What Mechanisms Drive Positive Group Treatment Outcomes in Compassion-Focused Therapy for PTSD Patients According to Therapists? A Qualitative Interview Study

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Abstract

Group Compassion-Focused Therapy (CFT) is a third-wave cognitive behavioural approach that aims to increase resilience and psychological flexibility, counteracting constructs such as guilt, shame, and self-criticism. For individuals with PTSD, these constructs are proven to be overdeveloped. Previous research has shown the effectiveness of group CFT in increasing psychological flexibility and resilience for individuals with a PTSD diagnose. Yet, limited research has been conducted on what working mechanisms drive positive group change in group-based CFT for individuals with PTSD, from a therapist perspective. This study aimed to discover what mechanisms of group-based CFT drive positive change for individuals with PTSD, according to therapists. This study followed a qualitative approach by conducting six semi-structured interviews with professionals who practice group CFT for individuals with PTSD, followed by a thematic analysis. The analysis identified five key themes according to the data given by the participants: (1) internalising compassion, (2) emotional openness and safety, (3) the group as a corrective relational space, (4) the therapist as compassionate co-regulator and educator, and (5) readiness for change and reflective engagement. This research showed that resistance may be seen as an integral component of therapeutic change, rather than an obstacle, highlighting its role in fostering transformation when sufficiently supported.

Keywords: Compassion-Focused Therapy (CFT), Post-traumatic stress disorder (PTSD), group therapy, working mechanisms

Contents

Introduction

Post-traumatic stress disorder (PTSD) is a mental disorder which can be developed after exposure to actual or threatened death, serious injury, or sexual violence (Association, 2013). Its symptoms can be grouped into four types of clusters. The first one is the reexperiencing of the traumatic event, the second is the increased arousal (hyperarousal), the third is the avoidance of any stimuli which is related to the trauma and the fourth one is negative alterations in cognitions and mood (Li et al., 2020; Segman & Shalev, 2009). Next to these clusters, the symptoms must be present for at least one month (Association, 2013). PTSD has become a common disorder in recent years. According to de Vries and Olff (2009), the lifetime prevalence of PTSD was estimated at 7.4%. In the Netherlands, 3.7% of the population was identified as having PTSD in 2022, with approximately half of these cases linked to the impact of the COVID-19 pandemic (RIVM, 2022). Furthermore, the American Psychological Association's *2022 COVID-19 Practitioner Impact Survey* reported a 64% increase in trauma- and stressor-related disorders, such as PTSD, attributed to the effects of COVID-19 (APA, 2023). In recent years, PTSD among the global population has increased due to refugees who are exposed to war (Bilewicz et al., 2024). The rising demand for mental health care comes at a cost, namely, the increasing pressure on mental health care professionals to meet the growing need for resources and services (Pappas, 2022).

For the treatment of people who have PTSD, the two most prevalent ones are Eye Movement Desensitisation Reprocessing (EMDR) in combination with Prolonged Exposure (PE) (Van Pelt et al., 2021). EMDR requires patients to recall traumatic events while they are experiencing bilateral sensory input. The bilateral sensory input aims to help the brain process the traumatic event. Its rationale is to allow the traumatic memory to be integrated into a less

distressing manner, reducing the memory's emotional disturbance and vividness (De Jongh et al., 2024). Moreover, PE suggests that PTSD symptoms keep intruding on patients due to the avoidance of trauma-related thoughts and situations (McLean & Foa, 2024). PE helps confront these thoughts and situations, which will help process traumatic memories. McLean and Foa (2024) explain that PE involves a repeated process of visiting trauma-related thoughts, memories and situations to activate the fear structure, after which the unhelpful and inaccurate cognitions are disconfirmed. Both EMDR and PE are supported by empirical evidence, which shows that these tools help patients reduce their PTSD complaints (McLean et al., 2021; Wright et al., 2024).

The aforementioned treatments have demonstrated their effectiveness; however, these effects tend to diminish over time. Research indicates that dropout rates for trauma-focused therapies remain a significant concern (Kehle-Forbes et al., 2016). Engaging in trauma-focused therapy requires individuals to confront distressing memories, which necessitates an acceptance of situations that elicit negative emotional states, such as fear, shame, and self-blame. This necessity is shown to be difficult for individuals with PTSD; some may engage in self-sabotage by avoiding these confrontations, ultimately leading to ineffective outcomes or treatment dropouts (Pradhan et al., 2015).

Additionally, while EMDR and PE primarily target traumatic memories, they do not adequately address high levels of self-criticism, guilt, and shame, which can hinder successful engagement in therapy for individuals with PTSD (Au et al., 2016). These negative emotions create a psychological barrier that not only impedes therapeutic progress but also limits an individual's ability to fully engage in and benefit from interventions such as PE and EMDR. Given these limitations, clinicians have turned to alternative therapeutic approaches that may

provide more comprehensive and effective treatment options for individuals with PTSD, which also address important themes as guilt, shame and self-criticism (Schefft et al., 2023).

Compassion-focused therapy and working mechanisms

Compassion-Focused Therapy (CFT) is a third-wave cognitive behavioural therapy (CBT) that extends beyond traditional CBT's focus on maladaptive thoughts and behaviours by emphasising context, function, and psychological flexibility. Integrating mindfulness, acceptance, interpersonal dynamics, and meta-cognition, CFT explores individuals' relationships with their thoughts and behaviours (Hayes & Hofmann, 2021). It stems from the evolutionary, social, and developmental psychology, indicating three core emotion regulation systems: threat, drive, and soothing (Gilbert, 2009). Gilbert (2009) suggests individuals predominantly operate in the threat and drive systems, contributing to emotional dysregulation and distress. CFT seeks to activate the soothing system to promote emotional balance through safety, kindness, and care.

A key aim of CFT is to cultivate self-compassion by encouraging acceptance of internal experiences and present-moment awareness (Rodriguez-Muñoz et al., 2023). This includes reducing self-criticism and shame while building emotional resilience and a compassionate self-view (Spector et al., 2024). These self-regulatory processes help address limitations in trauma-focused therapies like EMDR and PE, which often overlook self-criticism and shame, thereby hindering engagement and long-term outcomes (Kehle-Forbes et al., 2016; Pradhan et al., 2015).

