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“The most important thing in therapy is the relationship”

Women Survivors of Child Sexual Abuse describe their Experiences of
Psychological Therapy

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Submitted in Fulfilment of the Requirements for the Degree of
Professional Doctorate of Counselling Psychology

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PREFACE

The following preface introduces a doctoral portfolio; consisting of three pieces of work related to aspects of theory and practice in Counseling Psychology, with a particular focus on adult Childhood Sexual Abuse (CSA) survivor's therapy experiences. The three pieces of work will be introduced separately, followed by a section that will describe the themes that link the separate pieces of work together.

Outline of Portfolio

The first part of the portfolio (Part A), presents a qualitative researches study on women Childhood Sexual Abuse (CSA) survivors lived experience of accessing and utilising psychological therapy. Six women who had experienced sexual abuse in childhood, and who had undergone therapy for the effects of CSA took part in this study. Data was analysed using Interpretive Phenomenological Analysis (IPA), in order to facilitate an in-depth analysis of these experiences (Smith, Flowers & Larkin, 2009). Four superordinate themes related to survivors' experiences of therapy were identified. The findings are considered in relation to the wider literature. Potential implications for clinical practice, and policies are addressed, and suggestions for further research is provided.

The second part of the Portfolio (Part B) provides a detailed reflection of a case study demonstrating my experience of working therapeutically with a male CSA survivor, presenting with complex and multifaceted needs in the context of a short-term IAPT therapy service. In particular, it considers the professional aspects of clinical practice throughout work with this particular client. More specifically, it shows my attempt to adapt and stay within a Cognitive Behavioural Therapy (CBT) framework, in the context of increasingly complex presentation which was unfolding during the therapy process. The case was chosen to illustrate my learning and development related to CBT theory and practice, as well as my ability to reflect on and adhere to complex information, and incorporating this into a changing formulation and treatment plan, and integrating knowledge into future practice.

The last part of the portfolio (Part C) presents a condensed version of the research prepared for submission to an academic journal. The focus of the paper is on survivors' perspectives on accessing and utilising psychological therapy. The journal of Child Sexual Abuse was considered to be an appropriate target for the submission of this paper, which is considered a primary source of peer reviewed, published research on the topic of Child Sexual Abuse. This journal was used as a guideline on the format of the publishing paper.

Linking Themes: CSA survivor's experiences of Psychological therapy

Previous research has shown there is a distinctive lack of published research on survivors' perceptions of treatment effectiveness. Furthermore, that more research is needed in order to further understanding of this population group (Chouliara et al., 2012). This portfolio has therefore aimed to increase the understanding of survivors' experiences of therapy. A number of shared themes across all three pieces of work were identified, relating to the psychological treatment of survivors. More specifically, the importance of the therapeutic relationship was a reoccurring theme throughout this portfolio. The development of a trusting therapeutic alliance was considered important for engagement, progress and healing. Additionally, key characteristics and qualities of the therapist seemed to have been key for the development of a trusting therapeutic alliance. Another theme that was recurrent was the experience of shame, guilt and self-blame, related to the survivors' experience of abuse and its role in inhibiting progress and healing. Additionally, themes related to power and control were also present, including its impact on engagement, sharing and healing.

Overall, this portfolio highlights the need to increase awareness of survivors' unique experiences of therapy, in order to better meet the multifaceted needs of survivors. Although current national guidelines on evidence based practice exist for a number of mental health disorders, including PTSD (NICE, 2005), such guidelines do not exist for CSA survivors. This is particularly concerning as previous studies have consistently shown that survivors of CSA are more likely to experience a number of physical, social and psychological difficulties. As

such, Counselling Psychologists are likely to come in contact with, and work with this client group, but there are no clinical guidelines for the high number of CSA survivors that experience psychological distress, but do not meet the criteria for PTSD. This further highlights the importance of studies exploring survivors' perspectives of therapy, including helpful and unhelpful practices, in order to integrate knowledge and inform clinical practice. It is hoped that the different perspectives offered in this portfolio, including the perspective of the survivor in the research, as well as the critical evaluation of psychological treatment for this client group, provide a wide understanding of the unique needs of this client group, including appropriate ways of responding to and working with the effects of CSA, in order to facilitate help-seeking and better meet survivors' needs.

