

Experiences of Psychotherapy Among Adult Survivors of Complex Post-Traumatic Stress Disorder: A Systematic Review and Meta-Ethnography

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Acknowledgments

Abstract

Background: Complex post-traumatic stress disorder (CPTSD) is associated with significant relational, emotional and identity-related difficulties, often rooted in prolonged interpersonal trauma. Despite increasing recognition of CPTSD, less is understood about how individuals experience accessing and engaging in psychotherapy, particularly within real-world service contexts. This review synthesised qualitative research to develop a conceptual understanding of these experiences and the therapeutic journey from the perspective of those directly affected. **Method:** Systematic searches across four databases identified 15 studies, representing the perspectives of 242 adults with CPTSD. A meta-ethnographic approach was used to analyse and integrate findings, allowing for the development of higher-order interpretations across studies. **Results:** Three interconnected processes characterised participants' experiences of therapy. Establishing relational safety and trust was central to engagement and formed the foundation for therapeutic work. This enabled trauma processing and the development of coping strategies, often described as gradual and emotionally demanding. Over time, participants described increasing empowerment, self-compassion and acceptance, alongside a growing capacity to make sense of their experiences. Recovery was experienced as cyclical rather than linear, with individuals revisiting earlier stages in response to new challenges and changing life circumstances. **Conclusions:** Findings highlight the importance of relational, trauma-informed and flexible approaches to psychotherapy. Improving access to specialist, consistent support and addressing systemic barriers remain essential to meeting the complex and evolving needs of people with CPTSD, particularly within stretched service systems.

Keywords: CPTSD, psychotherapy, recovery, trauma-informed care, meta-ethnography

Introduction

Complex Post-Traumatic Stress Disorder (CPTSD) is increasingly recognised as a global mental health concern with population prevalence estimates typically ranging from around 2-8% and substantially higher rates reported among trauma-exposed groups (Maercker et al., 2022). CPTSD was formally included in the International Classification of Diseases (ICD-11) in 2018 and extends beyond core PTSD symptoms by involving persistent difficulties in emotional regulation, self-concept and interpersonal relationships (National Health Service [NHS], 2021; NICE, 2018; Rosenfield et al., 2018). People with CPTSD experience higher rates of comorbidities and social isolation compared to those with PTSD (Coventry et al., 2020; Dagan & Yager, 2019; Karimov-Zwienenberg et al., 2024). These challenges often co-occur with physical health problems, increased healthcare utilisation and elevated risk of self-harm or suicide (Iazzolino et al., 2024; Jannini et al., 2023). While these distinctions are observed across cultural contexts (Cloitre et al., 2020), the complexity of CPTSD symptoms can present challenges for accurate diagnosis and treatment, sometimes resulting in fragmented care (Brown, 2021). CPTSD also shares features with borderline personality disorder (BPD), including emotional dysregulation, interpersonal difficulties and disturbances in self-organisation, contributing to ongoing diagnostic debate. However, CPTSD is distinguished by the presence of core PTSD symptoms and is conceptualised as arising following prolonged or repeated traumatic experiences. While both conditions may involve difficulties in self-concept and relationships, CPTSD is typically characterised by a persistently negative self-concept, whereas BPD has been associated with broader instability in identity and sense of self. Although overlap and comorbidity are common, CPTSD is recognised as a distinct diagnostic construct within the ICD-11 (Cloitre et al., 2014; Maercker et al., 2022).

In the United Kingdom (UK), recommended trauma treatments include Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) (NHS, 2024; NICE, 2018). People with CPTSD typically require longer-term, phased and more personalised interventions which address stabilisation, trauma processing and reintegration (Corrigan et al., 2020; Karatzias et al., 2018; Voorendonk et al., 2020). Therefore, concerns have been raised about applying PTSD-derived treatment models to CPTSD without adaptation, particularly given CPTSD's broader psychosocial impact (Alpert et al., 2024; Resick et al., 2012). This is especially relevant in the UK, where CPTSD is increasingly recognised as a significant concern within specialist mental health services, such as community mental health teams, psychological therapy services, psychiatry, and specialist outpatient services. Although lifetime prevalence in the general population has been estimated at approximately 13%, substantially higher rates have been reported in treatment-seeking populations and specialist trauma services (Karatzias et al., 2017, Murphy et al., 2021; NHS Education for Scotland & Scottish Government, 2025). While the NHS has developed specialised services and frameworks following CPTSD's ICD-11 inclusion (NHS England, 2024; 2019a; 2019b), regional disparities and inconsistent implementation remain (Health Education England, 2023; Hopkins, 2020; UK Psychological Trauma Society, 2017).

Recognition and treatment of CPTSD varies significantly across global healthcare systems. Regions following the ICD-11 guidelines including much of Europe and Australasia increasingly implement specialised therapy protocols (de Boer et al., 2021). In contrast, the United States does not recognise CPTSD within the DSM-5-TR (Nussbaum, 2022), instead categorising its symptoms under PTSD or borderline personality disorder (Herzog et al., 2020; Maercker et al., 2022). Awareness is also growing in regions affected by conflict, particularly in parts of the Middle East and Africa, although access to specialised

psychotherapy often remains limited (Bovey et al., 2024; Rink & Lipinska, 2020; Vallières et al., 2018). In some Asian contexts, emerging treatment approaches integrate culturally specific healing practices with contemporary psychotherapy (Ho et al., 2020). These variations highlight ongoing inequities in recognition, treatment provision and access to care.

Given the relatively recent formal recognition of CPTSD and the continued development of its evidence base, a focused review of the literature is timely. While quantitative research has explored a range of therapeutic interventions for CPTSD (e.g., Darby et al., 2023; Hébert & Amédée, 2020; Lampe et al., 2024), these studies tend to prioritise symptom outcomes and offer limited insight into the lived experience of engaging in psychotherapy. Existing systematic reviews highlight the effectiveness of evidence-based approaches, yet also point to ongoing challenges around standardisation, cultural responsiveness and longer-term impact (Blackie et al., 2024; Karatzias et al., 2019b; Purnell et al., 2021). From a counselling and psychotherapy perspective, understanding how individuals experience therapy, particularly the relational, contextual and meaning-making aspects of the process, is central to informing practice. Although some qualitative syntheses have begun to explore trauma-focused therapies (e.g., Lepistö et al., 2025), these often take a broad view of trauma and do not attend specifically to the distinct relational and identity-related complexities of CPTSD. As such, there remains a lack of interpretative work that emphasises survivors' experiences of psychotherapy and how recovery unfolds within therapeutic relationships.

This review aims to address this gap; by synthesising qualitative research on the experiences of adult survivors of CPTSD in accessing and engaging with psychotherapy, this review aims to develop a deeper, practice-relevant understanding of how individuals with

CPTSD experience psychotherapy, with particular attention given to relational processes and recovery pathways.

Method

Design

This review was informed by an interpretivist paradigm, which assumes that experiences are understood through the meanings which individuals attribute to them and that knowledge is generated through the interpretation of those experiences (Mayan, 2016). Consistent with this position, the aim was not to aggregate findings but to develop higher-order interpretations of how individuals with CPTSD experience psychotherapy. Given this focus, a meta-ethnographic approach was chosen (Noblit & Hare, 1998; Sattar et al., 2021). Meta-ethnography enables the interpretative synthesis of qualitative studies while preserving contextual nuance, generating higher-order conceptual insights (third-order constructs) through the re-interpretation of participant accounts (first-order constructs) and study findings (second-order constructs). This study was prospectively registered with PROSPERO.

Systematic Search

The first author conducted the original systematic searches in January 2024, on four relevant databases: PsycINFO, CINAHL, MEDLINE and Academic Search Ultimate. Search terms were used to identify qualitative literature on people with CPTSD experiences of psychotherapy. The search strategy utilised free-text search terms (Table 1) across the following areas: CPTSD, psychotherapy and qualitative research. Searches were conducted in January 2024. Boolean operator 'OR' was employed within concept searches, and 'AND' was used to combine search terms. Searches were restricted to titles and abstracts. This systematic review was conducted and reported in accordance with PRISMA guidelines.

