healthcare**  
from the heart of  
your community

**Berkshire Healthcare**   
NHS Foundation Trust

Jennifer Readings  
Doctorate in Clinical Psychology  
Royal Holloway, University of London  
Egham Hill  
Egham  
TW 20 0EX

**Research & Development**  
Fitzwilliam House · Skimped Hill Lane  
Bracknell · Berkshire · RG12 1BQ  
t: 01344 415825  
f: 01344 415666  
e: [research@berkshire.nhs.uk](mailto:research@berkshire.nhs.uk)

date: 4 September 2015

Our Ref: 2015/28                      REC Ref: 15/NW/0563  
Study title: Evaluation of a phase-based treatment for complex PTSD  
Start date: 4 September 2015    End date: 30 June 2106

Dear Ms Readings

### Confirmation of Trust Management Approval

On behalf of Berkshire Healthcare NHS Foundation Trust, I am pleased to confirm Trust Management Approval for the above research on the basis described in the application, protocol and other supporting documents. Approval is conditional on reporting up-to-date recruitment when requested and the submission of a brief final report of research findings. Failure to do so may result in approval being withdrawn.

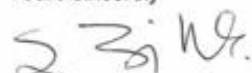
If there are any changes to the study protocol, the R&D Department must be informed immediately and supplied with any amended documentation as necessary, including confirmation that the amendments have been favourably reviewed by the Sponsor and the Ethics Committee. If the end date changes from that shown above, then please inform BHFT R&D Manager. Trust approval will cease on the end date above. Please contact the R&D Manager to discuss any extension.

The R&D Department is required to monitor the progress of all research in the Trust under the Department of Health's Research Governance Framework. You will be contacted in due course with a request for reports of progress, and for a brief final report of research findings.

If you have any questions about the above, or you require any other assistance, then please contact the R&D Department.

I wish you every success with the study.

Yours sincerely



**Dr Justin Wilson**  
Medical Director

From the **1 July 2015** Berkshire Healthcare NHS Foundation Trust is a **smoke free** organisation.

To help protect our staff and people who use our services from the harmful effects of tobacco smoke, please do not smoke anywhere on our sites, or during appointments when our staff are at your home. If you would like support to quit please speak to your healthcare professional or contact **Smoke Free Life Berkshire** on **0800 622 6360** or text **QUIT** to **66777**

[www.berkshirehealthcare.nhs.uk](http://www.berkshirehealthcare.nhs.uk)

## Appendix D: Royal Holloway Departmental Ethics Committee approval

Ref: 2015/104 Ethics Form Approved

psychology.it.support@rhul.ac.uk

Fri 25/09/2015 11:37

To:pava056@rhul.ac.uk <pava056@rhul.ac.uk>; Brown, Gary <Gary.Brown@rhul.ac.uk>;

Cc:PSY-EthicsAdmin@rhul.ac.uk <PSY-EthicsAdmin@rhul.ac.uk>; Zagefka, Hanna <Hanna.Zagefka@rhul.ac.uk>; Lock, Annette <Annette.Lock@rhul.ac.uk>; uqjt005@rhul.ac.uk <uqjt005@rhul.ac.uk>;

Application Details: View the form click [here](#) Revise the form click [here](#)

Applicant Name: **Jennifer Readings**

Application title: **Evaluation of a phase-based treatment for complex PTSD**

Comments: Approved.

## Appendix E: PCL-5

### PCL-5

**Instructions:** Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

<i>In the past month, how much were you bothered by:</i>	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

## Appendix F: BTSS CPTSD measure

Version 1, 26.05.2015

<i>In the past month have you:</i>	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
1. Had difficulties regulating your emotions (e.g. acting in unhelpful ways, difficulties containing your emotions, self-harm, using alcohol or drugs to cope)					
2. Experienced any difficulty in your capacity to relate to other people? (e.g. not trusting, feeling like other people judge me, having angry outbursts, difficulties managing relationships, avoiding relationships)					
3. Experienced any difficulties with your attention and feeling in the here-and-now? (e.g. losing track of time, losing awareness of your surroundings, spacing out)					
4. Experienced any unexplained health problems? (e.g. headaches, stomach distress, unexplained pains, or worry about physical health problems?)					

## Appendix G: FCSRS

### Self-Criticising/Attacking & Self-Reassuring Scale

When things go wrong in our lives or don't work out as we hoped, and we feel we could have done better, we sometimes have *negative* and *self-critical* thoughts and feelings. These may take the form of feeling worthless, useless or inferior etc. However, people can also try to be supportive of themselves. Below are a series of thoughts and feelings that people sometimes have. Read each statement carefully and circle the number that best describes how much each statement is true for you.