ABSTRACT

This study set out to explore the experience of psychological therapy amongst women survivors of Childhood Sexual Abuse. The aim is to give a voice to survivors' unique experiences of therapy, in order to better meet the multifaceted needs of survivors and to inform policies and clinical practice.

The research utilised a qualitative form of enquiry, in order to stay rooted in the participants' experience. Six women who had experienced sexual abuse in childhood, and who had undergone therapy for the effects of Childhood Sexual Abuse took part in this study. Individual semi-structured interviews were conducted in order to gain insight into participants' experiences of therapy, and the data was analysed using Interpretive Phenomenological Analysis. The findings demonstrated that there were four superordinate themes related to participants' therapy experiences: 'The help-seeking journey', 'Development of the therapeutic alliance', 'Salient therapeutic experiences', as well as 'Healing as a process'. Additionally, each superordinate theme consisted of a number of sub-themes. The findings are considered in relation to the wider literature. Potential implications for clinical practice and policies are addressed, and suggestions for further research are provided.

Keywords: *childhood sexual abuse, adult, women, survivors, psychological therapy, Counselling, experiences, perspectives.*

“I have always been really interested in how useful therapy is. I have always found it really useful. A lot of what people say; there is no evidence for it. I wanted to take part to say this is how it has helped me” (Tina, 1: 6-9)

1. INTRODUCTION

1.1. Introduction

The topic of Child Sexual Abuse (CSA) has generated increased political and social attention in the UK, following the revelations concerning Jimmy Savile and the subsequent police investigation, operation 'Yewtree' (Gray & Watt, 2013). The increased public and political attention has encouraged many survivors to disclose their experiences of abuse. According to the National Police Chiefs Council, there had been a 71% increase in the number of CSA cases reported to the police in the year leading up to 2015. Similarly, the National Association for People Abused in Childhood (NAPAC) reported that between October and November of 2012 there were 8000 calls made to their helpline, whereas the previous year, at the same time, this figure was 2,500 (HMIC, 2013). Despite these rises, studies have shown that limited attention has been paid to the availability and appropriateness of treatment for the long-term effects of CSA (Lowe & Balfour, 2015; Smith, Dogaru, & Ellis, 2015; Chouliara et al., 2012).

Although there is still disagreement in the literature on the 'best' therapeutic approach (Wise, Florio, Benz, & Geier, 2007), the most common treatment approaches for survivors include trauma focused or exposure based treatment, (Cloitre, Stovall, McClough, & Levitt, 2004; Folette & Ruzek, 2006; Putnam, 2009), including anxiety management, exposure, and cognitive restructuring (Foa, Davidson & Frances, 1999). However, much of the research looking at the evaluation of these therapy approaches tends to be informed by professional views rather than survivor perspectives (Smith et al., 2015). In fact, in a recent systematic review on international research, Chouliara et al. (2012) highlighted that there is a distinctive lack of published research on survivors' perceptions of treatment effectiveness, particularly in the United Kingdom. As a result, it is unclear whether survivors perceive their needs and service provision in the same way as clinicians, or whether their needs are met in clinical settings (Draucker & Petrovic, 1997). Furthermore, existing research in this field is

characterised by a number of methodological limitations, including inconsistencies and a wide variability in methodology and focus, which makes findings difficult to compare and weakens the capacity to generalise results (Chouliara et al., 2012). In this context, this study aims to explore CSA survivors' experiences of psychological therapy, in order to build on existing evidence based on the adequacy of therapy for survivors of CSA.