[Table 1 near here]

Papers were selected for inclusion based on the following criteria (see Table 2): participants aged over 18 years; engagement in therapy; inclusion of qualitative data analysis; publication in English in a peer-reviewed journal; presentation aligning with the NHS definition of CPTSD (NHS, 2021). Given the recognised overlap between CPTSD and BPD, studies were not excluded on the basis of comorbid personality disorder diagnoses. Rather, eligibility was determined by whether participants were identified as having CPTSD, or experiences consistent with the NHS (2021) description of CPTSD. Restricting inclusion to formally diagnosed cases was considered inappropriate given CPTSD's relatively recent recognition in the ICD-11 and ongoing international variation in diagnostic practices. No date restrictions were applied to capture studies predating formal CPTSD diagnosis and to reflect evolving conceptual and diagnostic understandings. Papers were excluded if they focused solely on therapists' or professionals' perspectives, combined therapist and patient views without clear distinction, or did not sufficiently differentiate CPTSD from PTSD according to the NHS (2021) definition.

[Table 2 near here]

The initial database search yielded 2502 papers, from which 1824 remained after duplicate removal, utilising the method described by Bramer et al. (2016). Subsequently, the titles and abstracts of these papers were screened, resulting in 57 papers eligible for full-text retrieval. Following further examination of the full texts, 15 papers met the inclusion criteria for the review. To ensure the review remained current, the second author reran the searches in June 2026 using the original databases, search terms, and eligibility criteria, covering the

period from February 2024 to June 2026. The updated search identified 1,088 records. Following removal of duplicates, 1,069 records were screened by title and abstract, resulting in eight full-text articles being assessed for eligibility. No additional studies met the inclusion criteria. Eligibility decisions and uncertainties regarding study inclusion were discussed among the authors throughout the review process. As independent duplicate screening was not undertaken, inter-rater agreement statistics were not calculated. The search process is presented in the PRISMA flow diagram in Figure 1.

[Figure 1 near here]

Quality Appraisal

Quality appraisal was conducted by the first author using the Critical Appraisal Skills Programme (CASP) Quality Checklist (2018). Numerical values were assigned to each paper using Duggleby et al. (2010) rating system. This scoring system yields a maximum score of 24. The papers obtained scores ranging from 22 to 12, as detailed in Table 3. All papers were included regardless of CASP scores. Appraisal decisions and any uncertainties regarding study quality were discussed with the second and third authors throughout the review process, who provided supervision and guidance. As quality appraisal was not conducted independently by multiple reviewers, discrepancies and inter-rater agreement were not assessed. The results were used to contextualise each study's strengths and limitations within the synthesis. This reflects recommendations against excluding qualitative research solely on rating scores, recognising methodological diversity and the interpretive nature of quality assessment (Mayan, 2016).

[Table 3 near here]

Data Synthesis

Data abstraction and synthesis adhered to the established approach to meta-ethnography, as outlined by Noblit and Hare (1998) and refined by Sattar et al. (2021). Initially, papers were repeatedly read to develop a comprehensive understanding of the experiences of adults with CPTSD in psychotherapy. Key constructs and concepts relevant to this experience were identified and noted. Subsequently, first- and second-order constructs were extracted from all papers, allowing for an in-depth analysis of their content. These constructs were then examined, categorised and compared based on their shared and disparate characteristics. Through this iterative process, third-order constructs emerged, providing a more comprehensive understanding of the synthesised findings. A line-of-argument synthesis of all third-order constructs concluded the analysis process (see Figure 2).

Reflexivity

This review was informed by an interpretivist paradigm, recognising that the synthesis process is influenced by researchers' perspectives and interpretations. The first author was a Clinical Psychology trainee with an interest in trauma and psychotherapy, while the second and third authors are experienced researchers with expertise in qualitative methods and trauma-related mental health difficulties. Reflexivity was considered throughout the review, with the first author leading the analysis and the second and third authors providing ongoing supervision and critical discussion of emerging interpretations and higher-order constructs. This process helped ensure that the synthesis remained grounded in the primary studies.

Results

Study Characteristics

Fifteen papers were included in the meta-ethnography, of which key characteristics are summarised in Table 4. Publications ranged from 1997 to 2023. The studies were conducted in various countries, including the United Kingdom ($n=6$), United States of America ($n=3$), Israel ($n=3$), Canada ($n=2$), and Australia ($n=1$). The review encompassed data from 242 participants with sample sizes ranging from 36 to seven, in addition to one case study. Of these participants, 178 identified as female and 64 as male. The included studies represented a diverse range of psychotherapeutic approaches for CPTSD and complex trauma. Group-based interventions were most commonly represented ($n = 8$), including trauma-focused, schema therapy, voicework, and nature-assisted group programmes. Other approaches included body-oriented therapies ($n = 2$), culturally adapted CBT interventions ($n = 2$), and phase-oriented treatments ($n = 2$), one of which incorporated Compassion Focused Therapy principles. Three studies explored experiences of psychotherapy more broadly without focusing on a specific therapeutic model. Interventions were delivered across a range of settings, including specialist trauma services, inpatient programmes, psychiatric hospitals, and community-based services. Where reported, treatment intensity and duration varied considerably, although several studies did not specify the number of sessions completed. This diversity should be considered when interpreting the findings presented below.

[Table 4 near here]

Data Translation

This meta-ethnography generated a model that conceptualises how individuals accessing psychotherapy for CPTSD engage and how this, in turn, impacts on their recovery process; CPTSD clients move through three interconnected stages while often revisiting earlier phases (Figure 2). As illustrated, *establishing relationships and trust* forms the

foundation of this process, as relational safety enables meaningful therapeutic engagement. This trust supports trauma processing and psychological adaptation, involving the gradual confrontation of distressing memories, regulation of emotional responses and navigation of therapeutic challenges. Over time, this can foster personal empowerment and growth, including greater self-compassion, self-acceptance and insight into the impact of trauma. However, this journey is rarely linear. Difficulties encountered during trauma processing may renew the need for safety, leading individuals to revisit trust-building before progressing further. Relational trust therefore acts both as a prerequisite for therapy and an ongoing stabilising resource. As distress levels fluctuate, survivors may need to re-establish safety at different points, while developing empowerment and coping capacity that support continued trauma processing and psychological growth.

[Figure 2 near here]

Construct One: Establishing Relationships and Trust

Establishing relationships and trust emerged as essential for therapeutic progress in CPTSD recovery. Trust functioned as both a prerequisite for engagement and a catalyst for growth, emerging as a dynamic, multi-contextual process that underpinned post-traumatic recovery. This construct was highlighted in 13 of the included papers (see Table 5). Trust developed across three contexts: individual therapy (Subconstruct 1: Relationship with Therapist), within group settings (Subconstruct 2: Relationship with Group) and the wider community (Subconstruct 3: Relationship with Community).

Relationship with Therapist. The therapeutic relationship emerged as the primary context for establishing trust, functioning as a crucial foundation for personal empowerment

and navigating challenges. Participants consistently emphasised the therapist's ability to create safety and acceptance was fundamental to developing the therapeutic relationship for people with CPTSD (Draucker & Petrovic, 1997; Willis et al., 2023), “I felt so close to her [the therapist]...the therapy eased my discomfort feelings and that was enough” (Shamai & Levin-Megged, 2006, p.701). Trusting the therapist also helped some participants to engage more deeply in the healing process: “I was not trusting anybody in the world...I started to love people, to trust people” (Matheson & Weightman, 2021, p.693). Relational trust in the therapist functioned as a stabilising force, enabling participants to navigate vulnerability, confront emotions and develop coping mechanisms.

However, the therapeutic relationship also presented challenges when some survivors found it difficult to establish a sense of safety and trust: “I worked with [the therapist] for a year and probably for the first 5 months it felt really dangerous to be in a relationship with her” (Matheson & Weightman, 2021, p.693). Additionally, participants sometimes experienced a complex dynamic in which support was valued despite fluctuating feelings of connection and distance: “I respected [the therapist] very much and liked to talk with her, but I didn’t feel a real closeness” (Shamai & Levin-Megged, 2006, p.703). The therapeutic relationship emerged as vital and complex, with participants experiencing degrees of safety, trust and connection that influenced their recovery.