Please use the scale below:

Not at all like me	A little bit like me	Moderately like me	Quite a bit like me	Extremely like me
0	1	2	3	4

#### When things go wrong for me:

1.	I am easily disappointed with myself.	0	1	2	3	4
2.	There is a part of me that puts me down.	0	1	2	3	4
3.	I am able to remind myself of positive things about myself	0	1	2	3	4
4.	I find it difficult to control my anger and frustration at myself.	0	1	2	3	4
5.	I find it easy to forgive myself	0	1	2	3	4
6.	There is a part of me that feels I am not good enough.	0	1	2	3	4
7.	I feel beaten down by my own self-critical thoughts.	0	1	2	3	4
8.	I still like being me.	0	1	2	3	4
9.	I have become so angry with myself that I want to hurt or injure myself.	0	1	2	3	4
10.	I have a sense of disgust with myself.	0	1	2	3	4
11.	I can still feel lovable and acceptable.	0	1	2	3	4
12.	I stop caring about myself.	0	1	2	3	4
13.	I find it easy to like myself.	0	1	2	3	4
14.	I remember and dwell on my failings.	0	1	2	3	4
15.	I call myself names.	0	1	2	3	4
16.	I am gentle and supportive with myself.	0	1	2	3	4
17.	I can't accept failures and setbacks without feeling inadequate.	0	1	2	3	4
18.	I think I deserve my self-criticism.	0	1	2	3	4
19.	I am able to care and look after myself.	0	1	2	3	4
20.	There is a part of me that wants to get rid of the bits I don't like.	0	1	2	3	4
21.	I encourage myself for the future.	0	1	2	3	4
22.	I do not like being me.	0	1	2	3	4

## Appendix H: Interview schedule

### Post-Treatment Debrief Interview Schedule

Version 2, 30.01.16

[Introductions, Consent, etc.]

“The treatment programme at the Berkshire Traumatic Stress Service usually consists of three different phases that clients complete in order: A Psychoeducation group, a Compassionate-Resilience Group, and then individual CBT. Can you tell me which phases of the treatment did you were you offered, and which you did?” Did you complete all the phases you started?

- Did you have any worries or concerns about starting the treatment programme?

**Can you tell me about what it was like to attend the Psychoeducation group (Phase 1)?**

- Did you find the topics covered and the materials helpful? If so, what was most helpful about the group?
- Was there anything that was unhelpful, or which you found very difficult?
- How did you find the group format? Were there any downsides?
- To what extent do you feel this phase helped you with the difficulties you were experiencing?

**Can you tell me about what it was like to attend the Compassionate-Resilience group (Phase 2)?**

- Did you find the topics covered and the materials helpful? If so, what was most helpful about the group?
- Was there anything that was unhelpful, or which you found very difficult?
- How did you find the group format? Were there any downsides?
- To what extent do you feel this phase helped you with the difficulties you were experiencing?

**Can you tell me what it was like to do the individual trauma-focused therapy (phase 3) with your therapist?**

- Did you find this work helpful? If so, what was most helpful about it?
- Was there anything that was unhelpful, or which you found very difficult?
- Were you and your therapist able to find ways of bringing what you learned in the C-R group into the individual work? If so, how did you feel this worked?
- To what extent do you feel this phase helped you with the difficulties you were experiencing?

**Overall treatment:**

- Overall, how did you feel it worked doing the treatment in 3 different phases?
- Did you have much of a wait between starting the different phases? Was this helpful/unhelpful for you?
- Did you find any of the phases much more helpful, or much less helpful, than the others?
- What was it like to come to the end of the treatment?
- If you could have changed anything about the treatment, or the way it was delivered, what would it be?
- Would you recommend this treatment to a friend or family member who was experiencing similar difficulties to you? If so / not – why?
- Is there anything else you would like to tell me about your experience of this treatment programme?

**For participants who withdrew before completion of phase 3:**

I understand you didn't start/ compete phase 2/3 of the treatment. At what point did you withdraw?

- You do not have to tell me your reasons for withdrawing from the treatment but if you feel comfortable to do so, can you tell me what made you decide to finish your treatment at that point?
- Do you think there was anything that could have been done differently to help you complete the treatment?
- Overall, how did you feel it worked doing the treatment in 3 different phases?
- Did you have much of a wait between starting the different phases? Was this helpful/ unhelpful for you?
- Did you find any of the phases much more helpful, or much less helpful, than the others?
- If you could have changed anything about the treatment, or the way it was delivered, what would it be?
- How do you feel now you have stopped the treatment?
- Would you recommend this treatment to a friend or family member who was experiencing similar difficulties to you? If so / not – why?
- Is there anything else you would like to tell me about your experience of this treatment programme?