This chapter will consider existing literature and ways of conceptualising the lived experience of adult women who have experienced CSA, and who have undergone therapy for the effects of CSA. Firstly it will review findings related to the definition and prevalence of CSA. It will then consider empirical studies of the possible impacts of CSA on women's wellbeing, including a review of relevant conceptual theories for the understanding and development of CSA outcomes. Support services and interventions for CSA survivors will be discussed with a particular focus on help-seeking behaviour, as well as counselling and therapy interventions for survivors. The chapter will end with a summary and rationale for the current study.

1.2 . Prevalence estimates and definition of CSA

1.2.1. Definitions of CSA

There appears to be a lack of consensus among researchers on how to define CSA, (Johnson, 2008). Most general population surveys define CSA as 'unwanted sexual contact' without describing specific behaviours. Other studies distinguish between 'contact abuse and 'non contact abuse', or 'penetrative abuse' and 'non penetrative' abuse (Cashmore & Shackel, 2013). Variations also exist in the way the relationship between the victim and the perpetrator is described in the literature, and is often categorized as either "within the family' or 'outside the family' abuse (Cashmore & Shackel, 2013). Nevertheless, a number of controversies have been identified when trying to establish a definition of CSA, including discrepancies around contact abuse, and non- contact abuse, in particular, whether non-contact offences such as exhibitionism should be considered as abuse. Furthermore, there is

a limited agreement on the characteristics of abuse, such as cut off age for consent to sexual interaction, as well as the classification relating to seriousness of the abuse (Cashmore & Shackel, 2013; Scottish Executive, 2002). A comprehensive analysis of definitions of CSA, including the various characteristics of the abuse, such as the types of sexual behaviors that are included is outside the scope of this research, however, it is important to understand how CSA is defined, and how it varies across literature, as this has shown to affect the way findings may be compared, and the conclusions that can be drawn.

For the purpose of this study, the definition of CSA proposed by the UK Government will be used:

“Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children” (Department of Education, 2015, p. 93).

Guided by other researchers in this field, the term Child Sexual Abuse, and Childhood Sexual Abuse are used interchangeably in this study. The term perpetrator, abuser and offender are also used interchangeably. Lastly, the term survivor has been used over the term victim, as guided by other studies (Cashmore & Shackel, 2013).

1.2.2. Prevalence estimates of CSA

Given the lack of consensus on the definitions used in research studies, the extent of the problem of CSA is difficult to estimate. Nevertheless, international prevalence studies have shown that in general, CSA is more common among girls than boys, with global prevalence rates reaching 18-20% for girls, and 8% for boys (Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). Another study conducted on prevalence rates of CSA across 55 studies, from 24 countries reported that between 8-31% of females and 3-17% of males experienced sexual abuse in childhood (Barth, Bermetz, Heim, Trelle, & Tonia, 2012). In the UK, it has been found that between 5-10% of girls, and 5% of boys have been exposed to penetrative sexual abuse, with estimates up to three times higher for children who have been exposed to any form of sexual abuse (Gililbert et al., 2008).

The variability in prevalence rate across studies has been related to methodological issues, including varying definitions used in both the literature (Wilson, 2010), the cut-off age used to define CSA (Kristensen & Lau, 2005) as well as differences in the research design and data collection method used (Johnson, 2008; Scottish Executive, 2002). In addition, studies have shown there appears to be a discrepancy between the low official reports of CSA and the high rates of CSA in self-report studies. For instance, a meta-analysis study by Putnam (2003) looked at estimates of CSA in 217 studies, published between 1980-2008. It was found that estimates of CSA were 30 times greater in studies relying on self-reports in comparison to official reports, based on data from child protection services and the police, indicating that there is high prevalence of under-reporting, particularly in official reports (Putnam, 2003). In fact, studies highlight that many victims continue to be unrecognised, as they do not disclose the abuse (Putnam, 2003). This phenomenon is often referred to as 'the tip of the iceberg' where only a minority of CSA situations are visible, while a large proportion remains undetected (MacMillan Jamieson, & Walsh, 2003). This is supported by numerous studies, which shows that CSA is generally under-reported, particularly in males (Cawson, Wattam, Brooker, & Kelly, 2000; Scottish Executive, 2002; Collin-Vézina, Daigneault, &

Hébert, 2013; Barnett, Miller-Perrin, & Perrin, 2005; Stern, 2010).