Research indicates that giving and receiving compassion can be particularly challenging for individuals with PTSD, as many struggle with self-blame, shame, and feelings of unworthiness (Gilbert et al., 2011, 2014; Matos et al., 2016). Accepting self-compassion can feel threatening because it confronts patterns of self-criticism, which hinders access to warmth,

soothing, and reassurance. Within CFT, addressing this resistance is crucial, as the development of self-compassion enhances emotional regulation and promotes both internal and interpersonal safety. Conversely, persistent difficulties with compassion can disrupt therapeutic mechanisms and limit CFT's impact. By activating the soothing system, CFT compensates for limitations in EMDR and PE, which focus predominantly on trauma processing but often neglect the cultivation of self-compassion (Ashfield et al., 2020). While traditional trauma-focused therapies remain effective for PTSD, CFT demonstrates comparable outcomes (Belrose et al., 2019). Hamrick and Owens (2019) further support this by showing that self-compassion significantly reduces PTSD symptoms, particularly by decreasing self-blame and disengagement coping. These findings highlight self-compassion as an important component of long-term psychological well-being.

Group CFT and working mechanisms

CFT can be delivered individually and in groups. Given the increasing pressure on healthcare professionals due to high service demands, group CFT offers an efficient alternative by enabling therapists to support multiple clients simultaneously with fewer resources than individual therapy (Fawcett et al., 2019; Pappas, 2022). As a result, clients receive care more quickly, reducing wait times. Liddell et al. (2016) investigated the therapeutic competencies necessary for positive outcomes of group-based CFT. Through a Delphi study, they identified a framework comprising six overarching domains of competence, capturing essential therapist skills and knowledge. These domains are competencies in creating safety, meta-skills (e.g. empathic listening), non-phase-specific skills (e.g. building a therapeutic alliance), phase-specific skills (e.g. stabilisation and safety), knowledge and understanding (e.g. the neurobiology of trauma) and use of supervision (e.g. reflecting on clinical challenges). Together, these differential

therapeutic competences allow for a positive group effect. Even though competencies cannot be seen as a working mechanism, they are related and drive mechanisms of change (Kazdin, 2007). To illustrate, warmth and competence of a therapist may help build the therapeutic alliance, which promotes motivation and allows mechanisms of change to occur (Seewald & Rief, 2023).

According to Lucre et al. (2024), group members identified peer support and psychological safety as central therapeutic conditions in CFT, which facilitated three key interpersonal processes: first, practicing compassion by attending to others' suffering; second, receiving compassion from peers; and third, learning to navigate group dynamics in a safe, supportive environment. These concepts are often underdeveloped in individuals with a history of trauma. Complementing this, Ashfield et al. (2020) identified two additional mechanisms of change in group-based CFT among individuals with PTSD. The first involves the cultivation of understanding, achieved through psychoeducation, such as learning about the brain's response to trauma, and the shared narratives within the group, which help participants make sense of their internal experiences. The second mechanism centres on emotional engagement and the ability to face previously avoided feelings within a supportive environment, promoting compassionate interpersonal connections and reinforcing emotional safety.

Although previous research has begun to explore the working mechanisms of group-based CFT from the perspective of individuals with PTSD, the therapist's perspective remains limited in the literature (Gryesten et al., 2023; Yap et al., 2024). Most studies to date have focused primarily on client-reported mechanisms and experiences, potentially overlooking the insights therapists can offer regarding therapeutic processes, group dynamics, and intervention efficacy. This is a notable gap, since therapists offer insights about the mechanisms of change, which may not be fully accessible through client reports alone. Understanding working

mechanisms is important given the rising prevalence of PTSD, limitations of traditional trauma treatments, and the need to refine interventions based on how and why change occurs (Karatzias et al., 2019). By focusing on therapists' perspectives, this study aims to expand current knowledge and contribute to a more comprehensive understanding of group CFT mechanisms, to enhance treatment efficacy (Tolin et al., 2023).

Methods

Design

This study adopted the interpretivism/constructivism paradigm, exploring subjective meaning-making derived from lived experiences (Junjie & Yingxin, 2022b). This paradigm aims to discover the working mechanisms of group-based CFT for individuals diagnosed with PTSD. This approach was chosen to obtain insights from therapists' experiences in delivering group CFT to this population, using the thematic analysis by Braun and Clarke (2006). The study was initiated following ethical approval from the Ethics Committee of the Faculty of Behavioural, Management and Social Sciences (BMS) at the University of Twente.

Participants

The participants were recruited from the organisation where the researcher was completing an internship. All participants work at the same mental health care company in the Netherlands. This research consisted of 6 participants, four female (66.67%) and two male (33.33%). The ages of the participants ranged from 29 to 59, with an average age of 41 years (*SD* = 10.59). Participants were included if they had experience in practising CFT for individuals with PTSD. The professions of the participants differed, for example, on participant is occupied as a clinical psychologist and one as a psychomotor therapist. All professions of each participant

can be observed in Table 1, together with the demographics. All participants practised the same 12-week group CFT program. Four were trained by a clinical psychologist, and two were trained by the founder of the CFT program. Two of the six participants are guiding the male CFT group as well as the heterogeneous group (male/female). The other four participants only focused on the female CFT group.

Table 1

Oversight of participants' characteristics

Participants	Gender	Nationality	Age	Profession	Type CFT group
1	Female	Dutch	46	Clinical psychologist	Female group
2	Female	Dutch	59	Experience expert	Female group
3	Female	Dutch	28	Outpatient social worker	Part-time group
4	Male	Dutch	38	Healthcare psychologist	Male group
5	Male	Dutch	43	Psychomotor therapist	Male group
6	Female	Dutch	29	Basic psychologist	Female group

Compassion-focused therapy program

The program is based on the book by Lee and James (2013), called 'Compassionate-Mind Guide to Recovering from Trauma and PTSD, Using Compassion-Focused Therapy to Overcome Flashbacks, Shame, Guilt, and Fear'. The CFT program begins with approximately five individual sessions with a psychologist. During these sessions, the therapist and client collaboratively construct the client's life story, providing an overview of significant positive and negative life events. This narrative serves as a foundation for the subsequent development of a CFT formulation. The CFT formulation serves as a therapeutic framework that focuses on the client's emotional memories, emotion-regulation systems, and processes of self-identification. This statement shows one's fear/threats (others are untrustworthy, I am not good enough), sculpt protective strategies (e.g. keep distance and keep feelings to oneself) and consequences of those strategies (e.g. loneliness, feelings of failure). With the insights gained from this formulation, the client transitions into the group phase of the program.

