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Portfolio submitted in fulfilment of the requirements for
the Professional Doctorate in Counselling Psychology

**Journeys from shame to self-compassion:
Addiction and the role of developmental trauma in
adulthood**



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Sept 2022

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List of Abbreviations

Adverse Childhood Experience (ACE)

Adverse Childhood Experience Questionnaire (ACE-Q)

Brain Disease Model of Addiction (BDMA)

Childhood Maltreatment (CMT)

Childhood Physical Abuse (CPA)

Childhood Sexual Abuse (CSA)

Childhood Trauma (CT)

Childhood Trauma/Adversity (CT/A)

Childhood Trauma Questionnaire (CTQ)

Co-dependency Anonymous (CODA)

Cognitive Behavioural Therapy (CBT)

Counselling Psychology (COP)

Compassion Focused Therapy (CFT)

Developmental Trauma (DT)

Developmental Trauma Disorder (DTD)

Diagnostic and Statistical Manual (DSM-V)

Early Life Stress (ELS)

Eye Movement Desensitisation and Reprocessing (EMDR)

Grey Matter Volume (GMV)

Interpretive Phenomenological Analysis (IPA)

Post Induction Therapy (PIT)

Post-traumatic Stress Disorder (PTSD)

Self-Medication Hypothesis (SMH)

Somatic Experiencing (SE)

Substance Abuse Disorder (SUD)

Trauma Reduction Programme (TRP)

World Health Organisation (WHO)

Declaration

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Acknowledgments

I would like to acknowledge the courage of the seven participants who took part in this study. I thank you for your time and courage in trusting me with your stories and allowing me a glimpse into your world.

My gratitude to David Smallwood, who runs the aftercare group for helping to facilitate initial access to a hard-to-reach group.

To my supervisors Dr Nollaig Frost and Dr Aylish O'Driscoll for your support, dedication and kindness throughout. I feel very fortunate to have been your supervisee.

To my Mum, Dad, brother and Tia for your endless patience, humour, generosity, love and belief in me. Thank you!

To my wonderful friends Farah, Mary, Samantha and Andreas for making this journey more manageable and for making me smile when I really needed it.

Lastly to my beautiful dogs, Cathy and Teddy who both worked hard on the stress reduction front throughout this journey.

Preface

This section introduces the three components that make up my Doctoral Portfolio: a research study, a combined client case study/ process report and a publishable paper.

This portfolio is a product of my journey towards becoming a Counselling Psychologist and it is my hope that these three components demonstrate my ability to combine working as a scientist practitioner with being a reflective practitioner when carrying out research as well as in my therapeutic practice.

The three individual components that make up this portfolio share several common threads: a pluralistic view of being, the presentation of shame and addiction and the role of developmental trauma on adult life.

Pluralistic view of being

The focus on subjectivity in this work highlights the pluralistic view of being that runs through all three components of this portfolio. My use of Interpretive Phenomenological Analysis (IPA) in the research study to try and capture some of the individual lived experience of the participants reflects my belief in the uniqueness of human experience. The epistemological lens and methodology used to research the experience of attending a trauma reduction programme (TRP) for addicts in recovery intentionally considers the existence of multiple meanings and realities. Similarly, the therapeutic modality, of Compassion Focused Therapy (CFT), used in the combined case study/ process report is motivated by a pluralistic epistemology (Cooper & Dryden, 2015). With this in mind, I was driven by the individual and holistic need of my client, who I have called Jane, and

her preferred way of working rather than simply applying a generalised theory (Cooper & McLeod, 2011). This understanding of the uniqueness of human experience is in line with Counselling Psychology values (Douglas et al, 2016).

Shame

Reduction of feeling of shame is one of the threads that the three components share. Shame was a major theme that came out as part of the research findings. The role shame played in maintaining addictive behaviours was heavily suggested by the analysis and the understanding the participants had of the roots of their shame was as coming from their negative childhood experiences. The reduction of shame as part of the treatment process was described by the participants in the research and was also an intentional focus of mine during my work with Jane¹ in the clinical case study. The approach I used in the clinical case study was CFT and although this was not specifically the approach in the TRP looked at in the research, there were elements of cross over with the CFT approach such as the encouragement of greater self-acceptance.

Addiction and the role of developmental trauma on adult life

The phenomenon being focused on in my research study was the experience of attending a developmental trauma reduction programme for self-identified addicts in recovery. The role of developmental trauma was therefore in the room during the research process. This was also the case with my clinical work with Jane. Jane did not have a history of addictive process personally but did identify

¹ A pseudonym was used throughout, and all identifying information removed in order to protect the client's identity.

as having experienced developmental trauma and this having impacted her mental health in adult life. The choice of how we worked together was heavily influenced by Jane's early experiences of trauma and as such this can very much be seen as a linking theme running through all three components of this portfolio. In the case study addiction of a parent had left a legacy of trauma on Jane's adult life. This was something which was being worked on and which Jane felt acutely aware of not passing onto her children. The participants in the research study had all struggled with addictions of different sorts and the interplay with generational trauma was significant. For some of the participants addiction of parents had also played a role in the developmental trauma they had experienced, for others an awareness of not wanting to cause this sort of trauma to their own children formed a driver for seeking treatment.

Sections of the portfolio

Section A: Doctoral Thesis

This original piece of qualitative research aims to explore how self-identified addicts, in recovery, experience attending a trauma reduction programme. My hope is that this research project adequately demonstrates my ability to design and carry out an ethical psychological study and show my understanding of IPA (BPS, 2014; HCPC, 2015).

Taking on this research had specific interest to me due to my time working in an inpatient facility treating people for addiction. Service users at the treatment facility were asked to complete an Adverse Childhood Experience (ACE) questionnaire (Felitti et al., 1998) when they arrived and although this was a useful starting point it struck me how varied and subjective the experiences people had had were. It

saddened me to hear how often those who came in for addiction treatment had experienced ACEs in their lives and how rarely these appeared to have been given much attention by professionals. This became an area I had a desire to research further. My own, anecdotal, experience was that developmental trauma was present in many of those seeking treatment for addiction but was not often factored into the treatment process. The literature review confirmed a strong association between developmental trauma and addiction but not a consistency of treatment approach. The majority of the research looking at combined addiction and trauma focused interventions are positivist and quantitative in nature. There appears to be little qualitative work in this area and of the research that does exist the focus seems to have been more on the practitioners rather than service users. There is a lack of available research on how individuals in recovery from addiction experience trauma-focused work and more studies are therefore required in order to look at these experiences in depth. On this basis this research used IPA to try and gain a deeper understanding of the individual participant's lived experience of attending a TRP while in recovery from addiction. It is my hope that the qualitative and phenomenological stance taken allowed the participants to express complex emotions in describing their experience.

The limitations in capturing the full essence of another person's subjective lived experience is recognised by this approach and as such the aim of this study was to try and capture glimpses of the participants lived experience through engagement in interpretation (Langdrige, 2007). The data was collected through semi structured interviews with seven participants. The interviews were carried out individually and each interview took between 60-90 mins. This

method is appropriate for collecting rich accounts of subjective lived experiences (Smith, Flowers & Larkin, 2009).

The following Superordinate Themes emerged: 'Making sense of intense emotional response to painful memories of childhood', 'Search for external relief', 'Acceptance of themselves with compassion and without shame and judgment'.

Through the Analysis Chapter, I aimed to get as close to the lived experience of the participants as possible. Through the Discussion Chapter I aimed to further these insights by relating the findings to existing literature and theory.

This research focuses on the experience of a vulnerable and often stigmatised social group who, to date, have not been given a voice to express their lived experience of attending a trauma focused intervention while in addiction recovery. It is my hope that the insights from this research can encourage therapists to design and put into practice interventions and policies that are better informed by end user experience.

Section B: Combined Client Study/ Process Report

Working with shame and guilt in adjustment to chronic illness using Compassion Focused Therapy

The combined client study/ process report demonstrates my work with a woman struggling with shame and guilt in adjustment to chronic illness using CFT. My Counselling Psychology training, along with my pluralistic epistemological stance allowed me to draw from a number of evidence-based approaches of therapy to find an approach that best suited my client's subjective individual needs (BPS, 2015; HCPC, 2015; NICE, 2011; Gabriel, 2015).

I chose to include this piece of work firstly due to my developing interest in working with shame. Secondly, I chose this case as it was the first time, I had used CFT in a chronic illness setting and so I believe I learnt a great deal, including developing skills and knowledge in working with chronic illness presentations as well as using CFT in a flexible, client led manner. A further reason is I believe this demonstrates my ability to work in an integrated manner. I have interpreted CFT as a form of theoretical integration as although this approach is referred to by some as a form of third wave CFT (Beaumont & Martin, 2015; Gooding, Stedmon, Crix, 2020), the creator of CFT describes it as an approach that integrates techniques from CBT, neuroscience, attachment theory, evolutionary psychology as well as Buddhist principles (Gilbert, 2009). This view of CFT is backed up in the research for example being described as an integrative approach by Matos & Steindl in 2020.

I further chose to include this work in the portfolio as I believe it highlights the power of the social psychology element of CFT. The focus on social connectedness and affiliation allowed me to feel I could work to keep the context of Jane's difficult early life history in the room while also emphasising the positive steps she had taken to build relationships that could serve as important resources for emotional regulation (Bohlmeijer, 2017). I believe this helped Jane to realise her own agency in relation to the relationship with her sisters. I believe social connectedness also emerged as being an important factor for the participants in my research study and as such is also a connecting element.

Section C: Publishable paper

This section aims to demonstrate my ability to compose a publishable paper based on an original piece of research. Therefore, my goal was to produce a paper that comprises the material included in my Research Study (Section A) in a concise manner, whilst still maintaining the richness of information. This publishable paper was written in line with the specific guidelines for the publishing in the journal of *Psychology and Psychotherapy: Theory Research and Practice*.

I considered a number of well-known journals prior to selecting this specific journal. However, I consider the trauma-focused understanding of my piece of research, as well as the range of behaviours considered as addictive by the participants in this study to mean that psychological and psychotherapeutic practitioners and professionals from all relevant backgrounds could benefit from the scope of this study and therefore, I chose the *Psychology and Psychotherapy: Theory Research and Practice* journal. I believe publishing in this journal will reach the largest audience of practitioners from a diverse range of disciplinary fields who are interested in addiction and developmental trauma.

I presented findings from all three of my superordinate themes due to the themes being intrinsically interlinked. I aimed to give voice to the subjective lived experiences of the participants in my study by including as many direct quotes as possible in order to best capture their idiographic experiences in their own words. As with the main research study this approach is in line with IPA principles (Smith et al., 2009).

It is my hope that readers of this paper will gain an insight that could encourage practitioners to consider inclusion of both assessment of the need for TRP treatment, perhaps through an ACE questionnaire,

as well as addiction treatment as part of the suggested integrated approach to treatment planning. Treating addiction in isolation may potentially miss fundamental aspects of the addiction process such as underlying trauma.

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Section A: Doctoral Thesis

**An Interpretive Phenomenological Analysis of the lived
experience of attending a trauma reduction programme whilst in
recovery from addiction**

Abstract

Introduction Individuals presenting for addiction treatment are known to have higher levels of developmental trauma. There has been limited qualitative research into the experience of trauma reduction interventions from the perspective of addict attendees.

Aim The purpose of this study is to gain a deeper understanding of the lived experience of attending a developmental trauma reduction programme for self-identified addict participants in recovery.

Method Seven adult participants who self-identified as addicts were recruited from the aftercare group of a developmental trauma reduction programme. Semi-structured interviews were carried out, audio-recorded and transcribed. The data was analysed using Interpretative Phenomenological Analysis (IPA).

Findings Three main Superordinate themes emerged from the data: 'Making sense of intense emotional response to painful memories of childhood', 'Search for external relief', 'Acceptance of themselves with compassion and without shame and judgment'.

All participants reported negative childhood experiences and subsequent shame and loss of self-esteem. Participants also reported difficulty with understanding their emotions and conflict in their adult lives. Participants reported searching for external relief through various means including self-medication and striving for high levels of external validation. Lastly themes around a need to recognise causes, having a language to explain, confronting shame, group connection and a move towards self-acceptance emerged.

Conclusions This work has implications for professionals and policy makers regarding the continued lack of integration of trauma

interventions into addiction treatment planning. It highlights the legacy of shame and low self-esteem left by the participants experience of developmental trauma. The analysis also highlighted the desire for a deeper understanding about the roots of their addictive processes by the participants. The research indicates that addiction treatment may present a window of opportunity for trauma interventions to improve resilience and self-esteem in this population, possibly helping with treatment drop out rates and reducing relapse rates.

Chapter 1: Introduction and Literature Review

1.1: Introduction and Purpose of chapter

As discussed in the preface, my personal interest into the potential link between developmental trauma reduction treatment and addiction treatment was triggered by the experience I gained working at an addiction rehabilitation clinic prior to joining the doctoral course.

In this first chapter, I introduce the topic of addiction by providing some background information on the current rates and consequences of addiction globally as well as more specifically in the UK. Following this I review the current academic literature on the possible causes of addiction including any possible links between addiction and developmental trauma. I then go on to review the literature on treatment options for trauma and addiction. I will particularly highlight the deficit of literature looking at the experience of addiction treatment involving developmental trauma from the perspective of those receiving the treatment. I then look at the implications for Counselling Psychology.

The structure of this chapter is as follows. In section 1.2 I review the academic literature related to the subjects of addiction and trauma treatment. This will be divided into sub-sections: 1.2.1 gives an overview of the approach to the literature review; 1.2.2 gives the main body of results of the literature review; and 1.2.3 gives the conclusions from the literature review. Then in section 1.3, I consider any gaps in the academic literature identified by the review, describe the resultant aims of the research study and define the research question to be considered in the study.

Literature review

1.2.1: Overview

The review aims to explore the literature on developmental treatment and on addiction treatment to better understand if a link exists, if so why and what the implications are in terms of treatment options. A comprehensive search of electronic databases was undertaken to identify literature on the topic of developmental trauma, childhood maltreatment, childhood trauma, trauma, adult substance and process addiction and related treatments. A literature search was carried out using the databases PsychInfo, Scopus, Embase and Google Scholar. The following keywords and phrases were used to locate articles: substance-abuse treatment, gambling addiction treatment; sex addiction treatment; process addiction treatment; addiction treatment, childhood-trauma treatment, childhood-maltreatment, child-abuse, neglect and developmental trauma. Articles more than 10 years before the start of the study (pre-2010) and those not written in English were excluded. The only exception to this was the landmark 1998 study by Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks (1998). The snowball-method was used with recent key documents to find other relevant sources. The initial search produced a high number of results and so I used a tighter selection criteria to keep the review more focused. I used the funnel approach to focus only on the literature that looked at treatment approaches combining developmental trauma and addiction.

The following also includes literature covering psychological models of interest in the topic. These are not limited to the ten-year constraint placed on the study review.

1.2.2 Results of the literature review

Scale

Addiction is a major and increasing challenge causing widespread economic, societal, and personal problems (Littel, van den Hout & Engelhard, 2016). For instance, the World Health Organisation (WHO) estimates that approximately 31 million people globally have a drug use disorder (WHO, 2020). In 2018 there were 4,359 drug related deaths in England and Wales (ONS., 2019). Figures in 2017 found parts of the UK were found to have the highest drug related deaths in Europe. Death by overdose is a major risk with substance addiction (Kimber et al., 2019). Death by suicide is also one of the significant risk factors with Esang & Ahmed (2018) highlighting that there was a 10-fold increase in the chances of dying by suicide for those individuals with a substance addiction. Problem gambling is also recognised as being associated with significantly greater suicide risk (Tovino, 2016; Gill, Ahmadi & Pridmore, 2014; Suissa, 2011). In 2020, there was over 93,000 deaths from drug overdose in the US, the highest number in a single year to date (Proctor, Lipsey & Rigg, 2022). 40% of people with a substance use disorder in the US report not receiving treatment due to stigma related reasons (Wakeman & Rich, 2018).

Addictions can come in many forms, and process addictions, such as gambling and sex, are now increasingly recognised and treated alongside substance addictions (Wilson & Johnson, 2013).

The Crime Survey for England and Wales for 2018-19 estimated that one in five adults aged 18-74 were subjected to at least one form of child abuse before age 16 which approximates to 8.5 million people (ONS, 2020). The WHO distinguishes four types of childhood-maltreatment (CMT): physical abuse (CPA), sexual abuse (CSA), emotional and psychological abuse and neglect (WHO, 2016). The latter two are less well studied and harder to quantify due to there rarely being any physical signs and also the challenge of ambiguous and often overlapping definitions (Tonmyr, 2011).

Current literature indicates that CMT can stunt the development of healthy emotional regulation (van der Kolk, B. A, et al., 2005; Cloitre, Cohen & Koenen, 2010). This related emotional dysregulation can lead to the use of maladaptive self-soothing behaviours such as substance abuse (Cloitre, 2013) to avoid painful emotions and memories. Post-Traumatic Stress Disorder (PTSD) has been linked with emotional dysregulation (Gerra et al, 2014) as well as interpersonal difficulties (Cloitre., 2013).

Definition and Diagnosis

Addiction, trauma and recovery were all key phenomena being considered in this research and yet clear definitions are not agreed upon in the literature.

Addiction

Addiction as defined by the DSM-V includes a number of substance addictions but only one behavioural or process addiction at present; gambling addiction (APA, 2013). This definition would exclude sex, shopping, sugar, stealing and gaming addictions for example. Definitions that understand addiction as unhelpful repetitive

behaviours driven by chemical reward (Koob & Volkrow, 2010), on the other hand are wider and might be said to include these areas. The Alcoholics Anonymous organisation defines addiction as including “physical allergy”, “mental obsession” and “spiritual malady” and includes a wide range of behaviours as addiction including, shopping, sex and stealing (Volenik, 2021). Indeed, debate continues into what the DSM and ICD should include in their definitions (Grant & Chamberlain, 2016).

This research looks at both substance and process addictions as although different drugs and behaviours can present in different ways, all addictions were viewed through a similar lens in the trauma reduction programme looked at in my study. This is in line with much of the research that sees addictions as sharing either a common neurobiology (Gold, 2020) or at least aetiology (MacKillop, 2017). The definition of addiction used in this research is led by the participants own subjective understanding of addiction and as such was based on the participants self-identifying as addicts and was wider than would be captured by the DSM-V criteria.

Trauma

Trauma has been defined by Professor of Psychiatry and director of the National Complex Trauma Treatment Network, Bessel van der Kolk (1994), “as an unbearable event or series of events...that overwhelm the individual’s capacity to cope in that moment”.

A general issue that the literature review highlighted is the lack of a consistent definition or diagnostic of developmental trauma. This adds to the existing challenges of diagnosing developmental trauma and can lead to under-diagnosing. Experiences that could be considered developmental trauma are defined in various ways throughout the

academic literature including, maltreatment, early life stress (ELS) (Enoch., 2011), childhood-trauma (Fitzpatrick et al., 2020) adverse childhood experiences (ACE) (Strine et al., 2012) abuse (Butt, Chou & Browne, 2011), interpersonal trauma in childhood (Kisiel et al., 2014) complex trauma (D'Andrea et al., 2012) and developmental trauma (Pratchett & Yehuda, 2014).

The latest version of the Diagnostic and Statistical Manual (DSM-V) diagnostic criteria for post-traumatic-stress-disorder (PTSD) does not make specific provision for developmental trauma and although the latest WHO Classification of Diseases (ICD-11) has distinguished between PTSD and complex-PTSD, which it was predicted would help capture more developmental trauma cases (Karatzias et al., 2017), both sets of criteria have been found to be diagnosing fewer cases of trauma in younger individuals (Eilers, et al., 2020). Dutch psychiatrist and trauma expert, Bessel van der Kolk, tried to address this issue in 2005 by proposing the Developmental Trauma Disorder (DTD) (van der Kolk., 2005) but limited work has been done with this (McDonald, Borntrager, & Rostad., 2014).

The challenge of developmental trauma meeting the necessary criteria in order to be recognised as PTSD by the DSM-V was highlighted by a 2014 study (McDonald, et al., 2014). The results showed that 559 reported adverse or stressful life events met the criteria used by the study (a modified version of the DTD) compared with only 120 when using the DSM-V (McDonald, et al., 2014). This supports earlier findings by D'Andrea Stolbach, Ford & van der Kolk (2012) who stressed the importance of a developmentally appropriate form of trauma diagnosis so as to reduce misdiagnosis. This said, implementation or use of a formal DTD criterion has been criticized by some, as its focus on aetiology is inconsistent with the solely

descriptive nature of the current diagnostic framework (Schmid, Petermann, Fegert, 2013).

Recovery

Similarly, to the aforementioned terms, “recovery” from addiction has many varied definitions and is not something that is agreed upon in the literature. Recovery is a subjective concept and can include a change of behaviour for a certain length of time as well as total abstinence or be more based on a harm reduction understanding (Inanlou et al., 2020).

Throughout this research the term being “in recovery” was used to reflect the participants self-definition of being recovering addicts. Self-identifying as being “in recovery” was also a prerequisite for attending the aftercare group.

Due to the phenomenological nature of this research, I was led by the definitions used by the participants in my study. As in the literature the definitions used by the participants were varied. I believe this reflects the nuanced and subjective nature of the phenomena under investigation as well as the truly subjective nature of the lived human experience.

This research looks at the experience of attending a trauma reduction programme (TRP) that focuses on developmental trauma. The participants in the study self-identified as addicts, as being in recovery and as having experienced developmental and did not need to meet PTSD criteria for attendance of this intervention. In line with

this focus of the study the literature review is focused on developmental trauma.

For clarity and flow I have referred to the different forms of childhood abuse, neglect and trauma as developmental trauma in the subheadings and in my narrative throughout.

PTSD and Addiction

The literature showed that comorbid presentation of PTSD and Substance Use Disorder (SUD) was common (Anderson et al, 2016; Brewerton, 2017; Logrib, Zorilla & Koob, 2012). Furthermore, the review of the literature highlighted how this comorbidity led to complexity in treatment as well as an amplified chance of morbidity (Shorter, Hsieh & Kosten, 2015).

A 2021 study of 14,484 Chinese men in a prison found a significant relationship between PTSD and a history of alcohol and gambling addiction (Geneg, Zhan, Zhang & Wang, 2021). This study further underlines the relationship between trauma and addiction as well as the potential social consequences of these areas if left untreated.

A systematic review showed that PTSD and gambling addiction and problematic use were regularly found to co-occur with a notable link between gambling addiction and PTSD symptom severity (Moore & Grubbs, 2021). This review also highlighted how people presenting with co-occurring gambling addiction and PTSD often reported finding treatments that focused on the PTSD more useful.

Developmental Trauma and Substance Addiction

A systematic review on childhood sexual and physical abuse found that sexual abuse was significantly and consistently associated with

adult SUD but that although an association between physical abuse and drug misuse was found in some studies the results were inconsistent and due to the cross-sectional design used by most of the studies it was not possible to infer causation (Butt, Chou, Browne, 2011).

Adverse Childhood Experiences (ACEs) were most notably linked with problematic substance use in the now landmark 1998 study by Felitti et al (1998) that showed a significantly increased risk of health issues including addiction and drug abuse because of adverse childhood experiences. This study created the 10 item Adverse Childhood Experiences-Questionnaire (ACE-Q) to try to correlate negative childhood experiences with health outcomes in adulthood (Zarse et al, 2019). Given its significance and highly pertinent nature, it was included in this literature review despite not meeting the time frame criteria. The study included a range of ACEs such as physical abuse, verbal abuse, sexual abuse and emotional neglect. Since then, the literature has continued to reflect the association and correlation between addiction and ACEs and DT (Young-Wolff et al, 2010; Strone, et al, 2012; Eames et al, 2014). A recent qualitative review looked at nearly two decades of academic research that used the ACE-Q and noted the significantly increased risk for a broad range of causally linked conditions, including addictions (Zarse et al, 2019).

A study by He et al (2020) noted there are relatively few studies on how ACEs lead to drug addiction and the role of resilience and depression in this process. Hence the main aim of their study was to determine the proportion of those with ACEs who take drugs in adulthood and how resilience and depression affect this relationship. The study results showed that ACEs were positively correlated with

depression, and resilience was negatively correlated with ACEs and depression; and ACEs not only affected drug addiction through these factors alone but also through their combined action, indicating that depression led to drug addiction while resilience weakened the effect of ACEs on depression and drug addiction. Furthermore, abuse, neglect, and family dysfunction were considered significant predictors of drug addiction.

A US study found that childhood-trauma/adversity (CT/A), measured by the Childhood Trauma Questionnaire (CTQ) (Bernstein et al., 1998) was linked, not only, to increased likelihood of alcohol use but also predicted the severity of alcohol use (Eames, et al., 2014). The findings back up an earlier study by Strine et al (2012) which found the ACE score was positively correlated with alcohol use. The findings also support a 2010 twin study (n=3527) that found CMT was linked with an increased likelihood of meeting the criteria for alcohol use disorder in adult life by 1.7 times (Young-Wolff et al., 2010).

A Norwegian study compared CMT, also using CTQ, between participants with SUD and a control group made up of participants with mild to moderate mental health disorders but no SUD (Rasmussen, et al., 2018). The study showed that the SUD group had a higher number of CMTs as well as more severe and also reported more avoidance symptoms. The female participants reported higher and more serious incidents of CMT compared to males but there were no gender differences in the clinical PTSD symptoms. The results add further evidence for the link between developmental trauma and adult addictive behaviour, evidence for potential gender discrepancies and evidence for a link between avoidance and SUD.

Developmental Trauma and Process Addiction

The findings from a 2021 study published in the *Journal of Gambling Studies* gave support to a link between trauma in childhood and gambling addiction (Horak et al 2021). This study found that childhood trauma was a significant predictor of receiving a gambling disorder diagnosis in adult life and also noted that life stressors acted as a mediating factor. This study supports the association between maltreatment in childhood and gambling addiction in adult life found in an earlier Canadian study (Hodgins et al, 2010). Another 2010 study highlighted the inter-relationship between multiple different types of child abuse and severity of gambling addiction (Felsher, Derevensky, Gupta, 2010).

There are limited qualitative studies looking into this area, but a study that used IPA and thematic analysis to look at the experience of six females who identified as problem gamblers and as having experienced childhood trauma identified five themes that link childhood trauma to the development of gambling addiction as well as its role in maintaining the addiction (Nixon et al, 2013). The themes included a low self-esteem related one focused on “the not good enough self” as well as illustrating the trauma repetition cycle through trauma leading to gambling and then gambling becoming traumatic.

McGeague, 2014, emphasised the high rates of DT in people with sex addiction and highlights how clinicians as well as researchers frequently describe sex addiction as a way of coping with DT related pain. For women with sex addiction the frequency and severity of DT has been found to be even higher (Griffie et al., 2012).

A 2011 study, published in *The Journal of Treatment and Prevention*, looked at the relationship between sex addiction and paraphilias and

found the aetiology of sex addiction could be traced back to childhood trauma (Birchard, 2011). A later study echoed the understanding of sex addiction stemming from a history of abuse (Riemersma & Sytsma, 2013). This study went further and distinguished between what they termed, “classic”, sex addiction which they said was linked with a history of childhood abuse as well as insecure attachment patterns and impulse control difficulties and “contemporary” sex addiction. The contemporary form was rapid onset and believed to be linked more to exposure to graphic material online. This study noted that the treatment approach differed for these two categories.

A 2010 study in the USA into treatment for PTSD related to childhood abuse noted that the effectiveness of interventions looking at trauma related to childhood is notably less studied compared with adult-onset trauma (Cloitre et al, 2010). This further highlights the gap in this area and the need for further research to be done in order to better understand this important topic.

The potential benefits of better understanding the link between DT and addiction is illustrated by the literature above and further highlighted by the role it is suggested as playing in both relapses back into addictive behaviour (Choi et al., 2013; Brown et al., 2013) as well as retention rates during addiction treatment (Kumar et al., 2016).

Although the academic literature shows clear evidence for a link between DT and addiction there are some studies that have questioned the strength of this link. A study by Mergler et al., (2018) found only limited differences in the symptoms of SUD between participants with DT and no trauma. These findings support earlier work by Kok et al., (2015) whose work also raised a question mark

over the value of including DT measures in SUD studies. These findings question the link between DT and SUD and question the benefit of including separate DT and PTSD measures in SUD studies.

Theories explaining the relationship between Developmental Trauma and Addiction

Jacob's General Theory of Addiction

The findings showing the link between DT and a range of different addictive behaviours are in line with Jacob's General Theory of Addiction that understands addiction as being a dependent state developed over time to try and reduce stress. This theory understands people's risk for developing addictions as being based on two interrelated factors. Firstly, childhood experiences that lead to a significant sense of inadequacy and secondly, an unusual physiological resting state (Jacobs, 1986). According to Jacob's theory, addiction is linked to a drive towards high risk, repetitive activities that provide a sense of "escape" from chronic stress. The escape is proposed to be experienced as a form of "dissociation" by those engaging in the addictive process (Jacobs, 1998).

Jacob's theory has found only some empirical support in the academic literature. A 2012 empirical study looked at 190 individuals with gambling addiction, specifically focused on the use of electronic gaming machines and found empirical validation for Jacob's theory that links early experiences, psychological distress and addictive behaviour. The study highlighted the importance of including trauma and attachment assessments into addiction treatment.

Self-Medication hypothesis (SMH)

SMH is based on the concept that inadequate nurturing was received in childhood by primary caregivers and consequently the ego does not fully develop. This underdeveloped ego leads to difficulty in affect regulation and ability to self-soothe in an appropriate fashion. (Khantzian, 1985). SMH understands the suffering caused by this deficit to underlie all addictive behaviour (Khantzian & Albanese, 2008).

A recent systematic review noted that, presently, SMH has received the highest amount of empirical attention in the academic literature. The review looked at 24 studies into SMH and concluded that although there is evidential support for this hypothesis there is a lack of rigorous empirical evidence due to methodological limitations (Hawn, Cusack, Amstadter, 2020).

A qualitative study by Tronnier (2015) used SMH (Khantzian, 1985) and Regulation Theory (Schoore., 2012) to explain the link between childhood trauma and SUD. Tronnier (2015) argued that Regulation Theory can help address maladaptive self-soothing behaviours such as addiction by instead intentionally harnessing the autonomic nervous system to mediate affect arousal.

Messma-Moore (2017) considered the implications of PTSD and childhood maltreatment and showed it leads to a range of impacts including emotional dysregulation and SUD (MessmaMoore & Bhuptani, 2017). The findings give support to the SMH. This said, SMH has been criticised by others, such as Lembke, 2012 for being reductionist and not representing the complexities of addiction. Furthermore, Lembke warned it could be misunderstood as a justification for substance use.

Somatic aspect to trauma treatment

Several high-profile clinicians and academics have argued that trauma is far more than just a cognitive issue and is in fact experienced and held in both the body and the brain (Van der Kolk, 2014, Levine 2010). Van der Kolk in his 1994 paper argued that trauma memories lead to biological stress changes in the body that present in a variety of ways including difficulty managing emotional responses.

Peter Levine proposed a trauma treatment approach called Somatic Experiencing (SE) which emphasised the essential inclusion of body work in trauma treatment (Levine, 2010). In a more recent paper Payne, Levine and Crane-Godreau (2015) highlight how SE can be used as a combined form of treatment with cognitive and exposure therapies.

The value of incorporating somatic elements of work into trauma therapy with addicts in this way is consistent with work by Serebrenick-Hai (2015) who looked at how SE can be used to help reduce trauma symptoms in addiction. Scheffers et al (2018) emphasised the particular importance of understanding the somatic element when working with DT.

There are several aspects raised by this part of the literature review that may be of direct relevance to the TRP within my study. The TRP being studied includes somatic elements as part of the treatment used.

Shame

Randles & Tracy (2013) did a study of recovering alcoholics and found that shame may motivate hiding, escape and general

avoidance of the problem leading to higher risk of relapse. Low self-esteem and shame are commonly reported by adult addicts (Ferree, 2010; Sweeney, 2018). This finding can be seen as giving support to using a trauma informed approach to addiction treatment which encourages a curiosity about “what happened to you” rather than a more binary or static “what is wrong with you” approach (Sweeney et al, 2018). This is consistent with the understanding of addiction from a developmental perspective, as a maladaptive self-soothing behaviour that is learnt during childhood or adolescence as a reaction to adverse circumstance (Carruth & Wallen, 2014).

A study by Lopez-Castro et al (2019) indicated that focusing on shame in trauma interventions was likely to be of significant importance due to the moderating affect it has on DT.

Co-dependency

Co-dependency is a term that initially developed in the addictions field in the 1970's to explain the relationship between unhealthy family relationships and addiction (Calderwood & Rajesparam, 2014). Despite criticism for being theoretically weak (Lee, 2014) this is a concept that has continued to grow in use in the addiction field as well as the self-help literature (Calderwood & Rajesparam, 2014) and popular culture, even featuring in a popular US TV show, House MD (Amaro, 2012). Bacon et al (2018) used IPA in a study to explore the lived experience of co-dependency from the viewpoint of self-identified co-dependents. The study noted that a review of the literature showed that the concept of co-dependency appeared to lack a clear theoretical basis and the concept itself had been the target of criticism due to a perceived lack of clarity, strong stereotyping, and negative labelling attributes (Orford, 2005;

Calderwood and Rajesparam, 2014). Nonetheless, the study noted the concept has proven resilient, as demonstrated by the significant number of academic papers published globally. For Bacon's (2018) participants, co-dependency was far more than a concept but was felt to be something that felt solid and real, and there was a belief that there is a direct link between co-dependency and addiction.

Attachment

A 2014 qualitative study that looked at seven treatment-seeking substance users found the relationship with their psychologists helped address unresolved attachment trauma and in turn achieve abstinence or reduced substance misuse (Waters, Holtum & Perrun, 2014). The study used narrative analysis and the overarching theme found was that the role of the therapist was as a secure attachment figure and this relationship subsequently led to the development of surrogate internal-working-models (Waters et al., 2014). This study highlights the significance of reducing childhood-based attachment trauma in relation to substance misuse.

Schindler (2019) reviewed the literature on the relationship between attachment style and SUD. The review was extensive, including thirty-four cross-sectional studies and three longitudinal research studies. The study found that insecure-attachment and SUD were confirmed as linked according to the cross-sectional studies, whilst the longitudinal studies confirmed insecure-attachment as an SUD risk factor. However, while the relationship between an insecure-attachment style and SUD was confirmed by these studies, the relationship appeared to be stronger in adolescence in comparison with adults.

Addiction Aetiology

A debate has been going on in the academic literature for a number of years in regard to whether a medical model, more commonly now referred to as a brain disease model of addiction (BDMA), or a biopsychosocial model, which allows for choice, is more accurate (Russell, Davies, Hunter, 2011; Wiens & Walker, 2014).

The BDMA understanding of addiction is that it is a chronic relapsing condition (Heyman, 2011). Furthermore, it holds that addict brains are different from non-addict brain and the addictive behaviour shown in addicts is down to these differences and has become involuntary. The reason for this brain difference is explained by exposure to drugs, so may not be applicable to process addiction.

The biopsychosocial model holds that genetic, biological, sociocultural and psychological elements influence addictive behaviour but that people caught in destructive addictive patterns retain the ability and agency to change their behaviour (Wiens & Walker, 2014; Becona, 2018). Proponents of this view argue the BDMA model leads to a diminished sense of agency and even learned helplessness (Vohs & Baumeister, 2009).

The BDMA has support from large agencies, particularly in the US, such as the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) (Volkow & Koob, 2015). The BDMA model can be said to have helped reduce levels of stigma associated with the previously held “moral failing” explanation for addictive behaviour (Lewis, 2017) but exacerbate other forms of stigma such as prognostic pessimism (Kvaale, Haslan & Gottdiener, 2013; Lebowitz, 2014). This model has been described as the most prominent and also the one that represents the dominant

view among addiction professionals (Wiens & Walker, 2014). This said, some clinicians working in the addiction sphere have argued against the BDMA model. For example, Dr Gabo Mate (2022) argues that the BDMA relies on the idea of addiction as hereditary yet there is a lack of gene evidence to support this. In addition, Dr Mate argues that BDMA is pathologising and therefore is associated with increased levels of stigma towards the person struggling with addiction. Dr Mate instead suggests addiction is an attempt to solve emotional pain and therefore to effectively solve the challenge of addiction it is necessary to look at where the emotional pain stems from and address this as the primary problem (Mate, 2012).

Koski-Jannes (2004) found that the understanding of the treatment provider was the biggest predictor for the sense that service users made of their own understanding of their addiction. This highlights the importance of this debate in terms of knock-on effects for the end users.

Relapse and Retention

Drop-out and relapse are major challenges for addiction treatments (Choi et al., 2013). Historically trauma treatment was intentionally not addressed in addiction work based on the idea that trying to deal with difficult memories would lead to early relapse (Brown et al., 2013). Although the risk of not addressing underlying trauma has been documented in the literature the treatment process for addiction and trauma is still often fragmented (Brown et al., 2013).

Van Dam et al (2014) looked at the effect of CMT on substance use relapse rates using trauma specific reductions in limbic grey matter volume (GMV) as a predictor. The study found that reduction in size of the GMV area of the brain related to CMT predicted the severity of

relapse. The study also found that CMT was a predictor for rate of relapse which supported earlier work by Hyman et al (2008) who found the severity of CT to be predictive of cocaine relapse in women. The measures and method were clear and included CTQ to assess CMT, MRI to measure changes to the brain and breathalyser and urine toxicology screens to measure substance use. The study had high originality as is thought to be the first study that has looked at the potential role of CMT on the neurobiological changes corresponding with SUD. This study has clear implications for clinical practice and highlights the importance of factoring in service user's trauma history in addiction treatment planning.

A 2016 study by the American Academy of Addiction Psychiatry found that there was a significant positive correlation between severity of DT and probability of leaving addiction treatment early (Kumar et al., 2016).

Combined Addiction and Trauma Treatment

Eye Movement Desensitisation and Reprocessing (EMDR)

EMDR is based on the adaptive information processing model and is an evidence-based treatment, for helping with traumatic memories that have been stored in a dysfunctional way (Shapiro, 2017; Carletto et al., 2018).

A study by Perez-Dandieu & Tapia (2014) looked at the effectiveness of using standard EMDR for treating addiction and trauma in 12 female SUD participants. EMDR was not found to decrease alcohol or drug use in the participants compared to treatment as usual but PTSD symptoms were reduced demonstrating that standard EMDR can be effective in this population.

An Italian pilot study looked at combined trauma-focused (TF) and addiction-focused (AF) EMDR as an additional treatment for SUD patients (Carletto et al., 2018). The participants were measured for ACE and trauma. The combined TF and AF EMDR approach when added to the treatment as usual was found to significantly improve trauma symptoms.

The findings by Carletto et al (2018) give support to the potential benefits of combining addiction and trauma focused interventions. A recent book written as a guide to therapists goes into detail about how to treat addiction using EMDR in a trauma focused way (Marich et al, 2022). Their book describes how the very human coping mechanism of dissociating under certain circumstances can be amplified for survivors of trauma when addictive chemicals and behaviours are added into the equation. The guide emphasises the importance of treating the trauma that, if left untreated, continues to drive people to external relief through numbing using addictive behaviours and substances.

Despite the 20 years since EMDR was invented very limited research exists looking at the feasibility and efficacy of EMDR which focuses on addiction (Markus & Hornsveldt, 2017). Limited qualitative studies seem to have been carried out into what service users have to say about EMDR addiction focused work. This said, a study was done looking at the experience of addiction continuing care from a service user perspective and this study indicated that EMDR was seen as playing a crucial role in the overall treatment process (Marich, 2010). .

Seeking Safety (SS)

SS is a CBT based model that aims to address the co-occurring disorders of PTSD and SUD (Lenz, Henesy & Karisse, 2014). Lenz et al., (2014) carried out a meta-analysis of the effectiveness of 12 SS Programmes (n=1997) for co-morbid PTSD and SUD. PTSD symptoms were reduced across all studies with medium effect sizes, but only modest decreases were found in terms of SUD. The size of studies looked at was modest and so meta-regression was not possible.

A US study reviewed the effectiveness of SS in 74 incarcerated females and SS was found to be effective in reducing PTSD symptoms (Wolff et al., 2012). Clinical interviews were conducted and 75% of the respondents said they found SS useful in lowering traumatic stress symptoms, and substance use. A limitation of these findings is that the data was not confirmed through a clinically administered instrument. A further weakness of the study was that no substance use measures were taken post study and so it is not possible to say how effective SS was in treating SUD.

Kaiser et al (2015) carried out a SS study with SUD and co-occurring PTSD using female German outpatients as participants. Though a number of studies had been carried out in America, this was only the second published study on SS in a European sample. The study identified improvements in PTSD symptoms, but SUD symptoms did not show improvements at the treatment end. However, improvement was shown in later follow-up. Kaiser noted that a large number (20 out of 53 studies) did not complete the full set of SS modules.

A limitation of the SS studies is that they have largely focused on female participants and so it is not possible to say whether the

findings would generalise to a wider population. Overall, the studies using SS show positive outcomes though there are still some questions raised over its effectiveness on SUD and also the implications of partial use of SS modules in some treatments.

SS focuses on SUD and not on other addictions and only looks at trauma as understood by a PTSD diagnostic criterion. Although this approach is attempting to address the gap in clinical application it is currently limited in its application and consequently on how much we can generalise from it. Further research is needed into combined approaches using more varied addictive presentations and different measures of trauma, in particular DT.

Overall, there is a notable lack of qualitative data in this area investigating the service user experiences of this form of treatment.

Other Trauma-based approaches to Addiction care

Trauma Informed Care (TIC)

TIC is a holistic approach (Shier et al., 2017) that blends relational, organisational (Bloom, 2010) and trauma theory (Hefferman & Blyth, 2014). TIC is based on understanding trauma in the context of a person's experience rather than pathologising and is focused on making the organisation as a whole trauma-informed in order to avoid re-traumatising. Trauma-informed organisations aim to follow five guiding values: safety, choice, empowerment, trustworthiness and collaboration (Harris & Fallot, 2001).

A study (Hales et al 2019) that took place in a non-profit residential addiction treatment centre found that implementing TIC significantly reduced the number of early client discharges from treatment. Early discharge is a major ongoing challenge for addiction treatment

outcomes (Choi, et al., 2013). As such the implications of these findings are that organisations offering addiction treatment should consider becoming trauma informed organisations. A limitation of this study is that validated measures were not used to collect the data so the reliability can be called into question.