1.2.3. Nature and characteristics of CSA

Studies have shown that some populations are at a higher risk of CSA in comparison to the general population. Being female has consistently been identified as a major risk factor for CSA, as studies have shown that girls are two times more likely to be victims than boys (Stoltenborgh et al., 2011). Prevalence of disability has also been linked to increased risk of CSA. A study in the UK identified that the rate of CSA amongst disabled children shows an increased likelihood of up to three times in comparison to non-disabled children (Carlson, Maciol, Schneider & Sibling, 2006). In terms of age, school aged children and adolescents are most vulnerable to CSA, and approximately 25% of survivors report that they were abused before the age of 6 (Putnam, 2003). Estimates regarding the nature of abuse is difficult to estimate, however a UK study conducted by the NSPCC showed that among people aged 16-24, there was a 21% prevalence of non-contact CSA for females and 11% for males, whilst the prevalence of contact CSA was 16% for females and 7% for males (Cawson et al., 2000).

The literature on the impact of socioeconomic status (SES) and ethnicity on CSA is limited. Nevertheless, the 'Children in need' government statistics (2003) suggest that the proportion of 'non-white' ethnicities is between 1.2 and 1.7 times the national average. However, there were large variations between Black Minority Ethnic (BME) communities, with children of black or mixed ethnic identity over-represented, whilst children of an Asian ethnic identity were under-represented (Barn, Sinclair, & Ferdinand, 1997). However, these findings should be interpreted with caution, as some authors in the US have suggested that certain populations of children have been over-represented in research which has focused on vulnerable populations, such as Black American children from low SES, which may create the belief that race and ethnicity are risk factors for CSA (Kenny & McEachern, 2000). However, research on the impact of SES has shown that low SES has been linked to an

increased risk of physical abuse and neglect, however no such link has been found for CSA (Coulton, Crampton, Irwin, Spilsbury, & Korbin, 2007; Sedlak et al., 2010) More research is therefore needed in order to investigate the relationship between SES, ethnicity and the prevalence of CSA.

Other factors which have been linked to a higher risk of CSA include children that come from dysfunctional family environments, characterised by fragmented and chaotic family dynamics (Bhandari, Winter, Messer & Metcalfe, 2011), the absence of one or both parents and substance abuse (Wolfe, 2007). There is also some evidence to suggest that CSA is more likely to occur within the family, where the child knows the perpetrator (Saidi, Odula & Awori, 2008). Furthermore, that repeated sexual abuse is more commonly linked to interfamilial CSA, whilst single incident abuse is more likely to be perpetrated by someone outside the family (Kristensen & Lau, 2005). The most frequent reported perpetrators are male; fathers, stepfathers, and other male relatives, including siblings (Kristensen & Lau, 2005; Tarczon & Quadara, 2012; Csorba et al., 2006; Watts & Zimmerman, 2002).

1.3 Long term effects of CSA

Adult survivors of CSA are more likely to present with a large number of psychological/emotional, social/relational and physical/sexual difficulties (Cawson et al., 2000; McGee, Garavan, deBarra, Byrne, & Conroy, 2002) and variations have been found in both the frequency and intensity of symptoms amongst survivors (Davies & Petretic - Jackson, 2000). The complexity of the problems associated with the impact of CSA means that treatment and interventions for the effects of CSA are often varied and long-term, and often associated with higher costs for survivors, related to an increased number of doctor visits (Chartier, Walker & Naimark, 2007; Saied-Tessiet, 2014). Many of the problems experienced by survivors of CSA (i.e. guilt, shame, low self esteem, issues with control, difficulties with intimacy) lead to diagnosable mental health issues such as depression, anxiety, PTSD, eating disorders and sexual disorders (Williams & Poijula, 2002; Blumer,