The group phase spans 12 weeks, with weekly sessions of approximately two hours, held by two to three therapists, depending on the group size. The psychologists who conduct the initial individual sessions do not necessarily continue into the group phase; they will meet with their clients for individual sessions before, during and after the group phase. Group sessions can be held in homogeneous or heterogeneous groups, depending on the size of the group. When there is a mixed group or a male group, a male therapist is present. During group sessions, clients are encouraged to share experiences, gain psychoeducational insights, and cultivate a compassionate mindset. Clients will also have individual sessions during the group phase; these can be seen as complementary to the group phase, in which progress or stagnation will be discussed. After the group phase, the therapist writes a compassionate letter to the client,

reinforcing their progress and motivation for change. Following this, individual sessions may resume. For some clients, this marks the beginning of targeted trauma-focused interventions, such as PE and EMDR. For others, the therapeutic goals may already have been achieved, and treatment concludes at this stage.

Procedures

The data collection period consisted of four weeks in total and started from the 10th of February 2025 and ran until the 6th of March 2025. Following ethical approval from the University of Twente's ethics committee, participants were recruited, and appointments were scheduled through verbal communication at the practice. At the start of the interview, participants were asked to fill out an informed consent form. The researcher explained their rights within this research and that participants could drop out at any time. After consent was given, the interviewer started the recording and continued with the interview. During the interview, the researcher focused on responses relevant to the research question and asked follow-up questions to explore interesting answers in more depth. At the end of the interview, participants had room to share thoughts or ask questions. The interviews ranged in duration from 24 to 43 minutes and were conducted in Dutch. All interviews were double recorded using electronic devices, namely, a laptop and a mobile phone. The room in which the interviews were held could differ; however, these remained in the same building.

Interview Scheme

This study employed a constructivist/interpretivist paradigm, which facilitated an understanding of meaning-making based on subjectivity through the implementation of a thematic analysis (Braun & Clarke, 2006; Junjie & Yingxin, 2022b). Data were collected through semi-structured interviews, which were conducted using a structured interview scheme (see

Table 2). The thematic domains of the interview were derived from previous empirical findings and relevant literature concerning CFT for individuals with PTSD. Drawing on this body of evidence, five overarching domains were developed to guide the interview: General information, Therapist/client factors (Ashfield et al., 2020; Liddell et al., 2026), Intra- and interpersonal processes (e.g., Lucre & Clapton, 2021; Sommers-Spijkerman et al., 2018), Barriers to compassion as mechanistic obstacles (e.g., Gilbert et al., 2011, 2014; Matos et al., 2017), and Sustainability of CFT (e.g., Kehle-Forbes et al., 2016; Pradhan et al., 2015). The interview comprised a total of 15 core questions, with additional follow-up questions posed when clarification or elaboration was required. The domains were explicitly or implicitly mentioned within the literature referred to in this research.

Table 2

Interview scheme for the interview with psychologists

Domain	Theme
1. General information	Rationale of CFT, experience, profession and implementation in practice.
2. Therapist/client factors	Therapeutic skills/knowledge and client skills/knowledge
3. Intrapersonal and interpersonal processes	Self-reassurance and social roles
4. Barriers to compassion as mechanistic obstacles	Resistance and fear of compassion
5. Sustainability of CFT	Long-term effect of CFT

Data analysis

The transcribed interviews were uploaded to Atlas.ti version 25 to start the different phases for a thematic analysis. The thematic analysis was selected due to its flexibility in nature and its ability to recognise different patterns in the data. For the thematic analysis, the six phases by Braun and Clarke (2006) were followed. The first phase included data familiarisation, which was done by re-reading the transcribed interviews. After re-reading, recurring and noteworthy answers were noted. For the second phase, the transcriptions were analysed using Atlas.ti, to create initial codes that were data-driven. The general information was used for participant descriptions and was not included in the creation of codes and themes. Since this research aimed to identify the working mechanisms behind group CFT for PTSD individuals, particular patterns related to working mechanisms were looked for. The decision was made not to include the data from the domain ‘’sustainability’’, since sustainability is not a construct for a working mechanism; it is the effect of the working mechanisms themselves. Thus, this information would not contribute towards answering the research question; hence, the reason to remove the domain from this research.

Through inductive coding, an initial set of codes was created, which was revised. As stated by the third phase of Braun and Clarke (2006), themes were explored according to the created codes. First, codes were clustered based on their latent meaning and not only based on the surface topic. Next, relationships were sought to find overarching themes and sub-themes. After these initial themes were constructed, the fourth phase by Braun and Clarke (2006) was executed. This allowed for a revision of the five themes to judge for internal homogeneity and external heterogeneity (Patton, 1990). Then, the final phase included answering the research

question based on the finalised themes. All codes and themes were translated from Dutch to English.

Results

The results of the thematic analysis revealed a total of 35 codes. Based on these codes, a total of five themes were created, which can be observed from Table 3. These five themes are 1) Internalising compassion, 2) Emotional openness and safety, 3) Group as corrective relational space, 4) Therapist as compassionate co-regulator and educator and 5) Readiness for change and reflective engagement.

Table 3

Overview of themes and codes

Theme	Codes
Internalising compassion	Internalising the compassionate voice; Compassionate voice through group support; Creating a compassionate voice through self-reassurance; Resistance to compassion; Difficulty receiving compassion; Sustainability of CFT.
Emotional openness and safety	Willingness to be vulnerable; Openness to the group; Group safety; Closed group format; Homogeneity in the group; Guilt; Compassion toward shame

Group as a corrective relational space	Recognition among group members; Feeling seen and valued; Shared experience of trauma; Group support; Group bonding through mutual help; Problem-solving as a group; Navigating group conflict; Productive friction and growth; Avoiding subgroup formation;
Therapist as compassionate co-regulator and educator	Therapist as attachment figure; Therapeutic relationship; Therapist modelling compassion; Therapist firmness and clarity; Therapist learning process; Therapist vulnerability; Knowledge of CFT and PTSD; Psychoeducation
Readiness for change and reflective engagement	Reflective ability; Mentalising ability; Willingness to change; Motivation for change; Taking responsibility; Taking position

Internalising Compassion

Internalising compassion exemplifies how clients, during the group CFT, create an internal compassionate voice for themselves. This internal compassionate voice helps clients reduce self-blame and increase self-reassurance. Furthermore, it enables clients to recognise when they are operating from the drive or threat system and redirect themselves toward the soothing system through the use of this internal voice. Within this theme, self-reassurance plays a central role, since the creation of an inner compassionate voice, a form of self-reassurance. The process of cultivating self-reassurance is particularly significant as it represents a capacity that many group members have lacked throughout their lives. Once clients can identify their internal

critic and counter it by articulating what they truly want for themselves, they begin to build this inner compassionate voice:

It could be the case that the internal bully starts acting up again, but that bully will always be present in life. However, when one becomes aware of the fact that he/she does not want to be ruled by that voice, one can rely back on that compassionate internal voice which acts as a contradictor to the internal bully (I6).