Relationship with Group. Group relationships, trust-building and bonding were essential to the group experience, offering participants a space for meaningful connections and mutual support: “It was really nice to be able to connect with others...” (Younan et al., 2018, p.472). While some initially struggled with trust, the group environment fostered meaningful connections over time (Bahu, 2019; Matheson & Weightman, 2021). Participants

found support in shared experiences, empowering them to face challenges together: “We are stronger and we will use this experience to support others” (Bahu, 2019, p.14). Mutual support was particularly evident during difficult moments: “The group singing enabled mutual support and to be there for each other during unbearably difficult moments” (Riabzev & Bensimon, 2023, p.5).

The group provided a sense of belonging and shared experience, alleviating isolation while reinforcing the interconnectedness between trust, empowerment and shared emotional growth (Chouliara et al., 2020; Hegarty et al., 2022; Younan et al., 2018). Many participants found comfort in knowing others had faced similar difficulties: “There’s huge comfort in knowing that there’s other people out there that suffer the same” (Willis et al., 2023, p.12). The group setting also provided a supportive, non-judgemental atmosphere where participants could express themselves freely without fear of criticism: “I knew when I got there that I would be understood, that I wouldn’t be judged” (Ashfield Chan & Lee, 2021, p.293). This sense of acceptance fostered safety and encouraged continued engagement, despite personal challenges (Shorer et al., 2023; Bahu, 2019). However, some participants experienced persistent feelings of disconnection: “I always...felt different from everybody. And then I wasn’t allowed to talk about that...” (Palmer et al., 2007, p.70). While group settings generally fostered belonging and mutual support, they require careful facilitation to balance inclusivity with individual needs.

Relationship with Community. Reintegrating into the community was a key aspect of post-traumatic growth for many participants (Riabzev & Bensimon, 2023). Growth was reflected in participants’ ability to engage socially without fear: “I can socialise more now without feeling panicky or thinking that I am going to be attacked” (Matheson & Weightman,

2021, p.693). Therapy helped reduce fear of others, shift perceptions of social interactions and reduce barriers: “I was afraid...that everybody was out to hurt me...I’ve met up with a couple of friends...before that wouldn’t have happened” (Willis et al., 2023, p.10). This reduction in fear enabled participants to rebuild relationships and expand their social circles (Riabzev & Bensimon, 2023). Therapy also fostered a restored sense of belonging; participants who felt disconnected began reconnecting with their communities: “I have this sense of belonging, connectedness, whereas before...I was terrified of this world” (Parker et al., 2007, p.69). This transformation allowed them to re-establish meaningful relationships and engage in the wider community: “I isolated myself...now I am going to the temple and speaking to the family I live with. I am making an effort to relate to people” (Bahu, 2019, p.14). This shift from social withdrawal to active community participation highlights therapy’s role in rebuilding social confidence and sense of belonging.

Overall, relational trust served as the foundational mechanism enabling other elements of recovery, including empowerment and coping mechanisms to develop. By fostering emotional safety, trust allowed participants to explore trauma. Its cyclical nature ensured continuity across therapeutic contexts, with trust cultivated in individual and group therapy facilitating community reintegration and reinforcing participants’ capacity for connection. As both a catalyst and stabilising force, trust bridged therapeutic processes with broader social and emotional growth, highlighting its central role in the iterative nature of CPTSD post-traumatic growth.

Construct Two: Trauma Processing and Psychological Adaptation

Following the establishment of relational trust, participants progressed to trauma processing and psychological adaptation. This involved confronting distressing experiences

(Subconstruct 1: Confronting Trauma), regulating intense emotions (Subconstruct 2: Managing Emotions) and navigating persistent struggles despite therapeutic progress (Subconstruct 3: Navigating Difficulties). Trauma processing required a sense of safety within therapy, enabling participants to engage with painful memories while developing adaptive coping strategies. Psychological adaptation reflected an ongoing, cyclical process where progress coexisted with continued challenges. While some participants reported increased self-awareness and resilience, others found trauma's impact enduring, reinforcing the need for sustained support. In the present synthesis, resilience is understood as a dynamic process of engaging with recovery and drawing upon personal, relational and therapeutic resources despite ongoing trauma-related difficulties. Adaptation refers to the development of coping strategies and increased capacity to navigate the emotional and interpersonal consequences of trauma, rather than implying complete symptom remission or functional recovery. A distinct set of 13 studies captured these complexities, illustrating the long-term, nonlinear trajectory of recovery and adaptation (see Table 5).

Confronting Trauma. For many participants, revisiting traumatic memories was emotionally intense and painful, yet an essential part of healing (Shamai & Levin-Megged, 2006). Participants expressed varied emotional readiness for confronting trauma (Parker et al., 2007). Some felt overwhelmed by the prospect of revisiting painful experiences: “It’s too much to ask, we are gonna get you ready in one year after 35 years of craziness...” (Matheson & Weightman, 2021, p.693). Others found the process more manageable when guilt, blame and shame were disentangled from their experiences, allowing them to process trauma with less distress: “When I took the sort of guilt and the blame out of it, it makes the whole situation...not seem so scary...” (Ashfield Chan & Lee, 2021, p.298). Although confronting trauma was painful, many saw it as a necessary step towards healing: “Painful...emotional

torture...but at the same time helpful” (Younan et al., 2018, p.473). The emotional burden was sometimes mitigated by the professionalism and structure of therapeutic environments, helping participants feel safer during the process: “Exposure, exposure, exposure...frightened all of us...but under a controlled environment...it was just brilliant” (Willis et al., 2023, p.9). Adequate preparation, especially in group therapy, enabled participants to manage emotional triggers more effectively (Hegarty et al., 2022).

Therapeutic settings also encouraged connection and mutual understanding: “Talking about trauma helped us to bond as a community. We really wanted to support each other” (Bahu, 2019, p.15). Confronting trauma in group or individual therapy encouraged healthier coping strategies and alleviated its emotional burden, supporting adaptive coping and an increased capacity to manage ongoing challenges despite persistent trauma-related difficulties: “Instead of just going away and hiding, you are dealing with things more” (Chouliara et al., 2020, p.2905). However, not all participants benefitted. Some found trauma discussions overwhelming, triggering strong emotional reactions: “The minute somebody starts [saying anything] that’s even close to home...I have been in total crying, cold sweats and had to leave the room” (Palmer et al., 2007, p.71). These varied responses underscore the complexity of trauma work, reinforcing the need for careful preparation, tailored support and a flexible approach.

Managing Emotions. Therapy played a crucial role in helping participants regulate intense emotions that often emerged throughout the healing process. Many initially struggled with overwhelming anger and anxiety (Willis et al., 2023): “In the beginning of the group therapy, I had so much rage in me” (Matheson & Weightman, 2021, p.693). As therapy progressed, however, it supported the development of self-awareness and reduced emotional intensity: “I’m not in that hyper, hyper alert anymore...I’m just being more comfortable with

me” (Ashfield Chan & Lee, 2021, p.297). Grounding techniques and mindfulness practices proved effective in managing distress (Bahu, 2019). These strategies helped participants refocus and regain a sense of stability: “I ground myself, stop, take a deep breath, and just acknowledge that I’m gonna be ok” (Parker et al., 2007, p.70). These practices strengthened the body-mind connection, promoting emotional stability (Price, 2002): “I learned to relax my muscles from the inside...rather than just looking at myself from the outside” (Price, 2005, p.53). Grounding techniques and mindfulness practices acted as bridges between immediate emotional stabilisation and long-term cognitive flexibility, demonstrating that regulation tools can foster empowerment over time.