Papaj, & Erolin, 2013). Providing an outline of the relationship between CSA outcomes and diagnostic classification, including its relationship to service utilisation, is outside the scope of this research. However, important to note that many survivors exhibit symptoms that are consistent with different mental health classifications, and that clients that present with such diagnostic conditions may also be survivors of CSA (Blumer et al., 2013). In fact, women survivors of CSA access services from a wide range of statutory, voluntary and private health organizations, and often experience a number of challenges related to this process (Smith et al., 2015). The literature on survivors help-seeking behavior and service utilisation patterns, and its implication on therapy, will be discussed in more depth at a later stage in this research. The following section will provide an overview of the literature examining the impact of CSA on survivors' psychological, physical and social wellbeing and functioning. Much of the research in this area has predominantly used retrospective designs. However, earlier research utilised cross sectional studies with clinical or convenience samples, whilst more recent studies have used random community samples, birth and twin cohorts. These studies have generated more reliable and generalisable findings (Cutajar et al., 2010).

1.3.1. Mental health and Psychological/Emotional Wellbeing

The psychological consequences of CSA are well documented in the literature (Walsh, Fortier, & DiLillo, 2010). Such effects include, but are not limited to, depression, psychological distress, poor self-esteem (Freshwater, Leach & Aldridge, 2001; Johnson, 2004), substance abuse, suicide attempts (Dube et al., 2001; Plant & Miller, 2004), severe posttraumatic stress symptomatology (Petrak & Campbell, 1999), psychopathology disorders (Owens & Chard, 2003), dissociative and personality disorders (Fleming, Mullen, Sibthorpe, & Bammer, 1999; Simpson & Miller, 2002; Cutajar, 2010) as well as self-destructive behavior (Merrill, Thomsen, Sinclair, Gold, & Milner, 2001). In recent years, CSA has also been associated to psychotic disorders, including schizophrenia and delusional disorder (Bendall, Jackson, Hulbert, & McGorry, 2011). A recent Meta-analysis by Chen et al. (2010), provides further understanding on CSA outcome. The authors explored the evidence for CSA and a

lifetime diagnosis of psychiatric disorders. The findings indicated a strong consistent relationship between CSA and a number of mental health difficulties, including depression and anxiety, PTSD, eating disorders, sleep disorders and suicide attempts. Both males and females were found to be at a greater risk of experiencing these problems later in life, irrespective of how old they were when the abuse occurred. However, the review did not find a significant relationship between CSA and a diagnosis of schizophrenia, or somatoform disorders, furthermore, there was not enough evidence to examine bipolar disorder or obsessive-compulsive disorder (Chen et al., 2010).

1.3.2. Intimacy, relationship and behavioral difficulties

There is evidence to suggest that adult survivors of CSA may experience greater difficulties with intimacy and interpersonal relationships (Abdulrehman & De Luca, 2001). As a result of the abuse and subsequent betrayal, the survivor might experience difficulties in establishing trusting attachments. For instance, Rellini and Meston (2006) found that women with a history of CSA tended to have issues related to sexual functioning and difficulties with significant and intimate relationships. Furthermore, Peleikis, Mykletun, and Dahl (2004) reported that these women often experienced challenges related to aspect of care (warmth, consideration, and affection) and control (intrusive, critical, and dominant attitudes and behaviors). Survivors were also less likely to perceive their current romantic partners as supportive, caring, and open to communication and were less likely than other women to be sexually faithful to their partners and spouses (Colman & Widom, 2004).

