Exploring clients' and therapists' experiences of compassion focused therapy in fostering post-traumatic growth

Exploring Clients' and Therapists' experiences of Compassion Focused Therapy in fostering Post-Traumatic Growth

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Declaration

This work has not previously been presented in any form to the university or to any other body for the purpose of assessment, publication or for any other purpose. Apart from any references or bibliographies cited in this work, I confirm that this work is a result of my own efforts, under the supervision of Dr Christopher Cockshott and Dr Rosalyn Collings.

Signature – Chloe Ward

Date – 12th November 2022

Abstract

Introduction: Within the trauma-based literature, research has started to highlight how some individuals may experience positive, life-changing responses following traumatic life events which have been described as post-traumatic growth (PTG). Research has started to focus on the role of trauma-based psychotherapy approaches in the facilitation of PTG for individuals who have experienced trauma, with limited research focusing specifically on sexual abuse.

Aim: This research aims to capture two different perspectives through two separate studies. The first study sets out to explore clients' experiences of compassion-focused therapy in facilitating post-traumatic growth following experiencing sexual abuse. The second study sets to explore Compassion-focused therapists' experience of compassion-focused therapy facilitating post-traumatic growth for clients who have experienced sexual abuse.

Methodology: Interpretative Phenomenological Analysis (IPA) was employed as an approach to understand lived experiences and the meanings/understandings which my participants have ascribed to those experiences. IPA was employed due to the limited amount of qualitative research which has focused on this phenomenon. *Method*: Semi-structured interviews were carried out with participants to examine their phenomenological experiences online. *Participants*: Three client participants were interviewed for the client study and eight therapist participants were interviewed for the therapist study.

Findings: For the client study, four superordinate themes were found: Life before therapy, the therapeutic process, changes within oneself and regaining aspects of their life back. For the therapist study, four superordinate themes were also found: Working through the therapeutic process, the witnessing of changes, maintenance of PTG post-therapy and knowing CFT works at a personal level.

Conclusions: Within both studies, the important role of de-shaming and taming the inner critic was discussed. The facilitation of PTG was experienced and witnessed by both sets of participants and the maintenance of PTG post-therapy was explored.

Implications: The findings highlight the importance of further research into this phenomenon, exploring different types of trauma with CFT and different study designs. Implications for practice are discussed, which include the use of CFT-based work within Improving access to psychological therapies (IAPT).

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My research would not have been possible without my research participants who gave their time to talk through their experiences and helped me to highlight the importance of completing research that focuses on individuals who have experienced sexual abuse, the role of post-traumatic growth and the implications of CFT.

Dedications

I would like to dedicate this doctorate to those family members and close friends around me. The encouragement and support that you have given me throughout has helped me more than I can put into words.

Chapter 1: Introduction

Thesis Structure

Chapter one will provide the reader with a brief outline of the thesis structure and an introduction and contextualisation of the research topic.

Chapter two contains a comprehensive literature review of my research area which sets out to inform the subsequent research aims through acknowledgement and a critical review of the current empirical evidence into trauma-based treatments and post-traumatic growth. Firstly, the review will set out the research topic in context considering the relationship between psychotraumatology, and the positive psychology movement. Which will then move the review towards trauma-based treatments and any research which has been investigated these treatments and PTG. The review considers any limitations of this research and concludes with research which has focused on CFT and PTG for various other traumatic experiences.

Chapter three covers the methodology chapter, providing the epistemological foundations and rationale for this research.

Chapter four covers an explanation of the methods section which includes the participants details, the data collection, and the analysis stages. This chapter also covers the ethical considerations and the trustworthiness, quality, and reflectivity of this research.

Chapter five is the data analysis of the participant's narratives, first, the client study is presented and then the therapist study is presented in Chapter 6. Tables are given which present the development and emergence of the themes for each study. Four superordinate themes were discovered for each study, which will be followed by quotes from the participant's data.

Chapter seven is the discussion providing a summary and critical evaluation of the findings considering the data analysis for each study, regarding the theoretical understanding of the topic area and the emerging findings. I discuss each study separately before bringing them together to

consider both perspectives for the first time. Theoretical and practical implications are discussed, alongside limitations of this research and areas for further research.

Chapter eight is a reflective appraisal of my experience of carrying out the research, considering how this has added to my development as a researcher and a practitioner, the challenges of the research are discussed and how the research contributes to the field of counselling psychology.

The references and appendix section concludes this thesis.

Introduction to Research Topic

Across an individual's lifetime, there is the potential for an individual to experience difficult life events and personal adversities which can challenge an individual's ability to navigate through day-to-day life and cope emotionally, physically, and psychologically. One of these difficult life events includes experiencing sexual abuse, which can often result in personal distress and a range of emotional difficulties, some of which resemble post-traumatic stress disorder (PTSD). Throughout the years, professionals within the trauma field have focused on trying to reduce the negative consequences that the trauma has caused by alleviating the symptoms within their therapeutic work with clients. This is effective within the research field and both therapists and clients have witnessed a reduction in PTSD-like symptoms.

However, more recently there has been a shift towards positive psychology which considers the adaptive outcomes an individual may experience following experiencing a trauma. Researchers within the positive psychology field, recognise the negative consequences but also have started to explore what positive changes may be experienced (Joseph & Linley, 2008). These positive changes could be termed stress-related growth, adversarial growth, or post-traumatic growth (PTG).

Post-traumatic growth has started to be researched with trauma-based treatments such as Cognitive-Behavioural Therapy (CBT) and Eye Movement Desensitisation Reprocessing (EMDR). Research has started to look at PTG and Compassion-focused therapy which is a relatively new therapeutic approach within the research field for traumatic experiences such as bereavement (Johannsen & Schlander, 2022).

In the literature review that follows, an account of the processes, theory, research evidence-base and clinical treatments associated with trauma and PTG will be considered to gain knowledge, stimulate thought and suggest future research directions around the phenomenon of PTG. Consideration will initially be given to the nature of traumatic experiences and the psychological impact of distressing life events. The focus will move towards how people may adapt to these life events and can gain positive outcomes following their trauma. This will be explored in the context

of PTG from a theoretical perspective and then moving towards focusing on the fostering of PTG through trauma-based treatments. Finally, the review will consider any research which has focused on CFT and PTG with other traumatic experiences, and specifically sexual abuse within group-based programmes.

The overarching aim of my research is to consider the experience of CFT and post-traumatic growth from both the clients' and the therapists' perspectives. For my 'client' study, the research question is, 'How do clients who have undergone CFT make sense of its impact on their PTG'. For the 'therapist' study, my research question will be, 'How do compassion-focused therapists experience and make sense of post-traumatic growth for their clients?'

Chapter 2: Literature Review

In this chapter I will provide literature surrounding trauma, post-traumatic growth and compassion-focused therapy as outlined in the introduction. My search strategy for this literature review was through google scholar, APA PsycArticles and Web of science. My keywords that were used throughout this literature review were trauma, sexual abuse, CFT, PTG, shame, self-criticism, qualitative, IPA, and positive psychology. The search results were then narrowed down by focusing on research predominately over the past twenty years. For sections of my literature review, there were large amounts of data retrieved, therefore I compiled a list of articles with the key aspects of each article and reduced the data through frequency counts.

2.1 Trauma, Posttraumatic responses, and the view from Applied Psychology

Trauma can be explained as an emotional response to an incident or event which has occurred (Horowitz & Reidbord, 1992), this could include a single incident of trauma over one's lifetime, to more complex, cumulative traumatic experiences across the life course (Krystal, 1978). The initial reactions to trauma may include dissociation, sadness, anxiety, agitation and feelings of numbness and confusion (Elsesser et al. 2005). These single or cumulative traumatic experiences can also be described as adverse life events, which can inflict psychological, emotional, and physiological symptoms to occur for the individual (Briere, 1992).

For some individuals who have experienced these life events, the symptoms may develop and become more problematic within their life which can lead to a diagnosis of Post-Traumatic Stress Disorder (PTSD) (Yehuda, 2002). Within the Diagnostic and Statistical Manual of Mental Disorders, otherwise known as the DSM-5, for a diagnosis of PTSD to be met, individuals would have been exposed to a traumatic event, experience one or more symptoms which are within the intrusion category, one or more symptoms within the avoidance category, negative changes in feelings and mood and changes in arousal or reactivity (American Psychiatric Association (APA), 1994). The symptoms which fall under the intrusion category are those related to intrusive thoughts and memories of the traumatic event such as flashbacks, dissociation and repeated upsetting dreams

which relate to the event. Those symptoms related to avoidance include avoidance of specific places, people, objects, or situations which may bring up memories of the event. People who experience PTSD may experience a pervasive negative emotional state, experience an inability to recall the event, elevated self-blame, feelings of shame and self-criticism can also occur (APA, 1994). Finally, within the DSM-5 individuals with a diagnosis of PTSD often have trouble in concentrating, a heightened startle response and changes in behaviour which include irritability or aggression. For a diagnosis of PTSD to be met, symptoms must have lasted for over a month, interfere with aspects of an individual's life, and must not be due to a medical condition or substance misuse (APA, 1994). Within this diagnosis of PTSD, exposure to a traumatic event does not always have to be direct exposure, the exposure could be indirect through witnessing the event happening or having repeated exposure to distressing details of a traumatic event, which can be termed as vicarious trauma (APA, 1994). This type of vicarious trauma can be experienced by helping professionals such as the police or therapists (Jenkins & Baird, 2002).

2.2 PTSD and Sexual abuse

Recently, there has been an increase in individuals with a diagnosis of PTSD seeking support from services (Maniglio, 2013). Research has found this increase, especially, for those who have experienced a form of sexual abuse, both historic and recent (Maniglio, 2013). Those who have experienced sexual abuse have an increased likelihood of developing symptoms of PTSD (Finkelhor, 1987). Research has found these symptoms commonly include nightmares and intrusive thoughts (DiMauro & Renshaw, 2021). Bhuptani and Messman-Moore (2019) also found that these individuals experienced high levels of shame and self-criticism, which will be further discussed in this literature review. Most of the research within the trauma field highlights the extent to which traumatic experiences can cause significant distress, however, it is important to note that not all individuals develop the symptoms of PTSD due to variables that may buffer the impacts such as mediators and moderators (Norris & Slone, 2014). These mediators and moderators for why individuals may not experience traumatic symptoms can include the role of social support, individuals' personality, and emotional regulation skills (Gaher et al. 2013). Christopher (2004)

highlighted that responses to trauma include individuals working through their trauma as part of the natural adaptive processing using all the available social resources and coping strategies from within their own life. Herman (2015) provides research to discuss how individuals may recover following a traumatic event. They emphasise that recovery involves the development of a renewed sense of safety, stabilisation of trauma symptoms through emotional regulation and the development of personal control and trust. They also noted recovery includes the client's re-storying of their lives, which can be completed alone however many individuals require support through this process. These changes which can occur during this recovery can lead to an accommodation of the trauma experience into an existing schematic framework described by Horowitz (2011) as the completion principle and by Janoff-Bulam and Timko (1987) as the restructuring of the person's assumptive world.

Research within my literature review is focused on the past twenty years, prior to this, literature has focused on the impact of sexual abuse on individuals and the forming of PTSD symptoms, exploring the impact sexual abuse has on an individual, mostly child sexual abuse (Gentile, Wolfe & Wolfe, 1989). For individuals who have been sexually abused, self-criticism and shame were started to be explored however the emphasis was on mental health difficulties such as depression and anxiety (Roesler & McKenzie, 1994). As research developed in this area surrounding sexual abuse and PTSD, theoretical approaches were started to be considered to help support individuals psychologically, in alignment with the NICE guidelines, third-wave approaches such as acceptance and commitment therapy (ACT) and compassion-focused therapy (CFT) were yet to be investigated.

2.3 The Theoretical Perspectives of PTG

In the past, there has been a focus within the trauma-based literature when focusing on trauma responses and PTSD on the negative consequences of trauma which focuses on the psychological and emotional distress people may experience (Dye, 2018). However, recently within the past ten years, there has been a shift within this focus in the literature towards a salutogenic perspective within the field of applied psychology, focusing on positive psychology and adaptive

outcomes (Joseph & Sagy, 2022). This salutogenic perspective within positive psychology allows individuals to develop an understanding of potential traumatic experiences which integrates post-traumatic distress alongside adaptive positive changes within a single conceptual framework (Joseph & Sagy, 2017). This perspective slightly moves away from the view of psychology being related by an illness ideology of mental health to a more holistic and wider contextual understanding of diverse responses to life changes and traumatic events (Joseph & Sagy, 2022). Authors have explored that those adverse traumatic experiences in which individuals may experience may not always have a detrimental outcome and there is a potential opportunity for positive outcomes to occur such as increased resilience (Holtge et al. 2018).

This positive psychology framework could contribute to the understanding of traumatic experiences through the interaction of a variety of concepts which can relate to personality and strategies of coping, along with sociological factors (Joseph & Sagy, 2017). This new integrative viewpoint provides a wider focus which can consider not only the negative outcomes but the possibility of experiencing growth and positive psychological changes which move beyond the idea of the recovery of resilience (Tedeschi & Calhoun, 2004). This literature review will now focus on these adaptive outcomes which can be experienced following a traumatic experience.

2.4 Adaptive outcomes following trauma

The positive changes that can occur following adversity have been recognised within literature which covers areas of philosophy and religion (Tedeschi & Calhoun, 1995). These positive changes can be reportedly found following experiences of sexual assault, military combat, and natural disasters (Tedeschi & Calhoun, 1995). These studies which focus on the adaptive outcomes that can occur following a traumatic experience are an important area within the research for several reasons. One is that focusing only on the negative consequences of trauma can lead to an understanding of posttraumatic reactions as being biased, secondly, any understanding of trauma reactions must consider the potential for changes which could be positive as well as negative for it to be considered comprehensive (Linley & Joseph, 2004). From an applied psychology perspective, it can be useful for clinicians to be aware of the potential for positive changes in their clients

following trauma. This awareness of potential changes can be used as a foundation for further therapeutic work, providing hope that the trauma can be worked through and that there is a possibility for there to be hope for their clients (Calhoun & Tedeschi, 1999). These adaptive outcomes can include a sense of meaning and purpose within life, building resilience and a greater appreciation for life.

Literature has focused on adaptive outcomes following various types of traumas, for example, literature by Calhoun et al (2010) focused on positive outcomes following bereavement for individuals. There has been evidence found through quantitative and qualitative research which has highlighted the negative impacts of losing a loved one, however, research has found that for some people, coping with bereavement can provide the context for significant positive changes (Cadell et al, 2003). Calhoun et al (2010) highlighted within their paper that it is equally as important to consider those negative outcomes from trauma as well as focus on the positives which may arise. They found that individuals within their research were experiencing significant psychological distress and major challenges to adjustment and adaption, but along with these negative aspects, there was a recognition of personal strengths in the context of adversity, these changes occurred through a timeline indicating the negative changes were experienced before adaptive outcomes. Other domains which were focused on included an experience of changing relationships with other people, a sense of connectedness and an appreciation of life.

The concept of an individual experiencing adaptive outcomes following an adverse experience has been linked with the humanistic field of research and psychotherapy. The sense of purpose and hope and meaning when individuals may be exposed to horrific experiences, has been explained in Viktor Frankl's work (1984). Also, the concept of self-actualisation (Maslow, 1968), Maslow describes that all individuals can become the best version of themselves, self-actualisation represents the highest-order motivations, which drive us to realise our true potential and achieve our 'ideal self'.

2.5 Adaptive outcomes following sexual abuse

Sexual abuse defines as unwanted sexual activity, with perpetrators using force, making threats, or taking advantage of victims who cannot give consent, commonly individuals will experience physical and emotional abuse alongside sexual abuse (Kazdin, 2000). Child sexual abuse refers to sexual abuse occurring when the individual is under the age of 16 (Johnson, 2014). Sexual abuse differs from other types of traumas as individuals have a greater possibility of experiencing guilt and shame as well as a lack of compassion for themselves due to the negative emotions experienced (Aakvaag et al, 2016). Research has explored the possibility of adaptive outcomes for individuals who have experienced sexual abuse, in particular childhood sexual abuse (Woodward & Joseph, 2003). Within their research through using thematic analysis, they identified three domains of themes related to positive change processes, these included an inner drive towards growth, vehicles of change and psychological changes. Participants noted how they had a belief or faith in themselves, changes in self-perception and relationships, an awakening of responsibility and a sense of experiencing validation and acceptance from others. Literature has specifically explored adaptive outcomes explored by women following an experience of sexual abuse. It has been found that women engaged in purposeful introspection to connect with themselves, utilized altruistic actions and identified a relationship with themselves (Guggisberg et al. 2021).

2.6 Defining Posttraumatic Growth

As explored within the earlier sections of this review, there has been a recent movement towards positive psychology and exploring these positive outcomes since the late 1990s. Positive psychology defines as the scientific study of what makes life most worth living (Compton, 2005). This branch of psychology focuses on the strengths, virtues and talents that contribute to successful functioning and enable individuals, groups and even communities to flourish (Compton, 2005). This perspective highlights that individuals have the drive to seek happiness within their lives, to be all they can be and to transcend surviving and creating a life that is meaningful and has a purpose (Tedeschi & Calhoun, 1995). Research has explored how the field of counselling psychology can benefit from reconnecting with positive psychology, reconnecting with its positive roots and engaging with the ideas and research that supports the positive psychology movement (Steffen,

Vossler & Stephen, 2015). By doing so, the field of counselling psychology can work towards developing a more balanced and strength-orientated way of working, with a commitment towards human flourishing and actualisation (Steffen et al, 2015).

This movement has been mirrored within the field of psychotraumatology (the study of psychological trauma) with new insights into the processes behind the growth experience that can be felt by individuals who have being exposed to trauma (Thomadaki, 2017). Tedeschi and Calhoun (1995) proposed the concept of Post-traumatic Growth (PTG) that includes a coherent conceptual model of PTG through examination and synthesis of the literature into positive changes following trauma. Tedeschi and Calhoun (1995) define PTG as the positive psychological change that is experienced because of the struggle with highly challenging life circumstances. The concept of PTG covers positive changes after trauma within three broad domains of change: changes in life philosophy, changes within the area of self-perception and changes in relationships with others, these areas are captured under the Post-traumatic Growth Inventory (PTGI).

The Post-Traumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996) was developed to evaluate whether or to what extent an individual may have achieved PTG. The inventory has excellent internal consistency (a.90), acceptable test-retest (r.71) and reliability (Tedeschi & Calhoun, 1996). Validity is supported by evidence that PTGI responses tend to be corroborated (r.69) by others close to the person reporting growth (Shakespeare-Finch & Enders, 2008; Weiss, 2002) and scores are not correlated with measures of social desirability (Tedeschi & Calhoun, 1996).

This inventory looks for positive responses within five different areas, these include an appreciation of life, relationships with others, new possibilities in life, personal strength, and spiritual change (Tedeschi & Calhoun, 1996). PTG involves psychological shifts in thinking and relating to the world and the self which can be termed as ‘life-changing’, that all contribute to a personal process of change (Calhoun & Tedeschi, 2004). Research has explored various factors which have been associated with adaptive growth following exposure to trauma such as spirituality (O’Rourke et al, 2008), social support (Ozbay et al.2007) and supportive therapy (Zoellner & Maercker, 2006). Regarding the domain of close and meaningful relationships with individuals

within the PTGI, research by Waugh et al (2018) gathered qualitative research focusing on PTG in bereaved parents has provided an example of such change (Waugh et al. 2018). The experience of deeper and more meaningful relationships can occur along with the loss or disappearance of other relationships.

These experiences of PTG have been shown to occur across many different traumatic events as shown within Linley and Joseph's (2004) empirical review of 39 studies. These include bereavement, personal illness, disability, physical and sexual abuse, natural disasters, and military combat. Research which has primarily focused on the nature of PTG in adult survivors of child sexual abuse found that in one study 87% of child sexual abuse survivors reported some improvement in their symptoms due to their adaptive ways of coping (Wright et al. 2007). Kaye-Tzadok and Davidson-Arad (2010), also found PTG among one hundred women survivors of childhood sexual abuse, relating to cognitive strategies, a reduction in symptoms and resilience. Hartley et al (2008) conducted an explorative study through Interpretative Phenomenological Analysis and conducted in-depth interviews with six women survivors who noted experiencing growth through relationships with others, making sense of their abuse and past behaviour, growth concerning culture and relating to self in a new way (Hartley et al. 2006). It appears that the phenomenon of post-traumatic growth occurs in a wide range of people facing a wide variety of traumatic circumstances.

An important consideration researcher Tedeschi and Calhoun (1996) have highlighted is that PTG can be experienced by individuals who have experienced various traumatic experiences as highlighted above. However, they are very clear that the positive changes do not detract from the distress experienced by people going through trauma reactions and not all people will experience positive changes, experiential processes of change or PTG. A meta-analysis by Vishnevsky et al. (2010) explored whether there were any gender differences in self-reported PTG from seventy studies. Their review found that there were limited gender differences for self-reported PTG between females and males (g= .27, 95% CI =.21, -.32). Within their findings they found that men were more likely to experience a traumatic event, whilst women were more likely to meet the criteria

for PTSD, possibly explaining why they may experience more PTG and seek support through psychotherapy. However, a limitation of this review was that there were more studies which focused on women and their traumatic reactions therefore generalisations may be limited.

Individual characteristics have been found to affect the likelihood that PTG may occur, and these include personality characteristics such as extraversion and openness to experience (Costa & McCrae, 1992), optimism was found to be also positively correlated to PTGI scores (Tedeschi & Calhoun, 1996) highlighting a correlation between optimism and cognitive processing. Another individual characteristic includes how an individual manages distressing emotions, being able to manage initial distress can allow for some degree of constructive cognitive processing to occur which can produce schema changes that can contribute to the experience of PTG. The support of others can aid the facilitation of PTG by providing a way to craft narratives about the changes that have occurred and offering perspectives that can be integrated into schema change (Neimeyer, 2002), focusing on determining the degree of willingness trauma survivors have to incorporate new perspectives or schema (Tedsechi & Calhoun, 1993).

Tedeschi and Calhoun (2004) propose that when individuals experience PTG, these changes have an ongoing mutual influence on the development of general wisdom about life. For individuals who experienced trauma, Tedeschi and Calhoun (2004) explain that their lives are often conceptualised by having a before and after, for example, before and after the loss of a baby or before and after the sexual assault. They described that the difficulty of dealing with trauma can lead to the possibility of PTG with a revised life story starting to form explaining the individual's life narrative and PTG may mutually influence each other. They explain that they believe PTG to be a process as well as ongoing growth and that some individuals will continue to experience these changes across their lifespan. Research has found that post-traumatic growth tends to start within three months of experiencing the traumatic event, with factors such as personality and support networks as influencers for PTG to be facilitated for an individual (Cho & Park, 2013).

However, like many concepts within the field, the concept of PTG is not without its limitations which have been noted throughout the Counselling/Psychotherapy literature. For

example, research has highlighted that positive life changes after an adverse incident have been interpreted very heterogeneously (Sumalla et al, 2009) such as adaptive or dis-adaptive distortions of reality, coping strategies, personality changes, and genuine changes of behaviour and identity. Authors have suggested that the influential assessment model of Tedeschi and Calhoun (1996) is likely to reflect a western worldview (Vazquez et al. 2014), explaining that notions such as stress, trauma and PTG are not perfectly transferred to non-westernised cultures. For example, Das (2006) developed the anthropological psychology of suffering which is considered a more accurate representation of the Indian concept of life. Compared with the common view of stress as perturbing to habitual homeostasis, the Indian concept of suffering refers to an intrinsic life condition, thus, the human being must develop detachment, immutability, and compassion to dominate it. Das (2006) explains that all individuals will experience some form of suffering in their lives and that suffering must be seen as part of normal life (Kieinman & Kleinman, 1999). Perez-Sales (2008) explain that cultural context moulds experience and the determinants of stress, shaping the types of events that an individual is likely to experience as traumatic or stressful, the appraisal of stressfulness and the coping strategies adopted. Thus, PTG and associated processes very likely depend a great deal on cultural factors and these need to be considered within this field (Vazquez & Paez, 2010).

A transcultural view of PTG involves analysing (a) if a similar concept exists in most cultures, and (b) what its nature would be from within the culture and (c) which occurs by observers outside of the culture perspectives. To deliberate these cultural considerations, Calhoun et al (2010) provided literature exploring the sociocultural considerations of PTG, including the use and adaptation of the PTGI in the non-westernised world, the concept of PTG in a variety of different geographical and cultural contexts and an examination of elements of culture that may be useful when looking at PTG in different cultures and the adaptability. This research concludes that the concept and assessment can be applied in other cultures, however, the choice of language and the definition of change may differ amongst different cultures.

2.6.1 Positive psychology and Counselling Psychology

When working with clients who have experienced stressful and traumatic events, positive psychologists are concerned with not only alleviating the distress but also facilitating positive functioning. Literature on the facilitation of growth following adversity is only beginning to develop within the past decade and to come to the awareness of researchers within the field of post-traumatic stress. A recent paradigm shift has been that facilitation of growth has become a goal of therapeutic intervention rather than only the alleviation of distress (Linley & Joseph, 2005).

It is important to note that the alleviation of PTSD symptoms does not necessarily indicate the presence of growth, the presence of growth incorporates various factors which may include a greater appreciation of life or spiritual changes, reduction of symptoms may occur before these changes are experienced for individuals. However, growth following adversity does seem to be predictive of more significant emotional adjustment over a long period of time (Park & Fenster, 2004) Research has found associations between benefit finding and lowered distress (Davis et al. 1998) and better physical health (Epel et al. 1998). Longitudinal studies such as those by Frazier et al (2001) found that sexual assault survivors who reported growth over 12 months following therapy were the least distressed of all participants. Further evidence has found that helping individuals to perceive and work towards growth has been used as a therapeutic vehicle to help individuals cope with adversity and illness (Kiecolt-Glaser et al. 2002; McFarland & Alvaro, 2000). This implication suggests growth may be a useful target of therapeutic interventions in both clinical and health settings, where the aim is long-term emotional and physical adjustment, and better coping, rather than growth. To gain a wider understanding of the clinical significance of PTG within the practising field of psychology, my review will now focus on the role of psychological interventions for trauma.

2.7 Research into treatment and Posttraumatic growth

Within the growing research field of PTG, factors associated with PTG have helped to increase the understanding of the processes involved in positive change following trauma. The importance of cognitive and affective processing, narrative meaning-making, and the interpersonal psychosocial factors towards the development of PTG leads to the consideration of the role current

trauma-focused therapies may have in offering a potential environment for the facilitation of PTG in a clinical context (Joseph & Linley, 2006).

Counselling psychologists aim to integrate theoretical and experiential factors to consider the applied aspects of the phenomenon (Cooper, 2009; Goldstein, 2009). Within the field of PTSD and PTG, this integration of theory, process and practice have also been considered important to understanding the phenomenological experiences of trauma and subsequent outcomes. Within my review, the focus will predominately be centred on the consideration of treatments for trauma, to the experience of PTG. By focusing on this area of trauma within clinical practice, my review will provide of background of the interventions available. Research has primarily focused on first-line treatments which are recommended by the National Institute of Clinical Excellence guidelines (NICE; 2019). These recommended treatments will be discussed separately, leading to why compassion focused therapy, as a new approach, will be considered in this research.

2.7.1 Cognitive behavioural therapy (CBT) and PTG

Firstly, research which has predominately focused on the application of trauma-focused CBT has found that this approach can lead to increased levels of PTG and improve emotional regulation techniques in children who have been abused (Farnia et al; 2018). This approach was found to help aid children who have experienced abuse to utilise healthy emotional recognition and regulation strategies. These studies' results confirmed another trauma-focused CBT study which looked at CBT's effectiveness in facilitating PTG for survivors of vehicle accidents (Zoellner & Maercker, 2006). Zoellner and Macercker (2006) found that within the CBT group of their study, increases in PTG were predominately in areas of new possibilities and personal strengths for individuals within their study.

Intrusive thoughts about traumatic events are an important factor in determining the development of PTG. Research has found that Trauma-Focused CBT can help alleviate the intrusive reexperiencing and rumination aspects associated with PTSD, focusing on an area of reflection and growth which is associated with aspects of PTG (Stockton, 2011). Furthermore, Nightingale et al

(2010) produced findings on the impact of receiving an HIV diagnosis has for an individual. They showed the effectiveness of this cognitive method in improving PTG and has helped individuals work through their difficulties concerning the trauma. Within this approach, it has been found that by focusing on thought-based ruminations and emotional regulation, the process of PTG can be facilitated (Shigemoto et al. 2017).

Within a study that focused on internet-based CBT intervention, 96 individuals were randomly assigned to either a treatment or waiting list control condition. They focused on posttraumatic stress reactions, depression, anxiety, optimism, and PTG. They found significant changes in PTG in the treatment group and significant symptom improvements in posttraumatic stress reactions. Their findings consolidated the potential of CBT to stimulate changes which resemble PTG for individuals (Knaevelsrud et al. 2010) with most improvements found for individuals after working through the cognitive processing element of CBT, as also found by Knaevelsrud et al (2010), no further follow up has been documented at this present date.

2.7.2 Exposure therapy and PTG

Research has focused on treatments for specific occurrences of PTSD and the relationship to PTG. For example, research by Foa et al (2005) focused on narrative exposure therapy for the treatment of child war survivors. This treatment was a short-term therapeutic intervention for six children experiencing difficulties with PTSD aged between twelve to seventeen years of age. Symptom reduction was evident immediately after treatment and the treatment outcomes were sustained at a nine-month follow-up. All participants reported functioning gains and an ability to reconstruct their traumatic experiences into a narrative with the use of illustrative material. It is noteworthy that these individuals had experienced multiple and very severe war events, although further research will need to be conducted to make such comparisons with different groups of adults and the applicability to the adult population.

Hagenaars and Van Minnen (2010) support the work of Foa et al (2005) with the role of exposure therapy in facilitating PTG for individuals. Hagenaars and Van Minnen (2010) explored

the relationship between exposure-based treatment for PTSD and the outcomes of PTG. Participants of their study had experienced a range of traumatic events such as road traffic accidents and loss, they were measured for their experience of PTG through completing the PTGI at different timescales, pre and post therapy. Researchers found that there was a significant improvement in participants' measures of growth following exposure therapy. A follow-up analysis was completed which focused on the sub-factors of the PTGI, and they found that the areas of personal strength, new possibilities and relating to others were the most significantly increased. From these findings, they suggested that these specific component elements of the growth measure may be related to the elements of mastery and improvements in social interactions developed through the exposure treatment. This study draws attention to the potential positive effects that treatments may have on personal growth.

2.7.3 Solution-focused therapy and PTG

The effectiveness of solution-focused therapy for individuals who have experienced trauma has also been explored, which was first reviewed by Eads et al (2019). Researchers found solution-focused therapy had an impact on individuals' trauma symptoms and recovery, increases in changes that resemble PTG and benefits for sleep difficulties. They found Solution Focused Therapy showed large effect sizes for PTG compared to a control group providing support that this approach encourages PTG and recovery. However, this review was only conducted on a small number of studies and consisted of a lack of high-quality controlled studies, which therefore significantly limits the conclusions that can be drawn regarding the effectiveness of this approach.

2.7.4 Eye movement desensitization reprocessing and PTG

A therapeutic approach which is also highly recommended for the treatment of PTSD is Eye Movement Desensitisation and Reprocessing (EMDR) (Shapiro, 2012). Research has recently started to explore the role of EMDR and the facilitation of PTG (Jeon et al. 2017). This study was conducted using a sample of ten survivors of a large-scale maritime disaster that occurred in South Korea in 2014. A total of eight sessions of EMDR were delivered over five months, and the PTGI

was measured pre-treatment, after sessions four, eight and three months after completion. These researchers found that after three months from therapy completion, significant increases were observed in PTGI scores, and a decrease in symptoms were experienced relating to PTSD was found. However, within this sample size of participants, one individual did not show any improvements in scores on the PTGI. This research however focused on a very specific type of trauma for a sample size of eight participants which limits the generalisability of their results. There was also no control group for comparisons and the PTG was not monitored any longer than three months after completion.

Further research has supported the work of Jeon et al (2017), a systematic review explored whether positive religious or spiritual change, an aspect of PTG can be facilitated through EMDR treatment. Loewenthal (2002) found multiple articles that highlighted religious and spiritual change can follow EMDR treatment and could also be a feature of overall PTG. However, further research is required to determine whether this change is independent of PTG or related to other aspects of PTG. For research that has highlighted the facilitation of PTG through receiving EMDR treatment, it has shown changes within the spiritual change and gratitude for life subscales of the PTGI (Jeon & Han, 2015). An Interpretative Phenomenological Analysis study focusing on the role of EMDR in facilitating PTG found that the revaluation phase of the treatment is a key aspect which influences this facilitation of PTG, and they highlighted that PTG is more than just symptom relief (Dickson, 2019).

2.7.5 Psychotherapy for survivors of sexual abuse

A variety of traumatic experiences have been explored within this review; however, sexual abuse has not been focused on regarding psychological interventions. Most of the literature has focused on therapeutic approaches when working with children who have been sexually abused. For example, the role of equine-facilitated therapy has been explored (Kemp et al, 2014), art therapy (Murphy, 1998; Pifalo, 2002) and narrative storytelling (Reichert, 1998). For adults who have been through an experience of sexual abuse individual and group therapy has been compared over a short period and improvements have been found in both symptoms and functioning (Stalker & Fry, 1999).

Core therapeutic concepts have been explored in psychotherapy which has been found to be helpful for working with those who have had this experience. These concepts include the acceptance of oneself as a survivor, experiencing adult sexuality as voluntary and mutual and focusing on living well in personal, sexual, marital, and parenting roles (McCarthy, 1997).

Within the literature, most of the research has focused on individuals who have been sexually abused as a child, with therapeutic approaches focusing on these traumatic experiences. The literature has provided support for the use of psychotherapy which is more individualised for the survivor as an important aspect in achieving optimal client outcomes for PTSD and the interpersonal difficulties which may arise from abuse (Cowan et al. 2020). They provide support for psychodynamic psychotherapy, trauma focused cognitive behavioural therapy and EMDR in the treatment of clients following sexual assault and abuse. Further support highlighted the role of psychosocial interventions that are informed by cognitive behavioural models, particularly those including trauma exposure can reduce post traumatic symptom severity (Lomax & Meyrick, 2022).

However, there is a lack of research which focuses on the role of PTG and how this can be facilitated through therapy for individuals who have experienced sexual abuse. Over the last decade, there have been systems of psychotherapy developed that integrate techniques from CBT with concepts of evolutionary, social, developmental, and positive psychology such as compassion-focused therapy (CFT). CFT has started to become more popular for practitioners to utilize whilst working with individuals who have trauma, especially focusing on levels of guilt and shame, linking to a lack of self-compassion, commonly experienced by those who have experienced sexual abuse.

2.8 Compassion Focused Therapy and Posttraumatic growth

The concept of compassion is a central aspect of the therapist-client relationship, alongside empathy and providing a non-judgmental therapeutic space. The concept of compassion has recently been considered through the lens of western psychological science and research (Davidson et al. 2002; Gilbert, 2000, 2005, 2009). Individuals can learn compassion and practise this skill which can have a positive impact on the neurophysiological and immune systems, as found by Davidson et al

(2003). Compassion-focused therapy (CFT) refers to the underpinning theory and process of applying a compassion model to psychotherapy (Gilbert, 2009). This approach consists of activities which attempt to develop compassionate attributes and skills, develop self-compassion, and focus on regulation. The philosophy that underlies this approach is the understanding of the psychological and neurophysiological processes which develop at a fast pace moving towards a more integrated biopsychosocial science of psychotherapy (Gilbert, 2009).