The Self-Regulation Model (SRM)

A US study proposed a novel model to inform the assessment and treatment of people presenting with addiction who have a history of attachment based or interpersonal trauma (Padykula & Conklin, 2010). The drive for the proposal of this new model was the perceived gap being left by the current trauma assessment tools. This study reiterates the frequency of comorbid addiction and trauma but highlighted that although common the numbers go even higher when a broader measure of trauma is used other than the DSM-V PTSD measure. The SRM purports to provide a client self-regulation profile which can be used by clinical staff as well as providing a structure to assess addictive behaviours and find more helpful forms of self-regulation. Padykula and Conklin argue this model provides a potential solution to the challenge of the increasing number of people seeking addiction treatment who have attachment trauma but do not meet the criteria for PTSD. Despite being cited over 100 times in the academic literature there is a lack of further research looking at applying this proposed model.

Addiction treatment

Cognitive Behavioural Therapy (CBT) based interventions for treating addictions have some of the highest levels of empirical support (Carroll & Kiluk, 2017). This said there are many approaches to treating addiction including pharmacogenetic (Helig et al, 2011), CFT

(Carlyle et al, 2019), Motivational Interviewing (Smedslund et al, 2011) and more self-help led options like 12-step programmes (Kelly, Humphreys & Ferri, 2020), Self-Management and Recovery Training (SMART Recovery) (Horvath & Yeterian, 2016). 12-step self-help programmes are some of the most commonly used structures for recovery from addiction (Horvath & Yeterian, 2016), perhaps due to them being freely available (Donovan et al, 2013). The NICE guidelines recommend self-help groups, brief interventions and contingency management as first line treatment for addiction (NICE, 2012). After that the guidelines recommend cognitive behavioural relapse prevention-based therapy or psychodynamic approaches.

This literature review focuses primarily on addiction treatments with a trauma focused element. In addition the review includes the 12-step based research for addiction treatment on the basis that attendance of a 12-step self-help programme was one of the most common forms of meeting the addiction treatment prerequisite for attendance of the TRP being looked at in this study.

Alcoholics Anonymous and other 12-Step support groups

Alcoholic Anonymous is arguably the most well-known addiction support group that uses the 12-step model but is not the only one (Krentzman et al, 2011). This is a self-help-based group and there are other groups within the AA group such as Narcotics Anonymous, Gambling Anonymous and Co-dependence Anonymous to name just a few (Krentzman et al, 2011). The 12-steps are a framework to follow for recovery from addiction that is based on an abstinence approach and follows a strict philosophy based on personal responsibility and group connection and support (Kaskutas, 2009; Witkiewitz et al, 2020). The 12-step approach holds addicts to be powerless over their

addiction and only through acceptance of this can people start the road to recovery (Kurtz, 2010). Traditionally, 12-step programmes and the rehab industry as a whole hold a disease model understanding of addiction (Conrad & Schneider, 2010; Lewis, 2017; Potik, 2020).

Research into the efficacy of 12-step addiction programmes is full of widely divergent views (Kaskutas, 2009). An academic specialising in the 12-step approach has argued that people struggling with addiction would benefit most from attending 12-step groups before other addictions treatments (Moos 2006). Moos suggests this approach is based primarily on longitudinal data from his study looking at participants who had professional addiction treatment and those who followed an AA support group approach. His study found recovery, as assessed by total abstinence from alcohol, was higher amongst the participants who attended the support group first and then attended professional treatment (Moos, 2006).

An article by Bevacqua and Hoffman (2010) argued that the AA approach was exclusivist and out of date. The article goes onto say that the AA approach offers a restrictive paradigm which reduced a complex variability of human personality into a “one size fits all” model.

Alcoholics Anonymous (AA) and other 12-step organisations look for what they term a “Higher Power” of some nature for addicts to connect to as part of their treatment process. What can function as a “Higher Power” varies and can include a religious God, the Universe, the support group itself and so on (Sussman et al, 2011). These groups also use the phrase “a power greater than ourselves”. Sussman et al (2011) suggested that in addiction recovery groups such as AA, that addicts may rely on this “Higher Power” to operate

as a “substitute addiction”. This suggestion from Sussman suggests attendance of 12-steps group does not address the underlying problem driving addictive behaviour. This is in keeping with Mate’s (2012; 2022) argument that addiction is not the primary problem but instead the reasons for the emotional pain driving it are.

Qualitative studies looking at 12-step groups

An IPA study looked at the paradox of self-surrender and self-empowerment (Medina, 2013). The study interviewed participants with an average of 16 years of sobriety and found that instead of a sense of losing themselves to the group, participants felt they had gained a stronger sense of self, agency and sense of connectedness.

A 2020 systemic review of qualitative studies looking at the experience of AA members found that the existing research was uncritical of the narratives given by members and lacked methodological rigor (Glassman, Rhodes, Buus, 2020). This study highlighted the need for more rigorous and high-quality qualitative research into this area.

A recent IPA study looking at the experience of attending a co-dependence 12-step support group found two contradicting and complementary themes; firstly, the study found that the participants experienced the group as a helpful tool but also that the group stopped feeling meaningful after the initial period of recovery (Bacon et al, 2021).

A 2021 study used thematic analysis to look at the politics of belonging in AA and found that there was a non-negotiable element of the AA approach that “addicts” were seen as having no control over

their addiction and consequently total abstinence was the only option for recovery (Glassman, Moensted, Rhodes & Buus, 2021).

A recent qualitative analysis of the experiences of former AA members who were disappointed with AA found a significant disparity between participant experiences and the idealistic principles put forward by AA (Glassman, Rhodes & Buus, 2022). This study also raised the issue of the unregulated status of these peer support groups and the implications this might have for clarity of information.

Psychological models

Internal Family Systems Therapy

The literature highlights that Internal Family Systems (IFS) (Schwartz, 1995) is a known lens for understanding and working with both addiction (Sykes, 2016; Wonder, 2013) and more commonly DT (Anderson & Sweezy, 2016; Hogdon et al, 2022; Schwartz, 2021). IFS is a psychodynamic model that uses an integrative approach to therapy that considers that there may be several internal child sub-personalities that are subconscious rather than conscious as they carry painful memories of childhood. A recent pilot study found using IFS to be effective in working to reduce trauma symptoms in a population who had undergone multiple childhood traumas (Hogdon et al 2022). IFS has been described as a neuroscience-informed model and one that offers a compassionate approach to reducing trauma (Bee, 2022).

Although some literature exists looking at IFS and addiction theoretically there is a lack of academic literature showing the approaches being used in addiction treatment in practice.

Gestalt Therapy

Gestalt therapy (GT) is shown in the literature to be used in addiction and self-medicating behaviour (Bagheri et al, 2018; Clemmens, 2012), and to a limited extent for sex addiction (Freeburg & Van Winkle, 2011) and suggested for use in love addiction (Raffagnino & Zerbetto, 2019). A 2010 qualitative study looked at a Gestalt perspective on the phenomenal world of addiction and considered addiction from the Gestalt perspective as a relational issue as a reaction to environment as opposed to a disease model understanding of addiction (Leung, 2010). This approach has also been shown to be used in trauma work (Copley & Carney, 2020) as well as more specifically in DT-based interventions too (Pfluger, 2013). Gestalt therapy is based on phenomenological and existential philosophies (Leung, 2010). The approach uses the concept that individual's perception is affected by a range of factors such as past experiences, environment, thoughts, emotions and needs. Gestalt chair work is an approach to therapy that allows an individual to imagine a significant person in their life, whether past or present and allows them to have an imaginary conversation in which they can address issues the individual may have such as sadness, abuse, and grief (Cohen, 2003). Gestalt chair work has the intention of removing emotional blocks by expressing unvoiced emotions. The use of Gestalt techniques in this way is in line with a recent APA paper that demonstrates the use of chair work for treating trauma (Kellogg & Garcia Torres, 2021). A 2020 qualitative study looking at what clients found helpful in trauma treatment, using Mayring's content analysis (Mayring, 2000; 2015) found that the experiential aspect of dialogical exposure therapy (a Gestalt based integrative therapy) was seen as most useful. From a theoretical perspective the understanding of

trauma as “unfinished business” suggests Gestalt therapy might be a strong choice of therapeutic intervention (Cohen, 2003).

Compassion Focused Therapy (CFT)

The literature shows that CFT has become a popular therapeutic approach for people presenting with low self-esteem (Andersen & Rasmussen, 2017) and high levels of self-criticism and shame (Carlyle et al, 2019) both found in people who have experienced DT as discussed earlier. A recent study looking at the feasibility of using CFT in treatment for Opioid Use Disorder found CFT was well tolerated by the participants and a feasible treatment option (Carlyle et al, 2019). A 2013 IPA study looking at the experience of using CFT for treating trauma found that participant's reported increased self-compassion and hope following the intervention (Lawrence & Lee, 2013).

CFT suggests that humans have evolved to cope through developing the capacity to access, tolerate and cultivate inner compassion. CFT was developed by psychologist Paul Gilbert (Gilbert, 2014) and draws on a range of evolutionary, social, developmental and Buddhist ideas. The main emphasis considers how humans have evolved to cope through developing the capacity of people to access, tolerate and cultivate inner compassion. Part of this is cooperation and sharing, experienced by the desire to be part of a group with a sense of belonging and connection. Gilbert's (2014) study talks of the potential for successful affect regulation, where individuals can feel safe and connected in an affiliative focused group to create relationships and bonds with others. Gilbert (2014) also linked the psychology of caring to the psychology of attachment theory (Bowlby, 1969, 1973; Mikulincer & Shaver, 2007) noting that the latter focused the provision

of a secure/safe base and having a safe haven that supports children's safety and development. Individuals for whom childhood carers were violent, frightening, abusive or neglecting may then have a reduced capability for experiencing and expressing affiliative motives and emotion.

Themes

A main theme highlighted in this literature review is the interrelated nature of DT and addiction and their related symptoms (Butt et al., 2011; Young-Wolff et al 2010; Eames et al., 2014; Strine et al., 2012; Rasmussen et al., 2018). Additionally, the review of the academic literature noted how often these two conditions present as co-morbid and the importance of understanding this relationship in order to be able to offer appropriate treatment (Boden et al., 2012; Ecker et al., 2018; Shorter & Hsieh, 2015).

Tronnier (2015) used the self-medication hypothesis, which sees addictive behaviour as a maladaptive self-soothing mechanism, to help to explain the relationship between DT and addiction through the lens of affect regulation. Attachment style was also found to be an important component in understanding early trauma and addictive behaviour (Waters et al., 2014; Schindler., 2019). Changes to the parts of the brain involved in reward were highlighted as also being explanatory factors for understanding the link between DT and later addictive behaviour (Enoch., 2011).

The potential benefits of better understanding the link between DT and addictive was illustrated by the importance it might play in both relapse (Choi et al., 2013; Brown et al., 2013) and retention (Kumar et al., 2016).

This literature shows that combined treatments are beginning to address the interrelated symptoms of trauma and addiction with EMDR showing some promising results, but more studies are needed to address the limitations of the SUD results (Perez-Dandieu et al., 2014; Carletto., 2018). The literature also shows the integrated concurrent approach offered by SS to be a hopeful area in terms of addressing PTSD and SUD symptoms. However, the review raises some questions over the treatment effectiveness on SUD and highlights a possible gap in SS studies in terms of gender inclusiveness and the full application of the SS modules (Wolff et al., 2012; Lenz et al., 2014; Kaiser et al., 2015). On balance, the review appears to support the view that addiction treatment is better carried out as part of a trauma informed approach that includes an integrated trauma and addiction treatment method as demonstrated by SS. Although it is noted that some concerns over the benefits of integrating trauma and addiction treatment were found in the literature (Kok et al., 2015; Mergler et al., 2018).

Although integrated studies are beginning to start addressing the clinical need for these cooccurring conditions, more studies are needed to better understand the benefits of a sequential approach compared with a concurrent (Butt et al., 2011; Van Dam et al., 2012).

1.2.3 Conclusions from the literature review

Although there is still some debate around the aetiology of addiction, in particular between the disease versus the psychosocial models, over whether addiction is primarily genetic or instead acquired as a result of traumatic lived experience (Hammer et al, 2013; Wiens & Walker, 2015), a large body of research literature shows that developmental trauma is positively correlated with addiction (Van

Dam, et al., 2014; Fuchshuber, et al, 2018; Hagborg, Thorvaldsson, Fahlke, 2020).

There is considerable qualitative research looking at addiction treatment in isolation and is outside the scope of this research due to the primary focus being on combined treatments. Due to the experience of the participants in this study qualitative studies looking at the 12 step-based addiction treatment approach and the gaps in this area have been mentioned above.

The notable lack of qualitative studies looking at the experience of attending developmental trauma treatment for people with addictive process leaves a significant gap in regard to the experience of individual differences, a point highlighted by Slatman (2014) in relation to dimensions of embodiment in medical practices more generally.

As described, there is well documented evidence linking developmental trauma and addiction. In addition, PTSD and SUD have been found to often co-occur, Boden et al (2012) found that between 35%-50% of people diagnosed with PTSD also meet the criteria for SUD. Despite the frequency of this co-morbidity the treatments being offered seem to be mainly focused on one condition in isolation (Wiechelt, S.A., 2014). A reason for this may be that addressing trauma and addiction simultaneously has been intentionally avoided for fear of destabilising early addiction recovery with trauma related symptoms such as flashback (Brown, Harris & Fallot, 2013). Ecker & Hundt (2018) warned that the treatment being received for these co-morbid conditions might not be optimal as they were usually designed with only one condition in mind and so do not take into consideration the inter-related symptoms.

It is clear that despite the positive correlation between addiction and trauma, clinical practitioner views on appropriate addiction treatment vary. Some clinical practitioners have concerns that addressing trauma and addiction jointly may destabilise addiction recovery (Brown et al., 2013; Gielen, 2014). For instance, Gielen (2014) noted that while 12 out of 14 clinical practitioners interviewed at an addiction care facility believed in joint treatment in theory, almost none were willing to allow this in practice. Other research has indicated the potential risks of not addressing underlying trauma as part of related addiction treatment, such as drop-out and relapse (Brown et al., 2013; Prangley et al., 2018). Studies have also shown that drop-out and relapse have been highlighted as significant challenges for addiction treatments (Choi et al., 2013; Guerrero et al., 2016; Landrum et al., 2015; Kumar et al., 2016; Whitten, 2020). Yet the addiction treatments being offered still often seem to be focused on addiction treatment in isolation, rather than including trauma reduction treatment (Wiechelt, 2014).

Additionally, while some studies have been carried out into addicts own direct experiences of addiction treatment (Shinebourne & Smith 2009; Rodriguez and Smith 2014; Coltea, 2016; McPhee & Fenton, 2015), there is a lack of research into recovering addicts' own individual perception of treatments that include trauma reduction treatment. This gap in the academic research literature means that in addition to a tendency to focus on addiction treatment in isolation of trauma reduction treatment there has also been a failure to give a voice to recovering addicts and their lived experience and views in this area.

In line with supporting research informed healthcare, as promoted by The United Kingdom's Cochrane and Campbell Collaboration, this

research aims to contribute to addressing this gap in the academic literature (Magill & Longbaugh, 2013).

1.3 Research Aims and Research Question

The literature review has highlighted a number of studies that give evidence of links between addiction and trauma. It also gives support to the idea of including trauma treatment as part of overall addiction treatment. However, as we have seen, the studies also highlighted practitioner concerns that addressing trauma and addiction in an integrated fashion may destabilize early addiction recovery. This resistance is potentially a very real issue as shown by the Gielen (2014) study where the majority of the clinicians interviewed at an addiction care facility believed in joint treatment in theory but almost none were willing to allow this in practice.

The majority of the studies reviewed were quantitative in nature which generated a range of statistical results that largely supported the links between addiction and trauma yet have failed to change the mindset of all treatment practitioners. Meanwhile there is a paucity of qualitative research into treatments that combine these two areas, and this absence is even more marked in relation to the lived experience of addiction treatment that encompasses DT treatment in some capacity so as to give the recovering addicts perception and experiences. The views of people with lived experience should be at the centre of the addiction treatment policy- making agenda so as to guide services on how best to support these individuals in a way that is most helpful and acceptable to them.

It can be argued that there is a strong need for research that reflects the lived experience of addiction treatment generally, but in particular those with a focus on treating both addiction and DT from the

perspective of the service user. This can then potentially be used to help design better, more optimal future studies into addiction treatment; to change the mindset of treatment practitioners to be less avoidant of joint treatment of addiction and trauma, whether it be concurrent or sequential; and to facilitate discussions with addiction treatment facilities about the potential benefit of including DT consideration into addiction treatment planning. Or becoming trauma informed organisations as discussed by Hales et al (2019).

This study aims to address this gap in the academic literature by exploring the experience of attending a trauma reduction programme whilst in recovery from addiction.

The study will consider the following research question:

What is the lived experience of recovering addict participants attending a PIT informed trauma reduction programme?

Specifically, the trauma reduction programme (TRP) that will be looked at in the study will be informed by *Post Induction Therapy*. Post induction therapy (PIT) is a trauma reduction programme run in a group format over five days on an outpatient basis. The therapy is focused on developmental trauma and is made up of a combination of psychoeducation, talk therapy and experiential work influenced by Gestalt therapy. Family Systems theory and Schema therapy serve as the theoretical framework (Bridge, 2016; Melody, 2003). The groups sizes are usually between four and six people with two facilitators and follows a relatively prescribed framework mainly based on talk therapy but also includes experiential parts on days three and four. (Bridge, 2016). For more information on PIT please see Appendix 1

PIT informed trauma reduction treatment was chosen for several reasons. Firstly, it is currently being offered in the UK, as part of related addiction treatment programmes, and so accessibility to potential participants was a realistic possibility. Secondly, I have personal experience of attending a PIT informed programme for training purposes while I was working which cemented my interest and curiosity to gain better understanding in this area. Thirdly, the content of the programme with its emphasis on systemic therapy and acknowledgment of the power of language is aligned with my personal social constructionist position which will be applied throughout this piece of work. Lastly the lack of research into the PIT approach meant there was a clear and identifiable gap in the literature.

The study aims to explore the lived experience of attending a PIT informed TRP while being in recovery from addiction as well as to elucidate the meaning participants make of their experience while acknowledging the role of the researcher in the interpretation process. Consideration of this topic will help fill the current gap in the academic literature and hence potentially allow clinical practitioners, including counselling psychologists, to cultivate a greater understanding of, and sensitivity for, the lived experience of recovering addicts attending a TRP. This awareness may, in turn, be of assistance in aiding clinical practitioners' ability to recognize when this type of treatment programme might be relevant to individual clients in the future therefore better supporting their treatment needs.

Furthermore, by giving a voice in the literature to recovering addicts who have attended a PIT informed TRP, it potentially increases awareness of this treatment option within the general public and hopefully helps facilitate more individuals to seek help from clinical

practitioners earlier. A better understanding of the experiences of individuals undergoing trauma treatment while in recovery from addiction may also help contribute to a reduction in stigma in this area. This would particularly be the case if this research is published in an open-access format as it would allow for increased impact and transparency of the findings.

This study will use the term “TRP” to refer to the PIT informed TRP to reflect the language used by the participants.

Chapter 2: Methodology

2.1 Purpose and Overview

The key purpose of this chapter is to describe what methodology and methods have been chosen for this study and to explain why they are best to address the study research question.

In overview, this chapter describes the ontological and epistemological underpinnings to the study, before then describing which methodology, methods and overall design have been chosen, and why they are considered best to address the research question. The chapter also discusses sampling and recruitment of participants, data collection procedures and analytic strategy along with sections on personal reflexivity, ethical considerations and quality criteria for the study.

2.2 Ontology and epistemology

Ontology refers to beliefs about the nature of the world whereas epistemology concerns the theory of knowledge. Essentially, ontology relates to what exists, while epistemology relates to what we can know. These are difficult and elusive areas to pin down. On one end of the spectrum, ontological realism accepts the existence of a single objective, measurable, fixed reality, while on the other end, ontological relativism accepts that multiple constructed realities exist (Willig, 2013). According to this latter position of ontological relativism, reality is 'subjective and influenced by the context of the situation, namely the individual's experience and perceptions, the social environment, and the interaction between the individual and

researcher' (Ponterotto, 2005, p.130). Whichever ontological position on the nature of reality we accept will then inform our approach to epistemology, which is what we can know (Outhwaite, 1987).

My own viewpoint leans towards a position that while there is an objective reality, what that is will inevitably be affected by individual perceptions of that reality. For instance, I believe that objective reality cannot necessarily be reliably and accurately measured given ultimately those measurements are affected by our perceptions. I also believe that the way that people perceive reality is to a large degree a consequence of their lived experience. I therefore do not subscribe to a strict realist ontological position that there is one fixed reality. However, I feel it is quite difficult to be categorical on this matter. On balance I believe that my ontological position is more aligned with the relativist than realist ontological position, so I choose to call myself a critical relativist.

In a similar fashion, Willig (2013) describes epistemological positions in research as being on a range between two extremes; 'naïve realist' at one extreme (taking the view that research can achieve results with a single objective reality), to 'radical relativist' on the other extreme (taking the view that the nature of research results is relative to the social, cultural, linguistic, and historical construction of the research). My personal epistemological viewpoint is essentially relativist in nature as I believe that what we perceive is considerably shaped by the social context in which we live as well as our own personal experiences. I believe context such as the social norms, culture, politics, and history I have been exposed to and experienced all help to inform my individual interpretation and the same holds true for each participant in this study and all other individuals. It is my belief that the nature of truth is subjective and socially constructed by

the people experiencing it as well as between those experiencing it (Gergen, 1999). My belief is that every individual's understanding of the world, each unique window through which the world is observed impacts our interpretation. I hold that the essence of experience informs everything that we do and although we can describe that experience to another person, they will not have the exact same lived experience and so will experience and make sense of it differently. This is in line with phenomenological philosophical principles with Willig (2013, p.52) commenting 'The appearance of an object as a perceptual phenomenon varies depending on the perceivers..... mental orientation (e.g., desires, wishes, judgements, emotions, aims and purposes)' and 'phenomenology focuses upon the content of consciousness and the individual's experience of the world'. With this understanding of human knowledge, it is accepted that the same phenomenon can be interpreted in many different and unique ways.

My overall ontological and epistemological positions therefore accept the existence of many perceptions of reality and knowledge influenced by the social, cultural, linguistic, and historical context of individuals, as well as the importance of the emphasis on their lived experience and the meaning attached. It is also social constructionist in nature (Gergen, 1999) as I believe that what we perceive is considerably shaped by the social context in which we live as well as our own personal experiences. As such this research will be conducted within a relativist ontological and epistemological position and through a social constructionist lens. This latter allows for the voices of the study participants as constructors and sense makers of their world and specifically their experiences of the TRP to be acknowledged and focused on (Ashworth, 2003; Darlaston-Jones, 2007). Through the social constructionist lens, it is understood that

this relational dynamic will play out during the interview process as well as during the group work done in the TRP and as such is vital to acknowledge (Darlaston-Jones, 2007).

Overall, given my ontological and epistemological position, my belief is that the nature of psychological therapy such as the TRP, is personal and subjective. This relativist ontological and epistemological position therefore is material to my choice of methodology and method and will be included as part of explaining the choice of methodology and method in section 2.3.1 and 2.3.2 below.

2.3 Methodology and methods chosen for the study

2.3.1 The study will be qualitative in methodology

The research aims of this study are to explore the individual lived experience of participants in the study and gain a better understanding of those aspects of the experience which they consider most significant. The core tenet of qualitative research is the meaning of experience and how experience is impacted by the individual's own subjective interpretation of the quality of the experience (Pietkiewicz & Smith, 2014). This essential core fits with the research aims and research question as well as my own ambitions to better understand the lived experience of the individuals in this study. In comparison, quantitative methodologies rely on hypotheses derived from theoretical models which are then tested through statistical analysis of experimental results to attempt to prove (or otherwise) the statistical validity of the hypothesis in question (Pietkiewicz & Smith, 2014). This is in sharp contrast with the aims of this study. Hence, given the stated research aim, a qualitative approach to the research was judged most appropriate.

2.3.2 The study will use Interpretative Phenomenological Analysis (IPA)

Building further on the research aim of exploring individuals' lived experience, the study will be phenomenological as it seeks to describe the "quality and texture" (Willig, 2013) of the participant's personal experiences of attending a TRP while in recovery from addiction. This study will also be interpretative in nature. Interpretive phenomenologists 'draw on insights from the hermeneutic tradition and argues that all description constitutes a form of interpretation' (Willig, 2013, p.56). In contrast, descriptive phenomenologists consider description as being primary (Giorgi & Giorgi, 2008). Given the aim of elucidating meaning from the lived experience of recovering addict participants in a TRP, interpretative rather than descriptive phenomenology was considered appropriate for the study. Given these characteristics required for the research aim, namely that the approach should be qualitative, phenomenological and interpretative in nature, the most appropriate qualitative approach for this study was to use IPA. Eatough & Smith (2017) noted that IPA is about focusing on experiences that really matter to individuals, describing IPA as a means for distinguishing between different aspects of experience and hence making decisions about which parts of that experience to focus on.

In addition, as a result of my epistemological position, my belief is that the nature of psychological therapy, such as trauma reduction therapy, is personal and subjective. From this starting point it is my belief that IPA, an approach that does not aim to capture an objective truth but a subjective lived experience, (Smith et al., 1999) is most

appropriate for this research. Although IPA studies have been noted as not always sufficiently recognising the role of language (Willig, 2008), this study will endeavour to make sure attention to language used is an integral part of the process while ensuring experience remains the primary focus (Smith, 2009). The IPA double hermeneutic, where the researcher interprets the study participants' own interpretations of their experience, will be an essential aspect of this awareness.

IPA is built on work by Husserl and Heidegger and aims to study the lived human experience and the ways these experiences are perceived (Smith et al, 2009; Finlay, 2011; Friesen, Henrickson & Saevi, 2012). Key to IPA is its idiographic and phenomenological emphasis, meaning it has a focus on the individual and personal experience of study participants and how they make sense of their subjective experience (Pietkiewicz & Smith, 2014). This emphasis by IPA resonates with the research aim of studying participant's individual personal experiences and sense making of attending a trauma reduction therapy while in recovery from addiction. IPA considers that this elucidation of meaning takes place in a double hermeneutic, where the researcher interprets the study participants' own interpretations of their experience, hence co-creating meaning, allowing a dual interpretation of the phenomena researched to happen (Alase, 2017; Creswell, 2013). Due to the relatively small number of participants in IPA studies, this approach gives greater opportunity for such a highly detailed analysis of individual comments and to reveal the "relatively rare utterance that is especially resonant and offers potent analytic leverage for the study" (Smith, 2011, p.6).

Finally, to draw out the personal accounts of the lived experience of study participants effectively yet remain free flowing and open in

nature, the interview process will be semi-structured allowing me, as the researcher, to remain flexible but obtain responses on particular subject matter (Barriball & While, 1994). The semi-structured approach has the advantage, over a more rigid highly structured interview approach, that the researcher can use the open nature of the interview schedule questions to build a rapport with the participant and funnel the analysis into detail as part of gently and sensitively probing into the participants' own areas of experiential interest (Smith, 2011).

Other qualitative research methods were considered for the study. Grounded Theory was assessed but was not considered appropriate to the aims of the study. GT seeks to construct theories about the phenomenon being considered (Charmaz & Henwood, 2008). However, as stated in chapter one, this study aims to give a voice to recovering addict participants' lived experience of trauma reduction treatment as there is a notable gap in the academic research conducted in this area. The study aims are not to construct a new theory of trauma treatment of recovering addicts in order to provide an explanatory framework with which to understand this phenomenon (Willig, 2013). Thematic Analysis (TA) was also considered for the study, but IPA was preferred as the study aimed to work with a smaller sample and maintain an idiographic focus, whereas TA appeared to be more suited for qualitative analysis of larger sample sizes where the researcher examines the data to identify patterns of meaning that are repeated.

2.3.3 Overall design approach for study

The overall design approach for the study is therefore qualitative in methodology, uses IPA as its method and employs semi-structured

one-to-one interviews with seven participants for data collection, to explore the lived experience of recovering addict participants attending a developmental trauma reduction programme.

2.3.4 Procedural Aspects

2.3.4.1 Sampling and Recruitment

Creswell (2012) commented that “a phenomenological study describes the common meaning for several individuals of their lived experience of a concept or phenomenon”. As such, sampling when using IPA benefits from purposive sampling, meaning that participants can be recruited who may be heterogeneous in other ways, but all share the common experience which is relevant to the research (Smith et al., 2009).

For this purpose, recruitment took place at an aftercare support group run for recovering addicts who have completed a TRP. Potential participants were approached using a recruitment email (Appendix 2) sent via a gatekeeper that contained clear, brief information about the study. To avoid any potential confusion the information emphasised that the study focuses on the experience of attending the TRP and not the aftercare group. The gatekeeper was the facilitator of the aftercare group; a counsellor with over 20 years of experience. A potential risk was that participants might feel under pressure to participate in the research from the aftercare facilitator acting as gatekeeper. I have discussed this risk under section five, Ethical Considerations. The email was sent to all members of the aftercare group so was not targeted to specific members of the group in any

way. The recruitment email directed any interested individuals to contact me, the researcher, via email in order to set up a screening phone call. The screening phone call was an opportunity for the inclusion and exclusion criteria to be assessed as well as for potential participants to ask any questions they might have.

There were no exclusion criteria in relation to sexual orientation, ethnicity, gender and religion. To meet the inclusion criteria for this study all participants were over 18, had completed a TRP following completion of addiction treatment, had been in recovery for a minimum of three months post-treatment and currently were attending a post-treatment aftercare programme. Although both recovery and addiction can be defined in a number of different ways, the recruitment for this research was based on the participants self-defining as being addicts and as being in a recovery for the specified amount of time. This is in line with the subjective and idiographic understanding of people that this qualitative research takes. The TRP follows the same treatment approach for people who have been treated for substance addictions such as alcohol or cocaine and process addictions such as gambling; following this approach the inclusion criteria for this study included people who had received treatment for either substance or process addiction.

After the screening call and having given the potential participants the opportunity to ask any questions about taking part, those participants who wished to continue and met the criteria were provided with the Participant Information Sheet (Appendix 3). All participants chose to continue. If they still wanted to participate in the study, they were asked by the researcher to sign a Consent Form (Appendix 4). A copy of the signed consent form was scanned and emailed to the

participants. The interviews took place between two and four weeks after receiving the participant information.

Seven participants participated in the study, in order to allow enough individual data to be collected while allowing an in-depth analysis of the results. This conforms to the guideline on participant numbers and length of interviews for IPA research studies (Alase, 2017). It is also in line with Smith's views "IPA is concerned with a detailed account of individual experience. The issue is quality, not quantity, and given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small number of cases" (Smith et al,2009) (p.51). With participant permission interviews were audio recorded and the dialogue immediately transcribed verbatim by me. After the interview each participant was provided with a debrief sheet (Appendix 6). The following table (Table 1) gives demographic details of the participants. One female and six males participated in this study. The relatively small number of participants allowed for the IPA goal of intense and detailed engagement with individual transcripts to be achieved. Participant number depicts the order in which they were interviewed. Gender, ethnicity, period of time in recovery (pre attendance of the TRP) and period of time from TRP completion to interview are shown in the table below, as these were evident from the interview content. The age range of the participants was approximately 25-55 years of age. No other demographic information was required or shared.

Table 1 Demographics

Participant number and pseudonym used	Gender	Ethnicity	Period in recover	Period from TRP to interview
P1 Arv	Male	White British	1 year	18m
P2 Boris	Male	White British	19	9m
P3 Charlie	Female	Black British	3m	2y
P4 Drew	Male	White British	18m	18m
P5 Euan	Male	White British	1 year	6m
P6 Freddy	Male	White British	4m	4y
P7 Gregory	Male	White British	3m	2y

2.3.4.2 Data Collection

As described in sections 2.3.2 and 2.3.3 earlier, the data collection method used for this study was semi-structured interviewing. This approach to interviewing was used because its flexible format enabled me to obtain plentiful, rich descriptions of the participants' lived experience, allowing me to adapt to their flow of dialogue and ask prompting questions, whilst simultaneously allowing participants to speak freely and elaborate. IPA does not mandate interviewing as the method of data collection, instead other data collection methods such as personal diaries can be used but semi-structured interviewing is the normal and most common means of data collection with IPA studies (Eatough & Smith, 2017) and was the chosen method for this study. The choice of semi-structured interviewing allowed me to draw out the experience of the participants while allowing the interviews to remain free flowing, and to use the open nature of the interview questions to sensitively probe for more detail into the participants' own areas of experiential interest (Smith, 2011). The interviewing allowed me as the researcher to become intimately familiar, in an idiographic sense, with the content of each interview (Smith, 2017). It was also my aim throughout the interviews to remain curious and open minded as to the unique experience of the participants in this study.

Interviews lasted between 60–90 minutes each and were carried out remotely via a university approved secure platform (Zoom). The interviews were carried out in this format due to government guidance as a result of the COVID-19 pandemic meaning meeting face-to-face interviewing was not possible. An outline interview schedule of questions and prompts was used (Appendix 5). The interview schedule questions were chosen to facilitate an open interaction and

encourage participants to explore their experience in a very personal, in-depth fashion, so each question was deliberately constructed to be open-ended rather than closed in nature, allowing the participant to shape the nature and duration of their answer rather than unintentionally influencing the direction of their response (Creswell, 2003). Note that all the participants recognised the treatment as the “trauma reduction programme” or “trauma reduction therapy” and that was the way the questions were phrased in the interviews. When carrying out the interviews, I was prepared for pauses and even extended periods of silence to allow participants, and myself, time to consider and reflect on the experience being discussed. I kept in mind the need not to allow the periods of silence to become uncomfortable, but I acknowledge silence can be helpful to the overall reflective quality of the interview (Pietkiewicz., & Smith, 2014).

Although there was no pilot for the interview schedule the schedule evolved in collaboration with my supervisor. I note that some of my initial questions were more direct in nature. After consideration with my supervisor and reflection I changed the format of the questions to better allow for an exploration of experience.

I was conscious not to lead the participants with my interview schedule and so this evolved version better fitted this goal. Once I started the interviews no major changes were made to the schedule but I note that I used the schedule very loosely throughout and was not led by it. Often I asked only one or two of the questions and the other information came out quite organically without the need for further questions.

I also sought to remain watchful for any non-verbal behaviour (such as emphasis by hand movements or facial expressions) and the need to be aware if the participant was becoming uncomfortable or

distressed by the interview (Pietkiewicz., & Smith, 2014). In practice, the interviews were all free flowing in nature without many pauses or extended periods of silence. All of the participants seemed keen to talk about their experience and appeared to interact well with me as the researcher/interviewer. None of the participants showed any signs of being uncomfortable or distressed by the interviews but rather seemed motivated by the interviews and most of them thanked me at the end of the interview for the opportunity to reflect more on the subject.

2.3.4.3 Analytic Strategy

This section describes the analytic strategy that was carried out for the study. The results of the IPA analysis are given in chapter three. It should be noted that at the very end of 2021 Smith et al (2021) published an update to their 2009 book in which they made some terminological changes without changing the underlying IPA process. In outline, the main terminology change was to change from the terminology of “emergent themes” being clustered into “superordinate themes” to use instead the terminology of “experiential statements” that are clustered to create “personal experiential themes”. It was accepted by Professor Smith that these terminological changes will take a period to bed in and that studies already using the existing terminology (as is the case with this study) do not have to change to the new terminology. The 2021 publication was flagged to me by my tutor in April 2022 and we discussed it. Given the relatively advanced stage I was at in my analysis (all the IPA interviews carried out and transcribed and two of the interviews having completed their IPA analysis and write-up) and given the limited nature of the terminological changes, changing to the new terminology was not seen as necessary. Therefore, after discussion with my supervising

tutor I continued with the existing IPA terminology rather than rework and rewrite my work to date. However, I have reflected some examples of the 'new' terminology in the following for completeness.

Each IPA interview was analysed individually, reoccurring comments noted, and any personal reactions recorded in case of presupposition (Smith., Jarman, & Osborn, 1999; Smith, & Osborn, 2003; Smith et al., 2009). Gradually themes from each interview emerged and then an overall hierarchy of related themes from the full set of interviews (Willig, 2013; Creswell, 2013). The IPA analysis used six steps (Smith et al., 2009; Pietkiewicz., & Smith, 2014) gradually building a list of themes, clustering them, creating a table of themes for the first participant interviewed and then continuing the analysis with other participants.

For each of the interview transcripts, the following steps were carried out:

Step one: I carefully read the transcript and listened to the audio recording twice prior to physically noting any comments. This allowed me to fully immerse myself in the transcript and help recall the actual interview and the way it was carried out. Each reading and listening allowed me more opportunity for greater awareness of the overall content and structure of the interview (Smith et al., 2009).

Step two: I then performed a line-by-line analysis of the text of the transcription while making notes in the right-hand margin of the document. These initial notes were broad and exploratory in nature, also including any observations and questions that I had. Where appropriate my thoughts and responses were also recorded in my research journal so as monitor and be aware of my personal reactions to the interview. I highlighted in bold any explicit descriptive

words or phrases in the transcription text that had been emphasized by the participant. Comments requiring more interpretation were then noted and where appropriate highlighted in the transcription text. These included any significant “linguistic comments” (Smith et al., 2009), such as the use of emphasis or repetition, in order to better describe the participant’s experience. I also noted more “conceptual comments” (Smith et al, 2009), that helped me as the researcher to gain a deeper understanding of the underlying nature of the participant experience.

Step three: This analysis then enabled me to make an initial identification of emergent themes (experiential statements in new terminology) that describe the essence of the participant experience. Emergent theme names “should capture something about the essential quality of what is represented by the text” (Willig, 2013, p.58). However, though the theme naming involved my own interpretation as researcher, they had to remain grounded in the participant’s own descriptions (Smith et al., 2009), (Pietkiewicz., & Smith, 2014). My initial views on emergent themes were captured in the transcript document in the left-hand margin of the transcript.

Step four: Having identified initial views on emergent themes for the transcript, I then firmed up these themes by taking out those that repeat, clustering where needed and finalising each theme name wording (‘personal experiential theme’ in the new terminology). As part of this, I looked for connections between the themes and how they related to each other and hence clustered them together into overall superordinate themes.

Gradually an interim table was produced for the transcript that sought to show the various levels of description and to start to make the connections to themes and superordinate themes for the participant.

The interim table showed all the various descriptive, linguistic, and conceptual comments made by each participant alongside the initial views of emergent theme names. Gradually the theme names were modified and firmed up to find a good fit with the sense and emphasis made by the participants as well as the actual comments themselves. The process of finding a good fit took considerable time and could not be rushed. The more time spent immersing myself in the audio recording and transcription, the more clarity I had over the individual importance to participants of specific themes and the choice of theme names that reflected their own words became clearer. As discussed earlier, IPA is interested in focusing on experiences that really matter to individuals (Eatough & Smith, 2017).

Step four was completed by the production of a summary table for the transcript to "obtain a clear and systematic overview of the themes" (Willig, 2013, p.61). As recommended (Willig, 2013, p.58) the summary table showed the final position for the superordinate and associated themes arising from the transcript along with some illustrative comments and associated references from the interviews that illustrated each theme.

Step five and six: step five was to repeat the previous steps for each transcription and participant, progressively building up a view of the themes. Step six was the final step and was to look for an overall pattern of themes across all the participant cases (Pietkiewicz., & Smith, 2014). An overall summary table of superordinate and underlying themes looking across all seven of the participant cases was produced that showed the final position for the superordinate (personal experiential themes in new terminology) and associated themes (experiential statements in new terminology) arising from all of the transcripts along with some illustrative comments and

associated references from the various interviews that illustrate each of the final superordinate and underlying themes.

2.4 Personal Reflexivity

I acknowledge that my starting point in doing this research was an understanding of addiction as a trauma-based maladaptive self-soothing behaviour. This view came because of my time working in an addiction clinic as well as through personal reading. An associated belief I held was that addressing underlying trauma could potentially be helpful in reducing addictive behaviour. During my time working at the addiction treatment facility, I had seen this trauma reduction treatment being delivered and heard anecdotal positive feedback from previous participants. These experiences had shaped my perspective about this intervention. I hope that personal reflection about my assumptions and potential biases by keeping a journal and carefully reflecting on my own comments has made my aim of consciously attempting to bracket these beliefs more effective and has facilitated me moving from a position of what Anderson (1995) calls pre-assumptions, where assumptions are less conscious, to a position of greater awareness. My intention and goal throughout this study has been to remain curious and open minded as to the unique experience of the participants in this study and to illustrate this experience authentically, recognising that I can only hope to get a partial glimpse into the lived experience of each participant. Nonetheless, the enthusiasm and energy that each participant put into the interviews allied to the commonality of themes that arose from the seven participants transcriptions gives a level of confidence as to the results of the analysis.

As described in section 2.3.1 earlier, qualitative research is uniquely concerned with the meaning of experience and how experience is impacted by the individual's own subjective interpretation of the quality of the experience (Pietkiewicz., & Smith, 2014). This essential core fits with my own ambitions to better understand the lived experience of the individuals in this study.

During my time working at the addiction treatment facility, I was able to attend a PIT informed TRP. This was prior to starting the Counselling Psychology Doctorate (DPsych) and several years before this research commenced but was involved in piquing my interest in the area. I note that this experience allowed me to have some experience of the group process that the participants were describing. Importantly I acknowledge the significant difference between my experience of attending the group as someone who does not identify as an addict and who was there as part of my training while at work.

I recognise that my stance on this aspect needs great care. The focus of the study is on the lived experience of recovering addicts who have undertaken the TRP treatment. Though I have undertaken the TRP training, I am not a recovering addict so my perspective can only be from that position. From this perspective I would be seen more as an observer of the TRP and of the participants. A significant element of difference that I noted in my journal was that my experience of attending the trauma reduction programme was for training during my clinical work and, although I found the process useful, I was not attending the course for the same reasons as the participants and as such their experience was likely to be significantly different.

In practice I was very careful to use my knowledge of the TRP as little as possible in any fashion to affect the actual interview comments. Though it helped me to understand the use of course-related language during the interviews, I tried to take care not to use my knowledge of the TRP to interject or influence the participant. I feel my experience of the TRP allowed me to approach the process of data collection with some knowledge of the language used in the programme and so potentially be better placed to pick up and understand nuanced responses of participants when I later analysed the transcriptions whilst all the time remembering to attempt to keep sufficient distance so as not to blur boundaries (Berger, 2015). Despite my best efforts I recognise that my knowledge is likely to have had some influence in terms of my expectations and assumptions about the group, even if only on an unconscious level.