Group therapy provided valuable support by allowing participants to share their experiences, helping to normalise distressing emotions: “I like it when people share. Like this is one of the most useful things that I’m gaining from this therapy, I’m starting to feel normal” (Hegarty et al., 2022, p.11). This demonstrated collective experiences could validate emotions and enhance emotional stability, linking collective relational trust with individual empowerment. However, some participants struggled with emotional disclosures in a group context: “Could be inappropriate at times and disturbing to other members of the group that were maybe not too outspoken...” (Chouliara et al., 2020, p.2904-2905). Others struggled to share their own experiences and emotions after hearing others’ trauma: “By the time the others talked, I couldn’t...because what I heard was very hard...and I’d think mine was so petty” (Palmer et al., 2007, p.70). This illustrates the need for careful facilitation to balance individuals’ differing needs and emotional safety.

Participants’ narratives reflect a dual experience of vulnerability and resilience, as they processed trauma while cultivating emotional strength. This underscores the challenges

of emotional regulation in therapy, where acknowledging past pain can act as a catalyst for personal growth (Shamai & Levin-Megged, 2006). Through these processes, participants' trauma-related symptoms were reduced and emotional regulation strengthened while gaining a renewed sense of hope and self-acceptance.

Navigating Difficulties. Many participants expressed frustration that therapy did not fully address their needs (Draucker & Petrovic, 1997; Shamaï & Levin-Megged, 2006). They often described unresolved trauma, viewing therapy as only the beginning of a longer healing journey: "I still feel like there's a lot of change to come with me...I just feel like this is the tip of the iceberg" (Ashfield Chan & Lee, 2021, p.296). Others felt that the duration of therapeutic interventions were insufficient for deep, lasting change and desired extended support: "Only after [the] 6th session I started to feel the benefits...I wish we had more sessions..." (Bahu, 2019, p.17). Beyond time constraints, some participants struggled to internalise key therapeutic concepts essential for psychological adaptation and self-compassion. This difficulty hindered progress: "I found compassion hard to grasp and haven't grasped it fully yet..." (Willis et al., 2023, p.14). While many found it easier to empathise with others, extending the same understanding to themselves remained a challenge. Additionally, unresolved feelings of emotional guardedness posed further barriers to recovery. Some participants acknowledged difficulty in opening up after engaging in therapy: "It's still hard for me to be completely open with other people. I'm pretty guarded" (Parker et al., 2007, p.71). Furthermore, some participants expressed concerns about regression, noting that revisiting traumatic memories sometimes triggered setbacks rather than progress: "...I realized that I started to sort of fall backwards with those things, because it brought them up again..." (Chouliara et al., 2020, p.2906). These experiences highlight the non-linear nature of trauma recovery, where confronting painful memories can both advance healing and, at

times, reintroduce distress. Given these complexities, many survivors expressed the need for extended therapeutic support to strengthen trust and develop coping mechanisms before fully engaging in trauma processing.

Construct Three: Personal Empowerment and Growth

The third construct highlights the transformative empowerment and growth survivors experienced through therapy. A key factor was relational trust, which connected therapeutic safety to trauma processing and allowed participants to engage more actively in their recovery. This construct was evident across 13 of the included studies, involving a distinct set of papers from constructs one and two (see Table 5). Participants described growth in three key areas, developing self-compassion (Subconstruct 1: Self-Compassion and Self-Acceptance), understanding trauma's impact (Subconstruct 2: Empowerment Through Understanding) and adopting a forward-looking perspective (Subconstruct 3: Positive Perception of the Future).

Self-Compassion and Self-Acceptance. Trust and psychological adaptation played a critical role in helping participants confront deep-seated self-blame and shame, fostering an environment where self-compassion could emerge. For many, a pivotal moment was recognising that their trauma was not their fault, which marked a significant turning point: "I had to realise that it's not my fault...the blame is with them...I think that was one of the biggest moments" (Ashfield Chan & Lee, 2021, p.295). By letting go of shame, participants became more open to self-compassion, which contributed to greater emotional resilience and empowerment (Hegarty et al., 2022; Shorer et al., 2023): "I'm able to just be compassionate with all aspects of my life...it makes me feel stronger and feel more empowered" (Ashfield Chan & Lee, 2021, p.296). Therapy helped transform participants' harsh self-criticism into a

more compassionate inner voice (Bahu, 2019): “I had a critic that was so loud...He ceases to exist...It’s more of a friendly voice...” (Willis et al., 2023, p.12). This shift enabled them to recognise their worth and believe they deserved happiness: “I feel that I deserve a good life, a happy life...it’s different from my views from before” (Parker et al., 2007, p.66). By gaining insight into their emotions and behaviours, participants approached post-traumatic growth with greater self-awareness and self-compassion, rather than judgment (Younan et al., 2018; Shamai & Levin-Megged, 2006; Price, 2005).

Empowerment Through Understanding. Therapy provided participants with a deeper understanding of their difficulties, enabling them to manage emotions more effectively (Younan et al., 2018). Many gained insights into the underlying reasons behind their behavioural and emotional patterns: “I have stopped criticising myself because I understand that I behaved in certain ways because of my childhood” (Willis et al., 2023, p.10). This understanding gave participants a sense of control, empowering them to take active steps in their recovery (Hegarty et al., 2022; Parker et al., 2007). Psychoeducation further reinforced this empowerment by helping participants make sense of their experiences, equipping them with the knowledge to navigate emotional challenges: “Psychoeducation helped me to understand what was happening with me” (Bahu, 2019, p.15). Physical awareness also played a vital role, enabling participants reconnect with their bodies, reduce disconnection and promote relaxation: “I feel that I’m more aware of what is happening in my body because of the breathing techniques we learned...These exercises really helped me” (Riabzev & Bensimon, 2023, p.4). By integrating physical and emotional awareness, participants developed practical tools to regulate distress, reflecting the interconnection between empowerment and emotional regulation (Price, 2005).

Ultimately, therapy offered valuable insights into emotional and physical experiences, helping participants reframe their trauma and approach healing with greater self-awareness: “[I] understand these things that I’m going through and the way I feel and it’s given me options of what I can do to get myself out of those feelings” (Ashfield Chan & Lee, 2021, p.298). This enhanced awareness strengthened their sense of control and provided effective coping strategies for ongoing self-regulation and post-traumatic growth (Draucker & Petrovic, 1997; Price, 2002).

Positive Perception of the Future. Therapeutic interventions instilled hope and optimism about the future. Witnessing the progress of others in similar situations created a shared sense of achievement and motivation: “You kind of watch each week as everyone progresses and it encouraged you to progress” (Ashfield Chan & Lee, 2021, p.294). Recognising that others had successfully navigated similar challenges encouraged those still struggling: “Other people have gone through similar and were managing...it gave me a bit of hope” (Willis et al., 2023, p.13). This collective experience strengthened participants’ belief in personal growth and resilience. Many also reported increased confidence in their ability to make meaningful changes: “I’m a lot more motivated, and I feel like I can do a lot more things now, so I am even more excited for the future” (Hegarty et al., 2022, p.13). As optimism grew, participants began envisioning positive lifestyle shifts: “I seem to have...improved belief in my ability...to make positive lifestyle change” (Price, 2005, p.53-54). This renewed sense of self-efficacy contributed to empowerment: “I can be at peace with who I am...I can make the world a better place” (Riabzev & Bensimon, 2023, p.6-7). Such transformations enabled participants to reshape their perceptions of the future, allowing them to move forward despite past trauma (Shorer et al., 2023). However, empowerment was not a linear process. Many participants struggled with internalising self-compassion and unlearning

deeply ingrained patterns of self-criticism. These challenges underscored the iterative nature of recovery, in which progress often involved setbacks but ultimately reinforced resilience and motivation.

Overall, personal empowerment and growth emerged as transformative aspects of the recovery process, deeply interconnected with relational trust and trauma processing. Developing empowerment allowed participants to reframe their trauma, cultivate self-compassion and envision a hopeful future. The cyclical nature of recovery highlighted the reciprocal relationship between trust, trauma processing and empowerment, demonstrating their central role in fostering cognitive flexibility and engagement.