Compassion-focused therapy arose from several observations. Firstly, individuals with high levels of shame and self-criticism can have great difficulty in being kind towards themselves or being self-compassionate. Second, it has been noted that shame and self-criticism difficulties are often rooted in a history of abuse, bullying, highly expressed emotions within the family, neglect, or a lack of affection (Gilbert & Andrews, 1998; Schore, 1998). Individuals who may have had these experiences can be sensitive to signs of rejection or criticism from others and start to turn often towards attacking themselves. Thirdly, it has been noted that working with shame and self-criticism requires a therapeutic focus on working with memories of such early experiences (Brewin, 2003, 2006). Fourth, clients who have engaged in the cognitive and behavioural aspects of therapy, by challenging their thoughts they can still feel stuck, and the blame may remain. It is often that individuals displaying these high levels of shame and self-criticism find it difficult to generate feelings of safeness and security within their relationships with themselves and others (Gilbert, 2009).

Within the approach of CFT, compassion is understood in terms of specific attributes and skills, central to this approach is compassionate mind training, by demonstrating the skills and attributes of compassion the therapist instils them into the client. The client is helped to develop an internal compassionate relationship with themselves to replace the blaming and self-critical one that is present. Gilbert (2009) explored the attributes of compassion, which include care for well-being, sensitivity, sympathy, distress tolerance, empathy, and non-judgment. The skills of compassion include creating feelings of warmth, kindness and support towards oneself and others. Within CFT, therapists will teach their clients to use these skills on themselves, focusing on fostering

compassionate attention towards oneself. Other compassion-based skills include compassionate reasoning, behaviour, feeling, sensation, and imagery. Therapeutic interventions may include compassionate letter writing, building a compassionate image, and exploring compassionate ways of thinking, breath work can be incorporated also (Beaumount & Hollins Marion, 2015).

Over the recent years, there has been a shift within the world of psychotherapy and an increase in the use of third-wave CBT approaches such as mindfulness (Williams, 2004), Compassion focused therapy (Gilbert, 2005) and acceptance and commitment therapy (Pierson & Hayes, 2007). Within the community where the care of others is of utmost importance, there is growing evidence to show that developing feelings of compassion for the self and others can have a profound impact on physiology, mental health, and wellbeing (Gilbert et al. 2006; Harman & Lee, 2010). A randomised controlled clinical trial which looked at the effectiveness of CFT compared to no treatment as a psychological intervention for clinical populations indicated that CFT was more effective in eating disorders (Duarte et al. 2017), depression (Noorbala et al. 2013), and psychosis (Braehler et al, 2013).

With CFT's growing evidence base for its use in a variety of difficulties (Leaviss & Uttley, 2014), approaches and models have started to focus on working with PTSD and trauma (Lawerence & Lee, 2014). To date, there are limited studies that have looked at the outcome of CFT in trauma populations. A study by Beaumount et al (2012) found that for clients who had experienced trauma, for those receiving CBT or for those receiving a combination of CBT and compassionate mind training skills (CMT) which is an aspect of CFT, both experienced a significant reduction in symptoms of anxiety, depression, avoidant behaviour, and intrusive thoughts. Interestingly, those participants in the combined CBT and CMT group reported significantly higher levels of self-compassion than those just receiving CBT.

An interesting piece of qualitative research explored people's experiences of compassion-focused therapy for trauma using an Interpretative Phenomenological Analysis (IPA) study (Lawrence & Lee, 2014). Five main superordinate themes emerged from the data, which included the battle to give up the inner critic, how it feels to develop self-compassion, the emotional

experience of therapy, self-compassion as a positive emotional expression and a more positive outlook in the present and for the future. They found that self-criticism formed an important part of the participants self-identity and at first there can be an aversive nature towards developing self-compassion, as found by the participants in this research (Lawrence & Lee, 2014). There was a sample size of eight participants, and the majority of the sample was female for this research. It may also be that due to the variety of traumatic experiences which were focused on in this study that self-compassion may differ depending on the nature of the trauma.

For individuals who have experienced sexual or domestic abuse, research has found high levels of shame and self-criticism for these individuals (Bhuptani & Messman-Moore, 2019; Lassri et al. 2018). Research by McLean et al (2018) highlights the effectiveness of CFT for working with individuals who have had an experience of sexual abuse, child sexual abuse specifically. Their work highlighted that through CFT, there can be an acknowledgement of the role of early attachment experiences, the cultivation of compassion to respond to feelings of shame, regulation of the threat-based system following trauma and an alternative to the avoidant-based coping strategies by responding to distress through compassion. They concluded by stating that the theoretical framework and core focus or aims of CFT are highly applicable for survivors of sexual abuse and hold significant promise as a treatment option for this client group. Further research has supported their claim, such as the work of Chouliara et al (2014), Irons and Lad (2017) and McLean (2021) with their compassion-focused group therapy work. However, work by McLean et al (2022) has focused on group based CFT, which can differ from individualised CFT, impacting aspects such as the therapeutic relationship. Within the CFT literature, most of the research focuses on only one perspective within this therapeutic relationship, which would provide multiple perspectives and provide further clinical implications for practice.

In relation to research which has focused on CFT and PTG, most of the research is within the field of physical health such as traumatic brain injury (Ashworth et al. 2011), COVID-19 (Matos et al. 2021) and cancer patients (Faghani et al. 2022). Natural disasters and the trauma individuals may experience following these events has been considered in relation to CFT and PTG (Liu et al.

2021). However, no research at current has focused on CFT and the facilitation of PTG for individuals who have experienced sexual abuse.

2.8.1 Therapists' perspective of CFT

Previous research within this literature review has included the use of quantitative research to look at the effectiveness of CFT or focused on the client's perspective. Both the client and therapist play an important role in any therapeutic process through the relationship, which is formed, therefore it is important to consider what therapists may believe may be working for their clients and what may not be working.

Gale et al (2017) focused on the therapists' experiences of the personal practice of CFT by producing a thematic analysis. The therapists identified compassion as a concept which can be adopted within their practice but also as part of their lifestyle through compassionate mind training. They explored the impact of personal practice on the therapists of compassion and how this may impact their therapeutic work. The themes which were identified included that with practice, the CFT exercises became automatic for the therapists outside of practice, self-compassion and compassion for others around them increased, they felt more present within the room with their clients, and they were more aware of the use of self and what they were bringing to the therapeutic space. Self-compassion is a concept therapists noted helped aid with compassion fatigue which can be a common experience that therapists can feel which can dampen the therapists' quality of life and professional work, alongside vicarious trauma. Quantitative research by Yip et al (2016) found a mediating role of self-compassion between mindfulness and compassion fatigue among therapists in Hong Kong, finding that aspects of compassion helped to work with preventing this fatigue. Finlay-Jones et al (2015) also found that self-compassion had significantly negatively predicted emotional regulation difficulties and stress difficulties among their sample of Australian psychologists.

2.9 Concluding comments and research aims.

Research has not yet focused on the effectiveness of individual CFT on facilitating aspects of PTG with other traumatic experiences such as with individuals who have experienced significant traumas such as sexual abuse.

Research has highlighted the role of adaptive outcomes following trauma, highlighting the positive psychology movement. Within this movement, the concept of PTG has been researched as a positive outcome which can be experienced by individuals following a trauma experience, with CBT and EMDR recognised as therapeutic approaches that may facilitate these positive changes for these individuals. The approach of CFT has being emerging within the field of psychology as an approach which can work effectively for those who have experienced trauma, and recently, with individuals who have experienced sexual abuse.

From the discussion of the above literature, there has been a narrow focus on therapeutic approaches role in facilitating PTG, whereas other evidence-based treatments such as CFT have received less attention within the literature. This limits the full understanding of the processes which may be involved in the facilitation of PTG. Sheikh (2008) recognised that research focusing on therapeutic approaches which may facilitate aspects of PTG is within its infancy stages. Sheikh (2008) state however how current trauma treatments have the potential to provide an environment conducive to PTG.

The research within this literature review highlights the current extent of the studies' endeavour to investigate the role trauma-focused therapies play in facilitating PTG. A key limitation within the research is that there has been an overemphasis on quantitative methodological approaches examining whether therapies can foster experiences of PTG. The research has predominately focused on control vs experimental group designs which is the 'gold standard' within research, exploring the findings through quantifiable measures. However, these measures do not provide a comprehensive understanding of the lived meaning-making processes shown to be important to experience growth following adversity. Furthermore, limitations have included limited

sample sizes which provide generalisability to specific traumas and with much of the research focus on CBT and EMDR as these are NICE approved therapies. These methodological and design difficulties further reduce the reliability of the results to demonstrate an understanding of the change processes involved in the facilitation of PTG.

Through the predominant quantitative focus within the research, studies can consider differences in PTG from pre- to post-therapy. This can acknowledge growth which may occur during therapy; however, it does not take account of the rich phenomenological experience of the therapeutic process. Research has predominately also focused on the impact/outcomes predominately through experiential research rather than the clients' experience of therapeutic approaches facilitating aspects of PTG. Research has highlighted that therapists also can experience aspects of self-compassion through the facilitation of this approach which can impact positively on their therapeutic practice. As noted, research into the area of CFT and PTG is within its early stages and is limited in exploring other significant trauma experiences such as sexual abuse. Research has found that individuals who experience sexual abuse are more likely to experience high levels of shame and self-criticism which the approach of CFT can target (Irons & Lad, 2017) and aspects of PTG could be facilitated however, this has not been explored within the literature at this present time.

The present research represents an attempt to meet these shortfalls in previous research by adopting a qualitative and phenomenological approach that will permit the exploration of the lived experiences of clients who have engaged with CFT, in addition, the current study considers the therapist's perspective of facilitating this approach. My research will also explore a new area of literature which has not been focused on, CFT and PTG and focuses on individuals who have experienced sexual abuse. To explore these lived experiences, Interpretative Phenomenological Analysis (IPA) (Smith, 2011) would provide a methodological approach were understanding the experience of PTG from both the client's and therapist's perspectives. This would emerge not through statistical examination of averages across groups of individuals but from the meanings of

significance individual participants give to their experiences during both receiving and facilitating CFT.

The advantages of using an IPA approach for my research include the exploratory nature of the study, and the phenomenological focus of the method, which is good for understanding the meanings and understandings of the participants concerning the chosen phenomenon. Also, the idiographic nature of this approach for the small sample size and in-depth nature of this study. The idiographic nature of IPA will be discussed further in chapter three and its strengths and weaknesses for this study.

Given the limited body of research evidence related to CFT and PTG, the present research will be carried out with a sample of clients who have completed their CFT treatment following receiving a diagnosis of PTSD and who have experienced of sexual abuse. The sample will also include CFT-trained therapists who have worked with clients facilitating this approach for individuals who have experienced sexual abuse. My research aims to separately gather the perspectives from both the client and therapist through two different studies: the client study and the therapist study. Through exploring these perspectives within the research, it is hoped that the findings may inform wider clinical knowledge for practitioners working within the area of trauma-focused therapy for individuals who have experienced sexual abuse.

The overarching aim is to consider the experience of CFT and post-traumatic growth from both the clients' and the therapists' perspectives. For my 'client' study, the research question is, 'How do clients who have undergone CFT make sense of its impact on their PTG'. For the 'therapist' study, my research question will be, 'How do compassion-focused therapists experience and make sense of post-traumatic growth for their clients?'

Chapter 3: Methodology

Within the methodology chapter, the rationale for why I choose the methodology will be discussed alongside the epistemological foundations of this research.

Methodological rationale & Epistemological foundations

Methodological Rationale

Firstly, I considered potential methodologies for exploring the potential facilitation of PTG following individuals experiencing trauma, specifically sexual abuse and utilising the CFT approach. Within the literature to date, both qualitative and quantitative methodologies have been adopted to explore this area of interest. Most of the quantitative research has explored outcome measures using psychometrics and drawn their conclusions through having a pre-test post-test design such as the work of Knaevelsrud et al (2010). Qualitative research in this area has provided insight into the lived experiences of PTG for individuals who have experienced a range of traumatic events. Qualitative research has also defined PTG and explored this concept on a longitudinal time scale focusing on individual experiences (Fossey et al. 2002; Sliverman, 2020).

Whilst exploring my choice of methodology, the aims of this research guided my decision. Willig (2013) suggests that the aims of research can be a suitable guide in choosing the right methodology for research. A qualitative phenomenological approach was adopted using Interpretative Phenomenological Analysis (IPA) was selected to explore the participant's experiences of compassion-focused therapy and the facilitation of PTG. Other factors that were considered for this decision were the underlying epistemological foundations of IPA and the alignment of this approach with the focus of this research which considers the exploration of lived experiences.

Within the therapeutic relationship, therapists, and clients both may experience CFT in facilitating PTG differently, therefore I choose IPA to explore both the client and therapists' experience through two different studies, providing different perspectives from each side of this therapeutic relationship on a similar phenomenon.

Epistemological Foundations

IPA has increasingly been growing as an approach to qualitative research within disciplines across human, social and health sciences (Taylor et al. 2013). IPA focuses on how individuals within a given context can make sense of a given phenomenon in each context (Flowers at al. 2009; ShineBourne & Smith, 2012). IPA has been informed by three key areas within the philosophy of knowledge, these include phenomenology, hermeneutics and idiography. Firstly, phenomenology is the philosophical approach to the study of experience. Phenomenologists have an interest in exploring how individuals experience life, what it may be like to be a human and what may contribute to how an individual views the world (Shinebourne, 2011). Whilst exploring the epistemological foundations of IPA which fit with my research, I focused firstly on the concept of phenomenological philosophy, which can provide details surrounding how to examine and comprehend lived experience. Within phenomenological philosophy, my research fits with the work of four pioneering figures, who have provided major developments in phenomenology, exploring what is most relevant to IPA, these are the work of Husserl, Heidegger, Merleau-Ponty and Sartre. In agreement with the work of Husserl (1931), he established the importance of the relevance of the focus on experience and perception. Heidegger, Merleau-Ponty and Sartre each then contributed to a view of the person as embedded and immersed in a world of objects and relationships, language and culture, projects, and concerns (Smith et al. 2009). Shifting the focus towards an interpretative and worldly position can enable researchers, such as with this research to understand individuals' perspectives within the lived world, which is an experience which is individual to every human. As IPA is phenomenological, this enables an ability to focus on a detailed exploration of a participant's world, enabling each participant to explore their experience of a similar phenomenon providing rich detailed accounts, accounts in which I aimed to find upon starting this research.

For this research, through adopting this methodology, exploration of individuals lived experiences can be provided and I can attempt to understand these experiences and other people's

relationships by adopting an interpretative stance, attempting to make meaning out of these lived experiences (Giorgi, 2010; Hendry et al. 2011).

The role of hermeneutics was also explored for my research, Hermeneutics is the theory of interpretation and involves the restoration of meaning (Ricoeur, 1970). IPA recognises that analysis always involves some form of interpretation and is strongly connected to hermeneutics in its recognition of the researcher's centrality to analysis and research (Brocki & Wearden, 2006). To explore and gain an insight into the individual's experience, IPA dictates the requirement for a double hermeneutic: "the participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world" (Smith, 2004, p. 40). Hermeneutics is relevant to my research as interpretations can be both derived from the participant's ability to explore their lived experiences with me and my ability as the researcher to interpret these experiences throughout the analysis stage of the research as I attempt to make sense of the participant making sense of their personal and social world. Therefore, highlights that I had an active role in this process, however, the process can be influenced by the researcher's preconceptions, which I needed to consider (Heidegger, 1962). These preconceptions could include the role of CFT as a therapeutic approach or my experience of working with this specific client group as a practitioner, therefore several measures were put in place to mitigate these risks of bias which will be explored within the methods chapter. For this methodological approach, it has been recognised that it is impossible to gain access to the exact world of another, completely or directly, therefore the objective is to obtain a description which gets as close to the participants as possible through the analysis stage and the role of bracketing for myself as the researcher (Larkin et al. 2006).

An additional major influence on IPA which is relevant to this research is idiography. Idiography is concerned with the particular in question, focusing on individuality and a commitment towards a rigorous finely textured analysis of contingent, unique, and often subjective phenomena (Moses & Knutsen, 2012). This is relevant as I aim to provide detailed and in-depth examinations of how individuals in their unique contexts will make sense of a given

phenomenon, by seeking to learn from each participant's story. Through deep individualised analysis, I aim to gain an informative understanding of participant's thoughts, beliefs, and behaviours. The idea of idiography contrasts with research within the psychology field which is nomothetic in nature and is focused on making claims or results at a group or population level, often found in quantitative research. Within IPA, there is a commitment to the particular in the sense of detail and therefore the depth of analysis and is committed to understanding how a particular phenomenon is understood by participants who have experienced a similar experience. Due to this nature, IPA tends to consist of small, purposively selected and carefully situated samples and can offer single-case analysis, which suits the specific aims of this research. Through doing so, I can seek to understand as much as possible about each case before moving on to the next within research (Cassidy et al. 2011).

Due to the interpretative nature of this approach, engaging in reflexivity plays a central role in the analysis as it helps the researcher to make their way through each participant's response, bracket any preconceptions and reflect an attentiveness to be aware of the influence of the researcher on the process (Shaw, 2010). Through the self-awareness in which I adopted, which was highlighted in my reflexive diary (Appendix K), any potential influences can be minimised, which research has found can increase understanding and allow for a more rigorous approach (Clancy, 2013).

To conclude, the philosophical and epistemological foundations of IPA can inform a methodology suitable for exploring the lived meanings of people and their interpretations of their experience which fits my research. Larkins et al, (2006) have emphasised that IPA can offer a flexible approach suited to giving participants a voice to their experiential claims and offering a person-in-context understanding of the meaning that is in individual experiences related to the lived world.

Within the literature, IPA studies have focused upon CFT for brain injury (Ashworth et al, 2015) and trauma specifically (Lawrence & Lee, 2014) including the impact of shame in adult women and CFT (Demir, 2014). Through IPA, perspectives have predominately focused on the

client's perspective and experience of CFT. Multiple perspective research has been completed for domestic abuse (Chowdhury & Winder, 2022); however, no current IPA research has focused on CFT on the facilitation of PTG for individuals who have experienced sexual abuse.

I choose IPA as the qualitative method over other qualitative methods for several reasons, firstly I was interested in lived experiences of my participants and providing my participants with a voice through a qualitative design, therefore content analysis was not chosen as I was interested in the experience of the phenomenon rather than quantifying the qualitative data. Thematic analysis was considered due to a focus on understanding the therapist's knowledge of a concept rather than experience, however, I was interested in seeking to find unique characteristics of individuals participants exploring differences and divergences in data (Braun & Clarke, 2021) Thematic analysis tends to search for patterning of meaning across participants and IPA fitted with my epistemology.

IPA was theoretically informed through the role of phenomenology, hermeneutics and idiographic nature which fitted my research. Through the analysis stage of IPA, there is a focus on examining each case before moving to another case, which thematic analysis as a method rather than a methodology, cannot provide. Regarding, my underlying epistemological position as a researcher, critical realism was considered. Critical realism, I believe accepts that there are stable, enduring features of reality that exist independently of human conceptualisation. Differences in the meanings individuals attach to experiences are considered possible as they experience different parts of reality. The work of Merleau-Ponty (Schmidt, 1985) and Sartre (Collier, 2013) surrounding critical realism influenced my work due to emphasis on phenomenology and their idea of perception inspired by Gestalt psychology (Kohler, 1929). This holistic non-cognitivist view influenced my work through recognising the contribution of phenomenological reflexivity and individuals as embedded and immersed in a world of objects and relationships, language and culture and concerns. My epistemological position fits with IPA due to the IPA being theoretically rooted in critical realism as found by Bhaskar (1978).

Given the central role that IPA offers with its focus on meaning and accounts of lived experience, IPA was therefore chosen to provide the approach best suited to examine participants' experiences. This approach was chosen before the development of interview questions began, devising data collection methods and collecting data focused on personal meaning and sense-making in a particular context for individuals who share a similar experience. The design and procedure will be covered in the next chapter.

Chapter 4: Methods

The methods chapter will cover the design, and the participants which include sections surrounding the sampling and recruitment process. The data collection alongside the data analysis process will be discussed. To conclude this chapter, trustworthiness, quality, and reflexivity will be discussed alongside the ethical considerations for this research.

4.1 Participants

4.1.1 *Sampling*

A purposive sample of eleven participants was recruited for my research, eight of these participants were therapists and three client participants who comprised a homogeneous sample. A homogenous sample is a purposive sampling technique which aims to achieve a homogenous sample, that is, a sample whose units share the same characteristics or traits. A smaller sample size was opted for in alignment with IPA's idiographic nature and allows an in-depth analysis as supported by Brocki and Wearden (2006) and Vasileious et al (2018). There was a difference in the sample sizes for the therapist and client study, this was due to specific inclusion/exclusion criteria for the client study for example to have only received compassion-focused therapy and the therapists were recruited about their overall experience utilising the CFT approach for this client group. CFT is also a new therapy, which provided further difficulty in finding clients who have had this specific approach. An additional consideration of the smaller client study sample size is the nature of the study and participants may have been wary of wanting to speak of their experience of therapy in case it opens their past trauma, this was considered within the study design process to focus on their

therapy instead of their experience of sexual abuse specifically. The sample size was influenced by the conventions and precedents laid down by extant IPA studies (Larkin et al. 2021), doctoral thesis requirements and restrictions, access to participants and the quality and richness of the participant's data. As to the idiographic nature of IPA and this research, the different sample sizes would still enable me to capture their perspective of this phenomenon by moving through a case-by-case analysis.

The choice of sampling was consistent with the qualitative paradigm and with IPA's orientation (Robinson, 2014). Purposive sampling was used meaning participants were selected purposively, as the participants are the experts who have had this shared experience of compassion-focused therapy. The participants were selected as they gained an insight into that experience, they can represent a 'perspective' rather than the population (Charles et al. 2015).

4.2. Recruitment

My client participants were recruited via the use of social media channels such as Linkedin and Twitter through a social media advertisement (Appendix A). This advertisement with permission was posted on support pages for the survivors of sexual abuse and through survivors UK social network platform. The participants then approached myself if they would like to participate.

My therapist participant group was recruited separately, to avoid any potential of the client and therapist recognising each other in the data, therefore, avoiding the therapist-client dyad. The participant group was recruited via social media and via a recruitment email sent via the Compassionate Mind Foundation google group (see Appendix B), in which recruitment emails were sent after a show of interest was displayed by therapists (see Appendix C). IPA has been used in the literature to explore two different perspectives, such as the work of Chowdhury and Winder (2022). Chowdhury and Winder (2022) explored a multi-perspective approach of UK-based Muslim female survivors of domestic violence and abuse and UK professionals working in a supportive capacity with both domestic violence and abuse victims/survivors and those perpetrating abuse within Muslim communities.

Information was provided in the initial recruitment emails and participant information sheets (Appendix D & E) regarding appropriate inclusion and exclusion criteria for both studies. Alongside the information sheet for both studies, the consent form was attached (Appendix D & E). My participants were provided with the opportunity to contact myself if they had any further questions or required any further information regarding the research. After reading the information sheet and agreeing to take part in the study, the consent form was required to be filled in and sent to me via email before the interview. Following their agreement to participate in the research they were contacted by myself to arrange a suitable time for the interview to take place via an online platform (zoom).

4.3 Inclusion and Exclusion Criteria

4.3.1 Client Study

4.3.1.1 Inclusion criteria.

1. Aged eighteen or over
2. Received a diagnosis of PTSD
3. Received a course of Compassion Focused Therapy which had ended within the last six months, this timeframe was due to clients having a clearer memory of the therapeutic process.
4. Have experienced sexual abuse

A measure was used to indicate whether aspects of PTG have been experienced by the client participants; Psychological Well-being Post-Traumatic Changes Questionnaire (PWB-PTCQ; Appendix F). This questionnaire is an 18-item self-report measure to assess perceived changes in psychological well-being following traumatic events. The scores can range from 0-105 on this inventory, higher scores are indicative of greater growth. The psychometric properties of this measure have been tested within the literature, for example across three samples, researchers found evidence for a single-factor structure, high internal consistency, six-month stability, and incremental

validity over and above existing measures of PTG as a predictor of subjective well-being (Joseph et al. 2012). The measure was sent to my participants to send back to myself alongside the consent form. A score over fifty-four indicates a positive change has been experienced (Joseph et al. 2012), however, aspects of PTG may not have been experienced. As this research is interested in individual experiences, the questionnaire will only be considered as an indication of whether PTG has been experienced, not as part of the inclusion/exclusion criteria, therefore, there was no necessary action to be taken if scores were low for participants.

4.3.1.2 Exclusion Criteria.

1. Participants are not to be undergoing any current therapy at the time of the interview
2. Participants with substance abuse misuse or dependency
3. Participants with current self-injurious behaviour or currently at high risk of suicidal or homicidal behaviour. This exclusion criterion was included to help protect and safeguard my participants.
4. Participants who have been out of therapy for longer than six months

This time frame enables time for reflection on the therapeutic process which will be asked within the client participant interviews. PTG can be a concept that can take years to experience after completion of therapy, however, there is a risk participant's will not be able to remember the therapeutic process as the length of time increases, therefore this exclusion criteria were added. This requirement is in line with many health services that provide a six-month follow-up period and within the literature reflecting upon changes that may have occurred for individuals (Leaviss & Uttley, 2015; Sommers-Spijkerman et al. 2018).

Current treatments for PTSD have recently narrowed their exclusion criteria in line with the research evidence thereby providing support for a wider set of individuals. However, due to the cognitive processing elements of the trauma treatments and the nature of the traumatic experience,

the above exclusion criteria are maintained to reduce potential risks to the individuals involved (Foa et al, 2007).

4.3.2 Therapist Study

4.3.2.1 Inclusion criteria

1. Received training in Compassion-Focused Therapy
2. To be registered with the BACP or the UKCP
3. To have utilised CFT within the private sector for clients who have experience(s) of sexual abuse

4.2.2.2. Exclusion criteria

Regarding the exclusion criteria for this study, I have asked for therapists to have worked with clients who have had experience(s) of sexual abuse within the private sector. Therefore, additional ethical approval for the National Health Service (NHS) was not required.

The inclusion and exclusion criteria were provided to clients verbally and information was provided via the information given within the recruitment stages before the interviews to due participants were suitable.

4.4 Participant details

Table 1 below outlines the characteristics of the participants involved in the client study. Two of the three participants were female (n=2), and one was male (n=1), all participants had experienced sexual abuse.

Table 1. *Client Participant demographics, therapy completion and trauma type*

Participant (Pseudonyms used throughout)	**Gender**	**Age**	**Was the sexual abuse, child sexual abuse?**	**Date Completed Therapy**	**PWB-PTCQ Scores (Max score – 105)**	**Diagnosis of PTSD**	**Identified Trauma**
Carol	Female	35	N	July 2022	66	Yes	Sexual Abuse
Karen	Female	32	Y	August 2022	82	Yes	Sexual Abuse
Bradley	Male	28	Y	August 2022	78	Yes	Sexual Abuse

A cut-off point regarding PTG level was determined by scores of 45 and below indicating none to low levels of PTG experienced, whereas scores of 46 and above represented medium to very high levels of PTG, this cut-off criteria has been supported in the literature (Mazor et al. 2016). In this study, the scores were only used as an indication rather than a measure, however, all three participants scored over the cut-off point of 46, indicating that all individuals experienced levels of PTG, with Karen scoring the highest on the PTGI.

Table 2 below outlines the characteristics of the participants involved in the therapist study. Six participants were female (n=6), and two participants were males (n-2), all participants were trained in CFT. Six participants were in the UK whilst one participant was in Australia and one in France, all members of the compassionate mind foundation. All participants held the equivalent or

above of the British Association for Counselling and Psychotherapy (BACP) or the UK Council for Psychotherapy (UKCP).

Table 2. *Therapist participants demographics.*

Participant (Pseudonyms used throughout)	Gender	Location	Training received in CFT	Professional Registration	Have utilised CFT for clients who have experienced sexual abuse
Jon	Male	UK	Yes	Yes	Yes
Max	Male	UK	Yes	Yes	Yes
Charlotte	Female	UK	Yes	Yes	Yes
Tracy	Female	UK	Yes	Yes	Yes
Paula	Female	UK	Yes	Yes	Yes
Kate	Female	UK	Yes	Yes	Yes
Sheila	Female	France	Yes	Yes	Yes
Michelle	Female	Australia	Yes	Yes	Yes

4.5 Data Collection

IPA is best suited for research which can invite participants to offer rich and detailed first-person accounts of their lived experiences (Alase, 2017). Therefore, the use of interviews is recommended, as they can provide an opportunity for the exploration and facilitation of stories, thoughts and feelings which relate to a phenomenon (Smith et al. 2009). Interviews demonstrate versatility, which provides a strength in qualitative research. The use of interviews within my

research can provide space for a detailed engagement with a small sample, accessing the chosen phenomenon from more than one perspective and reflecting the creative and reflective efforts of participants. Semi-structured one-to-one interviews for both studies was opted for, these forms of interviews are well-suited for in-depth and personal structure, as found within the research (Reid et al, 2005).

4.5.1 Development of interview schedule

The interview schedule was developed for the research to provide a 'sideways' approach to attempting to focus on the research question (Smith et al. 2009). Providing open-ended questions to the participants can enable the facilitation of discussion and the participants to explore their own experiences. Research has highlighted it is important to construct questions openly and not to make any assumptions surrounding the participant's experience (Smith, 2017). A copy of the interview schedules for both studies can be found in the appendix G and H.

The development of the interview schedule questions for both studies was informed following the completion of an extensive literature review which led to several key formative ideas being identified to explore the aims of the research.

For my client study, these formative areas included:

- What changes occurred during and after their CFT therapy?
- What was the role of the therapist during your therapy?
- Were there any difficulties or barriers faced?
- How do you view yourself, the world, and others after completing therapy?

From these key areas, eight open-ended interview questions were developed for my client study. My research aimed to provide participants with a voice to explain their lived experiences. Due to individual differences, the first question invited the participant to explain life before therapy if they wish to do so. It is important to note that not all individuals may experience aspects of PTG therefore throughout developing the open-ended questions there was scope for any negative changes

to be explored as well as difficulties faced within the process. There has been research which has highlighted the usefulness of the therapeutic relationship in providing a sense of safety and warmness (Allison & Rossouw, 2013), therefore a question was developed surrounding this finding.

For my therapist study, these formative areas included:

- Therapists within the field of psychology and their understanding of PTG
- The effectiveness of different CFT exercises
- What was the therapist's role during the therapy?
- Role of adopting compassion into their daily lifestyle outside of therapy

Six open-ended questions were developed for my therapist study. There was a limited amount of research which focused on therapists' experiences of delivering therapy (see chapter 2 for a review of the literature). Recent literature has started to explore the therapists' experience of vicarious PTG in psychotherapy (Arnold et al. 2005), therefore questions were developed surrounding the impact of working with trauma clients and the role of compassion outside of practice (Gale et al. 2017). Research has highlighted the positive psychology movement and the related concepts such as PTG (Lornas & Ivtzan, 2016), therefore, questions were developed surrounding the therapists surrounding this concept and what about CFT may facilitate aspects of PTG to occur.

In the process of developing both interview schedules from the formative questions which arose in the literature review, the open-ended questions provided clients with a phenomenological map during the interview to allow them to explore their lived experiences of PTG and their CFT therapy. The interview schedule followed a funnelled design to allow participants to provide a narrative across their whole therapy experience including before to after therapy without risking harm to the participants. The interview was delivered post-therapy and not completed pre and post therapy to avoid risking re-traumatisation for the client participants before they had undergone

therapy. Additionally, the questions did not ask about the client's experience of sexual abuse in the client study to avoid the potential harm to participants, these ethical issues will be further discussed.

4.5.2 Pilot Studies

A pilot study was also conducted for both studies to ensure the efficiency of the interview questions and the opportunity for any questions to be changed or developed if required. The interviews went well, and rapport was formed with the participants enabling discussions of their experience. The interviews were transcribed, and I reviewed the responses, this enabled a retrospective assessment of the appropriateness of the alternative and more suitable responses in terms of their content, tone and affect. The two pilot studies were used within the main analysis. There were no changes that were required following interviewing one client participant and one therapist participant. Due to being a practitioner myself, the only change was regarding my use of language as the researcher to ensure I do not agree with what the participants were discussing within the therapist interview.

4.5.3 The Interview Process

Within both interview schedules, there was a series of prompting questions to aid the exploration of the participant's experiences. These questions were structured by myself following the phenomenological map and were checked for appropriateness with my supervisory team, and ethical panel. They were then sent over to the Compassionate Mind Foundation, no specific feedback was received regarding changing the interview questions.

The participants were aware that the interview will be audio-recorded. The interviews were all audio recorded via the zoom meeting recording option and stored safely. The interviews ranged between 45-90 minutes, with an average of 50 minutes.

As the interviews reached the end, all participants were asked if they would like to add anything further which may not have been covered in the interview to further aid the exploration of their experience. Participants were then thanked for their time and were sent a debrief form (Appendix I & J) which explained the purpose of the research and provided information surrounding

how to withdraw their data if they choose to. Following the debrief form there was a list of support services for both studies if the participants would like to seek any additional support following the interview process. Participants were asked how they felt after the interview and asked if they would like to be placed on a mailing list to receive a copy of the final research findings.

4.6 Procedure

The interviews were conducted online due to the COVID-19 pandemic and were delivered on a platform of the participant's choice (mostly Zoom or Skype, which are both secure platforms). The interviews took place from October 2021 to December 2021. Due to the pandemic, the nature of these interviews was discussed with the supervisory team regarding the use of online interviews. By completing the interviews online there was scope to reach participants who lived in different parts of the UK and worldwide, therefore, providing potential practical benefits. However, there was the risk of losing the personal connection online and the importance of the researcher's interview style in exploring such a difficult topic was highlighted (Salmons, 2014). I found it was important to build a rapport before the interview to help minimise the risk of losing the personal connection online. Research surrounding the use of online qualitative interviews focused on the participant's and researcher's experiences and skills which could be utilized to help with this interview style, these skills include empathy, and having visible open body language and one which I felt was helpful was providing a comfortable, non-judgmental space for my participants through the use of language, tone and affect (Salmons, 2014., Milrick & Wladkowski, 2019).

The interview was scheduled at a time which was convenient for the participant, this choice helped aid a sense of personal control and help aid minimise the potential power imbalance that can occur in research interviews (Ross, 2017). It was important to explain the purpose and style of the research interview, so they knew what to expect due to the term interview being used across different contexts such as job interviews, the information sheet explained this to participants. Participants were also offered to see the interview schedule ahead of the interview if preferred, however, none requested the schedule beforehand. I aimed to provide a relational environment where the participants felt respected and comfortable as they explored their experiences. I also utilised

supervision and their personal therapy to manage my emotional reactions during exploring traumatic experiences. This enabled emotional stability for the participant, for the focus to be on the interview which enabled participants to elaborate and share their own experiences, this has been supported by Knox and Burkard (2009).

The environment was also created to promote a non-judgemental openness with the participants, remaining curious and utilizing the prompt questions if required but remaining sensitive to the experience which was been shared, this helped further minimise the power imbalance. The environment which was created is part of IPA's methodological approach, I was able to empathise with my participants during the interviews through my interview style, whilst being able to detach using bracketing and my own supervision. A rapport was built with the research participants from the initial contact during the recruitment stages to help aid a comfortable environment for the participants. Throughout the interviews, a genuine interest was shown for my participants experience through displaying attentiveness and empathy, this was as a researcher and from my experience of being a practitioner in the counselling psychology field. The interview schedule was flexible to enable participants to explore their experiences and some questions were asked earlier depending on what was explored.

At the end of the interview, a debrief was spoken through with the participants, support services and information were given, and participants were thanked for their time.