[Thank you, etc.]

## Appendix I: Participant Information Sheet



Doctorate in Clinical Psychology  
Royal Holloway  
Egham  
TW20 0EX  
Tel: 01784 414 012

### PARTICIPANT INFORMATION SHEET

#### Evaluating a phase-based treatment for Complex PTSD at Berkshire Traumatic Stress Service

We would like to invite you to take part in a research study evaluating the treatment programme for people with Complex Post-Traumatic Stress Disorder (cPTSD). Before you decide, it is important for you to understand why the research is being done and what it will involve. Please ask the clinician who has given you this sheet any questions you may have about the study.

#### What is the purpose of the study?

Individuals with PTSD from multiple or sustained traumatic events often experience unwanted symptoms that are additional to the symptoms typically experienced by people with PTSD from a single traumatic event. The treatment programme at the Berkshire Traumatic Stress Service (BTSS) has been designed specifically to help people with this range of difficulties.

This study aims to investigate how effective the treatment programme at the Berkshire Traumatic Stress Service is by analysing participants' anonymised scores on questionnaires as they progress through the treatment. These questionnaires are completed by all patients at BTSS for clinical purposes; by agreeing to participate in this study you agree to the use of this data for research purposes as well. The study also aims to find out what the treatment programme is like from the patients' perspective, and we will therefore be inviting all participants to be briefly interviewed about their experience of the treatment.

The data from this study will contribute to a doctoral thesis and will be submitted for publication in relevant journals. The findings may help future refinement of treatment for Complex PTSD.

#### What will happen to me if I take part?

Participating in this study will not affect the treatment you receive in any way. You will attend the same treatment sessions and complete the same questionnaires as patients who choose not to participate.

You may choose to consent only to have your treatment data used for research, or to also be contacted by the researcher at a future date regarding your experience of the treatment. If you consent to be contacted by the researcher then at the end of your treatment you will be invited to take part in a short, informal interview, either face-to-face or by telephone. This interview will last approximately 10-20 minutes and will be recorded. The recording can be stopped at any time, and words replaced or deleted. You will only be asked how you found the treatment; you will not be asked to disclose any personal information.

#### Expenses and payments

Participants who agree to take part in the short debriefing interview on a day which does not coincide with a routine visit to Berkshire Traumatic Stress Service can be reimbursed up to £10 for their travel expenses.



**Will my taking part in this study be kept confidential?**

All information you provide will be strictly confidential. However, if you disclose a risk of harm to yourself or others, or a criminal offence, this will have to be reported to the relevant authority.

The anonymised data will be stored on password-protected computers and in locked filing cabinets. Your data will be given a unique code that will be used in all data analyses instead of your name. Only the researchers will have access to a document that links your name to your code. Any direct quotes from your debriefing interview that are used in publications will be anonymised, and any information that might identify you will be changed or removed.

Responsible members of the Royal Holloway, University of London, or Berkshire Healthcare NHS Foundation Trust may be given access to the anonymised data for monitoring and/or audit of the study.

The results from this study may be published within the next 6 years. You will not be identifiable in any such publications. You can obtain a copy of any publications from the contact numbers below and you have the option on the consent form to select to be contacted about the results of the study. If you do request this then your contact details will be retained for this purpose.

**What will happen if I wish to withdraw?**

You have the right to withdraw from the study at any time, without giving a reason and without it affecting your right to treatment. If you withdraw, any data already collected will, with your consent, be retained and used in the study and analysis, however no further data will be used.

If you withdraw from treatment at Berkshire Traumatic Stress Service you will not be assumed to have withdrawn from the research study unless you specify that you wish to do so. If you withdraw from treatment but are willing to continue to participate in the study then we would very much like to invite you to participate in the debriefing interview about your experience of the treatment.

**Who is organising and funding the research?**

The study is a collaboration between Berkshire Traumatic Stress Service and Royal Holloway, University of London. Funding for reimbursement of travel expenses has been provided by Royal Holloway. The research project has been reviewed and supported by the [insert] Research Ethics Committee.

**What if there is a problem?**

Given the nature of this study, it is highly unlikely that you will suffer harm by taking part. If the brief interview causes you any distress you may speak your clinician at the Berkshire Stress Traumatic Service for support. Royal Holloway, as research Sponsor, has appropriate insurance in place in the unlikely event that you suffer any harm as a direct consequence of your participation in this trial.