This extract illustrates how an internal compassionate voice has been established and that individuals can rely on it as a stable foundation. If the internal bully reactivates feelings of self-blame, individuals are now equipped to respond by listening to their compassionate voice, thereby interrupting the cycle of self-criticism and building upon that internal compassion.

Additionally, the process of internalising a compassionate voice was linked to the group process within CFT. Therapists indicated that the development of a compassionate voice was strengthened by mutual support within the group. This support served as a reinforcing mechanism, as recognising elements of their own experiences in each other's stories helped to enhance motivation among group members. It became aware that the experiences of guilt are rather a self-generated process, which they are in control of. For example, when someone would explain their thoughts of guilt and self-blame, fellow group members helped to refer to the position that it is not their fault, which contributed to the creation of an inner compassionate voice:

Individuals can internalise the group and take them with them by thinking ''wait, the group thought I was of value and that I do matter". That makes the difference in the moments in life where one starts to become insecure again and falls back into self-blame and guilt. The correction of the group has the biggest effect, and this can be done individually and in the group (I1).

Self-reassurance plays an active and important role in the creation of this internal voice, which is related to one's capability for sustained emotion regulation. The process of creating an

inner compassionate voice is something which professionals explain as difficult. It was mentioned that group members show resistance towards compassion, especially in receiving compassion. Giving compassion is something which group members seemed to engage in naturally. However, receiving compassion, either from themselves or others, created more resistance. Professionals explain that this is something which individuals have not been experiencing for most of their lives. It is difficult for them to suddenly change their way of acting. In the background, the feelings of self-blame and guilt still play an active role, which limits individuals in continuing to feed the threat and drive system. Professionals explain that without resistance, they would not have been in this position of lacking the internalisation of compassion. It is the resistance to compassion which has allowed and supported the self-attacks of individuals who have not acquired an inner compassionate voice:

> *So what if there is resistance in CFT? That is beautiful since that resistance is what is attacking them. Without resistance, they would have been able to contradict those negative feelings and have a specific base they can land back on. If there is resistance, this base is missing, and the cycle needs to be broken (I5).*

Resistance is explained by professionals as something essential for group CFT. If there had been no resistance, they would have been able to accept what had happened and allow a compassionate interaction with themselves. Whereas individuals with resistance are restricting themselves from this interaction and internal process, keeping them further away from a self-soothing state.

Emotional Openness and Safety

Emotional openness and safety are a common theme in CFT, as mentioned by professionals. Professionals explain emotional openness as the ability to open up about one's internal emotional state. Professionals explain how it is important for individuals to open up

about what emotions are present. When someone is not willing to be vulnerable towards others in the group, the process of CFT will be hindered. On the one hand, it is one's vulnerability which will help the other in the recognition of their stories. Professionals mention that opening about what has been inside of them for as long as they can remember is always perceived as frightening. However, highly essential for the therapy to succeed. On the other hand, it is the vulnerability which will help build the group trust and group cohesion. Professionals mention that emotional openness is something which is required by all the CFT group members:

In the group, people should be able to open up and show their vulnerability. The CFT facilitates the process of people being able to voice themselves, and at the same time. If they are not able to position themselves as vulnerable in the group, that is a very difficult obstacle to overcome (I5).

Safety is another important part of this theme. Safety is better explained by the professionals as a safe environment where one feels comfortable sharing and caring because of its safe nature. Within the groups, there are house rules everyone is expected to follow. One of those rules is that difficulties are expected to be solved within the group, as a group. This safety within the group allows for a social connection to evolve and provides a stepping stone for members to share:

We have rules in the group when it comes to sharing. This reflects the safety of the group and how we interact with each other in a form of a social connection. This leaves room for sharing and being brave to do so. Emphasising the importance of group safety (I5).

Safety allows not only for individuals to tell their story, but also to acknowledge that they are not being punished for doing so. Telling their story is often something that they have not done before; this can be perceived as frightening. If there is no safe environment and one opens up while not feeling safe within the group, the drive and threat system will be alerted, and the soothing system remains untouched.

Group characteristics were considered important for fostering a sense of safety. The group sessions were conducted in a closed-group format, which promoted emotional intimacy and trust among participants. Interestingly, only one of the participants explicitly mentioned the importance of a closed-group format. On the other hand, three participants expressed a preference for homogeneous over heterogeneous groups, as this was perceived to enhance psychological safety. There seems to be more consensus on the homogeneity of the group, creating safety, compared to a closed-group format. In mixed groups, social connections tended to remain more superficial. This may relate to specific dynamics, for example, survivors of sexual assault are predominantly female, and the presence of male participants could disrupt the group atmosphere and heighten feelings of shame, even when active efforts were made to maintain a safe emotional climate. Additionally, professionals note that male participants often experience more difficulty engaging with their emotions, which may affect group cohesion and compromise the sense of psychological safety:

If there is a homogeneous group, there is more connection between the members of the group, which helps in building safety. There is more understanding between members of the group, whereas this is different with a heterogeneous group (I5).

Emotional openness and perceived group safety are identified as core mechanisms underlying the effectiveness of group CFT for individuals with PTSD. Participants describe a reciprocal dynamic: when group members do not feel safe, they are unlikely to express vulnerability; conversely, without emotional openness among members, a sense of safety is difficult to cultivate.

Group as Corrective Relational Space

The group as a corrective relational space reinforces the outcomes of CFT, according to professionals. It is considered "corrective" in the sense that interpersonal conflicts are addressed and processed within the group setting. Additionally, the group serves as a space where members are constructively challenged or corrected in their patterns of thinking and behaviour. Professionals note that individuals who tend to relapse into negative thinking are often gently corrected, either by individual members or by the group as a collective. This process of mutual correction, particularly when someone begins to revert to old patterns, contributes to a sense of being seen and valued by others. Simultaneously, it strengthens the overall sense of group cohesion and support. Professionals emphasise that within the CFT group process, every participant is both a recipient and provider of support and correction. Emphasising the importance of social roles within the group. Ultimately, group members engage in a shared journey of growth and change:

One of the rules we have is that when you miss two sessions, you are no longer part of the group. This was the case for one of the group members who lacked the will to change. However, when we discussed this with the group, they all vowed to make another change for this person. The group decided to be welcomed back, and this has given him another opportunity (I5).