4.7 Data Analysis process

Before the data analysis stage began, the interview schedules were transcribed, I read and re-read through each individual transcript before listening to the audio recording whilst making notes on the transcripts electronically. The notes in which were taken include notes on the use of language, exploratory comments, comments on the tone used and notes which indicated interpretation, an example of the noting used is provided in figure one.

To complete the data analysis, I followed the six stages of IPA which are proposed by Smith et al (2009), which describe IPA as a set of common processes and principles which are applied

flexibly. This includes moving from the particular to the shared and from the descriptive to the interpretative within the analysis and a commitment to understanding the participant's experience, with an emphasis on personal meaning-making in particular contexts (Smith et al, 2009). The client study was analysed separately using the outlined stages before I bracketed any pre-assumptions and moved towards steps one to six separately for the therapist study.

Stage one

The first initial stage involved me immersing myself into the data by completing the initial transcript from the audio recordings which involved the reading and re-reading of the interview scripts. The audio of the interview was listened to whilst reading the completed transcription. During this initial stage, the participant becomes the focus of the research and initial notes were made in a notebook during the transcription stages of any observations that were made to help aid the process of bracketing, allowing me to focus on the data. Repeated reading enabled a process of active engagement and the overall interview structure to develop, and narratives started to be explored within the interviews.

Stage two

The second stage involves the initial noting of impressions and comments on the data, this step examines semantic content and language use on an exploratory level. Smith et al (2009) suggest that there should be three levels of comments noted: Descriptive comments focusing on the content of what has been said, linguistic comments focused on exploring the specific use of language by the participant and conceptual comments focused on engaging at a more interrogative and conceptual level. I placed each transcript onto a Microsoft word document with three margins, the first focusing on emergent themes which will be discussed within the later stages, the middle, the original transcript and thirdly, the exploratory comments section. An example of this process within step two is below.

Figure 1. *An example of stage two IPA analysis for Karen (Client Study)*

Descriptive comments – describing content of what has been said (Normal text) Linguistic comments – Exploring the specific use of the language used *(italics)* Conceptual comments – Focused on engaging at more interrogative and conceptual level (underlined)

	anything in which I looked for, I just wanted someone who would understand me…. For me and hopefully help me get through these feelings in which I was having, I remember feeling low in myself but also the blame, the self-blame was the hardest part for me, I was hoping to help with that, I decided it was best for me to pay privately due to the pandemic, the waiting list was very long and for me I didn't want to have to wait any longer it was time for me to sort this out if I possibly could or even just talk to someone who may just understand me and help navigate through these feelings in which I was having it felt right, does that make sense at all? R – Yes completely thankyou for sharing that with me, would it be possible to tell me if you can remember about how you coped before going to therapy? K – In a nutshell, I didn't really, I was full of fear, full of fear that maybe something would happen again to me, feeling young again, maybe that I deserved it if something bad did happen to me again, I did go into gazes every now and again from the past and would just be in the best way I could explain in my own little bubble, I would have memories of the past just come up when I was trying to sleep also, they were the worse and horrible to experience, my heart would just jump out of my chest every time…. like I was back there, in terms of ways I would cope, I would feel very guilty to what happened and I would be full of the best way I could explain it as been shame, riddled with shame, I would just blame myself and I will be	*Sense of not been understood much in past - pause* Looking for a good therapeutic relationship and stability Role of blame and shame Looking to embrace on this journey in therapy, feelings of hopefulness *Checking for that understanding?* Regression – younger child Role of blame and that deserved what happened Did memories of childhood bring them back to trauma? Difficulties way of coping pre therapy Anxiousness related within sleep *Sense of been uncomfortable, physical signs present?* Been identified by shame

To ensure the trustworthiness of the comments, I would continuously check their comments for any influence from their fore-structuring and utilised the hermeneutic circle to move between text and analysis. I kept a spare notebook where any pre-conceptions and emerging meaning units were placed to bracket any theoretical assumptions at this second stage of analysis (Appendix K).

Stage three

In the third stage of the analysis, I consider emergent themes from the comments. I attempt to minimise the volume of detail whilst maintaining complexity in terms of mapping the interrelationships, connections, and patterns between the exploratory comments. These emergent themes were placed in the first column which can be seen below. The themes represent the participant's original words and my interpretations as the researcher.

Figure 2. *An example of Stage three IPA analysis for Karen (Client Study)*

Descriptive comments – describing content of what has been said (Normal text) Linguistic comments – Exploring the specific use of the language used *(italics)* Conceptual comments – Focused on engaging at more interrogative and conceptual level (underlined)

	anything in which I looked for, I just wanted	
Appreciation of feeling understood and validated in therapy	someone who would understand me…. For me and hopefully help me get through these feelings in	*Sense of not been understood much in past - pause*
Importance of the therapeutic relationship	which I was having, I remember feeling low in	Looking for a good therapeutic relationship and
Damaging role of blame and shame	myself but also the blame, the self-blame was the hardest part for me, I was hoping to help with that, I decided it was best for me to pay privately due to the pandemic, the waiting list was very long and for me I didn't want to have to wait any longer it	stability Role of blame and shame
Timing of the therapeutic process	was time for me to sort this out if I possibly could	
Feelings of hopefulness	or even just talk to someone who may just	
Importance of feeling understood and validated	understand me and help navigate through these feelings in which I was having it felt right, does that make sense at all? R – Yes completely thankyou for sharing that with me, would it be possible to tell me if you can remember about how you coped before going to therapy?	Looking to embrace on this journey in therapy, feelings of hopefulness *Checking for that understanding?*
	K – In a nutshell, I didn't really, I was full of fear,	Regression – younger child
Pre-therapy regression	full of fear that maybe something would happen	
Excessive blame and self-criticism	again to me, feeling young again, maybe that I deserved it if something bad did happen to me again, I did go into gazes every now and again from the past and would just be in the best way I could explain in my own little bubble, I would have memories of the past just come up when I was trying to sleep also, they were the worse and	Role of blame and that deserved what happened Did memories of childhood bring them back to trauma? Difficulties way of coping pre therapy Anxiousness related within sleep
'Riddled by shame'	horrible to experience, my heart would just jump	
Trauma identifying them	out of my chest every time…. like I was back there, in terms of ways I would cope, I would feel very guilty to what happened and I would be full of the best way I could explain it as been shame, riddled with shame, I would just blame myself and I will be	*Sense of been uncomfortable, physical signs present?* Been identified by shame

Stage four

As I moved towards the fourth stage of analysis, I searched for connections across the emergent themes. This next step involves the development of mapping how I think the themes fit together. I grouped each participant's theme on a word document as seen below. The process of abstraction was used to identify patterns between emergent themes and develop a new name for the cluster of 'like for like' themes.

Figure 3. *An example of stage four IPA analysis for Karen (Client Study)*

Abstraction leading to the development of a super-ordinate themes from this participant

The psychological consequences of sexual abuse

- Damaging role of blame
- Riddled by shame
- The loss and questioning of oneself
- Impact on relationships with self and others
- Avoidance as coping mechanism pre therapy

Trusting the therapeutic process

- Timing of the therapeutic process
- Importance of the therapeutic relationship (trust, understanding and validation)
- Role of expectations and previous experiences
- Importance of safety and security
- Difficulties with endings
- Therapist been a model of self-compassion

Renewed sense of hope for the future

- Desire to help others who have shared similar experience
- Regaining a sense of purpose and meaning
- Recognising their strengths going forward
- A new appreciation of life

Internalised changes

- Taming the critic
- De-shaming process
- Reconnected with oneself
- Confidence and body image
- Not all relationships are bad

Journey of self-discovery

- Journey towards self-acceptance
- Taking back power and control in life
- Changes in self-identity
- I am enough

Table of super-ordinate themes and themes from Karen's transcript

Themes	Page/line	Key words
The psychological consequences of sexual abuse		
Damaging role of blame	1/28	'deserved'
Riddled by shame	7/285	'aggressive' 'avoidance' 'rejected'
The loss and questioning of oneself	7/269	'disconnected' 'lone wolf'
Impact on relationships with self and others	1/36	'avoid intimacy' 'fear'
Avoidance as coping mechanism pre therapy	6/224	'mirrors' 'body image'
Trusting the therapeutic process		
Timing of the therapeutic process	1/11	'put off' 'right time'
Importance of the therapeutic relationship (trust, understanding and validation)	2/54	'warmth' 'acceptance'
Role of expectations and previous experiences	2/50	'to structured' 'faith'
Importance of safety and security	3/131	'ease' trust'
Difficulties with endings	5/205	'challenging' 'working towards'
Therapist been a model of self-compassion	4/136	'way of living'

Descriptive comments – describing content of what has been said (Normal text) Linguistic comments – Exploring the specific use of the language used *(italics)* Conceptual comments – Focused on engaging at more interrogative and conceptual level (underlined)

Renewed sense of hope for the future		
Desire to help others who have shared similar experience	7/279	'charity' , 'make a difference'
Regaining a sense of purpose and meaning	3/102	'actually go somewhere in life'
Recognition of strengths	6/255	'I am not a failure'
A new appreciation of life	6/251	'possibilities'
Internalised changes		
Taming the critic	4/150	'chair work' 'compassion'
De-shaming process	2/82	'acceptance' 'discovery'
Reconnected with oneself	8/320	'ready' 'involved'
Confidence and body image	7/299	'strengths' 'increase in mood and anxiety'
Not all relationships are bad	3/108	'healthy' 'self-worth'
Journey of self-discovery		
Journey towards self-acceptance	5/218	'used to hate' 'respected' 'compassionate image'
Taking back power and control in life	7/273	'been powerless' 'vision' 'how I can be in world'
Changes in self-identity	7/308	'recognition' 'positive 'shift'
I am enough	8/316	'worthy'

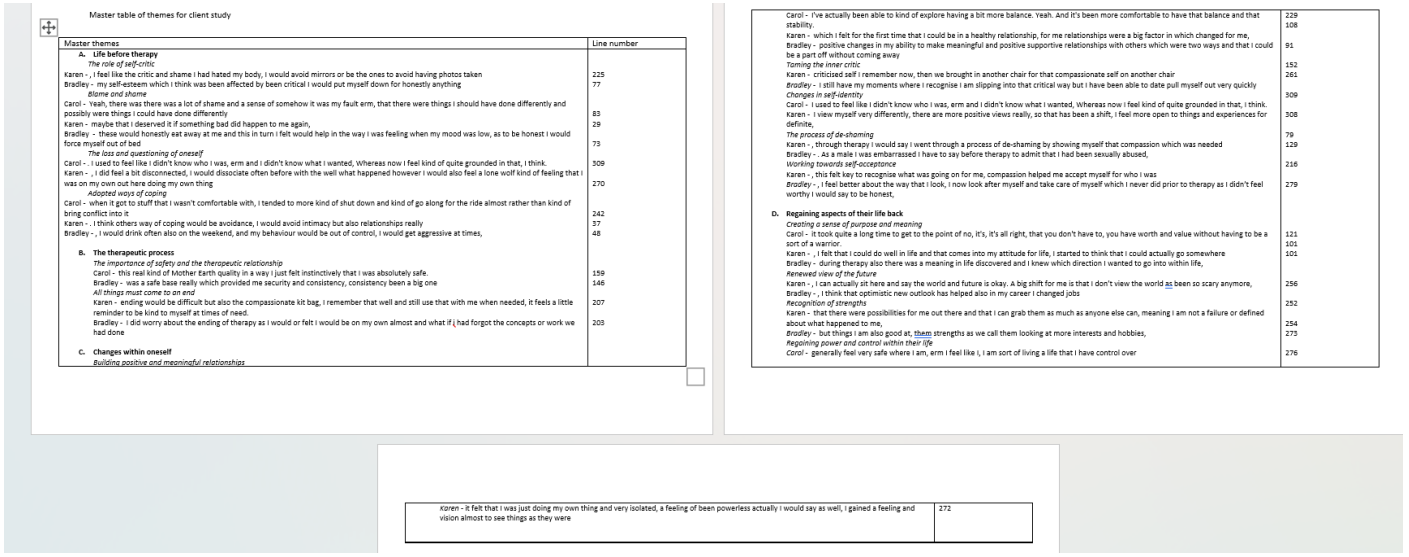
Stage five

The fifth stage of analysis involved me moving through the participant's interviews and repeating stages one to four. Whilst doing so, the bracketing process occurred for themes that had already been identified within each case to enable each case to be analysed separately and individually.

Stage six

Finally, the sixth stage is the search for patterns across all cases by comparing superordinate themes moving in the hermeneutic circle from the specific to the wider understanding of emergent themes. Smith et al (2009) suggest that it is helpful for me to move towards a more theoretical level which can aid interpretative convergence whilst ensuring that this convergence is located within the content of the individual participant's understanding of their experience. A table was produced to locate the shared superordinate themes, sub-themes, and example text from each participant for both studies. Both the client and therapist studies were analysed using the six steps and are presented separately in the results section, the two studies will be interpreted together only in the discussion section.

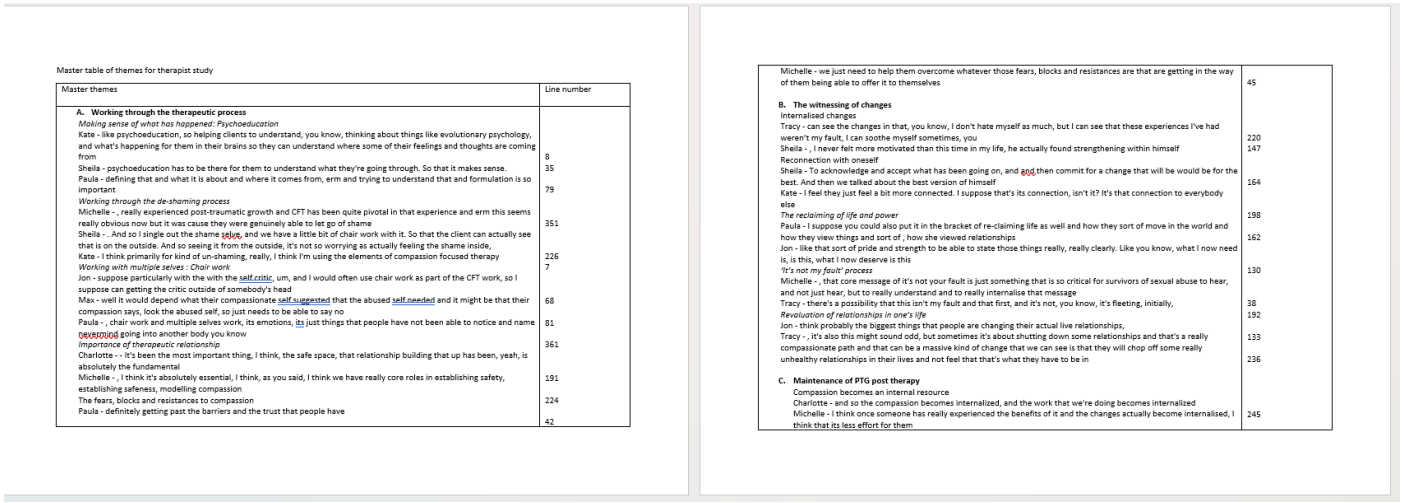
Figure 4. *Stage six of the IPA analysis for the client study*



Master table of themes for client study

Master themes	Line number
A. Life before therapy	
The role of self-critic	
Karen - , I feel like the critic and shame I had hated my body, I would avoid mirrors or be the ones to avoid having photos taken	225
Bradley - my self-esteem which I think was been affected by been critical I would put myself down for honestly anything	77
Blame and shame	
Carol - Yeah, there was there was a lot of shame and a sense of somehow it was my fault erm, that there were things I should have done differently and possibly were things I could have done differently	83
Karen - maybe that I deserved it if something bad did happen to me again,	29
Bradley - these would honestly eat away at me and this in turn i felt would help in the way I was feeling when my mood was low, as to be honest I would force myself out of bed	73
The loss and questioning of oneself	
Carol - I used to feel like I didn't know who I was, erm and I didn't know what I wanted, Whereas now I feel kind of quite grounded in that, I think.	309
Karen - , I did feel a bit disconnected, I would dissociate often before with the well what happened however I would also feel a lone wolf kind of feeling that I was on my own out here doing my own thing	270
Adopted ways of coping	
Carol - when it got to stuff that I wasn't comfortable with, I tended to more kind of shut down and kind of go along for the ride almost rather than kind of bring conflict into it	242
Karen - . I think others way of coping would be avoidance, I would avoid intimacy but also relationships really	37
Bradley - , I would drink often also on the weekend, and my behaviour would be out of control, I would get aggressive at times,	48
B. The therapeutic process	
The importance of safety and the therapeutic relationship	
Carol - this real kind of Mother Earth quality in a way I just felt instinctively that I was absolutely safe.	159
Bradley - was a safe base really which provided me security and consistency, consistency been a big one	146
All things must come to an end	
Karen - ending would be difficult but also the compassionate kit bag, I remember that well and still use that with me when needed, it feels a little reminder to be kind to myself at times of need.	207
Bradley - I did worry about the ending of therapy as I would or felt I would be on my own almost and what if I had forgot the concepts or work we had done	203
C. Changes within oneself	
Building positive and meaningful relationships	
Carol - I've actually been able to kind of explore having a bit more balance. Yeah. And it's been more comfortable to have that balance and that stability.	229
Karen - which i felt for the first time that I could be in a healthy relationship, for me relationships were a big factor in which changed for me,	108
Bradley - positive changes in my ability to make meaningful and positive supportive relationships with others which were two ways and that i could be a part off without coming away	91
Taming the inner critic	
Karen - criticised self I remember now, then we brought in another chair for that compassionate self on another chair	152
Bradley - i still have my moments where i recognise i am slipping into that critical way but i have been able to date pull myself out very quickly	261
Changes in self-identity	
Carol - I used to feel like I didn't know who I was, erm and I didn't know what I wanted, Whereas now I feel kind of quite grounded in that, I think.	309
Karen - I view myself very differently, there are more positive views really, so that has been a shift, I feel more open to things and experiences for definite,	308
The process of de-shaming	
Karen - , through therapy I would say I went through a process of de-shaming by showing myself that compassion which was needed	79
Bradley - . As a male i was embarrassed i have to say before therapy to admit that i had been sexually abused,	129
Working towards self-acceptance	
Karen - , this felt key to recognise what was going on for me, compassion helped me accept myself for who I was	216
Bradley - , I feel better about the way that I look, I now look after myself and take care of myself which I never did prior to therapy as I didn't feel worthy I would say to be honest,	279
D. Regaining aspects of their life back	
Creating a sense of purpose and meaning	
Carol - It took quite a long time to get to the point of no, it's, it's all right, that you don't have to, you have worth and value without having to be a sort of a warrior.	121
Karen - , I felt that I could do well in life and that comes into my attitude for life, I started to think that I could actually go somewhere	101
Bradley - during therapy also there was a meaning in life discovered and I knew which direction I wanted to go into within life,	101
Renewed view of the future	
Karen -, I can actually sit here and say the world and future is okay. A big shift for me is that I don't view the world as been so scary anymore,	256
Bradley - , I think that optimistic new outlook has helped also in my career I changed jobs	
Recognition of strengths	252
Karen - that there were possibilities for me out there and that I can grab them as much as anyone else can, meaning I am not a failure or defined about what happened to me,	254
Bradley - but things I am also good at, them strengths as we call them looking at more interests and hobbies,	273
Regaining power and control within their life	
Carol - generally feel very safe where I am, erm i feel like I, I am sort of living a life that I have control over	276
Karen - it felt that I was just doing my own thing and very isolated, a feeling of been powerless actually I would say as well, I gained a feeling and vision almost to see things as they were	272

Figure 5. *Stage six of the IPA analysis for the therapist study*



Master table of themes for therapist study

Master themes	Line number
A. Working through the therapeutic process	
Making sense of what has happened: Psychoeducation	
Kate - like psychoeducation, so helping clients to understand, you know, thinking about things like evolutionary psychology, and what's happening for them in their brains so they can understand where some of their feelings and thoughts are coming from	8
Sheila - psychoeducation has to be there for them to understand what they're going through. So that it makes sense.	35
Paula - defining that and what it is about and where it comes from, erm and trying to understand that and formulation is so important	79
Working through the de-shaming process	
Michelle - , really experienced post-traumatic growth and CFT has been quite pivotal in that experience and erm this seems really obvious now but it was cause they were genuinely able to let go of shame	351
Sheila - . And so I single out the shame selve, and we have a little bit of chair work with it. So that the client can actually see that is on the outside. And so seeing it from the outside, it's not so worrying as actually feeling the shame inside,	
Kate - I think primarily for kind of un-shaming, really, I think I'm using the elements of compassion focused therapy	226
Working with multiple selves : Chair work	7
Jon - suppose particularly with the with the self critic, um, and I would often use chair work as part of the CFT work, so I suppose can getting the critic outside of somebody's head	
Max - well it would depend what their compassionate self suggested that the abused self needed and it might be that their compassion says, look the abused self, so just needs to be able to say no	68
Paula - , chair work and multiple selves work, its emotions, its just things that people have not been able to notice and name nevermind going into another body you know	81
Importance of therapeutic relationship	
Charlotte - - it's been the most important thing, I think, the safe space, that relationship building that up has been, yeah, is absolutely the fundamental	361
Michelle - , I think it's absolutely essential, I think, as you said, I think we have really core roles in establishing safety, establishing safeness, modelling compassion	191
The fears, blocks and resistances to compassion	224
Paula - definitely getting past the barriers and the trust that people have	42
Michelle - we just need to help them overcome whatever those fears, blocks and resistances are that are getting in the way of them being able to offer it to themselves	45
B. The witnessing of changes	
Internalised changes	
Tracy - can see the changes in that, you know, I don't hate myself as much, but I can see that these experiences I've had weren't my fault, I can soothe myself sometimes, you	220
Sheila - , I never felt more motivated than this time in my life, he actually found strengthening within himself	147
Reconnection with oneself	
Sheila - To acknowledge and accept what has been going on, and and then commit for a change that will be would be for the best. And then we talked about the best version of himself	164
Kate - I feel they just feel a bit more connected. I suppose that's its connection, isn't it? It's that connection to everybody else	
The reclaiming of life and power	198
Paula - I suppose you could also put it in the bracket of re-claiming life as well and how they sort of move in the world and how they view things and sort of , how she viewed relationships	162
Jon - like that sort of pride and strength to be able to state those things really, really clearly. Like you know, what I now need is, is this, what I now deserve is this	
'It's not my fault' process	130
Michelle - , that core message of it's not your fault is just something that is so critical for survivors of sexual abuse to hear, and not just hear, but to really understand and to really internalise that message	
Tracy - there's a possibility that this isn't my fault and that first, and it's not, you know, it's fleeting, initially,	38
Reunation of relationships in one's life	192
Jon - think probably the biggest things that people are changing their actual live relationships,	
Tracy - , it's also this might sound odd, but sometimes it's about shutting down some relationships and that's a really compassionate path and that can be a massive kind of change that we can see is that they will chop off some really unhealthy relationships in their lives and not feel that that's what they have to be in	133
	236
C. Maintenance of PTG post therapy	
Compassion becomes an internal resource	
Charlotte - and so the compassion becomes internalized, and the work that we're doing becomes internalized	
Michelle - I think once someone has really experienced the benefits of it and the changes actually become internalised, I think that its less effort for them	245
Role of discipline and consistency	306
Sheila - no, that's long as they know, you know, they learn to drive the bicycle, but to ride the bicycle, but if you if you don't keep riding it, then you lose balance but then when you when you go back to it	
Michelle - I do think that is kind of helpful to consolidate erm you know treatment gains for all of a better phase	309
Reminders of therapy : Compassionate kit bag	305
Charlotte - so we consciously build up a kit bag for them that they can take with them, that gives them the compassionate tools that they need on my journey and I think that's a really important step	
Michelle - compassionate kit bag so you know I think that's a really important thing for maintenance, they have a solid sense of you know, what are the compassionate tools and strategies that they have available to them	257
PTG as a gradual process	323
Max - in order to get a real sense of post traumatic growth, there isn't enough of a gap between the end of the work I do with people and an opportunity to talk to them about where they are,	
Jon - , I think it's kind of knowing that actually, you know, if they do have a compassionate self on board, and it does show up regularly, I mean, this that's kind of like the motor for, for life long growth in a way	202
	363
D. Knowing CFT works at a personal level	
Therapist modelling compassion	
Jon - and you're doing it with the compassionate self or with the compassionate other, with me, stepping in and modelling compassion,	
Michelle - , modelling compassion, both for the clients and also self compassion in in being the, the compassionate mind for them when they're unable to be for them selves.	31
CFT role alleviating vicarious trauma	225
Kate - I think the use of compassion Focused Therapy within the therapy session, helps to mitigate that sense of vicarious trauma or the possibility of vicarious trauma because those feelings don't come	305
Charlotte - my own practice has been very, very important to me to be able to deal with that, and to manage that, and to make sure that it doesn't have any lasting impact on me, and I really have noticed a change in my ability to manage and cope	312
Growth and development of the practitioner	
Michelle - , it has been the thing that absolutely has contributed to the most significant growth for me personally, as well as professionally,	277
Jon - . I wouldn't be doing that when I started CFT to say, you know use me try thinking about bringing this to me and what I might say, or how we might deal with it together in the room.	345

4.8 Trustworthiness, Quality and Reflexivity

Within IPA, important considerations are required due to the co-construction of knowledge and understanding as the researcher brings their own experiences, their pre-conceptions, and ways of relating to the interpretation of any given phenomenological experience of a participant (Langdridge, 2007). The researcher can influence the qualitative research process throughout every stage of the research journey, this includes the choice of topic, the design choice, the methodology and the analysis including interpretations of the participant's data (Langdridge, 2007).

Therefore, due to these potential influences and biases, there must be strategies to ensure trustworthiness and research quality throughout the research process. Bracketing is a method which is used to mitigate the potentially deleterious effects of preconceptions that may taint the research process. This method was an important process that was employed throughout my research process to provide quality and trustworthiness of the process and findings (Roberts, 2013). This included answering the interview schedule for the therapist study myself before the interviews started due to being a practitioner myself and the use of keeping a bracketing journal. Research has highlighted the importance of having awareness of the fore-structuring of knowledge, experience and professional and personal positioning in relation to the researcher (Alase, 2017). Having this awareness, provided me with the chance to reduce the influence of any pre-existing assumptions to impact the research process (Alase, 2017).

Working within the field of counselling psychology, it has been important to consider any influences which may occur. Within my practice to date, I have frequently utilised aspects of compassion within my work foundationally to help aid the therapeutic relationship and process and as a skill which I have frequently encouraged past clients to adopt within their day-to-day lives. Through this insider perspective, I can recognise the usefulness of such an approach but also empathise with the participants within my client study. However, there are limitations to having such a perspective, this includes having preconceptions and my own opinions on this topic, therefore it was important to bracket these preconceptions throughout.

I approached this research with a belief in the phenomenological lived experiences of individuals and a belief that it is important to provide individuals with a chance to explore their lived experiences. I acknowledged this belief within the earlier stages of the research process and engaged with the design and analysis of the research from a reflexive position placing any therapeutic influences aside through bracketing. Regarding the therapeutic approach of CFT, I knew the concepts and practices which were involved in this approach due to previous clinical supervisors being trained in CFT, however, I had not received any CFT training. Before starting the research, CFT was an approach of interest of mine which I would like to develop further post-doctorate for future continuing professional development, however, I needed to be mindful that I may have limited understanding of some of the concepts of CFT due to the lack of training in this area. It was, therefore, important to acquire an interpretative stance during the analysis of findings and to focus on all participants' experiences not to focus on the therapeutic approach itself and knowledge I may have gained via reviewing the literature (Cohn & Lyons, 2003; Frels & Onwuegbuzie, 2012).

Moving slightly away from the therapeutic influences, the research area had significance to me throughout my professional but also personal life. Throughout these two areas of my life, I had witnessed individuals go through experiences of sexual abuse and who had received therapy for the trauma they had experienced. I had witnessed the impacts the traumas have had on those individuals and some of these impacts were positive, seeing individuals who have had complete changes in their view of life and selves, some of what has been achieved through support and therapy. It was vital to bracket these personal pre-conceptions that I may have around the area of experiences of sexual abuse and PTG and focus on the ability to tell my participants story through my own eyes. A research journal was kept throughout the entire process to aid the bracketing of these assumptions and it was important to check in with myself throughout, and the use of supervision helped aid this process through further exploration (Appendix K).

The use of a research journal has been supported by the literature that employs a process of reflective bracketing which minimises the impact of the researcher's ideas about the phenomenon affecting the process (Gearing, 2004; Tufford & Newman, 2012 & Fischer, 2009). This process of

bracketing aided my ability to hold any pre-assumptions whilst interpreting these lived experiences of the participants. My reasoning for employing the method of bracketing was due to frequently working with trauma within my therapeutic practice and I had utilised the concept of self-compassion, therefore, I wanted to take the opportunity to bracket any pre-assumptions which may have influenced the interviewing and analysis process. As well as the reflective journal, a notebook was kept aside from the initial two stages of the analysis as previously noted to bracket and identify any assumptions regarding any potential emergent themes in the participants narrative during the hermeneutic circle of interpretation. This process of keeping the additional notebook at hand further added trustworthiness and rigour to the interpretive process by recognising and holding any influence of the researcher on the process. This process has been supported for reflective bracketing in qualitative research (Ahern, 1999).

To help aid the rigour and trustworthiness of this qualitative research study, several factors were considered for the conceptualisations and criteria which can inform the trustworthiness and quality of data. I followed a set of quality criteria proposed by Yardley (2008), she proposed four key criteria areas which involve an emphasis on being sensitive to the context of the phenomenon examined, the commitment and rigour of engagement in the research process, transparency of the data analysis and coherence of the design and findings of the study and the subsequent impact and importance in presenting the findings. Sensitivity to context was considered through the consideration of my involvement as the researcher, and the consideration of power imbalance as previously mentioned. The sample size has previously been addressed in regard to exploring this phenomenon and coherence throughout the research process has been maintained. The practical and theoretical utility of this research has been considered regarding the practical implications for trauma-based research in the future with this client group and the usefulness of providing a multi-perspective study on what may or may not work during CFT has been able to be discussed from both the clients and therapists' perspective.

Consideration of other quality criteria was also considered such as those proposed by Steinke (2004), which proposes ways of ensuring quality throughout the research process and Smith (2011)

who produced a set of specific guidelines for high-quality IPA. To meet the guidelines produced by Yardley (2008) and Smith (2011), credibility checks were completed during the interpretative and analytical stages to check for validity. This included discussing the development and interpretation of themes within supervision. My adherence to IPA's principles and techniques throughout the analysis helped to guard against the potential drawbacks of being an 'insider'. They helped my analytic focus to combine a professional detachment with an empathic engagement towards participants (Smith et al. 2009), so that I could respond to their concerns in a manner that maintained my focus on the research question.

The process of triangulation occurred within the research process which can further promote the trustworthiness of the research findings (Willig, 2013). This was completed in this research through a peer review in which sample transcripts were presented to the research supervisor for a viewpoint of the emergent themes which have been found. This process enables a further check to be considered to check the reliability of the analysis of the emergent themes found by myself, this process has been supported within the literature (Jonsen & Jehn, 2009). A pilot study for both sets of studies was also employed, this was an opportunity for me to identify any issues with the interview schedule, with engagement in the use of oneself as the researcher within the research process and the modification of any interview questions. The implementation of a pilot study for both sets of research has been further supported in the literature (Kim, 201; Van Teijlingen & Hundley, 2001).

4.9 Ethical Considerations

Approval to commence with the research was obtained in April 2021 from the University of Wolverhampton FEHW research ethics committee (Appendix L)

4.9.1 Avoidance of psychological harm

The design of my research was kept to a post-therapy design, the reasoning was to minimise the risk of the clients re-living their traumatic experience before completing therapy. Another reason for a post-therapy design was those client participants may have developed coping strategies within

their CFT to help manage difficult experiences/emotions. Within CFT, there would be an opportunity for the client participants to work through exploring their traumatic experiences and possible therapeutic techniques. An important ethical consideration whilst delivering these interviews was the potential for re-traumatisation, I opted to complete interviews post therapy to enable the client participants to potentially explore their trauma in therapy first and the interview questions avoided asking directly about the sexual abuse. The focus instead was on the therapeutic journey which research has found to be effective in representing a positive experience for participants and a chance for reflection (Collings, 2019; Newman & Kaloupek, 2004). During the interviews with the client participant's two of the three client participants noted that the interview process was a positive experience, the other participant did not make a comment about whether the experience was positive or not. This was due to being able to reflect upon how far they had come but also to remember aspects of the therapy which were helpful, to continue to utilise in the future.

Within the literature, there is growing research which considers the impact working in trauma-focused therapy has on a therapist and the process of vicarious trauma (Jenkins & Baird, 2002). This includes hearing graphic accounts of the traumatic experience. The therapist participants were encouraged to utilize supervision if required following sharing their work with clients who have experienced sexual abuse during this interview. I, as the interviewer also needed to be considered due to the nature of the research. Supervision was available if required following completing these interviews, I also had the option to attend personal therapy if required, however, this was not felt necessary or needed throughout the research process. Regarding the risk and benefits of this research, the risk was reduced as it was discussing the process of therapy rather than focusing on the trauma itself. The benefits include gaining an understanding of the process of CFT and if CFT can facilitate aspects of PTG, then further implications within trauma-based treatments could be considered. Finally, it provided an opportunity for the client participants to have a voice to share their experience, who may not have had one before.

4. 9.2 Confidentiality and anonymity

Confidentiality and anonymity were of the utmost importance throughout this research process, and I followed the principles of the British Psychological Society (2010) ethical research guidelines. For all participants anonymity and confidentiality were maintained and respected throughout and details of this were given through participant information sheets before involvement in the research. All names were anonymised, and any personal identifying information was removed within both the transcripts and the write-up stages of this research to ensure anonymity. Participants who participated in the client study were separate from therapists who participated in the therapist study, therefore no internal recruitment occurred which limits the possibility of participants recognising themselves in the accounts of the therapists within the data write-up.

4.9.3 Data storage

Participant's consent forms, any questionnaires and audio recordings were all stored securely in line with the data protection procedures laid out by the University of Wolverhampton Research Ethics Committee. Encrypted files were used which were password protected. The data will be stored for two years following the completion of the interviews to enable time for the write-up, after this time, the data will be destroyed. The research interviews were then transcribed individually by me, and all data protection procedures were followed also within this process. Anonymity and confidentiality were kept using pseudonyms and removing any potentially identifying information from transcripts.

4.9.4 Safeguarding measures for participants and the researcher

Due to the nature of the research for both sets of participants, additional safeguarding measures were implemented. Participants were aware of any potential benefits and risks from participation, client participants were also provided additional support services such as survivors UK, Samaritans, and Rethink UK if they were required following the research debrief form (Appendix I & J). These support services provided contact details of wider psychological support therapy services if they felt they needed any further support after the completion of the research. During the interview itself, the participants were aware they could stop at any time if they needed a

break and were asked if they were okay following the interview to check in with their wellbeing before the debrief. From initial contact with the participants, I was respectful, displayed empathy and aimed to develop a rapport with the participants so they would feel as comfortable as possible during the process. Additional safeguarding measures for the therapist participants were asked if they could be utilising supervision or personal therapy if they required to speak to anyone post-interview. For myself, safeguarding measures were put in place due to the nature of what was explored in the interviews, therefore I had access to regular supervisory meetings with my research supervisors, clinical supervision outside of university and access to personal therapy which offers further space for reflection.