Additionally, several studies have highlighted that survivors of CSA are at a greater risk of re-victimization as well as alcohol and substance abuse in adulthood (Maker, Kemmelmeier, & Peterson, 2001; Arriola, Loudon, Doldren, & Fortenberry, 2005). For instance, it is estimated that two thirds of CSA survivors, may experience re-victimization during adolescents or in their adult life (Classen, Palesh, & Aggarwal, 2005). Furthermore, women survivors of CSA are up to four times likely to report sexual assault in adulthood (Kimerling, Alvarez, Pavao,

Kaminski, & Baumrind, 2007). Survivors may also experience a sense of fear about sex, sexual dysfunction and be confused about their sexual orientation (Cashmore & Shackel, 2013). Additionally, studies have found some evidence which indicates that a higher proportion of individuals with same sex orientations report CSA, and this relationship may be stronger for men. However, there is not enough evidence to draw any conclusions on its accuracy (Wilson & Widom, 2010). Some studies suggest that survivors of CSA are also at greater risk of engaging in risky behavior, including risky sexual behaviors such as unprotected sexual intercourse and having multiple sexual relationships (Arriola et al., 2005). However, some authors suggest that the age and gender of the survivor can influence the rates of risky sexual behavior in survivors of CSA. For instance, Van Roode, Dickson, Herbison, and Paul (2009) observed an increased rate in risky behavior (i.e. number of sexual partners, unhappy pregnancies and abortion and STI) among women survivors between the ages of 18-21, thereafter, rates were similar to those of non- abused women. More studies are therefore needed in order to shed light on the relationship between age/gender and risk behavior amongst survivors (Cashmore & Shackel, 2013).

1.3.3. Physical health

Several studies have also indicated that CSA survivors report more physical health problems than those without abuse (Irish, Kobayashi, & Delahunty, 2010; Wilson, 2010). In fact, literature on the physical impact of CSA has confirmed that there is a relationship between CSA and a number of serious and chronic adult physical effects, including but not restricted to urinary and gastrointestinal problems, obesity, headaches, and pelvic pain (Briere, 1992), compromised immune system functioning; sexual, gynaecological, and reproductive concerns; heart disease; cancer; liver disease; generalised pain; musculoskeletal complaints; and medically unexplained conditions (Mulvihill, 2005; Runtz, 2002; Sachs-Ericsson, Blazer, Plant, & Arnow, 2005; Cashmore & Shackel, 2013). A recent Meta analysis study by Irish et al., (2010) provide further evidence on the relationship between CSA and physical outcomes. It was found that adult survivors of CSA were more likely to experience problems with

physical health, including gastrointestinal problems such as irritable bowel syndrome, gynaecologic pain including chronic pelvic pain, as well as cardiopulmonary symptoms. They were also more likely to experience headaches, backaches, muscle and joint aches, as well as experience an increased risk of obesity. Survivors also reported poorer general health, as well as having more negative perceptions of their overall physical wellbeing.

1.3.4. Moderating factors impacting on CSA outcome

Studies have indicated that wide variations in symptomology exist between survivors of CSA, both in relation to onset of problems as well as symptoms that may exist (Cashmore & Shackel, 2013). A number of moderating factors have been identified which are believed to influence outcomes. However, the relationship does not seem to be one of simple cause and effect (Sneddon, 2012). The varying degrees of distress in survivors has been linked to factors, such as the relationship between the child and the perpetrator, and the gender and age of the child and the perpetrator (Cashmore & Shackel, 2013). Other factors which have been found to be important include the duration and form of the abuse, which may lead to a wide range of outcomes (Saywitz, Mannarino, Berliner, & Cohen, 2000). In general, more severe effects of CSA have been associated with frequent and prolonged CSA involving penetration. Furthermore, CSA perpetrated by a family member has also shown to impact severity of outcomes (Beitchman, Zucker, Hood, DaCosta, & Akman, 1991), as well as the child's family circumstances and context, which can serve as protective factors and impact the outcome (Fergusson & Mullen, 1999). Additionally, some studies indicate that victimization can contribute to an increased risk of PTSD, traumatic events and alcohol dependence (Ullman & Brecklin 2003). Nevertheless, there is also evidence to suggest that a significant proportion of victims do not exhibit clinical levels of symptoms (Saywitz, Mannarino, Berliner, & Cohen, 2000). Explanations proposed to explain this include; a lack of severity of abuse, symptoms not being detected by practitioners, development of avoidant coping that masks victims distress, or that asymptomatic survivors may be more resilient than the survivors who show symptoms (Williams & Gardell, 2012; Cashmore & Shackel,

2013).