If you wish to complain about any aspect of the way in which you have been approached or treated during the course of this study, you should contact Jenny Readings or Dr Jo Billings (see below), or Dr Gary Brown at Royal Holloway (01784 414 330). Alternatively you may contact the Royal Holloway Research Ethics Office (ethics@rhul.ac.uk) who will direct your complaint as appropriate.

*Principal investigators: Jenny Readings (01784 414 012)*

*Dr Jo Billings (0118 929 6400)*

## Appendix J: Participant consent form

Version 2, 02.07.2015



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### CONSENT FORM

Evaluating a phase-based treatment for Complex PTSD at Berkshire Traumatic Stress Service

Principal Investigators: Jennifer Readings, Dr Jo Billings.

Please initial box

1. I confirm that I have read and understood the information sheet dated 02.07.15. I have had the opportunity to ask questions, and have had these satisfactorily answered. I understand that my participation is voluntary, that I am free to withdraw at any time during the study, and refusal to participate will not affect the care I receive at the Traumatic Stress Clinic in any way.
2. I understand that if I withdraw from the study any data that has already been collected from me will be used in the study and analyzed, but no further data will be collected.
3. I give my permission to be contacted by the researcher to take part in a brief interview regarding my experience of the treatment programme. I understand that I do not have to agree to this interview in order to participate in the research.
4. I give permission for this interview to be audio recorded. I understand the audio recording will be destroyed once it has been transcribed.
5. I give my permission for anonymized quotes from my interview to be used in any publications that may follow from this research study. I understand that all personal details will be changed or removed to avoid identifying me.
6. I understand that relevant sections of my medical notes and data collected for the study may be looked at by regulatory authorities or by persons from the Trust where it is relevant to my taking part in this study. I give permission for these individuals to have access to this information.
7. I would like to be informed of the results of the study and therefore give my consent for my details to be retained so that I may be contacted with these results.
8. I agree to take part in this study.

-----  
Name of Participant                      Date                      Signature

-----  
Name of clinician                      Date                      Signature

## Appendix K: Sample of Coded Transcript 1

Date: 07/06/2016

P : ID : transcript.rtf

Page: 8/11

had enough tools to be able to cope with whatever was going to hit you, as such.

J: So thinking overall about this three phase treatment, which is quite an unusual way of doing treatment, um, how do you feel it worked having the treatment in those three different phases?


2: I thought it was brilliant. Because as much as they were all sort of very very different, they all pieced together quite well, and I think going through the third and final stage which was the hardest stage um, having the group therapies to begin with helps build your confidence for when going into that third phase, and it builds on others as well, and I think that helps as a person knowing that they're going to be okay afterwards when going into their third phase, so, yeah

J: And did you have much of a wait between the, doing each of the phases? Or did you move on quickly

2: I think there was a bit, yeah there was a bit of a wait in going from um the second phase to the third phase

J: How did you find that?

2: It was, it was a little bit distressing as such, because I felt like I had done so well, and accomplished so much in the first phase and the second phase that I was so ready to go onto the third one, and that wait in between I felt like yeah I had a certain amount of tools to cope, but I wasn't quite there yet, and it was still affecting my everyday life and the



- Phase based - positive
- Psychoeducation and CR group prepare for trauma focus
- Confidence
- Wait between phases
- Wait between phases
- Coping strategies

## Appendix L: Sample of Coded Transcript 2

Date: 07/06/2016

P : ID transcript.rtf

Page: 5/24

in front of you that I've never even really realised were symptoms, you know, like the insomnia I just assumed that I had insomnia [laughs]

J: You hadn't made a connection

028 5: No, I'd never made the connection. I

029 mean I do suffer from insomnia slightly on its own as it turns out, but, you know, nowhere near to the extent that I used to suffer from it. And yeah, just having the reassurance that there were other people going through it as well, that you're not on your own, because everything prior to that point had always been very hushed up, and you know, I'm nearly [age] for god's sake and I started in mental health when I was twelve, you know, and it was the dirty family secret, you know. And this just made it open, and the fact that there were other people sat there with me and, you know, some of them were my age, some of them were younger than me, but I think we'd all to some extent experienced that 'oh it's a dirty secret and you're on your own and you've got to cope with it on your own and you've got to be silent about it'. Being in a group made it easier, a lot easier to accept the fact that you've got to go through this process and get some help, it was quite nice. And the fact it was all girls together helped [laughs].

J: Yeah. And did you find the topics covered and the materials useful, as a whole, or?

030

5: Mm, yeah, I mean um, I think we all found different things like the relaxation techniques that we'd been taught and stuff like that, some of them worked for us and some of them didn't, um. But having like the closet analogy of you

031

- Group - Normalising
- Group - Not alone
- Reducing shame
- Group - gender of participants
- Group - Different pace suits different people
- Relaxation