4.9.5 Informed consent and withdrawal of data

My research followed all guidelines regarding research ethics for informed consent where participants were given a comprehensive information sheet outlining the research study (Appendix D&E), they were also asked prior to the interview if they understood what the research entailed and if they had any questions. Participants were informed they were able to withdraw their data from the research up until one month after their interview had been completed, at that time analysis stages were starting and were provided with contact details if they wanted to do so. Participants were also given a consent form (Appendix D&E), which outlined the research, the use of data storage regarding the use of encrypted password-protected files and the use of audio recording during the interview. Participants were advised that their data will be stored securely using an encrypted device and password-protected files.

Chapter 5: Client Study Findings

5.1 Client study findings

Following the Interpretative Phenomenological Analysis of participant's accounts of their experiences of their CFT therapy, four superordinate themes emerged from my data as detailed in Table 3 below:

Table 3. *Superordinate and sub-themes*

Superordinate themes	Subthemes
5.1.1 Life before therapy	5.1.1.1 *The role of the self-critic*
	5.1.1.2 Blame *and shame*
	5.1.1.3 *The loss and questioning of oneself*
	5.1.1.4 *Adopted ways of coping*
5.1.2 The therapeutic process	5.1.2.1 *The importance of safety and the therapeutic relationship*
	5.1.2.2 *All things must come to an end*
5.1.3 Changes within oneself	5.1.3.1 *Building positive and meaningful relationships*
	5.1.3.2 *Taming the inner critic*
	5.1.3.3 *Changes in self-identity*
	5.1.3.4 *The process of de-shaming*
	5.1.3.5 *Working towards self-acceptance*
5.1.4 Regaining aspects of their life back	
	5.1.4.1 *Creating a sense of purpose and meaning*

5.1.4.2 *Renewed view of the future*

5.1.4.3 *Recognition of strengths*

5.1.4.4 *Regaining power and control*

These themes and sub-themes will each be explored in turn. Line numbers are denoted in parentheses after each quote and refer to the individual transcripts. The superordinate themes which were found resembled a timeline of the client's journey before therapy, during and after the therapy was completed.

5.1.1 Superordinate theme: Life before therapy

All three participants had experienced significant levels of distress before approaching therapy. These included an impact on their psychological well-being which affected not only themselves but their relationships and work life. Encapsulated in this overarching theme were sub-themes of the role of the self-critic, blame and shame, loss and questioning of oneself and adopted ways of coping. Participants discussed these factors as driving them towards approaching therapy.

5.1.1.1 Sub-theme: The role of the self-critic

Following experiencing sexual abuse, both Karen and Bradley explored the impact of the critical mind, or the 'self-critic' had on them. The self-critic affected their relationship with aspects of themselves such as their body image which led to avoidance behaviours, Karen describes this below:

'' A big role of compassion was actually my body image, I feel like the critic and shame I had hated my body, I would avoid mirrors or be the ones to avoid having photos taken, compassion helped me with this'' (Karen: 225-6)

The self-critic had impacted Bradley's ability to believe in his abilities, affecting his performance at work, these were discussed as he explored his goals for therapy, Bradley mentioned the impact of the self-critic and wanting to work on this within this therapeutic process.

'' I would be my worlds worse enemy really and critic that was enough, one I wanted to be less critical of myself and work on my self-esteem which I think has being affected by being critical I would put myself down for honestly anything and everything''. (Bradley: 77)

Both Karen and Bradley wanted to work on aspects of themselves, stating that they had become more critical of themselves following the traumatic experience and sought therapy to work through battling this inner critic. Carol did indicate that her self-criticism was high following the trauma, however, focused on the discussion surrounding the role of blame and shame which the next sub-theme captures.

5.1.1.2 Sub-theme: Blame and shame

The role of blame and shame post-trauma resonated amongst all three participants, with the two concepts interlinking for their experiences. Bradley explained that he experienced thoughts and feelings which were associated with 'it's my fault what happened to me'. This internal dialogue was influenced by the high levels of blame and shame which caused him to experience a low mood.

'' the feelings of shame and blame I had, these would honestly eat away at me and this in turn I felt would help in the way I was feeling when my mood was low, as to be honest I would force myself out of bed and do things but I would still blame myself that many years on''
(Bradley: 73)

Bradley described the blame and shame as eating away at him, a feeling which over time may indicate felt like it got worse. The choice of language ('eating away at him') reflects the impact these two emotions had on him, gradually having more of an effect on him over time, impacting his day-to-day life and having an impact on his wellbeing. The role of blame and shame was also described by Karen, as a feeling associated with guilt and feeling deserving of what

happened to her, linking with the role of the self-critic and the negative effects of these emotions on the individual.

‘’ *I would feel very guilty to what happened and I would be full of the best way I could explain it as been shame, riddled with shame, I would just blame myself and I will be beating myself up 24/7 even years after’’* (Karen: 33)

Bradley described the shame and blame as it was eating away at him gradually over some time, revealing the process of the shame and blame. Whereas Karen explained that she felt she was riddled with shame, a feeling which was hard to shift, a feeling all over the body and mind, impacting her day-to-day functioning in life. Carol discussed within her interview that when she looked back at her experience of sexual abuse and the placing of responsibility onto herself, she focused on what she could have done differently at that moment to prevent the sexual abuse from happening to her. This indicates that initially there was a sense of blame focusing on what she could have done differently as the individual who was abused, but there was an indication that this was a view she had previously (‘in hindsight’) and views may have changed slightly in the present day.

‘’Yeah, there was there was a lot of shame and a sense of somehow it was my fault erm, that there were things I should have done differently and possibly were things I could have done differently, you know, with hindsight’’. (Carol: 83)

5.1.1.3 Sub-theme: The loss and questioning of oneself

This theme concerns participant’s experiences of feeling lost within themselves, questioning their identity and unsure of whom they felt they were pre-therapy. Karen expressed feeling lost within herself before therapy and the trauma in which she experienced had impacted her ability to recognise who she was her identity and her personality. Karen also described feeling that no one would understand her leaving her feeling disconnected from the world around her, experiencing isolation.

'' I did feel a bit disconnected, I would dissociate often before with the well what happened however I would also feel a lone wolf kind of feeling that I was on my own out here doing my own thing and this felt quite isolating really, it felt that I was just doing my own thing and very isolated'' (Karen: 270)

Karen explained feeling like a lone wolf, indicating a feeling or sense of being alone within the world, the choice of words here with the comparison to a wolf highlights this sense of being alone therapy as wolves would tend to be in a pack. Carol echoes this feeling of being lost before commencing therapy describing a loss within their identity and a lack of direction within her life, describing a comparison to now post-therapy before with a sense of being grounded being felt.

'' I used to feel like I didn't know who I was, erm and I didn't know what I wanted, Whereas now I feel kind of quite grounded in that'' (Carol: 309).

Bradley, by contrast, did not express feeling lost within himself, however, the feeling of being disconnected impacted his ways of coping which is explored in the next subtheme (5.1.1.4).

5.1.1.4 Sub-theme: Adopted ways of coping

Participants identified that the role of blame, shame, the self-critic amongst feeling lost within oneself can lead to various ways of coping before commencing therapy as previously discussed. These coping strategies which all participants adopted could help aid the individuals get through their day-to-day lives or not think about what has happened leading to avoidance behaviours. Both Carol and Karen described a tendency to avoid as a way of coping, either by shutting down for Carol or in Karen's case avoiding parts of intimate relationships such as intimacy, and avoiding closeness to other individuals.

'' when it got to stuff that I wasn't comfortable with, I tended to more kind of shut down and kind of go along for the ride almost rather than kind of bring conflict into it'' (Carol: 245)

'' I think others way of coping would be avoidance, I would avoid intimacy but also relationships really as what if they could hurt me the way he did you know'' (Karen: 37)

Bradley explained a different way of coping which still can be an avoidant coping style, through the use of drinking which led to a cycle of him becoming aggressive, explaining he was out of control which led to him experiencing low mood and an inability to get out of bed, echoing depressive symptoms.

'' which I am sure we will cover how bad I was coping, I would drink often also on the weekend, and my behaviour would be out of control, I would get aggressive at times, then when I drank the next time I would hit an all-time low and be harsh on myself, attacking myself, not getting out of bed and this lasted for weeks before I would do the same again'' (Bradley: 48)

5.1.2 Superordinate theme: The therapeutic process

The participants outlined aspects within the therapeutic process which helped aid their experience of CFT and also the changes that they had felt within their self which resembled PTG. Encapsulated within this overarching theme were the subthemes of the importance of feeling safe and secure within therapy, the importance of the therapeutic relationship, and the role of endings, all things must come to an end. This theme captures what may have worked or did not work for participants which could provide future implications within trauma-based therapies.

5.1.2.1 Sub-theme: The importance of safety and the therapeutic relationship

All the participants had experienced therapy as a safe place and felt secure, which was meaningful through this trauma-related work. Many of the participants had previously experienced situations where they had felt unsafe, threatened or fearful. Through feeling safe and secure which was a feeling that was fostered within the therapeutic space, the client participants were able to explore their trauma. Carol described her therapist as having a 'mother earth quality' which helped aid her to feel safe within the therapeutic relationship.

'' She just had this, like, this real kind of Mother Earth quality in a way I just felt instinctively that I was absolutely safe. Which just felt really important'' (Carol: 158)

As Carol described the mother earth quality of her therapist, this brought a sense of feeling safe and secure, suggesting therapy became a safe base. Bradley's experience was similar to Carol's with the sense of safety but also the importance of consistency.

'' I think it's hard to admit but I had never felt safe really, I had never felt that sense of being safe and that everything will work out and be okay and actually with her in them sessions I did feel safe and there was a safe base really which provided me security and consistency, consistency being a big one as I had always worried that people would leave due to the way I treat them pushing them away but no matter what challenges came up, she didn't leave and she stayed with me all the way which meant a lot, I think the relationship helped me massively and couldn't have gone through them changes I mentioned without her there in terms of support'' (Bradley: 143)

As Bradley describes, the therapist being there for the client at the set arranged time and not leaving him throughout the process, sticking alongside him and supporting him helped him go through the process. This theme highlights the importance of fostering a place which brings a sense of safety for clients who may have felt very unsafe in the past and being there alongside the client providing 'a mother earth quality' (Carol) or that 'safe base' (Bradley).

Another aspect which brings this sense of safety and security is the therapeutic relationship as described by Karen and Bradley. They both expressed entering therapy with caution and anxiety, however, this eased as the therapeutic process continued due to this relationship being formed and maintained throughout. They described feeling comfortable and at ease with the therapist and not feeling judged:

'' *so she offered me a initial phone call really to see whether we would fit and work well together I think it was which was ever so helpful as I felt the warmth from day one, it felt different already, the lady did explain, the therapist I should say, was very much open on the call and even*

within fifteen minutes I felt comfortable with her, more than I had done with opening up to anyone before'' (Karen: 52)

'' *Honestly she was absolutely life changing to not sound cliché or cringe here at all, she fostered that good relationship as I mentioned, she listened which I needed with that feeling that I wasn't going to be judged and that I just needed to be myself and that was enough, I found that she was very compassionate actually which I think helped a lot as she role modelled as such that role of compassion which then helped me to pick up on how to be compassionate I would say''* (Bradley: 135)

An interesting reflection from Bradley's experience of the therapeutic relationship is that through the therapist modelling the compassion within CFT, he was able to see firstly how compassion works for the individual but also help aid the client start to be more compassionate towards himself. Karen also highlights the role of developing trust within the therapeutic relationship, which previously, it has been hard to trust anyone.

'*'in terms of trust, I have always found it very very hard to trust anyone, and in fact by how the therapist was on the first session I was able to trust the therapist actually a lot quicker than I had ever thought I would''* (Karen: 131)

This process of trusting and even disclosing to the therapist was through the therapist's ability to hold the client and their emotions, which will be discussed in Chapter 6, further highlighting the feeling of not being judged and the role of safety within their CFT experience

5.1.2.2 Sub-theme: All things must come to an end

This sub-theme discusses the role of endings within the therapeutic relationship, following experiencing a good therapeutic relationship, working towards the ending can be difficult for the participants. Karen and Bradley discussed the role of endings highlighting what may have worked for them and the anxiety surrounding working up towards an ending. Firstly, Bradley explains his anxiety surrounding the ending of the therapy. The participants can feel sceptical about ending therapy as they will go into the real world and the support framework of therapy is no longer there.

‘’ *I did worry about the ending of therapy as I would or felt I would be on my own almost and what if i had forgot the concepts or work we had done I didn't want to waste all that hard work, but we did this kit bag which was like full of reminders which was really helpful to do and helpful a lot I would say’’* (Bradley: 203)

Whilst focusing on how to work attentively towards endings and what may help clients build that bridge from therapy to life outside once the therapy is completed, Bradley explored the usefulness of the kit bag as a reminder post-therapy within CFT. Karen also recognised the importance of having reminders of therapy and compassion through the compassionate kit bag.

‘’ *I do feel that in a way endings have been difficult for me in general so I expected the ending to be challenging, looking at how therapy worked through helping me with this ending it would have definitely been to be noticeable of how the ending would be difficult but also the compassionate kit bag, I remember that well and still use that with me when needed, it feels a little reminder to be kind to myself at times of need.*’’ (Karen, 204)

Both Karen and Bradley noted the importance of attentively working towards the ending and knowing the ending was in sight, helping to prevent a feeling of being lost and working on building up their kit bag of reminders.

5.1.3 Superordinate theme: Changes within oneself

All participants had noticed positive changes within themselves which resembled PTG following receiving CFT and were in different areas of their life, which will be explored through the subthemes. These are changes which have been recognised by themselves, their therapist and the loved ones around them.

5.1.3.1 Subtheme: Building positive and meaningful relationships

As previously explored in the superordinate theme 5.1.1 which focused on the psychological impacts which the trauma has had on participants before therapy, some of the impacts were on the relationships around them, this could be unhealthy relationship cycles or

avoiding the closeness and intimacy of relationships. All participants were able to recognise the change within the relationships around them outside of therapy and the ability to build positive and supportive relationships. Both Carol and Bradley recognised their ability to build and foster these positive relationships, which felt secure.

'' like I've gotten to a place where I'm able to be in a relationship where I'm not constantly looking after someone else and neglecting myself, because I've actually been able to kind of explore having a bit more balance. Yeah. And it's being more comfortable to have that balance and that stability'' (Carol, 228)

'' there were positive changes in my ability to make meaningful and positive supportive relationships with others which were two ways and that I could be a part off without coming away'' (Bradley, 91)

Karen discussed the cycle of her past romantic relationships, which were unhealthy and emotionally abusive. She explained that she thought the way her past partner treated her was what love was meant to be like and now she can reflect upon this experience, learn from the relationship and develop this renewed sense of confidence going forward with romantic relationships.

'' I felt this renewed sense of confidence in which I felt for the first time that I could be in a healthy relationship, for me relationships were a big factor in which changed for me, I would say I was stuck in a pattern of unhealthy relationships in which I could probably say some form of abuse was happening, this comes down to my self-worth a little bit here, I had thought that was what love was in a sense and that to have someone around me and to show me that love, well what I thought was love, gave me a false sense of validation almost it made me feel wanted for the first time and actually it wasn't love, I was stuck in the same patterns of abuse'' (Karen, 107)

Karen uses the language of being stuck in the same patterns of abuse, this felt it was mirroring her childhood, possibly indicating there was no way out and similar feelings being experienced during these recent relationships as when she was younger.

5.1.3.2 Subtheme: Taming the inner critic

This sub-theme reflects the process of working through the role of the self-critic as explored in 5.1.1.1 through CFT. As Karen and Bradley had explored, the self-critic was having an impact on their body image and their self-esteem, their belief in their abilities. Through CFT, both of these participants recognised the changes in reducing internal critic. Karen discussed how she worked on this through chair work which is a common practice within the approach of CFT, focusing on role play and the use of the 'critical' and 'compassionate self' chair.

'' looking at what I would say was really helpful for that critical self I mentioned really, I remember almost like a role play or enactment shall I say between two different chairs the critical and then criticised self I remember now, then we brought in another chair for that compassionate self on another chair I remember at first I was a bit lost at the concept however this technique still to this day I remember how helpful it was and it enabled me to let that compassion in''

(Karen, 150)

Karen further reflects on the difficulty with grasping this concept initially, she explained it helped the therapist explaining the process through psychoeducation which further helped her to start to work through CFT. Whereas Bradley was able to recognise the usefulness of being able to work on not attacking himself through being compassionate and the ability to be aware of when he is starting to become more critical and utilising the techniques given to pull himself out of the critical state of mind.

'*' I still have my moments where I recognise I am slipping into that critical way but I have been able to date pull myself out very quickly, I think this has been one of the biggest changes in therapy for me really as I can say I have been able to move towards the other side and work towards been kinder and more warmer towards myself''* (Bradley, 263)

5.1.3.3 Subtheme: Changes in self-identity

These changes in self-identity reflect upon the previous feelings of being lost within oneself, as explained by Carol who explores how she feels more connected and a sense of feeling grounded in who she is as a person and where they would like to go in life.

'' there are a few moments and things I do that kind of helped me feel a bit more connected to myself. I used to feel like I didn't know who I was, erm and I didn't know what I wanted, whereas now I feel kind of quite grounded in that, I think'' (Carol, 308)

Karen reflects that she has started to view herself differently and they are positive views of herself, which is a change from pre-therapy, especially regarding her critical mind and her self-confidence. This encompasses a belief in herself to be able to do things that she may put her mind to which helps aid a renewed view of the future for her.

'' I view myself very differently, there are more positive views really, so that has been a shift, I feel more open to things and experiences for definite, increases in my self-esteem and most importantly I would say I feel that I am able to do things that I put my mind too, I held myself back so much before so this has been a big shift for me'' (Karen : 308)

5.1.3.4 Subtheme: The process of de-shaming

As previously explored in 5.1.1.2, the concepts of blame and shame can have negative impacts on an individual, which can leave them having responsibility for what happened to them and blaming themselves. Karen explored she went through this process of de-shaming when she worked through CFT and the shifting of responsibility which led to a feeling of self-acceptance.

'' Through therapy I would say I went through a process of de-shaming by showing myself that compassion which was needed and became more accepting of myself. The way in which I tell my close friends about this therapy experience is that I went through a process of acceptance and discovery and it was needed after so long'' (Karen: 79)

Whereas Bradley focused on the role of embarrassment he felt as a male survivor of sexual abuse, and that he felt ashamed he had let this happen to himself but also the role of gender and masculinity, highlighting that he may have felt that fewer males may report being sexually abused or it may even make him feel less of a man. He was able to reflect on the shift of this embarrassment which he explained he had been holding onto for a long time.

''As a male I was embarrassed I have to say before therapy to admit that I had being sexually abused, maybe as don't hear about it as much for males but also that male stereotype , going out beers watching the football on the weekend I used to just switch off from it, but actually I have recognised there is no shame in what happened to me and for me that is massive…''

(Bradley, 129)

5.1.3.5 Subtheme: Working towards self-acceptance

A key change Karen and Bradley experienced was the sense of building a more authentic self and acceptance of this authentic self. A greater understanding of oneself was gained and a different perspective on themselves was reflected in their interviews. Through accepting themselves as they are, changes developed in self-awareness through compassion for Karen and the ability to feel better about the way that they look and take care of themselves, which was discussed by Bradley.

''self-awareness that's it, this felt key to recognise what was going on for me, compassion helped me accept myself for who I was, who I had hated for so long, from my experiences in life, I just used to hate on myself, I was not happy with who I was or who I was going to be for my, well people around me in the future, I respected myself for the first time in a very long time and that was through compassion'' (Karen, 216)

'' I feel better about the way that I look, I now look after myself and take care of myself which I never did prior to therapy as I didn't feel worthy I would say to be honest, I feel I understand and look for the positivity in things in life, I actually to be honest view myself as more confident not just way I look but also in who I am,'' (Bradley, 279)

Through working through these changes, both participants were able to show respect towards themselves and confidence has grown in themselves helping with acceptance and overall day-to-day life.

5.1.4 Superordinate theme: Regaining aspects of their life back

The participants experienced several changes throughout their CFT therapy in comparison to their pre-therapy experiences. This superordinate theme covers the changes in their view of life, the future and themselves resemble PTG changes for all participants post-CFT.

5.1.4.1 Subtheme: Creating a sense of purpose and meaning

This sub-theme consists of the participants regaining a sense of purpose and meaning, focusing on their self-worth and value in life which may have been lost previously before therapy and a belief that they know they could have a sense of direction within their life. Both Bradley and Karen discussed this sense of having a direction in life which could give them meaning, and a change in their attitude to life.

'' erm during therapy also there was a meaning in life discovered and I knew which direction I wanted to go into within life, and more self-esteem I think I was more likely to go out and enjoy myself and actually enjoy myself, not just exist'' (Bradley : 101)

'' I started to think that I wasn't a bad person but also that I had potential in my life, I felt that I could do well in life and that comes into my attitude for life, I started to think that I could actually go somewhere, outside of that dead end job in which I was in as I explained but able to be, to feel like I had value and purpose'' (Karen: 101)

As well as the recognition of this value and purpose, Carol reflected that she does not need to be a 'warrior' anymore post-therapy, in which she had previously explored that the trauma identified her. That she has worth and value aside from her traumatic experiences which can help aid purpose and meaning. Carol's choice of words here (warrior) reflects a battle she has and will

still be going through; a chance or opportunity to fight for others when there was no one fighting for her, a real desire to help others and be strong.

'' And it took quite a long time to get to the point of no, it's, it's all right, that you don't have to, you have worth and value without having to be a sort of a warrior'' (Carol : 120)

5.1.4.2 Subtheme: Renewed view of the future

Bradley and Karen were able to focus on a positive view of the future, a view that the future may not be as scary or daunting as previously may have thought. The changes resembled a shift for new possibilities within life as explained by Bradley and an appreciation of life around them had started to develop as aspects of their life are gained back.

'' I think that optimistic new outlook has helped also in my career I changed jobs and did something I have always wanted to do but never had the guts to do not long ago and I couldn't be happier I did that as I feel better already, I took that leap of faith and it definitely played off, I think yet again its that appreciation and my faith has helped with this engagement thinking about it as I can say I am able to feel connected and more at peace at times which was a rarity before.''

(Bradley : 252)

'' I can actually sit here and say the world and future is okay. A big shift for me is that I don't view the world as being so scary anymore'' (Karen : 256)

5.1.4.3 Subtheme: Recognition of strengths

For Karen and Bradley, the experience of CFT led to changes in their view of themselves, there was a growing awareness of a stronger and more confident self, an ability to cope with the challenges of life. A reflection was shown through the participant's transcripts of the strength and positives within their life. This could include strengths within hobbies or interests as discussed by Bradley:

'' I have recognised not only just my limitations in which I was so used to picking up on before therapy but things I am also good at, them strengths as we call them looking at more

interests and hobbies, I am able to just sit and be at one with myself which is something I had never been able to do'' (Bradley : 272)

Karen described an ability to recognise that she can grab possibilities or opportunities within her life like anyone else and moves away from the feeling of being a failure, this has helped aid her confidence to grow and also to make the most out of her life.

'' I felt that I came out of therapy experience with a idea of a appreciation but also that there were possibilities for me out there and that I can grab them as much as anyone else can, meaning I am not a failure or defined about what happened to me'' (Karen: 253)

5.1.4.4 Subtheme: Regaining power and control

Through the therapeutic process, the approach of CFT, the therapeutic relationship and the changes in which they have experienced, Carol and Karen have been able to recognise that they have power and control within their life. Power and control may have been taken away from them during their traumatic experience, therefore, regaining these aspects in their life can bring a sense of safeness as described by Carol and a vision for the future as discussed by Karen.

'' generally feel very safe where I am, erm I feel like I, I am sort of living a life that I have control over, erm not in a but not in the kind of frantic way I used to want to be able to control things I feel comfortable with area. I feel like I have the influence to be able to affect what happens to me and affect things that are important to me, erm and I feel like I have a lot of sort of stability and strength,'' (Carol : 276)

'' it felt that I was just doing my own thing and very isolated, a feeling of being powerless actually I would say as well, I gained a feeling and vision almost to see things as they were, I always had quite a negative perception of the world around me'' (Karen: 272)

There was a desire to help others in similar situations as themselves as they work to regain this power and control. Carol and Karen displayed signs of altruism during them sharing their experiences through a desire to help others who have been sexually abused. There was a

‘’crusader’’ mentality as Carol expressed of trying their best to prevent as much as they could, other people experiencing what they had experienced. This then led to them sharing their experiences or volunteering within services that supported individuals who had experienced sexual abuse. Karen and Carol both shared this desire within their volunteering-based work, highlighting that the changes that resemble PTG could still be facilitated through this sense of giving back to the community, helping others and sharing their experiences.

‘’ I've had quite a sense that I needed to sort of somehow stop similar things happening to other people. Again, I think it was a way to manage and control what I felt about what happened to me. And I felt this kind of quite strong sense of like, needing to be a bit of a crusader.’’

(Carol: 107)

‘’ I also look to make a difference now and have done some work volunteering on a weekend with some charities that support women who have experienced sexual abuse, I wanted to share my experience but also try to make a bit of a difference even if it was a small difference if it can help someone then it’s better than nothing at all’’ (Karen: 277)

There was a difference noted between Carol’s and Karen’s experience within this sub-theme, Carol explained that helping others was a way of managing and controlling what had happened to her through this kind of work. Whereas Karen focused on how she can make a difference in the world around her and her view of the future.

Summary of the Client Study Findings

To conclude, the superordinate themes represent a journey which the client participants went through from life before CFT to life after therapy. Firstly, the life before therapy superordinate theme encapsulates the psychological impacts the sexual abuse had on the clients and reflects what clients would like to work on through approaching this kind of therapy. The therapeutic process is highlighted as important for the participants in their experience of this therapeutic approach focusing on the role of safety and the therapeutic relationship, this highlighted the importance of having consistency and a safe base as the therapist models

compassion for their clients. The changes the participants found throughout CFT are split into the changes found within themselves and regaining aspects of their life back which are both parts of PTG. Participants were able to recognise the changes within their relationships in their life, the role of personal strength, an appreciation for new with a renewed view of the future and a chance for new possibilities to occur in the future. The participants highlighted areas of the therapy which focused on the difficulties they experienced before therapy such as self-critic and the role of shame. CFT was able to target these areas to reflect the changes participants experienced in the subtheme changes within oneself.

Chapter 6: Therapist Study Findings

6.1. Therapist study

Following the Interpretative Phenomenological Analysis of therapist participants accounts of their experiences of this phenomenon, four superordinate themes emerged from my data as detailed in Table 4:

Table 4. *Table of Therapist superordinate themes and subthemes.*

Superordinate themes	Subthemes
6.1.1 Working through the therapeutic process	6.1.1.1 *Making sense of what has happened: Psychoeducation*
	6.1.1.2 *Working through the de-shaming process*
	6.1.1.3 *Working with multiple selves: Chair work*
	6.1.1.4 *Importance of therapeutic relationship*
	6.1.1.5 *The fears, blocks and resistances to compassion*
6.1.2 The witnessing of changes	6.1.2.1 *Internalised changes*
	6.1.2.2 *Reconnection with oneself*
	6.1.2.3 *The reclaiming of life and power*
	6.1.2.4 '*It's not my fault' process*
	6.1.2.5 *Revaluation of relationships in ones life*
6.1.3 Maintenance of PTG post therapy	6.1.3.1 *Compassion becomes an internal resource*
	6.1.3.2 *Role of discipline and consistency*
	6.1.3.3 *Reminders of therapy: Compassionate kit bag*

	6.1.3.4 *PTG as a gradual process*
6.1.4 Knowing CFT works at a personal level	6.1.4.1 *Therapist modelling compassion*
	6.1.4.2 *CFT's role in alleviating vicarious trauma*
	6.1.4.3 *Growth and development of the practitioner*

These themes and sub-themes will each be explored in turn. Line numbers are denoted in parentheses after each quote and refer to the individual transcripts.

6.1.1 Superordinate theme: Working through the therapeutic process

This superordinate theme covers what therapists believed to have been helpful as they worked through the therapeutic process with their clients who had experienced sexual abuse. Covering what may have worked well in their past therapeutic experiences and any difficulties they may have faced. Encapsulated in this overarching theme were the subthemes of making sense of what has happened: psychoeducation, working through the de-shaming process, working with multiple selves: Chair work, the importance of the therapeutic relationship, working attentively towards an ending and the fears, blocks and resistances to compassion.

6.1.1.1 Sub-theme: Making sense of what has happened: Psychoeducation

All participants noted the importance of walking the client through the psychoeducational parts of CFT, which in turn can help clients to make sense of what has happened and why they may be reacting the way they may be. The tricky brain for example, refers to as individuals go through life experiences, the brain becomes vulnerable to negative emotions such as anger and shame. Through doing so, there is a shared understanding that is fostered within the therapeutic room, and awareness and recognition are built.

'' So the psychoeducation has to be there for them to understand what they're going through. So that it makes sense. The fact that we have a tricky brain that we that we can't go to the

supermarket and just change the brain on the first shelf, because it's pink instead of green, we can't change it so that is what we are stuck with'' (Sheila : 35)

'' think I'm using the elements of compassion focused therapy, so, like psychoeducation, so helping clients to understand, you know, thinking about things like evolutionary psychology, and what's happening for them in their brains so they can understand where some of their feelings and thoughts are coming from'' (Kate : 7)

'' that psychoeducation bit around shame and what shame and self-guilt and you know the differences, kind of defining that and what it is about and where it comes from, erm and trying to understand that and formulation is so important'' (Paula : 79)

Participants all recognised the importance of taking time to explain to clients the processes which underlie CFT which in turn helps to aid the therapeutic relationship and the process for the client.

6.1.1.2 Sub-theme: Working through the de-shaming process

Many of the participants noted that clients will approach therapy with high levels of shame and blame following experiencing sexual abuse. Through CFT, they explored the usefulness and power of working through the de-shaming process for individuals. Through doing so, the clients can work through difficult emotions and shift the responsibility from themselves.

'' so I single out the shame self, and we have a little bit of chair work with it. So that the client can actually see that is on the outside. And so seeing it from the outside, it's not so worrying as actually feeling the shame inside, I can actually connect in a different way'' (Sheila : 226)

'' I think the psychoeducation has been the biggest kind of thing for the clients. Um, I think um yeah, I think unshaming has been the biggest thing that I've noticed. So clients can get that kind of understanding of what's going on for them.'' (Kate : 13)

Through these narratives, participants worked through the de-shaming process through the psychoeducation work and through multiple selves based work. Michelle identifies her clients

whom she has worked with who have experienced sexual abuse, to foster changes which resemble PTG, they have worked through this important de-shaming process. In turn, this can have a positive impact on the client's psychological well-being and the life around them.

'' there the clients I have in my mind that identify really, really experienced post-traumatic growth and CFT has been quite pivotal in that experience and erm this seems really obvious now but it was cause they were genuinely able to let go of shame, it's because they were genuinely able to let go of shame and believe in their worthiness'' (Michelle: 350)

6.1.1.3 Sub-theme: Working with multiple selves: Chair work

Whilst working on taming the inner critic and working on de-shaming process, the participants recognised the usefulness of working with chair work. Chair work is an experiential method of psychotherapy that is based on the belief that it is healing and transformative for people to speak from their inner voices, parts or selves and for them to enact or re-enact scenes from the past, present and future. Some participants noted this can be a difficult concept for clients to grasp, some may even leave the chair work to the later stages of the therapeutic process. Paula recognises that chair work may initially feel difficult for her clients and takes her time to ease her clients into this exercise whilst reflecting on her initial confidence in working with chairs within the therapeutic room.

'' when I had chairs out and I am actually sitting in as you know, such, it has being really weird experience for them and I know I had been very clunky at the beginning, erm using that a lot less skilful and so yeah I think people do, it's the chair work that feels a bit weird to people I find, erm also like and some people like, see its emotions again isn't it, chair work and multiple selves work, its emotions, its just things that people have not been able to notice and name'' (Paula : 358)

Whilst fostering the compassionate self, the use of chair work has been noted as a helpful technique for some participants.

'' suppose particularly with the with the self-critic, um, and I would often use chair work as part of the CFT work, so I suppose can getting the critic outside of somebody's head, and to be able to see the way that it relates to, to them'' (Jon : 68)

'' well it would depend what their compassionate self suggested that the abused self needed and it might be that their compassion says, look the abused self, so just needs to be able to say no, or, or to find or to punch this person or, or to run away or to be able to phone the police''

(Max : 80)

Both Max and Jon reflect through these extracts that through chair work, there is a possibility for the client to detach from their critical and abused self, working towards introducing that compassionate self as that detachment occurs.

6.1.1.4 Sub-theme: Importance of therapeutic relationship

This sub-theme focused on participants reflecting upon the importance of their therapeutic relationship with their clients. They discussed the development of trust and providing a safe base for the clients to work through their trauma. Max, Jon and Sheila all identified that the therapeutic relationship is important along with Michelle:

'' I think it's absolutely essential, I think, as you said, I think we have really core roles in establishing safety, establishing safeness, modelling compassion, both for the clients and also self compassion in in being the, the compassionate mind for them when they're unable to be for them selves. You know, I think that the therapeutic relationship is actually critical in this process''

(Michelle : 224)

'' It's been the most important thing, I think, the safe space, that relationship building that up has been, yeah, is absolutely the fundamental…… and that goes across all my clients, but particularly the clients who have experienced sexual abuse, making sure that they really feel that it's okay and that you will always be there, when you say you're going to be there, and you show up, you know, those basics, to create that really, really secure base and doing that consciously, has been really important'' (Charlotte : 191)

In these extracts from Michelle and Charlotte, the therapeutic relationship, the forming and maintaining of this relationship has been of utmost importance. They discuss within their interviews that clients who have experienced sexual abuse may approach therapy feeling uncertain of the process or wary of trusting another. Therefore, building a safe and secure base which is consistent for clients has shown to be helpful for clients to work through CFT and experience changes which resemble PTG.

6.1.1.5 Sub-theme: The ''fears, blocks and resistances'' to compassion

Many of the participants such as Jon and Charlotte stated that the concept of compassion can be difficult to grasp for this client group due to the role of shame and the self-critic. Trust can initially be difficult within the therapeutic process and can be a barrier for the client to engage in the therapy as Paula discusses below.

'' I think that is the bit that people can kind of struggle with, erm…. Just thinking about it and experience of it, I think once you have got past, theres definitely getting past the barriers and the trust that people have, I think when you do that.. not your fault focus and I think there is a lot of videos that are kind of used to that, I think that is the moment you can really get people to open up a little bit, to some of the CFT exercises which can be quite exposing..,''

(Paula: 41)

Paula recognises that clients have lost trust relationally within their lives and may find it difficult to open up to others, maybe due to the fear of not being able to be held emotionally or the fear of being hurt. She recognised the need to gain the trust of the client to work through the CFT work. The barriers to compassion are termed fears, blocks and resistances within the CFT language, some participants such as Michelle explored the need to work through these for compassion to be fostered by clients.

'' people learn how to do that and we don't, we actually don't need to teach clients generally how to be more compassionate, we just need to help them overcome whatever those

fears, blocks and resistances are that are getting in the way of them being able to offer it to themselves,'' (Michelle: 44)

6.1.2 Superordinate theme: Witnessing of Changes

All the therapist participants were able to witness some form of change within their clients throughout their CFT work. These changes, which will be outlined within the following subthemes, resemble PTG, such as internalised changes, a reconnection with oneself, the reclaiming of life and power, 'it's not my fault process', the recognition of strength and resilience and the revaluation of relationships in one's life.

6.1.2.1 Subtheme: Internalised changes

This theme highlights some of the changes that the participants have seen with their clients, which may include their view of their self, the shifting of blame and changes within their life. Tracy recognised the changes in how the client sees their self, their self-esteem which was linked with client's high levels of shame but also the ability to regulate their own emotions internally and self-soothe.