An important area that I kept in mind was that although there was an element of shared experience between myself and the participants because of me also attending a TRP, there remained the difference that I am not a recovering addict and my focus remained on understanding their individual experience.

My role as researcher in the IPA study required me to recognise the importance of the double hermeneutic of interpreting participant interpretations of their lived experience (Smith et al, 1999). As part of my preparation for the interviews and later analysis, I continued to reflect about my own life experiences, assumptions, preconceptions and in particular any biases regarding the research subject matter. As touched on earlier in this section, I sought to, bracket them and remain open minded and reflective as to the lived experience of the participants (Finlay, 2008; Smith, Flowers, & Larkin, 2009). I note that my intuitive concern here was that completely bracketing all such

preconceptions, assumptions and biases could be difficult in practice. On reading further I found that Allen-Collinson (2009), had written to argue that complete bracketing cannot be achieved so researchers should instead seek to be self-critical and self-aware so they can more effectively be aware of these areas. I sought to suspend or at the very least be aware of these views and monitor my reactions and feelings during the study. Through personal therapy and self-reflection, I have worked on elucidating the parts of myself that I am less familiar with in order that I can be more conscious of any assumptions and biases I might be bringing to the research process.

In order to remain mindful throughout this journey I kept a reflective journal throughout the process especially noting down any reactions or interpretations to participants I observe. In addition, I used the meetings with my research supervisor as well as research-based peer support groups as an opportunity to get an outside view on the process to minimise any imposition of my own understanding and as an aid to developing my table of themes. This was of particular importance when the themes showed a certain similarity. Initially I was concerned that I might be unconsciously imposing my own understanding of the experience onto the themes. I reflected on this and went back over my notes in my journal. I again spoke to my supervisor and ran the themes past her and my research group to ensure I had mitigated the risk of me imposing my own view.

I kept in mind how my role as the researcher and interviewer may have impacted the participants by acknowledging how my position may have been perceived as an authority figure by some participants. I aimed to remain vigilant to this potential perceived power dynamic and tried to convey the equal nature of the relationship in all interactions both verbally and through body language. Importantly I

tried to remain conscious of allowing the participants to lead the interview as much as possible. As the study was conducted online due to COVID-19 related restrictions, I also kept in mind that for some participants it may have felt more detached and could have taken longer for them to feel comfortable while for others the online format may have been preferable and allowed a sense of comfort and allow for a disinhibition effect (Suler, 2004).

2.5 Ethical Considerations

The participants in the study are all recovering addicts and have a history of trauma and as such are a potentially vulnerable group. In recognition of this the study was designed to re

cruit participants who are currently under the umbrella of an aftercare support group meaning if participation in the study was unsettling in any way, they had the option to receive support from the facilitator of the aftercare group, a counsellor with over twenty years of experience, as well as from the group itself.

A potential risk was that participants might feel under pressure to participate in the research from the aftercare facilitator who is acting as gatekeeper. To minimise this risk, the invitation to participate in the research was sent to everyone in the aftercare group and not to targeted individuals. In addition, participation in the study was anonymous and so the gatekeeper was not aware of who participated in the study unless the individuals chose to let him know. This was reiterated to all potential participants in the recruitment email.

The aftercare facilitator was aware that some of the people in the group would be taking part in the study and that they might approach him if they felt unsettled. Any communication, regarding the interview

process, between the research participant and their aftercare support group facilitator was decided on by the participant.

Although the subject matter is related to trauma, which I acknowledge could be an unsettling subject area, the study is specifically interested in the experience of the TRP and so did not ask directly about the underlying trauma itself. In addition, to attend the TRP all participants were required to be assessed by a psychiatrist to ensure they were considered sufficiently stable in their recovery and so this provided a significant element of reassurance.

Furthermore, attendance of the TRP and the aftercare group meant that all participants were familiar with the subject area that the interview schedule asked about. The hope was that this meant the study did not involve a risk of distress greater than that of normal life for the participants as participants had become accustomed to discussing their experience of attending the TRP. Moreover, participants were required to be in recovery from addiction to attend the aftercare group meaning that no participants were in active addiction during participation in the study.

In line with the ethical requirement for integrity, the researcher ensured all participants were provided with an information sheet, a consent form and a debriefing sheet and ensured the participants provided informed consent before taking part in the study. Participants were informed that all information is confidential as well as the limitation of that confidentiality. To mitigate any risk of distress to participants I aimed to conduct the interviews in a sensitive manner keeping in mind not to be intrusive with the questions. This was achieved by regularly checking that all participants were feeling

comfortable with the subject matter and were aware they can ask for a break or end the interview at any stage.

Furthermore, the counselling skills that I use in my clinical work with clients on a regular basis were used to ensure a safe and empathic space was created. This further helped ensure the interviews were conducted in a sensitive and compassionate manner to minimise, as far as possible, a perception of a power imbalance between researcher and participants. In addition, my hope was that this approach helped to situate me as a non-exploitative researcher (Berger, 2015).

Details of appropriate support and counselling services (such as Samaritans or AA) were provided to each participant prior to starting the interview process. I also made sure to safeguard against any unanticipated distress to myself by making use of supervision and personal therapy throughout the research project.

All precautions have been taken to ensure that participant data are kept private and confidential and that no individual will be identifiable. As such, personal participant details, including names and any identifying information, will be de-identified. Each interview was audio recorded and fully transcribed and audio recordings were used to ensure accuracy; participants in the study were fully informed of this and asked for consent to this approach. All recording and transcripts were encrypted and will be stored securely until they are destroyed in line with the Data Protection Act (2018)

City, University of London is the sponsor and the data controller of this study data. All data was de-identified and stored in a password secured laptop. The data will be kept for 10 years from when the study finishes and then destroyed, in line with the Data Protection Act

(2018) and City University legal data protection requirements as described within <https://www.city.ac.uk/about/governance/legal>. Following City's destruction of data guidance, the data to be destroyed will be logged with the university via the Service Now website.

As the interviews are required to be undertaken remotely in line with government guidance on the COVID-19 pandemic, a secure password protected online platform was used to conduct the interviews. After the interview, a debriefing process took place that allowed participants to ask any questions they might have. Participants were made aware that they were free to withdraw from the study at any time before commencement of the transcribing process (four days after the interview) without giving a reason. After transcribing started, participants were no longer able to withdraw their anonymised and confidentially handled data.

The project follows the British Psychological Society, 2014, BPS Code of Ethics and Conduct, 2018 and Health Care and Professions Council, 2016 research ethics guidelines. In order to ensure compliance with this the research was approved from City's Ethics Board prior to recruitment of participants.

2.6 Quality Criteria

Yardley (2000) noted the need for establishing criteria for validity within qualitative analysis and recognized the need for these criteria to be sufficiently open-ended and flexible so as not to overly stifle the quality of the qualitative study and as far as possible to enhance the quality without drawing on criteria more appropriate to quantitative studies. The criteria that Yardley identified should be applied to qualitative studies included 'sensitivity to context', 'commitment and

rigour', 'transparency and coherence' and 'impact and importance' by the study. In 2011, Professor Smith also published a guide for assessing quality criteria (Smith, 2011a; 2011b). The published criteria included whether a study followed the theoretical principles of IPA, the level of transparency, coherence, plausibility and interest, the adequacy of sampling used in a study and the strength of evidence given. These criteria from Yardley and Smith have all been considered in designing this study.

I also carried out a review of the design and methodology chosen in this study to confirm they conform to the Yardley criteria. For instance, with the first criteria, I assessed carefully the academic literature surrounding the study topic to remain up to date with relevant research. Furthermore, I remained conscious of the need for immersion in the data to properly apply IPA as a methodology as well as the importance of not influencing participants views and remaining sensitive to the balance of power within the interaction between researcher and participant. For the second criteria, in terms of commitment I had prolonged and full engagement with the study topic, a topic which has been of direct interest and involvement to me since working in this clinical area in 2018 at an addiction treatment facility. In terms of rigour, I, for instance, sought to ensure, with the aftercare group facilitator, that the participant sample available is substantiated as adequate for the study needs and ensured the Methodology (Chapter 3) clearly defines the six-step approach to data collection and analysis to be used. For the third criteria, I laid out a coherent fit between the research question, philosophical perspective, methodology, methods, and analytical strategy, aimed to have a transparent approach towards data collection and analysis and also reflected carefully on the potential issues and difficulties of

this study, such as the difficulty of bracketing prior views. Finally, the fourth criteria of impact and importance has been met by the need to fill a significant gap in the academic literature on the study subject and the need to give a voice to recovering addicts as to the lived experience of attending a trauma reduction programme. In addition, it is my intention to publish the research findings in an open-access format to allow for more accessibility and a higher impact.

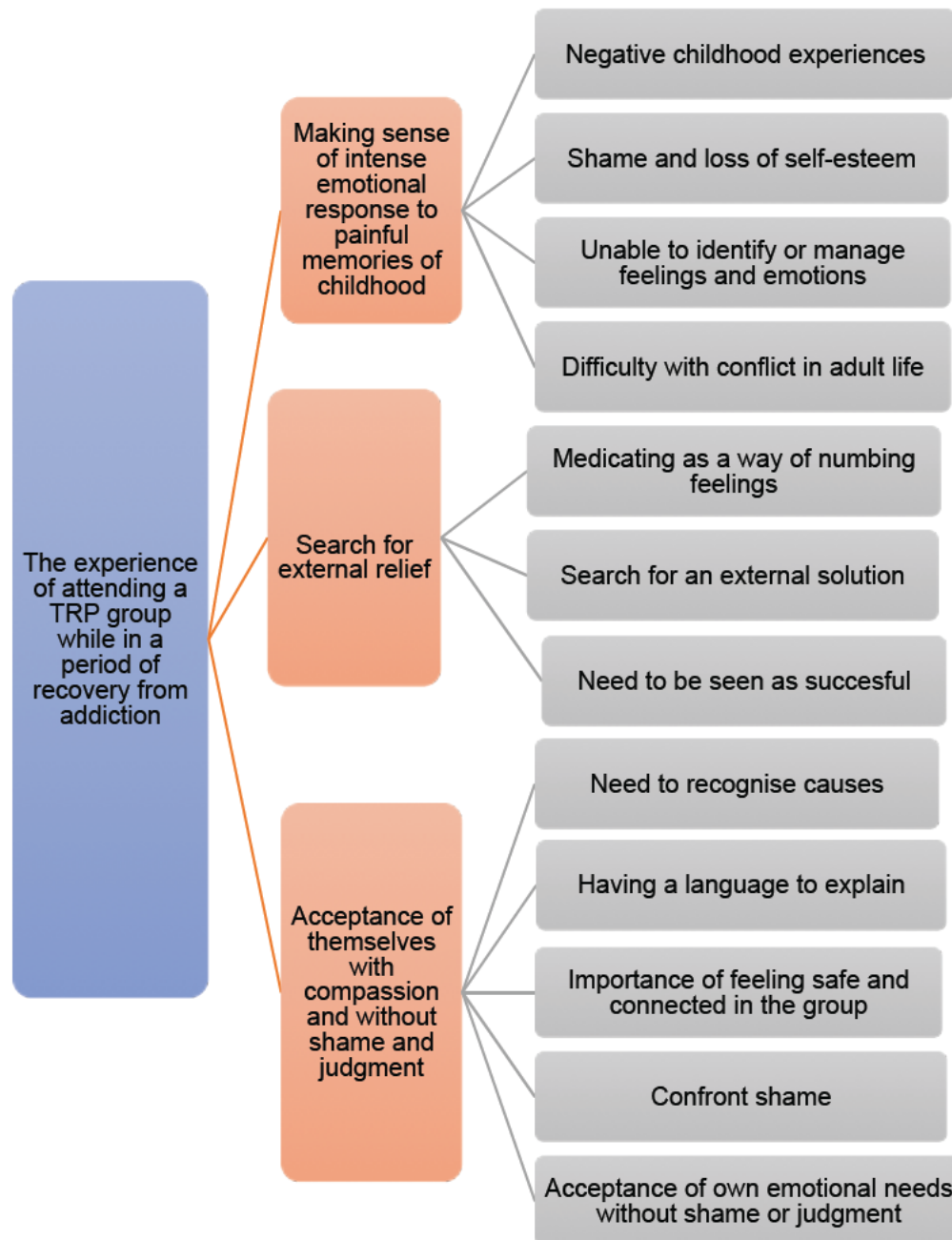
Chapter 3. Analysis

3.1 Overview of the chapter

This chapter gives the overall IPA analysis results of my study. A sample of a transcription is shown in Appendix 6. Tables showing a sample of the intermediate and all the summary tables created to complete the IPA analysis for each of the transcriptions are shown in Appendices 7-15. Appendix 16 shows the final summary table of the superordinate and underlying themes (across all transcriptions). Figure 1 below shows a Map of Themes illustrating the overall superordinate themes in orange and emergent themes in grey. An overview of the superordinate and underlying themes for each of the individual transcriptions are shown in the Appendix 17.

Section 3.2 describes the IPA analysis carried out to determine the emergent and superordinate themes. Section 3.3 describes the IPA analysis findings. Section 3.4 summarises the overall analysis findings.

Figure 1: Map of themes²



² This map of themes illustrates the development of superordinate themes in orange and underlying themes in grey. The boxes are all connected to represent the connection between the themes which influence each other to help understand the phenomena.

3.2 Detail of analysis carried out

The IPA analysis looked for connections and patterns between underlying themes and how they related to each other, clustering them together into overall superordinate themes. Initially this process was carried out for each transcription then later across all transcriptions. The initial clustering took several attempts, involving moving different themes around to form clusters of related themes. There were two aspects to the clustering process, abstraction, and subsumption (Smith et al., 2009). Abstraction involves putting like themes together and developing a new name for the resultant cluster. Whereas subsumption occurs where an initial theme itself acquires a superordinate status as it brings together a series of related themes. An example of this clustering in the individual transcriptions was the abstraction of two emergent themes from Arv's³ transcription, "Be seen as a success by others" and "Not being able to say no to work", into a superordinate theme name "Seeking success".

The summary table results of the analysis of the individual transcripts are shown in the Appendix 9-15. The results reflect the general commonality across the transcriptions in terms of the participant experiences of attending each of their individual TRP and resultant themes identified through the IPA analysis of each transcription. For all seven transcriptions, the analysis identified three superordinate themes. Comparing the three superordinate themes identified by the analysis also showed their similarity in number and nature of underlying themes across all the transcriptions. For Arv's transcription

³ All names and identifying characteristics have been changed throughout in order to maintain participant confidentiality. Pseudonyms are used throughout.

there were four underlying themes for the first superordinate theme, two underlying themes for the second superordinate theme and seven underlying themes for the third superordinate theme. This general pattern continued across the full set of transcriptions. For instance, for Boris' transcription there were four underlying themes for the first superordinate theme, two underlying themes for the second superordinate theme and six underlying themes for the third superordinate theme. For Charlie there were four underlying themes for the first superordinate theme, two underlying themes for the second superordinate theme and six underlying themes for the third superordinate theme. There were also some differences between theme names, as would be expected as the IPA process examines both the similarities and differences across transcriptions (Smith & Osborn, 2008). For example, in the second superordinate themes for Arv and Euan, Arv had the underlying theme name "Be seen as a success by others" while Euan had the underlying theme name "Over-achieving". However, in practice both sets of underlying themes related to a desire by the participant for external validation through being seen as successful. Examination of these quite limited differences helped me to better understand the underlying participant experiences and finalise the individual themes.

The final step in the analysis process was to build on the individual transcription analysis results to look for an overall pattern of superordinate and underlying themes across all the transcriptions to create an overall set of superordinate and underlying themes (Pietkiewicz., & Smith, 2014). The summary table produced from this final step is shown in Appendix 16. Figure 1 shows a Map of Themes illustrating the overall superordinate and underlying themes. As was the case for the clustering of the individual transcriptions, the final

step of clustering across all the participant cases was a gradual process, additionally involving consideration of superordinate as well as underlying themes to form the final set of superordinate and underlying themes. However, despite this, I found it an easier and quicker process compared to the process with the individual transcriptions. I feel this was because of the commonality of themes described earlier. The structure and content of the final superordinate and underlying themes generally conformed and fell out naturally from the pattern of superordinate and underlying themes identified for each of the seven participants.

Abstraction remained key to the final clustering process. As the process was now across all transcriptions, it was a matter of bringing together and naming related superordinate themes as well as underlying themes. The analysis had already shown that for each of the participants, there were three overarching superordinate themes that encapsulated their individual emergent themes. For two of the three, the similarity in superordinate names was apparent across the seven transcriptions. However, there was a small difference in the naming of the second of the final three superordinate themes.

An example of the difference in naming can be seen between the second superordinate name for Arv which was "Seeking success" and the second superordinate name for Drew which was "Seeking external relief to cope". However, analysis showed that the underlying themes were consistent between the participants. Key to naming the second overall superordinate theme was realising that for all the participants this second superordinate theme related to a search for forms of external relief. For Arv, Charlie, Euan and Gregory, one of

these forms included a need to be perceived externally as successful. The aim of this seemed to be to relieve the participants' emotional pain through the external relief of validation. Whereas for Boris, Drew and Freddy this was not one of the forms of external relief they emphasised. However, otherwise the underlying forms of external relief were similar between all seven participants. Since all the individual second superordinate themes were centred around an overarching superordinate theme of participant search for some form of external relief from their emotional pain, all the superordinate themes could be abstracted together to form a new overarching theme centred around the participant search for external relief, namely "Search for external relief" with underlying emergent themes that also included (for Arv, Charlie, Euan and Gregory) the search for success.

3.3 Analysis Findings

The IPA analysis was used to explore the lived experience of recovering addict participants in each of their five-day TRP group treatments. A detailed analysis for each participant that considers the emergent themes across all participants was produced. Following the idiographic approach of IPA, that aims to makes sense of the participants own individual and unique experiences, I have given relevant examples of comments and drawn insights from the study to give a voice to the participants on the relatively short but highly intense and challenging TRP.

With IPA, themes emerge from the analysis of the participant transcriptions, revealing patterns and similarities in the participant experiences contained within the transcriptions when considered across all participant transcriptions. The IPA analysis found that the

participants generally offered a very consistent set of views and used similar language to describe their experiences and insights arising from the TRP. These gave rise to three overall superordinate themes containing twelve emergent themes.

The superordinate themes are shown below. All three superordinate themes are intrinsically linked, rather than existing in isolation and have been clustered together by me with the aim of providing clarity in considering the research question. I did this with the aim of illuminating the experiences of the phenomenon being looked at. As part of this I acknowledge my engagement with the *double hermeneutic* process and how this may have allowed for a certain narrative to emerge showing my own sense-making of how self-identified addicts experienced attending a TRP group.

- “Making sense of intense emotional response to painful memories of childhood”,
- “Search for external relief”
- “Acceptance of themselves with compassion and without shame or judgement”.

3.3.1: Superordinate Theme – Making sense of intense emotional response to painful memories of childhood

The first superordinate theme arising from the IPA analysis of the lived experience of recovering addict participants in a TRP group relates to the insights it gave to the participants of their powerful emotional responses to their difficult childhood experiences. The nature of these negative childhood experiences varied but were all felt by the participants to be emotionally damaging, leading, they felt, to feelings of emotional loss, shame, and anger in later adult life with

associated difficulties in understanding and regulating emotional responses as adults. The superordinate theme “Making sense of intense emotional response to painful memories of childhood” encapsulates four underlying themes “Negative childhood experiences”, “Shame and loss of self-esteem”, “Difficulty with conflict in adult life” and “Unable to identify or manage feelings and emotions”. The various themes are described below.

3.3.1.1 Negative childhood experiences

The participants all describe how the TRP led them to reflect deeply on their negative experiences from childhood. These experiences took various forms such as violence, neglect, isolation, and emotional enmeshment.

For instance, Arv describes how he was the youngest in the family with a father who could not face adult issues:

“when I was probably from the age of about six, I guess, I was the youngest, he was unable to cope with life, he’d obviously had a terribly dysfunctional upbringing himself and he was more of a wounded child as a parent, than a functioning adult parent. And it manifested itself in kind of dark moods, anger, violence, all that kind of stuff” (1.1.1)

Arv is recalling his difficult childhood experiences with his father and seems to be making sense of his experiences through use of the TRP language, using terms such as “wounded child” and “functioning adult parent” to describe his father. Using this language might imply Arv internalising this terminology to scaffold his thinking. Arv’s use of the word “manifested” perhaps implies an understanding of his father’s

behaviour as having stemmed from his own experiences in childhood and was an expression of this rather than an indication of feelings towards Arv. Arv's observation that his father too had a difficult childhood seems to indicate a level of compassion for his father's childhood experiences indicating a resonance with the concept of generational trauma discussed during the TRP. There seemed to be a level of distance from the experience and sense of calm when Arv was recalling these memories. This aspect of accepting with compassion is reflected on more later in the third superordinate theme 3.3.3.

Arv seemed very aware of what he had lost as a result of his negative childhood experiences. He spoke of feelings of grief and the challenge and element of risk in facing these matters:

"I think there's an element of risk there, where it, because of what gets turned up, it's so powerful.... because you have that kind of awareness of something in your childhood which is negative, which has been taken away, which you've lost"
(1.6.1)

Arv here expressed his appreciation for the power of recalling his difficult childhood experiences and the risk of allowing himself the space to consider what they might mean, what was lost. Arv spoke about this using "you" rather than "I" perhaps indicating a desire to distance himself from his sense of loss. Perhaps it was also an indication of the support he felt from the TRP as being a shared and similar experience:

Arv recalled his sense that his family pretended that they lived in a peaceful and safe family environment, regardless of acts of violence by his father. Arv described how one of his brothers had been beaten up by his father, and the reaction of his family. They were all afraid to speak out and say anything about the violence:

“I mean I’m amazed that in those days nothing was ever followed up on and he spent the next two weeks sitting at our dinner table drinking his food through a straw and we all sat there and pretended that everything was normal, you know, because we were all frightened of saying something which would create some kind of reaction” (1.2.3)

Arv’s sense of helplessness and perhaps unexpressed anger at services and the greater system of which he was a part comes across by his “amazement” that “nothing was ever followed up on”. Arv describes the ongoing fear of further violence he felt as a child and how avoidance was the strategy he and his family used to try and stay safe. Arv gives voice to the group denial of what was going on and really conjures up the sense of almost a “freeze” response:

Arv was surrounded by violence not just at home but also at school.

“not only was it violent in the house, my father in his infinite wisdom sent us all to a Christian Brothers prep school in the 80s which, you know, wasn’t brilliant either so I guess I, so from about the age of about 8 I was just surrounded by violence everywhere, at school and home” (1.4.1)

Arv mentions that it was his father's decision to send him to a Christian school again perhaps highlighting the power his father held over him and the household decision making process. Arv's use of ironic humour with the term "infinite wisdom" perhaps implies his sense of frustration at the decision. The detail given of a "Christian prep school in the 80's" might be an intentional reference to illustrate how difficult it had been for Arv as a significant level of abuse in some of these schools during this time has subsequently come out. The omnipresent nature of violence for Arv during his childhood really comes across in the sentence "surrounded by violence everywhere".

Like Arv, Drew also described the difficulties he had with growing up in a violent household:

"when I was growing up my dad, my dad never really liked me, my dad was physically quite abusive, he would hit me and my sister really, really hard for just anything really, not because he needed to discipline us but just because he was angry, and it made him feel better to hit somebody" (4.2.2)

Drew's repetition of "really" in regard to how hard his father would hit him and his sister emphasises the strength and force of the physical abuse and pain that they had to endure. Also, the explanation Drew gives for the violence as not being for "discipline" but instead "just" because his father was "angry and it made him feel better" seems to represent the sense of futility he felt in regard to the suffering he went through. Also, of he and his sister being used as objects rather than related to as individuals in their own rights.

Drew went on to describe the sense he had made of his father's behavior following his attendance of the TRP:

"I'd never thought of my dad's behaviour as enmeshment, I always kind of thought it was more like abandonment, that I thought I wanted this loving father and he wasn't there and so that must have meant that I was abandoned and it was quite an eye-opener to have the therapist, you know, help me see that actually that is enmeshment, that actually it was about having this person, you know, like physical enmeshment, if I'm having this person who's just hitting me and physically abusing me, that that, yeah, that's just, that is a form of enmeshment, it's not abandonment, it's this person who's sort of invading my space" (4.2.2)

Drew seems to be describing his shift in understanding of the drivers behind his father's behavior. Prior to the TRP Drew seems to have understood that his father had wanted to get away from him to "abandon" him. But following the "eye opening" experience, at the TRP, Drew formed a different understanding of his relationship with his father as involving "enmeshment" issues. Drew's repeated use of "actually" seems to capture his sense of gaining this new understanding and of beginning to accept it. His father had been violent and invaded his physical personal space and Drew came to understand this as a form of "enmeshment" rather than "abandonment". Drew's repetition of the term "enmeshed" and "enmeshment" may imply the importance he is giving this term and new understanding of his father's own issues.

Drew described his shift in understanding during the TRP that he was emotionally enmeshed with both his parents:

“childhood was about enmeshment and it was about double-enmeshment you’re enmeshed by your dad and you’re enmeshed by your mum” (4.2.2)

Drew referring to “childhood” in this generic way, rather than specifically his own childhood might indicate his sense of not knowing any other way. Drew continues with the “you’re” rather than “I”. Perhaps he can be seen as expressing that he only understood childhood to be about enmeshment and about not having boundaries respected. He implies he understood his experience, at the time, to be a universal one. Drew’s continued use of the language of enmeshment seems to accentuate the real importance he has given this framework of understanding the relationship he had with his parents as a young person.

Drew described how his mother smothered him, feeling she invaded his personal space. Drew also said he had realised how she responded to his father’s violence by being overly emotionally “clingy” to him:

“my mum, although she had tried to be very nice, she had been far too clingy and there’d been some sort, some like inappropriate things that had gone on in my childhood” (4.2.2)

Here Drew seems to be describing the mixed messages he received from his mother as a child. He felt she was trying to be nice but instead leaned on him for support and was “too clingy”. Drew seems

to be describing his sense of this as being part of behavior he now understood as being inappropriate by his mother.

Boris described how he remembered his childhood as economically secure but emotionally empty. Boris recalls how he had felt emotionally abandoned as a child:

“Now I’m from, I had a, I had a private education, you know, we went on nice holidays, so we were, we were ...(PAUSE) kind of ok economically but, but there was a lot of emotional neglect and emotional abandonment” (2.3.1)

The reference to the financial benefits of private schooling and nice holidays felt to me to be in keeping with Boris’s struggle to give himself full permission to accept the difficulty he had experienced regarding his family. Boris seemed to minimise his experience at times during our conversation and this may have been further evidence of this. The pause before mentioning being financially ok might further imply a sense of embarrassment about naming his struggles, almost suggesting his experience was not worthy of attention due to his financial security. During the interview he expressed the view that others were surprised that he felt neglected and assumed his childhood was fine as his family were financially well off. The externally visible economic security seemed to provide a hiding place for his emotional neglect and abandonment.

During his interview, Boris also shared his experiences of being victimised at school. His body language of dropped shoulders and vocal emphasis indicated strongly to me how deeply he had felt emotionally hurt by the bullying he described.

“I was unhappy every day at school, I hated school, I was bullied, I was victimised” (2.3.1)

Boris stressed how he was “unhappy every day”, not just occasionally. He used the emphasis of having “hated” the experience. He further placed emphasis through the word “victimised”. He made no mention of talking to his parents about the situation or of having any support from them. He did not talk about what interaction he had with his parents over the bullying, but the implication appears to be that he felt unable to speak to them to tell them. He seemed able to recount to me his difficulty with school in a direct way with strong and absolutist language perhaps indicating continued black and white thinking regarding his time at school. But it might also be because of the TRP giving him a sense of having more freedom to confront these memories. Also, perhaps indicative of his greater ease, as a result of the TRP, of accepting the difficulties he experienced within his family.

3.3.1.2 Shame and loss of self-esteem

The participants all described how the TRP clarified their understanding of the emotions and memories associated with feelings of shame they carried from childhood.

Arv noted he felt that the participants confronting their feelings of shame was a central part of the TRP experience. He spoke enthusiastically about the power of the TRP for him and others to face up to their feelings of shame:

“Yeah, and that’s great as well because I think a big issue for everyone is shame, isn’t it, and that’s very toxic..... all the stuff which I’d been carrying around which has made me feel

like I'm different, that I've got this secret which I've been burying" (1.6.4)

Here Arv seems to be saying that recognising the shame is “great” as it involves acknowledging and bringing the shame out into the open and recognising where it belongs. Arv makes reference to “carrying” feelings of shame, almost separating himself from them perhaps allowing him more easily to put them down or give them back. Arv’s reference to feeling “different” implies the sense of disconnection he felt from others and of low self-esteem he had experienced. His use of “secret” and “burying” can be understood as forms of hiding capturing his struggle with shame and low self-esteem. Arv’s description of shame being a “big issue for everyone” gives insight into the sense he is making of shame. It perhaps implies his way of understanding shame now as no longer being as an isolating experience that needs to be hidden but instead a shared one that can be seen, discussed and understood. This can possibly be understood as a reflection of his reduced internal stigma towards his feelings of shame.

Arv expanded on how isolated he had felt as a child:

“it was very bad, I felt very alone, it was all, it was all the stuff which I now understand where those feelings came from. Fear, isolation, abandonment, all those things which came back from being in a house where, you know, I mean an example was my brother who passed away, he one time had to go to hospital to have his face stitched up” (1.2.3)

Arv's repetition of "very" really emphasises his strength of feeling. Arv describes the sense he has now made of his feelings of "fear" and "isolation" as stemming from his early developmental experiences of growing up in a household where violence was present.

Freddy spoke about the part of the treatment where he had the opportunity to imagine talking with his parents and "giving back shame" to them, emphasising a feeling of a lack of love in his family life which he described as traumatic:

"imagining our abusers are in a chair and just giving back their shame.....it was about the trauma of just not getting the love I needed from my parents" (6.4.2)

Freddy's use of the plural "our abusers" rather than singular tense "my abuser" perhaps highlights the importance of doing this experiential part of the TRP in a group format felt for him. The use of "just" in terms of "giving back the shame" seems to imply almost an ease of detaching himself from his sense of shame once he had realised it instead belonged to his abuser.

Drew recalled his feelings of shame:

"shame that, that I had, that I had picked up from my dad as a child, a shame that, that I felt as a result of some of the things he said and did" (4.2.2)

Drew here is describing the sense he was now making of where his feelings of shame derived from. Drew describes understanding his

sense of shame as originating from his father's words and behaviours towards him as a child.

Euan similarly described how he realised that he was "carrying" shame that he felt from his parents:

"It was kind of just identifying that I was carrying shame from my parents" (5.4.1).

He described how he felt he never fitted in with either his family or society:

"my growing up, my sexuality was a big thing for me, growing up gay. I didn't really feel like I belonged anywhere and then felt like I had, I never felt a sense of belonging or a normality" (5.10.1)

Interwoven with Euan's feelings of shame are the feelings of loneliness and sense of disconnection he felt as a child. The strength and reach of Euan's loneliness seems to be captured by him describing his feeling of not belonging "anywhere". Here he attributes much of this difficulty to the sense he was making of his sexuality and sense of identity and belonging as a consequence. Euan's use of the word "normality" perhaps implies an understanding of himself as an abnormal child. There is sense of low self-esteem, of being different, an outsider.

Charlie spoke of now recognising when she was "triggered" to have "shame attacks" by events at work that brought out default feelings in her of low self-esteem in comparison with others:

“shame attacks... I’ve been exposed to that being a West Indian, the inherited trauma of slavery was actually something to consider” (3.10.1)

Here Charlie describes how she experiences her shame as coming in moments of great intensity which she describes as “attacks” reminiscent of “panic attacks” perhaps. Charlie describes how she was now making sense of some of her sense of shame as stemming from systemic racism and from her identity as a black person.

Charlie went on to talk about the sense she was making of the impact racism had had on her self-esteem and ability to feel equal to others around her.

*“it feeds my low self-esteem because I’m always one below”
(3.10.1)*

Charlie’s use of the word “feed” perhaps implies that Charlie does not view the racism itself to be the cause of her low self-esteem, but she understands it as fuelling her existing feelings. The use of “always” seems to highlight the relentlessness of her feeling of being less than other people or “one below”.

For Gregory, in a similar fashion to Arv, hiding was linked to feelings of shame:

“My mother had an affair, this is pertinent...I was very young when I sprang them” (7.4.1)

Gregory describes finding out his mother was having an affair when he was a young child. His use of the colloquial term “sprang” for discovering what was happening really embodies his sense of surprise and shock as well as the speed of which this new information jumped out at him. The sense Gregory is now making of the affair comes across in the emphatic way he states “this is pertinent” in regard to the affair. This seems to highlight the importance he now gives the affair and also the use of “this” rather than “the” seems to imply the affair as well as what followed is what mattered to him.

Gregory goes on to describe his feelings of shame he felt around his mother and the sense he now makes of these feelings:

“But I felt a lot of shame around mum, I found it difficult for her, so I was, I was taking on her shame” (7.4.1).

Gregory describes his feelings of shame when he was in the presence of his mother and noting them as being “a lot” highlighting the strength of these feelings. Gregory’s use of the words “I found it difficult for her” describes mixed and perhaps conflicting feelings towards his mother, possibly implying a sense of concern for his mother, a sense that perhaps it was “difficult” for her too. He does not explicitly say this and the sense of shared or merged feelings between himself and his mother is captured well by that sentence. Gregory did not explicitly say his mother experienced any feelings of shame, but he describes the sense he made of his feelings of shame stemming from her feelings. It appears that he had a sense that she felt shame and he had to take some of this burden from her.

Gregory also described his memories of needing to hide his emotions for fear of the consequences:

“if we get upset with mum and her awful behaviour, Dad gets it in the neck” (7.5.1)

Here the “we” Gregory refers to is he and his sister. Gregory’s use of the word “awful” highlights the strength of feeling he had towards his mother’s “bad” behaviour. Interestingly, Gregory uses the present continuous tense “if we get” to describe he and his sister’s sense they could not show their emotions, their “upset”, in response to their mother’s behaviour. The “we” perhaps implies a sense of a shared experience with his sister, possibly highlighting agreement about the “awfulness” of the behaviour as well as the need to hide or withhold their feeling of being “upset” for fear of repercussions. The repercussions here are described as being against their father and the severity of the repercussions are captured by the use of the term, “get it in the neck”.

3.3.1.3 Unable to identify or manage feelings

Participants described understanding and managing their emotions as previously difficult. They expressed a sense of having a lack of emotional control in their lives.

Freddy described his difficulty with recognising emotions prior to his trauma treatment as follows:

“beforehand there was just a cacophonous committee of, you know, negative self-talk and childish emotions and I didn’t even recognise the emotions” (6.5.1).

The use of this rich term “cacophonous committee” seems to really embody and capture the sense of disharmony of competing thoughts and feelings Freddy was struggling with prior to attending the TRP. The reference to “childish emotions” could be understood as a judgment or even criticism of his emotions. In context of the “negative self-talk” and the difficulty recognising emotions the “childish emotions” Freddy refers to here can perhaps be understood as emotions he found unpredictable.

Freddy used the TRP to engage with his emotions and learn to manage them:

“get in touch with my, be in touch with my emotions and to manage them, learn to honour them, you know, learn to be functional and have boundaries” (6.14.2)

Freddy describing how he learnt to “honour” his emotions implies the importance he now gave them. I was struck by the apparent clarity over his emotional outlook that he had achieved, and his determination to “honour” his feelings in the future. The word “honour” is quite powerful and perhaps reflects a determination to maintain his emotional management in the future. Freddy goes on to link this to boundaries perhaps indicating his understanding of his emotions as having a protective role to play and also that they could be giving him necessary feedback. His use of the term “functional” is likely to be a reference to “functional adult” which is a term used in the TRP terminology. The adoption of the TRP terminology indicates how Freddy had internalized these concepts as a useful sense making framework.

Charlie described her struggle with understanding and naming how she was feeling:

“I just did not know how I identify this is fear, how do I identify that this is anger” (3.4.1)

Charlie's former sense of disconnection from her emotions is highlighted when she describes her difficulty of knowing how she was feeling. Her sense of confusion came across when she was recalling this as Charlie put her hands on her head at this point when she was talking, perhaps momentarily embodying that sense of confusion she had felt.

Charlie described a major shift in her understanding of her emotions through the TRP. She described how she moved from a position of being worried she never got truly angry to understanding it was one of her default emotions:

“my concern was that I was never getting really angry...I understood that was someone that was, um, rage was one of my default emotions” (3.4.1)

Charlie's sense of ownership of her feelings of anger and rage comes across here. The role it played in her sense of herself, of her identity, is highlighted by the use of the words “I was someone”. The ease and frequency of the rage is also captured by the term “default”. The term seems to imply a constant return to rage, conjuring up a “default setting” concept.

Charlie described her shift in understanding in regard to the potential usefulness of her feelings that rather than default to a feeling of rage, she felt she needed to learn to identify and “navigate” her way through her emotions:

“help me navigate through what I was experiencing inside” (3.4.1)

Charlie’s use of the term “navigate” felt quite illuminating. The term often used in nautical terminology implied a sense of her emotions feeling powerful, unknown and unpredictable, almost like the sea and implied her own previous sense of powerlessness to manage her feelings. But there also seemed to be an understanding now that her emotions were an internal tool that could help her to find her way through the turbulent outside world.

Similarly, Boris shared how learning to identify his feelings was something he had not known how to do prior to the TRP. Boris spoke about how learning to feel his feelings as well as understand their nature as temporary was also something he got from his experience of the TRP:

*“whatever those feelings are the first thing to do is I feel those feelings, that’s where I am, and I accept them and I’m ok with it. It does **not** mean I’m going to stay there...” (2.7.1)*

Boris’s sense of welcoming his feelings whatever they might be comes across here. It seemed Boris was understanding his feelings as a way to check in with himself and perhaps ground himself in that moment. Boris raised his voice when saying “not” which seemed to

emphasise the importance he was giving to his new understanding of the temporality of emotions. Here we perhaps also get an insight into his previous relationship with his emotions; his previous sense of fear that his emotions would stay and perhaps his former sense of powerlessness to tolerate this.

Boris described how prior to the TRP he had felt a strong need to avoid his feelings, indicating the sense he could not manage them:

“before it was always, right I need to be doing something, I need to phone somebody, help somebody, get to a meeting, get busy”. (2.7.1)

Boris’s sense of struggle to sit with his own feelings and manage them on his own comes across clearly here. He describes a sense of needing external distractions to avoid his feelings. This sense of urgency and rush to be busy comes across in the fast way he spoke and the list format of “phone somebody, help somebody, get to a meeting, get busy”. Also, the compulsion driving these behaviours is implied in the repetition of the word “need” in regard to how he felt about these things.

Drew described some strict rules he had internalised about feeling and how to manage them. Similarly, to Boris, Drew described dismissal and avoidance of certain feelings as his approach prior to the TRP:

“we don’t talk about feelings, sort of stiff upper lip, just get on with things, don’t show vulnerability, don’t cry, don’t get upset”
(4.3.1)

The “we” that Drew is referring to here is the English. This indicates the sense he was making of his approach to his emotions as being largely cultural. It also implies a normalisation of this avoidance or detachment from emotions. This could be interpreted as being an indication of how attached he felt to his way of understanding his emotions and perhaps how difficult it was for him to question this.

3.3.1.4 Difficulty with conflict in adult life

The participants varied in their adult responses to the emotional environment they were confronted with as children. Most became avoidant of potential conflict as adults in one form or another, such as resulting from disagreement of any kind, or intimate relationships while Charlie instead actively sought conflict to put herself in control of interactions with others.

For instance, Gregory described how he and his sister acted as a defence for their father against their mother’s verbal aggression and dominance to avoid conflict.

“because my mother is so strong, we, my sister and I.... we’ve been shielding dad” (7.5.1).

The sense Gregory made of he and his sister’s behaviour was as a response to his mother’s “strong” character. The use of the word “shielding” implies Gregory’s understanding of needing to protect his father against an attack of sorts.

He also came to understand his own adult behaviour as mirroring his father’s behaviour of never disagreeing or being confrontational:

“What was very interesting was that when I described my father she said who does that remind you of and I was like I don’t know, and I sort of heard all the voices around me sort of laughing, in a supportive way, going it’s you.” (7.5.1)

The “she” being referred to here is the therapist running the TRP. In the interview it was clear from Gregory’s body language and facial expression that he vividly remembered his surprise at realising he had been emulating his father’s submissive and avoidant behaviour. The surprise as well as perhaps the juxtaposition between what the other participants in the group observed about Gregory and what Gregory was aware of about himself is captured by the description of all the people around him laughing. The power this group feedback seemed to have for Gregory is captured by the description of being surrounded “all the voices around me”. The sense Gregory made of this as helpful and not overwhelming is emphasised in him underlining the laughter was “supportive”.

Similarly, Arv, described how, because of the very violent home life he was brought up in, he sought to avoid disagreement of any sort in his adult life. For instance, he was willing to accept any work assignment he was given, travel anywhere and never argue with his managers:

“I used to travel everywhere so I guess I was a bit of a workaholic and of course having been brought up in a violent household I was conflict averse” (1.1.1).

In the case of Drew, the avoidant behaviour took the form of avoidance of potential conflict arising from any form of close

relationships. His relationships with his family had left him feeling powerless and suffocated and he recalls mirroring this in his adult relationships as he would:

“feel suffocated and want to push them away” (4.2.2)

Drew’s strength of feeling about feeling his boundaries were being crossed is highlighted by his use of the word “suffocated”, a term that if allowed to continue would lead to death. His resultant desire to push others can perhaps be understood as feeling like a survival strategy for him.

As a result of the TRP, Drew felt he understood his need to have high levels of control in relationships and better understood why he had a pattern of often rejecting relationships outright. The experience of the TRP had:

“helped explain some things that I’d never really understood before, some patterns of behaviour. So, I’ve always been, I mean as an adult I’ve always been really bad with intimacy and very avoidant around intimacy, very love avoidant and so I just found myself in these patterns of behaviour again and again as an adult” (4.2.2)

The shift in understanding gained by Drew during the TRP is described here. Drew describes how he recognised he had repeating patterns of behaviour prior to attending the TRP but did not understand them. He shared how the sense he was now making of these patterns of behaviour was as being avoidant of intimate relationships. His use of the term “love avoidant” perhaps implies a

blurred concept of the sense he is making of his behaviour through a combination of previous self-help reading as well as the terms used in the TRP.