The decision-making within the group acts as a collective process. Although there were established rules that all members were expected to follow, the group consciously chose to disregard one of these rules to support a fellow member. This act of collective decision-making not only facilitated the group's development but also strengthened their bond through mutual support and solidarity. This problem-solving as a group acts as an important factor for individual change among members of the group. This does not mean that members of the group should

become best friends with each other; rather explains that differences are needed because that is what drives each other and allows for moments to learn from each other:

You do need some energy, and it's okay if there's a bit of friction. That's a really good point. People might get slightly irritated with each other but still maintain respect. Though "irritated" might be too strong a word. But it should affect them somewhat because that provides material to talk about. Because it's exactly when conflicts arise, or when dynamics clash, or when something happens that's not entirely pleasant, those are the moments that someone can reflect on and grow from (I5).

When compassionate correction through peers occurs, this is seen as an opportunity for change. Professionals mention that it is not a sign of failure or damage, but rather a change to build on group trust. The process of sharing within the group contributes to the creation of a space in which members feel comfortable forming relationships with one another. However, it is also possible that certain individuals may not get along, leading to interpersonal friction. In such cases, the risk of subgroup formation arises, which can undermine group cohesion as members begin to drift apart from the collective bond. Professionals emphasise that when such dynamics occur, it is essential to openly discuss the underlying tensions and work through them as a group. This process not only helps to restore cohesion but also promotes collective growth. In this way, the group can function as a corrective relational space. At the same time, professionals caution that excessive closeness within the group can present challenges, particularly when the CFT program comes to an end. One professional recounted a group that experienced difficulty detaching from one another at the end of the CFT process. The social support had been so strong that, once the group ended, members felt a renewed sense of loneliness. This highlights the importance of preparing for the process of detachment and guarding against overdependence.

Ultimately, individuals must be able to continue their journey independently, despite the growth they experienced as part of the group.

Therapist as compassionate co-regulator and educator

The theme of the therapist as a compassionate co-regulator highlights several ways in which the therapist contributes to the effectiveness of group CFT. For many group members, therapists are perceived as attachment figures throughout the therapeutic process. Some individuals even internalise the therapist in this role, which enables them to recall how the therapist supported them during their journey of internal growth. It should be noted that therapists also indicated that the members of the CFT group engage in individual one-on-one sessions with a therapist. These sessions take place before, during and after the group phase. This extract shows that besides the group work, the one-on-one work is also an important factor in assessing the development within the group:

They are doing important work within the group, and everything they dare to share and discuss in the group is valuable. However, some themes need to be explored more deeply with someone from their primary attachment system because those themes connect directly to their process. For that reason, it is also important that individual attention is given to members of the group (I1).

It is emphasised that professionals must be able to recognise and embody the very practices they encourage group members to adopt. This refers to the idea that therapists are not only present in their professional role but also serve as role models for the group. Specifically, therapists demonstrate how to apply a compassionate perspective toward themselves, thereby embodying the principles they promote within the group. By modelling self-compassion in their behaviour, therapists show authenticity and alignment with the therapeutic process. This modelling reinforces their commitment to the work and fosters a sense of shared experience. As a result, group members are more likely to feel seen, heard, and supported:

I think it's very important that therapist also understands what it means to look at themselves with compassion and that they share this with clients. They also show this in therapy, for example, by saying, "Oh, I understand that this is how it went for you. I recognise that, and I get it because you've been through something terrible." But then also asking, "What do you wish for yourself now?", so showing compassion toward the client as well. It's about a moment of recognition based on the therapist's own experience, but then also helping the client to respond differently, to put something compassionate in its place (I2).

This recognition between members and professionals helps in the common thought that the group learns together. However, the professionals also emphasise that it should not be forgotten that this is a dynamic learning process for the professionals as well. This learning cycle allows the therapist to show moments of vulnerability. This vulnerability also helps the clients in recognising that they are not the only ones who are learning within the group. Additionally, the data from the interviews shows different skills therapists ought to have to engage in group work. For example, the firmness of the therapist plays a role in how one deals with difficult situations. Not only firmness but also knowledge of PTSD is important. How does the brain act as a result of traumatic events, and how do people respond to those events:

To be honest in answering your question, I think you do need to have some understanding of PTSD, especially why shame, guilt, and self-blame are such important themes in PTSD. You need to have some knowledge of how these are common themes for most people with PTSD so that you can help them see that these responses aren't helpful, and that they're very normal reactions to what they've been through (I4).

By sharing knowledge on neurological mechanisms and the commonality of themes such as shame and guilt, a space is created in which individuals can better understand how past events have shaped their responses. Recognising that their emotional and physiological reactions are natural and common responses to trauma can foster self-understanding and reduce self-blame. Professionals emphasise that when therapists lack insight into key topics such as guilt and self-blame, core elements in the experience of PTSD, it becomes more difficult to fully comprehend and connect with their clients. On the other hand, they might miss important signs and cannot

test hypotheses or find connections between behaviour and thoughts. Such knowledge is, therefore, essential for providing effective and empathetic therapeutic support, which contributes to positive change in the CFT.

Readiness for change and reflective engagement

The reflexive capacity and motivation of group members refer to different but interconnected abilities. Based on data provided by the professionals, several core skills were identified as essential for CFT to be effective for individuals with PTSD. The most frequently mentioned requirement was the capacity to turn inwards and to mentalize what is occurring internally. To be precise, all the participants involved mentioned the ability to mentalize and turn inwards, at least once during the interviews. This consensus emphasises the importance of a mentalising ability and the capability of turning inwards, in group CFT. Individuals should be able to direct their attention inward and observe internal processes such as thoughts, emotions, bodily sensations, and memories. Simultaneously, they must possess the ability to understand and interpret these internal experiences through mentalization:

Because sometimes, people with a lower IQ or individuals who have never been in therapy and therefore have no concept of an inner world or emotions, or who are emotionally flat, may not be suitable for this type of therapy. CFT is not feasible in such cases because it requires the ability to turn inward and understand what is happening internally (I6).

Without the capacity to observe one's inner world, the ability to comprehend one's mental state is significantly compromised. Both internal observation and mentalizing ability were described by professionals as fundamental for achieving positive outcomes in CFT. Moreover, these capacities are viewed as essential prerequisites for engaging in any form of therapeutic intervention. In addition to the ability to turn inward and reflect on internal experiences, the willingness to change plays a critical role in facilitating therapeutic progress within CFT.