'' and you can see the changes in that, you know, I don't hate myself as much, but I can see that these experiences I've had weren't my fault, I can soothe myself sometimes, you know, so when my distress is, when I'm having flashbacks and nightmares, you know, they've, I can soothe myself a lot quicker.'' (Tracy : 220)

Other changes that were discussed included the ability for clients to spend time prioritising themselves, to focus on themselves and build up their sense of worthiness.

'' he said to me,' I never felt more motivated than this time in my life', he actually found strengthening within himself. And the commitment to actually carry on to build his body up because it's very thin, to, to go to a nutritionist to help them to have a better relationship with food'' (Sheila : 147)

Sheila recognised not only an internal change but one which could impact their relationship with themself and others around them which will be discussed in the sub-theme of revaluation of relationships in one's life (6.1.2.5).

6.1.2.2 Sub-theme: Reconnection with oneself

Clients can often approach therapy feeling disconnected and lost within themselves as the participants discussed in their interviews. As the therapy has progressed, the participants have witnessed clients starting to find themselves through the acknowledgement and acceptance process and a feeling of connection with themselves, connection linking to compassion and connecting with the world around them as discussed by Kate through her work with this client work.

''I feel they just feel a bit more connected. I suppose that's its connection, isn't it? It's that connection to everybody else. Because when we're traumatised, we're disconnected, and feel alone, sort of on the outside looking in, whereas I think with CFT, it really helps to break down some of those barriers and helps people to feel more connected to everything else and everybody else as well'' (Kate : 198)

As Kate discussed, a sense of connection can be gained for an individual, Sheila also discussed this sense of connection through acknowledgement and acceptance but also a commitment to oneself to work towards the best version of themselves.

'' To acknowledge and accept what has been going on, and and then commit for a change that will be would be for the best. And then we talked about the best version of himself. And how he sees the future now how he envisage that future for him and for his daughter'' (Sheila : 164)

This reflects the positive nature of CFT working with this client group to be able to commit to lasting change whilst looking at improving relationships with oneself and others around them through this sense of reconnection.

6.1.2.3 Subtheme: The reclaiming of life and power

Some of the participants discussed clients having a lack of control and power within their life following their trauma, which can lead a client to feel powerless and unsure of their place within the world. Paula reflected upon the clients being able to view the world differently through this reclaiming of life, but also the role of forgiveness and recognition.

'' suppose you could also put it in the bracket of re-claiming life as well and how they sort of move in the world and how they view things and sort of , how she viewed relationships so erm I guess there was a bit of forgiveness you know and also recognition of what people have done''

(Paula : 162)

Forgiveness and acknowledgement can both be difficult for clients to grasp. CFT can help clients find their strength to be able to regain this power and recognise their needs and wants within their life, as discussed by Jon.

'' right there's something about I don't know, like that sort of pride and strength to be able to state those things really, really clearly. Like you know, what I now need is, is this, what I now deserve is this and so many lines are drawn in the sand and I will not tolerate this anymore''

(Jon: 129)

Within this extract, Jon is referring to his clients being able to have a different view of the world around them, but also themselves, looking at their relationships but also what they deserve within this renewed view of their life.

6.1.2.4 Subtheme: 'It's not my fault' process

This subtheme links with working through the de-shaming process as outlined in the de-shaming process subtheme (6.1.1.2) and is associated with the blame that clients may hold before approaching therapy. Participants have been able to witness the gradual shift and change in clients being able to work through 'it's my fault' to 'it's not my fault' process. Michelle focused on the

importance of working through this process and the changes she has seen working towards 'it's not my fault' and the internalisation of this message.

'' that sense of, you know, that core message of it's not your fault is just something that is so critical for survivors of sexual abuse to hear, and not just hear, but to really understand and to really internalise that message'' (Michelle : 38)

Tracy discussed this internalisation of this message and focus, however, she recognised it is a gradual process which can initially be fleeting for clients due to the difficulties experienced with blame and shame.

'' so maybe, this isn't me being mad or bad, you know, maybe just maybe, there's a possibility that this isn't my fault and that first, and it's not, you know, it's fleeting, initially'' (Tracy : 191)

6.1.2.5 Subtheme: Revaluation of relationships in one's life

Participants discussed the impact trauma can have upon an individual but also their life around them including their career and also their relationships. By working through this process of therapy, some participants have been able to recognise changes in how clients have viewed relationships and the vulnerability clients have started to express within their relationships. Both Jon and Tracy discussed how the forming of healthy relationships can occur but actually, it can be the removal of unhealthy relationships for the individual which has been a positive change for the clients.

'' I think I think probably the biggest things that people are changing their actual live relationships, so I suppose unfortunately, what the protect strategies and creating, of course, people get stuck in relationships that are continued to be abusive and to be unhelpful. And I think the strength to be able to say, you know, I'm going to be willing to be on my own for a while, or to be able to find something different and then, you know, to be on that journey to see people find that different relationship'' (Jon : 133)

'' it's also this might sound odd, but sometimes it's about shutting down some relationships and that's a really compassionate path and that can be a massive kind of change that we can see is that they will chop off some really unhealthy relationships in their lives and not feel that that's what they have to be in'' (Tracy : 236)

Both accounts describe changes they have seen in clients' relationships outside of therapy, clients have been able to take control within their relationships and recognise what may be the right relationship for them and gaining autonomy within their lives.

6.1.3 Superordinate theme: Maintenance of PTG post therapy

Whilst being able to observe the changes outlined in witnessing of changes superordinate theme (6.1.2), the participants discussed how changes which may resemble PTG may be maintained post-therapy and how this could be achieved in their view. Within this overarching theme, the following sub-themes will be explored: Compassion becoming an internal resource, the role of discipline and consistency, reminders of therapy: compassionate kit bag and PTG as a gradual process.

6.1.3.1 Subtheme: Compassion as an internal resource

When discussing how the changes which resemble PTG are maintained post-therapy, the participants discussed how the techniques and tools that are used in therapy are not maintained as such, they believe that the concept of compassion is internalised by working through CFT. This results in clients utilising this compassionate self when they need to within life post-therapy.

'' how it is maintained, I think that I think once someone has really experienced the benefits of it and the changes actually become internalised, I think that its less effort for them , it takes less conscious erm work to go okay this is a situation where I am kind of triggered, what would compassionate mind perspective, what imagery practice or how can I think this through whatever lenses or access whatever strategy they have, I think it becomes more automatic for them'' (Michelle: 306)

'' so the compassion becomes internalized, and the work that we're doing becomes internalized, so that it's, it's, it's a gentle detachment, and their attachment is more to their own resources, rather than to me as a therapist,'' (Charlotte: 245)

Both accounts of Michelle and Charlotte highlighted the importance of compassion becoming an internalised resource, and that the emphasis of therapy towards the ending should specifically focus on how to foster and utilise this compassion when needed.

6.1.3.2 Sub-theme : Role of discipline and consistency

Some participants discussed the importance of clients maintaining and keeping up with what has been focused on throughout CFT, whether this is the practice of compassion or the compassionate self-reminders. They suggested that if they do not continue to practise the CFT principles, they can become lost, as discussed by Sheila below in her analogy of riding a bicycle. Sheila suggested that clients must continue to practise the compassionate self exercises outside of therapy or it may be that these skills or concepts are lost without practice.

'' that's long as they know, you know, they learn to drive the bicycle, but to ride the bicycle, but if you if you don't keep riding it, then you lose balance but then when you when you go back to it, it's quite easy and fast to to go back to the routine'' (Sheila : 310)

Michelle also agrees with the idea of consistency, terming compassion as a treatment gain specifically.

'' but I do think that is kind of helpful to consolidate erm you know treatment gains for all of a better phase,'' (Michelle : 305)

These accounts emphasise the requirement for the therapy to prepare the clients for their life outside of therapy and the consistency required for the changes to occur over a long time.

6.1.3.3 Subtheme: Reminders of therapy: Compassionate kit bag

Following on from the subtheme discussed above, Charlotte and Michelle both discussed the compassionate kit bag, which can act as a reminder of therapy incorporating the key practices

from their CFT journey. Incorporating this kit bag, can act as a reminder of therapy, but also can help individuals to work with those anticipated difficulties with endings for clients.

'' about compassionate kit bag so you know I think that's a really important thing for maintenance, they have a solid sense of you know, what are the compassionate tools and strategies that they have available to them and whats a way to help erm clients be able to cue to the need of and access them regularly'' (Michelle :323)

'' we consciously build up a kit bag for them that they can take with them, that gives them the compassionate tools that they need on my journey and I think that's a really important step, it's one of the most important steps that we do really, so, so that yeah, you know, obviously, we can't, it's up to them but we try and make that a conscious process and help them to understand really how they can take those tools with them, and use them, because that's such an important thing,''

(Charlotte : 257)

6.1.3.4 Sub-theme: PTG as a gradual process

Whilst discussing the concept of post-traumatic growth, Max and John both explored specifically that PTG are recognised and experienced over time. Max explores that it is difficult to discuss whether PTG has been fostered with his clients whilst they are in therapy and believes the changes are experienced post-therapy….

'' I think, in order to get a real sense of post traumatic growth, there isn't enough of a gap between the end of the work I do with people and an opportunity to talk to them about where they are, my my sense of post traumatic growth is that often people say that I'll never be grateful for what happened to me because it should never have happened but I have learned some really useful things as a result of what happened or there are ways I have changed which have been important or valuable to me'' (Max: 202)

Jon discusses through having the compassionate self which has been practised through CFT, this can be a motor for life-long growth, which may not always be shown initially within therapy however the changes can continue to occur through adopting this compassionate self.

'' I think it's kind of knowing that actually, you know, if they do have a compassionate self on board, and it does show up regularly, I mean, this that's kind of like the motor for, for life long growth in a way because if they can do that, then they can tap into multiple situations and life events and etc,'' (Jon: 363)

6.1.4 Superordinate theme: Knowing CFT works at a personal level

The final superordinate theme focuses its attention on the therapist's practice of compassion and the principles within CFT which has helped aid their work with this client group. This includes the therapist modelling compassion within their therapeutic work for clients, the personal influence CFT training has had on the therapist, the role of CFT supervision within this work, CFT's role in alleviating vicarious trauma whilst working with this client group and the growth and development of the practitioner within their practice.

6.1.4.1 Sub-theme: Therapist modelling compassion

Compassion was discussed as a tricky concept for clients to grasp throughout the CFT process, some participants recognised the importance of modelling compassion as the therapist. This could be achieved through the therapeutic relationship or the use of self as a therapist as discussed by Jon below. Through the therapist doing so, they believe that when compassion may be difficult for the client to adopt, the therapists can step in and help guide this process.

'' I think we have really core roles in establishing safety, establishing safeness, modelling compassion, both for the clients and also self-compassion in in being the, the compassionate mind for them when they're unable to be for themselves.'' (Michelle : 224)

'' but I think that's really congruent with CFT, and you're doing it with the compassionate self or with the compassionate other, with me, stepping in and modelling compassion, and encouraging them to be their compassionate self alongside me,'' (Jon : 31)

The participants reflected upon their use of themselves in therapy but also were able to model what compassion looks like as it is adapted within their day-to-day lives as an individual.

6.1.4.2 Sub-theme: CFT's role in alleviating vicarious trauma

Participants have recognised that through fostering compassion and the practices within CFT themselves as practitioners, that vicarious trauma can be alleviated. The impacts of vicarious trauma can frequently affect professionals such as psychotherapists and psychologists following working with clients who have experienced a form of trauma and clients recalling their experience. Both Kate and Charlotte discussed how they believe vicarious trauma has been alleviated through the self-practice of compassion and working with CFT for this client group.

'' , I think the use of compassion Focused Therapy within the therapy session, helps to mitigate that sense of vicarious trauma or the possibility of vicarious trauma because those feelings don't come'' (Kate: 305)

'' so I think it's been super important for me to have my own practice, especially when you are, you know, the client I had today, you know, has shared some significant and deeply, you know, deeply traumatic sexual abuse in quite graphic detail, and so that my own practice has been very, very important to me to be able to deal with that, and to manage that, and to make sure that it doesn't have any lasting impact on me, and I really have noticed a change in my ability to manage and cope with, you know, I've always been fine with it but actually, now, I have a different way of feeling settled with it and, yeah, I seem to be able to manage it far better than I could before and I think I have to put that down to my own personal practice and just general compassionate approach and ability to be able to tune into that compassionate self and that that's one of the greatest gifts really, of CFT'' (Charlotte: 310)

Both these accounts provide interesting reflections on the trauma field, vicarious trauma has been focused on within the research for professionals who work with individuals who have experienced trauma. These participants have found that compassion has helped aid that process for them and in turn helped aid their practice.

6.1.4.3 Subtheme : Growth and development of the practitioner

Some participants recognised the personal impact of CFT training and growth that has occurred as outlined above, however, some also recognised areas of growth and confidence within their practice increase through utilising this CFT approach.

'' because I think that the growth for me, both personally, and as a therapist, has been enhanced, like, you know, I'm, I'm in my 50s now, I've been doing this work for, you know, a very long time, decades and the last, you know, when I consider the the exponential growth, if you like me over the last five years, compared to my career before that, it has been the thing that absolutely has contributed to the most significant growth for me personally, as well as professionally'' (Michelle: 277)

Michelle reflected upon the growth she has experienced since she received CFT training whilst Jon reflected upon the use of trying new techniques and his confidence growing throughout to use himself within the CFT work for this client group.

'' and I want them to internalize me, and I'd encourage them to practice using the I think that's quite new actually. I wouldn't be doing that when I started CFT to say, you know use me try thinking about bringing this to me and what I might say, or how we might deal with it together in the room.'' (Jon: 344)

Summary of the therapist's findings

To conclude, my therapist study was able to encapsulate participant's experiences of delivering CFT for clients who have had experiences of sexual abuse and they were able to witness changes which resemble PTG for their clients. Firstly, working through the therapeutic process was covered in the working through the therapeutic process superordinate theme. This theme focused on what therapists believed to have worked with this client group, including the use of psychoeducation, the de-shaming process, working with multiple selves, the importance of the therapeutic relationship and the fears, blocks and resistances to compassion. This first theme encapsulated the key aspects of CFT and focused on what may or may not work in their

experience. The witnessing of changes which resemble PTG was covered in the second superordinate theme. The witnessing of changes theme included changes that therapists have seen as their client's change their view of themselves, reconnecting with parts of themselves, working through the 'it's not my fault process' and focusing on relationships within their life. The maintenance of these changes was covered in the third superordinate theme, compassion was seen as an internal resource which clients can gain access to anytime when it has been learnt, a sense of compassion being engrained for the clients, the role of discipline and consistency. The endings of therapy were covered through the role of the compassionate kit bag and consideration that PTG can be a gradual process was finally covered, suggesting PTG can take place during and after therapy, therefore PTG may continue to develop after the therapeutic process occurs. The final superordinate theme encapsulated the therapist using this approach themselves to practice and deliver CFT, where they model compassion for clients, feel a sense of growth and development within their practice and CFT alleviates vicarious trauma for some practitioners.

Chapter 7: Discussion

My research study aimed to consider the lived experiences of PTG through CFT for clients who had experienced sexual abuse and CFT-trained therapists working with this client group. The Interpretative Phenomenological Analysis approach provided narrative accounts of the participants' experiences and a range of sub-themes emerged during the analysis for both studies. These sub-themes were then clustered into superordinate themes which encompassed the lived experiences of all participants in both studies. Four superordinate themes for each study emerged from this abstraction process for both the client and therapist studies.

This chapter aims to first summarise and explore the themes and superordinate themes for the client study, placing them in relation to the literature review and the theoretical and applied knowledge concerning the facilitation of PTG. The chapter will then move to focus on the therapist study before a discussion of the client and therapist study's findings in conjunction with one another to form this multi-perspective study. The final sections will consider the clinical applications of my study alongside strengths, challenges, limitations, and recommendations for areas of further investigation raised by the study.

Summary and assessment of findings

Client study

Life before therapy

The participants described their experience of sexual abuse briefly whilst looking at their life before therapy. The participants had experienced many difficulties in coping with the emotional impact of their sexual abuse. Within the first superordinate theme of life before therapy, the participants provided an insight into these difficulties and their ways of coping before therapy and experiencing the changes they later discuss. Many of these difficulties were the reason that they reached out to therapy and were the goals of the therapeutic process. A difficulty which was commonly experienced across the participants was the role of the self-critic, that they had become more critical of themselves following their sexual abuse. Research by Bhuptani and Messman-

Moore (2019) has found high levels of self-criticism for individuals who have experienced sexual abuse. The impact of having high levels of self-criticism for an individual has been shown to affect satisfaction within romantic relationships, and attachment avoidance which links to my study as clients recognised an impact on their romantic relationships before therapy (Lassari et al. 2018) and confidence (Gilbert et al. 2010).

Alongside high levels of self-criticism, high levels of blame and shame were commonly experienced by participants in this study. This included them taking responsibility for what happened to them and blaming themselves for the sexual abuse that occurred. Within the literature, researchers have found high levels of trauma related shame and guilt following experiences of sexual abuse, and these become areas which can impact psychological well-being and PTSD symptoms (Aakvaag et al. 2016). Aakvaag et al (2016) found that there was a gender difference regarding women experiencing more trauma- related shame than men. This study had a limited sample size however both genders found trauma-related shame to be 'eating away at them' (Karen) before therapy. High levels of shame impact individuals' ability to process the abuse and can cause the maintenance of PTSD symptoms as found by Feiring and Taska (2005). High levels of shame and blame alongside self-criticism can cause individuals to feel lost within themselves, the participants recognised they felt lost in themselves in this study and feel isolated (Krayer et al. 2015), which can lead to maladaptive ways of coping.

The participants all recognised they had adopted different ways of coping following their sexual abuse, these included avoidance and the use of destructive behaviours such as substance misuse. Within the literature, qualitative research suggests that through qualitative findings, the way an individual copes following sexual abuse varies over time, some of the most common ways to cope is finding a way to psychologically escape the abuse which may be through avoidance, distraction or substance misuse as found by this research's findings. These coping strategies can provide useful at the time but become maladaptive in the long term. Over time, through sufficient support and psychological support, cognitive appraisal and positive reframing strategies can be adopted in the long term (Oaksford & Frude, 2004)

The therapeutic process

By working through CFT, my participants initially expressed some anxieties and uncertainties with starting the therapeutic process. Within the second superordinate theme of the therapeutic process, the participants provided insight into how the role of feeling safe and secure in the therapy was important to them. The therapists were able to put the clients at ease and provided a consistent safe base, this has been found to be important within the initial stages of trauma-based therapy (Lowe & Murray, 2014).

Feeling safe and secure can be fostered through the therapeutic relationship which all participants noted to be important within their CFT journey. Through these feelings, trust can be formed which was noted to be difficult for all participants, the therapists were able to remain emotionally attuned to the clients through the therapeutic work and model compassion as Bradley suggested in the therapeutic process subtheme. This helped aid Bradley through the modelling of compassion, and how to start to be compassionate towards himself. Within the research base, researchers such as Lawrence and Lee (2014) have focused on exploring individual's experiences of CFT for trauma, in general, using an IPA study. Previous research adopting IPA as an methodology found the therapeutic relationship within CFT for trauma helps aid individuals to have positive emotional responses to self-compassion, the role of acceptance and not feeling judged as important and helpful for clients and through the therapists believing in the clients to shift their beliefs about themselves, enabled them to focus on shifting these beliefs from self-blame to self-compassion. The clients in my study also reported not feeling alone with their struggles through the therapeutic relationship helping to aid the isolation and a lost feeling which many survivors feel. The importance of the therapeutic relationship within the literature has increasingly been found to be fundamental in contributing to therapeutic change for clients (Greenberg, 2008) which was mirrored through the client participant's experiences stating it was an important aspect of their therapy.

The role of endings in CFT has not specifically been documented in the literature, however the use of the compassionate kit bag was mentioned by Bradley and Karen within my study as

they worked attentively towards the ending of their CFT journey. Providing a tangible resource of the concepts which were covered within their CFT work, helped aid the ending of the therapy but also acted as a reminder post-therapy to be compassionate to themselves, as found by Lucre and Clapton (2021). The kit bag was found to create a tangible means of accessing compassion for the participants in this research who have experienced fears, blocks and resistances to compassion initially before starting CFT.

Changes within oneself

The experiences of sexual abuse left all participants feeling low in confidence and low self-worth which impacted their day-to-day life, and their relationships with themself and others. Within the participant's interviews, it became clear that through engaging in CFT changes were found within themselves. Participants all noted a change in their ability to build and maintain meaningful relationships whilst ending destructive relationships and cycles. Woodward and Joseph (2003) focused their research on the positive domains related to positive change processes, including an inner drive towards growth and changes in self-perception and relationships. Participants in this study expressed an ability to reflect upon their relationship whilst learning about their role in relationships. Positive changes in relationships with others are one of the domains focused on in the post-traumatic growth inventory (PTGI; Tedeschi & Calhoun, 1996). Participants were able to recognise their worth in relationships and end previous negative cycles of unhealthy relationships, strengthening their relationships with others in their life, this has been found as an indicator that post-traumatic growth have been facilitated (Calhoun & Tedeschi, 1999). These changes in relationships with others has been well documented within the research for clients who have worked on self-compassion and soothing in CFT (Gilbert, 2009; Araghian et al. 2020).

By working through CFT, my participants noted a difference in their self-critic. Self-criticism has been found to form an important part of an individual's self-identity which participants discuss in this study and at first can be an aversive nature of developing self-compassion (Lawrence & Lee, 2014). Lawrence and Lee (2014) found within their IPA research

that clients reported the battle to give up the inner critic using compassion in CFT amongst four other superordinate themes. McLean et al (2018) have also reported the usefulness of CFT when working with individuals who have had experiences of sexual abuse in taming the inner critic.

Within my study 'changes with oneself' superordinate theme, participants discussed changes in their self-identity and view of themselves, which have been fostered through taming the inner critic and taking away the responsibility from themselves, working on their shame and blame through CFT. McCarthy (1997) found that within trauma-focused therapy, changes are fostered through acceptance of oneself which was covered in the working towards self-acceptance sub-theme of this study, the shifting of responsibility and blame and experiencing adult sexuality as voluntary and mutual and focusing on living well in personal, sexual, marital, and parenting roles. By working through the de-shaming process in CFT, both Karen and Bradley recalled that they were able to show more acceptance towards themselves and shift the embarrassment and shame that they felt. Shame has been described as a feeling of being powerless and inferior (Gilbert, 1998). CFT uses a 'not your fault' approach which helps clients to understand the origin and maintenance of their problems are understandable which can be an important step in bringing compassion into one's experience (Irons & Lad, 2017).

Irons and Lad (2017), also found that helping clients manage their threat systems through CFT is an important process in the de-shaming process working towards self-acceptance, alongside developing the compassionate self. Self-acceptance has been found as a mediating role in the facilitation of CFT through mindfulness and breathwork (Wen et al. 2021), which is an area covered within CFT, acceptance was explored in this study's participant's accounts. Wang et al (2019) have also found through their research that individuals who have mental health difficulties such as PTSD were able to achieve post-traumatic growth with the ''transformed self'' via self-acceptance, self-exploration, self-worth and self-fulfilment through building inner resources and strengths promoting PTG.

Regaining aspects of their life back

As PTG was experienced, the participants recalled aspects of their life that were changing as they regained aspects of their old life back and create a different view of themselves and the future. Factors which have been significantly associated with PTG include having a sense of personal meaning, high life satisfaction and stability (Powell et al. 2012). PTG has also been found to be associated with a change in the sense of meaning in one's life (Park, 2010) and creating purpose through helping others as they regain control back over their lives. Both Karen and Carol reported they would like to make a difference and to stop similar things happening to others. The literature has specifically explored adaptive outcomes explored by women following an experience of sexual abuse and has found that women engaged in deliberate introspection to connect with themselves, utilized altruistic actions and identified a relationship with themselves (Guggisberg et al, 2021), supporting the altruism shown by both participants. Alongside creating a purpose and meaning, a renewed view of the future was experienced, which has also been shown in Lawrence and Lee's work (2014) as one of the domains of PTG they found in their sample. A positive outlook on the present and the future was beginning to be fostered by this studies participants, recognising that the future does not feel as scary anymore and that new possibilities were available for them.

Within my participant's accounts, through engagement with therapy, it became clear that the participants were able to recognise their strengths in the context of adversity, as found by Calhoun et al (2010). Personal strength represents positive responses to the PTGI (Tedeschi & Calhoun, 1996), which all participants score highly on. Strengths were gradually starting to be recognised in therapy, ones which had not been acknowledged before. Acknowledgement of strengths has been found to be an important aspect of PTG, representing a sense of mastery from completing the CFT process. The experiences of sexual abuse left some of the participants in this study with little control or agency over their life and their reactions. Within the sub-theme of regaining power and control, my participants account demonstrated how they moved beyond this position to start to regain control and power within their lives. Participants were able to recall developing a sense of control concerning a reconnection with life, feeling a sense of stability

(Carol) and gaining a vision as recalled by Karen. Participants described a feeling of being able to reconnect with life through being equipped with the tools and techniques through CFT. The ability to take back control through making choices in their life was demonstrated by Tedeschi and Calhoun (1996), they have shown how people who experience PTG tend to work on prioritising what is important to them in their lives and develop a sense of agency.

Therapist study

Working through the therapeutic process

Within my first superordinate theme, the participants were able to recall what they thought was helpful or what difficulties may have occurred when working with these clients who had experienced sexual abuse. My participants noted the importance of psychoeducation and explaining to the client why they may be reacting the way they are, helped with the therapeutic process. Research has supported the therapist participant's accounts through psychoeducation, providing a framework for clients to understand their painful emotions which are considered one of the layers of CFT, called compassionate understanding (Asano & Shimizu, 2018; Kolts, 2016).

Gilbert (2017) suggests that psychoeducation surrounding compassion will operate as insights and antidotes to harmful tendencies for the clients leading to the cultivation of compassion. The therapeutic approach of CFT arose from several observations, one being that individuals with high levels of shame and self-criticism can have great difficulty with being kind towards themselves, and these high levels tended to be rooted in a history of abuse and adverse experiences (Shore, 1998). My therapist participants recognised that clients could approach therapy by being very critical of themselves. Through CFT, my therapist participants recognised that their clients are helped to develop an internal compassionate relationship with themselves to replace the blaming and self-critical one that is present. Research has found through working through this de-shaming process, feelings of hating oneself are reduced, and depression and stress scores have been reduced (Lucre & Corten, 2013). The therapist being de-shaming and non-judgmental has also been found to facilitate this change for clients (Gilbert, 2009).

Another concept of CFT which was found to be useful when working with this client group was the use of chair work and working with the multiple selves, commonly the critical self. Multiple selves work has been found to help aid the differentiation of threat-based emotion and an exploration of their conflict, compassion is then applied to the client's affective world to aid regulation and integration (Bell et al. 2021). Through Bell et al's (2021) research they found with depression and low mood, which can be experienced for individuals with PTSD, chair work was found to be beneficial in working with multiple selves work and compassion can create a sense of personal coherence. Chair work helped within this research for my therapist's clients to be able to identify and separate emotion and in developing new forms of self-relating which helps individuals work through taming the inner critic.

As the therapist works through the therapeutic process, they will be aiming to be non-judgmental and de-shaming throughout the process. The importance of therapeutic relationships was highlighted as an important aspect for all participants in creating a safe and consistent base for clients, which helped their clients to feel safe and secure, helping to form trust and security. Research has explored the key competencies for therapists to deliver CFT appropriately using the CFT competency framework (CFT-CF). These included competencies in creating safety, which was composed of building and maintaining a therapeutic alliance with the client; modelling the compassionate self and de-shaming; conveying the 'it's not your fault process' which was a sub-theme in this research (Liddell et al. 2017). All these competencies can be brought together to provide a safe and consistent base for clients where trust can be formed, and clients can work through their difficulties to foster the changes witnessed by the participants in this study. My therapist participants were able to recognise the importance of creating this safe space, quotes from Charlotte and Michelle support this claim.

Finally, my participants explored that compassion can be initially difficult for clients to grasp and there can be many fears, blocks and resistances to compassion which can occur. These can include difficulties with trust, therapists aim to create a comfortable space in which trust can be formed through a good therapeutic alliance or the role of self-criticism and shame. Key aspects

of CFT are focusing on overcoming these barriers as explored by Charlotte. Literature has focused on therapist's experiences of how they may work with these barriers in the context of CFT, within a thematic analysis produced by Steindl et al (2022) four interrelated superordinate themes were produced, these included, it's not your fault psychoeducation, respect the wisdom so the importance of therapeutic relationship, the central role of formulation and an emphasis on experiential interventions. Recognition of working through these barriers to compassion by cultivating safeness and connection within the therapeutic relationship is critical to therapist's participants in this present study and the research. Interventions which have been found helpful in working with these barriers include coming back to the definition of compassion, validating these barriers, and linking these barriers to personal experiences and history and taking small steps to reiterate the 'it's not your fault' message (Irons & Beaumount, 2017).

The witnessing of changes

As my therapist participants worked through CFT with their clients they were able to start to recognise changes which were reported within sessions or changes they witnessed in the clients. Participants stated that as therapists they tend to recognise the changes in their clients before the clients recognises them. For example, some participants were able to recognise changes within the client's view of themselves. Research has supported that when these changes occur, they resemble PTG following therapy. For example, Hartley et al (2006) found survivors can experience growth through their relationships with others, growth concerning culture and relating to themself differently. Research by McCarthy (1997) further supports such changes occurring, for example, acceptance of oneself as the survivor, the prioritising of oneself and an increase in self-worth, as was also described by my participant, Tracy, in the subtheme of the witnessing of changes.

A change which was witnessed by my therapist participants included their clients being able to reclaim their life and power back following their trauma. Research within the domestic violence literature has supported this claim. Within the recovery process, there are intrapersonal processes and interpersonal processes occur. Intrapersonal processes include regaining and recreating one's identity, embracing the freedom and power to direct one's own life, fostering

acceptance and forgiveness of oneself and acknowledging the long-term process of overcoming abuse. Interpersonal processes included building positive social support and using one's experiences with abuse to help others (Flasch et al. 2015). Flasch et al's (2015) work support the similar claims found by my therapist participants in this present study and provides future implications for CFT therapists working in the trauma field.

Participants recognised that clients frequently came to therapy blaming their selves and were very critical of themselves, stating it's their fault. Therapists were able to see a shift in this belief and clients worked towards 'it's not my fault' process. Research supports this witnessed change, for example, McLean et al (2018) highlighted the effectiveness of CFT for working with individuals who have an experience of sexual abuse, through cultivation of compassion, the shame and blame were able to be reduced. They concluded their research by stating that the theoretical framework and core focus or aims of CFT are highly applicable for this shifting of blame for survivors of sexual abuse and hold a significant promise as a treatment option for this client group. Within Lawrence and Lee's (2018) research they supported the changes found throughout CFT for sexual abuse survivors. They found clients were able to give up the battle with their inner critic, develop self-compassion and clients were able to have a more positive outlook for the present and future.

Finally, my participants within the current study were able to witness changes in clients' relationship with themself as discussed but also their relationships with others. Woodward and Joseph (2003) also found this change in their participants which included positive change relating to an inner drive towards growth, vehicles of change and psychological changes. Within these three themes found through their thematic analysis, these researchers found that participants were able to recognise a belief and faith in themselves, changes in self-perception and relationships and a sense of experiencing validation and acceptance from others, all resembling aspects of PTG.

Maintenance of PTG post therapy

Within this superordinate theme, participants were able to recognise changes during the CFT process however, they explored how their clients would be able to maintain these changes once the CFT was completed and the client was outside of therapy. Within the literature, researchers have started to explore the concept of how clients maintain 'treatment gains' following therapy (Haas et al, 2002). Participants discussed the concept of compassion becoming internalised for clients, an internal resource as such for when clients need compassion whenever it may be needed in the future. Self-compassion has been found within the literature to be a good resource for individuals to adopt to deal with hardship (Lander, 2019) and has demonstrated many psychological benefits (Neff, 2009) which can be learnt and maintained through CFT. The role of discipline and consistency was discussed by some of the therapist participants regarding how to maintain the changes post-therapy, this includes keeping up with being compassionate to themselves after therapy. A way to remind clients to do so was discussed by participants in regard to the compassionate kit bag which is commonly used in CFT. The compassionate kit bag was developed as a means to draw together aspects of CFT to help clients to cultivate and facilitate their capacities for compassion (Lucre & Clapton, 2021). The kit bag can offer a creative and tangible means of accessing compassion, which can be worked upon in therapy and given to clients as a reminder of what they have covered in therapy for when they face possible distress in the future. This provides an opportunity for clients to be consistent and maintain the changes fostered through CFT and the cultivation of compassion (Lucre & Clapton, 2021). The compassionate kit bag may maintain compassionate smells, music, imagery, and touch (Lucre & Clapton, 2021). Some participants noted that subtle changes were witnessed during the therapeutic process that they discussed, however, they explained that PTG can be a gradual process. Tedeschi and Calhoun (2004) support this claim through their research on trauma and loss, stating that PTG is a process as well as ongoing growth, and some individuals will continue to experience changes across their lifespan post-therapy.

Knowing CFT works at a personal level

The therapeutic relationship was discussed above regarding how the therapist will help create a safe base for their clients. Participants also noted how CFT has been an approach in which they have adopted themselves outside of being a therapist. They recognised how through practising compassion themselves; they developed an understanding of the CFT concepts and how they worked but they also modelled the compassion for their clients. Gale et al (2017) supported this experience and recognised that compassion becomes a concept which is adopted as part of a therapist's lifestyle. When exploring the impact of the personal practice of compassion on a therapist's therapeutic work, these researchers found self-compassion for their clients increased, they felt more present in the room with their clients, and they were more aware of the use of self and what they were bringing to the therapeutic space.

Fostering self-compassion themselves as therapists was a concept in therapist participants noted was helpful with minimising compassion fatigue, this can be a common experience that therapists can feel which can dampen the therapist's quality of life and professional work, this alongside vicarious trauma. Research has also supported how therapists modelling compassion can help clients work through battling their inner critic and shame. This happens through therapists being compassionate and non-defensive when problems arise. Therapists at times can use their examples of when compassion has worked for them (Gilbert & Procter, 2006). The role of compassion and CFT's role in alleviating vicarious trauma was discussed by my therapist participants (Kate and Charlotte). Research by Yip et al (2016) found a mediating role of self-compassion between mindfulness and compassion fatigue across a sample of therapists in Hong Kong, they found compassion helped to work with preventing this fatigue, which was noted by some of the participants.

Finally, participants recognised the use of CFT training when reflecting on their growth and development as a practitioner. Michelle recognised the growth which has occurred for her personally and professionally since CFT training, whilst Jon recognised the ability to try new concepts in his work. This superordinate theme captured that CFT can be adopted by both the clients and the therapists, and it has been a useful concept, providing future implications for

trauma-focused therapists regarding CFT training and the role of compassion in the therapeutic relationship.

Client and Therapist Study

The client and therapist study ran separately within my research to explore two different perspectives on the phenomenon. This was the first piece of research exploring this phenomenon from the perspectives of both the therapist and the client. The findings have been discussed separately above, this section will focus on the similarities and differences between both the client and therapist samples. It is important to note that there were fewer participants in the client sample compared to the therapist sample, however, the themes captured can be still compared.

Both participant groups recognised the importance of the therapeutic relationship and safety within that relationship from both the client receiving CFT and the therapist facilitating CFT for this client group. Research has supported that the therapeutic relationship is noted as an important aspect of the therapeutic process, for example, Cooley and Lajoy (1980) found that there are several factors which are found to be important such as acceptance, understanding and safety, which positively correlated with reported levels of improvement after therapy. Gilbert (2022) has also noted the importance of the therapeutic relationship as a source of the variance in therapeutic outcomes. Gilbert (2022) recognises the challenges of working through the fears, blocks and resistances to compassion that clients may bring to therapy. Therapists have an important role in facilitating a safe base for clients and a compassion focus can be used in the therapeutic relationship. My research provides insight two how both sides of the therapeutic relationship have found CFT in regard to PTG being experienced.