1.3.5. Summary of the effects of CSA

The research findings discussed indicate that CSA is associated with a broad range of adverse outcomes for adult survivors. Research findings demonstrate persistent and adverse mental, physical, social, sexual, behavioral and interpersonal problems associated with CSA. These include the presence of depression and anxiety (Cashmore & Shackel, 2013) alcohol and substance abuse (Arriola et al., 2005) eating disorders, and an increased risk of re-victimization (Classen et al., 2005). More recent research has also identified a link between CSA and personality disorders (Fleming et al., 1999; Simpson & Miller, 2002; Cutajar et al., 2010) as well as psychotic and schizophrenic disorders (Hulbert, & McGorry, 2011). An increased risk of suicidal ideation and suicidal behavior has also been demonstrated (Cashmore & Shackel, 2013). The overview of CSA outcomes indicates that there are still a limited number of studies investigating the long-term effects of CSA. Further research is needed in order to shed light on the variations in survivors' experiences of CSA, as well as the impact of mediating factors on survivors' functioning and adjustment. An increased understanding in this field will assist professionals in the identification, treatment and prevention of CSA. Additionally, it can facilitate survivors in their ability to disclose their experiences and gain access to services that can provide specialised knowledge related to the experiences of CSA and its effects (Cashmore & Shackel, 2013).

1.4. Conceptual frameworks

The lack of single pattern symptoms to characterize the outcomes of CSA has contributed to the development of models that can provide comprehensive explanations of its' impact on the functioning and wellbeing of survivors. Much of the early research in this area focused on the identification of abuse related symptomology. Subsequent to this, a number of theoretical frameworks have been proposed in order to provide more systematic explanation of the adverse effects of CSA and trauma (Freeman & Morris, 2001). Theories that have been

proposed include Developmental Theory (Celano, 1992; Cole & Putnam, 1992) and Attachment Theory (Alexander, 1992), as well as the Traumagenic Dynamics model (Finkelhor & Browne, 1985). Conceptual frameworks that explain the development of adverse negative outcomes of CSA are important in order for appropriate interventions to be developed and implemented for survivors (Polly & Hulme, 2004). Therefore, in order to integrate knowledge about the effects of CSA, it is important to consider and evaluate prevalent conceptual frameworks related to the development of CSA outcomes. This section will provide an overview of these models, with a particular focus on the Traumagenic Dynamics model.

1.4.1. Traumagenic Dynamics model

Of the available frameworks, the Finkelhor and Browne (1985) model proposes the most referenced framework to understand the experiences of CSA, and the particular consequences for the survivors' wellbeing. Finkelhor and Browne (1985) model describes four so-called traumagenic dynamics, or trauma-causing factors, which can lead to adverse psychological effects in the child following sexual abuse. These factors include sexual trauma (Traumatic Sexualisation), the adult's betrayal (Betrayal), stigma (Stigmatisation) and the child's powerlessness (powerlessness). According to Finkelhor and Browne (1985) the traumagenic dynamics are generalised dynamics, and can occur in other forms of trauma. However, the combination of these four dynamics in one set of circumstances makes it unique to the trauma of CSA, and thereby differs from other childhood traumas, such as physical child abuse (Finkelhor & Browne, 1985).

According to Finkelhor and Browne (1985), the four dynamics can distort children's self-concept, worldview and cognitive and affective capacities, and thereby create trauma. Furthermore, it is stipulated that the behavioural problems associated to survivors of CSA are a result of the child's attempt to cope with the world through these distortions. Finkelhor and Browne (1985) argue that the four traumagenic dynamics exist in various degrees amongst

all CSA experiences. However, due to the variations of each abuse experience (i.e. characteristics and frequency of abuse, the relationship between the child and the perpetrator, quality of support from family) the child, or survivor might experience particular dynamic more or less than the other. The following section will describe each of the four dynamics (Traumatic Sexualisation, Betrayal, Powerlessness & Stigmatisation) and how they relate to the commonly observed effects of CSA.