Boris described a moment in the TRP process where he felt able to address his avoidance of conflict more directly:

“The con, the conflict with him, I found that very difficult, Jonathan, because he didn’t speak like I do and he wasn’t from the same, he wasn’t middle class so suddenly I don’t feel safe, like I don’t feel safe. You know, you make up judgements straight away about people and I didn’t particularly feel safe with him and I was able to overcome it but that was, that was difficult, that was difficult” (2.6.1)

Here Boris describes a conflict he had with one of the other attendees in his TRP group. Boris’s brief stammer over the word “conflict” perhaps implies a continued sense of anxiety about conflict. Boris’ use of my name felt relevant; I felt aware of him trying to connect with me on a more personal level. I wondered if he saw me as more similar to him, more “middle class” than the person he was describing and felt more comfortable talking to me about this situation as a consequence. There were no overt indications of this possible “middle-class” perception from the other interviews, but it is something I have kept an awareness of.

Boris’s repetition of “I don’t feel safe” highlights the strength of reaction he was having to understanding his sense of difference in social class to one of the other attendees. His use of the word “suddenly” also captures how quickly his feelings came in and the

sense he was making of the person not speaking in the same way as him as being unsafe. Boris describes how the differences were experienced by him as “difficult” and as a “conflict”. Again, Boris’s repetition of “difficult” really highlights his strength of reaction. Boris expressly says he felt able to overcome these feeling and shares his understanding of his observations as being “judgments”. His use of “you” rather than “I” in terms of the judgments implies a distance and perhaps a desire to normalise fear of difference.

In summary, this superordinate theme which comprises the four emergent themes of “Negative childhood experiences”, “Shame and low self-esteem”, “Unable to identify or manage feelings and emotions” and “Difficulty with conflict in adult life” paints a vivid picture of how, through the TRP experience, the participants felt able to make sense of their difficult childhood years. The impact to their self-esteem shown up by the TRP was demonstrable from their comments. The superordinate theme also highlights how challenging it felt for the participants to explore their painful childhood memories and emotions as part of the treatment programme but also how supported they felt during the process.

The essence of these points from the first superordinate theme arising from the TRP and its link to the second superordinate theme is, I feel, summed up well by this quote from Drew:

“because of the childhood I had, I didn’t, I think I just didn’t develop any kind of innate sense of self-worth, any innate self-esteem, any real belief in myself. So, it kind of made sense that I spent quite a lot of my childhood, I could understand after doing the trauma programme why I spent so

much of my childhood trying to escape. I mean sort of, you know, escape via video games or reading or food, whatever, and it made sense how, you know, when I got into adulthood why drugs were, well why being high was so appealing”
(4.6.1)

3.3.2 Superordinate Theme - Search for external relief

The second superordinate theme arising from the IPA analysis of the lived experience of recovering addict participants in a TRP group relates to the participants’ recognition of their search, as adults, for some form of external relief from the intense emotional response to their painful memories of childhood. This search took various forms for participants but there are common themes to their experiences. It includes self-medicating to numb their pain; intensively seeking external success in their work or public lives; or attempting to use external bodies (such as AA or GA) to relieve their emotional issues without taking on board the need for personal internal change on their part.

The forms of external actions taken to gain some relief therefore varied between participants but were uniformly described by the participants as feeling unsuccessful. The superordinate theme “Search for external relief” encapsulates three emergent themes “Medicating as a way of numbing feelings”, “Search for a solution external to themselves” and “Be seen as success by others”. This is described in detail below:

3.3.2.1 Medicating as a way of numbing feelings

Following the insights gained from the TRP, all the participants described believing that they exhibited addictive behaviour as a way

to numb their emotional issues. These addictive behaviours varied between the participants but included addictions to drinking, gambling, drugs, manic exercise, love, pornography, rage, obsessive over-working and over-eating.

For instance, the addictive behaviours used to cope by Arv included binge drinking and manic exercise.

“I mean I was binge drinking; I was exercising like a lunatic at certain times, I mean it was just, I look back and it was manic, completely manic.... I just kind of isolated, drank, didn’t see anyone at all...trying to medicate” (1.2.1)

Here Arv described how he isolated himself from people and drank in an attempt to “medicate” which can be understood as an insight into his understanding of alcohol almost as a medicine to try and feel better. The use of the term “just” in regard to the isolation really highlights his sense of being alone as well as perhaps his feeling of not knowing what else to do. Arv’s repetition of the word “manic” underlines his understanding of his behaviour as being extreme. This is further highlighted by his use of his description of himself as “exercising like a lunatic”. The use of the word “lunatic” can be understood as an insight to his understanding of how disordered his behaviour was at this time.

For Gregory it was a combination of things:

“My acting out was probably alcohol and porn and then... perfectionism and I would have a lot of rage (2.4.1)

Gregory referred to his behaviours as “acting out” perhaps indicating his acceptance and internalisation of language used in AA and other similar 12-step programmes. Here he categorised the different behaviours together which perhaps shows his understanding of them as similar.

While for Freddy the addictive behaviours took the form of not just substances but also intensive work, obsessive activity, relationships; anything to divert him:

“It was never particularly any one substance, I would work very intensely, I would be very obsessive about all kinds of different things, different people, sometimes her, sometimes other people.” (6.2.1)

Freddy’s use of words such as “intensively” and “obsessive” implies his sense of compulsion and need to be involved with many “different” kinds of activities and people. The grouping together of substance and behavioural addictions highlights his understanding of these as being similar or the same in his experience. The “her” Freddy refers to here is his ex-girlfriend and the inclusion of her in this list highlights Freddy’s understanding of this relationship as having a similar base to other addictive processes, he has.

“I would be quite upset about work as well so work addiction and then maybe have a bender every other, you know, one every other night” (6.3.1)

Freddy goes on to describe his understanding of his relationship with work as being a form of work addiction. His description of getting

“quite upset about work” and then categorising work as an addiction implies his sense that he was disproportionately emotional about work, perhaps in a similar way as he was about his relationships. The sense he is making of his relationship with various behaviours is coming across here.

For Charlie, as described in 3.3.1.3 earlier, one of her default emotions was rage. Here Charlie describes her sense of enjoyment of her rage and all of the physiological reactions to rage; the description of the “dryness in my mouth” “heartbeat” all implies the intensity of embodied feelings. Charlie expressly describes making sense of her relationship with rage as a form of addiction. Her use of “100%” highlights the importance this understanding of her rage has for her.

“one of my addictions was rage, I was 100% addicted to rage. I, I like the feeling, I like the, the dryness in my mouth, I like the heartbeat” (3.4.1)

3.3.2.2 Search for an external solution

Some of the participants noted how the TRP had brought them to the belief that the use of addiction treatment groups such as AA and other 12-step organisations were not, by themselves, sufficient to achieve the long-term stable recovery they sought.

For instance, Boris spoke about being a member of Gamblers Anonymous for 19 years and though he felt he had learnt to manage his gambling he still felt vulnerable to fresh addictions. His use of the phrase “something was missing” highlighted his sense that he had not achieved what he sought from the organisation despite spending

a significant period of time trying. He raised his voice slightly in emphasise when he used the words “for a number of years”:

“I’d been with Gamblers Anonymous for a number of years but there was something missing” (2.1.1).

His shoulders drooped a little as he went onto speak about his experiences:

“I feel that I’ve been out of control for so many years I’ve indulged in, say it’s another addiction for example, um, would just stay up all night working” (2.4.4)

Boris’ describes his feeling he had lost control for an extended period. The use of “so many years” really highlights how long this time period felt for him. Boris’s understanding of his relationship with work as being “another addiction” that he “indulged in” highlights his understanding of work as another form of external relief.

It could be understood that Boris was using the various 12-step organisation as a way of addressing his loneliness:

“when I didn’t have a girlfriend on a Saturday night I had to get in the car and drive to a 12-step meeting because I couldn’t be on my own” (2.5.1)

Boris’ use of the words “had to” really highlights his sense of compulsion and sense of loss of control. Boris seems to be describing using relationships as a form of external relief, something that allowed him to tolerate being alone. When he didn’t have a

girlfriend, he instead felt he “had to” go to another form of external solution.

Boris described how he had attended a wide range of 12-step organisations over the last 19 years:

“I kept going to, kind of moving around different 12-step fellowships, Co-Dependents Anonymous, ACA which was Adult Children of Alcoholics” (2.1.1).

This movement from one support group to another seems to indicate Boris’s unease with the stability of his recovery and his longing for a solution external to himself. Boris describing his behaviour as “kind of moving around different fellowships” evokes a picture of a sort of nomadic search for connection. The mention of ACA perhaps also highlights Boris’ curiosity to understand his addiction through a generational trauma lens. The elaboration as to what ACA stands for seems to imply that Boris expected me not to know, perhaps illustrating his understanding of me as an outsider from the AA community. Alternatively, this could be understood as a reflection of him feeling the ACA group was just less well known.

Similarly, to Boris, Arv recognised that he had tried many addictions groups without fully resolving his issues. He noted:

“I’d gone to loads of different, I tried all sorts of different groups...I’d gone to Workaholics Anonymous” (1.5.2)

The ongoing search for answers and support is highlighted by the description of himself as trying “loads” of “different groups”. The

repetition of “different” perhaps indicates an open mindedness but also could be understood to represent the importance of the search.

He went on to say:

“I think AA is much harder and it’s like, you know, you’ve got to stop that, that’s it” (1.6.2)

Arv describes a similar search for help with his addiction, trying different groups and also mentions his struggle with the process. Arv’s mention of AA as “harder” and “you’ve got to stop that” can be understood as a reference to the abstinence approach without explanation as to the why behind the behaviour, “that’s it”.

Arv describes below how, despite trying many approaches to manage his drinking, he had struggled with periods of relapse into active addiction:

“I did a lot of things and, you know, so I stopped drinking, I’d stopped all that sort of stuff and then I went back into it again and again” (1.5.2).

Arv’s use of “again” repeatedly can be understood as portraying the cycle he felt stuck in. His use of ‘all that sort of thing’ perhaps indicating the exhaustion with it that he felt.

In the case of Freddy, he tried a different path to try to give himself relief. He saw himself as a “*typical kind of sex addict*”. The use of the word “*typical*” here implies perhaps a normalising of his behaviour or

at least gives us insight into the sense he was making of himself as a sex addict almost in terms of identity and belonging to that group.

“It was a mass of sort of fantasy addiction or sex, not fantasy addiction, I was, the thing I did that would annoy my, my girlfriend was I was always checking out other women, just sort of, which I now recognise as typical kind of sex addict, sexual addict type stuff.” (6.2.1)

Freddy describes repeatedly looking at other women and how he was aware this annoyed his girlfriend. His use of the word “always” to describe this behaviour highlights how relentless he felt it to be. Freddy describes how he understood this behaviour to be a combination of fantasising about sex and sex itself. He then describes how he now understands this behaviour through a sex addiction lens.

Freddy goes on to describe how he perceived his girlfriend as wanting to have control over him:

“I think she wanted to have more control over me, part of the relationship being toxic” (6.1.1).

He emphasised the word “more” while seeming to scowl, perhaps an expression of momentary anger. The use of the word “toxic” here highlights the strength of feeling Freddy has in regard to his previous relationships and perhaps relational patterns.

Even though Freddy had considered himself an atheist, he hoped that converting to his ex-girlfriend's religion might be a means to achieve more closeness to her.

"I tried to make myself believe in Allah, I read the Koran, went to some courses and so on and I'd been quite staunchly atheist before I met her. But I tried to make myself believe in her God" (6.11.1).

The strength of desire for a connection with his ex-girlfriend can be seen here. Freddy highlights the difference between his previously atheist position to one where he considered becoming a Muslim.

When that didn't give him what he was searching for he instead switched to attending another self-help group to try and find an external solution but also felt this didn't work for him.

"So, I did CODA instead, but I also did it co-dependently because I wanted my now ex-girlfriend to do SLAA...then we would both be fixed and then we would come back together and live happily after" (6.11.1)

Freddy describes how he moved from pouring his energy into his relationship with his ex-girlfriend into a different form of external relief; co-dependents anonymous (CODA). His use of CODA perhaps reflects a feeling, even prior to the TRP, that he viewed his relationships as not being as healthy and balanced as he would have liked. In the interview, he smiled slightly as he made the comment "live happily after". This comment seemed to emphasise the feeling of how much he wanted an external panacea to his emotional pain. His

smile at this point could be understood as embarrassment at this statement but I instead understood it as an indication of distance from those desires.

The participants' experience of the TRP was very different from their experience of groups such as the AA which, they felt, did not necessarily try and address underlying causes but instead were all about behavioural management. The study participants appeared to find that the TRP helped give them the means to find a solution within themselves through making sense of their own experiences and choices.

3.3.2.3 Need to be seen as successful

Some of the participants (Arv, Charlie, Euan and Gregory), saw external success, as perceived by others, as a further way of coping with their emotional issues and a way to give themselves a sense of increased self-esteem. For instance, Charlie felt an overwhelming and urgent desire to be seen as a success, rooted in her conflicted feelings from childhood over her ethnicity and being an orphan. Through the TRP, she recognised her feelings on this formed a cycle which fed her sense of urgency and low self-esteem:

“this sense of urgency makes me always just to want to over-achieve but it's not always possible because I'm a black female in a society and in a biased society in the world so I will keep on comparing myself to others and I will always be under, which feeds my low self-esteem because I'm always one below. And my low self-esteem then feeds my need to change and just have it better, which will feed my sense of urgency” (3.10.1)

Charlie's use of the present continuous tense rather than the past tense seems to indicate this is a pattern of thought regarding success she continues to struggle with but is more aware of and able to question. Also, there seems to be a realisation about the roots to her sense of urgency and unrelenting drive as well as a greater understanding of the interplay between her sense of needing to achieve and her experience as a black woman living within a wider system where systemic racism remains a major issue.

This feeling of needing to defend against outside prejudice is echoed by participant Euan. He noted that he had a need to be seen as successful as a defence against feeling seen by society as inadequate and insufficient.

"I was an over-achiever because I felt inadequate as a gay, young gay man" (5.12.1).

Here, the use of the past tense by Euan indicates he may no longer hold this view of himself. This suggests a move away from a previously internalised homophobic position.

In the case of Arv, he placed emphasis on how in his childhood his father valued success in financial and status terms and the strain this put onto the participant and each of his siblings, often coping in later adult life by striving for high status and income and by seeking to please by never saying no to work demands. He reflected that:

"my dad had her (his sister) on a bit of a pedestal because she was a real high-flyer academically and also, she started

earning significant amounts of money quite early on and he was pretty money obsessed, that was how he valued” (1.2.4).

Arv mainly maintained a quiet and reflective manner throughout the interview but at some points such as when he used the words “obsessed” and “that was how he valued”, his voice hardened a little and his face became a little tighter. His use of the word “pedestal” appears to highlight his clear memory of the gulf between how he was treated in comparison to his sister.

Arv recognised that in response to his difficult family life and in particular his father’s attitudes, he had sought as an adult to please people by accepting all work demands. His use of the words “it all catches up with you eventually” was said with a shrug of his shoulders and a shake of his head. He did not elaborate on this choice of words further, but the possible implication may well have been in how this eventually linked into his addictive behaviours:

“So, people pleasing and that can make one quite successful in a work environment, but it all catches up with you eventually, I guess” (1.1.1)

The use of therapeutic language such as “people pleasing” can be understood as an indication of acceptance of this concept and perhaps an internalisation of this shared language.

Arv recognised his need to learn to set boundaries for him to have more control and regulation over his life. He noted that the TRP had included activities that had helped him work on boundary management:

“I think the trauma programme has given me a lot, a huge amount, I can empathise but what it’s also done is it’s helped with boundaries as well” (1.3.1)

Arv’s emphasis on the “huge” benefit he had gained from the TRP seems to emphasise his strength of feeling. Arv’s highlighting of his sense that his ability to empathise as well as have better boundaries has improved as a result of the TRP clearly put across the sense he had made of the TRP experience.

In the case of Gregory, there was a desire to demonstrate success through never making errors and a need for perfectionism.

“All my decisions had to be perfect” (7.4.1)

Shortly after making this comment in the interview, he suddenly shared how he had been very strongly influenced by his mother. Though he did not explicitly link his need to be perfect to his relationship with his mother, his strong emphasis on being “heavily impacted” by her and on her role as “the higher power” may perhaps imply this.

“heavily impacted by my mother, she’s the higher power in the family” (7.4.1).

Here the use of “higher power” can be understood in several ways. It perhaps indicates an acceptance of shared language often used in the AA recovery community and implies a level of belonging to this group. It also can be understood to highlight, perhaps, the almost

God like, power and influence Gregory experienced his mother as having over the family.

Gregory described the moment during his trauma treatment when he realised that the description of his father also related to him:

“will never ever complain...you’re describing yourself” (7.5.1).

This part of the TRP experience appears to have struck Gregory forcibly. As already discussed for 3.3.1.4, Gregory also recognised that he avoided conflict and sought to be liked by others, in a similar fashion to the behaviour of his father. He had been aware that his mother was domineering but he had not realised his own mirroring of his father’s behaviour led to his reluctance to disagree. This desire to be seen as a success sometimes included a reluctance to say no to requests by others so as not to be judged difficult by others.

This was the case for both Arv and Gregory. For Arv, he recognised that he had found it difficult to refuse demands for his work time:

“the way I dealt with it was a whole range of different things when I look back at it and it’s amazing how oblivious one can be. I mean work” (1.2.4).

In the case of Gregory, it became evident to him during the TRP that he, just like his father, found it difficult to refuse others. As well as to give himself permission to have his own needs met:

“goes out of his way to help people and will never complain” (7.5.1).

In summary, this superordinate theme paints a picture of how, through the TRP experience, the participants felt able to make sense of their adult reaction to their difficult childhood years. This superordinate theme explores the insights the TRP experience provided to help the participants make sense of their use of addictive behaviours and other behaviours they used to give them some external relief from their internal emotional pain.

3.3.3 Superordinate Theme - Acceptance of themselves with compassion and without shame or judgement

The third and final superordinate theme arising from the IPA analysis of the lived experience of recovering addict participants in a TRP group relates to the participants' recognition of their need to accept themselves without shame or judgment and with a greater understanding of and compassion for others, including for their families. There was also a recognition that participants needed to be in a place emotionally where they were ready to accept and fully immerse themselves in the TRP. The importance of having a language they could use to explain their feelings was emphasised as was the need for the feelings of safety and connection that came out of the TRP groups. The participants described a sense of having come to accept and like themselves, not feel they were different (better or worse than others) or shameful and a newfound belief that they could face their issues rather than medicate.

The superordinate theme "Accepting of themselves with compassion and without shame or judgement" encapsulates five emergent themes, "Need to recognize causes", "Having a language to explain", "Importance of being safe and connected in the group", "Confront

shame” and “Acceptance of own emotional needs without shame or judgement”. The following describes the various emergent themes:

3.3.3.1 Need to recognise causes

The participants all appeared to recognise their own emotional challenges and feel a strong need to accept the impact these had had on them if they were to maintain their recovery. They appeared to feel that the TRP gave them the chance to have an insight and understanding of the causes of their emotional issues.

For instance, it was apparent by the enthusiasm in his voice that Drew had a sense of accomplishment that, through the TRP, he felt he had a far deeper understanding of the causes of his addictive behaviour than he had ever achieved before:

“I feel like the trauma programme was an opportunity to sort of really drill down deep into some of the childhood stuff which I’d sort of been able to like skim the surface of in recovery” (4.4.1).

It was apparent from the interview that Drew felt that this “drill down” process within TRP had given him confidence that he had a much deeper understanding of these causes than previously. It felt to me that this clarity had been a powerful experience. Listening to him in the interview, it felt that it all quite suddenly became clearer to him. As he put it, it all “fell” into place:

“that’s when those pieces really fell into place” (4.2.2)

For Freddy, it was key to learn about his own feelings, to be able to identify and name them and feel less detached from them. This was

something that he found challenging. It was illuminating that he still has the feelings chart from the TRP. It perhaps highlights how much it meant to him to make this first step into identifying and managing his emotions:

“Learning how to feel, I mean I, I still have the feelings chart.... In the beginning I had to refer to it a lot just to figure out what am I actually feeling” (6.6.1).

Charlie described vividly how the TRP had given her the means to understand what had driven her addictive behaviours and appreciate these causes. The rich way she expressed her new understanding as peeling the layers of an onion indicates how powerfully she now visualises her feelings:

“now that I’ve peeled the onion of the trauma that I’ve been a victim of, how do I then counter its necessity, tendency to express itself in the media of addiction” (3.17.1)

Furthermore, Charlie’s use of the word “it” to refer to her trauma seems to imply a useful distance from the experience rather than an identification with the trauma that the use of “my” could have implied. The distance seemed to be allowing her to be curious about the way it interplayed with her addictive behaviour.

The participants all identified that attendees of the TRP needed to be in a mindset where they felt ready to accept the underlying emotional causes of their addictions rather than simply reverting to seeking to medicate the pain through addictive behaviour. For example, Arv commented that:

“I don’t think you can do this kind of work until your head is in a space where you’re actually dealing with the stuff which has gone on over the years, as opposed to trying to medicate”
(1.2.1)

Arv comment that not “trying to medicate” while doing the TRP seems to highlight his understanding that those in active addiction would not be appropriate for the TRP group.

Boris strongly recommended the trauma treatment but was similarly emphatic that individuals need to be emotionally ready to fully embrace the TRP, however challenging they might find it to drill deep inside themselves to their emotions and childhood memories:

“I have no hesitation in recommending it, but it needs to be done in the right way and at the right time” (2.13.1).

So, while the trauma treatment seemed to have very much been accepted by the participants, they also stressed that it is not a silver bullet by itself and required participants to be ready to fully immerse themselves in the TRP. A recognition by the participants that not everybody was emotionally ready for this treatment came across as well as the importance of “not medicating” while doing the TRP. The participants stressed the need for this readiness to recognise and accept the causes of their adult difficulties to complete the TRP successfully and maintain a long-term stable recovery.

3.3.3.2 Having a language to explain

All the participants used the language from the TRP as a shared, common language. Examples of frequently used terms were reference to themselves as a “wounded child” and the close examination within the programme of participants own “family of origin” along with other widely used programme terms such as “co-dependency” and “enmeshment”. This shared language was used extensively and in a fluid fashion to explain their comments. All the participants reported finding the language used in the TRP a powerful tool, that enabled them to comprehend the emotional challenges and issues raised through the programme. As Charlie put it, having this common, shared language was significant and it appeared to have given her more confidence and allowed her to have more nuance in her way of perceiving the world; to be more accepting that many aspects of life can be “grey” rather than either black or white in their nature:

“I tend to see things, and I’m much better at it but I used to see the world in black and white. Healthy, not healthy, good, bad, wrong, correct, and there was no grey in my world”

(3.3.1)

Because of the experience of undertaking the TRP Charlie seems to feel she can understand and explain events in her life in a broader and richer way. She used strong imagery in describing how she feels she had actually helped create abuse towards herself through her behaviours:

“And I realised that it’s like I had glasses, you know it’s like I was colour blind and I just got these glasses on or something changed and that I started looking around my life and I saw colours all around, vibrant but also in the positive but also very dark in the negative. I saw my, how I had been also a perpetrator of abuse towards myself and how, it’s like I, I opened my eyes and I saw the dead bodies of my life” (3.3.1)

The perspective shift that Charlie is naming here felt significant. It seems to have allowed her a freedom to experience her world and interactions in a radically different way. A shift away from her sense of being “colour blind” viewing things in a black and white way. Also perhaps implying her sense of being driven by the rage that previously threatened to erupt against others, to one where she felt she had the ability to understand emotional situations more effectively. The “colour” that Charlie describes as entering her life was not all positive and we get a taste of the power of those negative feelings with her description of being able to see “the dead bodies of my life”.

“the Trauma Reduction Programme, it’s the framework that it gave me in terms of some of the tools, some of the communication tools, some explanation of emotions” (3.4.1).

Charlies sense of gaining a support structure, a sort of scaffolding from her attendance of the TRP is underlined by her description of having been given a “framework” with ways of communicating and understanding her emotions.

The participants described in their various ways how they now had a language they could use to create distance from their thoughts and assumptions to challenge them if they wished as well as gain a greater understanding as to where these beliefs had come from.

Boris described this as follows:

“you say, what’s going on, who’s voice is this, what age is it, what part of me, what would functioning adult say” (2.9.1)

Drew described the language used in the TRP as using shared terms from the 12-step addiction programme and how this allowed the TRP to feel like a good continuation of the work he had been doing. His emphasis on TRP and 12-step as a “natural” combination is interesting and will be part of the discussion within chapter four:

“there was lots of language of 12-step recovery so yeah in a way it did feel like a very natural extension of, of recovery” (4.4.1)

Drew explained how he found it reassuring to hear the familiar language used and how, for him, it felt as though the TRP followed on from his addiction treatment well. He appeared to find the shared language of TRP and that used for 12-step mutually helpful and easy to engage with:

“the kind of 12-step language which I remember thinking for me was very familiar and very comforting and very easy to engage with” (4.4.1)

3.3.3.3 Importance of being safe and connected in the group

As the analysis of the transcriptions progressed, it became more and more evident that for all the participants a key aspect of the TRP was their sense of feeling extremely safe and connected within the treatment groups.

For instance, when I talked with Drew about what he had experienced as the most challenging aspect of the TRP, he admitted that being open emotionally was potentially a very vulnerable position to be in. However, he had not found this to be a problem because of the closeness and security of the treatment group. He felt extremely safe and cared for in the group. As Drew put it:

“I suppose there were, as I say because, because opening up and getting vulnerable doesn’t come naturally I think there were, there were definitely moments in the week when I felt that, when I sort of felt sort of a natural tendency creeping in to close up a little bit. But I didn’t find that happened too overwhelmingly, just because I did feel very safe and very comfortable in a group with people I cared about and understood” (4.3.1)

Drew went on to describe the strong sense of safety he felt and the sense he made of that experience. It was powerful to see how he expressed the experience as being “the most well” he had ever felt, and this seemed to really highlight the sense he made of his experience. His whole-body language emphasised this. His shoulders went back, his head lifted and there was a smile on his face as he spoke about the group:

“it’s probably the most well I’ve ever felt in my life. I just felt completely looked after and supported” (4.4.1).

Freddy was similarly enthusiastic when talking about the treatment group. He emphasised how the group had given him the “courage” to be open. He looked pleased by his memory of feeling enabled by the strong sense of openness and trust in the group to reveal himself in a way that he was very unused to and that gave him the courage to speak freely:

“somehow I’d had the courage to put that out there and then when other people had done the same, I was like ok yeah, so this is, in this context not that unusual” (6.15.1).

It came across from talking with Freddy that he felt the combination of language framework and methods allied with a very safe group setting and trusted therapists gave him the confidence to do the programme:

“it was good to have been introduced to boundaries and functional adult and all that stuff by seriously professional therapists in a very safe setting” (6.16.1)

Charlie emphasised the importance she felt in regard to the strength of intimacy and openness she experienced. She used words such as “cosiness” and “close” to express why she could be so open at the TRP. This was accentuated by the fact that there were only the two of

them at that particular TRP. The word “cosiness” is a vivid one; it really demonstrates how she recalled being relaxed:

“I think the cosiness of this very close group I could open more. And for me it was 100% my ... just the fact that it was just the two of us” (3.5.3)

Furthermore, Charlie highlighted that the trust she had experienced with the only other member of her group was intense and, she felt, key to her recovery:

“I think she has been instrumental in my recovery... because someone else I share, we shared the experience” (3.5.4).

The sense of importance Charlie gave the shared aspect of the TRP was highlighted by her use of the word “instrumental”; really conveying the idea of the harmony she felt with the other participant.

Arv expressed his views on the different ways that AA and TRP group communication worked:

“on the trauma programme it’s the group thing which was scary and that’s very powerful because it’s different to going to an AA meeting or something because AA, people share, right, but you don’t have that same connectivity. Because I think on the trauma programme, when you get there, suddenly you kind of go on this journey with these other people who you end up in the group with” (1.3.1)

Arv described initially finding the treatment group a scary and daunting challenge in comparison with other activities such as AA he had attended previously. Arv used AA language of “sharing” to describe the way the group communication worked there and contrast it with the experience of going on a “journey” with the TRP group. The importance he gave to the connectivity and shared experience within the TRP group is perhaps captured by his choice of the word “journey”. Despite Arv’s initial concerns, the experience of connectivity within the group seemed to win him over with him describing it as “powerful”.

The treatment group was also initially particularly challenging for Boris. He felt an immediate fear in his initial meeting with the other member of the group, saying he felt “wiped out”. But he did feel it was positive to have high levels of “attention” from the therapist indicating the small size of group worked for him so, though he found the experience tiring he also found it positive, repeating it felt “good”.

“I felt wiped out. It was good, I mean it was good having, it was just me and this other guy and the therapist, it was good having all that attention from the therapist for 5 days” (2.15.1)

The group can be seen to be a focal aspect of the TRP treatment. Drew described the process he went through as part of the treatment group and how the therapist sought to “*just try and get an idea of what our childhood had been like*” (4.2.2) gradually building up a shared understanding between the individual and the group. Building up trust for Drew and the other participants and allowing them to be

fully involved and completely immersed and trusting in in the various techniques used such as “inner child” or “giving back shame”:

“after each exercise the group would sort of share back and identify with things and share how we responded to it” (4.2.2)

However, it was also evident that the aftercare group that the participants were part of was also very important in maintaining the experience of the TRP treatment group; that sense of safety and connection that had been created through the TRP. The planned questions within the participant interviews were not about the experience of the aftercare group but this is something that came up organically and consistently from all participants and so is important to include and reflect on. The participants seemed to all feel the need for a continuation of the group setting, to retain that sense of security and connection with others who had had similar experiences as them and have to opportunity to lean on that group if the need arose. This reflects an understanding, from the participants, that despite their recovery they remained vulnerable to their negative childhood experiences. The experience of the TRP was very much mitigated and made sense of in an ongoing way with the aftercare group being a major part of that. The following accounts from Euan, Arv, and Gregory highlight these points.

For instance, as had been emphasised by participants in describing the TRP, Euan emphasised the importance of the sharing within the aftercare group, and noted that:

"It's like, you know, it's going to the post-care group, it's sharing and, you know, there's, there's magic that happens" (5.3.2).

Arv also reflected on the importance of the aftercare group:

"it's because people have all gone through and done the work and also that there's this identification across all the people as well" (1.11.2)

Arv describes the reasons he found the aftercare group an important space. He describes how the people in the aftercare group have "done the work" perhaps echoing the idea of a shared journey from earlier. The importance of being able to feel that sense of identification with others is highlighted by Arv too perhaps implying it is this identification that leads to a sense of safety and connection in the group.

Gregory's shared his experiences of the TRP group:

"I can remember it, so I had a lot of misgivings about going there because I heard that things were done in groups and I didn't really want to do stuff in groups and I totally change my mind about that". (7.5.3)

He described how he had initially been apprehensive about attending the TRP because of the group format of the TRP but had changed his perspective following the experience. The extent of the shift of perspective is perhaps underlined by Gregory's use of the term "totally".

Gregory went on to say that:

“I got a touch of some feelings and doing it in a group I found extraordinary because I never thought I would want to do it in a group, it would be too shameful...and of course that’s the interesting double bind because you’re so full of shame you don’t want to be vulnerable but actually vulnerability is often the antidote in a supportive environment (7.5.3)

These reflections by Gregory are insightful. They seem to draw together a range of themes. He reflects on being in touch with his feelings, on his feelings of shame, on the power of the group, on his own feelings of vulnerability and fear of speaking out.

Gregory goes on to describe his experience within the group format further:

“But it was still very light touch, very supportive and I really loved being in the group and I didn’t think I would, but I loved it. Funny enough, somebody was telling their story and, you know, and then you’re asked to give feedback, a bit like they do in David’s Monday night group and it really hit me, I really felt the journey they’d been on, I felt their, their bravery, their honesty and that really struck me. And I remember mentioning it to the lady who took us, whose name I can’t recall, and she said, you know, that empathy really helps, helps people in the group listening to others because then the shame’s got nowhere to hide”. (7.5.2)

The recognition of others' courage and his feelings of empathy for the other members of the group, as well as the importance Gregory is giving this, come across. The impact of listening to other people sharing their experiences comes across thanks to Gregory's choice of language to describe this as "really hit[tting] him". It seems to have given him an insight into himself and helping him to become more self-aware and have greater self-esteem. Again "shame" is linked in and Gregory shares his understanding of the benefit of the group format in helping treat shame by not allowing it to have anywhere "to hide".

So multiple themes come together here through the medium of the treatment group. Which perhaps is the essence of the TRP, the bringing together of the various experiences through the security and connectiveness of the group. It is also worth noting that he relates the aftercare group meetings to the TRP group very closely which indicates the way the participants saw the aftercare groups as an extension of the TRP group.

3.3.3.4 Confront shame

For all the participants, a common and significant thread arising from the TRP was the underlying shame they had picked up because of their negative childhood experiences and the importance of confronting this.

Euan spoke of "going back" by which he referred to the TRP technique of visualising their past abusers. He described how emotional that experience was. He used examples of the TRP language "giving back" and "carried" to describe his strong desire to

free himself from the feelings of shame and desire to feel safe as follows:

“giving the shame back that I’ve carried and, um, it was an incredibly emotional experience of just kind of, um, you know, just going back to those key points, I guess, in my life, where I’d made decisions to act in a certain way or behave, and to kind of give back, in my instance to give back the shame that I’ve carried” (5.3.1)

The power that the shame had in Euan’s life can be heard here. Euan describes his experience of revisiting, during the TRP, different important memories where shame had played a role for him and diminishing his sense of shame by “giving it back”. He conjures up a heaviness to the shame by saying he had been “carrying” it.

He also used more of the TRP language in effectively referring to his “inner child” when talking of reassuring his younger self:

“And identifying that I was safe and ok because I, I kind of remember feeling quite unsafe and not ok as a child so it was just kind of going back and sort of reassuring the younger me” (5.4.1)

This continued use of shared language implies an acceptance of the underlying ideas as well as an indication of the participants finding the language a useful framework to explain.

Freddy noted the emotional pain he felt as a teenager. His inner turmoil as a young person comes out very strongly and vividly. He paints a clear picture of his teenage fears and the emotional pain he felt. Even though he uses relatively soft terms like “teased” the pain he felt as a teenager comes through:

“I was, you know, of a slight build I was teased about it as a teenager like, you know, teenage kids do and I had, you know, took it seriously, felt I had to prove that oh I must be straight”
(6.4.2).

The strength of his pain is then illustrated by the use of words like “hugely volcanic rage” as a result of the “bullying” (he no longer uses the softer term “teased”) that he was fearful of exploring. He appears to have been fearful of exploring his childhood experiences in case of releasing this anger:

“a lot of what had kept me back was certainly a fear of this, from sort of really exploring my feelings was this fear of this hugely volcanic rage I had always of being bullied at school and so on” (6.15.1).

For Drew, he felt shame from his relationships with his father. He noted that his shame was “picked” up as a child from his father. This is very much using the TRP language around shame:

“shame that, that I had, that I had picked up from my dad as a child,” (4.2.2)

He felt this shame was due to his understanding that his father had not accepted his sexuality:

“Obviously, I’m gay and he didn’t, he had a real, he didn’t know how to handle that at all” (4.2.2).

Despite an initial reluctance to be part of a group and speak out openly Drew became trusting in the techniques used and willing to embrace them such as *“washing away the shame”*. He was able to accept others in the group holding up a blanket to cover him while he used a towel to clean himself. Something that, as someone who had described himself as *“brought up not to talk about feelings”* (4.2.1) seemed like a significant step change in his attitude.

Drew noted that he felt the *“healing”* and *“almost womb like”* effects of the group (4.3.1). He felt he was able to use the TRP to free himself from the shame he felt from both his parents by:

“metaphorically washing myself and again that was about just clearing away, cleaning away some of the shame” (4.2.2)

The use of the term “cleaning away” can be understood as conveying the power the sense of shame had over Drew; a sense he was dirty or tainted and needed to be cleaned. Furthermore, the sense of safety he is describing from the group as being “womb like” seems to really highlight the power of the group in helping him heal his feelings of shame.

Arv emphasized the importance of feeling safe *“this feeling of safety”* (1.5.7) and not feeling different, of not feeling he had to hide and bury his memories which he had hidden as somehow shameful. He recalled how one of the participants described her shame at being raped as a child and *“had carried that shame...and was unable to share it”* (1.5.7) until the TRP and how enthused he was at the openness and safety of the treatment group. Arv put this as follows:

“the key thing for me on the trauma programme is the offloading of all the shame” (1.11.3).

He embraced the TRP techniques so that he could finally learn that he was not “different”, and he did not need to hide the memories of violence any longer as somehow shameful:

“because it reinforced that view that all the stuff which I’d been carrying around which has made me feel like I’m different, that I’ve got this secret which I’ve been burying actually doesn’t matter” (1.6.4)

And instead, he could, through the medium of TRP, confront his abusers. This was very important to Arv. He showed how much he embraced the technique in describing it as “actually” going back to face his abusers:

“you actually go back, and you confront what happens with the abusers” (1.7.1)

3.3.3.5 Acceptance of own emotional needs without shame or judgement

In their various ways, the participants all voiced the importance of the increased self-awareness arising from the TRP. The participants all reported feeling less overwhelmed by emotions. They described having less of a sense of being triggered by external events. Completion of the TRP seems to have led to participants being able to look at their memories with more detachment. As Charlie put it:

“you’re so self-aware because typically you would say black or white, like I’m on this one, I’m in recovery or I’m on this one and I’m just like actually I’m in grey” (3.15.2).

As a result of experiencing the TRP, she now felt more able to identify when a potentially difficult situation might arise where feelings of shame and rage might be triggered. In addition, she now felt a greater understanding and acceptance of her emotional reactions to situations and people and therefore felt able to cope better:

“because I can identify when I have these shame and blame attacks, I can also see and it’s like I can accept things” (3.12.1)

All participants emphasised the importance of learning to accept with compassion and without judgement of either themselves or others such as family. They variously spoke of the need not to blame others, of the need for compassion and love, and making peace with their childhood as shown in the following participant accounts for this, the final emergent theme.

As Euan expressed it, it was a sudden clarity of why the participants “are the way they are”. He uses the word “you” rather than “I” and it comes across as a much more general statement about all of the participants rather than just Euan by himself. He stresses that the clarity includes not laying blame to others.:

“it’s that lightbulb moment of perhaps realising that’s why you are the way that you are and, you know, it’s, it’s funny because you, you come out not, I don’t blame my parents for what happened, it’s not about blame and that’s what you learn” (5.7.1)

Arv put it simply as now feeling “so much more” compassion. Compassion along with feelings of love and peace resonates throughout the participant descriptions:

“because I feel now, I’ve got so much more compassion” (1.2.3).

Boris also expressed the need to love and accept himself and others:

“You know, the more I love and accept myself the more I love and accept other people” (2.15.1).

Drew emphasised that he had made “peace” with his childhood issues not by pretending the issues were not there but by accepting and making peace with his experiences. He expressed it as follow:

“I had made peace with my childhood, it didn’t mean that I, it’s not like I looked back and saw my childhood any differently, I didn’t look back and remember it as this happy peaceful experience because it wasn’t, but I just felt I’d kind of made peace with it” (4.4.1)

Arv even took a philosophical view about the difficulties he had encountered in their life, feeling that the TRP had shown him the positives that he could take from his life because of his experience of the programme.

For example, Arv described his new compassionate viewpoint and its impact on his life now:

“I feel, it sounds weird, but I feel like it’s a gift in a way, having gone through that journey because I feel now I’ve got so much more compassion for people which I didn’t have before. I was always sort of, you know, I’ve always cared about people, but I didn’t understand, and I think with the Trauma Week in Arizona as well, the people that I met there, I think that was incredible. And it’s something which I think is a real, it’s a real blessing so I don’t have, you know, I’m happy to talk about it” (1.2.3)

Arv’s use of the terms “gift” and “blessing” really highlights the sense he is making of his difficult experiences after having attended the TRP.

Boris similarly described his more open and compassionate approach to people. He was happy and enthusiastic in his manner when talking about this:

“I’ve become much more compassionate and much softer and a number of people have said to me that I’m a very different person, you know. And I already kind of consider myself to be quite intense so for them to say to me I’m very different now I’m like, you know, God, what was I like before” (2.10.1)

It was a significant change from the previous position he had described in the interview of persistent fear and distrust of others in a rather judgemental fashion:

“I don’t feel the need to be controversial and to make people, you know, dislike me” (2.15.3)

Overall, this final superordinate theme describes how, through the TRP, the participants were able to use the self-knowledge they had achieved to confront the shame and anger they had carried from childhood and accept themselves and others with a feeling of compassion and without continued judgement over either themselves or childhood families or carers. The participants now felt more accepted, not judged. As Arv expressed it:

“But it’s not like that anymore, you know, and they can see whatever they want, and no-one gets judged” (1.9.1)

3.4 Summary: Stability in recovery – yet still vulnerable

This section summarises the IPA analysis findings. In chapter four, the findings from this analysis will be discussed along with the theoretical basis and clinical implications of these findings, and conclusions drawn.

The analysis identified three overarching superordinate themes. The first superordinate theme “Making sense of intense emotional response to painful memories of childhood”, explores the insights the TRP provided to help the participants make sense of their difficult childhood experiences. The impact to their self-esteem shown up by the TRP was demonstrable from their personal accounts.

The second superordinate theme, “Search for external relief”, describes how, through the TRP experience, the participants were also able to make sense of their adult reaction to these difficult childhood years. This superordinate theme explores the insights from the TRP that helped the participants make sense of their use of addictive behaviours and other behaviours they used to give them some external relief from their internal emotional pain.

The third and final superordinate theme, “Acceptance of themselves with compassion and without shame or judgement”, describes how, through the TRP, the participants were able to use the self-knowledge they had achieved to confront shame and anger they had carried with them from childhood and accept themselves and others with a feeling of compassion and without judgement. A common aspect to this final superordinate theme expressed by the participants was a strong belief that the TRP is important to maintaining a stable recovery and

therefore has an important role to play within an integrated addiction treatment programme. For instance, Drew noted that he had been in recovery for over three years and had observed that trauma in childhood is a common factor in adult addiction and he recommended that anyone in an addiction recovery programme should include TRP as part of this.