Both the client and therapist participants were able to recognise that one of the changes which resembled PTG was the reclaiming of life and power, which included reclaiming control in their lives from two different perspectives. Another change upon which both sets of participants reflected was the process of de-shaming throughout CFT which helped aid the client towards the changes which were discussed. Within CFT there is an aim to understand and experience

emotions, to normalise and de-shame negative emotional responses, through doing so, this aids clients to move away from condemning and blaming behaviours towards improved emotional regulation and a positive sense of self. Both sets of participants were able to recognise how clients were able to work through this de-shaming process to help aid the 'it's not my fault process'. The role of shame and self-critic can become the fears, blocks and resistances to compassion which was explored in my therapist's study. Steindl et al (2022) highlighted therapist's perspectives on working with these blocks and resistances and recognised the importance of working through these, validating and de-shaming the client's blocks and resistances which was described as crucial in CFT.

A similarity which was discussed by both sets of participants was the role of the self-critic and working on taming this inner critic through CFT. Research has found that clients who have experienced sexual abuse experience difficulties with shame and self-criticism (Lassri et al, 2018). Both clients and therapists recognised the impact the self-critic can have on an individual's self-esteem and self-acceptance. In Coaston's (2019) paper, Coaston explained reducing self-criticism through the concept of compassion, working on fostering a good therapeutic relationship, focusing on chair work and compassionate mind training which is part of CFT. Both the clients and therapists recognised a reduction in self-criticism through CFT, and the therapists explored during chair work to work on taming the inner critic in this study.

Through working on taming the inner critic, both clients and therapists recognised that clients were able to work on accepting themselves and shifting the blame that they have held onto since the trauma. Within the therapist study, they mentioned the use of chair work to work through the multiple selves in taming the inner critic (Bell et al, 2020), highlighting the usefulness of the CFT principles and techniques in facilitating these changes for clients. Through working on their relationship with themselves, relationships with others were evaluated, including the ending of destructive relationships and the building of positive relationships for clients. Therapists were able to witness these changes for their clients, growth associated with relationships with others is associated with post traumatic growth. The building of positive and meaningful relationships

based on affection and caring can show many physiological and psychological beneficial effects (Cozolion, 2013), which can be formed through a sense of belonging and acceptance (Cacioppo & Patrick, 2008). Karen and Carol recognised past unhealthy patterns in their relationships and worked through the forming of positive relationships in their life resembling growth and change.

The role of endings was discussed within both studies and the therapist participants discussed the importance of attentively working towards an ending which helped aid their client's anxieties surrounding the therapeutic process coming to an end. Therapists explored the usefulness of having the compassionate kit bag which was discussed by some of the client participants to help aid the ending of the therapeutic process. The role of endings have being discussed within the literature, regarding the ethical issues which can arise (Mangione et al. 2007) and attentively working to an ending so that the ending is in sight for both the therapist and client to work towards (Murdin, 2013). Finally, there was a similarity regarding internalised changes that both the clients experienced and therapists witnessed concerning clients working towards self-acceptance and reconnecting with themselves. This helped aid self-esteem but also the clients belief in their abilities, searching for new possibilities in life which can be described as an aspect of PTG (Calhoun & Tedeschi, 2014).

There were some subtle differences noted between both sets of participants in the exploration of their experiences of CFT facilitating PTG. This may be due firstly to the client and therapists are different sides of the therapeutic relationship and the client has described their life before therapy and then therapists the personal application of CFT for them. The client participants were able to reflect upon a renewed view of the future which included an appreciation of life, which was discussed as the 'future not looking as scary anymore'. Within this view of the future, client participants recognised the ability to be able to make a difference for similar individuals who have experienced sexual abuse. Dracucker et al (2011) participants' displayed altruism in helping others who have been in a similar situation, which helped aid their healing journey but also prevented any way they could for others to not have a similar experience as them. These findings resemble some of the client participant's experiences and can provide insight into a

variety of processes and enabling factors that facilitate healing in several domains following experiences of sexual abuse.

There were differences in the language used between both client's and therapist participant's descriptions of their experiences. The therapists were able to reflect on what concepts within CFT were useful when working with this client group whereas the client participants remembered aspects such as the use of chairs with their therapy. Therapists recognised the importance of psychoeducation and explained the concepts such as the tricky brain and threat systems, which have been recognised in the literature (Matos & Steindl, 2020). The psychoeducation can include information on compassion and loving kindness and information which can be provided to explain why clients may have the reactions they may be including the role of blame. The clients within the discussions of their experiences did not note the importance of psychoeducation, however, they recognised the concepts which worked well for them regarding the changes they experienced. Research has found that clients will remember significantly the impact of the therapeutic relationship and the in-session outcomes in regard to the changes experienced (Timulak, 2010). Timulak (2010), also found that client's perceptions of therapy may differ dramatically from that of the therapist. Furthermore, the relational and emotional aspects of significant moments may be more important for the clients rather than the cognitive aspects of therapy which are frequently stressed by the therapists which may explain these findings may explain these differences. Clients reflected upon their experiences up until six months after the therapy was completed, so there could have been a chance for the changes which they reflected upon to be a gradual process which was what the therapists noted. The gradual process of post-traumatic growth has been reflected in the literature with a sample of participants with chronic fatigue (Arroll & Howard, 2013) and survivors of violence (Tedeschi, 1999).

To conclude, through exploration of the two studies, these findings have highlighted that both the clients and therapists have reflected upon the processes within CFT and their therapeutic journey changes which have resembled PTG. My study has enabled there to be two different perspectives to provide future implications for this research area which will be later discussed.

Concluding Remarks: The Facilitation of PTG

The participant accounts of their experiences of CFT and clients moving beyond their trauma provided a rich narrative description and important insights into the lived experience of the participants as they had engaged in CFT therapy. Through the application of IPA, these insights emerged from the participants' experiences and allowed the research aims to be considered and explored.

Both sets of participants were able to explore the facilitation of PTG through CFT from different accounts, the therapist's and client's perspectives. The clients recalled how their life was before attending therapy in regard to the psychological impacts the trauma had upon the individuals and ways of coping with their trauma, feeling anxious, avoidant and withdrawing away from life. Client participant's relationships with themselves were disrupted but also their relationships with others. Therapist participants also recognised the impact of fears, blocks and resistances which clients have as they approach therapy, this may be client's shame, and self-criticism or difficulties with trust. Both sets of participants reflected on what may have been useful throughout the process in facilitating changes for them, this included the use of chair work, taming the inner critic and working through the de-shaming process. The therapeutic environment allowed clients to engage with their trauma at a cognitive and affective level.

As both sets of participants reflected upon the therapeutic process, what may have worked and not have worked, changes started to be witnessed and experienced. These noted changes which were explored included internalised changes, a reconnection with oneself, the building and forming of positive meaningful relationships, a new appreciation of life, personal strengths recognised and an improvement in emotional regulation. These changes all resemble PTG which has occurred for all client participants and was witnessed by all therapist participants in their work.

My study aimed to extend the knowledge within the CFT literature concerning PTG from exploration from two different perspectives, both client's and therapist's viewpoints were

explored. It appeared that aspects of CFT were beneficial in facilitating PTG, which included the compassion within the therapeutic relationship, which was modelled by the therapists, the de-shaming processes within CFT and CFT's focus on taming the inner critic. The findings from both studies demonstrated several factors which were influential in the facilitation of PTG.

Implications for practice

The exploratory findings from both sets of my participants' accounts extend the knowledge of the facilitation of post-traumatic growth through therapeutic approaches and provide new literature on the facilitation of PTG through CFT for individuals who have experienced sexual abuse. The majority of past literature on the experience of PTG has focused on either the cognitive elements believed to be important to experiences of PTG or focused upon the therapeutic relationship. The participants in this study did engage at a cognitive level through their reappraisals around their self-concepts, the shifting of blame and the meanings associated with their trauma experiences. My research, therefore, supports the proposition that psychotherapeutic approaches for PTSD with some form of cognitive and information processing such as what can be facilitated within the earlier stages of CFT can be important in the facilitation of PTG. This proposal fits with current theoretical suggestions of the role of positive accommodation of trauma-related information into revised schematic changes around self, and self in relation to the world (Joseph & Linley, 2005).

Both sets of participants explored how the quality of the therapeutic relationship they had with their therapist/client was important to the experience of change and PTG. This was demonstrated through the participants discussing the importance of the therapist modelling compassion, the role of safety and trust and working through the therapeutic journey together. The therapeutic relationship enabled clients to explore and re-evaluate their lived experiences, their sense of self and their self in relation to their future world, in order to alleviate their symptoms of PTSD and grow towards PTG. The recommendations from my research for practitioners includes the focus required on forming this therapeutic relationship with clients in this client group, the

ability to show empathy and building a sense of security and safety, all areas which the client participants noted as important in the therapeutic process.

My findings highlight aspects of CFT which have important relevance to clinical practice for clients to explore their positive adaption following their trauma. Through the role of compassion in CFT, clients were able to work through shifting their levels of blame and working on taming their inner critic. High levels of blame and self-criticism have been documented throughout the literature as difficulties which individuals who have experienced sexual abuse hold. The compassionate mind training, which therapists facilitate, has enabled a shift for clients to work through a de-shaming process and become kinder and more compassionate towards themselves. Through doing so, clients can foster a different view of themselves, others, and the future and build positive meaningful relationships. A connection with oneself and the world was discussed throughout both studies, throughout and after the CFT process. These connections enabled individuals to be able to find meaning and purpose within their lives, regaining aspects of their life back, regaining power and control and recognition of their strengths.

An important finding from the interpretative level of analysis from the therapist study is the consideration of how these documented changes throughout CFT are maintained once therapy has been completed. Therapists provided important considerations as to how clients may be able to continue to foster these positive adaptions after completion of therapy. These included the role of discipline and consistency, that compassion becomes an internal resource and the role of endings. An implication for practice is for the role of endings to be considered carefully, them to be planned and worked towards, so clients are aware of the ending approaching. Also, a further recommendation is to incorporate reminders of therapy for clients such as the compassionate kit bag, which was ably documented within the client study's findings.

The findings of my research also suggest a renewed consideration in the commissioning of services beyond a narrow focus on symptom reduction alone. The revolving door syndrome has long been recognised as a difficulty within the medical model of mental health provision, this syndrome refers to clients returning into therapy. However, as my research suggests,

commissioning of treatments such as CFT which focuses on fostering these internal resources of compassion for long-lasting change, fosters a good therapeutic relationship in which the therapist can model self-compassion, offers an effective treatment for both PTSD recovery but also assists clients to be more fully functioning, so aids relapse prevent and clients returning to therapy.

My study's findings also imply the training of practitioners within existing trauma treatments. CFT is a fairly new approach within the world of psychotherapy, one which is increasingly becoming focused on within trauma-based literature. The findings suggest that within the training of counselling psychologists, and those trauma-based practitioners, awareness of this approach, training for CFT and the awareness of the possibility of PTG being fostered through psychotherapy can offer future benefits through being aware of the processes which may enable positive changes for their clients. Within this training environment, the role of de-shaming, taming the inner critic and the other documented changes can be explored further. The therapeutic relationship as with many psychotherapy approaches is important to provide safety within trauma-based work and to model this self-compassion for their clients.

All client participants had CFT over a period of a minimum of six months, which may not fit with some of the shorter-term services within the UK, such as the adult improving access to psychological therapies programme (IAPT). My research has highlighted for the participants of this study, the facilitation of PTG can be fostered through CFT, an approach which may sit differently from more cognitive-based approaches such as trauma-focused CBT and EMDR. Being a newer approach, and as research develops and is cited on CFT, there could be scope to incorporate the aspects of CFT within a six to eight-week programme which can fit within services such as IAPT in the future.

Strengths, Challenges and Limitations

My research study consisted of a client study and a therapist study, which provided insight into both sides of the therapeutic relationship providing multiple perspectives. My research was the first to provide a multi-perspective account of this phenomenon, providing a more holistic

picture and gaining a deeper understanding of the phenomenon. There was scope within this research to find different perspectives on CFT, however, it was challenging at times to keep any presumptions from each study separate. The use of bracketing and keeping a reflexive journal was important to help minimise these biases.

Another strength of my research was that this research was the first to explore the role of CFT in fostering PTG for individuals who had experienced sexual abuse. However, as previously noted, it was important for both the client and therapist study to be conducted and analysed separately to avoid any preconceptions or biases to impact the findings of both studies. Therefore, the two studies were only discussed within the final stages of the discussion section.

Interpretative Phenomenological Analysis was chosen to explore the lived experiences of both sets of participants. Smith et al (2009) outlined that this approach can provide individualised analysis which is in the unique accounts of the participants. A strength of my research was the ability to be committed to the ideographic nature of IPA. One of my study's strengths was the ability to explore the experiential claims of each participant within the production of the wider encompassing superordinate themes. My study's findings were able to provide an understanding of how this phenomenon is experienced by the individuals providing rich as well as unique data (Smith, 2011).

IPA however could be argued to have provided some limitations in the exploration of the facilitation of PTG with this therapeutic approach. As previously explored within the methods section, Willig (2013) has highlighted the influence which a researcher may have on the research process and findings. This may particularly have an impact on the analysis stages within IPA due to the interpretative nature of this approach. However, I was able to recognise the potential for this influence within the earlier stages of my research process. Therefore, being able to align my research practice with the processes of reflexivity, bracketing and engagement in the hermeneutic circle (Smith et al, 2009; Yardley, 2008). To do this, I completed a bracketing interview for myself, and kept a research reflective journal throughout the process (see appendix) this ensured I

was able to limit any potential bias which ensured the trustworthiness of my findings as discussed in more detail in the methodology/method section.

The sampling method which was chosen in this research was purposive sampling, however, this could provide strengths and limitations for this research. Within the literature, Smith et al (2009) for example have suggested the use of a homogenous sample to explore in depth of the chosen phenomenon. Therefore, the therapists were recruited in such a way, as were the client's participants, who had experienced sexual abuse, received a diagnosis of PTSD, and received CFT within the past six months. This provided an opportunity to focus solely on experiences of sexual abuse, CFT for sexual abuse and working towards positive change. However, focusing on one trauma, provided a narrowly constrained sample, limiting the number of individuals in which I was able to recruit. There was a significant difference in the number of clients I was able to recruit for the client compared to the therapist study. However, this outlined limitation could conversely represent a strength of the client study as there was an ability to explore in depth the client's experience of CFT.

Another limitation within the sampling section concerns the female-to-male ratio of participants, in the therapist study there were only two males and within the client study, only one participant out of three was male. Within the PTG research, gender differences have been explored but only small to moderate effect sizes have been found (Vishnevsky et al. 2010). Within the compassion-based literature, some research has highlighted that males self-reported more self-compassion than females (Yarnell et al. 2015; Yarnell et al. 2019). However, within both the client and therapist studies, the gender differences were minimal, and the experience of the males was similar to those of the females within the limitation. The themes were checked to determine that the themes were well-represented across all participants, superordination themes were presented in all/most male participants, as were the sub-themes. When considered from this standpoint, the prevalence of themes across the sample, the themes demonstrated a high degree of congruence in males and females, therefore, this potential limitation may be less influential to this study.

However, it would be suggested for further qualitative research to explore these gender differences for individuals who have experienced sexual abuse to further clarify and differentiate any effects.

My client study asked that participants are out of therapy within six months to provide an opportunity for recollection and reflection post-therapy. However, by asking participants to discuss their experience retrospectively, there could be multiple factors which may influence the memory processes. For example, the client participants were asked about their ways of coping before therapy. Safer and Keuler (2002) found that individuals can overestimate their levels of pre-therapy distress, which may lead to an illusion of positive change. The research did try to attempt to limit these limitations by having a six-month limit on participants being out of therapy, due to the chances of memory being affected. Therefore, the findings of my study must still give regard to the retrospective quality of the participant's accounts considering this methodological limitation, PTG can take time, so it is finding a fine balance.

Following on from the last methodological consideration, for the client study, participants were only asked about their experience of CFT and PTG post-therapy. Therefore, there was no indication within my study of the levels of PTG pre-therapy. This provides a possible limitation as the clients may have experienced some changes themselves following their trauma pre-therapy. However ethically, this was unsuitable to do at the time of research due to not having access to clients longitudinally as they approached therapy for a pre-post therapy design, this could be further researched in the future. Finally, the participant's accounts were analysed through IPA, a qualitative approach, the research relied on participants recollection and self-reporting experiences of CFT and PTG. Quantitative research has found significant reductions in PTSD symptoms and increases in PTGI scores pre and post-therapy. Therefore, there may be further scope for there to be a mixed quantitative and qualitative design to provide a richly detailed account of participant's experiences whilst providing quantifiable data pre to post-therapy.

Recommendations for further research

As noted in the previous section, there are noted strengths and limitations of the present research. My research provided new multi-perspective insight into experiences of PTG through CFT following experiences of sexual abuse. As an exploratory investigation into this phenomenon, my research has provided pointers for further research which could build on these initial exploratory findings. For the client study, the methodological limitations of retrospective self-report suggest that further research could employ a longitudinal perspective employing a mixed methods approach over the course of pre-therapy to post-therapy, which could provide more differentiation to the insights highlighted in this study. This methodological approach could provide the temporal nature of change over a longer period of time, a quantifiable measure of PTG pre and post therapy and would further highlight key experiences and processes that occur for participants. These findings would provide greater generalisability to these subsequent findings.

A further recommendation is to consider the gender ratio from this research and to consider further exploring if there are gender differences in this phenomenon. I believe this could be achieved through a larger sample size and the recruitment process. There have been reported differences in self-reports of compassion, self-criticism and shame following experiences of sexual abuse, therefore this would provide further findings in this area.

To extend the current findings, it is suggested that further research investigates the maintenance of PTG over time. The therapist participants specifically investigated the maintenance of PTG considering the role of endings and consistency. Further research looking into the maintenance of PTG, could provide clinical implications to help aid relapse prevention and long-lasting change for clients.

Finally, future research could trial a short-term CFT programme within services such as IAPT. This could be trialled within a local trust and formed as a programme which aims to be administered as trauma-focused treatment over the UK, as the research for CFT grows every year.

Conclusion

This research was the first to focus on this phenomenon; CFT and the facilitation of PTG for individuals who have experienced sexual abuse. My research has provided an original contribution to literature which has focused on this phenomenon from multiple perspectives providing an insight to both sides of the therapeutic relationship, clients and therapists. My research has provided implications for both clinical practice and research within the counselling psychology field.

To conclude, the research question for my client study was 'How do clients who have undergone CFT make sense of its impact on their PTG'. The client participants were able to recognise PTG through various aspects of their life, including relationships with others and an appreciation of life. They were able to recognise aspects of CFT which helped to facilitate these changes, highlighting a positive experience, and recognising life-long changes. For my therapist study, the research question was 'How do compassion-focused therapists make sense and experience PTG within their clients'. This research question was answered, with therapists highlighting aspects of change throughout their practice which they have witnessed, focusing on the de-shaming element of CFT for this client group and the positive impact this has on individuals who have high levels of shame and blame following experiencing sexual abuse. This research has explored both research questions, for these two samples, experiences of PTG were facilitated through the practice of CFT from both perspectives.

Chapter 8: Reflective Appraisal

Throughout this research process, there were a series of stages which the research moved from the inception and planning to the implementation of the IPA and the representation of the participant experienced during the analysis. I felt through completing this research process that I was able to progress and develop as a scientist-practitioner and as a researcher in my role as a counselling psychologist. Within this reflective appraisal, I aim to highlight the insights that I have gained through this research process and indicate how these have contributed to this development as I work towards the end of my qualification.

As with much of the research within the field, there were challenges that I faced throughout the stages of the research process. From the initial stages of my research where I was discussing the potential of this topic area, I started to keep a reflective journal which became essential throughout this process. My decisions surrounding the choice of this research topic had been shaped by many decisions. My interest surrounding post-traumatic growth first began whilst I was studying for my master's degree. During this degree, I worked through various topics which introduced me to the concept of positive psychology and the newly emerged concept of post-traumatic growth.

As a practitioner, I had always worked within the trauma field and worked with many trauma-based treatments for clients who had experienced a variety of different traumatic experiences. Upon reflection, I felt something was missing in my trauma-based work and that there was an approach in which I had not come across which may be beneficial for working with these clients away from the structured approaches I had utilised before. During my clinical supervision before my doctoral studies, this was where I was introduced to compassion- focused therapy. Therefore, the inception of the research into PTG and CFT was developed from a mixture of many different strands of prior experience, from an academic starting point in my master's degree and my clinical experience within my workplace pre-doctorate within supervision.

At the beginning of my research journey, my research journal acted as a guide and a map of the planning of this project and helped aid the organisation. During the initial decision-making stages, I recognised the desire for my research to make an impact within the trauma-based field and provide further applications on working with this specific client group.

A difficulty in which I faced with this research which was a fundamental learning point for me as a developing researcher, concerned the initial stages of recruitment. I had set out initially to potentially consider individuals who had completed a course of CFT therapy and their therapists incorporating the client-therapist dyad as a post-therapy design. As a qualitative study, this would bring scope to research how both individuals in the dyads experienced CFT from a client and therapist perspective. The research initially was approved by the University of Wolverhampton ethics board which amendments. However, following discussions with like-minded professionals, there were further ethical considerations which needed to be considered regarding this dyad. This was due to the clients having finished therapy with their therapists, it would be unethical for therapists to contact clients to get back in contact with their clients to see if they would participate. Another consideration is that the therapists and clients could potentially recognise each other through the anonymised transcripts. Therefore, I went back to the drawing board and considered how I could gain both the therapists and clients to explore both perspectives. I decided on two recruitment routes for the therapist and client study (compassionate mind foundation and social media) intending to recruit the participants separately and run two studies. Throughout this time my supervisory discussions and my annual progress review were beneficial in considering my options and responses. In our discussions, I explored how I could potentially reach the clients for the client study through different avenues on social media. Initially, the recruitment for the client study was slower to pick up however I managed to slowly recruit some participants after interviewing for my therapist study.

Following working through this dilemma that I had initially faced with my research and recruitment; I was able to recognise these difficulties early within my research process to make the amendments and continue with my research. In my reflective notes, I recognised the uncertainty

that these initial difficulties had created for me. However, they also showed that I was able to adapt quickly and be versatile whilst making the required changes.

Once recruitment was completed, I drew my attention to the process of engaging with the participants and their research interviews. In the interviews, for the therapist study firstly, they talked through their experience of CFT from a practitioner's point of view for this client group. I noted in my journal how initially my first interview which I completed as a pilot study, my responses were those from a like-minded practitioner rather than a researcher within this interviewing process. I recognised this was due to me resonating with what the therapist participant was discussing. However, I recognised this through my self-awareness and was able to bracket my responses and work on my interviewing style for the following therapist interviews. I completed a bracketing interview also before I started my therapist interviews to bracket my pre-conceptions and to prevent deflection away from the participant's accounts and continued to develop and maintain the rapport necessary for them to openly explore their experiences. This was an important learning point for me in carrying out the research interviews firstly in the therapist study and then within the participant study. As the interviews progressed, I felt I was able to develop as a researcher and recognised the necessary ethical and scientific responsibility and flexibility to get the existential importance of the interview topic, as noted by Kvale and Brinkman (2009).

As I worked through the data analysis stages for both studies, I recognised the importance of representing the participant's voices. I had a discussion with a peer surrounding the abstraction of themes and the worry of minimising the participant's experience and as it may feel less representative. This discomfort was also discussed in supervision surrounding a feeling of moving away from the individual's account. However, as the analysis progressed, I became to realise the importance of the hermeneutic circle which allowed me to return to individual transcripts allowing communication between the overarching themes and individual participant's accounts. As the superordinate themes took shape in both studies, I felt they were increasingly reflecting the voices

of all the participants in the hermeneutic circle and provided the depth of meaning and significance to represent the participants lived experiences.

This research process has represented significant insights for me. There was recognition of my ability to reflect and adapt following feedback regarding my research design which was an important learning experience for me. My engagement in this research process has enabled me to develop as a researcher completing interviews and as a practitioner. This research provided me with insights into CFT and its implications whilst working with individuals who have experienced sexual abuse. However, in line with the concept of post-traumatic growth, insight has been gained into how individuals can demonstrate resilience, growth within their relationships and internalised changes which resemble a move towards the future in a different way they had possibly imagined post-trauma. I felt I have been able to recognise the links between research, theory and therapeutic practice in reflecting on participant's life experiences.

As I reflect on the whole research process, I have recognised my experience as a researcher has had important implications as I move towards the final stages of my qualification. Through gaining two perspectives I have been able to first recognise what parts of CFT, and therapy, in general, are helpful when working with this client group, helping clients to work through moving from distress towards the potential for life-changing personal growth. From gaining a client's perspective, this has given clients a voice to be able to highlight what they have found helpful throughout their therapy experience, providing future implications for therapists within the trauma field to consider. As I have worked with clients recently, I have been able to recognise them as survivors rather than victims of abuse as they have the inner resources and resilience to keep going even in the face of adversity. Finally, the last reflection, is that I am very passionate about my research and wanted to spread the word about CFT for trauma due to the approach being new within the literature. I aim to produce a journal article highlighting the therapist's experience of CFT with this client group post-doctorate (Appendix M). My reasoning for doing so, is due to the sample size of this research and to provide a perspective of what may and may not be working in the practical field amongst like-minded professionals working in this field.

References and Appendix

References

Aakvaag, H. F., Thoresen, S., Wentzel-Larsen, T., Dyb, G., Røysamb, E., & Olff, M. (2016). Broken and guilty since it happened: A Population Study of Trauma-Related Shame and Guilt After Violence And Sexual Abuse. *Journal of affective disorders*, *204*, 16-23.

Ahern, K. J. (1999). Ten Tips For Reflexive Bracketing. *Qualitative health research*, *9*(3), 407-411.

Alase, A. (2017). The Interpretative Phenomenological Analysis (IPA): A Guide To A Good Qualitative Research Approach. *International Journal of Education and Literacy Studies*, *5*(2), 9-19.

American Psychiatric Association. (1994). Diagnostic And Statistical. *Manual Of Mental Disorders*.

Araghian, S., Nejat, H., Touzandehjani, H., & Bagherzadeh Golmakani, Z. (2020). Comparing the effectiveness of quality of life therapy and compassion-focused therapy on the quality of interpersonal relationships and distress tolerance in women with marital conflict. *Journal of Fundamentals of Mental Health*, *22*(3), 190-201.

Arroll, M. A., & Howard, A. (2013). 'The letting go, the building up,[and] the gradual process of rebuilding': Identity Change And Post-Traumatic Growth In Myalgic Encephalomyelitis/chronic Fatigue Syndrome. *Psychology & health*, *28*(3), 302-318.

Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious Posttraumatic Growth In Psychotherapy. *Journal of Humanistic Psychology, 45(2),* 239-263.

Asano, K., & Shimizu, E. (2018). A Case Report Of Compassion Focused Therapy (CFT) For A Japanese Patient With Recurrent Depressive Disorder: The Importance Of Layered Processes In CFT. *Case reports in psychiatry*, *2018*.

Ashworth, F., Gracey, F., & Gilbert, P. (2011). Compassion Focused Therapy After Traumatic Brain Injury: Theoretical Foundations And A Case Illustration. *Brain Impairment*, *12*(2), 128-139.

Beaumont, E., & Hollins Martin, C. J. (2015). A Narrative Review Exploring The Effectiveness Of Compassion-Focused Therapy. *Counselling Psychology Review*, *30*(1), 21-32.

Beaumont, E., Galpin, A., and Jenkins, P. (2012). 'Being Kinder To Myself': A Prospective Comparative Study, Exploring Post-Trauma Therapy Outcome Measures, For Two Groups Of Clients, Receiving Either Cognitive Behaviour Therapy Or Cognitive Behaviour Therapy And Compassionate Mind Training. Counselling Psychology Review, 27, 31-43.

Bell, T., Montague, J., Elander, J., & Gilbert, P. (2020). "A Definite Feel-It Moment": Embodiment, Externalisation And Emotion During Chair-Work In Compassion-Focused Therapy. *Counselling and Psychotherapy Research*, *20*(1), 143-153.

Bell, T., Montague, J., Elander, J., & Gilbert, P. (2021). Multiple Emotions, Multiple Selves: Compassion Focused Therapy Chairwork. *the Cognitive Behaviour Therapist*, *14*.

Bhaskar, R. "A Realist Theory Of Science (Hassocks: Harvester)." (1978).

Bhuptani, P. H., & Messman-Moore, T. L. (2019). Blame And Shame In Sexual Assault. In *Handbook of sexual assault and sexual assault prevention* (pp. 309-322). Springer, Cham.

Bonanno, G. A. (2004). Loss, Trauma, And Human Resilience: Have We Underestimated The Human Capacity To Thrive After Extremely Aversive Events?. *American psychologist*, *59*(1), 20.

Braehler, C., Gumley, A., Harper, J., Wallace, S., Norrie, J., & Gilbert, P. (2013). Exploring Change Processes In Compassion Focused Therapy In Psychosis: Results Of A Feasibility Randomized Controlled Trial. *British Journal of Clinical Psychology*, *52*(2), 199-214.

Brewin, C. (2003). *Posttraumatic Stress Disorder: Malady Or Myth?*. Yale University Press.

Brewin, C. R. (2006). Understanding Cognitive Behaviour Therapy: A Retrieval Competition Account. *Behaviour research and therapy*, *44*(6), 765-784.

Briere, J. N. (1992). *Child Abuse Trauma: Theory And Treatment Of The Lasting Effects*. Sage Publications, Inc.

British Psychological Society. (2010). Code Of Human Research Ethics. Leicester: BPS.

Brocki, J. M., & Wearden, A. J. (2006). A Critical Evaluation Of The Use Of Interpretative Phenomenological Analysis (IPA) In Health Psychology. *Psychology and health*, *21*(1), 87-108.

Cacioppo, J. T., & Patrick, W. (2008). Loneliness: Human Nature And The Need For Social Connection. New York, NY: Norton

Cadell, S., Regehr, C., & Hemsworth, D. (2003). Factors Contributing To Posttraumatic Growth: A Proposed Structural Equation Model. *American Journal of Orthopsychiatry*, *73*(3), 279-287.

Calhoun, L. G., Cann, A., & Tedeschi, R. G. (2010). The Posttraumatic Growth Model: Sociocultural Considerations.

Calhoun, L. G., & Tedeschi, R. G. (1998). Beyond Recovery From Trauma: Implications For Clinical Practice And Research. *Journal of social Issues*, *54*(2), 357-371.

Calhoun, L. G., & Tedeschi, R. G. (1999). *Facilitating Posttraumatic Growth: A Clinician's Guide*. Routledge.

Calhoun, L. G., & Tedeschi, R. G. (2004). AUTHORS'RESPONSE:" The Foundations Of Posttraumatic Growth: New Considerations". *Psychological inquiry*, *15*(1), 93-102.

Calhoun, L., Tedeschi, R., Cann, A., & Hanks, E. (2010). Positive Outcomes Following Bereavement: Paths To Posttraumatic Growth. *Psychologica Belgica*, *50*(1-2).

Cassidy, E., Reynolds, F., Naylor, S., & De Souza, L. (2011). Using Interpretative Phenomenological Analysis To In form Physiotherapy Practice: An Introduction With Reference To The Lived Experience Of Cerebellar Ataxia. *Physiotherapy theory and practice*, *27*(4), 263-277.

Christopher, M. (2004). A Broader View Of Trauma: A Biopsychosocial-Evolutionary View Of The Role Of The Traumatic Stress Response In The Emergence Of Pathology And/or Growth. *Clinical psychology review*, *24*(1), 75-98.

Cho, D., & Park, C. L. (2013). Growth Following Trauma: Overview And Current Status. *Terapia psicológica*, *31*(1), 69-79.

Chouliara, Z., Karatzias, T., & Gullone, A. (2014). Recovering From Childhood Sexual Abuse: A Theoretical Framework For Practice And Research. *Journal of psychiatric and mental health nursing*, *21*(1), 69-78.

Chowdhury, R., & Winder, B. (2022). A Web Model of Domestic Violence and Abuse in Muslim Communities—A Multi Perspective IPA Approach. *Social Sciences*, *11*(8), 354.

Clancy, M. (2013). Is Reflexivity The Key To Minimising Problems Of Interpretation In Phenomenological Research?. *Nurse researcher*, *20*(6).

Coaston, S. C. (2020). Taming The Brain Weasels: Reducing Self-Criticism Through Externalization And Compassion. *Journal of Creativity in Mental Health*, *15*(2), 176-188.

Cohn, E. S., & Lyons, K. D. (2003). The Perils Of Power In Interpretive Research. *The American journal of occupational therapy*, *57*(1), 40-48.

Collier, A. (2013). Realism and formalism in ethics. In *Critical Realism* (pp. 695-701). Routledge.

Collings, S. J. (2019). A Proposed Model For Evaluating The Impact Of Participating In Trauma-Focused Research. *South African journal of psychology*, *49*(2), 241-252.

Cooley, E. J., & Lajoy, R. (1980). Therapeutic Relationship And Improvement As Perceived By Clients And Therapists. *Journal of Clinical Psychology*, *36*(2), 562-570.

Cooper, M. (2009). Welcoming The Other: Actualising the Humanistic Ethic At The Core Of Counselling Psychology Practice. *Counselling Psychology Review*, *24*(3), 119-129.

Cooper, M., McLeod, J., Ogden, G. S., Omylinska-Thurston, J., & Rupani, P. (2015). Client Helpfulness Interview Studies: A Guide to Exploring Client Perceptions of Change in Counselling and Psychotherapy. *Unpublished manuscript retrieved from https://www. research gate. net/profile/Mick_Cooper*.

Costa Jr, P. T., & McCrae, R. R. (1992). Four Ways Five Factors Are Basic. *Personality and individual differences*, *13*(6), 653-665.

Cowan, A., Ashai, A., & Gentile, J. P. (2020). Psychotherapy with Survivors of Sexual Abuse and Assault. *Innovations in clinical neuroscience*, *17*(1-3), 22.

Cozolino, L. (2013). The Social Neuroscience of Education. New York, NY: Norton

Das, V. (2006). Life and Words: Violence and the Descent into the Ordinary. California University Press, Ed.).

Davidson, R. J., Harrington, A., & Rosch, E. (2002). Visions of Compassion: Western Scientists and Tibetan Buddhists Examine Human Nature. *Contemporary Psychology [APA Review of Books]*, *48*(3), 330.

Davidson, R. J., Kabat-Zinn, J., Schumacher, J., Rosenkranz, M., Muller, D., Santorelli, S. F., ... & Sheridan, J. F. (2003). Alterations in Brain and Immune Function Produced by Mindfulness Meditation. *Psychosomatic medicine*, *65*(4), 564-570.

Davis, C. G., Nolen-Hoeksema, S., & Larson, J. (1998). Making Sense of Loss and Benefiting from the Experience: Two Construals of Meaning. *Journal of personality and social psychology*, *75*(2), 561.

Dickson, J. J. (2019). An Interpretative Phenomenological Analysis (IPA) of the link between EMDR and Post-Traumatic Growth.

DiMauro, J., & Renshaw, K. D. (2021). Trauma-Related Disclosure in Sexual Assault Survivors' Intimate Relationships: Associations with PTSD, Shame, and Partners' Responses. *Journal of interpersonal violence*, *36*(3-4), NP1986-2004NP.

Draucker, C. B., Martsolf, D. S., Roller, C., Knapik, G., Ross, R., & Stidham, A. W. (2011). Healing from Childhood Sexual Abuse: A Theoretical Model. *Journal of Child Sexual Abuse*, *20*(4), 435-466.