Discussion

This meta-ethnography was the first to explore experiences of psychotherapy among adult survivors of CPTSD, synthesising 15 studies to develop a conceptual understanding of recovery processes. A key finding is the dynamic and reciprocal nature of post-traumatic growth, with relational trust emerging as foundational to emotional safety. This trust enables psychological adaptation and supports personal empowerment, equipping individuals to engage with and integrate traumatic experiences. These interconnected processes reinforce one another, highlighting the cyclical nature of recovery and the need for sustained, flexible and trauma-informed therapeutic support.

The review highlights relational trust as central to engagement across therapeutic contexts. It facilitates emotional safety within individual therapy, group settings and community reintegration, aligning with research on its foundational role in therapy (Finsrud

et al., 2022). While therapeutic alliance reflects collaboration, relational trust represents a deeper sense of safety (Podolan & Gelo, 2024), particularly important in CPTSD, where trust may take longer to develop (NICE, 2018). Group therapies fostered connection and shared understanding (Alldredge et al., 2021; Conan et al., 2023), while individual therapy enabled relational depth, though often marked by ruptures and repair. Trust also supported community integration (Evans, 2021; Herman, 2023). These findings align with wider literature emphasising safety in trauma recovery (Allen, 2021; Office for Health Improvement & Disparities, 2022; Wampold, 2021), while highlighting challenges in achieving this consistently (Matheson et al., 2020).

Findings of this review also emphasise the non-linear and evolving nature of CPTSD recovery. Participants described varying responses to trauma processing, from overwhelming distress to gradual acceptance. This variation reflects the importance of relational trust, psychological adaptation and empowerment in shaping therapeutic engagement. These findings align with literature that critiques the limitations of current frameworks in addressing the ongoing and cyclical nature of post-traumatic recovery (Horesh & Lahav, 2024; Stadtmann et al., 2018). Although NHS (2024) guidelines advocate for trauma-informed and comprehensive care, many participants expressed current interventions did not always meet their needs (Ford, 2021). The Mental Health Strategy for England (Department of Health and Social Care, 2011) aims to improve services for individuals with complex trauma, yet practical limitations remain. Challenges such as staff shortages, funding constraints and limited availability of long-term therapy restrict survivors' access to consistent and flexible care (Dacre & Fonagy, 2021). Additionally, the cyclical nature of post-traumatic growth suggests recovery requires adaptable, sustained therapeutic support rather than fixed-session models. While UK policies increasingly recognise this need (NHS, 2019; NICE, 2018; Office

for Health Improvement & Disparities, 2022), disparities in service provision persist (British Medical Association, 2024). Without consistent long-term support, many survivors struggle with residual trauma-related challenges, reinforcing the need for holistic, survivor-led and responsive therapeutic interventions.

This review recognises personal empowerment and growth as integral to trauma recovery, aligning with empirical evidence (Delker et al., 2020; Henson et al., 2021; NICE, 2018). Relational trust emerged as a key mechanism enabling survivors to develop self-compassion and deeper insight into their distress. By fostering self-acceptance and reducing self-criticism, therapy reframed experiences in ways that strengthened psychological resilience. These findings align with existing literature and clinical guidelines (Braehler & Neff, 2020; Department of Health and Social Care, 2011; Lakioti & Stalikas, 2020).

However, some survivors struggled to achieve these benefits, highlighting variability of therapeutic outcomes. Furthermore, therapeutic interventions also increased hope, optimism and confidence, empowering survivors to reshape their perceptions of the future. This aligns with research and policy emphasising the relationship between empowerment and trust in promoting long-term emotional well-being in trauma survivors (Murphy et al., 2023; Office for Health Improvement & Disparities, 2022; Roseman, 2024). Despite recognition of these principles, challenges remain in embedding them within UK mental health services (British Medical Association, 2024; Funk & Bold, 2020). The variation in recovery experiences underscores the need for flexible, holistic therapeutic approaches that address systemic barriers while accommodating different trauma trajectories (Brähler, 2023; van der Westhuizen et al., 2023).

The findings may also have implications for the conceptualisation of CPTSD. Participants' accounts closely reflected the disturbances in self-organisation domains

described within the ICD-11 framework, including difficulties with emotional regulation, a persistently negative self-concept, and challenges within interpersonal relationships (Cloitre et al., 2013; Maercker et al., 2022). Therapeutic change was frequently described in relation to improvements in these areas, suggesting that they may represent particularly salient aspects of recovery from CPTSD. Notably, dissociation did not emerge as a prominent feature of participants' accounts despite its frequent association with complex trauma within the broader trauma literature (e.g., Herman, 2015; van der Kolk et al., 2005). While this should be interpreted cautiously given the focus on psychotherapy experiences rather than symptom presentation, the findings may provide tentative support for contemporary conceptualisations of CPTSD that position disturbances in self-organisation as central features of the condition.

Clinical Implications

The findings highlight several important clinical considerations for supporting adults with CPTSD. A strong therapeutic alliance underpins recovery, forming the foundation for psychological adaptation, trauma processing and personal empowerment. Given the impact of trauma on trust and emotional regulation, clinicians should anticipate varied responses to therapy and adopt flexible, relationally attuned approaches (Cloitre et al., 2020; Popolo et al., 2024). Trust-building requires consistent validation, open communication and sufficient time (NICE, 2018; Ramasubramanian & Riewestahl, 2021). In group settings, while shared understanding can foster connection, some individuals experience isolation, highlighting the need to actively support cohesion and relational safety (Allen, 2021; Herman, 2023). A second implication concerns the need for tailored interventions that account for the complexity of CPTSD. Emotional readiness to engage with trauma varies, requiring clinicians to pace interventions and support gradual exposure within safe environments (Bryngeirsdottir & Halldorsdottir, 2022; Contractor et al., 2022). Emotional regulation

difficulties remain central, suggesting the integration of grounding and mindfulness strategies (Shnaider et al., 2022; Tull et al., 2020). However, the diversity of experiences identified within this review also highlights the importance of flexibility in therapeutic approaches. Depending on an individual's needs, emotional regulation may be supported through a range of interventions, including acceptance-based approaches, mentalisation-informed therapies, dialectical behavioural strategies, and trauma-focused interventions such as EMDR. These approaches may facilitate emotional awareness, distress tolerance, reflective functioning, and psychological flexibility, all of which may support engagement in trauma processing. The findings therefore support the need for individualised and responsive treatment planning rather than a single therapeutic approach for all individuals with CPTSD. Persistent challenges, including the need for ongoing support, further highlight the importance of longer-term, flexible therapeutic frameworks (Brown, 2021; van der Kolk, 2014). A third implication relates to fostering empowerment, hope and self-compassion. Therapeutic approaches should support individuals in reframing self-critical beliefs and developing a more compassionate self-understanding (Garbutt et al., 2023; Winders et al., 2020). Given the cyclical nature of recovery, interventions must remain adaptable and responsive to individual trajectories (Purnell et al., 2021; Weaver et al., 2021). Finally, systemic barriers within UK services continue to limit access to appropriate care. Limited resources and session availability constrain the delivery of sustained, trauma-informed support (Aguilera, 2018; de Boer et al., 2022). Addressing stigma and improving access to flexible, person-centred interventions remain key priorities (Plante et al., 2022; Su & Stone, 2020). Overall, these findings emphasise the need for integrated, trauma-informed approaches that are relationally grounded, flexible and responsive to the complexity of CPTSD recovery.