Professionals noted that the therapeutic process begins with a fundamental openness, the willingness to change. Without this readiness to confront emotional pain and share personal experiences, the likelihood of successful engagement in CFT diminishes significantly. Willingness reflects a client's attitudinal stance toward change, the openness and readiness to engage with the process, regardless of how difficult it may be.

By contrast, motivation to change involves the internal drive and energy to pursue that change. One may be willing to change yet lack the motivation to undertake the emotional and psychological effort required. Conversely, an individual may recognise the need for change but not feel emotionally or cognitively ready to engage in the process. Professionals consistently described both motivation and willingness as essential conditions for initiating and sustaining CFT. In the absence of either, therapeutic progress is likely to be obstructed, and treatment outcomes may not be maintained over time:

There has to be some kind of basic foundation, you need something to work with. What's most important is having a clear sense of will, the awareness of, "Okay, I want this for myself." If that is missing, then no form of therapy, not even this one, is likely to be effective. That's something you have to be able to hold someone accountable for. If a person repeatedly lacks that willingness or motivation, then the process becomes somewhat pointless (I3).

Once an individual possesses the internal drive for change, it is important to remember that there will be moments during the process when one will show less willingness and motivation, but that is part of the learning curve. What is important is to remind them of the position they took for themselves. They chose a position of change, and they wanted to take responsibility for that change. Professionals mention that it is important to remind them of that position and that this is what they want for themselves:

When a shift in will or motivation occurs during the process, you repeatedly return to the question: "Wait a minute, you don't have to do this for me. You are here voluntarily. What is it

that you want for yourself? Where do you want to go?" Since they had a clear will at the beginning of the process (I2).

It is not uncommon for motivation or the will to change to fluctuate throughout the therapeutic process. According to therapists, such decreases often serve as critical moments in which clients are challenged to apply what they have learned. Rather than viewing these setbacks as failures, they can be reframed as opportunities to practice resilience and self-compassion. These experiences mirror real-life challenges that may arise after the group sessions have ended, highlighting the importance of developing coping strategies that sustain change. A temporary decline in motivation, therefore, should be seen not as something negative but as a meaningful part of the change process, offering clients the chance to show their growth and reinforce their commitment to change.

Discussion

This research aimed to explore the working mechanisms underlying group CFT for individuals with PTSD. Based on interviews with six professionals, five key themes emerged as central to therapeutic change: (1) internalising compassion, (2) emotional openness and safety, (3) the group as a corrective relational space, (4) the therapist as compassionate co-regulator and educator, and (5) readiness for change and reflective engagement.

The internalisation of compassion is central to activating the soothing system in CFT, primarily through developing a compassionate inner voice (Gilbert, 2009). PTSD often disrupts this system, and CFT addresses this by fostering self-reassurance, an internal dialogue that enhances emotional regulation (Sommers-Spijkerman et al., 2018). While resistance to compassion is often seen as a barrier, this study reframes it as a meaningful sign of engagement with core emotions like shame and self-criticism (Matos et al., 2017). Rather than hindering

progress, resistance activates the threat system, and when met with compassion from therapists or peers, it facilitates soothing. This dynamic highlight resistance as a potential catalyst for change within Gilbert's (2011) three-system model.

These findings build on Ashfield et al.'s (2020) mechanisms of "experiencing" and "understanding". The theme of internalising compassion reflects the challenges of receiving compassion and confronting avoided emotions, supported by group dynamics. This study further distinguishes between internal emotional processes and relational mechanisms, identifying them as interrelated but separate. The mechanism of "understanding" is also expanded. Therapists are shown not only as educators but as compassionate co-regulators who model emotional attunement and form attachment-like bonds, broadening their role in facilitating therapeutic change.

Emotional openness and safety were described as vital mechanisms for positive change in group-based CFT (Cave et al., 2016; Marmarosh et al., 2022; Thompson & Girz, 2019). While these studies emphasise the importance of both constructs, the present findings suggest a dynamic interplay, as participants described how emotional openness and safety seemed to mutually reinforce one another. Rather than treating these constructs as separate, this study highlights how participants perceived them as interdependent processes within the therapeutic group.

Moreover, previous research has suggested that homogeneity in group-based interventions can enhance therapeutic outcomes, particularly in CFT groups for individuals with personality disorders or psychosis (Lucre & Corten, 2012; Vivolo et al., 2025). The present study extended this insight to PTSD populations, indicating that homogeneous group construction facilitated understanding, psychological safety, and emotional openness. Shame and guilt, central

emotional themes in PTSD, were more readily explored in contexts where participants felt understood by others with similar experiences. This finding contrasts with earlier work by Nicholas and Forrester (1999), who argue that heterogeneous groups help alleviate suffering by exposing members to interpersonal challenges they might otherwise avoid. For example, female survivors of sexual assault may initially feel unsafe in groups with male members, but confronting this fear can lead to therapeutic breakthroughs. These findings suggest that both homogeneous and heterogeneous group compositions have value, depending on the therapeutic goals. Homogeneous groups may enhance safety and early engagement, while heterogeneous groups may stimulate interpersonal growth and resilience on a deeper level (Lucre & Corten, 2012; Nicholas & Forrester, 1999; Vivolo et al., 2025).

The theme of the therapist as a compassionate co-regulator underscored the multifaceted role therapists play in the group phase of CFT. Beyond their clinical expertise, therapists served as attachment figures and role models, actively engaging in the behaviours and emotional openness expected of group members. This role is grounded in the evolutionary and attachment-based foundations of CFT, which explain psychological distress as resulting from an overactive threat system and the absence of emotional safety. These foundations give CFT therapists a more relational and emotionally involved role than therapists in other group psychotherapies. Matos et al. (2017) support this view, highlighting that therapists who embody and model compassion contribute to greater therapeutic effectiveness. This goes beyond what is usually seen in other group therapies like CBT, where therapists often take a more structured and educational role, focused on changing thoughts and behaviours (Gryesten et al., 2023; Singh, 2015).

Readiness for change and reflective engagement were identified as central working mechanisms that facilitated therapeutic progress in group-based CFT for individuals with PTSD.

Existing research suggests that individuals who enter therapy with a higher degree of readiness for change tend to experience more favourable treatment outcomes (Boswell et al., 2012; Crane et al., 2024). In the current study, therapists observed that some clients temporarily lost motivation or direction during the group process, which disrupted their engagement. However, these fluctuations were often addressed and reversed through interpersonal interactions within the group. Both therapists and fellow group members played an active role in helping individuals regain clarity about their therapeutic intentions by modelling commitment, offering emotional support, and fostering a sense of shared purpose. The resolution of this ambivalence within the group is consistent with the principles of motivational interviewing by Millner and Rollnick (1995). Through this model, readiness for change can be viewed as a dynamic process by enhancing intrinsic motivation and reflective engagement.