Duarte, C., Pinto-Gouveia, J., & Stubbs, R. J. (2017). Compassionate Attention and Regulation of Eating Behaviour: A Pilot Study of a Brief Low-Intensity Intervention for Binge Eating. *Clinical psychology & psychotherapy*, *24*(6), O1437-O1447.

Dye, H. (2018). The Impact and Long-Term Effects of Childhood Trauma. *Journal of Human Behavior in the Social Environment*, *28*(3), 381-392.

Elsesser, K., Sartory, G., & Tackenberg, A. (2005). Initial Symptoms and Reactions to Trauma-Related Stimuli and the Development of Posttraumatic Stress Disorder. *Depression and Anxiety*, *21*(2), 61-70.

Epel, E. S., McEwen, B. S., & Ickovics, J. R. (1998). Embodying Psychological Thriving: Physical Thriving In Response To Stress. *Journal of Social issues*, *54*(2), 301-322.

Faghani, F., Choobforoushzadeh, A., Sharbafchi, M. R., & Poursheikhali, H. (2022). Effectiveness of Mindfulness-based Supportive Psychotherapy on Posttraumatic Growth, Resilience, and Self-Compassion In Cancer Patients: A Pilot Study. *Wiener klinische Wochenschrift*, *134*(15-16), 593-601.

Farnia, V., Naami, A., Zargar, Y., Davoodi, I., Salemi, S., Tatari, F., ... & Alikhani, M. (2018). Comparison of Trauma-focused Cognitive Behavioral Therapy and Theory of Mind: Improvement of Posttraumatic Growth and Emotion Regulation Strategies. *Journal of education and health promotion*, *7*.

Feiring, C., & Taska, L. S. (2005). The Persistence of Shame Following Sexual Abuse: A Longitudinal Look at Risk and Recovery. *Child maltreatment*, *10*(4), 337-349.

Feng, Y., Zhou, X., Liu, Q., Deng, T., Qin, X., Chen, B., & Zhang, L. (2022). Symptom Severity and Posttraumatic Growth in Parents of Children with Autism Spectrum Disorder: The Moderating Role of Social Support. *Autism Research*.

Finlay-Jones, A. L., Rees, C. S., & Kane, R. T. (2015). Self-Compassion, Emotion Regulation and Stress among Australian Psychologists: Testing An Emotion Regulation Model of Self-Compassion using Structural Equation Modeling. *PloS one*, *10*(7), e0133481.

Fischer, C. T. (2009). Bracketing in Qualitative Research: Conceptual and Practical Matters. *Psychotherapy Research*, *19*(4-5), 583-590.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences Therapist Guide. New York, NY: Oxford University Press

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and Evaluating Qualitative Research. *Australian & New Zealand Journal of Psychiatry*, *36*(6), 717-732.

Frankl, V. E. (1984). *Search For Meaning*. Mount Mary College.

Frazier, P., Conlon, A., & Glaser, T. (2001). Positive and Negative Life Changes following Sexual Assault. *Journal of consulting and clinical psychology*, *69*(6), 1048.

Frels, R. K., & Onwuegbuzie, A. J. (2012). Interviewing the Interpretive Researcher: An Impressionist Tale. *Qualitative Report*, *17*, 60.

Gaher, R. M., Hofman, N. L., Simons, J. S., & Hunsaker, R. (2013). Emotion Regulation Deficits as Mediators between Trauma Exposure and Borderline Symptoms. *Cognitive therapy and research*, *37*(3), 466-475.

Gale, C., Schröder, T., & Gilbert, P. (2017). 'Do you practice what you preach?'A Qualitative Exploration of Therapists' Personal Practice of Compassion Focused Therapy. *Clinical Psychology & Psychotherapy*, *24*(1), 171-185.

Gearing, R. E. (2004). Bracketing in Research: A Typology. *Qualitative health research*, *14*(10), 1429-1452.

Gilbert, H. (2004). The Therapeutic Relationship in Compassion Focused Therapy. In *Compassion Focused Therapy* (pp. 385-400). Routledge.

Gilbert, P. (2000). Internal 'Social' Conflict and the Role of Inner Warmth and Compassion in Cognitive Therapy. *Genes on the couch: Explorations in evolutionary psychotherapy*, 118-150.

Gilbert, P. (Ed.). (2005). *Compassion: Conceptualisations, Research and Use In Psychotherapy*. Routledge.

Gilbert, P. (2009). Introducing Compassion-Focused Therapy. *Advances in psychiatric treatment*, *15*(3), 199-208.

Gilbert, P. (2017). A Brief Outline of the Evolutionary Approach for Compassion Focused Therapy.

Gilbert, P., & Andrews, B. (Eds.). (1998). *Shame: Interpersonal behavior, psychopathology, and culture*. Oxford University Press.

Gilbert, P., Baldwin, M. W., Irons, C., Baccus, J. R., & Palmer, M. (2006). Self-Criticism and Self-warmth: An Imagery Study Exploring their Relation to Depression. *Journal of Cognitive Psychotherapy*, *20*(2), 183-200.

Gilbert, P. (2009). Introducing Compassion-Focused Therapy. *Advances in psychiatric treatment*, *15*(3), 199-208.

Gilbert, P., McEwan, K., Irons, C., Bhundia, R., Christie, R., Broomhead, C., & Rockliff, H. (2010). Self-harm in a Mixed Clinical Population: The Roles of Self-criticism, Shame, and Social Rank. *British Journal of Clinical Psychology*, *49*(4), 563-576.

Gillies, J., & Neimeyer, R. A. (2006). Loss, Grief, and the Search for Significance: Toward a Model of Meaning Reconstruction in Bereavement. *Journal of constructivist Psychology*, *19*(1), 31-65.

Gilbert, P., & Procter, S. (2006). Compassionate Mind Training for People with High Shame and Self-criticism: Overview and Pilot Study of a Group Therapy Approach. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *13*(6), 353-379.

Giorgi, A. (2010). Phenomenology and the Practice of Science. *Existential Analysis: Journal of the Society for Existential Analysis*, *21*(1).

Goldstein, R. (2009). The Future of Counselling Psychology: A View from Inside. Counselling Psychology Review, 24(1), 35-37)

Greenberg, L. (2008). Emotion and Cognition in Psychotherapy: The Transforming Power of Affect. Canadian Psychology, 49(1), 49–59. DOI: 10.1037/0708-5591.49.1.49

Guggisberg, M., Bottino, S., & Doran, C. M. (2021). Women's Contexts and Circumstances of Posttraumatic Growth after Sexual Victimization: A Systematic Review. *Frontiers in psychology*, *12*.

Haas, E., Hill, R. D., Lambert, M. J., & Morrell, B. (2002). Do Early Responders to Psychotherapy Maintain Treatment Gains?. *Journal of clinical psychology*, *58*(9), 1157-1172.

Harman, R., & Lee, D. (2010). The Role of Shame and Self-critical Thinking in the Development and Maintenance of Current Threat in Post-traumatic Stress Disorder. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *17*(1), 13-24.

Hartley, S., Johnco, C., Hofmeyr, M., & Berry, A. (2016). The Nature of Posttraumatic Growth in Adult Survivors of Child Sexual Abuse. *Journal of child sexual abuse*, *25*(2), 201-220.

Heidegger, M. (1962). *Being and Time*. Oxford: Blackwell.

Herman, J. L. (2015). *Trauma and Recovery: The Aftermath of Violence--from Domestic Abuse to Political Terror*. Hachette uK.

Höltge, J., Mc Gee, S. L., Maercker, A., & Thoma, M. V. (2018). A Salutogenic Perspective on Adverse Experiences. *European Journal of Health Psychology*.

Horowitz, M. J. (1993). Stress-Response Syndromes. *International handbook of traumatic stress syndromes*, 49-60.

Horowitz, M. J. (2011). *Stress response syndromes: PTSD, Grief, Adjustment, and Dissociative Disorders*. Jason Aronson, Incorporated.

Horowitz, M. J., & Reidbord, S. P. (1992). Memory, Emotion, and Response to Trauma. *The handbook of emotion and memory: Research and theory*, 343-357.

Husserl, E. (1931). General Introduction to Pure Phenomenology . (W. R. Boyce Gibson. Trans.).. London: Routledge

Irons, C., & Beaumont, E. (2017). *The Compassionate Mind Workbook: A Step-By-Step Guide to Developing Your Compassionate Self*. Robinson.

Irons, C., & Lad, S. (2017). Using Compassion Focused Therapy to Work with Shame and Self-criticism in Complex Trauma. *Australian Clinical Psychologist*, *3*(1), 1743.

Janoff-Bulman, R., & Timko, C. (1987). Coping with Traumatic Life Events. In *Coping with negative life events* (pp. 135-159). Springer, Boston, MA.

Janoff-Bulman, R. (1989). Assumptive Worlds and the Stress of Traumatic Events: Applications of the Schema Construct. *Social cognition*, *7*(2), 113-136.

Janoff-Bulman, R. (2014). Schema-Change Perspectives on Posttraumatic Growth. In *Handbook of posttraumatic growth* (pp. 81-99). Routledge.

Jayawickreme, E., & Blackie, L. E. (2016). *Exploring the Psychological Benefits of Hardship: A Critical Reassessment of Posttraumatic Growth*. Dordrecth: Springer International Publishing.

Jenkins, S. R., & Baird, S. (2002). Secondary Traumatic Stress and Vicarious Trauma: A Validational Study. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, *15*(5), 423-432.

Jeon, S. W., & Han, C. S. (2015). An Open Trial of EMDR as Promotion for Post-Traumatic Growth. *Brain Stimulation: Basic, Translational, and Clinical Research in Neuromodulation*, *8*(2), 337.

Jeon, S. W., Han, C., Choi, J., Ko, Y. H., Yoon, H. K., & Kim, Y. K. (2017). Eye Movement Desensitization and Reprocessing to Facilitate Posttraumatic Growth: A Prospective Clinical Pilot Study on Ferry Disaster Survivors. *Clinical psychopharmacology and neuroscience*, *15*(4), 320.

Johnson, C. F. (2004). Child Sexual Abuse. *The Lancet*, *364*(9432), 462-470.

Jonsen, K., & Jehn, K. A. (2009). Using Triangulation to Validate Themes in Qualitative Studies. *Qualitative research in organizations and management: an international journal*.

Joseph, S. (2003). Person-Centred Approach to Understanding Post-Traumatic Stress. Person-centred practice, 11, pp 50-75.

Joseph, S. (2004). Client-Centred Therapy, Post-Traumatic Stress, and Post-Traumatic Growth: Theoretical Perspectives and Practical Implications. Psychology and Psychotherapy: Theory, research and Practice, 77, pp 101-120.

Joseph, S., & Linley, P. A. (2006). Growth following Adversity: Theoretical Perspectives and Implications for Clinical Practice. *Clinical psychology review*, *26*(8), 1041-1053.

Joseph, S., Maltby, J., Wood, A. M., Stockton, H., Hunt, N., & Regel, S. (2012). The Psychological Well-Being—Post-Traumatic Changes Questionnaire (PWB-PTCQ): Reliability and validity. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(4), 420.

Joseph, S., & Sagy, S. (2017). Positive Psychology in the Context of Salutogenesis. *The handbook of salutogenesis*, 83-88.

Joseph, S., & Sagy, S. (2022). Positive Psychology and Its Relation to Salutogenesis. In *The Handbook of Salutogenesis* (pp. 233-238). Springer, Cham.

Kaye-Tzadok, A., & Davidson-Arad, B. (2016). Posttraumatic Growth Among Women Survivors of Childhood Sexual Abuse: Its Relation to Cognitive Strategies, Posttraumatic Symptoms, and Resilience. *Psychological trauma: theory, research, practice, and policy*, *8*(5), 550.

Kazdin, A. E. (2000). *Encyclopedia of psychology* (Vol. 8, p. 4128). American Psychological Association (Ed.). Washington, DC: American Psychological Association.

Kemp, K., Signal, T., Botros, H., Taylor, N., & Prentice, K. (2014). Equine Facilitated Therapy with Children and Adolescents Who Have Been Sexually Abused: A Program Evaluation Study. *Journal of child and family studies*, *23*(3), 558-566.

Kiarasi, Z., Emadian, S. O., & Hassanzadeh, R. (2022). The Effectiveness of Compassion-Focused Therapy on Posttraumatic Growth and Body Image Fear in Females with Breast Cancer. *Rooyesh-e-Ravanshenasi Journal (RRJ)*, *10*(12), 109-118.

Kiecolt-Glaser, J. K., McGuire, L., Robles, T. F., & Glaser, R. (2002). Emotions, Morbidity, and Mortality: New Perspectives from Psychoneuroimmunology. *Annual review of psychology*, *53*(1), 83-107.

Kim, Y. (2011). The Pilot Study in Qualitative Inquiry: Identifying Issues and Learning Lessons for Culturally Competent Research. *Qualitative Social Work*, *10*(2), 190-206.

Kleinman, A., and Kleinman, J. (1999). The Moral, the Political and the Medical: A Sociosomatic view of Suffering. In Y. Otsuka, S. Shizu, and S. Kuriyama (Eds.), Medicine and the history of the body. Tokyo: Ishiyaku Euroamerica.

Knaevelsrud, C., Liedl, A., & Maercker, A. (2010). Posttraumatic Growth, Optimism and Openness as Outcomes of a Cognitive-Behavioural Intervention for Posttraumatic Stress Reactions. *Journal of health psychology*, *15*(7), 1030-1038.

Knox, S., & Burkard, A. W. (2009). Qualitative Research Interviews. *Psychotherapy research*, *19*(4-5), 566-575.

Köhler, W. (1929). Gestalt psychology.

Kolts, R. L. (2016). *CFT made simple: A Clinician's Guide to Practicing Compassion-Focused Therapy*. New Harbinger Publications.

Kolokotroni, P., Anagnostopoulos, F., & Tsikkinis, A. (2014). Psychosocial Factors Related to Posttraumatic Growth in Breast Cancer Survivors: A review. *Women & Health*, *54*(6), 569-592.

Krayer, A., Seddon, D., Robinson, C. A., & Gwilym, H. (2015). The Influence of Child Sexual Abuse on The Self from Adult Narrative Perspectives. *Journal of child sexual abuse*, *24*(2), 135-151.

Krystal, H. (1978). Trauma and Affects. *The psychoanalytic study of the child*, *33*(1), 81-116.

Kvale, S., & Brinkman, S. (2009). Interview Quality. *Interviews: Learning the craft of qualitative research interviewing*, 161-175.

Lander, A. (2019). Developing Self Compassion as a Resource for Coping with Hardship: Exploring the Potential of Compassion Focused Therapy. *Child and Adolescent Social Work Journal*, *36*(6), 655-668.

Langdridge, D. (2007). Phenomenological Psychology: Theory, Research and Method. Harlow, England: Pearson

Larkin, M., Watts, S., & Clifton, E. (2006). Giving Voice and Making Sense in Interpretative Phenomenological Analysis. *Qualitative Research in Psychology, 3,* 102-120.

Lassri, D., Luyten, P., Fonagy, P., & Shahar, G. (2018). Undetected Scars? Self-criticism, Attachment, and Romantic Relationships Among Otherwise Well-Functioning Childhood Sexual Abuse Survivors. *Psychological Trauma: Theory, Research, Practice, and Policy*, *10*(1), 121.

Lawrence, V. A., & Lee, D. (2014). An Exploration of People's Experiences of Compassion-Focused Therapy for Trauma, using Interpretative Phenomenological Analysis. *Clinical psychology & psychotherapy*, *21*(6), 495-507.

Linley, P. A., & Joseph, S. (2004). Positive Change following Trauma and Adversity: A Review. *Journal of traumatic stress: official publication of the international society for traumatic stress studies*, *17*(1), 11-21.

Leaviss, J., & Uttley, L. (2015). Psychotherapeutic Benefits of Compassion-Focused Therapy: An early systematic review. *Psychological medicine*, *45*(5), 927-945.

Liddell, A. E., Allan, S., & Goss, K. (2017). Therapist Competencies Necessary for the Delivery of Compassion-Focused Therapy: A Delphi study. *Psychology and Psychotherapy: Theory, Research and Practice*, *90*(2), 156-176.

Loewenthal, K. M. (2022). Religious Change and Post-Traumatic Growth following EMDR Trauma Therapy. *Mental Health, Religion & Culture*, 1-8.

Lomax, J., & Meyrick, J. (2022). Systematic Review: Effectiveness of Psychosocial Interventions on Wellbeing Outcomes for Adolescent or Adult Victim/Survivors of Recent Rape or Sexual Assault. *Journal of health psychology*, *27*(2), 305-331.

Lomas, T., & Ivtzan, I. (2016). Second Wave Positive Psychology: Exploring the Positive–Negative Dialectics of Wellbeing. *Journal of Happiness Studies*, *17*(4), 1753-1768.

Lowe, C., & Murray, C. (2014). Adult Service-Users' Experiences of Trauma-Focused Cognitive Behavioural Therapy. *Journal of Contemporary Psychotherapy*, *44*(4), 223-231.

Lucre, K., & Clapton, N. (2021). The Compassionate Kitbag: A Creative and Integrative Approach to Compassion-Focused Therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *94*, 497-516.

Lucre, K. M., & Corten, N. (2013). An Exploration of Group Compassion-Focused Therapy for Personality Disorder. *Psychology and Psychotherapy: theory, research and Practice*, *86*(4), 387-400.

Liu, A., Wang, W., & Wu, X. (2021). The Mediating Role of Rumination in the Relation Between Self-Compassion, Posttraumatic Stress Disorder, and Posttraumatic Growth Among Adolescents after the Jiuzhaigou Earthquake. *Current Psychology*, 1-14.

Mangione, L., Forti, R., & Iacuzzi, C. M. (2007). Ethics and Endings in Group Psychotherapy: Saying Good–Bye and Saying it Well. *International Journal of Group Psychotherapy*, *57*(1), 25-40.

Maniglio, R. (2013). Child Sexual Abuse in the Etiology of Anxiety Disorders: A Systematic Review of Reviews. *Trauma, Violence, & Abuse*, *14*(2), 96-112.

Maslow, A. H. (1968). Toward a Psychology of Being, 2nd Edn New York. *NY: Van Nostrand Reinhold.[Google Scholar]*.

Matos, M., & Steindl, S. R. (2020). "You Are Already All You Need To Be": A Case Illustration of Compassion-Focused Therapy for Shame and Perfectionism. *Journal of Clinical Psychology*, *76*(11), 2079-2096.

McFarland, C., & Alvaro, C. (2000). The Impact of Motivation on Temporal Comparisons: Coping with Traumatic Events by Perceiving Personal Growth. *Journal of personality and social psychology*, *79*(3), 327.

McLean, L. (2021). Compassion Focused Group Therapy for Adult Female Survivors of Childhood Sexual Abuse: A Mixed Methods Preliminary Study.

McLean, L., Steindl, S. R., & Bambling, M. (2018). Compassion-Focused Therapy as an Intervention for Adult Survivors of Sexual Abuse. *Journal of child sexual abuse*, *27*(2), 161-175.

McMillen, J. C., & Cook, C. L. (2003). The Positive By-Products of Spinal Cord Injury and Their Correlates. *Rehabilitation Psychology*, *48*(2), 77.

Mirick, R. G., & Wladkowski, S. P. (2019). Skype In Qualitative Interviews: Participant and Researcher Perspectives. *The Qualitative Report*, *24*(12), 3061-3072.

Moses, J. W., & Knutsen, T. L. (2019). *Ways of Knowing: Competing Methodologies in Social and Political Research*. Macmillan International Higher Education.

Murdin, L. (2013). *How Much is Enough?: Endings in Psychotherapy and Counselling*. Routledge.

Murphy, J. (1998). Art Therapy with Sexually Abused Children and Young People. *International Journal of Art Therapy: Inscape*, *3*(1), 10-16.

National Institute for Health and Care Excellence (Great Britain). (2019). *Post-Traumatic Stress Disorder*. National Institute for Health and Care Excellence (NICE).

Navab, M., Dehghani, A., & Karbasi, A. (2019). The Effectiveness of Compassion-Based Therapy on Post Traumatic Growth in Mothers of Children with Attention Deficit/Hyperactivity Disorder. *Quarterly Journal of Child Mental Health*, *6*(1), 239-250.

Neff, K. D., Leary, S. C. I. M., & Hoyle, R. H. Individual Differences in Social Behavior (pp. 561-573). New York: Guilford Press.

Neimeyer, R. A. (2006). Making Meaning in the Midst of Loss. *Grief Matters: The Australian Journal of grief and bereavement*, *9*(3), 62-65.

Newman, E., & Kaloupek, D. G. (2004). The Risks and Benefits of Participating in Trauma-Focused Research Studies. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, *17*(5), 383-394.

Nightingale, V. R., Sher, T. G., & Hansen, N. B. (2010). The Impact of Receiving An HIV Diagnosis and Cognitive Processing on Psychological Distress and Posttraumatic Growth. *Journal of traumatic stress*, *23*(4), 452-460.

Noorbala, F., Borjali, A., Ahmadian-Attari, M. M., & Noorbala, A. A. (2013). Effectiveness of Compassionate Mind Training on Depression, Anxiety, and Self-Criticism in a Group of Iranian Depressed Patients. *Iranian journal of psychiatry*, *8*(3), 113.

Norris, F. H., & Slone, L. B. (2014). Epidemiology of Trauma and PTSD. In M. J. Friedman, T. M. Keane & P. A. Resick (Eds.), Handbook of PTSD: Science and Practice (2nd ed., pp. 100– 120). New York, NY: Guilford Press.

Oaksford, K., & Frude, N. (2004). The Process of Coping Following Child Sexual Abuse: A Qualitative Study. *Journal of Child Sexual Abuse*, *12*(2), 41-72.

O'Rourke, J. J., Tallman, B. A., & Altmaier, E. M. (2008). Measuring Post-Traumatic Changes in Spirituality/Religiosity. *Mental Health, Religion and Culture*, *11*(7), 719-728.

Ozbay, F., Johnson, D. C., Dimoulas, E., Morgan III, C. A., Charney, D., & Southwick, S. (2007). Social Support and Resilience to Stress: From Neurobiology to Clinical Practice. *Psychiatry (Edgmont)*, *4*(5), 35.

Pals, J. L. (2006). *Constructing the" Springboard Effect": Causal Connections, Self-Making, and Growth Within the Life Story*. American Psychological Association.

Park, C. L. (2010). Making Sense of the Meaning Literature: An Integrative Review of Meaning Making and its Effects on Adjustment to Stressful Life Events. *Psychological bulletin*, *136*(2), 257.

Perez-Sales P. (2008). Positive Psychotherapy in Adverse Situations. In C. Vázquez and G.

Hervás (Eds.), Applied Positive Psychology (155-190). Bilbao: Desclee De Brouwer.

Pierson, H., & Hayes, S. C. (2007). Using Acceptance and Commitment Therapy to Empower the Therapeutic Relationship. *The therapeutic relationship in cognitive behavior therapy*, 205-228.

Pifalo, T. (2002). Pulling Out the Thorns: Art Therapy with Sexually Abused Children and Adolescents. *Art Therapy*, *19*(1), 12-22.

Powell, T., Gilson, R., & Collin, C. (2012). TBI 13 years on: Factors Associated with Post-Traumatic Growth. *Disability and rehabilitation*, *34*(17), 1461-1467.

Pringle, J., Hendry, C., & McLafferty, E. (2011). Phenomenological Approaches: Challenges and Choices. *Nurse researcher*, *18*(2).

Reichert, E. (1998). Individual Counselling for Sexually Abused Children: A Role for Animals and Storytelling. *Child and Adolescent Social Work Journal*, *15*(3), 177-185.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring Lived Experience. *The psychologist*.

Ricoeur, P. (1970). Freud and Philosophy: An Essay on Interpretation. (D. Savage, Trans.). *New Haven, CT: Yale University Press.*

Roberts, T. (2013). Understanding the Research Methodology of Interpretative Phenomenological Analysis. *British Journal of Midwifery*, *21*(3), 215-218.

Robinson, O. C. (2014). Sampling in Interview-Based Qualitative Research: A Theoretical and Practical Guide. *Qualitative research in psychology*, *11*(1), 25-41.

Roesler, T. A., & McKenzie, N. (1994). Effects of Childhood Trauma on Psychological Functioning in Adults Sexually Abused as Children. *The Journal of nervous and mental disease*, *182*(3), 145-150.

Rogers, C. R. (1959). *A Theory of Therapy, Personality, and Interpersonal Relationships: As Developed in the Client-Centered Framework* (Vol. 3, pp. 184-256). New York: McGraw-Hill.

Ross, K. (2017, September). Making Empowering Choices: How Methodology Matters for Empowering Research Participants. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* (Vol. 18, No. 3, p. 17). DEU.

Ryff, C. D., & Singer, B. (2003). Flourishing Under Fire: Resilience as a Prototype of Challenged Thriving.

Safer, M. A., & Keuler, D. J. (2002). Individual Differences in Misremembering Pre-Psychotherapy Distress: Personality and Memory Distortion. *Emotion*, *2*(2), 162.

Salmons, J. (2014). *Qualitative Online Interviews: Strategies, Design, and Skills*. Sage Publications.

Schmidt, J. (1985). *Maurice Merleau-Ponty: between phenomenology and structuralism*. Macmillan.

Schneider, K. J., & Krug, O. T. (2010). *Existential-Humanistic Therapy* (pp. x-164). Washington, DC: American Psychological Association.

Schore, A. N. (1998). Early Shame Experiences and Infant Brain Development. *Shame: Interpersonal behavior, psychopathology, and culture*, 57-77.

Shapiro, E. (2012). EMDR and Early Psychological Intervention Following Trauma. *European Review of Applied Psychology*, *62*(4), 241-251.

Shaw, R. (2010). Embedding Reflexivity within Experiential Qualitative Psychology. *Qualitative research in psychology*, *7*(3), 233-243.

Shigemoto, Y., Low, B., Borowa, D., & Robitschek, C. (2017). Function of Personal Growth Initiative on Posttraumatic Growth, Posttraumatic Stress, and Depression Over and Above Adaptive and Maladaptive Rumination. *Journal of Clinical Psychology*, *73*(9), 1126-1145.

Shinebourne, P. (2011). The Theoretical Underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis: Journal of the Society for Existential Analysis*, *22*(1).

Silverman, D. (Ed.). (2020). *Qualitative Research*. sage.

Smith, J. A. (2004). Reflecting on the Development of Interpretative Phenomenological Analysis and Its Contribution to Qualitative Research in Psychology. *Qualitative research in psychology*, *1*(1), 39-54.

Smith, J. A. (2011). Evaluating the Contribution of Interpretative Phenomenological Analysis. *Health psychology review*, *5*(1), 9-27.

Smith, J. A. (2017). Interpretative Phenomenological Analysis: Getting at Lived Experience. *The Journal of Positive Psychology*.

Smith, J. A., Flower, P., & Larkin, M. (2009). *Interpretative Phenomenological analysis: Theory, Method and Research*. London: Sage.

Smith, J. A., & Shinebourne, P. (2012). *Interpretative Phenomenological Analysis*. American Psychological Association.

Sommers-Spijkerman, M. P. J., Trompetter, H. R., Schreurs, K. M., & Bohlmeijer, E. T. (2018). Compassion-Focused Therapy as Guided Self-Help for Enhancing Public Mental Health: A Randomized Controlled Trial. *Journal of consulting and clinical psychology*, *86*(2), 101.

Stalker, C. A., & Fry, R. (1999). A Comparison of Short-Term Group and Individual Therapy for Sexually Abused Women. *The Canadian Journal of Psychiatry*, *44*(2), 168-174.

Steffen, E., Vossler, A., & Stephen, J. (2015). From Shared Roots to Fruitful Collaboration: How Counselling Psychology Can Benefit from (Re) Connecting with Positive Psychology. *Counselling Psychology Review*, *30*(3), 1-11.

Steindl, S., Bell, T., Dixon, A., & Kirby, J. N. (2022). Therapist Perspectives on Working with Fears, Blocks and Resistances to Compassion in Compassion Focused Therapy. *Counselling and Psychotherapy Research*.

Steinke, I. (2004). Quality Criteria in Qualitative Research. *A Companion to Qualitative Research*, *21*, 184-190.

Stockton, H., Hunt, N., & Joseph, S. (2011). Cognitive Processing, Rumination, and Posttraumatic Growth. *Journal of Traumatic Stress*, *24*(1), 85-92.

Sumalla, E. C., Ochoa, C., & Blanco, I. (2009). Posttraumatic Growth in Cancer: Reality or Illusion?. *Clinical psychology review*, *29*(1), 24-33.

Taylor, B., Francis, K., & Hegney, D. (2013). *Qualitative Research in the Health Sciences*. New York:: Routledge.

Tedeschi, R. G. (1999). Violence Transformed: Posttraumatic Growth in Survivors and Their Societies. *Aggression and Violent Behavior*, *4*(3), 319-341.

Tedeschi, R. G., & Calhoun, L. G. (1993). Using the Support Group to Respond to the Isolation of Bereavement. *Journal of Mental Health Counseling*.

Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and Transformation*. Sage.

Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the Positive Legacy of Trauma. *Journal of Traumatic Stress*, *9*(3), 455-471.

Tedeschi, R. G., & Calhoun, L. (2004). Posttraumatic Growth: A New Perspective on Psychotraumatology. *Psychiatric Times*, *21*(4), 58-60.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. Psychological Inquiry, 15(1), 1-18.)

Tennen, H., & Affleck, G. (2002). Benefit-Finding and Benefit-Reminding. *Handbook of Positive Psychology*, *1*, 584-597.

Thompson, S. C. (1985). Finding Positive Meaning in a Stressful Event and Coping. *Basic and Applied Social Psychology*, *6*(4), 279-295.

Timulak, L. (2010). Significant Events in Psychotherapy: An Update of Research Findings. *Psychology and Psychotherapy: Theory, Research and Practice*, *83*(4), 421-447.

Tufford, L., & Newman, P. (2012). Bracketing in Qualitative Research. *Qualitative social work*, *11*(1), 80-96.

Vázquez, C., Pérez-Sales, P., and Hervás, G. (2008). Positive Effects of Terrorism and Vázquez, C. y Hervás, G. (2010). Terrorist attacks and Benefit Finding: The Role of Positive and Negative Emotions. Journal of Positive Psychology, 5, 154-163.

Van Teijlingen, E. R., & Hundley, V. (2001). The Importance of Pilot Studies.

Vishnevsky, T., Cann, A., Calhoun, L. G., Tedeschi, R. G., & Demarkis, G. J. (2010). Gender Differences in Self-Reported Posttraumatic Growth: A Meta-Analysis. Psychology of Women Quarterly, 34, 110-120.

Wang, X., Lee, M. Y., & Yates, N. (2019). From Past Trauma to Post-Traumatic Growth: The Role of Self in Participants with Serious Mental Illnesses. *Social Work in Mental Health*, *17*(2), 149-172.

Waugh, A., Kiemle, G., & Slade, P. (2018). What Aspects of Post-Traumatic Growth are Experienced by Bereaved Parents? A Systematic Review. *European Journal of Psychotraumatology*, *9*(1), 1506230.

Wen, X., An, Y., Zhou, Y., Du, J., & Xu, W. (2021). Mindfulness, Posttraumatic Stress Symptoms, and Posttraumatic Growth in Aid Workers: The Role of Self-Acceptance and Rumination. *The Journal of Nervous and Mental Disease*, *209*(3), 159-165.

Williams, J. M. G. (2004). Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse. *EUROPEAN PSYCHIATRY*, *19*.

Willig, C. (2013). Introducing Qualitative Research in Psychology (2nd ed.). Berkshire: Open University Press

Wolfe, V. V., Gentile, C., & Wolfe, D. A. (1989). The Impact of Sexual Abuse on Children: A PTSD Formulation. *Behavior Therapy*, *20*(2), 215-228.

Wong, P. T. (2006). Existential and Humanistic Theories.

Woodward, C., & Joseph, S. (2003). Positive Change Processes and Post-Traumatic Growth in People Who Have Experienced Childhood Abuse: Understanding Vehicles of Change. *Psychology and Psychotherapy: Theory, Research and Practice*, *76*(3), 267-283.

Wright, M. O. D., Crawford, E., & Sebastian, K. (2007). Positive Resolution of Childhood Sexual Abuse Experiences: The Role of Coping, Benefit-Finding and Meaning-Making. *Journal of Family Violence*, *22*(7), 597-608.

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and Justifying Sample Size Sufficiency in Interview-Based Studies: Systematic Analysis of Qualitative Health Research Over A 15-Year Period. *BMC medical research methodology*, *18*(1), 1-18.

Vázquez, C., Pérez-Sales, P., & Ochoa, C. (2014). Posttraumatic Growth: Challenges From a Cross-Cultural Viewpoint. In *Increasing Psychological well-being in clinical and educational settings* (pp. 57-74). Springer, Dordrecht.

Yardley, L. (2008). Demonstrating Validity in Qualitative Psychology. *Qualitative psychology: A practical guide to research methods*, *2*, 235-251.

Yarnell, L. M., Stafford, R. E., Neff, K. D., Reilly, E. D., Knox, M. C., & Mullarkey, M. (2015). Meta-Analysis of Gender Differences in Self-Compassion. *Self and identity*, *14*(5), 499-520.

Yarnell, L. M., Neff, K. D., Davidson, O. A., & Mullarkey, M. (2019). Gender Differences in Self-Compassion: Examining the Role of Gender Role Orientation. *Mindfulness*, *10*(6), 1136-1152.

Yehuda, R. (2002). Post-Traumatic Stress Disorder. *New England journal of medicine*, *346*(2), 108-114.

Yip, S. Y., Mak, W. W., Chio, F. H., & Law, R. W. (2017). The Mediating Role of Self-Compassion between Mindfulness and Compassion Fatigue Among Therapists in Hong Kong. *Mindfulness*, *8*(2), 460-470.

Zoellner, T., & Maercker, A. (2006). Posttraumatic Growth and Psychotherapy.

Zoellner, T., & Maercker, A. (2006). Posttraumatic Growth in Clinical Psychology—A Critical Review and Introduction of a Two Component Model. *Clinical psychology review*, *26*(5), 626-653.

Appendix

Appendix A – Client Study Social Media Advertisement

PARTICIPANTS NEEDED

UNIVERSITY OF WOLVERHAMPTON

'Exploring clients' and therapists' experiences of Compassion Focused Therapy in fostering Post-Traumatic Growth'.

Researcher – Chloe Ward, Trainee Counselling Psychologist [redacted]

What is this research about? I am interested in interviewing clients who have received therapy following experiencing sexual abuse to see if aspects of Post-Traumatic Growth have been experienced.

Who do I aim to recruit? I aim to recruit eight participants who have recently been clients within therapy who have a diagnosis of PTSD and who have experience(s) of sexual abuse. I am also running a separate study which explores therapists' perspective. Both the therapist and client study will be interviewed and analysed separately.

What is involved? You will be asked to attend an online interview with myself, which is likely to last between 45 to 60 minutes with interview questions focusing on your experience of therapy and life after therapy.

If you are interested in taking part in this research or would like more information, please contact myself via the email address above.

This research has been approved by the University of Wolverhampton ethics panel.