The analysis indicates that, after experiencing the TRP, participants felt more at peace with themselves, largely free of the shame they felt previously. This was seen as fundamental by participants in being able to free themselves from the emotional constraints of their negative childhood experiences so as not be as vulnerable to relapse from addiction recovery. Nonetheless, the participants did not find that simply having experienced the TRP was a guaranteed solution in terms of resolving the emotional roots of their behaviour. They took a far more nuanced view. The participants still felt vulnerable to their negative childhood experiences but now felt able to use the TRP framework to maintain their stability in recovery. Participants also noted that individuals taking the TRP must be mentally and emotionally ready for the challenging openness required for the treatment and recognise through it the need to become more self-aware, rather than seeking an external way of medicating their emotional pain.

The three superordinate themes describe a picture of a shift in perspective for participants to a current position of acceptance of their negative childhood experiences without feelings of personal shame and anger and without continued feelings of blame and anger towards others, in particular their parents and families. The participants also expressed the view that the current stability they felt

within their lives in turn reflected in the resultant stability within their families and relationships.

For Gregory the recognition of achieving his desire of having a family life had only come to him recently, but he was now able “in hindsight” to see that it was only since the trauma treatment that he had started to build a stable family life. For Drew, he had lost his sense of anger towards his father and replaced it with a sense of greater control and stability in his current relationship with his parents. Overall, participants generally felt an increased sense of understanding towards the difficulties in their childhood family situations with Arv for example describing a sense of liberation from his feelings of resentment.

Drew painted a clear picture of how the TRP had enabled him to understand and accept why he was drawn to addiction and how having that context meant he felt he could maintain his recovery. However, despite these positive views about the TRP, the participants did not simply see the programme as a guaranteed solution in terms of treatment. They took a far more holistic view and recognised that they had to take an on-going personal responsibility for their own well-being, remembering the TRP and maintaining vigilance over their own behaviours. For instance, Drew noted that he now felt willing to take personal responsibility for managing his addictive behaviours and so look after his own well-being. Arv expressed it powerfully as a calm sort of vigilance.

Participants all noted the critical importance of the groups they were part of during the TRP. The feelings of safety, of connectivity and of openness from being within the group was seen as key to their

treatment, allowing each of them to reach a very detailed and intimate level of understanding of their emotional issues. The participants also recognised the importance of the aftercare group as a way of maintaining the same sense of closeness and connectivity they had achieved with their TRP groups. Participants also generally viewed a combination of 12-step addiction treatment and TRP as both being required for a successful recovery from addiction.

Chapter 4. Discussion

4.1 Purpose and Overview

In Chapter Four, sections 4.2 to 4.4, I will build on and elaborate the interpretative accounts from the findings in Chapter Three and aim to show how an IPA study can elucidate particularity whilst being able to make, although cautiously, more general knowledge assertions that can inform COP and wider clinical care. These sections will place this discussion within the wider context of the current academic literature and will be organised within the three superordinate themes. Nonetheless, the way that the superordinate and emerging themes relate to each other is maintained throughout these sections. These sections will consider whether the study findings are consistent with or vary from the current literature. In section 4.5, I consider possible limitations of the study. In section 4.6, I consider potential future research arising from the findings of my study or the questions that arose during the process of reflection. In section 4.7, I consider some potential implications for counselling psychology (COP) as a field. In section 4.8 I consider my personal reflexivity. I then summarise my overall findings and draw some conclusions in section 4.9.

4.2 Superordinate theme one: Making sense of intense emotional response to painful memories of childhood

The accounts of emotional difficulty in adulthood following negative childhood experiences found in this study are in line with a large body of literature that has looked at the impact of adverse childhood experiences (ACES) on adults (Felitti et al., 1998), and that showed a significantly increased risk of health issues including addiction and drug abuse following adverse childhood experiences. The Felitti et al (1998) study included a range of adverse childhood experiences such

as physical abuse, verbal abuse, sexual abuse and emotional neglect. While this ACE questionnaire was not used in this study so an ACE measurement cannot be given for each participant, the experiences recounted by each participant were in line with the adverse experiences in the ACE questionnaire (Felitti et al, 1998).

The superordinate theme, “Making sense of intense emotional responses to painful memories of childhood”, is made up of four emergent themes, “Negative childhood experiences”, “Shame and low self-esteem”, “Unable to identify or manage feelings and emotions” and “Difficulty with conflict in adult life”. Overall, this superordinate theme paints a vivid picture of how, through the experience of attending a TRP, the participants made sense of the difficult emotional environment permeating their childhood years and their emotional and behavioural responses to this as adults.

In addition, the superordinate theme highlights how challenging it felt for the participants to drill into their negative childhood memories and emotions of shame as part of the treatment programme but how they recognised it as being helpful in terms of making sense of their experiences. This is in line with a qualitative study that used IPA to look at the client experience of a trauma intervention involving “reliving” where the clients recounted their traumatic events in the present tense (Shearing, Lee & Clohessy, 2011). The Shearing et al, 2011 paper found superordinate themes of “Painful but achievable” and “Positive change”.

The negative childhood experiences highlighted by the findings from my study took a range of forms such as violence, neglect, and emotional suffocation. All participants noted their belief that these experiences had significant impacts on their adult lives. The

participants referred to the resultant shame they struggled with in their adult lives and which they had received from their parents. Gregory, for example, described himself as feeling a “lot of shame” around his mother (7.4.1) while in my interview with Drew, he felt he had “picked up” the shame from his father (4.2.2).

The findings describe how the TRP experience allowed the participants to revisit their childhood abusers and, as adults, start to come to terms with their childhood experiences. This part of the TRP treatment experience was frequently referred to by the participants and seemed to be held as important by them. The importance the participants allocated to chair work seemed to be in the way it allowed the participants to get a sense of confronting their abusers from the past and coming to terms with their past abuse. For instance, when I interviewed Freddy, he described an event where he visualised confronting his past abusers directly (6.4.2). This is from emergent theme “Shame and loss of self-esteem” of the first superordinate theme. This also features strongly in the emergent theme “Confront shame” from the third superordinate theme, where the participants move from a position of simply giving an account of their experiences of shame and loss of self-esteem to a position where they are able to confront their childhood abusers and “give back” their shame.

The participants described experiences of sitting in one chair and visualising an important person in their childhood in an empty chair next to them. Understanding this through a Gestalt theory lens, this exercise can be understood as using Gestalt chair work and having the intention of removing emotional blocks by expressing unvoiced emotions. This use of Gestalt techniques for treating trauma is in line with an APA paper that demonstrates the use of chair work for

treating trauma (Kellogg & Garcia Torres, 2021). A qualitative study into what clients found helpful in trauma treatment, using Mayring's content analysis (Mayring, 2000; 2015) found that the experiential aspect of dialogical exposure therapy (a Gestalt based integrative therapy) was seen as most useful. My study, although not directly looking at what was useful, can be said to echo the sentiment in the positive way that the participants spoke about the Gestalt chair based experiential element of the TRP.

Part of the overall TRP experience that was frequently referred to by the participants was communicating with their internalised younger selves, referred to by the participants as, "wounded child" and "inner child". It was striking how, in my interview with Arv, he vividly recalled being a six-year-old child confronted by the dark moods and violence of his father who Arv now realises through the TRP was more "wounded child" than "functioning adult" (1.1.1).

As described in chapter three, TRP delves deeply into the participant "family of origin" and "inner child" states to build an understanding within the treatment group. For instance, Arv connected the family of origin and co-dependency themes as the precursor of delving into his inner child states in what he clearly considered the core, or as he put it, the "*nitty-gritty*" (1.3.2), of the TRP experience. The participants described how challenging this task had felt, describing how the facilitators had included buckets by the sides of the chairs during the experiential part in case the participants had strong physical reactions to the treatment. For instance, Arv painted a vivid picture of a room prepared very deliberately; with one chair situated in the middle of the room with a bucket close to it in case of vomiting through the stress of delving into their past childhood experiences (1.3.2). He described it looking "hardcore" (1.3.2). From the rich descriptions given by the

participants of this part of the TRP it could perhaps be understood that this element of the experience which actively recognised the embodiment of their trauma particularly resonated with the self-identified addict participants. Perhaps an inference can be made here about the potential importance of bringing in somatic elements to trauma work with addict service users.

Participants found it difficult to identify or manage their feelings as adults. In the case of Freddy, he had difficulty with even recognising his emotions prior to his trauma treatment as described in chapter three section 3.3.1.3 “Unable to identify or manage feelings”. The challenge of identifying and managing their emotions which the research uncovered is in line with a psychodynamic understanding of addiction as being fundamentally a self-regulation disorder, where suffering stems from difficulty with emotional regulation (Khantzian, 2012).

Difficulty identifying emotions can be understood as Alexithymia, a psychological construct introduced in 1973 as a way of understanding emotional dysregulation (Sifneos, 1973). The findings from this study are in line with other studies suggesting a link between Alexithymia and DT (Schimmenti & Caretti, 2018) as well as both substance and process addiction (Hamidi et al., 2010; Orsolini, 2020).

One of the common aspects arising from the IPA analysis leading to this first superordinate theme was the theme of participant low self-esteem and the sense the participants made of it. For instance, Drew seems to have a developmental understanding of where his lack of self-worth stemmed from as well as the impact that had on his behaviour as a child by “*escaping through computer games*” as well as an adult through “*being high*” (4.6.1) Low self-esteem and shame

are commonly reported states by adult addicts (Sweeney, 2018). This is in line with the findings reported in the study. The IPA analysis used in this study additionally allowed for an insight into the sense the participants made of their lack of self-esteem as stemming from their early negative childhood experiences as well as driving their avoidance and addictive behaviours as adults. This arguably novel finding is in line with using a trauma informed approach to addiction treatment which encourages a curiosity about “what happened to you” rather than a more binary or static “what is wrong with you” approach (Sweeney et al, 2018). In addition, it is in line with the understanding of addiction from a developmental perspective, as a maladaptive self-soothing behaviour that is learnt during childhood or adolescence as a reaction to adverse circumstance (Carruth & Wallen, 2014).

An aspect of the TRP treatment that was frequently referred to by the participants in relation to all three superordinate themes was *co-dependency*. The participants used this term as part of their shared language, and all appeared to recognise it as meaning a difficulty with having a healthy, mutually satisfying relationship with others, captured most notably in the emergent theme “Difficulty with conflict in adult life”. Establishing a mutual understanding within the group of the participants’ family of origin and co-dependency appeared to be seen as part of the initial three days build towards the challenging task of looking inside their emotions and memories while confronting their past abusers. This appeared to have had the twin objectives of establishing an open, trust-based group environment for all the participants in the group whilst also emotionally and mentally preparing the participants for their confronting of their past abusers.

Bacon et al (2018) used IPA in a study to explore the lived experience of co-dependency from the viewpoint of self-identified codependents. The study noted that a review of the literature showed the concept of co-dependency appeared to lack a clear theoretical basis and the concept itself had been the target of criticism due to a perception that it lacked clarity (Orford, 2005; Calderwood and Rajesparam, 2014). Despite this, the study noted that the concept has proven resilient, as demonstrated by the significant number of academic papers published globally for example: in Italy (Lampis et al. 2017), in Iran (Askian et al.2016), Taiwan (Chang 2012, 2018), Australia (Marks et al. 2012). For Bacon's (2018) participants, co-dependency was far more than an idea but something that felt very real, as shown by the following quote from Misha, one of the participants in the Bacon (2018) study: *"I think all addiction patterns come from co-dependency. Co-dependency is the mother ship of all addictions!"* This comment is a strong statement, but it demonstrates the strength of feeling by participants in that study. Though possibly not to the same extent as Misha in the Bacon (2018) study, co-dependency was also seen as significant in their understanding of themselves by the participants in the present study. For instance, Freddy described how he saw co-dependency as being a strong part of his emotional make-up and how "co-dependent" and "enmeshed" he now saw his relationship with his former girlfriend was (6.2.1).

Shame was another important, and interlinked, aspect of this first superordinate theme. For instance, Drew describes picking up his shame from his father. While for Arv, he described seeking to bury and hide from these feelings of shame, commenting on how he and his family had resorted to burying their feelings and memories as nothing was ever done about the family violence they were

confronted with. Participants sometimes reacted by either actively avoiding or conversely actively seeking conflict with others, the latter being the case for Charlie with her previous use of rage as a default position to control her interactions with others (3.4.1). For all participants shame was highlighted as a reaction to their painful memories of childhood. This is in line with findings from recent studies suggesting shame can significantly contribute to developing trauma symptoms (La Bash & Papa, 2014).

As described in chapter one, studies such as Waters et al (2014), and Schindler (2019) do indicate possible links between attachment relationships and addictive behaviour. In the second volume of his trilogy on attachment theory "Separation: anxiety and anger", John Bowlby (1973) found that attachment styles develop in childhood as a process of emotional regulation and were important to an understanding of adult feelings of insecurity with the relationship between attachment and fear being activated in childhood by a perception of potential danger. In response, the child seeks closeness to someone they perceive as a secure attachment figure. According to attachment theory, adult anxiety may in turn come about from these negative childhood experiences.

In comparing the theory and research behind attachment theory with the findings from my study, several of the themes arising from my study appear to chime with earlier studies. For instance, the emergent themes encapsulated within the superordinate theme "Making sense of intense emotional response to painful memories of childhood", namely "Negative childhood experiences", "Shame and loss of self-esteem", "Unable to identify or manage feelings and emotions" and "Difficulty with conflict in adult life" all appear potentially consistent with the behaviour attributed in attachment

theory to insecure attachment styles developed in childhood. I have therefore looked at several studies that relate to attachment theory and DT to examine these possible parallels in more detail.

Schindler (2019) found that insecure attachment styles increase the risk factor for substance abusers. Cross-sectional studies have also consistently shown a link between insecure attachment and substance abuse (Iglesias, et al., 2014; Schindler & Broning, 2015). Some longitudinal studies and meta-analyses similarly indicate that insecure attachment in childhood increases the risk of substance abuse (Branstetter, Furman & Cotrell, 2009; Danielsson, Romelsjoe & Tengstroem, 2011; Zhai et al., 2014). The longitudinal data from the Schindler (2019) study indicated a bi-directional relationship between SUD and insecure attachment. This finding gives support to the idea of addiction treatment benefiting from focusing on both addressing the addictive behaviour as well as the attachment difficulty, or what could be understood as DT.

The Schindler (2019) study noted insecure individuals can form attachment styles that include “enmeshed” or “anxious” behaviour, seeking closeness with an attachment figure to reduce their own emotional distress. Schindler (2019) also noted that insecure attachment styles may engage in behaviours that use avoidance of others as a strategy to reduce their emotional distress, or they may have a disorganised pattern of attachment. The study considered how the latter form of attachment can be associated with traumatic experiences, or with loss and neglect. Schindler noted that models of attachment patterns often use the dimensions of anxiety and avoidance, concluding that an implication for treatment is that inclusion of an attachment style assessment for service users as part of treatment planning would be beneficial. The study also noted that

relapses could be seen as resultant examples of avoidance of relationships with the treatment givers.

Comparing these findings with the results of my own study, parallels can be seen. My study had as its first superordinate theme “Making sense of intense emotional response to painful memories of childhood” and as two of its underlying emergent themes “Shame and loss of self-esteem” and “Difficulty with conflict in adult life”. These mirror the findings of the Schindler study in that the recovering addiction participants in my study had experienced similar situations of negative childhood experiences. Furthermore “Difficulty in conflict in adult life” can be understood as illuminating the participants’ experience of feeling they needed to avoid conflict with others in order to maintain adequate closeness. The relapses described by some of the participants in my study (such as Arv) can be understood as being a form of avoidance as described by Schindler.

4.3 Superordinate theme two: Search for external relief

The second superordinate theme captures how the participants made sense of their search for external solutions as relief from their internal emotional pain. For example, Drew said, *“I could understand why, why I looked to external things to change my behaviour”* (4.6.1). For all participants, this search for external relief included addictive behaviours. These took a variety of forms, often multiple for each participant, such as drinking, gambling, drugs, manic exercise, love addiction, pornography, rage, obsessive over-working and over-eating. As Arv expressed it, they were *“trying to medicate”* (1.2.1).

Several of the participants (Arv, Charlie, Euan and Gregory) also described feeling a need to be perceived as successful by others as described through the emergent theme “Need to be seen as

successful". This desire to impress others by their perceived success in their workplace came to be understood by the participants as an attempt to reduce their feelings of loneliness and emotional neglect and build their self-esteem. The attempt to improve his mask of success through external validation was described by Gregory, "*I always had to show people that I was tough and in control*" (7.4.1). This theme of a drive for external validation amongst the recovering addict participants attending a DT focused treatment group, echoes findings by a recent paper published in the *Journal of Mental Health and Addiction* that found approval seeking behaviour was positively associated with addictive behaviour by people with early maladaptive schemas (Arpaci, 2021).

An IPA study was carried out in 2021 into young people's experience of alcohol and other addictive substances (Guest, Copello and Michail, 2021). Though the subject of that study centred on its implications on attempted suicide, there are possible parallels between this study and my own.

A superordinate theme found in the Guest et al (2021) study that has parallels with the second superordinate theme in my study is the "The double-edged sword of alcohol and substances", in which the study participants described how they used alcohol and substances to help them cope with overwhelming emotions. One of the underlying themes being "Using alcohol and substances to escape unwanted emotions". This appears to parallel the emergent theme from my study of "Medicating as a way of numbing feelings". Though the addictive behaviour in my study covered both substance and process abuse, both studies highlighted the desire to use addictive behaviour as an external solution to escape feelings and emotions. In my interview with him, Euan expressed this view clearly and in a way that

appears to closely match the Guest et al (2021) finding: *“Because I now understand that I’ve been, that I have been using substance to, um, you know, hide my feelings or mask my feelings”* (5.8.1).

A further type of external solution that a number of the participants described was attendance of a variety of addiction support groups in search of relief and answers. The participants sometimes attended these groups for many years without finding the relief they were looking for. For example, Boris tried a range of 12-step fellowships over a period of nineteen years. Alcoholics Anonymous (AA) and other 12-step organisations look for what they term a “Higher Power” of some nature for addicts to connect to as part of their treatment process (Sussman et al, 2011). Sussman et al (2011) suggested that in addiction recovery groups such as AA, that addicts may come to depend on this “Higher Power” to operate as a “substitute addiction”. This suggests attendance of 12-steps group does not necessarily address the underlying problem driving addictive behaviour. This is in line with Mate’s (2012; 2022) argument that addiction is not the primary problem but rather the reasons for the emotional pain driving it are. The experiences of the study participants were not negative towards the use of 12-step organisations such as the AA, but they reported feeling them lacking in some way. The participants often saw the use of such organisations and TRP as an effective combination.

The findings in this study could be understood within the context of addiction aetiology. A discussion has been going on in the academic literature for several years whether a brain disease model of addiction (BDMA), or a choice model of addiction is more accurate (Russell, Davies & Hunter, 2011). The choice model believes that people caught in damaging addictive patterns maintain the capacity to change their behaviour. The BDMA understanding on the other hand is that

addiction is a chronic relapsing condition (Heyman, 2011). Furthermore, it holds that behaviour shown in addicts is due to differences found within the brain and therefore has become involuntary. It is worth noting that the reason for this brain difference is explained by exposure to drugs, so may not be applicable to process addictions. The BDMA is supported by organisations such as the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (Volkow & Koob, 2015). The BDMA model can be argued to have helped reduce stigma levels associated with the “moral failing” explanation for addictive behaviour (Lewis, 2017). But other well-known experts within the addiction treatment community dispute the BDMA model’s accuracy saying it is pathologising and consequently associated with perpetuating stigma and shame (Mate, 2015).

The participant’s understanding of addiction as a behaviour due to their early experience is in line with Mate’s explanation of addiction as being associated with adverse childhood experience (Mate, 2012; 2022) rather than being in line with a strictly BDMA understanding. The majority of the participants in the study had attended 12-step-based recovery programmes prior to attending the TRP. Traditionally these programmes and the rehab industry as a whole take a BDMA stance on addiction (Conrad & Schneider, 2010; Lewis, 2017; Potik, 2020).

The adversity and stress in childhood that were frequently referred to by the participants in the present study strengthen the argument, given by Mate (2012; 2022), for an understanding of addiction as a response to human experience rather than a genetic predetermination. It also gives further support to treating addiction along with trauma reduction; again, in line with the Mate’s view that in

order to effectively treat addiction an understanding of the underlying emotional pain is essential (Mate, 2012).

In this study the participants acknowledged the benefits of 12-step programmes despite their disease model understanding of addiction but also did not find this understanding to be sufficient to help them find recovery from their addictive behaviours. Instead, the participants' accounts indicate that they found the more "choice" based understanding of addiction to resonate with them and their experiences. This choice-based understanding of addiction, that was used in the TRP, allowed the participants to make sense of their addictive behaviours in a way that they had not found possible by attending 12-step AA based programmes. The findings from this study support findings by Lewis (2011) that argue that the disease vs choice debate is perhaps presented as a false dichotomy.

Koski-Jannes (2004) identified that the understanding of the treatment provider was the most significant predictor for the sense that service users made of their addiction. This should have meant that people who go through a 12-step recovery programme would have a disease-based understanding of their addiction. Something they needed to accept as not having any control over. This seems to be brought into question by the findings here. The participants reported attending 12-step programmes for up to nineteen years and still were open to a different point of view on their addiction from a non-disease perspective.

Perhaps what these findings suggest is that instead of people in recovery picking up the understanding of addiction from their treatment provider in a non-questioning way, as suggested by Koski-Jannes (2004), instead the explanation that resonates with the

individual's own understanding is the most powerful predictor of effective treatment outcomes. That is to say, a treatment approach that feels aligned to the individuals' own understanding of their addiction journey is most likely to get most buy in and therefore lead to high motivation for change and long-term recovery.

A possible implication for clinical application is that the experience of differing points of view may be experienced as positive. It may indicate that clinical application can move away from the disease model's view of there being something wrong with the person and a lack of ability to change, yet still see the power of the group in AA and other 12-step organisations as nurturing and reparative.

4.4 Superordinate theme three: Acceptance of themselves with compassion and without shame or judgement

The third superordinate theme, "Acceptance of themselves with compassion and without shame or judgement", showed how, because of the TRP, the participants were able to use the self-knowledge they had gained to confront the negative childhood experiences and shame they had "carried" with them from childhood. This superordinate theme describes a significant shift in perspective for the participants, to a position of acceptance of their childhood experiences without feelings of shame or blame towards others.

This superordinate theme can also be understood as capturing the participants' sense of having their reactions to their trauma "normalized" and "destigmatized". The TRP seems to have stressed that the reactions the participants had to their adverse and abnormal experiences were understandable and "normal". This is in line with a trauma informed understanding of addiction (CSAT, 2014).

“Need to recognise causes” is one of the emergent themes for the final superordinate theme. Drew felt the TRP had allowed him the opportunity to “*drill down*” (4.4.1) into the causes of his addictive behaviour by looking at his childhood experiences which previous addiction treatment had only skimmed the surface of.

Internal Family Systems (IFS) (Schwartz, 1995) is a psychodynamic model that uses an integrative approach to therapy that considers that there may be several internal child sub-personalities that are subconscious rather than conscious as they carry painful memories of childhood. This theory is part of the underlying TRP framework and can be understood as giving the participants a lens by which to understand these different parts of themselves. The inclusion of the IFS framework can perhaps be understood as a tool by which to give voice to their internal experiences. This is captured in the emergent theme “Having a language to explain” the internal experiences they had been going through.

A pilot study found using IFS to be effective in working to reduce trauma symptoms in a population who had undergone multiple childhood traumas (Hogdon et al 2022). The utility in terms of framework of understanding, for the participants in my study, is captured in the theme a “language to explain”. This seems to echo the findings of the Hogdon et al (2022) study from a more subjective experiential perspective.

The somatic based experiences recalled by the study participants such as those experienced by Drew of “*metaphorically washing myself*” (4.2.2). with the use of blankets to wash away his feelings of shame and enmeshment (see chapter three section 3.3.3.4) seemed a particularly vividly recalled technique to the participants. They

spoke about these group experiences with comments such as feeling “safe” Arv (1.5.7) and “healing” and “almost womb like” Drew (4.3.1), comments reflected by the emergent theme, “Importance of feeling safe and connected in the group”. Through a trauma theory lens, it can be understood that the participants are describing the TRP as having a somatic element here (Payne, Levine, Crane-Godreau, 2015), reflecting the understanding of trauma, especially DT or PTSD, as being an embodied experience rather than simply cognitive (van der Kolk, 2014).

The participants’ comments about safety and healing appear to indicate they found the somatic aspects of the TRP useful, and they all appeared to recall these aspects vividly. From that position we can then say that the inclusion of somatic elements into TRP is in line with previous findings that suggest inclusion of techniques that focus on somatic functioning and nervous system regulation is important in trauma practice (Dent, 2020). The participants’ experience of the inclusion of these somatic elements as useful, memorable, and positive is a particularly novel aspect of this study. As shown by the literature review in chapter one, there is a limited number of studies looking at the experience of attending trauma treatment, especially treatments focused on developmental based trauma.

The inclusion of this somatic element to this TRP is very much in line with recent studies that suggest that trauma is far more than just a cognitive issue and is in fact experienced and held in both the body and the brain (Van der Kolk, 2014, Levine 2010). Incorporating somatic elements of work into trauma therapy with addicts in this way is consistent with work by Serebrenick-Hai (2015) who looked at how such inclusion can be used to help reduce trauma symptoms in substance abuse addiction. Scheffers et al (2018) also highlighted the

importance of considering the somatic element when working with DT. Although not completely in line with the Trauma Resiliency Model (TRM) which argues for a fully “bottom up” approach to treatment, the inclusion, in this way, of some “bottom up” techniques are in line with a more holistic, integrative understanding of (trauma) treatment (Grabbe & Miller-Karas, 2018).

One of the key aspects of the TRP experience that was frequently talked about by participants was shame and how to deal with it. They often referred to “giving back the shame” as part of the treatment. The belief was consistent that by recognising the shame, confronting the abusers and communicating with their “inner child”, the participants could “give back” their feelings of shame to their abusers. The shame reported by all participants in this study, combined with their voiced enthusiasm and determination to change their addictive behaviours, can be seen as echoing the findings of a US study into motivation for change that found that shame was a predictor for willingness to change the self (Lickel et al, 2014). The high levels of shame along with choice to attend the TRP, along with the enthusiasm for change of addictive behaviour reported by the participants, can be said to give support to a 2013 US study by Flanigan which suggested, specifically, that shame can act as a motivator to change for individuals struggling with addictive behaviour. Within my study, the findings described an experience in which the participants recognise the role that shame and resultant damage to self-esteem had played in their adoption of addictive behaviours (as described in the emergent theme “Shame and loss of self-esteem” of the first superordinate theme) and the need to truly understand this emotion within themselves and confront it through the third superordinate theme (in particular emergent themes “Importance of being safe and

connected in the group”, “Having a language to understand” and “Confront shame”) as part of completing the TRP and achieving a stable recovery. The importance the group structure of the TRP seemed to play for the participants in being able to confront their feelings of shame in a safe way echoed findings by an IPA study looking at shame reduction using group CBT (Spragg & Cahill, 2015). The Spragg et al (2015) study highlighted the how the group format can help facilitate the reduction of shame in OCD. My study similarly highlighted the role shame plays in addiction and how the group structure can be experienced as nurturing and beneficial in shame reduction.

Flanigan (2013) highlights the importance of shame reduction in breaking the vicious cycle of relapse. The participant accounts uncovered by my IPA study echo this importance. In my interview with Arv, he emphasised that the “key” thing for him from the TRP was the shame reduction he had achieved, or as he worded it, the “*offloading of all the shame*” (1.11.3) in emergent theme “Confront shame”. He went on to describe how he had broken the cycle (of relapse) with the benefit of learning how to successfully manage relationships with family and other people. Or for example, the group experience that Charlie had which she felt was key to her recovery as there was such trust that it was fundamental to her own recovery process.

Shame has also been found to lead to avoidance behaviour as well as relapse; Randles & Tracy (2013) conducted a study with recovering alcoholics and found that shame may motivate a desire to hide, escape, and generally avoid the problem. The suggestion that shame as well as stigma associated with addiction can prevent individuals from seeking help was echoed by a more recent study published in the *Substance Abuse and Rehabilitation Journal*

(Crapanzano et al, 2018). This could explain a lot of the initial avoidance behaviour reported by the participants prior to attending the TRP, as well as the relapses reported by many along their addiction treatment journey. The determination to change reported by the participants can perhaps be understood as being, in part, driven by a desire to reduce their feelings of shame combined with a belief that that is possible. This reduced shame in turn might facilitate a more stable addiction recovery as it might allow for less avoidance and relapse behaviour. This combination can perhaps be understood as arising because of attending both the recovery and trauma reduction programmes.

A study by Lopez-Castro et al (2019) suggested that focusing on shame in trauma interventions was likely to be of particular importance because of the moderating affect it has on interpersonal trauma. Addressing the participant's poor self-perception via self-compassion, rather than simply cognitive means, seems to have offered a change agent that resonated with the participants in this study.

Shame has been found to be a challenging thing to measure and the attempts to capture it via quantitative means have been criticised for missing the essence or detail of the individuals' experience (Montes Sanchez, 2014). There is a lack of research into the subjective lived experience of shame and so the indication of a sense of reduction in shame captured by this superordinate theme is arguably quite novel. Shame has been shown to strongly lead to the maintenance of trauma symptoms (Candea & Szentagotai, 2013), and so this finding should be considered in terms of clinical implications going forward. One such potential implication is that using compassion building in this way to reduce feeling of shame could be useful in people who

have experienced trauma. This is in line with a recent multiple baseline study that suggested compassion-based therapy could be useful for trauma related shame (Au et al, 2017). This can be linked to CFT (discussed later in this section) as well as being linked to the Clinical Case Study included in this thesis portfolio on the limitations of CBT and solely cognitive approaches when working with trauma. A further clinical implication is the potential benefit of the group format offered by the TRP.

As also discussed in 4.2, part of the experience of the TRP that was frequently referred to by the participants was their internalised younger selves such as “wounded child” and “inner child”. Euan described how, through visualising communication with his internalised younger inner self, he felt he could reassure him and comfort him from his fears, which in turn was of help in resolving his own feelings of anxiety and sadness *“And identifying that I was safe and ok because I, I kind of remember feeling quite unsafe and not ok as a child so it was just kind of going back and sort of reassuring the younger me”* (5.4.1). This was all part of the “Confront shame” emergent theme that is part of the acceptance that is central to this final superordinate theme. Not feeling safe when younger can also be understood through a CFT lens (discussed later in this section) in which this would be considered to be an under evolved soothing, caring and contentment system.

All the participants in my study emphasised the importance of having a language they could use to comprehend their emotional pain and manage it. I thought Charlie described it eloquently by saying that before the TRP *“it’s like I was colour blind”* (3.3.1). Fundamental to being able to do this was the need for a feeling of safety and

connection within the TRP group which was emphasised by all participants.

This greater self-awareness of the causes of their addictive behaviour by the study participants can be linked to study findings by Castine et al (2019) that looked at cocaine addicts and how greater self-awareness building in interventions could be beneficial in reducing treatment dropout rates and addiction treatment outcomes generally. There is a strong similarity in findings regarding the importance of self-awareness.

The Guest et al (2021) study discussed in 4.3 also identified a superordinate theme, "The complexity of relationships", illuminating how the study participants gave importance to feeling supported and being able to talk to others but felt that was not always easy. One of the underlying themes to this superordinate theme was "Still needing a connection despite the difficulties". Participants spoke of feeling excluded and not understood by others and how important it was to have a feeling of support and connection. This theme appears to echo themes arising from my own study, most notably the emergent theme "Importance of feeling safe and connected in the group" where the feeling of safety and connection with other members of the treatment group was an essential aspect to the TRP. All the participants in my study stressed the importance of the openness and trust within the TRP treatment group

Another superordinate theme that has some parallels to my own study from the Guest et al (2021) study was "Reflecting on the ongoing process of recovery". This superordinate theme from Guest et al (2021) related to how the participants made sense of experiences of their recovery process. This was seen as vital in their ability to

reflect and move away from self-harming. There are two of the underlying themes that appear to mirror to some extent the findings from my study. One is “Increasing understanding of the self and experiences”. Participants identified that the process of receiving a diagnosis was a difficult experience but helped them to make sense of their experiences and provided them with some explanation that they could understand. The second underlying theme was “Taking responsibility for recovery” where participants talked about the need to take personal responsibility for their own recovery and the importance of being in the ‘right mindset’ for this recovery to be effective. These two themes compare well with the findings from my own study, specifically the themes “Need to recognise causes” and “Acceptance of own emotional needs without shame or judgement”, where the participants in my study all recognised the need for them to be ready to take responsibility and to be self-aware enough to confront and accept the causes of their behaviour rather than simply seek external relief for the pain. For instance, in my interview with Boris he emphasised that he had no hesitation in recommending the trauma treatment but was emphatic that individuals need to be emotionally ready to fully embrace the treatment *“you can get plenty of people who do trauma week and they won’t benefit because they’re not going to...apply it”* (2.13.1). So, while the trauma treatment was believed in by the participants, they also stressed that it is not a guarantee by itself and that participants need to be ready to fully immerse themselves in the treatment.

The final theme “Acceptance of own emotional needs without shame or judgement”, also attempts to capture the participants’ expression that the stability they now felt in their recovery in turn reflected in the stability within their families and relationships. For example, in my

interview with Drew, he was visibly pleased that he no longer felt the same anger he had against his father and had replaced it with a greater sense of agency over his own life, expressing that he felt *“more sense of control over my life”* (4.5.1).

The intervention described by the participants in my study can be said to have some similarities to Transactional Analysis (TA) (Berne, 1957). Most notably through the language used in the TRP which can be seen as heavily influenced by the ego states described by Berne (1957). Although different in that it does not involve “life play” or “caressing” the TA goal of increasing an individual’s awareness of their own agency can be said to be similar (Forghani, Rajaei, Bayazi, 2021). This final superordinate theme “Acceptance of own emotional needs without shame or judgment” includes having the inner confidence to manage your own ongoing recovery.

A 2017 efficacy study found TA applied to an addiction group as effective in reducing addiction severity as measured by the addiction severity index (ASI) (Etemadi-Chardah, Matinpour, & Heshmati, 2017). Two groups were established, one control, one experimental. Group therapy using TA approach was carried out on the experimental group for 10 sessions, each session for 2 hours (one session per week). The results were that the use of group therapy using TA accounted for 76% of the changes in psychological status, 43% of the changes in drug abuse status, and 49% of the changes in alcohol consumption status in patients under methadone treatment.

The results from this study suggest that TRP, like the group TA above can be used to enhance individual’s ability to reduce addictive behaviour and diminish frequency of relapse. Understanding this through a TA lens would suggest that focus on an individual’s agency

and sense of responsibility for their actions and behaviours is helpful in creating motivation for change and establishing long term recovery from addiction. The clinical implication here is that inclusion of therapy that fosters a greater belief in the possibility of change on an individual level should be considered when designing addiction treatment programmes.

The willingness to show compassion for themselves and others for example described by Boris as *"I've become much more compassionate"* (2.10.1) and Arv as *"I feel now I've got so much more compassion"* (1.2.3) are part of the emergent theme "Acceptance of own emotional needs without shame or judgement" and is resonant with the ideas of Compassion Focused Therapy (CFT) (Gilbert, 2014). CFT suggests that humans have evolved to cope by developing the capacity of people to cultivate an inner compassion. Participants in my study also emphasised the importance of the group format of the TRP treatment which similarly sits well with CFT. The participants in my study all stressed the safety and closeness of the treatment group as a key aspect to the success they found from the TRP treatment. Looking at the theoretical basis that could be considered to underpin this led me to CFT which was developed by psychologist Paul Gilbert (2014) and which draws on a range of evolutionary, social, developmental and Buddhist ideas. The main emphasis considers how we have evolved to cope through developing this inner compassion. Part of this inner compassion is through cooperation and sharing, experienced by the desire to be part of a group with a sense of belonging and connection. The study shows how individuals can feel safe and connected in an affiliative focused group to create relationships and bonds with others. Gilbert's (2014) study also linked the psychology of caring to the psychology of

attachment theory (Bowlby, 1969, 1973; Mikulincer & Shaver, 2007), noting the importance of having a safe haven that supports children's safety and development. Adults whose childhoods were violent, frightening, abusive or neglectful may have a reduced capability for experiencing and expressing affiliative motives and emotion. There appear to be some clear parallels between a CFT approach and the one used in the TRP in this study.

The participants did not simply see the programme as a guaranteed solution to maintaining their recovery but saw it as part of a more holistic part of their recovery; for example in his interview, Drew noted *"my recovery now is sort of a much wider all-encompassing process"* (4.8.1). Recognition that they had to take an ongoing personal responsibility for their own wellbeing, by maintaining self-awareness and vigilance over their own behaviours was also drawn out and illustrated by this final superordinate theme for example Arv said, *"you have to be...vigilant but the vigilance doesn't have to be as intense, it becomes more a kind of...pattern of thinking and living"* (1.1.4). This recognition of personal responsibility along with the understanding of the TRP as being part of a holistic approach to recovery is in line with a choice-based rather than disease-based model of addiction understanding (Russell, Davies, Hunter, 2011).

The choice-based model, or what Pickard (2017) refers to as a "Responsibility without blame" framework, is said to avoid creating further stigma into the area of addiction. Addiction is a highly stigmatised issue around the world (Pickard, 2017). Stigma has been shown to worsen self-esteem as well as increase levels of isolation and shame (Flanagan, 2013).

Participants generally viewed a combination of 12-step addiction treatment and TRP as being helpful for a successful recovery from addiction. Drew said, *"I certainly think for anyone in 12-step recovery...I would recommend the programme, yeah without hesitation"* (4.10.1). This demonstrates the confidence that seemed evident in the manner the participants spoke about their recovery and the way they reported being more able to emotionally accept their own needs as part of the final emergent theme in this final superordinate theme, "Acceptance of own emotional needs without shame or judgement".

Novel findings

The discussion in sections 4.2 to 4.4 highlights several original findings reached in the study.

Overall, I believe this study shows that aspects of different psychological models and techniques, from CFT, TA, Gestalt and somatic elements, can be drawn together and gives insight into how this combined approach to treating DT is experienced by (self-identified) addicts in recovery.

The first such finding is that the study participants appeared to find the somatic aspects to the TRP useful and is something they all appeared to recall vividly. The inclusion of somatic elements into TRP is in line with previous findings that suggest inclusion of techniques that focus on somatic functioning and nervous system regulation is important in trauma practice (Dent, 2020). The indication from the participants that they experienced the inclusion of these somatic elements within the TRP as being useful, memorable, and positive appears to be an original finding of this study. As shown by the literature review in chapter one, there is a limited number of studies

looking at the experience of attending trauma treatment, especially treatments focused on developmental trauma.

Another potentially novel finding from the study relates to low self-esteem and shame. These are commonly reported feelings by adult addicts (Sweeney, 2018) which is consistent with the findings reported in the study. However, the IPA analysis used in this study additionally allowed an insight into the sense the participants made of their lack of self-esteem as originating from their early negative childhood experiences as well as driving their addictive behaviours as adults. This finding is in line with using a trauma informed approach to addiction treatment which encourages a curiosity about “what happened to you” rather than a more binary or static “what is wrong with you” approach.

A further original finding suggested from the study is that instead of people in recovery picking up their understanding of addiction from their treatment provider, in a non-questioning way, as suggested by Koski-Jannes (2004), instead the explanation that resonated with my study participants was that a treatment approach that felt aligned to their individual understanding of their addiction journey was most likely to get acceptance from them and therefore lead to greater motivation for change and long-term recovery. This is important both specifically for inclusion of trauma reduction treatment as part of addiction treatment, but also more generally in terms of how COP practitioners can consider their approach towards working with addicts to agree a treatment plan by not only using one model of understanding addiction but drawing on several to incorporate the different aspects of subjective and individual understanding.

Another potentially important finding relates to the improvement in participant levels of shame through self-compassion, rather than purely cognitive means. There is a lack of research into subjective experience of shame after trauma interventions. Shame has been shown to strongly lead to the maintenance of trauma symptoms (Candea & Szentagotai, 2013) and so this finding should be considered in terms of clinical implications going forward.

Finally, a systematic review highlighted how people presenting with co-occurring gambling addiction and PTSD often reported finding treatments that focused on the PTSD more useful (Moore & Grubbs, 2021). My study echoes this finding and suggests it can be taken further as the participants in the study found the trauma focus useful and were struggling with a wider range of addictions than just gambling. The extension to this understanding from the service user perspective is another illuminating and novel finding.

4.5 Study Limitations

A potential limitation is that, as all the participants were recruited from the aftercare group, it could be said that their choice to attend the aftercare group indicates they had a positive experience with the TRP. This means the experience of those people who attended the TRP but did not attend the aftercare group, or who dropped out early, were not captured in this study. However, IPA seeks to investigate the experiences of a homogenous group (Smith et al, 2009) which would imply that there are advantages to the sampling from the aftercare group.

A further potential limitation of the study is the risk that participants may have felt under pressure to participate in the research from the aftercare facilitator who also acted as gatekeeper. To mitigate this

risk, the invitation to participate in the research was sent to everyone in the aftercare group and not to targeted individuals. In addition, participation in the study was anonymous and so the gatekeeper was not aware of who participated in the study unless the individuals chose to let him know. Any communication, regarding the interview process, between the research participant and their aftercare support group facilitator was decided on by the participant. Nonetheless, there remains a possibility that participants felt some personal pressure to participate. However, none of the participants voiced any such feelings to me either during or since the interviews. Nor has the facilitator of the aftercare group come back to me that any concerns have been raised by participants. Plus, on a personal level, the enthusiasm and energy that each participant put into the interviews and their strongly voiced support for the study gives me a level of confidence that the participants were comfortable with volunteering to be participants in the study. Furthermore, the sample of seven participants for this study were recruited from a total population of twenty-five people in the aftercare group indicating the majority of people felt comfortable enough to decline the invitation to take part and therefore did not feel under pressure from the gatekeeper.

The fact that the phenomenon being asked about in this study had taken place in the past means that it was retrospective in nature. This means that a potential weakness is the recall biases that might have been present in the participants' accounts (Sedgwick, 2014). Furthermore the difficulty of separating the experience of attending the trauma reduction group from talking about the experience during the aftercare group may have further contributed to the recall bias challenge. This could have been more marked than average as trauma and certain kinds of addiction, such as substance addiction,

are associated with negative effects on memory recall (Najavits et al, 1997).