The importance of reflective engagement in this process is supported by prior trauma-focused research. Cloitre et al. (2006) emphasised that emotion regulation and reflective capacity are prerequisites for effective trauma processing. Fonagy et al. (2017) similarly identified the ability to mentalise, that is, to make sense of one's own and others' emotional states, as a key mechanism in trauma recovery. These capacities help individuals disrupt patterns such as avoidance and self-criticism, which often inhibit emotional healing. The present findings align with and expand upon this literature by illustrating how group CFT supports the development of reflective engagement, thereby increasing psychological flexibility and facilitating the internalisation of compassion.

Interestingly, Bell et al. (2019) state that the role of embodying and enacting aspects of the self in a chair intervention (also known as chair-work) can be seen as a mechanism of change in group CFT. This intervention allows individuals to access the self through the switching of the

critical and self-compassionate self. The intervention allowed for a change in the mind through interaction with the body. Compared to this research, compassionate enactment through embodiment has not been stated as a mechanism of change. It has been mentioned by one participant as one example of an exercise which is implemented in the 12-week therapy, which has proven its impact among members of the group. Possibly suggesting it is rather part of the process of the internalisation of a compassionate voice, rather than a mechanism of change.

The five working mechanisms mentioned may be seen as supporting and reinforcing each other. They do not support positive change if present in isolation. For example, safety within the group allows for openness. In turn, this allows for the internalisation of compassion. Then, the role of the therapist as co-regulator supports the group as a relational space and reinforces motivation and reflexivity. A safe and corrective group, together with a skilled and compassionate therapist on their own, do not contribute towards positive change if there is no readiness for change. This shows that the mechanisms are of importance as a working system, rather than an individual step in group CFT.

Strengths and limitations

The current research had several aspects which show the strong fundamentals of the study. For instance, this research provided insights into the working mechanisms of group-based CFT for individuals with PTSD. These insights were gained through a thematic analysis by Braun & Clarke (2006), which allowed for in-depth exploration of therapists' knowledge, experiences and opinions. This resulted in data which explains the working mechanisms on individual, inter-personal and group levels, suggesting multi-level mechanisms.

The diversity in professional backgrounds among participants enriched the data by providing varied insights rooted in different experiences within mental health care (Moser & Korstjens, 2017). Such variation enhances the transferability of findings across settings (Ahmed, 2024; Stalmeijer et al., 2024). However, as all participants were affiliated with the same clinical organisation, a degree of homogeneity may persist. Shared organisational values could shape similar perspectives (Shilo et al., 2019). Attention should be put towards the risk of personal and professional biases in only using interviews as a data collection method. While this does not invalidate the findings, it represents a limitation that should be acknowledged.

Another limitation of this study is the lack of inter-rater reliability, due to the absence of a second coder. This agreement between coders is missing, which fails to emphasise objectivity and consistency in the creation of the codes (Castleberry & Nolen, 2018). This limitation should be considered when interpreting the themes developed in this research. Disregarding this limitation are Braun and Clarke (2021), as they state that the creation of themes is rather a meaning-making process than an objective consensus between two coders. Nonetheless, this should not disregard the impediment of the process of triangulation (Carter et al., 2014). Another limitation which disregards the process of triangulation was the decision to only include therapists' perspectives, rather than a therapist-client perspective. The design to only include therapists as participants limited the potential meaningful views by participants, which might have shown a limited understanding of the working mechanisms in group CFT (Carter et al., 2014). Nevertheless, the themes explored in this research remain insightful to the outcomes of the study.

Implications and future research

This research identified five working mechanisms for group CFT for individuals with PTSD. These mechanisms could contribute towards training professionals not only in their knowledge and understanding of the therapy. It adds to this knowledge of being able to model compassion within the group, present themselves as vulnerable and align emotionally with their clients to allow for the creation of attachment figures (Gilbert & Procter, 2006; Matos et al., 2017). Therapists in group CFT should be supported in the development of several soft skills such as co-regulation, psychological safety and emotional attunement. Furthermore, the group design and selection ask for a careful selection of homogeneous groups, with participants who have proven their willingness and motivation for change. Lastly, therapists should allow moments of reflection on their emotional contribution and openness, as this has been shown to reinforce emotional openness and group cohesion within the CFT groups (Marmarosh et al., 2022).

It is suggested for future research to broaden the richness of the data through the inclusion of client perspectives and different data collection methods. For example, different perspectives (therapist and client), observational studies and focus groups (Caillaud & Flick, 2017; Palinkas, 2014). This allows for both methodological and data triangulation, as well as transferability of the data, which contributes to answering the research question (Stalmeijer et al., 2024). The inclusion of clients' perspectives also allows for a comparative analysis between the perspectives of therapists and clients (Carter et al., 2014). Furthermore, it is recommended to broaden the sample of participants to different clinical institutions. The inclusion of participants from different institutions limits the risk of participants relying on their institutional norms. Finally, it is suggested for future research to implement a longitudinal and mixed methods design

to investigate the working mechanisms over time. While this research gained information from a single snapshot, further research could gain insights into the long-term effects of the working mechanisms identified within this research. This could contribute towards relapse prevention.

Conclusion

This research aimed to identify the working mechanisms which drive positive group treatment outcomes in CFT for PTSD Patients**.** Through the implementation of a thematic analysis, five key working mechanisms were identified: internalising compassion, emotional openness and safety, the group as a corrective relational space, the therapist as a compassionate co-regulator, and readiness for change and reflective engagement. These working mechanisms highlight the importance of relational and emotional processes in CFT, rather than skills acquisition. While resistance to compassion initially appeared as an obstacle, it was often reframed through group processes as part of the change process, emphasising its role in transformation when adequately supported. This process not only facilitated individual emotional growth but also contributed to the development of a cohesive group identity grounded in shared compassion and relational safety. Yet, the role of peer interactions is not to be forgotten; fellow group members were also identified as crucial sources of support, validation, and shared growth. These findings suggest an environment where both the therapist and the group members collaboratively contribute towards the creation of a group space which allows for transformation.

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Appendix A

Informed consent

<u>Informatieblad voor onderzoek</u>

What Mechanisms Drive Positive Group Treatment Outcomes in Compassion-Focused Therapy for PTSD Patients According to Therapists? A Qualitative Interview Study

Doel van het onderzoek
Dit onderzoek wordt geleid door Lieve van der Valk
Het doel van dit onderzoek is door middel van een qualitatief onderzoek te ondervinden wat de werkende mechanismes zijn achter een positieve verandering in CFT voor PTSS clienten.