Limitations and Future Research

The findings should be interpreted in light of several limitations. Firstly, inclusion criteria were based on the NHS description of CPTSD rather than formal diagnosis, which may have introduced variability in participant characteristics. However, given CPTSD's relatively recent inclusion in the ICD-11, its absence from the DSM-V and ongoing international diagnostic inconsistencies, restricting inclusion to formally diagnosed cases would likely have excluded relevant research. This more inclusive approach allowed for consideration of studies conducted before formal recognition and in regions where CPTSD is not routinely diagnosed, though it required researcher judgment in determining eligibility. As diagnostic practices become more standardised, future review may apply stricter criteria to enhance comparability. Additionally, quality appraisal identified several recurring limitations across the included studies, such as limited reporting of researcher reflexivity, insufficient detail regarding recruitment and sampling procedures, and variable reporting of ethical considerations. Several mixed-methods studies also provided relatively brief qualitative findings compared with studies employing exclusively qualitative designs. Nevertheless, all studies demonstrated sufficient methodological rigour to contribute meaningful insights relevant to the review question, and key concepts were identified across studies of varying methodological quality. Secondly, methodological diversity across included studies posed challenges for the synthesis. Although most studies were qualitative, five used mixed-method designs from which only qualitative data were extracted, and analytical approaches varied widely. Furthermore, studies did not consistently report their underlying philosophical or epistemological positioning, making it difficult to assess the influence of differing paradigmatic assumptions on the findings. While this diversity provided rich contextual insights, it may limit the development of cohesive theoretical models of CPTSD recovery. More research using consistent qualitative methodologies and clearer reporting of underlying research paradigms could strengthen future synthesis. Thirdly, demographic limitations affect

generalisability. Samples were predominantly female and drawn largely from Western contexts, and the restriction to English-language publications may have excluded important non-Western perspectives. Additionally, the studies spanned over two decades (1997-2023), a period during which CPTSD conceptualisations and treatment approaches evolved substantially. Earlier studies may therefore reflect different diagnostic frameworks and therapeutic assumptions. Future research should prioritise culturally diverse samples and longitudinal or mixed-method designs to better understand recovery trajectories across contexts. Finally, relatively little research has examined psychotherapists' experiences of working with CPTSD, highlighting an important area for future research. This would provide valuable insights into the challenges, intervention adaptations, and the therapist-client dynamic, ultimately supporting improved treatment delivery for people with CPTSD.

Conclusion

Relational trust emerges as a central foundation for therapeutic engagement in work with CPTSD, underpinning key processes of trauma processing, adaptive coping, personal empowerment and post-traumatic growth. Across the synthesis, trust was closely linked to the development of emotional safety, enabling individuals to engage more fully in therapy, cultivate self-compassion, and begin to make sense of their experiences. In this context, trust is not simply a feature of the therapeutic alliance, but a dynamic and evolving process that supports acceptance, reduces trauma-related distress and fosters renewed hope for the future. At the same time, survivors continue to face significant challenges within and beyond therapy, including confronting traumatic memories, managing intense and fluctuating emotional states, and navigating systemic barriers to accessing consistent care. Recovery was consistently described as cyclical rather than linear, with individuals moving between phases

of vulnerability, adaptation and growth. This highlights the need for counselling and psychotherapy approaches that are flexible, paced and responsive to shifting needs over time. While psychotherapy plays a vital role in supporting recovery, the findings suggest that current provision does not always meet the complexity and diversity of survivors' experiences. For practitioners, this underscores the importance of prioritising relational trust, supporting the development of empowerment and self-agency, and working collaboratively with clients in a way that honours their individual recovery trajectories. At a service level, there is a clear need to enable longer-term, person-centred and trauma-informed care that reflects the relational and non-linear nature of CPTSD recovery.

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Table 1.

Search Terms Used for the Systematic Search.

	Domain	Search Terms
S	Sample	(DE "DESNOS" OR DE "Complex Trauma" OR DE "Complex PTSD") OR TI (DESNOS OR ((prolonged OR complex OR severe OR endur* OR persistent OR chronic OR recurrent) N3 (post#trauma* OR trauma*)) OR "C#PTSD") OR AB (DESNOS OR ((prolonged OR complex OR severe OR endur* OR persistent OR chronic OR recurrent) N3 (post#trauma* OR trauma*)) OR "C#PTSD")
PI	Phenomenon of Interest	((psych* OR mental) N3 (therap* OR counsel* OR intervention*)) OR psychotherap*
D	Design	Not specified to include all qualitative methods
E	Evaluation	Patient experiences, identified through screening
R	Research Type	((“semi-structured” OR semistructured OR unstructured OR informal OR “in-depth” OR indepth OR “face-to-face” OR structured OR guide) N3 (interview* OR discussion* OR questionnaire*)) OR (“focus group*” OR qualitative OR ethnograph* OR fieldwork OR “field work” OR “key informant”) OR “interpretive phenomenological analys*” OR “grounded theory” OR “grounded-theory” OR “grounded#theory” OR “thematic analysis” OR “thematicanalysis” OR “thematic#analysis” OR “content analysis” OR “contentanalysis” OR “content#analysis” OR “narrative” OR “mixed method*” OR “mixedmethod*” OR “mixed#method*”

Table 2.

Study Eligibility Criteria.

Inclusion	Participants aged 18 years and above Therapy delivered by a qualified human therapist Inclusion of qualitative data analysis Published in English Published in a peer-reviewed journal Presentation aligning with NHS (2021) CPTSD definition No date restrictions applied
Exclusion	Focus solely on therapists' or professionals' perspectives Combined perspectives of therapists and patients in a manner that could not be disaggregated Lacked clarity regarding CPTSD versus PTSD based on the NHS (2021) definition

Table 3.*CASP Tool Ratings.*

No.	Author(s)	Research Design	Recruitment	Data collection	Reflexivity	Ethical issues	Data analysis	Findings	Value of research	Total
1	Matheson & Weightman (2021)	2	3	3	3	2	3	3	3	22
2	Riabzev & Bensimon (2023)	3	2	3	3	2	3	3	2	21
3	Ashfield, Chan & Lee (2021)	2	3	3	3	3	2	2	3	21
4	Willis, Dowling & Deehan (2023)	3	2	2	2	3	3	2	3	20
5	Younan, Farrell & May (2018)	2	3	2	3	3	2	3	2	20
6	Parker, Fourt, Langmuir, Dalton & Classen (2007)	2	3	3	2	2	3	2	2	19
7	Hegarty, Ehntholt, Williams, Kennerley, Billings & Bloomfield (2022)	2	3	2	2	2	2	2	2	17
8	Chouliara, Karatzias, Gullone, Ferguson, Cosgrove & Burke Draucker (2020)	2	2	3	1	2	2	2	2	16
9	Bahu (2019)	2	2	2	1	2	2	2	2	15
10	Shamai & Levin-Megged (2006)	2	2	3	1	1	2	2	2	15

11	Price (2005)	2	2	2	2	2	1	2	2	15
12	Shorer, Shacham & Bloch (2023)	3	1	2	1	2	1	2	2	14
13	Price (2002)	2	2	2	2	2	1	1	2	14
14	Palmer, Stalker, Harper & Gadbois (2007)	2	1	2	1	1	1	2	2	12
15	Draucker & Petrovic (1997)	2	2	2	1	1	1	2	1	12

Table 4.*Characteristics of Included Studies.*

Author(s) of Paper	Research Question/Aim	Methodology	Participants	Country	Key findings
Ashfield, Chan & Lee (2021)	To investigate the mechanisms of change at an individual and group level for individuals completing treatment for Complex-PTSD.	Constructivist Grounded Theory. Semi-structured interviews following attendance of the group.	11 females who attended specialist PTSD service.	United Kingdom	The main factors of change were the strong relationships built in the group and developing a deeper understanding of themselves, which helped participants feel less shame and get ready for exposure-based therapy.
Bahu (2019)	Explore the mental health difficulties associated with severe trauma as experienced by refugees and asylum seekers, and issues related to psychological treatments.	Thematic Analysis and quantitative measures. Verbal feedback provided post intervention.	16 Tamil refugees and asylum seekers (10 males and 6 females).	United Kingdom	The intervention involving culturally tailored CBT showed noticeable improvements in the wellbeing of participants.
Chouliara, Karatzias, Gullone, Ferguson, Cosgrove & Burke Draucker (2020)	Develop a framework for therapeutic change processes in group therapy for complex interpersonal trauma.	Interpretive Phenomenologi cal Analysis. Semi-structured interviews post treatment.	16 female survivors of interpersonal trauma.	United Kingdom	The key processes of change identified included: self- versus others, trust versus threat, confrontation versus avoidance, and superficial repairs versus genuine healing.
Draucker & Petrovic (1997)	To describe male survivors’ perceptions of their therapeutic needs and therapy experiences.	Content Analysis. Unstructured interviews post therapy.	19 men who were sexually abused as children.	United States of America	The therapeutic process is a journey where the therapist acts as a guide, knowledgeable about issues faced by male survivors, open