As the interviews had to be carried out online due to COVID19 restrictions the limitations associated with working in an online format may also apply such as potential difficulty building rapport, the conversation possibly feeling abrupt to participants and missed non-verbal communication. The amount of non-verbal communication that could be observed by me was limited due to the screen size and seating position of the participants, meaning I could mainly only see the top third of them. I attempted to pay very close attention to the non-verbal signs that were available for me to observe. Also, it could be that the participants might have felt more at ease having the conversation in person and would therefore have felt more able to share information. I felt that, despite the format, good rapport was established with all of the participants based on my own feeling and also on many of the participants volunteering feedback at the end of the conversation saying that they had felt comfortable throughout and found the conversation enjoyable.

There were also limitations in terms of gender and ethnicity in the sample, with all bar one of the participants being male and only one of the participants being non-white. Furthermore the setting of the intervention being in a private facility meant that there were also economic limitations to the demographics of the participants.

4.6 Future research

As mentioned above, only one of the study participants, was of non-white ethnicity. She was also the only female in the study. The experiences discussed by the participants may have been impacted by their own characteristics and intersectionality which may be

different to those from different genders, cultures, and ethnicities. It would be of value to future research into this area to include participants of wider ethnicities, cultures, and genders to see whether their lived experience of trauma reduction treatment varies from this study and how these influences shape people's views and descriptions of their experiences of the study area.

As discussed earlier in section 4.5, it could also be argued that since all the participants attended the same aftercare group and therefore all were perhaps of a similar positive viewpoint as to the worth of the TRP, then an area of future research could be into this aspect. The research could try and recruit participants who had completed the TRP and chosen not to continue with the aftercare group, perhaps indicating a less favorable experience of the TRP or just different. I note not involving the aftercare group may cause practical challenges with recruiting as well as potential ethical challenges in terms of potentially reducing the ongoing support structure available to participants.

Another area for possible future research relates to the risk described in 4.5 that participants may have felt under pressure to participate in the research from the aftercare facilitator who is also acting as gatekeeper. A future study could instead consider recruiting participants in a similar study without using the facilitator in a gatekeeper role.

Further research may also want to include a quantitative element, in order to be able to include outcome measures to better understand the efficacy of the TRP being looked at both in terms of trauma symptoms and addiction recovery measures.

A potential area for future research could be to consider using an alternative method, such as narrative analysis as used in Waters et al, 2014, in order to draw out different perspectives and meanings on how identity may be reformulated after taking part in the TRP, since using IPA whilst giving insight to lived experience does not tell you about identity.

Future research would also benefit from taking a longitudinal stance to again better understand the interaction effect of the TRP on the addiction recovery journey of the participants longer term.

This research focused on an example of sequential trauma reduction treatment, after participants first completed addiction treatment. Further work looking into the experience of attending concurrent addiction and trauma treatments would be beneficial to understanding whether these different formats are experienced differently by service users.

4.7 Implications for Counselling Psychology

It is the duty of Counselling Psychologists to use knowledge to “inform practice and be able to promote awareness of actual and potential contribution of psychological services” (HCPC, 2015, p.23). Spivak and Willig (2010) indicated that listening to individuals’ needs and recommendations can be critical to improving clinical practice and treatment provision.

I reflect here on what the potential practical implications of the knowledge gained from my study are for Counselling Psychology. The phenomenon explored in this study being a trauma intervention as experienced by addicts in recovery is very much relevant to both research and clinical practice in the field of Counselling Psychology.

Counselling Psychologists work both clinically and as researchers with individuals who are struggling with both addiction and trauma and as such insight into this area is highly relevant.

The phenomenon was explored using the qualitative phenomenological method of IPA and this approach allowed for a deep exploration of the subjective lived experience of recovering addict participants attending a TRP (Smith et al., 2009). This approach is very much in line with the humanistic ethos held by Counselling Psychology which stresses both the importance of subjectivity and intersubjectivity (Douglas et al., 2016).

Supporting social justice through research, clinical practice and engagement with policy is an important feature of Counselling Psychology (Douglas., 2016, Milton, 2010., Moradi et al., 2010). In order to do this effectively it is vital that Counselling Psychologists are well informed in regard to the factors effecting the areas they practice in so as to be aware of any blind spots or oppression taking place, such as stigma or overlooked groups. This research focuses on the experience of a vulnerable and often stigmatised social group, members of whom, to date, have not been given a voice to express their lived experience of attending a trauma focused intervention while in addiction recovery. Raising awareness of the lived experience in this area will allow for Counselling Psychologists to design and put into practice interventions and policies that are better informed. It is my hope this awareness can also be extended to the Counselling Psychology training institutions so as to help Counselling Psychologists become more sensitive to the lived experience of self-identified addicts attending trauma treatment.

Analysis of my study's findings indicates a need for an integrated, holistic approach to addiction treatment. In practical terms, that appears to translate into recognising the study participants' experiences and concerns about their emotional processes (issues with childhood trauma, shame, low self-esteem) being regarded as part of and as important as treating the physical nature of their addiction (direct addiction treatment). It is my hope that this research will raise awareness of the PIT informed TRP as the findings that came out of the analysis seem to indicate potential benefits for service users. It is worth noting that, although the PIT approach looked at indicated it had benefits, the cost of attending prohibits access to all. Counselling Psychologists could perhaps consider how elements of this approach could be integrated into other approaches that are more accessible.

This study, when looked at through the lens of theory as described in sections 4.2 to 4.4, has highlighted a number of suggestions for counselling psychology.

Counselling Psychologists could consider the implications of how strongly this study indicates that recovering addicts want to have their voices heard in terms of any research into interventions with a focus on developmental trauma and the recovery journey and try and address this gap with further qualitative research facilitating voices being given to this, often stigmatised, group.

There is a strong indication, from this study, that a BDMA understanding of addiction can feel limited and leave individuals who attend forms of addiction treatment that solely apply this understanding feeling misunderstood. This sense of feeling misunderstood could lead to further marginalisation of this group as

well as higher risk of early drop out from treatment and relapse. The themes in this study indicate that a more trauma-based understanding of addiction is what resonated with the lived experience of the participants. The inclusion of this trauma-based understanding in clinical practice for addiction as well as policy considerations when planning and delivering addiction treatment policy is vital.

Furthermore, Counselling Psychologists could consider the implications of how strongly the participants in this study expressed the view that TRP treatment is an important part of an integrated approach to addiction treatment and that this observation is supported more widely through the lens of theory as discussed earlier. Counselling Psychologists could therefore consider including developmental trauma assessments, perhaps through the ACE questionnaire, but also other psychological assessments such as for attachment style, for service users as part of their treatment planning.

In addition to dealing with the trauma aspects of addictive behaviours, this approach may help build the relationship with service users to improve the likelihood of successful addiction treatment and reduce the likelihood of relapse and treatment drop out. It is noted that using the ACE questionnaire alone has been found not always to capture the gravity of the experience and so a trauma informed framework along with the ACE questionnaire might be a better approach in order to capture the lived experience of service users (Mendel, Sperlich & Fava, 2021). Treating addiction in isolation may potentially miss fundamental aspects of the addiction process such as underlying trauma.

This study indicates that the TRP treatment itself is just part of the process and it may be important to have well organised aftercare support in place so that recovering addicts continue to have the group support of others who have been part of a similar TRP that they have experienced. Continuing to have that trust and connection with others was indicated to be a crucial part of the TRP process. Counselling Psychologists may also benefit from consideration of this for service development going forward.

4.8 Reflexivity

My initial experiences of attending a PIT informed TRP as part of my work experience and training prior to starting the DPsych gave me a curiosity about this intervention. The gap in the literature on this area and specifically on the PIT approach further fuelled my desire to do research into this area. My curiosity initially took the form of wondering about efficacy and so initially my plan had been to do a quantitative study focusing on outcome measures to try and measure the effectiveness of this intervention. Whilst still a valuable piece of research to be done, the literature review also showed the benefit of doing a piece of qualitative research in this under-researched area. This also fitted with the limited time and other resources available to me. This change of direction happened early on in my research journey which allowed me the time to reflect on what I really wanted from this research. My move to a more phenomenological approach in this research felt aligned to my personal journey as part of the Counselling Psychology training. By this I mean that a more subjective focus on individual lived experience, using IPA, is both more in line with COP values and my own personal understanding of the world and people. I realised as part of my reflection process that I identify as a social constructionist and this reflection and, I believe,

subsequent growth has benefited me personally, professionally and academically as a researcher. I believe the benefits have come in the form of increased flexibility in my thinking and a more consciously open-minded approach to people.

In research terms, reflexivity requires self-awareness about how the researcher potentially influences the outcome of research due to their own approach and assumptions when searching for meaning in the data (Finlay & Gough, 2003). An example of this is that I started this research journey with an assumption that recovery was abstinence-based. I quickly became aware of my assumption and realised that recovery was subjective, and abstinence was only one of many understandings of it. Not only did my own personal view change as a consequence of the research but also my self-awareness which allowed me to better bracket my views and assumptions.

I was aware of the need to allow the participants space to open themselves up and speak freely in the interviews as well as for me not to engage with them as a therapist, a behaviour I could quite easily move into. My role on this study was as a researcher, and I prepared myself for this prior to each interview with a brief meditation exercise with a focus on breathing exercises to relax myself and focus directly before each interview. I had the interview schedule of questions to hand and briefly refreshed my memory on the schedule prior to each interview then kept the schedule of questions out of sight of the participants. I wanted the interviews themselves to be a conversation and feel like this to the participants rather than feel like a formalised meeting. This was to relax the participants and avoid any feeling that there were any expected or correct answers to my questions. I was careful about not making comments during their responses to avoid interrupting their natural conversational flow.

However, I used my body language to show that I was listening and highly present throughout the conversation. I did not use the interview schedule questions as a checklist, just a guideline to keep the interview flexible. I also changed the order of my questions at times, as the participants would answer some of my planned questions before I asked them. On some occasions I used my prompts to encourage them to expand on their answers and speak more about a particular question. I was always conscious of the need to collect data through their accounts while encouraging the participants to explore their experiences freely and without any direction from myself. On occasions it was challenging to separate my therapist identity from my role as researcher, but I was mentally prepared for this, and, listening back to the recordings of the interviews and reading the transcripts, I believe I maintained my role as researcher throughout the seven interviews and also maintained this separation of roles throughout the research.

Throughout the study, I have continued to reflect about my own life experiences, assumptions, preconceptions and in particular any biases regarding the study subject matter and sought to, as far as possible, bracket them and remain open minded and reflective as to the lived experience of the participants (Finlay, 2008; Smith, Flowers, & Larkin, 2009). I was also aware that my own lifeworld would play a role in influencing the interpretive process (Smith et al., 2009). To mitigate the extent that my lifeworld came into the interpretation process I stayed close to the information provided by the participants and used a triangulation approach, by passing my interpretations past my supervisor and research working group.

As I noted in Chapter two, Methodology, my concern here has been that completely bracketing all such preconceptions, assumptions and

biases is very difficult in practice. Allen-Collinson (2009) has argued that complete bracketing cannot be achieved so researchers should instead seek to be self-critical and self-aware so they can more effectively be aware of any preconceptions, assumption, or biases. Throughout the research I have therefore sought to either suspend or at the very least be aware of these views and monitor my reactions and feelings during the study. Through maintaining a personal journal, personal therapy and self-reflection, I have sought to work on elucidating the parts of myself that I am less familiar with in order that I can be more conscious of any assumptions and biases I might be bringing to the research process.

Though I attempted to maintain a reflexive attitude prior to my research study, I believe the reflexive attitude I have used in carrying out this study has now become a deeper part of how I carry out my current client work as well. I believe that, even more than was previously the case, I attempt to engage in more self-enquiry by writing careful personal reflections on how I approach clients' assessments and treatment plans.

The epistemological stance taken assumes that the findings can only give us a glimpse of the different realities of the participants in this study (Willig, 2013) and I feel this research has met its goals of offering some insight into the experience and meaning-making of attending a TRP whilst in recovery from addiction.

4.9 Summary and Conclusions

Research indicates that trauma is positively correlated with addiction (Van Dam, et al., 2014; Fuchshuber, et al., 2018; Hagborg, Thorvaldsson, Fahlke, 2020). However, despite this correlation, in practice addiction treatments often focus on addiction treatment in

isolation, without the inclusion of trauma reduction treatment (Wiechelt, 2014). This gap in the research literature has been the driver for this study. The findings of this study offer the following insights regarding the experiences of recovering addicts of attending a TRP and specifically in terms of the given research question:

What is the lived experience of recovering addict participants attending a PIT informed trauma reduction programme?

Seven participants participated in the study. IPA analysis of the transcription texts resulted in three superordinate themes and twelve emergent themes reflecting how attending the TRP helped the individual participants make meaning out of their lived experience. The participants' experience of making sense of their emotional reactions to their negative childhood memories was illuminated by the first superordinate theme. The second superordinate theme highlights the participant's search for external relief from these strong negative emotions. The final superordinate theme showed the participants letting go of the shame they had been carrying and reaching a deep acceptance of themselves.

The openness and enthusiasm all participants showed in sharing their various lived experience resulted in data that was rich in content for my study. The participants in the study all expressed a strong belief in the worth of TRP and its value in helping each of them maintain a stable recovery from addiction. As a result, I believe that the insights obtained from this data have potentially significant implications for addiction treatment.

A takeaway from the experience of attending the TRP, that was frequently referred to by the participants, was a reduction in the intensity of their emotions and related fear of being overwhelmed, as

well as less sense of being “triggered”. This reduction in emotional intensity therefore can be linked to reduced triggers for using addictive behaviours and so potentially less risk of relapse. It is also perhaps a sign of the perceived success of the TRP by the participants that they were able to look at their memories with more detachment.

Despite these positive views about the TRP, the participants did not simply see the treatment as a guarantee in terms of treatment success. They took a more considered stance on this. Participants instead noted that those undertaking the TRP must recognise, through it, the need to make changes to become more self-aware and have a different relationship with their emotions, rather than relapsing into seeking external ways to reduce their emotional pain.

The discussion within this chapter has sought to show how the findings from this study can be understood theoretically and to show how this adds to the field of knowledge. The findings are shown to be consistent with earlier research, for instance, that shame reduction is helpful to breaking the cycle of relapse (Flanagan, 2013). The study also contributes some novel findings: the first indicates that the participants experienced the inclusion of somatic techniques within the TRP as memorable, and positive. This appears to be an original finding of this study given the lack of studies looking at the experience of addicts attending trauma treatment, particularly treatments with a focus on childhood trauma.

Another novel finding from the study concerns low self-esteem and shame. While these are frequently described feelings by adult addicts in the academic literature, the IPA analysis used in this study gave a fresh insight into the sense the participants made of their lack of self-

esteem as stemming from their negative childhood experiences as well as driving their avoidance and addictive behaviours as adults.

A further original finding suggested from the study is that a treatment approach that feels aligned to service users own understanding of their addiction journey is more likely to get greater acceptance from them and therefore may lead to increased motivation for change and recovery.

An important finding from this study relates to the improvement in participant's levels of shame through self-compassion, rather than through purely cognitive means. Research is lacking into the subjective experience of shame following trauma interventions, but shame has been shown to strongly contribute to the maintenance of trauma symptoms and so this finding, although only anecdotally positive, should be considered in terms of clinical implications going forward.

In conclusion, the research has shown a change in perspective for the participants to a position where they can be accepting of their negative childhood experiences without feelings of personal shame and overwhelming anger towards others. In turn this is reflected in the resultant stability within their current families and relationships. The common theme expressed by the study participants was a strong belief that the TRP is significant to maintaining a stable recovery from addiction and therefore has an important role to play within an integrated addiction treatment programme.

The findings suggest that Counselling Psychologists would benefit from considering the inclusion of developmental trauma reduction treatment, such as the PIT informed approach, when working with

addicts in recovery as part of ongoing addiction treatment and recovery planning.

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APPENDICES

Appendix 1: Post Induction Therapy (PIT)

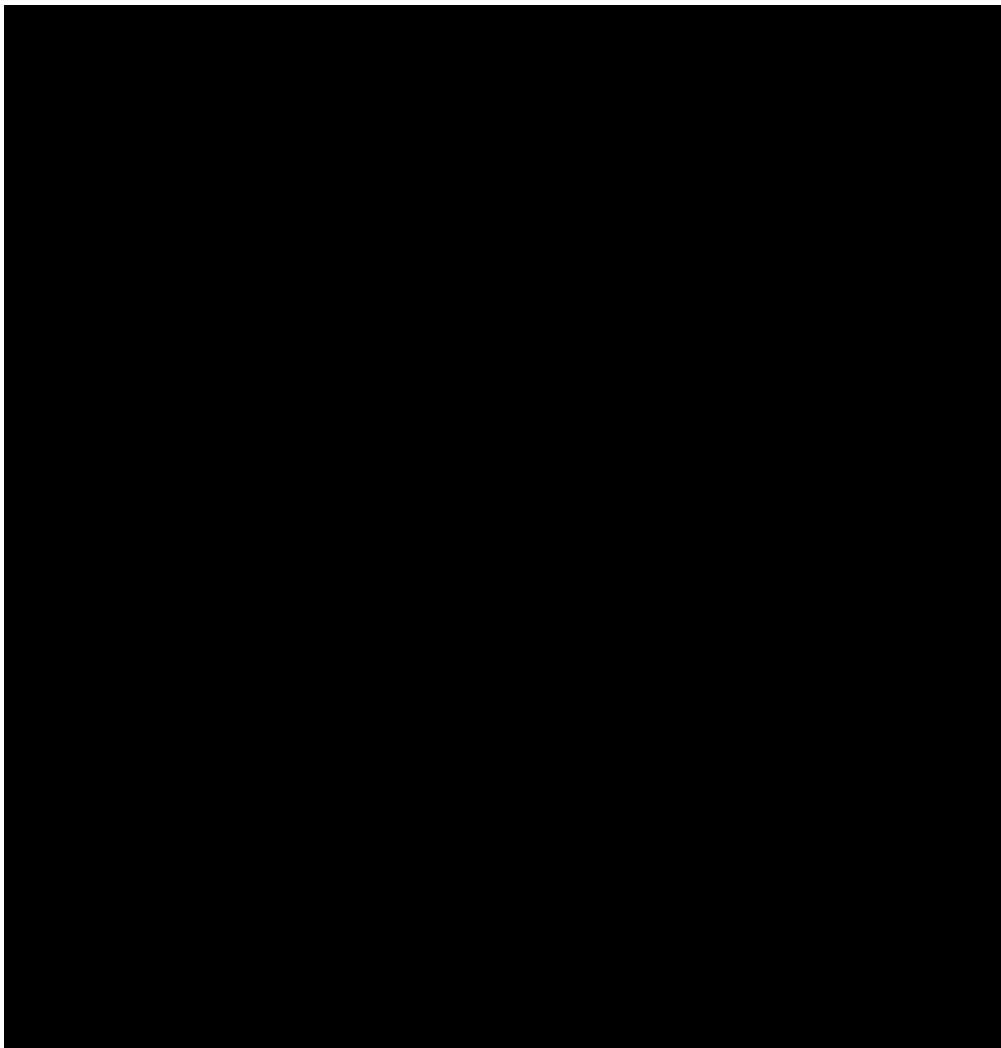


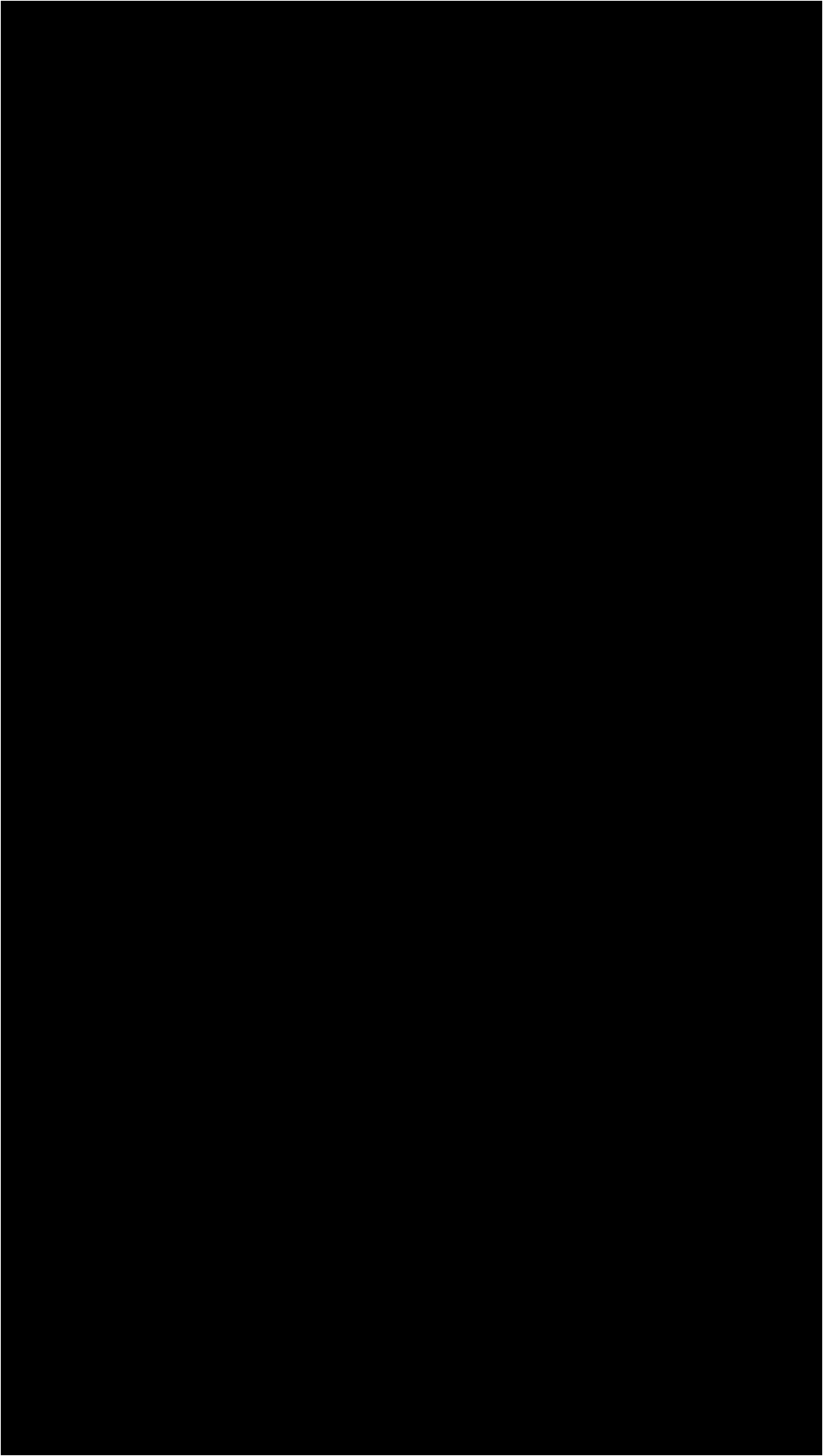
Introduction

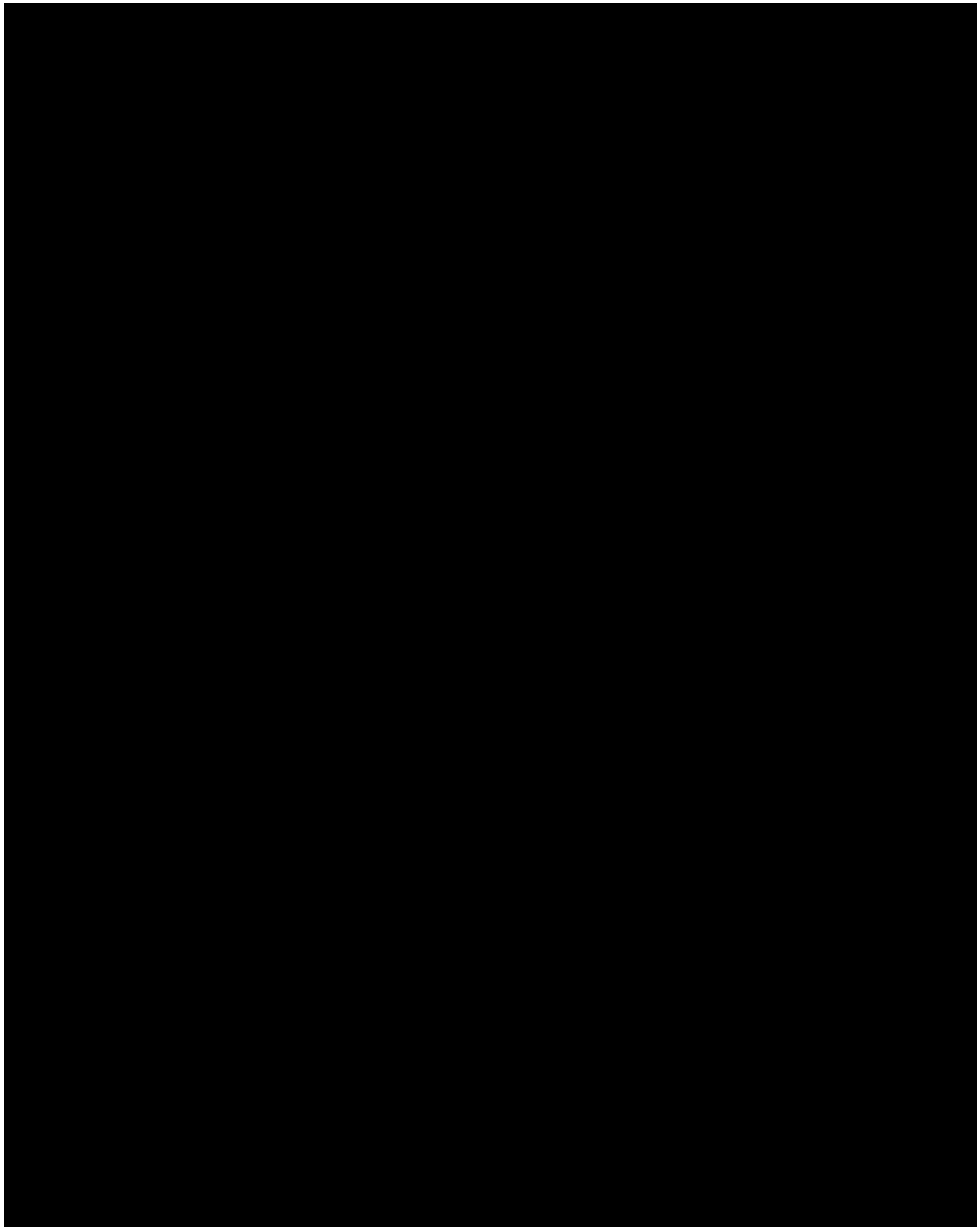
PIT is a five-day group trauma reduction therapy programme run on an outpatient basis in the UK. The focus of the intervention is on developmental trauma. PIT uses an integrative approach informed by Gestalt, Family Systems theory, Transactional Analysis and Rational Emotive Therapy.

All participants are asked to complete a family of origin form and a history of relational trauma worksheet and timeline in order to appropriately arrange the groupings of the session (Bridge, 2016; Melody, 2003).

Structure of the programme (Bridge, 2016; Melody, 2003).







Appendix 2: Recruitment Email

Date: February 2021

From: Jonathan.smy-aristizabal@city.ac.uk

Subject: Participants needed for research in experience of PIT informed therapy

David has kindly sent this email on my behalf to all members of the aftercare group. I am carrying out a doctorate in Counselling Psychology at City, University of London. As part of this I am carrying out research into experiences of trauma reduction therapy through the Post Induction Therapy (PIT) informed model whilst in recovery from addiction treatment. Participation will involve taking part in 1-2 interviews for approximately 60-90 minutes each. The study is offered with complete anonymity. If you are interested in learning more about the research and potentially taking part in it, we can arrange a short phone call to discuss. I have outlined the purpose of the study below.

Outline Purpose:

Addiction is a global challenge causing widespread economic, societal and personal problems. Yet there is a lack of research into recovering addicts own perception of treatments that include trauma reduction therapy such as that offered by the PIT informed model of trauma reduction as part of addiction treatment. The study is interested in what that experience was like for you and aims to give voice to what is an under-represented group in the academic literature.

Participation in the project is voluntary, and you can choose not to participate in the project. It is up to you to decide whether to take part. If you are interested in having a brief discussion, please contact me by email and I will arrange a phone call so we can discuss in more detail. Prior to the call I will also send you an information sheet giving more detail about the study as input to the conversation.

If you are interested, please contact me on Jonathan.smy-aristizabal@city.ac.uk

Many thanks

Jonathan Smy-Aristizabal

If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at dataprotection@city.ac.uk

Appendix 3: Participant information sheet



REC reference number: ETH2021-0673

Date: February 2021

Title of study: What is the lived experience of recovering addict participants attending a PIT informed trauma reduction programme?

Name of principal researcher: Jonathan Smy-Aristizabal

I am carrying out a doctorate in Counselling Psychology at City, University of London. I would like to invite you to take part in my research into your experience of trauma reduction therapy (through the Post Induction Therapy (PIT) informed model of trauma reduction) whilst in recovery from addiction treatment.

Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. You will be given a copy of this information sheet to keep.

What is the purpose of the study?

Addiction is a global challenge causing widespread economic, societal and personal problems. For instance, the World Health Organisation estimates that approximately 31 million people globally have a drug use disorder. Yet there is a lack of research into recovering addicts own perception of treatments that include trauma reduction therapies as part of addiction treatment therefore not giving a voice to recovering addicts and their experiences into this area. Hence the purpose of this study is to better understand the lived experience by the participants of psychological therapy with a focus on past trauma whilst in recovery from addiction treatment such as that offered by the PIT informed model of trauma reduction. The study is interested in what that experience was like for you and aims to give voice to what is an under-represented group in the academic literature. The study is being undertaken as part of a training to obtain

a Professional Doctorate in Counselling Psychology and is due to be completed in September 2022.

Why have I been invited to take part?

You have been invited to take part in this study as you have the kinds of experiences that the study is interested in learning more about. More specifically, you are an adult (18 or above), you have completed a PIT informed trauma reduction programme as part of an addiction treatment programme and you are in recovery as part of an after-care support group.

Do I have to take part?

Participation in the project is voluntary, and you can choose not to participate in the project. It is up to you to decide whether to take part. If you do decide to you will be asked to sign a consent form. However, even if you decide to take part you are still free to withdraw any time before commencement of the transcribing process (4 days after the interview) without giving a reason. At this stage, all records and data pertaining to your participation will be deleted. After transcribing starts you will no longer be able to withdraw your anonymised and confidentially handled data.

What will happen if I take part?

Participation will involve a 60-90 minutes interview that it is expected (due to the current Covid-19 pandemic) will take place over Zoom at a time of your choosing. Potentially (and only if this acceptable to you) there will be a second, follow up interview. Before the initial interview, a pre-interview telephone call will be set up with myself to ensure the research study will be appropriate for you and will also be an opportunity for any questions you have to be answered. Between recruitment and the interview, I will be available (via email, telephone or Zoom) to ensure you have all the information you require and are able to ask any questions. The study will then require you to sign and return a consent form before meeting virtually to conduct the interview. No preparation is required for the interview or interviews. At the end of the interview, you will be given a debrief sheet. Before ending the meeting, you will again be given the chance to ask any further questions and thanked for your participation.

What are the possible disadvantages and risks of taking part?

Questions that pertain to trauma treatment could potentially be upsetting to some participants although the subject matter asked about in the interview will be related to content covered in the PIT treatment process and aftercare group and so should not be unfamiliar. To mitigate any risk of distress to participants I will conduct the interviews in a sensitive manner keeping in mind not to be intrusive with the questions, this will be achieved by regularly checking that all participants are feeling comfortable with the subject matter and are aware they can ask for a break or end the interview at any stage. Participant will dictate the content of the interview and no pressure to discuss content that might be upsetting will be applied. All precautions will be taken to allow participants space to discuss the areas they feel most comfortable with.

What are the possible benefits of taking part?

There is a lack of research into recovering addicts own perception of treatments that include trauma reduction therapies as part of addiction treatment therefore not giving a voice to recovering addicts and their experiences into this area. Taking part in the study will be an opportunity to allow your voice and experience to better inform academic research on this area and give new viewpoints reflecting the lived experience of such treatment.

Conflicts of interests

There are no conflicts of interests between the researcher and the topic being studied.

What should I do if I want to take part?

If you wish to take part please contact me on Jonathan.smy-aristizabal@city.ac.uk

Data privacy statement

City, University of London is the sponsor and the data controller of this study based in the United Kingdom This means that we are

responsible for looking after your information and using it properly. The legal basis under which your data will be processed is City's public task.

Your right to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personal-identifiable information possible (for further information please see <https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/>).

City will use your name and contact details to contact you about the research study as necessary. If you wish to receive the results of the study, your contact details will also be kept for this purpose. The only people at City who will have access to your identifiable information will be the principle researcher. City will keep identifiable information about you from this study for 10 years after the study has finished.

You can find out more about how City handles data by visiting <https://www.city.ac.uk/about/governance/legal>. If you are concerned about how we have processed your personal data, you can contact the Information Commissioner's Office (IOC) <https://ico.org.uk/>.

What will happen to the results?

The results will be published as part of a doctoral thesis. They may also be used to inform future research papers or book chapters on issues pertaining to psychological therapy with a focus on past trauma whilst undergoing addiction treatment. Throughout all these publications, anonymity will be maintained. I would also be happy to send you a copy of the final research results. If this is of interest, please just let me know using the contact details given at the end of this information sheet.

Who has reviewed the study?

This study has been approved by City, University of London Research Ethics Committee.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is 'What is the lived experience of recovering addict participants attending a PIT informed trauma reduction programme?'

You can also write to the Secretary at:

Anna Ramberg Research Integrity Manager

City, University of London, Northampton Square London, EC1V 0HB

Email: Anna.Ramberg.1@city.ac.uk

Insurance

City University London holds insurance policies which apply to this study, subject to the terms and conditions of the policy. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Further information and contact details

If you require any further information or have any questions please get in touch with the principle researcher, Jonathan Smy-Aristizabal using the following email: Jonathan.smy-aristizabal@city.ac.uk

Thank you for taking the time to read this information sheet.

Appendix 4: Informed Consent Form

Name of principal researcher: Jonathan Smy-Aristizabal

REC reference number: ETH2021-0673

Title of study: What is the lived experience of recovering addict participants attending a PIT informed trauma reduction programme?

Please tick or initial box

1	I confirm that I have read and understood the participant information dated February 2021, for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged.	
3.	I understand that I will be able to withdraw my data up to the time of transcription (4 days after the interviews)	
4.	I understand that personal information may be shared with members of the research and/or teaching team at City, University of	
5.	I agree to the interview being audio recorded	
6.	I agree to the use of anonymised direct quotes	
7.	I understand that the duty of confidentiality is not absolute and in exceptional circumstances this may be overridden by more compelling duties such as to protect individuals from harm.	
8.	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
8.	I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.	
9.	I agree to take part in the above study.	

Name of Participant
Date

Signature

Name of Researcher
Date

Signature

When completed, 1 copy for participant: 1 copy for researcher file.

Appendix 5: Interview schedule



1) How did you come to have trauma reduction therapy? (Clarification - recommended once on addiction treatment programme? Did you select the treatment programme because of the PIT informed element?)

2) Could you describe what happened during trauma reduction therapy in your own words?

Prompt: what was helpful? What was missing? What did the therapy feel like?

3) How did you feel when you were in therapy?

Prompt: physically, emotionally, mentally? How did you interpret this?

4) What did you experience as the most significant challenge during the trauma reduction therapy?

5) Do you feel the experience of the trauma reduction therapy has impacted on your understanding of your relationship with addiction? If so, how?

6) How does it feel to consider recommending the trauma reduction therapy to a friend? How do you interpret this?

7) Do you think there is anything I have missed that could be helpful in understanding anything you want to say? (Optional)

Appendix 6: Debrief Information



What is the lived experience of recovering addict participants attending a PIT informed TRP?

Thank you for taking part in this study. Now that it is finished, we'd like to tell you a bit more about it.

Addiction is a global challenge causing widespread economic, societal and personal problems. For instance, the World Health Organisation estimates that approximately 31 million people globally have a drug use disorder.

Research studies give evidence of links between addiction and trauma. Yet there is a lack of research into recovering addicts own perception of treatments that include trauma reduction therapies as part of addiction treatment therefore not giving a voice to recovering addicts and their experiences into this area.

Hence the purpose of this study was to better understand the lived experience by the participants of psychological therapy with a focus on past trauma whilst in recovery from addiction treatment such as that offered by the PIT informed model of trauma reduction which you have been involved in. The study is interested in what that experience was like for you and aims to give voice to what is an under-represented group in the academic literature. You were therefore invited to take part in this study as you have the kinds of experiences that the study is interested in learning more about. More specifically, you are an adult (18 or above), you have completed a PIT informed trauma reduction programme as part of an addiction treatment programme and you are in recovery as part of an after-care support group.

If you have any concerns or questions about the study, please contact me, *Jonathan Smy-Aristizabal* including
REC reference number: ETH2021-0673 (Psychology Department)
Email Jonathan.smy-aristizabal@city.ac.uk

For further support or information regarding any relationship related concerns please see the below websites or contact your GP:

<https://www.nhs.uk/live-well/healthy-body/drug-addiction-getting-help/>

<https://www.alcoholics-anonymous.org.uk/>

<https://online.ukna.org/>

<https://www.samaritans.org/>

THANK YOU AGAIN FOR YOUR CO-OPERATION

Appendix 7: Sample of transcript 1

Emergent
themes:

*Accepting
without
judgement*

“so much
more
compassion
for people”
(1.2.3)

*Burying
painful
emotions
and
memories*

“pretended
that
everything
was normal”
(1.2.3)

*Not being
able to say no*

her life has
just been
about work”
(1.2.3)

P (1.2.3) Yeah, no it is, absolutely it is, and one of the things I, I feel, it sounds weird but I feel like it's a gift in a way, **having gone through that journey** because I feel now I've got so much **more compassion for people** which I didn't have before. I was always sort of, you know, I've always cared about people but I didn't

understand and I think with the Trauma Week in Arizona as well, **the people that I met there, I think that was incredible.** And it's something which I think is a real, it's a real blessing so I don't have, you know, I'm happy to talk about it, I mean I was in a right old state at one point, that's how I would describe it but that's, you know, that's just part of the journey and I think probably most, everyone's on a different point and there's no end, you know, we're just existing in just the most **functional, happy, peaceful** way we can. I mean the other thing I've got quite into is meditation and that sort of stuff as well, which I love, becoming a bit of a hippy, but yeah I mean that time, it was, it was very bad, I felt very alone, it was all, it was all the stuff which **I now understand** where those feelings came from. **Fear, isolation, abandonment,** all those things which came back from being in a house where, you know, I mean an example was my brother who passed away, he one time had to go to hospital to have his **face stitched up**, I mean I'm amazed that in those days **nothing was ever followed up** on and he spent the next two weeks sitting at our dinner table drinking his food through a straw and we all sat there and **pretended that everything was normal**, you know, because we were **all frightened of saying something** which would create some kind of reaction. So yeah that sort of stuff is, it was bound to come up. I think the other thing is some people are probably more sensitive than other people, I think I'm probably quite a sensitive person so I felt things quite deeply. I mean I've got a sister who is older who, I mean I guess she was old enough to remove herself a little bit from the situation when it was happening, she could spend time with her friends but she's now **very, very senior** at one of the top accounting firms, one of their top partners, she's an absolute, you know, **high flyer**. She's also a compulsive fixer so she picked up that as well so it affects everyone differently and **her life has just been about work** really, I guess, whereas I'm, you know, work for me is, I like to be interested in stuff and to do something which makes me feel like I'm doing something worthwhile but it's a means to an end as well. It's that balance.

Initial exploratory notes taken:

People at TRP were incredible.

Learning the importance of compassion, love.
Understanding of his own emotional pain.

Painful memories. Feelings of fear, isolation, being abandoned.

Bad things happen to his brother. Badly injured. Nothing done about it. Pretended all was ok.

Fear by everybody.

He learnt that money, status, never refusing opportunities was the way forward?

Importance of money and status noted. Linked to importance of role. The importance and value that his father attributed to these things explicitly noted "high flyer".

Appendix 8: Example of interim table of emergent and superordinate themes (for transcript one)

Shows details of the interim table that was produced for the first transcript that sought to organize the three levels of description (descriptive, linguistic and conceptual) and to start to make the connections to emergent themes and superordinate themes for the participant.

Transcript Number	Descriptions frequently used	Key linguistic comments	Key conceptual comments	Resultant emergent	Superordinate emergent
	Father was “unable to cope” “violent” “anger” “dark moods” for father and siblings, He was always “feeling attacked”,	“I was the youngest, he was unable to cope with life” (1.1.1) “all frightened of saying something” (1.2.3) “I mean I remember being thrown across rooms by my hair loads of times and stuff like	He was “conflict averse” (1.1.1) “I was surrounded by violence everywhere” (1.4.1) The family “pretended that everything was normal” (1.2.3)	Negative childhood experiences Burying painful emotions and memories	Intense fears of painful emotions and memories

	“Work”, “Workaholic”, “Money”, “Senior”, “high-flyer” “people pleasing”	“really top chef” (1.1.1) “run my own company” (1.1.1) “her life has just been about work” (1.2.3) “had her on a pedestal” (1.2.3) “how he saw success” (1.2.4)	“I had people working for me all over the place” (1.1.2) “the way I dealt with it was a whole range of different things when I look back at it and it’s amazing how oblivious one can be. I mean work”	Be seen as a success by others Not being able to say no to work	Seeking success
	“learning to say no” “boundaries”	“what’s happened to him... because he’s really helpful” (1.1.2)	“just learning to say no” (1.1.2) “practice saying no” (1.1.2)	Right to say no	Accepting with compassion and without shame or judgment

	“catching up”	“it was catching up” (1.1.1)	“it all catches up with you eventually” (1.1.1)	Avoidance of conflict in adult life	Intense fears of painful emotions and memories
	“buried”	you get on with stuff” (1.1.1)	“I probably buried which was quite toxic” (1.1.1)	Burying painful emotions and	

	“no judgment”, “group dynamic”, “connectivity”, “use a language”, “open up”. “journey”	“having gone through that journey” (1.2.3), “having gone through that journey rather than just thinking oh what a bastard they are, often I’ll sort of think well where’s that coming from” (1.8.3) “before I did all this stuff I was always feeling attacked” (1.8.3) “at the end	“because I feel now I’ve got so much more compassion” (1.2.3), “to be able to open up” (1.3.1), “because that’s quite hard when you’ve buried stuff for all those years. “it’s not like that anymore, you know, and they can see whatever they want and no-one gets judged” (1.9.1) “I just	Accepting without judgement	Accepting with compassion and without shame or judgment
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	“Binge drinking”, “Exercising like a lunatic”,	“I just kind of isolated, drank, didn’t see anyone at all” (1.2.1)	“Trying to medicate” (1.2.1)	Medicati ng	Intense fears of painful emotions and memorie
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	“Different groups”, “AA”, “come to terms with the child trauma”	“I started going to AA” (1.2.1), “I’d gone to loads of different, I tried all sorts of different groups” (1.5.2), “I did a lot of things and, you know, so I stopped drinking, I’d stopped all that sort of stuff and then I went back into it again” (1.5.2), “things I’ve used to numb certain feelings” (1.5.3) “trauma reduction	“I don’t think you can do this kind of work until your head is in a space where you’re actually dealing with the stuff which has gone on over the years, as opposed to trying to medicate” (1.2.1), “I think AA is much harder and it’s like, you know, you’ve got to stop that, that’s it” (1.6.2),	Need to confront causes rather than medicate Confront shame	Accepting with compassion and without shame or judgment
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Appendix 9: Example of interim table of emergent and superordinate themes (for transcript seven)

Shows an example of the interim table that was produced for the seventh transcript that sought to organize the three levels of description (descriptive, linguistic and conceptual) and to start to make these connections to emergent themes and superordinate themes for the participant.