This research will be conducted under the supervision of Dr Christopher Cockshott [redacted] & Dr Rosalyn Collins [redacted]

Appendix B – Recruitment Email to Compassionate Mind Foundation Group

The Compassionate Mind Foundation

Office 29, Riverside Chambers,

1 Full Street,

Derby,

DE1 3AF

Dear Sir/Madam,

I am writing to you today as I am currently aiming to complete my thesis for my doctorate in Counselling Psychology which is based on Compassion-Focused Therapy. The title of my research is as follows, **'Exploring clients' and therapists' experiences of Compassion Focused Therapy in fostering Post-Traumatic Growth.**

Throughout and within my past counselling experience I found aspects of Compassion Focused Therapy to be helpful when working with individuals who have had experiences of sexual abuse. As part of my research, I have completed a comprehensive literature review and focused on whether there has been any research in the past focusing on whether Compassion-Focused Therapy could foster aspects of Post-Traumatic Growth to be experienced for individuals who have had experiences of sexual abuse. There has been no research focusing on these aspects published to date. Therefore, I wanted to bring two areas in which I am passionate about; Compassion-Focused Therapy and Post-Traumatic Growth together within a piece of research which could have both theoretical and practical implications.

I am currently within the recruitment stage of my research where I aim to recruit six compassion focused therapists working within the private sector and six clients to run two separate studies to gain two different perspectives (therapists and clients). I aim to firstly interview therapists to ask them of their experiences of working with this approach with individuals who have experienced sexual abuse. I would ask them to attend an interview online via Microsoft Teams which should last between 45-90 minutes.

My primary route of recruitment is to seek Compassion-Focused Therapists within the private sector. I am writing to see whether yourself as a foundation would possibly be able to place an advertisement recruiting possible therapists or signpost myself towards potential participants in which may be happy to participate in my study. If there are any further questions surrounding my research, I have provided my contact details below.

Finally, I would like to thank you for taking the time to read my letter today,

Best wishes,
Chloe Ward (Trainee Counselling Psychologist)
Email Address – [e-mail address redacted]

Recruitment email – Therapist Study

Exploring clients' and therapists' experiences of compassion focused therapy in fostering post-traumatic growth.

Dear Sir/Madam,

I am conducting research as part of my doctorate in Counselling Psychology at the University of Wolverhampton under the supervision of Rosalyn Collings and Christopher Cockshott. This research aims to explore clients' and therapists' experiences of compassion focused therapy in fostering post-traumatic growth. This research will have two studies running alongside each other, one study will focus on gaining the therapists experience and the other, their clients experience.

I am seeking compassion focused therapists who would be willing to have an interview with myself at a mutually convenient time which may last 45-90 minutes. This interview would ask questions about your experience of working with clients who have had a experience of sexual abuse, focusing on what may have worked or may have not worked in facilitating post-traumatic growth, offering a space for reflection. I aim to gather different perspectives on the same phenomenon through completing two separate studies. The interviews will either be face to face or online via Microsoft teams, the interviews will be audio-recorded and transcribed for the data analysis stages.

If you are interested in participating, please send an email to [e-mail address redacted] confirming you would like to take part in the research. Information sheets and an informed consent form providing more information can be sent over to you via email.

Participation in this study is completely voluntary, and you may wish to withdraw up to two weeks after interview completion or avoid answering any questions in which may be uncomfortable. All data will be made anonymous to ensure your privacy will be protected at all stages of the research.

Many thanks,

Chloe Ward

[e-mail address redacted]

Appendix D – Client Information sheet and consent form

Information sheet – Client Study

Exploring clients' and therapists' experiences of compassion focused therapy in fostering post-traumatic growth.

Researcher - Chloe Ward

Research Supervisors – Dr Rosalyn Collings and Dr Christopher Cockshott

Client Study

Information for participants

Thank you for considering participating in this study which will take place over the upcoming year (2021) This information sheet outlines the purpose of the study and provides a description of your involvement and rights as a participant if you agree to take part.

1. **What is the research about?**

My research aims to explore whether individuals can experience aspects of Post-Traumatic Growth (PTG) after having therapy. PTG is a new concept in the therapy world, which is defined as the positive life-altering changes which may occur after an individual has experienced a traumatic experience. Compassion Focused Therapy is one of the therapeutic approaches which may be used which can be utilised by therapists when working with clients who have experienced traumatic experiences such as sexual abuse and can target areas such as shame and self-criticism. There are also many other therapeutic approaches utilised by therapists. I am interested in individuals' experiences of therapy following experiencing an experience(s) of sexual abuse, providing an opportunity for reflection after you have completed therapy.

I aim to run two separate studies which will be analysed separately, for this study I aim to recruit six participants who have completed therapy, who have had experience(s) of sexual abuse, are over the age of 18. My second study is exploring therapists experience of therapy with their past clients. The two studies will be run separately and analysed separately.

This interview will focus on your experience alone. The interview questions will involve your experience of therapy and will not focus on your experience(s) of sexual abuse, the interview schedule will be sent to you via email prior to the interview so you are able to see what questions will be asked.

2. Do I have to take part?

It is completely your decision if you decide to take part in this study, if you do decide to take part, I will ask if you can sign the attached informed consent form, fill out the PTG questionnaire attached and send this back to me via email. Once the signed forms have been sent, we can agree on a convenient time to complete this interview and I will send the interview schedule to you in advance.

3. What will my involvement be?

If you decide to take part, you will be asked to attend an interview online via Microsoft teams which will last between 45-90 minutes. These interviews will take place at a mutually convenient time and will be audio-recorded so I can transcribe these in the later stages of my research for analysis. These audio recordings alongside any forms or transcripts will be stored in an encrypted folder which will be password protected. I would like to ensure you that all personal identifying information will be anonymised from the transcription stage up to the final write up. All participants can access and view the results of this study once completed.

4. How do I withdraw from the study?

You can withdraw from the study at any time during the interview and up to one month after your interview without having to give a reason, meaning you can say you would not like to continue participating in this research within this stage. You have a right to not answer any questions in the interview if you do not wish too and stop the interview any time you wish. If you do decide to withdraw from the study, I will not retain any information you have given and will safely dispose of your forms/recordings and transcripts. There are no right or wrong answers within this interview experience, it is based completely on your experience.

5. What will my information be used for?

I am currently studying my Professional Doctorate in Counselling Psychology at the University of Wolverhampton, so any information or data collected within this project will form my final year project/thesis. The final project may be used to write a future report or journal article.

6. Will my taking part and my data be kept confidential? Will it be anonymised?

The records and data from this study will be kept confidential unless confidentiality is needed to be broken due to the risk of harm to yourself or others. Only myself and my supervisory team listed above will have access to the files and any audio recordings. Your data will be anonymised, so your name will not be used in any reports or publications resulting from the study. All digital files, transcripts and summaries will be given codes and stored separately from any names or other direct identification of participants. Any hard copies of research information will be always kept in locked files.

7. Who has reviewed this study?

This study has been approved by the FEHW Psychology ethics committee at the University of Wolverhampton to ensure this research is suitable and safe for participants to partake in.

8. What if I have a question or complaint?

If you have any questions regarding this study please contact the researcher, Chloe Ward, email address is [e-mail address redacted]. Or, alternatively, you could contact the research supervisors at the University, Dr Rosalyn Collings [e-mail address redacted] and Dr Christopher Cockshott [e-mail address redacted].

If you wish to raise concerns regarding research being undertaken by the University you may wish to contact the research integrity leads in the first instance.

The senior lead for research integrity is the Dean of Research - Professor Silke Machold

The administrative lead is the Research Integrity Manager - Miss Jill Morgan

Alternatively, the University of Wolverhampton has incorporated its policies and procedures for Anti-Bribery, Staff Interests, Fraud, and Whistleblowing into one Transparency Policy https://www.wlv.ac.uk/about-us/governance/legal-information/corporate-compliance/transparency/. Please report any concerns to transparency@wlv.ac.uk"

If you are happy to take part in this study, please sign the consent sheet attached, answer the questionnaire, and send back to myself via email ([e-mail address redacted]).

UNIVERSITY OF WOLVERHAMPTON

Client Study Consent Form

Exploring clients' and therapists' experiences of compassion focused therapy in fostering post-traumatic growth.

Researcher – Chloe Ward

PARTICIPATION IN THIS RESEARCH STUDY IS VOLUNTARY

I understand I will be interviewed and asked questions about my experience as a client and asked to talk about the therapy I received.	YES/NO
I have read and understood the study information sheet, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.	YES / NO
I consent voluntarily to be a participant in this study and understand that I can refuse to answer any questions and that I can withdraw from the study at any time up one month after your research interview, without having to give a reason.	YES / NO
I agree to the interview being audio recorded.	YES / NO
I understand that the information I provide will be used for a research project at the University of Wolverhampton and that the information will be anonymised.	YES / NO

I agree that any information which personally identifies myself will be removed and my name will be anonymised and can be quoted in the research.	YES / NO
I understand that my data will be stored securely and within an encrypted electronic device	YES/NO
I understand that if I inform the researcher that myself or someone else is at risk of harm they may have to report this to the relevant authorities - they will discuss this with me first but may be required to report with or without my permission.	YES/NO
I understand that under freedom of information legalisation I am entitled to access the information I have provided at any time while it is stored.	YES/NO

Please retain a copy of this consent form.

Participant name:

Signature: _____ Date _____

Interviewer name:

Signature:_____ Date _____

UNIVERSITY OF WOLVERHAMPTON

For any more information on your participation in this research, please feel free to contact myself - Chloe Ward ([e-mail address redacted])

Appendix E – Therapist Information Sheet and Consent form

Therapist Study – Information Sheet

Exploring clients' and therapists' experiences of compassion focused therapy in fostering post-traumatic growth.

Researcher - Chloe Ward

Research Supervisors – Dr Rosalyn Collings and Dr Christopher Cockshott

Therapist Study

University of Wolverhampton

Information for participants

Thank you for considering participating in this study, which will take place over the upcoming year (2021) This information sheet outlines the purpose of the study and provides a description of your involvement and rights as a participant if you agree to take part.

1. **What is the research about?**

The current research explores the process of compassion focused therapy and the potential links with Post-Traumatic Growth. My interests surround the therapeutic approach of Compassion-Focused therapy. Throughout the literature, this approach can target areas such as self-criticism and work with individuals who have a high level of shame, which can be a useful approach to utilise in practice when working with clients who have had experience(s) of sexual abuse (both historic and recent).

My aim for this research is to complete two separate studies. For this study, I aim to recruit ten compassion focused trained therapists who have adopted the approach of CFT within their practice to work with clients with experience(s) of sexual abuse.

I will provide a copy of your interview schedule prior to the interview so you are able to be aware of what questions will be asked. The questions will predominately focus on your experience of using this approach with your past clients who have had these experiences, focusing on what may have worked well or not so well, and the impact of working with clients who have had trauma on yourself as the therapist.

The second study in which I will be completing separately involves the client's perspective of whether they experienced aspects of PTG during or following therapy. By completing both studies separately, I aim to gather two different perspectives of Compassion-Focused Therapy.

2. Do I have to take part?

It is completely up to you whether you decide to take part, if you do decide to take part, I will ask you to sign a consent form which is attached to this information sheet and to send these back to myself via email. You also have the option to stop the interview at any stage if you would like to take a break and you have the right to withdraw your data up to a month after the interview has been completed. The interview schedule will be sent to yourself in advance so you are aware of what I will ask in the interview.

3. What will my involvement be?

For this study, I aim to recruit ten therapists who are compassion focused trained. Once the consent form has been signed and sent back to myself, I will ask if you can attend an interview online via Microsoft teams. This interview will be at a mutually convenient time, with the aim of the interview lasting between 45-90 minutes. Within the interview, I will ask you about your experience of using CFT as an approach when working with clients who have had experience(s) of sexual abuse, asking questions surrounding what may and may have not worked well during past therapy experiences.

Finally, if you were to take part, as with my other study, support services are offered as part of my debrief form, however, I would like to ask that you are able to utilise supervision or personal therapy if you feel it may be required following the interview. I would like to assure you that any data in which will be gathered in both studies in this research will be kept confidential and any personal identifying information will be anonymised. The opportunity to read your transcript or the final write-up will be offered also.

4. How do I withdraw from the study?

Both during the interview and up till one month after your interview has been completed, you have the right to withdraw from the study. You also have the right to not answer any questions in which you may not want too, and you can stop the interview at any time you wish. If you do wish to withdraw from the study, I will not retain the information in which you have given, and your forms/recordings/transcripts will be safely disposed. There are no right or wrong answers within this interview experience, it is based completely on your experience.

5. What will my information be used for?

I am currently studying my Professional Doctorate in Counselling Psychology at the University of Wolverhampton, so any information or data collected within this project will form my final year project/thesis. The final project may be used to write a future report or journal article.

6. Will my taking part and my data be kept confidential? Will it be anonymised?

The data from this study will be kept confidential unless confidentiality is needed to be broken due to yours or others safety. Only myself and my supervisory team listed above will have access to the files and any audio recordings. Your data will be anonymised, so your name will not be used in any reports or publications resulting from the study. All digital files, transcripts and summaries will be given codes and stored separately from any names or other direct identification of participants. Any hard copies of research information will be always kept in locked files.

7. Who has reviewed this study?

This study has been approved by the FEHW Psychology ethics committee at the University of Wolverhampton to ensure this research is suitable and safe for participants to partake in.

8. What if I have a question or complaint?

If you have any questions regarding this study please contact the researcher, Chloe Ward, her email address is [e-mail address redacted]. Or, alternatively, you could contact the research supervisors at the University, Dr Rosalyn Collings ([e-mail address redacted]) and Dr Christopher Cockshott ([e-mail address redacted]).

If you wish to raise concerns regarding research being undertaken by the University you may wish to contact the research integrity leads in the first instance.

The senior lead for research integrity is the Dean of Research - Professor Silke Machold

The administrative lead is the Research Integrity Manager - Miss Jill Morgan

Alternatively, the University of Wolverhampton has incorporated its policies and procedures for Anti-Bribery, Staff Interests, Fraud, and Whistleblowing into one Transparency Policy https://www.wlv.ac.uk/about-us/governance/legal-information/corporate-compliance/transparency/. Please report any concerns to transparency@wlv.ac.uk"

If you are happy to take part in this study, please sign the consent sheet attached and send this back to myself via email at your earliest convenience ([e-mail address redacted]).

Therapist Study Consent Form

Exploring clients' and therapists' experiences of compassion focused therapy in fostering post-traumatic growth.

Researcher – Chloe Ward

PARTICIPATION IN THIS RESEARCH STUDY IS VOLUNTARY

I understand I will be interviewed and asked questions about my experience as a therapist and asked to talk about my experiences of working with CFT, focusing on what may or may not have worked well within my practice.	YES/NO
I have read and understood the study information sheet, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.	YES / NO
I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and that I can withdraw from the study at any time up to one month after your research interview without having to give a reason.	YES / NO
I agree to the interview being audio recorded.	YES / NO
I understand that the information I provide will be used for a research project at the University of Wolverhampton and that the information will be anonymised and additional consent will be required if published.	YES / NO
I agree that any information which personally identifies myself will be removed and my name will be anonymised and can be quoted in the research.	YES / NO
I understand that my data will be stored securely and within an encrypted electronic device.	YES/NO
I understand that if I inform the researcher that myself or someone else is at risk of harm they may have to report this to the relevant authorities - they will discuss this with me first but may be required to report with or without my permission.	YES/NO
I understand that under freedom of information legalisation I am entitled to access the information I have provided at any time while it is stored.	YES/NO

Please retain a copy of this consent form.

Participant name:

Signature: _____ Date _____

Interviewer name:

Signature:_____ Date _____

For any more information, please feel free to contact myself - Chloe Ward ([e-mail address redacted])

Appendix F – PWB-PTCQ

Psychological Well-Being – Post-Traumatic Change Questionnaire (PWB-PTCQ)

Think about how you feel about yourself at the present time. Please read each of the following statements and rate how you have changed as a result of the trauma.

5 = Much more so now
4 = A bit more so now
3 = I feel the same about this as before
2 = A bit less so now
1 = Much less so now

..... 1. I like myself
..... 2. I have confidence in my opinions
..... 3. I have a sense of purpose in life
..... 4. I have strong and close relationships in my life
..... 5. I feel I am in control of my life
..... 6. I am open to new experiences that challenge me
..... 7. I accept who I am, with both my strengths and limitations
..... 8. I don't worry what other people think of me
..... 9. My life has meaning
..... 10. I am a compassionate and giving person
..... 11. I handle my responsibilities in life well
..... 12. I am always seeking to learn about myself
..... 13. I respect myself
..... 14. I know what is important to me and will stand my ground, even if others disagree
..... 15. I feel that my life is worthwhile and that I play a valuable role in things
..... 16. I am grateful to have people in my life who care for me
..... 17. I am able to cope with what life throws at me
..... 18. I am hopeful about my future and look forward to new possibilities

Add up your scores to all 18 statements. Scores over 54 indicate the presence of positive change. The maximum score is 90. The higher your score, the more positive score you have experienced.

You may have changed more on some areas than others. Self-acceptance (statements 1,7 & 13), autonomy (statements 2, 8 & 14), purpose in life (statements 3, 9 & 15), relationships (statements 4, 10 & 16), sense of mastery (statements 5 11 & 17), and personal growth (statements 6, 12 & 18).

Appendix G – Client Study Interview Schedule

Interview schedule – Client Study

Can you tell me what led you to seeking help from psychological therapy?

- (Prompt: Can you tell me how you coped before therapy?)

What expectations did you have about therapy?

- (Prompt: What did you want to change or work on?)

Could you tell me about any or if you experienced any positive changes during your time in therapy?

- (Prompt: Did anything change for the better?)
- (Prompt: Do you feel you are a different person because of therapy?)
- (Prompt: What changes have you experienced about your attitude towards life?)

What was your experience of working with your therapist as you went through therapy?

- (Prompt: Could you describe a typical therapy session for me?)
- (What was the role of Compassion, what was the role of trust and safety?)
- (Prompt: Was it important to have a good therapeutic relationship?)
- (Prompt: How important was feeling safe during therapy for you?)

What were the difficulties you faced in therapy?

- (Prompt: What was the best experience, the most challenging experience, and key points in therapy)
- (Prompt: What was your experience of starting compassion focused therapy?)

To what extent did therapy match your expectations?

- (Prompt: Did you find the therapy useful? Did you accomplish your aims of therapy?)

How do you view your world around you and the future now?

- (Prompt: Did you experience a sense of renewal? Do you feel more engaged within the world?)

How do you view yourself now after completing therapy?

- (Prompt: How do you feel other people may view you also?)
- (Prompt: Do you practice in self-compassion post therapy?)

Appendix H – Therapist Study Interview Schedule

Interview schedule – Therapist Study

Before we start this interview, this interview is focused on the use of compassion-focused therapy for individuals who have had experience/s of sexual abuse, if any other approach has been using in conjunction, if we could focus on CFT for the purpose of today's interview that would be helpful for research purposes. If CFT is frequently used alongside another approach, please feel free to tell me and I will note this down also.

What are you experiences of using this approach for individuals who have had experiences of sexual abuse?

- (Prompt: How do you decide which clients may be suitable for compassion focused therapy?)
- (Prompt: Are there any aspects which work particularly well within this approach for these individuals?)

What is your understanding of Post-Traumatic growth?

- (Prompt: Can you give an example of a time you have experienced or witnessed post traumatic growth with a client?)
- (Prompt: What techniques did you use to foster client determination and resilience?)

In your experience what is it about compassion focused therapy that helps clients to overcome or work through their trauma?

- (Prompt: Were there any barriers to clients first starting compassion focused therapy?)

When working with clients, what techniques or interventions within this approach do you find useful?

- (Prompt : Are any mindfulness exercises used? Any appreciation exercises? Chair?
- (Prompt: Are any psychoeducation on the three systems of threat, drive and caregiving explained?)

Could you tell me of your experiences of the importance of the therapeutic relationship in facilitating post-traumatic growth?

- (Prompt: Is the initial forming of the therapeutic relationship important?)
- (Prompt: What is your experience of the importance of trust and the client feeling safe in therapy?)
- (Prompt: What changes do you notice in your client throughout the therapeutic journey?)

What typical outcomes do you experience with a client when using compassion focused therapy?

- (Prompt – specifically when facilitating Post-traumatic growth?)
- (Prompt – How do clients maintain Post-Traumatic growth post therapy?
- (Prompt – Have any clients in the past returned to you, if so, why/what changed?)

What impact has working with trauma had upon you?

- (Prompt – Has working from a compassion focused therapy approach changed your approach to life?)
- (Prompt – Are there any wider implications of using this approach? Personal life? Choices/career)

- (Prompt – Do you feel there any wider applications of this approach within the field of Counselling Psychology)
-

Appendix I – Client Study Debrief Form

Research Debrief Form – Client study.

Exploring clients' and therapists' experiences of therapy in fostering post-traumatic growth.

Client Research Debrief Statement

Researcher – Chloe Ward ([e-mail address redacted])

I would firstly like to thank you for taking the time to participate in my study, I appreciate the time and effort you have taken to complete this interview. Through your participation, I have been able to gather data which will be used to analyse whether individuals can experience aspects of PTG following having therapy. I aimed to provide a space of reflection for you to explore your past therapy and to see how life has been following having therapy. My research question for this study was 'How do clients who have undergone CFT therapy experience make sense of its impact on their PTG'. Once my two studies are completed separately, I aim to complete an overall discussion on what may be working or what may not be working in therapy to provide further implications for trauma-based therapy.

I have provided my email address above if there are any follow up questions or anything in which you would like to ask myself as the researcher.

As mentioned in the information sheet and the consent form, the interviews have all been audio-recorded for data analysis purposes. All audio recordings are kept within an encrypted folder and any data with personal identifiers will be removed or anonymised. I would like to emphasise that your data will be treated with the strictest confidentiality. As stated within these forms, all participants are given one month to withdraw their data following their interview, to do so, please just contact myself.

If you would like access to the study results, please let me know at the email address above and these studies finding can be sent to yourself upon completion in July 2022.

Following completion of this interview, I have attached a list of support services below if you feel that you would like to seek any additional support or to speak to someone.

Thank you again for your participation,

Chloe Ward

[e-mail address redacted]

Support services for research participants

Following completion of this research interview, if you feel distressed at all or would like to speak to a professional, I have provided some support services below –

Samaritans

Phone: 116 123 (free 24-hour helpline)

Website : http://www.samaritans.org/

SANE

Text care: comfort and care via text message, sent when the person needs it most: http://www.sane.org.uk/textcare

Rethink Mental Illness

Support and advice for people living with mental illness.

Phone : 0300 5000 927 (Monday-Friday, 9:30-4pm)

Website : http://www.rethink.org/

MIND

Phone: 0300 123 3393 (9am-6pm)

Website: http://www.mind.org.uk/

NAPAC (Open 10-9:00pm on Monday-Thursday & 10-6:00pm on Fridays)

Support line: 0808 801 0331

The Survivor Trust (Open Mon - Fri 10am – 8:30pm, Sat 10am – 12:30pm, 1:30pm – 4:30pm and 6pm – 8:30pm & Sun 1:30pm – 4:30pm and 6pm – 8:30pm)

Free Helpline : 08088 010818

SHOUT

UK's first 24/7 text service, free on all major mobile networks, for anyone in crisis anytime, anywhere, a place if need immediate help.

Text : 85258 Website : https://www.giveusashout.org

By doing this interview, if you feel there are aspects which you would still like to work on through therapy, or to speak to a professional therapist, the following website can help aid you with your search –

Counselling directory - https://www.counselling-directory.org.uk/

Appendix J – Therapist Study Debrief Gorm

Research Debrief Form – Therapist study

Exploring clients' and therapists' experiences of compassion focused therapy in fostering post-traumatic growth.

Therapist Research Debrief Statement

Researcher – Chloe Ward ([e-mail address redacted])

I would firstly like to thank you for taking the time to participate in my study, I appreciate the time and effort you have taken to complete this interview. My overall aim of this research is to gain two perspectives, both the therapists and client's perspectives of whether individuals who have had experience(s) of sexual abuse can experience aspects of PTG following completing Compassion-Focused Therapy.

For this study, I aimed to provide a space for reflection for yourself as the therapist to reflect upon what may or may not be working when utilising this therapeutic approach in practice for individuals with this experience. My research question for this study was 'How do compassion-focused therapists experience post-traumatic growth within their clients?'. I hope this interview has provided further insight into the concept of post-traumatic growth.

I have provided my email address above if there are any follow up questions or anything in which you would like to ask myself as the researcher.

As mentioned in the information sheet and the consent form, the interviews have all been audio-recorded for data analysis purposes. All audio recordings are kept within an encrypted folder and any data with personal identifiers will be removed or anonymised. I would like to emphasise that your data will be treated with the strictest confidentiality. As stated within these forms, all participants are given one month to withdraw their data following their interview, to do so, please just contact myself on the above email address.

If you would like access to the study results, please let me know at the email address above and these study findings can be sent to yourself upon completion in July 2022.

As well as access to supervision, I have attached a list of support services in which you can seek if you become distressed upon completion of the study and would like additional support.

Thank you again for your participation,

Chloe Ward

[e-mail address redacted]

Support services for research participants

Following completion of this research interview, if you feel distressed at all or would like to speak to a professional, I have provided some support services below –

Samaritans

Phone: 116 123 (free 24-hour helpline)

Website : http://www.samaritans.org/

SANE

Text care: comfort and care via text message, sent when the person needs it most: http://www.sane.org.uk/textcare

Rethink Mental Illness

Support and advice for people living with mental illness.

Phone : 0300 5000 927 (Monday-Friday, 9:30-4pm)

Website : http://www.rethink.org/

MIND

Phone: 0300 123 3393 (9am-6pm)

Website: http://www.mind.org.uk/

NAPAC (Open 10-9:00pm on Monday-Thursday & 10-6:00pm on Fridays)

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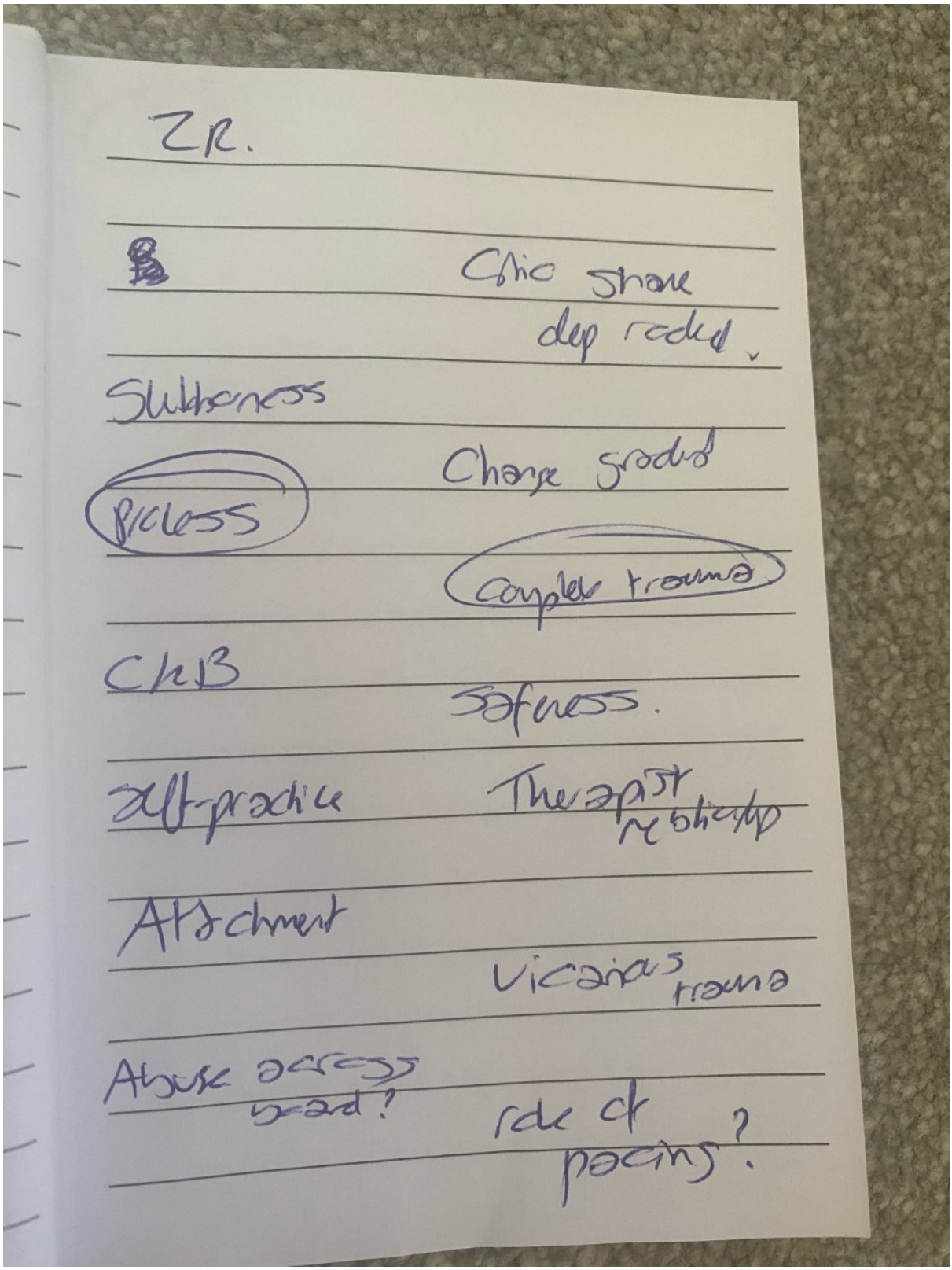
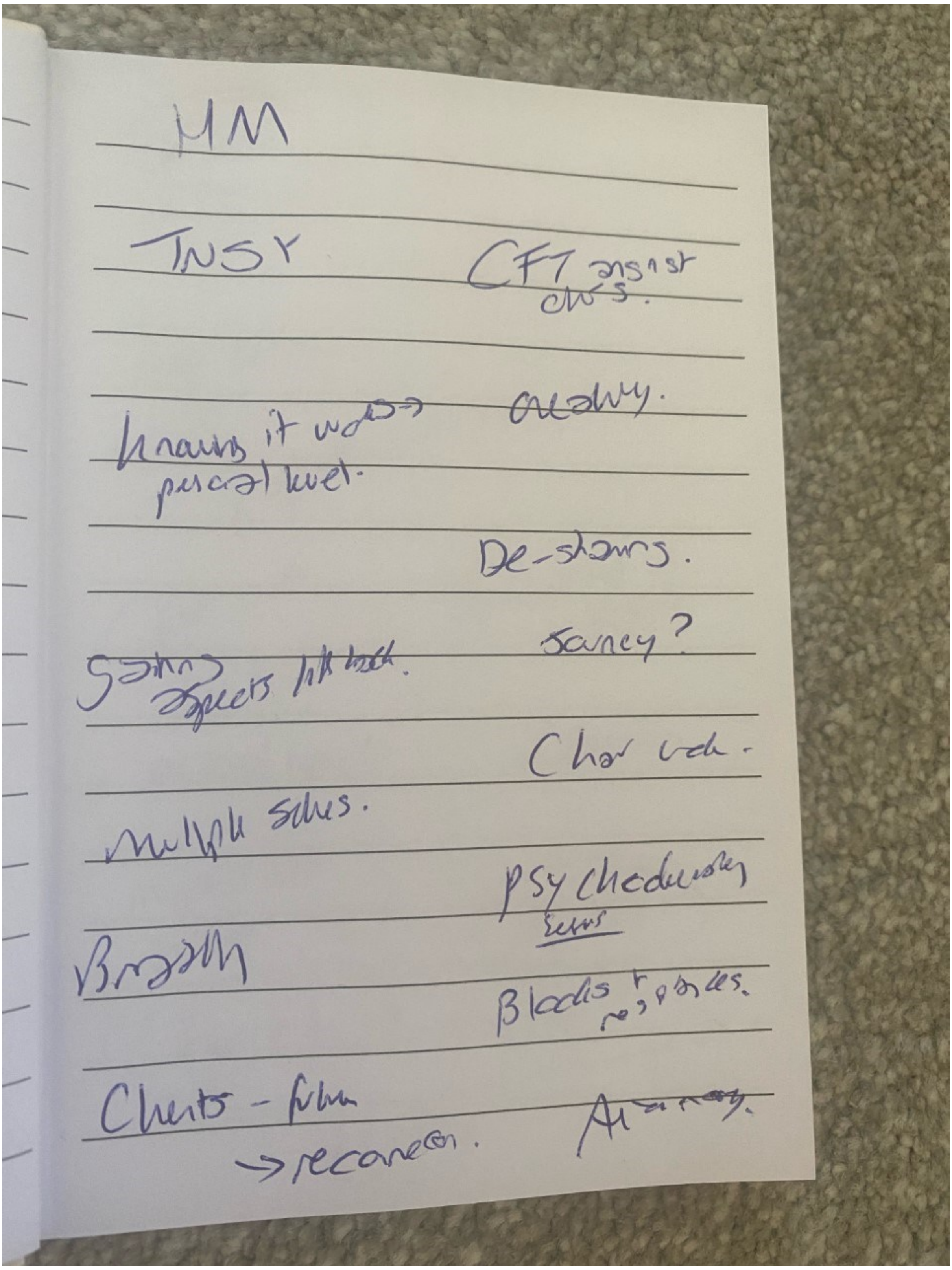
UK's first 24/7 text service, free on all major mobile networks, for anyone in crisis anytime, anywhere, a place if need immediate help.

Text : 85258 Website : https://www.giveusashout.org

Appendix K – Researchers Bracketing Notebook




MM
TNSY
personal level.
multiple sides.
Clients
→ reconnection.

Appendix L – University of Wolverhampton Ethics Approval

Dr Alexandra Hopkins RN PhD MSc MBA RNT RCNT DANS
Dean of the Faculty of Education Health and Wellbeing

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20th April 2021

1220CWUOWPSY
C. Ward
University of Wolverhampton
FEHW

Dear Chloe,

Re: Exploring clients' and therapists' experiences of compassion focused therapy in fostering post-traumatic growth, 1220CWUOWPSY.

The Psychology Department Ethics Panel has considered and reviewed your submission. On review your Research Proposal was passed and given approval **2A-Supervisor to Monitor**. Please address the minor amendments detailed below.

Required amendments:

- Consider the burden on the participants of such a long information sheet. Although the applicant has done a commendable job on addressing the concerns raised by the panel previously. The suggestion to have two information sheets has been enacted but provides more information that is necessary. Given the level of detail provided in the information sheet the panel would recommend cutting down the very long information sheet. The information sheets need to be re-worked so that they only contain necessary information for participants and are in lay language. The inclusion and exclusion criteria N of participants etc. seems rather too detailed for the participants. Ask yourself what do participants need to know to make an informed decision about whether they should take part. Also use more paragraphs in the PIS to break up your writing and make it more pleasant for participants to read..

In addition, the reviewers had additional comments which are advisory:

- The panel queried why the focus on sexual abuse survivors? PTSD is

comprised by a multi-factorial cognitive and emotional pathway(s), which can manifest by numerous experiences outside the range of what is considered normal experiences.

- Panel memebrs were confused as to why the study focuses on PTSD (PTG) includes survivors of SA, yet does not require an inclusion criteria of actual PTSD. We understand that not everyone who experiences sexual trauma develops PTSD, but isn't that literally the point of the study, to ascertain if change/growth happens post trauma? So, by implication, should the researcher not formally assess for PTSD subclinical symptomology? The panel felt this aspect would benefit from more thought or consideration and could be tightened up. Should this result in any further changes could be submitted as minor modification for Chair's action to the ethics panel.

If this is student research, supervisors must ensure the minor amendments have been completed prior to commencement of data collection. A condition of this approval is that Supervisors must read through and check the revised applications and email a confirmation to fehwethics@wlv.ac.uk to confirm they have occurred. Students, please contact your supervisor for assistance with making amendments to your proposal. Supervisors, you must read through and check the revised applications prior to resubmitting them to fehwethics@wlv.ac.uk.

Best wishes in the future.
Yours sincerely

Dr. Darren D. Chadwick
Chair – Psychology Department Ethics Panel
Reader in Applied Psychology
Department of Psychology