					about the therapy process, connected to the client and respectful of the client's personal journey.
Hegarty, Ehntholt, Williams, Kennerley, Billings & Bloomfield (2022)	Explore patient experiences of factors influencing treatment acceptability and potential mechanisms of therapeutic change in a sample of participants in The Recovering from Child Abuse Programme (RCAP) which is a CBT group for people with CPTSD.	Reflective Thematic Analysis. Therapy sessions were recorded and transcribed and group members completed written feedback forms after each session.	10 outpatient females from a specialist psychological trauma service in an ethnically and socially diverse area in London.	United Kingdom	The programme led to cognitive changes, enhancing emotional regulation and self-concept, effectively addressing key characteristics of CPTSD.
Matheson & Weightman (2021)	Explore the views of patients in the community on psychotherapy for the diagnosis of CPTSD.	Thematic Analysis. Semi-Structured interviews post intervention. 1:1 and feedback group meetings between researchers.	24 former patients from trauma service, 6 had researcher role and interviewed the other participants (14 females and 10 males in ethnically and socially diverse area in London).	United Kingdom	Relationships are really important to rebuild in recovery, sufficient time is needed to develop trust with a therapist.
Palmer, Stalker, Harper & Gadbois (2007)	To understand how the participants experienced the process groups from an inpatient programme for traumatic stress recovery.	Ethnographic Approach, Constant Comparative Method and Quantitative Measures. Semi-structured interviews took place 6-8 months after the	30 participants from inpatient hospital (mainly private) who experienced childhood abuse (25 females and 5 males).	Canada	Programmes for trauma should be person-centred and acknowledge that individuals are at various stages of recovery. Flexibility and individual assessment for readiness to

		interviewee had been discharged from the inpatient programme.			engage in group therapy are crucial.
Parker, Fourt, Langmuir, Dalton & Classen (2007)	To understand how women with a history of childhood maltreatment experienced the Women Recovering from Abuse Programme (WRAP), an existing intensive group treatment programme.	Phenomenology Semi-structured interviews at least 6 months after finishing the WRAP.	7 females with a history of childhood maltreatment and who had completed the WRAP.	Canada	Participants lives improved significantly after completing the WRAP programme and they continued to progress on their recovery journey from trauma.
Price (2005)	Examine the efficacy and the perceived influence on abuse recovery of body-oriented therapy.	Content Analysis and quantitative measures. Questionnaire with open questions before intervention, after and follow-up.	24 females in psychotherapy for child sexual abuse.	United States of America	Massage and body-oriented interventions impact recovery from abuse in significant yet distinct ways, involving different perspectives in relationship to self.
Price (2002)	Examine quantitative and qualitative effects of body-oriented therapy as an adjunct to psychotherapy for a woman with a childhood history of physical and sexual abuse.	Descriptive Case Study Multi-Model Methods. Interviews, written questionnaires and standardised questionnaires. Measures taken pre and post intervention.	Case study of female with a history of significant abuse.	United States of America	Mood states consistently improved throughout the intervention; qualitative findings highlighted the beneficial effects of body-oriented therapy on feelings of security, emotional connection and psychotherapeutic progress.
Riabzev & Bensimon (2023)	Examine a voicework intervention with women coping with the effects	Interpretive Phenomenological Analysis.	17 females in an inpatient treatment centre for sexually	Israel	The voicework group resulted in positive changes in personal,

	of incest, understand its meaning for the participants, and examine its potential to promote well-being.	Focus group interviews before and after intervention.	assaulted women.		social and spiritual domains.
Shamai & Levin-Megged (2006)	Explore how Holocaust survivors experience therapy.	Phenomenological Analysis. Interviews 1-3 years after finishing therapy.	11 Holocaust survivors (2 males and 9 females).	Israel	Effective therapy frequently occurred when the traumatic narrative was encapsulated and distanced from other segments of the life story.
Shorer, Shacham & Bloch (2023)	Qualitative exploration of combining nature and group therapy in a long-term, group adventure therapy programme for veterans with chronic PTSD.	Thematic Content Analysis. 4 focus group meetings.	10 male military veterans with chronic PTSD.	Israel	Nature-assisted therapy offers a promising additional intervention, especially for clients who do not achieve adequate progress through other individual or trauma-focused therapies.
Willis, Dowling & Deehan (2023)	Explore the impact of trauma exposure in childhood on participants lives before and after having completed a phase-orientated intervention for complex trauma. The second aim of this study was to explore the role of a compassion-based approach in responding to these trauma-related difficulties at pre- and post-	Content Analysis. Semi-structured interviews pre and post intervention.	10 females from a private hospital mental health service who completed the trauma programme.	United Kingdom	There is great benefit in incorporating a CFT model into a phased-oriented approach where initial stabilisation is followed by exposure/trauma-focused therapy.

	intervention stages.				
Younan, Farrell & May (2018)	Pilot study exploring the feasibility and effectiveness of a 4-week inpatient group schema therapy programme for adults with complex trauma in a psychiatric hospital setting.	Thematic Analysis and quantitative measures. Semi-structured interviews pre-, post- and 3 months after treatment.	36 participants in a private psychiatric hospital (8 males and 28 females).	Australia	Group schema therapy is beneficial for improving mental health and addressing maladaptive schemas in cases of complex trauma.

Table 5.*Summary of Constructs, Subconstructs, and Supporting Studies.*

Construct	Subconstructs	Number of Studies	References
Establishing Relationships and Trust	Relationship with Therapist, Group, Community	13	Bahu (2019); Chan & Lee (2021); Chouliara et al. (2020); Draucker & Petrovic (1997); Hegarty et al. (2022); Matheson & Weightman (2021); Palmer et al. (2007); Parker et al. (2007); Riabzev & Bensimon (2023); Shamai & Levin-Megged (2006); Shorer et al. (2023); Willis et al. (2023); Younan et al. (2018)
Trauma Processing and Psychological Adaptation	Confronting Trauma, Managing Emotions, Navigating Difficulties	13	Ashfield Chan & Lee (2021); Bahu (2019); Chouliara et al. (2020); Draucker & Petrovic (1997); Hegarty et al. (2022); Matheson & Weightman (2021); Palmer et al. (2007); Parker et al. (2007); Price (2002); Price (2005); Shamai & Levin-Megged (2006); Willis et al. (2023); Younan et al. (2018)
Personal Empowerment and Growth	Self-Compassion and Acceptance, Empowerment Through Understanding, Positive Perception of the Future	13	Ashfield Chan & Lee (2021); Bahu (2019); Draucker & Petrovic (1997); Hegarty et al. (2022); Palmer et al. (2007); Parker et al. (2007); Price (2002); Price (2005); Riabzev & Bensimon (2023); Shamai & Levin-Megged (2006); Shorer et al. (2023); Willis et al. (2023); Younan et al. (2018)