Transcript Number	Descriptions frequently used	Key linguistic comments	Key conceptual	Resultant emergent	Superordinate emergent
	“drinking”, “depressed”, “suicidal”, “anxiety”, “co-dependency”,	“I was very depressed and suicidal” (7.1.1) “never considered myself an alcoholic” (7.1.1)	“off the chart in anxiety” (7.1.1) “co-dependency” (7.1.1)	Having a language to explain	Accepting with compassion and without shame or judgement
	“I don’t identify as an alcoholic”, “I never thought I had a	“I don’t identify as an alcoholic, but to be honest with you it’s sort of angels on a pinhead” (7.3.1)	“I never thought I had a problem ... Would I say I am in recovery, yes I would” (7.3.1)	Need to recognise causes rather than medicate	Accepting with compassion and without shame or judgement
	“pornography”, “sex”, “alcohol”	“I was also using pornography a lot and I went to a sex addict sort of centre” (7.3.1)	“My acting out was probably alcohol and porn” (7.4.1)	Drinking and pornography as ways of medicating	Avoiding conflict due to

	“shame”, “rage”, “anxiety”	My mother had an affair, this is pertinent” (7.4.1)	“I was very young and I sprang them”	Negative childhood experiences	Avoiding conflict due to memories of shame
	“importance”, “perfect”, “tough”, “control”	“I had quite a, quite an important job” (7.4.1) “show people that I was tough and in control” (7.4.1)	“All my decisions had to be perfect” (7.4.1) “that ...”	Importance of appearing successful	Seeking success to protect external image of control
	“mother”, “awful behaviour”, “father” “nicest” “shielding”	“I’d written a lot about my mother and very little about my father” (7.5.1) “you’ve mentioned nothing about your father and she started to open the door” (7.5.1) “nicest and kindest man I know” (7.5.1) “if we get upset	“you’re describing yourself” (7.5.1) “we’ve been shielding” (7.5.1)	Hiding from memories Avoidance of conflict in adult life	Avoiding conflict due to memories of shame
	“never complain”	“goes out of his way to help people and will never ever complain” (7.5.1)	you’re describing yourself” (7.5.1)	Afraid to be judged	Seeking success to protect external image of control

	“Shame”, “empathy”, “group”	“I realised I was actually just full of shame from my parents” (7.4.1) “shame’s got nowhere to hide”. (7.5.2) “like a weight had lifted off my shoulder” (7.5.3) “family of origin” (7.5.1) “wounded child” (7.5.3) “codependency ... made a huge amount of sense so lightbulbs are already going off” (7.5.3)	“That empathy really helps, helps people in the group listening to others” (7.5.2) “very supportive environment that was without judgement” (7.5.3) “And I was crying like a baby, I was holding this and crying and it really surprised me where	Confront shame Accepting without judgement Having a language to explain	Accepting with compassion and without shame or judgement
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“uncover”, shone a light”, “accepting ”, “supportiv e”, “unjudgme ntal”	“still scared about what I was going to uncover and what the end of it was going to be but in a comfortable way” (7.6.1) “less anxious about what people would think of me” (7.6.1) “I feel much better in myself” (7.6.1) “authentic inner child”, “wounded child” (7.7.1)	“shone a light into the dark corners” (7.6.1) “more accepting of myself” (7.6.1) “My challenge was nervousne ss about how I would be judged”. (7.7.1) “a surprise that I had to readjust my, my own	Confront shame Right to say no Acceptin g without judgemen t Having a language to explain	Acceptin g with compassi on and without shame or judgeme nt
“drinking”, “run”	“I just did that to run away” (7.9.1)	“Because for me it got to the source of it” (7.9.1)	Hiding from memories	Avoiding conflict due to memories

	“question”, “realise”, “huge”	“the trauma course just knocked all the other skittles out” (7.9.2) “stuff like perfectionism and rage and angst and anxiety, that’s all tailed off” (7.10.2) “if I hadn’t done that I would have kept on making the same mistakes in my relationships” (7.12.1)	“because it made me question my processes and it made me realise where they were coming from” (7.10.1) “living with it has made a huge difference” (7.10.1) “co-dependency”, “wounded child”,	Accepting causes of conflict avoidance behaviour Having a language to explain	Accepting with compassion and without shame or judgement
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Appendix 10: Summary table of the superordinate and emergent themes (for transcription one)

The summary table shows the final position for the superordinate and associated emergent themes arising from the transcript along with some illustrative comments and associated references from the interviews that illustrate each theme.

Superordinate theme	Associated emergent theme	Comments to illustrate each theme	Reference in transcription
Intense fear of painful emotions and memories	Negative childhood experiences	Father had “dark moods, anger, violence”.	1.1.1
	Burying painful emotions and memories	“pretended that everything was normal”	1.2.3 1.1.1
	Avoidance of conflict in adult life	“having been brought up in a violent household I was conflict averse”	1.2.1
	Medicating to numb out feelings	“Trying to medicate”, “I just kind of	

Seeking success	Be seen as a success by others	“I had people working for me all over the place”	1.1.2
	Not being able to say no to work	“the way I dealt with it was a whole range of different things when I look back at it and it’s amazing how oblivious one can be. I mean work”	1.1.1

Appendix 11: Summary table of the superordinate and emergent themes (for transcription two)

The summary table shows the final position for the superordinate and associated emergent themes arising from the transcript along with some illustrative comments and associated references from the interviews that illustrate each theme.

Superordinate theme	Associated emergent theme	Comments to illustrate each theme	Reference in transcription
Inability to relate to others in response to emotional abandonment	Negative childhood experiences	“there was a lot of emotional neglect and emotional abandonment”	2.3.1
	Shamed and angered by memories of bullying	“I was unhappy every day at school, I hated school, I was bullied, I was victimised”	2.3.1
	Unable to relate to others but fearful of being alone	“when I didn’t have a girlfriend on a Saturday night I had to get in the car and drive to a 12-step meeting because I couldn’t be on my own”	2.5.1 2.6.1
	Conflict with others due to being fearful of	“I found that very difficult, Jonathan, because he didn’t speak like I do	

Search for external relief	Search for an external solution	“I kept going to, kind of moving around different 12 step fellowships, Co-Dependents Anonymous, ACA which was Adult Children of Alcoholics” (7.1.1)	2.1.1
	Gambling and intense work as ways of numbing	“for example, um,	2.4.4

Acceptance of himself and others	Recognition of own emotional needs rather than seeking external solution	“I’m much more able to set limits, look after myself, you know, take care of myself”	2.4.4
	Willingness to change	“you can get plenty of people who do trauma week and they won’t benefit because they’re not going to, you know, they’re not going to apply it so I have no hesitation in recommending it, but it needs to be done in the right way and at the right time”	2.13.1 2.4.1
	Importance of being safe and connected in the group	“I built up quite a strong, you know, I felt very sort of, if you like, affectionate towards the therapist or sort of, it was quite a strong connection”	2.9.1
	Having a language to explain		2.5,1
	Being able to be alone	“you say, what’s going on, who’s voice is this, what age is it, what part of me, what would functioning adult say” (7.9.1)	2.15.1
		“I’m better off being on you	

Appendix 12: Summary table of the superordinate and emergent themes (for transcription three)

The summary table shows the final position for the superordinate and associated emergent themes arising from the transcript along with some illustrative comments and associated references from the interviews that illustrate each theme.

Superordinate theme	Associated emergent theme	Comments to illustrate each theme	Reference in transcription
Intense anger in response to painful emotions and memories	Negative childhood experiences	“feeling a lot of guilt....I cannot be ungrateful to the people that raised me”	3.8.1
	Hiding from memories of loss	“And a lot of the doors and the gates that I had closed re-opened” (3.1.1)	3.1.1
	Controlling others to manage conflict in adult life	“I’ve been able to manage my life this way because everything was under control”	3.1.1
	Rage, work and over-eating as ways of medicating to numb feelings	“one of my addictions was rage, I was 100%”	3.4.1

Living life with a continual sense of urgency and need for success	Feeling powerless in a cycle of judgement	“a sense of you have no control of your life” (3.10.1)	3.10.1
	Be seen as success by others	“I was surrounded by people that were scrutinising me”	3.1.1
		“this sense of urgency makes me always just to want to	3.10.1

Accepting with compassion and without shame or judgement	Need to recognise causes rather than medicate	“now that I’ve peeled the onion of the trauma that I’ve been a victim of, how do I then counter its necessity, tendency to express itself in the media of addiction”	3.17.1
	Accepting causes of conflict controlling behaviour	“because I can identify when I have these shame and blame attacks, I can also see and it’s like I can accept things”	3.12.1
	Confront shame		3.8.1
	Having a language to explain	“What I’m carrying away I need to let go”	3.3.1
	Importance of the group	“I realised that it’s like I had glasses, you know it’s like I was colour blind”	3.5.3
	Accepting and managing of	“this very close group I could open more” “you’re so self-aware	3.15.2

Appendix 13: Summary table of the superordinate and emergent themes (for transcription four)

The summary table shows the final position for the superordinate and associated emergent themes arising from the transcript along with some illustrative comments and associated references from the interviews that illustrate each theme.

Superordinate theme	Associated emergent theme	Comments to illustrate each theme	Reference in transcription
Avoiding intimacy in response to painful memories of enmeshment and violence	Negative childhood experiences Shamed by memories of violence and rejection	“an eye-opener to have the therapist, you know, help me see that actually that is enmeshment” “shame that, that I had, that I had picked up from my dad as a child,”	4.2.2 4.2.2
	Seeking space to avoid feeling suffocated in relationships Addictive behaviour to cope with life	“feel suffocated and want to push them away” “I looked to external things to change my behaviour”	4.2.2 4.6.1

Accepting with a sense of freedom and without shame or judgement	Need to recognise causes rather than medicate	“that’s when those pieces really fell into place”	4.2.2
	Importance of the group	“it’s probably the most well I’ve ever felt in my life. I just felt completely looked after and supported”	4.2.1
	Confront shame and anger	“I felt a lot of anger dissipated quite quickly, having done the trauma programme, anger towards my parents, I felt that I just didn’t carry that sort of anger that I had towards them in the same way”	4.4.1
	Having a language to explain		4.4.1
	Sense of freedom	“I feel like the trauma programme was an opportunity to sort of really drill down deep into some of the childhood stuff which I’d sort of been able to like skim the surface of it in recovery”	4.4.1
	Accepting and managing of	“I do remember afterwards feeling a sense of freedom”	4.6.1

Appendix 14: Summary table of the superordinate and emergent themes (for transcription five)

The summary table shows the final position for the superordinate and associated emergent themes arising from the transcript along with some illustrative comments and associated references from the interviews that illustrate each theme.

Superordinate theme	Associated emergent theme	Comments to illustrate each theme	Reference in transcription
Emotional isolation in response to painful memories of childhood	Negative childhood experiences	“my growing up, my sexuality was a big thing for me, growing up gay. I didn’t really feel like I belonged anywhere and then felt like I had, I never felt a sense of belonging or a normality”	5.10.1
	Shamed by memories of emotional neglect	“identifying that I was carrying shame from my parents that I, I kind of gave back to them, if you get what I mean, because it’s their shame, not mine”	5.4.1

External activities as a way of relief	Overachieving	“I was an over-achiever because I felt inadequate as a gay, young gay man”	5.12.1
	Drug taking as a way of suppressing feeling	“Because I now understand that I’ve been, that I have been using substance to, um, you know, hide	5.8.1

Acceptance of emotional needs	Need to accept causes rather than medicate to suppress the pain	“it’s that lightbulb moment of perhaps realising that’s why you are the way that you are”	5.7.1
	Confront shame	“for me it was just my mum having a breakdown and me feeling responsible for her. That was like my, the basis of a lot of my trauma, you know, and a lot of carried shame and stuff from my parents’ issues”	5.7.3 5.5.1
	Importance of being safe and identified within the group	“ I’m still friendly with the guy that I did the process with but, you know, he was a stranger and I’m like bawling my eyes out in front of him and I’m going to places that are extremely painful for me in front of essentially three strangers”	5.3.1
	Having a language to explain		5.7.1
		“I was learning	

Appendix 15: Summary table of the superordinate and emergent themes (for transcription six)

The summary table shows the final position for the superordinate and associated emergent themes arising from the transcript along with

some illustrative comments and associated references from the interviews that illustrate each theme.

Superordinate theme	Associated emergent theme	Comments to illustrate each theme	Reference in transcription
Lack of emotional understanding in response to negative childhood experiences	Negative childhood experiences	“was about the trauma of just not getting the love I needed from my parents”	6.4.2
	Shamed and angered by memories of bullying and concerns over sexuality	“I was, you know, of a slight build I was teased about it as a teenager like, you know, teenage kids do and I had, you know, took it seriously, felt I had to prove that oh I must be straight”	6.4.2 6.5.1
	Unable to understand or manage feelings	“beforehand there was just a cacophonous committee of, you know,	

Acceptance of emotional boundaries	Recognition of emotional complexity rather than seeking external solution	“the sense of, the sense of functional adult I guess helped me recognise that the things that I thought were crazy, because in any objective sense they were, they were actually crazy, it wasn’t me being wrong. I guess it gave me a bit more sense of reality”	6.11.2
	Importance of being safe in the group in order to confront shame and anger	“That’s probably the biggest challenge of the course, is really feeling safe enough, somehow feeling safe enough to really go as deep as, as deep as we can”	6.15.1 6.8.1
	Having a language to explain	“the emotions kind of bounce off, bounce, the emotions coming in from outside kind of bounce off. And that was in conjunction with an exercise where they kind of gave colours to the painful emotions”	6.11.3
	Need for boundaries	“I think there’s a	6.14.2

Appendix 16: Summary table of the superordinate and emergent themes (for transcription seven)

The summary table shows the final position for the superordinate and associated emergent themes arising from the transcript along with some illustrative comments and associated references from the interviews that illustrate each theme.

Superordinate theme	Associated emergent theme	Comments to illustrate each theme	Reference in transcription
Avoiding conflict due to memories of shame	Negative childhood experiences	My mother had an affair... "I was very young and I sprang them"	7.4.1
	Hiding from memories of shame	"you've mentioned nothing about your father, and she started to open the door"	7.5.1
	Avoidance of conflict in adult life	"we've been shielding"	7.5.1
	Drinking and pornography aa ways of medicating	"I was also using pornography a lot and I went to a sex addict sort of centre"	7.3.1

Seeking success to protect external image of control	Importance of appearing successful	“All my decisions had to be perfect”	7.4.1
	Afraid to be judged by others so never refuses	“goes out of his way to help people and will never ever complain...you’re describing yourself”	7.5.1

Accepting without shame or judgement	Need to recognise causes rather than medicate	“I never thought I had a problem... Would I say I am in recovery, yes I would” (2.3.1)	7.3.1
	Accepting causes of conflict avoidance behaviour	“if I hadn’t done that, I would have kept on making the same mistakes in my relationships”	7.12.1
	Confront shame		7.6.1
	Right to say no	“shone a light into the dark corners” (2.6.1)	7.6.1
	Having a language to explain	“less anxious about what people would think of me”	7.6.1
	Loved being part of the treatment group	Uses language such as “wounded child”, “family of origin” and “co-dependency” to explain	7.5.3
	Accepting without	“I really loved being in the group and I didn’t think I would, but I loved it”	7.5.2
			7.5.3

Appendix 17: Overall summary table of the superordinate and emergent themes (for all transcriptions)

The summary table shows the final position for the superordinate and associated emergent themes arising across all of the transcripts along with some illustrative comments and associated references from the interviews that illustrate each theme.

Superordi nate	Associated emergent theme	Comments to illustrate each theme	Reference in transcription
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Making sense of intense emotional response to painful memories of childhood	Negative childhood experiences	“an eye-opener to have the therapist, you know, help me see that actually that is enmeshment”	4.2.2
			1.6.4
	Shame and loss of self-esteem	“I think a big issue is shame”	6.5.1
	Unable to identify or manage feelings and emotions	“beforehand there was just a cacophonous committee of, you know, negative self-talk and childish emotions and I didn’t even recognise the emotions”	1.1.1
	Difficulty with conflict in adult life	“having been brought up in a violent household I was conflict averse”	

Acceptance of themselves with compassion and without shame or judgement	Need to recognise causes	“I don’t think you can do this kind of work until your head is in a space where you’re actually dealing with the stuff which has gone on over	1.2.1
	Having a language to explain	the years, as opposed to trying to medicate”	3.3.1
	Importance of being safe and connected in the group	“I realised that it’s like I had glasses, you know it’s like I was colour blind”	4.2.1
	Confront shame	“it’s probably the most well I’ve ever felt in my life. I just felt completely looked after and supported”	4.4.1
	Acceptance of own emotional needs without	“I felt a lot of anger dissipated quite quickly, having done the trauma programme, anger	3.15.2

Appendix 18: Superordinate and emergent themes for transcripts 1 to 7

Participant pseudon	Resultant emergent themes	Superordinate emergent themes
Arv	• Negative childhood experiences • Burying painful emotions and memories • Avoidance of conflict in adult	• Intense fears of painful emotions and memories
	• Be seen as a success by others • Not being able to say no to work	• Seeking success
	• Need to recognise causes rather than medicate • Accepting causes of conflict avoidance behaviour • Power of the group • Confront shame	• Accepting with compassion and without shame or judgment

Boris	• Negative childhood experiences • Shamed and angered by memories of bullying • Unable to relate	• Inability to relate to others in response to emotional abandonment
	• Search for external solution • Gambling and	• Search for external relief
	• Recognition of own emotional needs rather than seeking external solution • Willingness to change • Importance of being safe and connected in the group • Having a	• Accepting of himself and others
Charlie	• Negative childhood experiences • Hiding from memories of loss • Controlling others to manage conflict • Rage, work and	• Intense anger in response to painful emotions and memories

	• Feeling powerless in a cycle of judgement	• Living life with a continual sense of urgency and need for success
	• Need to recognise causes rather than medicate • Accepting causes of conflict controlling behaviour • Confront shame • Having a	• Accepting with compassion and without shame or judgement
Drew	• Negative childhood experiences • Shamed by	• Avoiding intimacy in response to painful memories of enmeshment and violence
	• Seeking space to avoid being suffocated in relationships • Addictive	• Seeking external relief to cope

	• Need to recognise causes of avoidant behaviour • Importance of the group • Confront shame and anger • Having a language to	• Accepting with a sense of freedom and without shame or judgement
Euan	• Negative childhood experiences • Shamed by memories of	• Emotional isolation in response to painful memories of childhood
	• Over-achieving • Drug taking as a way of	• External actions as a way of relief
	• Need to accept causes rather than medicate to suppress the pain • Confront shame • Importance of being safe and identified within a group • Having a language to explain	• Acceptance of emotional needs

Freddy	• Negative childhood experiences • Shamed and angered by memories of bullying and concerns over sexuality	• Lack of emotional understanding in response to negative childhood experiences
	• Search for an external solution • Sex, work and intensity of life as ways of validating	• Search for an external solution as a way of validating and relief
	• Acceptance of emotional complexity rather than seeking external solution • Importance of being safe in the group in order to confront shame	• Recognition of emotional boundaries

Gregory	• Negative childhood experiences • Hiding from memories of shame • Avoidance of conflict in adult	• Avoiding conflict due to memories of shame
	• Importance of appearing successful • Afraid to be	• Seeking success to protect external image of control
	• Need to recognise causes rather than medicate • Accepting causes of conflict avoidance behaviour • Confront shame • Right to say no • Having a language to	• Accepting without shame or judgement

Section B

**Specialist Group Supervision: Combined Client study/Process
report**

Case Study: Working with shame and guilt in adjustment to chronic
illness using Compassion Focused Therapy

Introduction

I chose this case firstly due to my developing interest in working with shame and guilt. Secondly, I chose this case as it was the first time, I had used compassion focused therapy (CFT) in a chronic illness setting and so I believe I learnt a lot, including developing skills and knowledge in working with chronic illness presentations as well as using CFT. A further reason was, that one of the chronic conditions being adjusted to was Long Covid (LC) which felt particularly useful to know more about as it seems likely this will continue to regularly present in the practice room as I qualify (Raveendran, Jayadevan & Sashidharan, 2021).

Demographics

Jane is a white female in her late 40's with severe asthma and LC. Jane lives in a London housing estate. Jane used to work as a nursery school assistant but has not been working for the past two years due to worsening physical health.

Context of the work

I saw Jane in an NHS, trust, within a physical health department that was made up of a multidisciplinary team consisting of nurses, physios, and psychologists. The team was headed up by a highly specialised clinical psychologist. My role within the team was to offer short term therapy to clients who were struggling psychologically as a result, at least in part, to their physical health condition. This formed part of the wider MDT goal of allowing clients to remain outpatients as long as possible.

Theoretical orientation

The modality I used with Jane was CFT. I have interpreted CFT as a form of theoretical integration as although this approach is referred to by some as a form of third wave CBT (Beaumont & Martin, 2015; Gooding, Stedmon, Crix, 2020), the creator of CFT describes it as an approach that integrates techniques from CBT, neuroscience, attachment theory, evolutionary psychology as well as Buddhist principles (Gilbert, 2009). This view of CFT is backed up in the research for example being described as an integrative approach by Matos & Steindl in 2020.

I chose this approach firstly, because research has shown CFT to be effective in reducing psychological distress in people living with chronic illness (CI), (Carvalho et al, 2021). Furthermore, this has been found to be particularly true where high shame and guilt are factors which I, and my supervisor, believed to be the case for Jane (Dolezal & Lyons, 2017). In addition, guilt has been found to be (De Ridder et al, 2008) one of the most commonly associated sources of distress in management of long-term conditions such as asthma and so of particular importance to focus on in this case.

The information that Jane provided could be understood from an attachment based psychodynamic perspective as a lot of the information she shared was developmental in nature and this approach was discussed as an option with my supervisor. Due to the short-term nature of the work in this setting it was decided that a purely psychodynamic approach would not be suitable. One of the reasons why CFT was chosen as the approach is the inclusion of attachment theory (Matos & Steindl, 2020).

Furthermore, CFT's intentional incorporation and naming of the importance of wider social and economic issues (Gilbert, 2009) seemed particularly relevant in this case, due to the role economic hardship played in Jane's early life and the sense she made of this. In addition, the limitations in terms of access to technology meant video sessions were not possible and the sessions took place over the telephone.

CBT was initially considered to look at the social anxiety symptoms but due to the nature of the shame and guilt that came up in the assessment in combination with Jane's negative experience with CBT a few years earlier it was decided, by my supervisor and I, that CFT would be the most suitable approach.

Client study

Referral

A nurse who works as part of the MDT made the referral. The referral was made after Jane reported feeling high anxiety generally and fear when leaving the house, described as agoraphobia by the nurse, which was impacting her breathing. No risk was reported, and Jane was not taking any psychotropic medication when referred. The case was allocated to me by my line manager and supervisor in part because Jane had less severe physical symptoms compared to the other clients I was seeing and so my supervisor suggested there might be scope for more consistent psychological work on a weekly basis. On learning this rationale my initial response was to feel hopeful to work with Jane. My initial thoughts were that perhaps CBT for social anxiety might be most appropriate.

Assessment

I used an assessment questionnaire as a template, as per procedure in the service, to gather the information. I followed the template loosely in order for the conversation to flow naturally. The initial assessment was done over the course of two weekly sessions but was an ongoing process as more information was shared by Jane. This section reflects the information gathered during all of our work together.

The sessions took place over the phone as Jane said she did not feel comfortable to meet in person as she felt worried about catching Covid, anxious about her appearance and felt obligated to use her time to help her family with child caring duties and so my impressions were all based on voice. Jane said she did not have access to a smart phone or laptop for video sessions. Jane was warm and friendly to me throughout the sessions.

Presenting problem

The presenting problem was anxiety around leaving the house, due to fear of catching Covid again and symptoms of agoraphobia and difficulty adjusting to the impact her worsening physical health was having on her day-to-day life. Jane said she felt angry at her asthma as she felt if it wasn't for that then she would have been able to better fight off the Covid. Jane said due to her low energy levels and fear of catching Covid she avoided going outside and felt guilty as this had meant she was not able to help out her children and sisters in the way she previously had.

The sense Jane reported making of her presenting problems was that she was having difficulty adjusting to her chronic illness symptoms

and felt frustrated with herself for not being more adaptable and a strong sense of confusion why she wasn't being.

Jane said she was reaching out for therapy now was for two reasons. Worsening breathing symptoms and energy levels following hospitalisation in ICU with Covid and difficulty adjusting back to life at home. Also, the shrinking of her social circle due in part to Covid restrictions and in part her anxiety around socialising had meant she had come to feel the relationship with her sisters was particularly problematic and she wanted to address how this could be different as it was causing her a lot of distress.

Risk

No current risk to self or others identified.

Family and wider context

Jane lives with her partner and two of their three adult children in London. Jane described the relationship as very close between all of them especially her partner.

Jane still has regular contact with her sisters but says she feels she has to "put in all the effort" and said she often finds herself feeling rejected and confused about what she had done wrong. Jane said she had been told by friends and her partner's family that she would be better off without them in her life as they caused her stress.

Physical health difficulties

Jane was diagnosed with asthma when she was twenty-four. Jane caught Covid in 2020 and had to be treated in ICU and at one point was told she might die and to say goodbye to her family. Jane recovered from the main symptoms of Covid but continues to live with

LC symptoms. Jane said she had tried wearing wigs but does not feel comfortable with how they look. Jane was diagnosed by GP with LC but chose not to be seen by a LC specific service due to her reporting she felt high levels of comfort from her ongoing relationship and familiarity with the department she was being seen in for her asthma, where I worked and saw her.

Previous mental health input

Jane's only previous experience of therapy was seeing a psychologist in 1996 for short term CBT therapy, while experiencing post-natal depression after having a premature baby. Jane said she did not find this experience useful as although she was able to question some of her thoughts, she still felt stuck in her emotions and so didn't feel it worked well.

Goals for psychological support

Jane said she wanted to feel less worried about going outside the house and also to have a "new way of thinking" about her low energy levels and to reduce the level of frustration she feels with herself about this. Jane would also like to better understand the difficult relationship she has with her two older sisters which she feels is causing her an increasing amount of distress.

Formulation

Together Jane and I used the CFT three circles model to get an understanding of her current emotional framework (Gilbert, 2009). Jane can be described as having an overly developed threat and self-protection system. This is evident based on what Jane said about experiencing high levels of threat-based emotions such as of anxiety,

about social interaction, health, and safety generally and anger in regard to relationships. Jane can be understood to have an underdeveloped soothing system as we discussed how she struggled with feeling safe and offering herself kindness as well as receiving kindness from others. Here we noted that offering kindness and compassion to others was a big part of Jane's identity and was closely linked to her strong feelings of guilt when she felt unable to do this due to her ongoing physical health conditions.

The drive system, which previously was more active prior to the worsening of Jane's physical health symptoms, had been reduced. Jane previously worked as a primary school assistant and was in charge of running the household and helping her children and sisters. Jane also said that she and her husband would enjoy going shopping and going on holiday together but since developing LC symptoms she has stopped being able to engage in any of these drive and vitality based activities. We formulated together that the reduction in this area, due to life circumstance, was contributing to her level of threat-based emotions increasing as it had left her with a sense she was not being useful and therefore triggering her fears that she would be rejected or excluded by her family, especially her sisters (Irons & Beaumont, 2017).

For a longitudinal formulation we used the four columns model (Irons & Beaumont, 2017).

Early experiences

Jane experienced a number of traumatic early life events. Jane shared experiencing a prolonged experience of sexual assault from the ages of 12 to 14 by an adult male neighbour. Jane said she tried

to raise this to her parents and teachers but was not believed and no action was taken.

Jane and her sisters were not allowed to go outside the flat if the parents were not around. The sisters were locked in the flat during school holidays while the parents were both at work. Jane reported a general sense of the household being chaotic and unpredictable and that her parents were unaffectionate. Here we formulated together that these experiences may not have allowed the soothing system to get a chance to thrive and grow.

Key fears

These difficult early life experiences shaped Jane's key fears such as that people would leave her when she needed them. The fear of abandonment is particularly present in relation to her sisters. A further but related fear is that she will let people down if she is not useful to them and then they will abandon her.

We formulated that these fears are likely to have developed, in part, due to Jane's parent's own fears that the world was a dangerous place and the strict rules they had in place for their daughters. Jane remembers feeling breathless and worried a lot as a child and longing for attention from her parents and older sisters who often ignored her. We formulated that these experiences were likely to have contributed to the threat system being the most developed of the three systems.

I believe the recollection of these early experiences can be understood as emotional shame memories (Matos, Steindler, Gilbery, Pinto-Gouveia 2020) and may be contributing to Jane's view of herself as worthless and weak and others as rejecting, more powerful than her and aggressive. An increase in feelings of shame in

adulthood has been rooted in shame experiences in childhood (Matos et al, 2020).

Coping strategies

Jane reported feeling a need to be vigilant for potential danger and how tiring this felt for her. Because of this, Jane uses the coping strategy of avoidance of situations she deems dangerous which include places with more than a few people in. Jane is afraid her sisters will abandon her and so she uses a coping strategy of appeasing them by not speaking up if she disagrees with something or something is difficult or inconvenient for her. Jane reported an ongoing sense of doubting herself and lacking in self-confidence. Due to this, a third major coping strategy we identified was an avoidance of taking decisions on her own.

Intended and unintended consequences

The intended consequence of Jane's avoidance of busy areas is that her fears of catching Covid were kept at bay but the unintended consequences were that her support network shrunk, and Jane felt more aware of the difficult relationship with her sisters. Another unintended consequence is the feelings of guilt that Jane felt in regard to not being able to be "useful" to people anymore.

The intended consequence of appeasement was avoiding total abandonment by sisters but had the unintended consequences of Jane feeling deep frustration at not getting her needs met from the relationship. As Jane's health worsened her energy levels dropped meaning she was less able to play the role of helper for her sisters leading to more heightened fear of rejection. Furthermore, her fear of catching Covid again meant she avoided most of the people that had

previously made up her support network. Jane realised that her sisters had become more central in her life than before and this focus on them had brought to her attention that the cost of the relationship might be higher than she realised and could be linked to her physical distress symptoms.

The avoidance of making decisions on her own was something that came up in our relationship regularly as Jane deferred to me, as a professional, often. We spoke about this dynamic in the sessions and identified how this had the intended consequence of Jane often feeling reassured by having the opinion of someone she deemed an “expert” but had the unintended consequence of her continuing to doubt her own opinions and therefore had the unintended consequence of continuing her sense of lack of agency.

We formulated that a major block to Jane’s ability to adapt to the changes she was experiencing was the significant levels of shame and guilt that were present for her as noted in the emotional shame memories.

Treatment plan

Jane and I decided that our work was going to focus on helping her adapt to the changes she was experiencing both physically and psychologically as result of her LC symptoms and the worsening of her asthma. The focus would be on helping her reduce her feelings of shame in relation to the adjustments she was needing to go through.

We agreed to start this process by doing some psychoeducation on how brains evolved in order to help de-shame the strong anxiety reactions Jane often had. Then cultivate Jane’s soothing system by using a combination of posture based and facial expression focused mindfulness exercises (Irons & Beaumont, 2017). We agreed Jane

would repeat these exercises on her own in between the sessions to build her sense of agency in regard to accessing this part of herself when she needed to. We then agreed to use compassionate mind training (CMT), an element of CFT, which also focuses on activating the self-soothing system but mainly through visualization and reflection journaling exercises. The goal here was to strengthen Jane's compassionate mind to self, other and team voices (Beaumont & Martin, 2015). We then agreed to direct this more developed compassionate mind to allow for experiencing compassion from others and allowing for self-compassion through visualization exercises to continue to activate the soothing system. Once in the soothing system more firmly we could explore the coping strategies and their intended and unintended consequences from a more "new brain" stance (Gilbert, 2009).

Interventions

The progress felt challenging at times due to a number of factors including the mode of therapy being over the telephone meaning I felt limited in my assessment of the initial grounding exercises. This was useful in that it showed me how reliant I had become on body language feedback and that it was possible to check verbally if necessary, which is what we did in the end. Also, I found myself comparing my use of CFT with clients in a previous placement and realizing that I needed to adapt the language I was using. My previous experience of using CFT had been in a university setting and I had felt that the language around, evolution and the nervous system had been taken on board quite easily. In this case Jane seemed to struggle to understand, what on reflection, might have been overly technical language. I quickly adapted the language to convey the underlying message which seemed to help.

Jane developing courage, throughout the session, to offer herself compassion by valuing her own time as well as recognizing the unintended consequences of her not speaking up in her relationships with her sisters felt significant. Relationships that are perceived as stressful have been shown to have a significant detrimental impact on chronic illness management and as such Jane gaining clarity in this area felt like an important moment for her (Petrie, 2019).

Overall, I feel the interventions were successful in helping to reduce Jane's feelings of shame and in helping Jane to identify the unintended consequences of her coping strategies and to feel some agency over them in a de-shaming way.

Use of supervision

Supervision was particularly helpful in working with the pull to rescue that I felt quite strongly with Jane. It was a dynamic that Jane and I spoke about in our sessions and I felt better able to manage this challenge with the support of my supervisor who helped me remain aware of the dynamic in the room.

PTSD after ICU is common (Davydow et al, 2008); this was something that I discussed with my supervisor and was aware of as a possibility when assessing Jane. Jane did not show signs of flashbacks or intrusive memories and so it was decided, along with my supervisor that Jane was not currently showing signs of PTSD and so this was not an area we focused on in our work together.

Also, the challenge of early trauma being present in the short-term work with Jane was something supervision was really helpful in managing. I was conscious of showing Jane that I could hear how difficult the sexual assault had been for her and not leaving her feeling dismissed as she had done when she reported the incidents

as a child. Yet at the same time I was also aware of the limitations of the short-term frame we were working in. My supervisor helped me see the benefits of helping Jane name the shame and show how it might have impacted Jane's coping strategies.

When Jane made the disclosure about the sexual assault when she was a child I spoke about the potential for a safeguarding concern with my supervisor. We agreed I would speak to Jane in the following session to find out more details about the man she mentioned and during this sessions Jane confirmed he was dead. As agreed with my supervisor no further action was needed in regard to safeguarding.

Outcome and ending

We had a total of ten sessions together, the ending was planned, and we had discussed the ending from session one. We had a planned review at week three where Jane expressed some anxiety about the end. Consequently, we agreed to have our final two sessions fortnightly rather than weekly in order to allow the end to be more gradual and for Jane to get used to the idea. We had a review again at week seven where Jane said she was feeling more prepared.

I felt sad to say goodbye to Jane as I felt we had formed a strong bond but I felt pleased for the progress that she had made and I took encouragement from the feedback received that she had had a positive experience. Jane said she was aware of the option to come back to the service and have further sessions if required and I think this helped to make the ending feel gentle.

Outcome measures

Two outcome measures were used as part of the work with Jane. Firstly, the hospital anxiety and depression scale (HAD) which

indicated that Jane's depression and anxiety levels dropped from clinical levels to within normal range during our sessions which I felt was encouraging. A limitation here is that a 2012 systemic review found that the HAD scale is not a dependable measure (Coyne & Sonderen, 2012). Jane's score on the second measure, the patient reported experience measure (CORE PREM) indicated a positive overall experience of the therapy. In addition, the CORE PREM allows for qualitative feedback which indicated Jane felt "understood and not judged" during our sessions which I felt pleased about.

The CORE PREM is typically used in home and bed based intermediate care services similar to the one where I saw Jane and this measure had received high reliability (Teale & Young, 2015). Overall, the feedback gained through the outcome measures was positive although I acknowledge the significant limitations of primarily quantitative feedback including perhaps Jane's desire to be generous in her scoring.

Perhaps going forward using an outcome measure that was more specific to psychological adjustment to chronic disease might gain more relevant information. Although, I note that, currently the most commonly used outcome measure in chronic health, the ICF, is lacking in this area (Dekker & de Groot, 2018).

Process report

This is taken from the final ten minutes of session six. I chose this interaction as I feel it highlights Jane's sense of "stuckness" that she felt towards the issue with her sisters and demonstrates me offering a different type of conversation to one where everyone is telling her what to do in relation to them. Overall, I have wanted to help Jane understand why this was such a difficult question for her through the

use of collaborative formulation. In this section I was trying to increase Jane's flexibility with how she thinks about the issue and recognise that she has some options and agency. I feel this section brings in a lot of the main themes that arose throughout our work and is representative of our work overall.

This session started off focused on an incident with Jane's heart palpitations earlier in the week where an ambulance had to be called out and how much stress this had caused her as well as feeling emotional and upset about family relational dynamic. The session explored Jane's coping strategy in regard to the relationship with her sisters and the unintended consequences of that strategy.

Prior to the start of the transcript, we had spoken again about the concepts of different affect systems. The transcript starts with a discussion on flows of compassion.

Transcript

Mins 40-50.41

CP1: I see you showing loads of compassion to your kids, your partner, your godchildren and, you know, partners family and other people...

Comm1: My aim here was to highlight Jane's ability to offer compassionate "flow" to others (Irons & Beaumont, 2017).

CL1: Yeah

CP2: I hear that a lot...and I wonder if it's harder for you...(client interrupts)

Comm2: My aim here was going to be to explore my formulation that Jane finds it harder to offer herself compassion.

Jane interrupted quite regularly in our sessions. I wondered whether this was a desire to control the sessions or more a fear of not being heard by me. It made my attempts to summarise my understanding tricky at times. I wondered if I was interrupting her flow.

CL2: (interrupted) ...even my sisters...

CP3: Yes, and your sisters, yes yes

Comm3: I knew this was really important to Jane so was quite emphatic with my response although I wondered about the driver behind Jane's compassion to her sisters. It felt in keeping with her tendency to avoid conflict and I wondered if it was being driven by her underlying fear of rejection. It didn't feel like the right moment to explore this, but I noted it as being important to come back to.

CL3: so, if they're sick or whatever I'll go and make food. Like when my sister had covid...ummm I went there and cooked food for 2 days for them. I bought them vitamins and orange juice and loads of stuff that would, you know, that they could snack on and stuff.

Comm4: I felt Jane was overexplaining, as I had observed often in our sessions. The understanding I make of this is that she is used to not feeling heard.

CP4: Yeah

CL4: You know, because I do care. Because I don't think there is anyone in the world, I hate apart from that one man.

Comm5: Reference made to a male neighbour who abused Jane when she was a child.

CP5: Yeah

CL5: There is nobody that I can physically think of that I actually dislike...or...anybody, I don't think there is anybody. People might be bad or horrible, and I may think that is wrong but I don't hate anybody...and I could never hate my sisters despite the ongoing abuse, I should say, really that I feel I get from them all the time..I still don't hate them...

Pause

...And I have said to my children, and to (*partner*), if I die, I don't want them at my funeral

CP6: Oh wow...ok...that's...(client interrupts)

Comm6: I was shocked by the force of her comments but also wondered whether it was an opportunity for her to access the seeming strength, courage, determination and perhaps anger behind the comment to build her own wise compassionate self. My aim in saying wow was to demonstrate the strength of emotion I was picking up on to Jane.

CL6: (interrupts) ...because you can't go to show your respects to somebody that you kept on hurting over and over and over again because you didn't really care about that person anyway.

Comm7: It did not seem that Jane was listening

CP7: Yeah, I can really hear that. It's quite a...it feels like a really powerful thing to hear and a really powerful thing to say to your partner and your kids. You know? That you're...you're sort of clearly stating that you recognise that...or you don't feel as though your sisters do care for you. Right?

Comm8: I wanted to reflect back the strength I had picked up in her statement in the hope that was something M could access more often on her own.

Pause

CL7: I think, um...like, because of what the man did to me, I wouldn't go to his funeral because I don't like him and it would be false for me to go there and I feel

(PAUSE)...

and I wouldn't want...yeah...if somebody is hurting you all the time then it's a lie to go to their funeral.

Comm9: I found this confusing. Perhaps showing link with trauma and early memories and the strength of feeling and sense of injustice. More pauses by her than usual.

CP8: Yeah

CL8: You don't just go because that was my sister, I have to go, then go to the funeral and cry because that person is gone. You know, you have to make life count now and, you know, be nice to the people that are here and that are around you.

Comm10: This sounded like a real change for Jane in that I interpreted this as her valuing her time more and tapping into her wise self that appreciates life is hard but also showing the courage to know what she can change to alleviate some of the distress she was feeling (Irons & Beaumont, 2017). On reflection it could have been useful for me to verbalise this to M. I felt pleased hearing her accessing this courage and allowed myself to reflect that it seemed M had taken on board some of the concepts we had discussed.

CP9: Yeah, no, I can really hear that. Umm...

Comm11: Wanted to show I was a long side her

CL9: I think I have enough going on with my heart and medical worries and...and have to put up with their rubbish as well. That's unnecessary.

Comm: Development of courage and assertiveness

CP10: Yeah, I can hear that a lot and I'm really conscious that... you...it sounds as though you're saying that you would like some distance?