Hoe gaan we te werk?
U neemt deel aan een onderzoek waarbij we informatie zullen vergaren door:

- **U te interviewen en uw antwoorden te noteren/op te nemen via een audio-opname/video- opname.** Er zal ook een transcript worden uitgewerkt van het interview.

Potentiële risico's en ongemakken

- **Er zijn geen fysieke, juridische of economische risico's verbonden aan uw deelname aan deze studie**. U hoeft geen vragen te beantwoorden die u niet wilt beantwoorden. Uw deelname is vrijwillig en u kunt uw deelname op elk gewenst moment stoppen.

Vergoeding
U ontvangt voor deelname aan dit onderzoek **geen** vergoeding.

Vertrouwelijkheid van gegevens
Wij doen er alles aan uw privacy zo goed mogelijk te beschermen**. Er wordt op geen enkele wijze vertrouwelijke informatie of persoonsgegevens van of over u naar buiten gebracht, waardoor iemand u zal kunnen herkennen.**
Voordat onze onderzoeksgegevens naar buiten gebracht worden, worden uw gegevens zoveel mogelijk geanonimiseerd, tenzij u in ons toestemmingsformulier expliciet toestemming heeft gegeven voor het vermelden van uw naam, bijvoorbeeld bij een quote.

In een publicatie zullen anonieme gegevens of pseudoniemen worden gebruikt. De audio-opnamen, formulieren en andere documenten die in het kader van deze studie worden gemaakt of verzameld, worden opgeslagen op een beveiligde locatie bij de Universiteit Twente en op de beveiligde (versleutelde) gegevensdragers van de onderzoekers.
De onderzoeksgegevens worden bewaard voor een periode van zes maanden.

De onderzoeksgegevens worden indien nodig (bijvoorbeeld voor een controle op wetenschappelijke integriteit) en alleen in anonieme vorm ter beschikking gesteld aan personen buiten de onderzoeksgroep.

Tot slot is dit onderzoek beoordeeld en **goedgekeurd door de ethische commissie van de faculteit BMS (domain Humanities & Social Sciences)**

Vrijwilligheid

Deelname aan dit onderzoek is geheel vrijwillig. U kunt als deelnemer uw medewerking aan het onderzoek te allen tijde stoppen, of weigeren dat uw gegevens voor het onderzoek mogen worden gebruikt, zonder opgaaf van redenen. Het stopzetten van deelname heeft geen nadelige gevolgen voor u of de eventueel reeds ontvangen vergoeding.
Als u tijdens het onderzoek besluit om uw medewerking te staken, zullen de gegevens die u reeds hebt verstrekt tot het moment van intrekking van de toestemming in het onderzoek gebruikt worden.
Wilt u stoppen met het onderzoek, of heeft u vragen en/of klachten? Neem dan contact op met de onderzoeksleider.

Lieve van der Valk
L.s.vandervalk@student.utwente.nl
+316 36 42 46 79

Voor bezwaren met betrekking tot de opzet en of uitvoering van het onderzoek kunt u zich ook wenden tot de Secretaris van de Ethische Commissie/ domein Humanities & Social Sciences van de faculteit Behavioural, Management and Social Sciences op de Universiteit Twente via ethicscommittee-hss@utwente.nl. Dit onderzoek wordt uitgevoerd vanuit de Universiteit Twente, faculteit Behavioural, Management and Social Sciences. Indien u specifieke vragen hebt over de omgang met persoonsgegevens kun u deze ook richten aan de Functionaris Gegevensbescherming van de UT door een mail te sturen naar dpo@utwente.nl.

Tot slot heeft u het recht een verzoek tot inzage, wijziging, verwijdering of aanpassing van uw gegevens te doen bij de Onderzoeksleider.

Door dit toestemmingsformulier te ondertekenen erken ik het volgende:

1. Ik ben voldoende geïnformeerd over het onderzoek door middel van een separaat informatieblad. Ik heb het informatieblad gelezen en heb daarna de mogelijkheid gehad vragen te kunnen stellen. Deze vragen zijn voldoende beantwoord.
2. Ik neem vrijwillig deel aan dit onderzoek. Er is geen expliciete of impliciete dwang voor mij om aan dit onderzoek deel te nemen. Het is mij duidelijk dat ik deelname aan het onder- zoek

op elk moment, zonder opgaaf van reden, kan beëindigen. Ik hoef een vraag niet te beantwoorden als ik dat niet wil.

Naam Deelnemer:	Naam Onderzoeker:
Handtekening:	Handtekening:
Datum:	Datum:

Appendix B

Interview questions

Background Information & Conceptualisation of CFT

1. What is your age?
2. What is your educational background?
3. What is your work experience and your experience with CFT?
4. How were you trained in providing CFT?
5. Can you explain what CFT is?
6. How is CFT applied within your workplace?
7. Can you explain what you see as the rationale for CFT in treating PTSD patients?
8. How does CFT help clients regulate emotions differently compared to other trauma therapies?

Mechanisms of Change in CFT for the Treatment of PTSD

9. Which therapeutic skills contribute to positive change in CFT for PTSD?
10. What therapeutic knowledge is necessary to create positive change in CFT for PTSD?
11. What client knowledge contributes to positive change?
12. What client skills contribute to positive change?
13. What are your thoughts on the role of self-reassurance in CFT for PTSD?
14. What are your thoughts on social roles/connectedness in CFT?
15. Which group characteristics contribute to positive change in CFT?

Addressing Fear of Compassion & Resistance to CFT

16. What difficulties have you encountered when applying CFT to this target group?
17. How have you dealt with these difficulties?

18. How do you deal with resistance to giving and receiving compassion in PTSD patients?
19. How can such resistance be prevented?

    Long-Term Effects of CFT

20. Which mechanisms within CFT itself ensure long-term effects?
21. Which characteristics of group dynamics ensure that the effects of CFT are maintained over the long term?

Appendix C

Artificial Intelligence (AI) statement

During the preparation of this work, the author(s) used ChatGPT, Scopus, Atlas.ti, Web of Science, Google Scholar, Science Direct, SAGE Journals Online, SpringerLink, Wiley Online Library and Scribbr, to provide examples on how to implement an a thematic analysis, how this analysis could benefit current research outcomes, analyse the actual data in a software program, collect information which contributes to the literature review, check for flow and structure in the actual research and help understanding correct forms citations. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the work.