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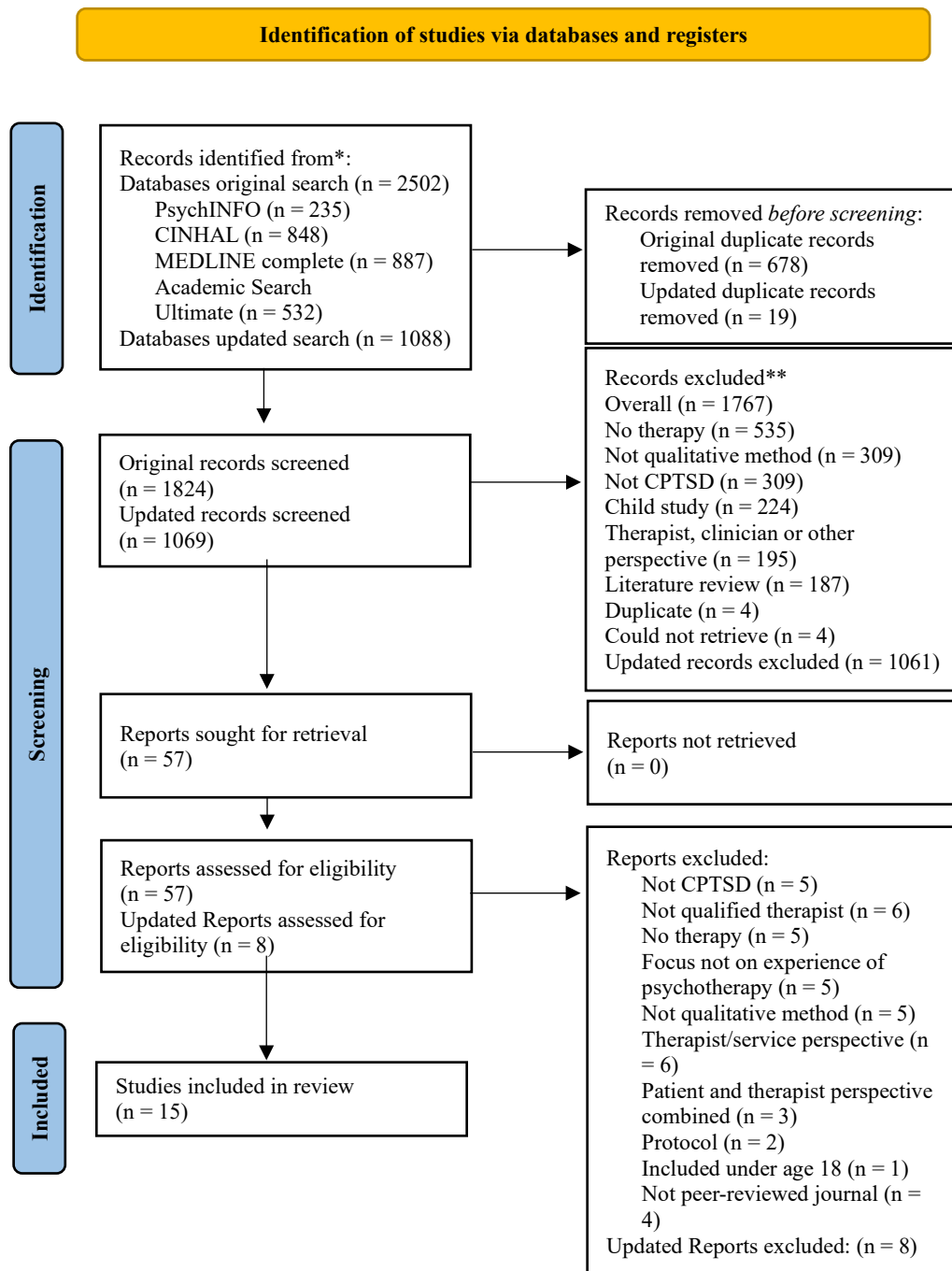


Figure 1.

PRISMA Flow Diagram Demonstrating Screening and Selection.

Flow diagram of study identification, screening, eligibility, and inclusion in accordance with PRISMA guidelines. Of 2,502 records identified, 15 studies were included in the final synthesis following duplicate removal and staged screening. An updated search conducted in

June 2026 (February 2024–June 2026) identified no additional records which met the inclusion criteria.

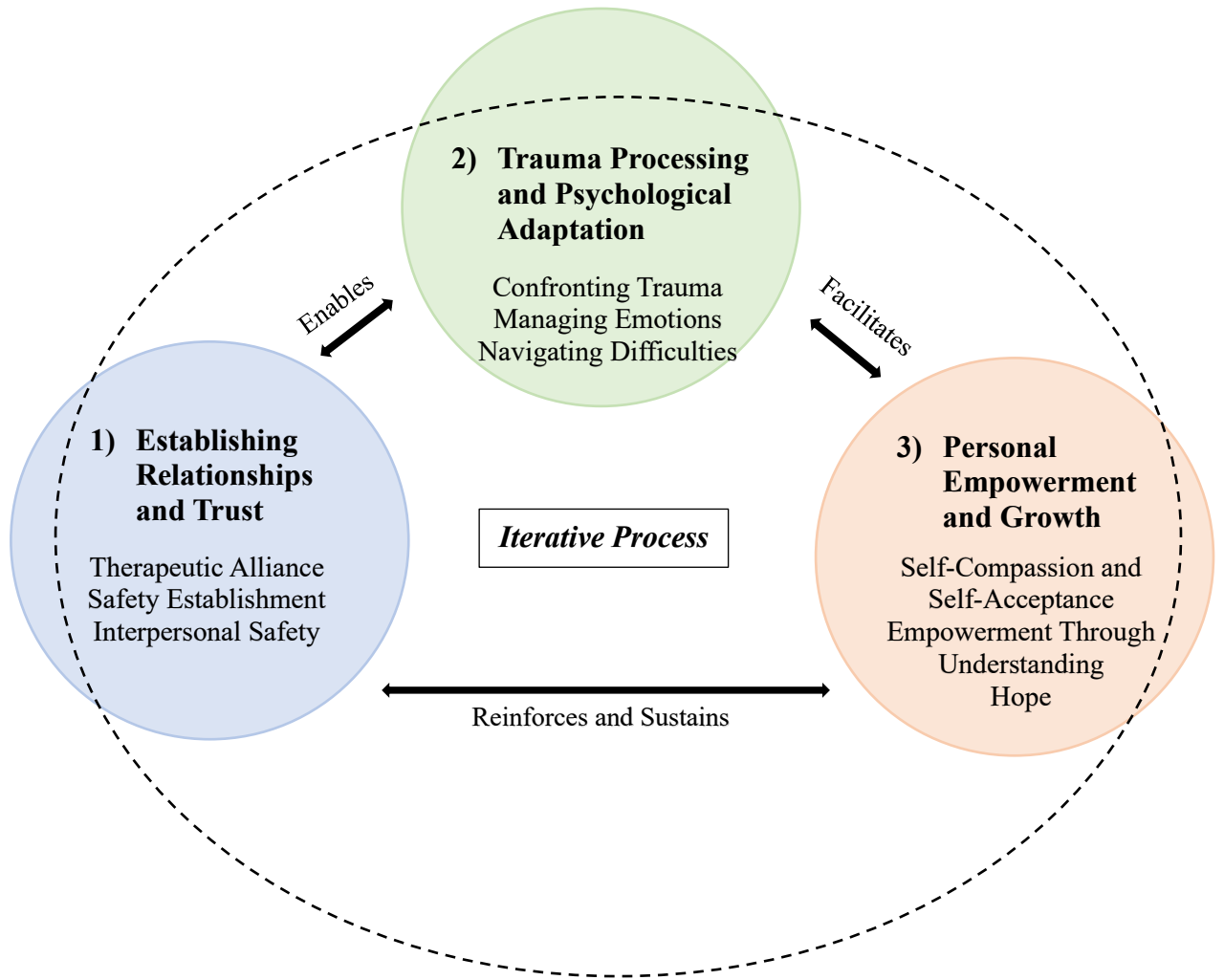


Figure 2.

The Interconnected and Cyclical Therapeutic Processes for People with CPTSD.

This figure presents a dynamic model illustrating how individuals engage in psychotherapy for CPTSD through interrelated and recursive processes. It depicts recovery as a non-linear progression, in which movement between phases is fluid rather than sequential. The model emphasises the central role of relational processes in enabling engagement, alongside the ongoing interaction between emotional regulation, meaning-making, and the development of agency. It also highlights how individuals may cycle between phases in response to changing levels of distress, reflecting the adaptive and evolving nature of recovery within therapeutic contexts. Overall, the figure underscores the importance of sustained relational support and flexibility in facilitating continued engagement and psychological growth.