Comm12: I was looking for clarification while also summarising and encouraging what I was hearing as the development of courage and assertiveness in M as well as a motivation to care for her own well-being (Gilbert, 2009). On reflection this could have been phrased more tentatively as it seems too directive and maybe even assumptive. Perhaps I could have asked an open question to clarify.

CL10: To be honest, I wouldn't mind if they wasn't really in my life. I think it would be less stressful and from a couple of years ago from the Dec to the January or February, when...it was the first time that we haven't that we never spoke for that long. It was the happiest months of my life.

CP11: I think you're speaking to something really important there so you know, it's worth listening to, kind of, what that part of you is saying now...I can kind of hear quite loud and clear that you had a lot of peace from choosing to be more assertive and um, you know, maybe that is something for you to reflect on because, compassion, comes in different formats and there's, you know...a way of thinking about is...if you, kind of, were walking along and saw someone

drowning, struggling to swim in the river and you just jumped in to rescue that person but then half way in you realised, you know, I can't swim...

Comm13: My aim is to highlight the unintended consequences Jane is realising and naming. Also, to introduce in more detail the idea of wisdom into the understanding of compassion through use of a metaphor (Irons & Beaumont, 2017).

Reflecting on this I wonder if by offering that metaphor at this point it is putting some of my own view across of what Jane should do – e.g. the benefits of being more assertive.

CL11: (interrupts) that would be a true fact (laughs)

CP12: Ok (laughs) so a good example for you

Comm14: It felt like Jane connected to the metaphor

CL12: Yeah

CP13: That would not have been a compassionate choice because in the end really two people need to be rescued or perhaps two people will drown. So actually, a really important part of compassion is wisdom. Right?

Comm15: Aim was to further introduce the importance of wisdom in compassion through continuing with the metaphor (Irons & Beaumont, 2017).

CL13: Yeah

CP14: Wisdom to ask yourself, is this going to be good for me? As you say, to manage the situations that you're having to manage at the moment, you know, you've got asthma to think about, you've got, you know (I tut)...some left over things from Covid) , you've potentially got

a heart situation going on and these are major things to consider in terms of adjustment and in terms of looking after yourself and you know, being compassionate to other people is important and being compassionate to yourself is really important as well and part of that is being wise about what really compassion looks like.

Comm16: Aim to focus on flow of compassion towards self (Irons & Beamont, 2017) and increase sensitivity to own needs (Gilbert, 2009).

I felt conscious of not using the wrong language...but felt frustrated with the vagueness and complexity of Jane's condition.

CL14: So would it be bad, to cut them off?...and just not have them in my life? Like the middle sister, I do love her children.

Comm17: (sharp intake of breath by me) I felt frustrated that Jane was asking again for me to essentially make a decision for her. I worry that perhaps the wise self is not as fully developed in Jane as I had previously thought. This is something we had spoken about before, but Jane keeps re-visiting it. I feel worried that I might come across as being evasive.

CP15: Yeah

Comm18 Aim here is to show I am with her, active listening rather than agreeing or answering her question.

CL15: (client sounds out of breath) ...and I do love her grandchild, but I could quite...sorry...I just walked up some stairs, the escalator wasn't working...

Comm19: Jane mentioned she would need to be out of her flat for this session to drive her daughter to a medical appointment. Jane confirmed the session primarily took place in a private place while

she waited but at one stage she needed to move briefly. This did not appear to impact the flow of the session.

CP16: I can hear you're quite out of breath there.

Comm20: Aim was to show I was with her and am paying attention to what is happening with her. She did not have to specifically say she is out of breath, but I knew what she was highlighting...and showed her this so she would feel heard.

CL16: *(gasps and laughs)* Umm...yeah, I often do think about just cutting them off...but then I think, that is selfish of me to do that.

CP17: I think that...I'm conscious that we only have a few minutes left and I don't want to avoid answering your question, but I think it's...I guess, I just want to leave you with a couple of things to think about. One is, again, it's not for me to, kind of, tell you whether it would or wouldn't be, kind of, in your best interests, right? It's...errr but it would be...kind of ask yourself, what...Jane is this person who has navigated many difficulties and navigated them well. You know, in your life and you've kind of brought together this really loving and compassionate family and you've nurtured many friendships...

Comm21: My aim was to manage the ending of the session but also encourage Jane to feel more able to rely on her own opinion by directly tapping into the self-compassionate part of her. I note my own feelings of frustration here and wonder if me saying "again" sounds harsh? Although my tone of voice is gentle.

CL17: Yeah

CP18: ...and you've overcome a lot of difficulties, health wise and you know, you were initially referred with a lot of anxiety about going

outside, and now I can see that you are going outside more regularly and developed all of these close relationships, right?

Comm22: Aim is to highlight progress made by Jane so far in the sessions as well as the strength, courage and commitment she is demonstrated in managing past difficulties in line with building her habit of compassionate thinking and reflection (Irons & Beaumont, 2017).

CL18: Yeah

CP19... and what would that wise part of you, suggest? What would that wise part of you suggest to someone else in your shoes?

Comm23: Aim was to build up idea of the wise self in M and show that it is possible to access that part when needed. I did not expect her to answer immediately...my aim was it to be a question to reflect on before our next session, but Jane seemed clear at this point.

CL19: (laughing and very clearly stating) To cut them off

CP20: Yeah...pause...it's quite a quick response, right?

Comm24: I was surprised how assertive and clear Jane was being in her opinion. I felt that she was accessing a more courageous part of her but also conscious we were nearing the end of the session so exploring this further would need to wait.

CL20: Yeah

CP21: It feels as though that's clear to you

Comm25: Aim to reflect the assertiveness and courage

CL21: It is clear to me. It's like, I've never felt so...(sigh)...it's like ummm. I just feel like, it's just too much stress, too much headache, too much everything.

Comm26: Realising and naming unintended consequences

CP22: Yeah

CL22: You know? And um...without them, it's not a headache, it's not a stress

CP23: Yeah

Comm27: Aim to encourage what sounds to be Jane realising her own agency to change her behaviour and coping strategy with her sisters

CL23: Life is better

CP23: *(soft, gentle, slow voice)* Yeah, and it's worth stopping and just reflecting on that feeling, right? You're having quite a lot of thoughts and I'm sure there are probably quite a few feelings going through your body at the moment and it's worth pausing and maybe not...you don't have to make a decision right away but it's something we can continue processing...what it's like to think about that together...

Comm28: Aim through tone and speed of voice and encouragement was to slow down. Based on trying to activate soothing system response. I wanted to end the session but also not dismiss what Jane was saying and highlight that we could continue next week. Also, I wanted to try and tap into the embodied part of the experience Jane was having when she was connected to this courageous part of herself (Iron & Beaumont, 2017).

Ideally, I would have done this after a pause, but it was the end of the session. Also, it would have been better for me to be more explicit and tap into how Jane's body was feeling for example by asking about her shoulders and face (Gilbert, 2009).

CL24: Yeah

CP24: ...and to talk, continue to talk, about what the intended and unintended consequences are of you, kind of, coping strategies, so ummm, I'm kind of conscious that we are at time...

Comm29: My aim here was to try and frame our next session so we could pick up with what felt like an important moment for Jane. A moment where I felt she was realising her own agency to change her coping strategies. I didn't want Jane to feel dismissed, but I was also conscious we were at the end of the session.

CL25: Yeah

CP25: How are you feeling after our session?

CL26: Err, I feel actually a bit relieved

Session ending and evaluation

The session ends here, and we agreed to speak at the same time the following week. In the remaining three sessions we continued to work on building Jane's flow of compassion towards herself. Jane continued to diligently complete the visualisation exercises and there was evidence of a more developed soothing system as well as ability to question her coping strategies without becoming overly anxious.

The experience of zooming in on this segment felt challenging at times. I initially felt frustrated that I had so few recordings to pick from and worried there wasn't enough going on here. But on reflection I feel there were strengths in this piece. The use of the metaphor technique which I felt helped Jane have a clearer understanding of and make greater connection with the wise part of her compassionate

self. Encouraging Jane to connect with her feelings on a somatic level as well as helping her to name the unintended consequences of her coping strategies.

I also think this section is useful as it illustrates a challenge in our relational dynamic. On reflection I wonder if sometimes during our work I ended up overworking and offering too much of a summary commentary and whether this fed in at all to the dynamic of how Jane was often seeking my opinion on her situation and inviting me to tell her what to do. I was aware of feeling a pressure to help her in a more tangible way than I usually feel with other clients and this dynamic was something I struggled with a little through our sessions and regularly discussed in supervision.

Reflection

Overall, I believe this piece of work has shown my competence in using CFT in working with shame-based adjustment difficulty to worsening chronic illness. This was reflected in the quantitative outcome measures and qualitative feedback Jane gave. As well as in my observations that Jane moved from primarily being in her threat system and unable to question her coping strategies to spending increased periods, often at her choice, in her soothing system and able to feel a sense of agency over her coping strategies.

In addition, this case raised numerous reflections on my identity and learning as a trainee counselling psychologist as well as on applying CFT as an approach.

On the macro level the work with Jane highlighted the difficulty socio economics can play in terms of access to services. Jane did not have

a smart phone and her household did not have a laptop as they could not afford the expense. As Jane felt unable to attend the sessions in person due to social and health anxiety and a sense of obligation to look after her extended family the sessions took place over the phone. This was sometimes challenging in terms of my interpretation of what was happening within the sessions was limited to audio although at times I wondered whether it meant I listened ever harder. I felt grateful that the service and my supervisor, due to their experience of the need for this with the client group, allowed for flexibility in the way of working.

Jane reported feeling confused with some of the early CFT psychoeducation I did in regard to old brain and new brain concepts and the roles the different parts of the nervous system play in terms of our felt emotional and somatic responses (Gilbert, 2014). This contrasted notably with the response to CFT work I had done previously in a university setting and I wondered how much of a role Jane ending her education at 16 played. Here I note that Jane reported feeling a pressure from her parents to finish school and get a job which is likely to have been impacted by the economic pressure Jane reported the family was under at the time. An important takeaway for me was for me to always be conscious of my communication style and to be flexible in my approach and to remain conscious of assumptions I was making. Specifically, in terms of applying CFT in similar situations leading with the three circles explanation of affect regulation might be a better fit. A further important takeaway here is for me to observe when my own uncertainty in regard to working with new presentations means I default to my “safe place” of the cognitive explanation.

My work with Jane helped me to see the essential role the experience of oppression and powerlessness can have on mental health in terms of ongoing feelings of inferiority, shame, guilt and self-criticism. I felt honoured that Jane trusted me enough to share with me the multiple experiences of powerlessness she had felt throughout her developmental years. The intentional inclusion of the social context that CFT makes felt useful for me and although I note that the power threat meaning framework (Johnston & Boyle, 2018) is another useful way of including these areas in clinical work, I felt CFT allowed me to keep these essential elements in the room and help Jane make sense of how these experiences had shaped her way of engaging through the world in a de-shaming and non-pathologising way.

A further takeaway for me was highlighting the power of the social psychology element of CFT. The focus on social connectedness and affiliation allowed me to feel I could work to keep the context of Jane's difficult early life history in the room while also emphasising the positive steps she had taken to build relationships that could serve as important resources for emotional regulation (Bohlmeijer, 2017). I believe this helped Jane to realise her own agency in relation to the relationship with her sisters.

I feel that through our work Jane gained an increased sense of flexibility in regard to the three coping strategies which we identified. Although we agreed that further work would be useful in regard to Jane finding more adaptive coping strategies for crowded places, Jane still reported a marked improvement in relation to her avoidance level on this front. Jane said she felt more able to leave the house in order to do her day-to-day tasks following adopting the habit of daily grounding techniques through breath work.

The avoidance of conflict with her sisters was the area where Jane said she felt the most had changed. Through our work together, Jane decided to change her coping strategy all together and verbalise her feelings directly with her sisters. This sense of agency which Jane seemed to gain I believe can be attributed in large part to the focus on helping her build and connect with the wise, courageous part of herself which she had lost contact with.

As supported by the research, Jane's ability to be more flexible in her coping strategies was key to her ability to successfully adapt to her new situation following her worsening physical health (De Ridder et al, 2008). This was something I held in mind during our work and perhaps, as I am relatively inexperienced in working in a physical health setting, contributed to my sense of needing to work extra hard.

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Section C: Publishable Piece

Title: A qualitative exploration of the lived experience of recovering addict participants attending a trauma reduction programme

Short title: A qualitative exploration of the lived experience of recovering addict participants attending a trauma reduction programme

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Abstract

Objective The purpose of this study is to gain a deeper understanding of the lived experience of attending a trauma reduction programme for self-identified addict participants in recovery.

Method Seven adult participants were recruited from the aftercare group of a trauma reduction programme. Semi-structured interviews were carried out, audio-recorded and transcribed. The data was analysed using Interpretative Phenomenological Analysis (IPA).

Results Three main Superordinate themes emerged from the data: **‘Making sense of intense emotional response to painful memories of childhood’, ‘Search for external relief’, ‘Acceptance of themselves with compassion and without shame and judgment’.**

All participants reported negative childhood experiences and subsequent shame and loss of self-esteem. Participants also reported difficulty with understanding their emotions and conflict in their adult lives. Participants reported searching for external relief through various means including self-medication. Themes around a need to recognise causes, having a language to explain, confronting shame and a move towards self-acceptance also emerged.

Conclusions This work has implications for professionals regarding the lack of integration of trauma interventions into addiction treatment planning. It highlights the legacy of shame and low self-esteem left by the participants’ experience of developmental trauma. The research indicates that addiction treatment may present a window of opportunity for trauma reduction, possibly helping with treatment dropout rates and reducing relapse rates.

Keywords: addiction, childhood trauma, developmental trauma, trauma reduction treatment, post induction therapy

Data availability statement:

All relevant data is within the paper and the Supporting Information section. Further data available on request.

Funding:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors

Introduction

Addiction is a major and increasing challenge causing widespread economic, societal, and personal problems (Littel, van den Hout & Engelhard, 2016). For instance, the World Health Organisation (WHO) estimates that approximately 31 million people globally have a drug use disorder (WHO, 2019). In 2018 there were 4,359 drug related deaths in England and Wales (ONS, 2019). Death by suicide is also one of the significant risk factors with Esang & Ahmed (2018), highlighting that there was a 10-fold increase in the chances of dying by suicide for those individuals with a substance addiction. Problem gambling is also recognised as being associated with significantly greater suicide risk (Tovino, 2016; Gill, Ahmadi & Pridmore, 2014). In 2020 there was over 93,000 deaths from drug overdose in the US, the highest number in a single year to date (Proctor, Lipsey & Rigg, 2022). 40% of people with a substance use disorder in the US report not receiving treatment due to stigma related reasons (Wakeman & Rich, 2018).

Although there is still some debate around the aetiology of addiction, in particular between the disease versus the psychosocial models, over whether addiction is primarily genetic or instead acquired as a

result of traumatic lived experience (Hammer et al, 2013; Wiens & Walker, 2015), a large body of research literature shows that trauma is positively correlated with addiction (Van Dam, et al., 2014; Fuchshuber, et al, 2018; Hagborg, Thorvaldsson, Fahlke, 2020). Despite the positive correlation between addiction and trauma, clinical practitioner views on appropriate addiction treatment vary. Some clinical practitioners have concerns that addressing trauma and addiction jointly may destabilise addiction recovery (Brown et al., 2013; Gielen, 2014). For instance, Gielen (2014) noted that while 12 out of 14 clinical practitioners interviewed at an addiction care facility believed in joint treatment in theory, almost none were willing to allow this in practice. Other research has indicated the potential risks of not addressing underlying trauma as part of related addiction treatment, such as drop-out and relapse (Brown et al., 2013; Prangle et al., 2018). Studies have also shown that drop-out and relapse have been highlighted as significant challenges for addiction treatments (Choi et al., 2013; Guerrero et al., 2016; Landrum et al., 2015; Kumar et al., 2016; Whitten, 2020). Yet the addiction treatments being offered still often seem to be focused on addiction treatment in isolation, rather than including trauma reduction treatment (Wiechelt, 2014). Additionally, while some studies have been carried out into addicts' own direct experiences of addiction treatment (Shinebourne & Smith, 2009; Rodriguez and Smith, 2014; Coltea, 2016; McPhee & Fenton, 2015), there is a lack of research into recovering addicts' own individual perception of treatments that include trauma reduction treatment.

The current study

This study therefore aims to address this gap in the academic research literature by exploring the experience of attending a trauma

reduction programme (TRP) of treatment whilst in recovery from addiction. Specifically, the trauma reduction programme (TRP) that will be looked at in the study will be informed by *Post Induction Therapy*. The reason PIT was chosen is that there is a notable lack of research looking at this approach and it is currently offered in several British treatment facilities and so access to participants was possible. Post induction therapy (PIT) is a trauma reduction programme run in a group format over five days on an outpatient basis. The therapy is focused on developmental trauma and is made up of a combination of psychoeducation, talk therapy and experiential work influenced by Gestalt therapy. Family Systems theory and Schema therapy serve as the theoretical framework (Bridge, 2016; Melody, 2003). This study will use the term “TRP” to refer to the PIT informed TRP to reflect the language used by the participants.

Methodology and Methods

Sample selection

I adopted a qualitative design using purposive sampling and Interpretative Phenomenological Analysis (IPA) as its methodology (Smith et al., 2009). I recruited participants from an aftercare group for recovering addicts who had completed a TRP. To meet the inclusion criteria for this study all participants had to be over 18, have completed TRP treatment following completion of addiction treatment, have been in recovery for a minimum of three months post-treatment and currently be attending a post-treatment aftercare programme. My aim was to recruit 6-8 participants.

Participants

7 participants participated in the study. Table 1 gives demographic details of the participants. One female and six males participated in this study. Participant number depicts the order in which they were interviewed. Gender, ethnicity, period of time in recovery (pre attendance of the TRP) and period of time from TRP completion to interview are shown in the table below, as these were evident from the interview content. The age range of the participants was approximately 25-55 years of age.

Table 1: Demographics

Participant number and pseudonym used	Gender	Ethnicity	Period in recover	Period from TRP to interview
P1 Arv	Male	White British	1 year	18m
P2 Boris	Male	White British	19	9m
P3 Charlie	Fema	Black British	3m	2y
P4 Drew	Male	White British	18m	18m
P5 Euan	Male	White British	1 year	6m
P6 Freddy	Male	White British	4m	4y
P7 Gregory	Male	White British	3m	2y

Procedure

I used semi-structured one-to-one interviews for data collection. A copy of the interview schedule can be seen in Appendix A. Interviews lasted between 60–90 minutes each and were carried out remotely via secure platform. The interviews were carried out in this format due to COVID-19 government guidance. The research followed the British Psychological Society, 2014, BPS Code of Ethics and Conduct, 2018

and Health Care and Professions Council, 2016 research ethics guidelines. The research was approved from City University's Ethics Board prior to recruitment of participants (ETH2021-0673). Participants received participant information sheets and signed consent forms. After the interviews the participants received debrief sheets.

Analysis

I analysed the transcripts using an IPA approach. Key to IPA is its idiographic and phenomenological emphasis, meaning it has a focus on the individual and personal experience of study participants and how they make sense of their subjective experience (Pietkiewicz & Smith, 2014). IPA acknowledges the role of the double hermeneutic process, that I as the researcher was interpreting the participant's accounts. This explicit acknowledgment was important as I had experience in the TRP model gained during my clinical training.

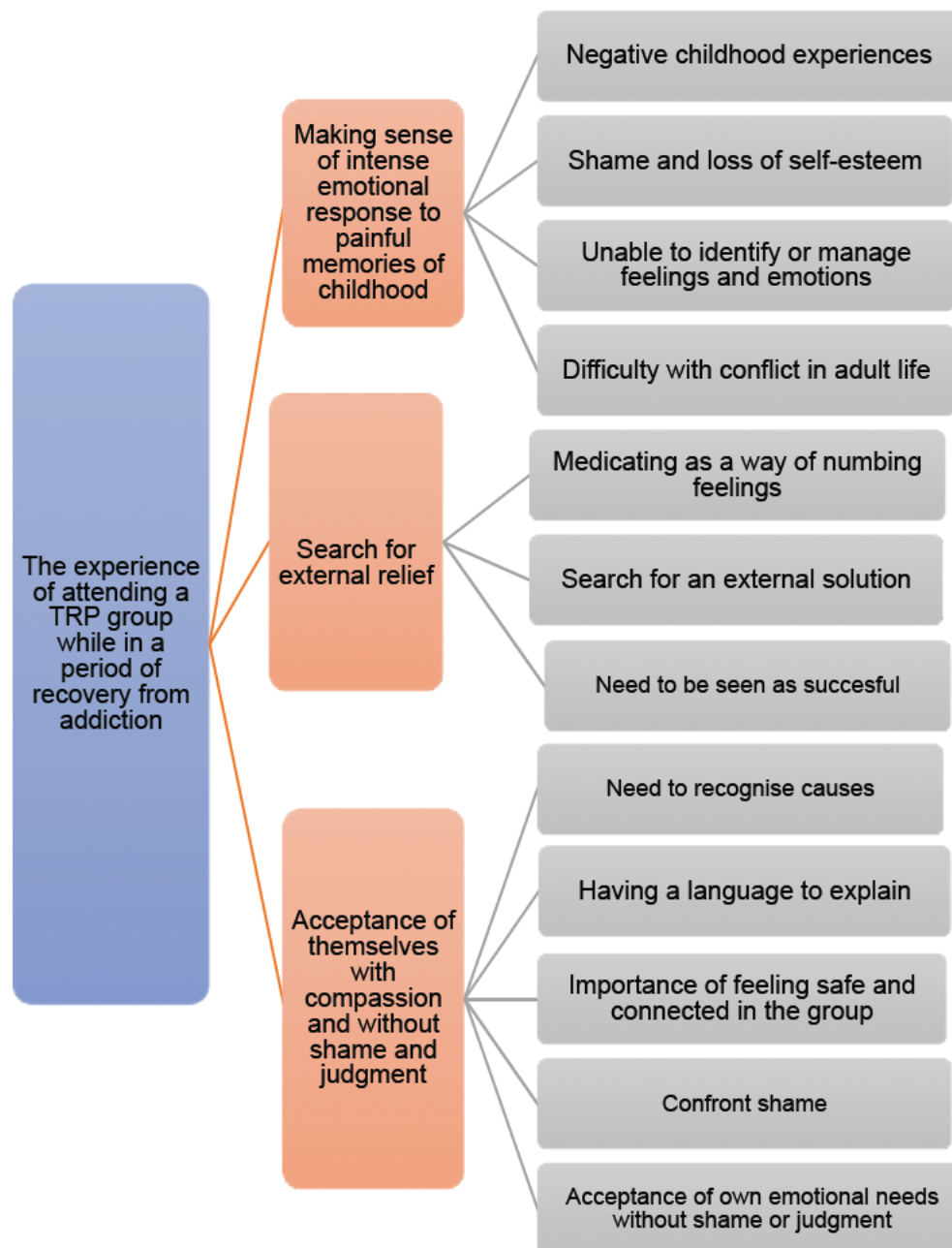
The IPA analysis used six steps (Smith et al., 2009), (Pietkiewicz., & Smith, 2014) iteratively building a list of themes, clustering them, creating a table of themes for the first participant interviewed and then continuing the analysis with other participants. The steps were (1) numerous reading of the transcripts; (2) initial line by line analysis with note taking with a focus on the semantic content; (3) initial identification of emergent themes; (4) looking for connections across the emergent themes to cluster into superordinate themes; (5) repeating previous steps for each transcript; (6) searching for overall pattern of themes across all transcripts and grouping into superordinate themes (Smith et al., 2009).

To improve rigour, I passed my interpretations by both my peer research group and research supervisor regularly.

Results

Analysis of the individual transcripts identified 3 superordinate themes made up of 12 emergent themes. The themes are all connected and influence each other to help understand the phenomena. A map of themes can be seen in Figure 1 below with the boxes connected to represent the interrelated nature of the themes.

Figure 1: Map of themes



Superordinate Theme 1: Making sense of intense emotional response to painful memories of childhood

1.1 Negative childhood experiences

The participants all described how the TRP led them to reflect on their negative experiences from childhood. These experiences took various forms such as violence, neglect, and emotional enmeshment. For instance, Arv describes how he was the youngest in the family with a father who could not face adult issues:

“was probably from the age of about six I guess, I was the youngest, he was unable to cope with life, he’d obviously had a terribly dysfunctional upbringing himself and he was more of a wounded child as a parent, than a functioning adult parent. And it manifested itself in kind of dark moods, anger, violence, all that kind of stuff”

Arv seemed very aware of what he had lost because of his negative childhood experiences. He spoke of feelings of grief and the challenge and element of risk in facing these matters:

“you have that kind of awareness of something in your childhood which is negative, which has been taken away, which you’ve lost”

Like Arv, Drew also described the difficulties he had with growing up in a violent household:

“when I was growing up my dad, my dad never really liked me, my dad was physically quite abusive, he would hit me and my sister really, really hard for just anything really, not because he

needed to discipline us but just because he was angry and it made him feel better to hit somebody”

1.2 Shame and loss of self-esteem

The participants all described how the TRP clarified their understanding of the emotions and memories associated with feelings of shame they carried from childhood.

Arv noted he felt that the participants confronting their feelings of shame was a central part of the TRP experience. He spoke enthusiastically about the power of the TRP for him and others to face up to their feelings of shame.

“Yeah and that’s great as well because I think a big issue for everyone is shame, isn’t it, and that’s very toxic..... all the stuff which I’d been carrying around which has made me feel like I’m different, that I’ve got this secret which I’ve been burying”

Arv’s reference to feeling “different” implies the sense of disconnect from others and of low self-esteem he had experienced. His use of “secret” and “burying” can be understood as forms of hiding and low self-esteem within the family.

Euan described how he realised that he was “carrying” shame that he felt from his parents:

“It was kind of just identifying that I was carrying shame from my parents” (5.4.1).

He described how he felt he never fitted in with either his family or society:

“my growing up, my sexuality was a big thing for me, growing up gay. I didn’t really feel like I belonged anywhere and then felt like I had, I never felt a sense of belonging or a normality”
(5.10.1)

Interwoven with Euan’s feelings of shame are the feelings of loneliness and sense of disconnection he felt as a child. Here he attributes much of this difficulty to the sense he was making of his sexuality and sense of identity and belonging. Euan’s use of the word “normality” perhaps implies an understanding of himself as a child as abnormal. There is sense of low self-esteem, of being different, an outsider.

1.3 Unable to identify or manage feelings

Participants described understanding and managing their emotions as previously difficult. They expressed a sense of having a lack of emotional control in their lives.

Freddy described his difficulty with recognising emotions prior to his trauma treatment as follows:

“beforehand there was just a cacophonous committee of, you know, negative self-talk and childish emotions and I didn’t even recognise the emotions”

The use of this rich term “cacophonous committee” seems to really embody and capture the sense of disharmony of competing thoughts and feelings Freddy was struggling with prior to attending the TRP.

Charlie similarly described her struggle with being able to understand and name how she was feeling:

“I just did not know how do I identify this is fear, how do I identify that this is anger”

1.4 Difficulty with conflict in adult life

The participants varied in their adult responses to the emotional environment they were confronted with as children. Most became avoidant of potential conflict as adults in one form or another, such as resulting from disagreement of any kind, or intimate relationships.

Arv described how, because of the very violent home life he was brought up in, he sought to avoid disagreement of any sort in his adult life. For instance, he was willing to accept any work assignment he was given, travel anywhere and never argue with his managers:

“I used to travel everywhere so I guess I was a bit of a workaholic and of course having been brought up in a violent household I was conflict averse”

In the case of Drew, the avoidant behaviour took the form of avoidance of potential conflict arising from any form of close relationships. His relationships with his family had left him feeling powerless and suffocated and he recalls mirroring this in his adult relationships as he would:

“feel suffocated and want to push them away”

Superordinate Theme 2: Search for external relief

The second superordinate theme relates to the participants' recognition of their search, as adults, for some form of external relief from the intense emotional response to their painful memories of childhood.

2.1 Medicating as a way of numbing feelings

All the participants believed they exhibited addictive behaviour as a way of coping to numb their emotional issues

For instance, the addictive behaviours used to cope by Arv included binge drinking, over-work and manic exercise:

I mean I was binge drinking, I was exercising like a lunatic at certain times, I mean it was just, I look back and it was manic, completely manic.... I just kind of isolated, drank, didn't see anyone at all...trying to medicate”

Here Arv described how he isolated himself from people and drank to “medicate” which can be understood as his view of alcohol almost as a medicine.

2.2 Search for an external solution

Some of the participants noted how the TRP had brought them to the belief that the use of addiction treatment groups such as the AA and

other 12-step organisations were not, by themselves, sufficient to achieve the long-term stable recovery they sought.

For instance, Boris described how he had attended a wide range of 12-step organisations over the last 19 years:

“I kept going to, kind of moving around different 12-step fellowships, Co-Dependents Anonymous, ACA which was Adult Children of Alcoholics”

This movement from one support group to another seems to indicate Boris’s unease with the stability of his recovery and his longing for a solution external to himself. Boris describing his behaviour as *“kind of moving around different fellowships”* evokes a picture of a sort of nomadic search for connection.

Arv also recognised that he had tried many addictions groups without fully resolving his issues. He noted:

“I’d gone to loads of different, I tried all sorts of different groups”

Arv describes below how, despite trying many approaches to manage his drinking, he had struggled with periods of relapse into active addiction:

“I did a lot of things and, you know, so I stopped drinking, I’d stopped all that sort of stuff and then I went back into it again and again”

Arv's use of "again" repeatedly can be understood as portraying the cycle he feels stuck on. His use of 'all that sort of thing' perhaps indicating the exhaustion with it that he feels.

2.3 Be seen as successful

For some of the participants, they saw external success as perceived by others as a further way of coping with their emotional issues and a way to give themselves a sense of increased self-esteem. For instance, Euan noted that he had a need to be seen as successful as a defence against feeling seen as inadequate and insufficient"

"I was an over-achiever because I felt inadequate as a gay, young gay man"

Here, the use of the past tense by Euan indicates he may no longer hold this view of himself.

Superordinate Theme 3: Acceptance of themselves with compassion and without shame or judgement

3.1 Need to recognise causes

The participants all identified that attendees of the TRP needed to be in a mindset where they felt ready to accept the underlying emotional causes of their addictions.

For example, Arv commented that:

“I don’t think you can do this kind of work until your head is in a space where you’re actually dealing with the stuff which has gone on over the years, as opposed to trying to medicate”

Charlie described vividly how the TRP had given her the means to understand what had driven her addictive behaviours and appreciate these causes:

“now that I’ve peeled the onion of the trauma that I’ve been a victim of, how do I then counter its necessity, tendency to express itself in the media of addiction”

3.2 Having a language to explain

All the participants used the language from the TRP as a shared, common language. This shared language was used extensively and in a fluid fashion to explain their experiences.

Boris described this as follows:

“you say, what’s going on, who’s voice is this, what age is it, what part of me, what would functioning adult say”

Charlie seemed to feel she could understand and explain events in her life in a broader and richer way:

“And I realised that it’s like I had glasses, you know it’s like I was colour blind and I just got these glasses on or something changed and that I started looking around my life and I saw colours all around”

3.3 Importance of being safe and connected in the group

As the analysis of the transcriptions progressed, it became more evident that for all the participants a key aspect of the TRP was the extremely safe and connected nature of the treatment groups the participants were in.

For instance, Drew admitted that being open emotionally was potentially a very vulnerable position to be in. However, he had not found this to be a problem because of the closeness and security of the TRP treatment group:

“there were definitely moments in the week when I felt that, when I sort of felt sort of a natural tendency creeping in to close up a little bit. But I didn’t find that happened too overwhelmingly, just because I did feel very safe and very comfortable in a group with people I cared about and understood.....it’s probably the most well I’ve ever felt in my life”

Gregory noted that:

“I got a touch of some feelings and doing it in a group I found extraordinary because I never thought I would want to do it in a group, it would be too shameful...and of course that’s the interesting double bind because you’re so full of shame you don’t want to be vulnerable but actually vulnerability is often the antidote in a supportive environment”

These reflections by Gregory are very insightful. He reflects on being in touch with his feelings, on his feelings of shame, on the power of

the group, on his own feelings of vulnerability and low self-esteem and fear of speaking out. Multiple themes that come together here through the medium of the treatment group.

3.4 Confront shame

For all the participants, a common and significant thread arising from the TRP was the underlying shame they had picked up because of their negative childhood experiences and the importance of confronting this.

Euan used examples of the TRP language “giving back” and “carried” to describe his strong desire to free himself from the feelings of shame and desire to feel safe as follows:

“giving the shame back that I’ve carried and, um, it was an incredibly emotional experience of just kind of, um, you know, just going back to those key points, I guess, in my life, where I’d made decisions to act in a certain way or behave, and to kind of give back, in my instance to give back the shame that I’ve carried”

The power that the shame had in Euan’s life can be heard here. Euan describes his experience of revisiting, during the TRP, different important memories where shame had played a role for him and diminishing his sense of shame by “giving it back”. He conjures up a heaviness to the shame by saying he had been “carrying” it.

Similarly, Drew felt he was able to use the TRP to free himself from the shame he felt from both his parents by:

“metaphorically washing myself and again that was about just clearing away, cleaning away some of the shame”

3.5 Acceptance of own emotional needs without shame or judgement

In their various ways, the participants all voiced the importance of the increased self-awareness arising from the TRP. They had less of a sense of being triggered by external events. Completion of the TRP seems to have led to participants being able to look at their memories with more detachment.

For instance, Charlie now felt more able to identify when a potentially difficult situation might arise where feelings of shame and blame might be triggered. In addition, she now felt a greater understanding and acceptance of her emotional reactions to situations and people and therefore felt able to cope better:

“because I can identify when I have these shame and blame attacks, I can also see and it’s like I can accept things”

Participants emphasised the importance of learning to accept with compassion and without judgement of either themselves or others such as family. As Euan expressed it:

“it’s that lightbulb moment of perhaps realising that’s why you are the way that you are and, you know, it’s, it’s funny because you, you come out not, I don’t blame my parents for what happened, it’s not about blame and that’s what you learn”

Overall, this final superordinate theme, describes how, through the TRP, the participants were able to use the self-knowledge they had achieved to confront the shame and anger they had carried from childhood and accept themselves and others with a feeling of compassion and without continued judgement over either themselves or childhood families or carers. The participants now felt more accepted, not judged. As Arv expressed it:

“But it’s not like that anymore, you know, and they can see whatever they want and no-one gets judged”

Discussion

This is the first study to examine the experience of attending a developmental trauma reduction programme for addicts in recovery. The findings describe how the TRP experience allowed the participants to revisit their childhood abusers and, as adults, start to come to terms with their childhood experiences. The importance of the Gestalt chair work involved seemed to be in the way it allowed the participants to get a sense of confronting their abusers from the past and coming to terms with the past abuse. The use of Gestalt techniques for treating trauma in this way is in line with a recent APA paper that demonstrates the use of chair work for treating trauma (Kellogg & Garcia Torres, 2021).

One of the common aspects arising from the IPA analysis leading to the first superordinate theme was participant low self-esteem and the sense the participants made of it. Low self-esteem and shame are commonly reported feelings by adult addicts (Sweeney, 2018). This is

in line with the findings reported in the study. The IPA analysis used in this study additionally allowed for an insight into the sense the participants made of their lack of self-esteem as stemming from their early negative childhood experiences as well as driving their avoidance and addictive behaviours as adults. This, arguably, novel finding is in line with using a trauma informed approach to addiction treatment which encourages a curiosity about “what happened to you” rather than a more binary or static “what is wrong with you” approach (Sweeney et al, 2018). In addition, it is in line with the understanding of addiction from a developmental perspective, as a maladaptive self-soothing behaviour that is learnt during childhood or adolescence as a reaction to adverse circumstance (Carruth & Wallen, 2014).

Shame was another important, and interlinked, theme. This is in line with findings from recent studies suggesting shame can significantly contribute to developing trauma symptoms (La Bash & Papa, 2014).

The results give insight to how the participants made sense of their search for some external solutions as relief from their internal emotional pain.

Several of the participants described feeling a need to be seen as successful by others as a form of external solution. This theme of a drive for external validation amongst the recovering addict participants attending a developmental trauma focused treatment group, echoes findings by a recent paper published in the *Journal of Mental Health and Addiction* that found approval seeking behaviour was positively associated with addictive behaviour by people with early maladaptive schemas (Arpaci, 2021).

A further type of external solution that several participants described was attendance of a variety of addiction support groups without finding the relief they were looking for. For example, Boris tried a range of 12 step fellowships. Alcoholics Anonymous (AA) and other 12-step organisations look for what they term a “Higher Power” of some nature for addicts to connect to as part of their treatment process. Sussman et al (2011) suggested that in addiction recovery groups such as AA, that addicts may rely on this “Higher Power” to operate as a “substitute addiction”. This suggestion from Sussman suggests attendance of 12-step groups does not address the underlying problem driving addictive behaviour. This is in keeping with Mate’s (2012; 2022) argument that addiction is not the primary problem but instead the reasons for the emotional pain driving it are. The experiences of the study participants were not negative towards the use of 12 step organisations such as the AA but consistently reported feeling lacking in some way. The participants often saw the use of such groups and trauma reduction treatment as an effective combination.

Perhaps what these findings suggest is that instead of people in recovery picking up the understanding of addiction from their treatment provider as suggested by Koski-Jannes (2004), instead the explanation that feels aligned to the individuals’ own understanding of their addiction journey is most likely to get most buy in and therefore lead to high motivation for change and long-term recovery.

One of the key aspects of the TRP experience that was frequently talked about by participants was shame and how to deal with it. The participants expressed a strong belief that by recognising the shame and through confronting the abusers and communicating with their inner child like states, the participants could “give back” the shame

they had felt as adults back to their abusers. The findings described an experience in which the participants recognise the role that shame and resultant damage to self-esteem had played in their adoption of addictive behaviours.

Shame has also been found to lead to avoidance behaviour as well as relapse; Randles & Tracy (2013) did a study of recovering alcoholics and found that shame may motivate hiding, escape, and general avoidance of the problem. This could be understood as explaining a lot of the initial avoidance behaviour reported by the participants prior to attending the TRP as well as the relapses reported by many along their addiction treatment journey. The determination to change reported here can perhaps be understood as being, in part, driven by a desire to reduce their feelings of shame combined with a belief that that is possible. This reduced shame in turn might facilitate a more stable addiction recovery as it might allow for less avoidance and relapse behaviour.

The findings are shown to be consistent with earlier research, for instance, that shame reduction is helpful to breaking the cycle of relapse. The study contributes novel findings concerning low self-esteem and shame. While these are frequently described feelings by adult addicts in the academic literature, the IPA analysis used in this study gave a fresh insight into the sense the participants made of their lack of self-esteem as stemming from their negative childhood experiences as well as driving their avoidance and addictive behaviours as adults.

Another finding from this study relates to the improvement in participant's levels of shame through self-compassion. Research is lacking into the subjective experience of shame after trauma

interventions, but shame has been shown to strongly lead to the maintenance of trauma symptoms as well as negatively impacting addiction recovery. With this in mind this finding, should be considered in terms of clinical implications going forward.

Limitations

The fact that the phenomenon being asked about in this study had taken place in the past means that it was retrospective in nature. This means that a potential weakness is the recall biases that might have been present in the participants accounts. This could have been more marked than average as trauma and certain kinds of addiction, such as substance addiction are associated with negative effects on memory recall.

As the interviews had to be carried out online due to COVID19 restrictions the limitations associated with working in an online format may also apply such as potential difficulty building rapport, conversation possibly feeling abrupt to participants and missed non-verbal communication

Future Research

This research focused on an example of sequential trauma reduction treatment, after participants first completed addiction treatment. Further work looking into the experience of attending concurrent addiction and trauma treatments would be beneficial to understanding whether these different formats are experienced differently by service users.

Future research could include a quantitative element, to be able to include outcome measures to better understand the efficacy of the

TRP being looked both in terms of trauma symptoms and addiction recovery measures.

Future research could also benefit from taking a longitudinal stance to better understand the interaction effect of the TRP on the addiction recovery journey of the participants longer term.

It would be important for future research to include participants from other ethnic backgrounds who self-identify as addicts in recovery and who have attended the TRP to see if similar themes arise.

Practitioner Points

The study findings indicate a need for an integrated, holistic approach to addiction treatment. In practical terms, that appears to translate into recognising the study participants experiences and concerns about their emotional processes (issues with childhood trauma, shame, low self-esteem) being regarded as part of and as highly as treating the physical nature of their addiction (direct addiction treatment).

Practitioners could therefore consider including trauma assessment for service users as part of their treatment planning. In addition to dealing with the trauma aspects of addictive behaviours, this approach may help build the relationship with service users to improve the likelihood of successful addiction treatment and reduce the chances of relapse and treatment drop out.

This study indicates that the TRP treatment itself is just part of the process and it may be important to have well organised aftercare support in place so that recovering addicts continue to have the group support of others who have been part of a similar TRP that they have experienced. Continuing to have that trust and connection with others

was indicated to be a crucial part of the TRP process. COP practitioners may also benefit from consideration of this for service development going forward.

Conclusions

The research has shown a change in perspective for the participants to a position where they can be accepting of their negative childhood experiences without feelings of personal shame, blame and anger towards others. This is reflected in the stability within their current families and relationships. The common theme expressed by the participants was a belief that the TRP is important to maintaining a stable addiction recovery and has an important role to play within an integrated addiction treatment programme.

This research focuses on the experience of a vulnerable and often stigmatised social group who, to date, have not been given a voice to express their lived experience of attending a trauma focused intervention while in addiction recovery. It is my hope that the insights from this research can encourage therapists to design and put into practice interventions and policies that are better informed by end user experience.

Supporting information



Appendix A: Interview schedule

1) How did you come to have trauma reduction therapy? (Clarification - recommended once on addiction treatment programme? Did you select the treatment programme because of the PIT informed element?)

2) Could you describe what happened during trauma reduction therapy in your own words?

Prompt: what was helpful? What was missing? What did the therapy feel like?

3) How did you feel when you were in therapy?

Prompt: physically, emotionally, mentally? How did you interpret this?

4) What did you experience as the most significant challenge during the trauma reduction therapy?

5) Do you feel the experience of the trauma reduction therapy has impacted on your understanding of your relationship with addiction? If so, how?

6) How does it feel to consider recommending the trauma reduction therapy to a friend? How do you interpret this?

7) Do you think there is anything I have missed that could be helpful in understanding anything you want to say? (Optional)

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