1.4.1.1. Traumatic sexualisation

Traumatic sexualisation is a process in which the child's sexuality, including feelings and attitudes, are not formed in a developmentally and interpersonally functional fashion as a result of sexual abuse (Finkelhor & Browne, 1985). Traumatic sexualisation can occur in a number of ways, including children learning that sexual activity is exchangeable for receiving rewards, gifts privileges, attention, and using this in order to satisfy a variety of developmental needs. It can happen when the child is "repeatedly regarded by the offender for sexual behaviour" (Finkelhor & Browne, 1985), that is inappropriate for their level of development. In addition, the child can develop confusion about sexual behaviour, morality and norms, which are transferred to the child from the perpetrator. Traumatic sexualisation can also occur through memories of the abuse itself, and the association of frightening memories and/or events to the sexual activity. The consequences of being exposed to traumatic sexualisation in childhood can lead to difficulties related to sexuality in adulthood (Holmes & Slap, 1998).

1.4.1.2. Betrayal

The betrayal dynamic refers to "*the abused child discovering that an adult, whom they have been dependent on has caused them harm*" (Finkelhor & Browne, 1985). This can occur both during the course of abuse or in its aftermath, and can take different forms. For instance, the child may discover that they have been exploited and manipulated by a trusted person, through misrepresentations about moral standards, or by treating them with disregard. This

betrayal might be reinforced by wider society, as trusted adults fail to or are unwilling to protect or believe them, following disclosure of the abuse. As a result of such betrayal, the child might develop difficulties in adulthood, particularly related to attachment as well as difficulties with intimacy and intimate relationships (Abdulrehman & De Luca, 2001; Finkelhor & Browne, 1985).

1.4.1.3. Powerlessness

This dynamic refers to “the process in which the child’s will, desires, and sense of efficacy are continually contravened” (Finkelhor & Browne, 1985). There are several aspects of the abuse experience that contribute to this dynamic, including the sense of powerlessness resulting from repeated violations of the child’s physical boundaries by the perpetrator against their will. Furthermore, the child’s inability to stop the abuse from occurring can reinforce the child’s sense of powerlessness over the situation. This is further increased when children experience fear, or are unable to make adults understand or believe their experiences (Finkelhor & Browne, 1985). The sense of powerlessness increases the risk of developing difficulties associated to anxiety and victimisation in adulthood (Barnes, Noll, Putnam & Trickett, 2009).

1.4.1.4. Stigmatisation

The final dynamic, stigmatisation, refers “to the negative connotations (shame, guilt, badness) that are communicated to the child around the experiences”, and that subsequently become incorporated into the child’s view of themselves (Finkelhor & Browne, 1985). Stigmatisation can occur in a number of ways, it can be communicated directly via the perpetrator, who may blame the child for the abuse, or convey a sense of shame and guilt about the behaviour, or through a pressure for secrecy. Stigmatisation can also be reinforced through inferences drawn from societal attitudes and negative reactions to disclosure of abuse, thereby increasing the child’s sense of guilt, shame and isolation (Finkelhor & Browne, 1985). The consequences of stigmatisation can lead to difficulties in adulthood in

the form of a negative self-concept, and self-harming behaviour (Mullen & Fleming, 1998).

Finkelhor and Browne (1985) Traumagenic Dynamics model was chosen for this study, as it provides a systematic framework for understanding the multifaceted outcomes of CSA. Despite this, researchers have highlighted that the model is lacking an empirical base (Hulme, 2004; Cantón- Cortés, Rosario Cortés & Cantón, 2012). The authors highlighted that they used clinical experience, rather than empirical or experimental data to develop their theories about the effects of CSA. The lack of empirical data has lead to questioning of the reliability and generalisability of the model (Polly & Hulme, 2004; Cantón- Cortés et al., 2012) and more research is therefore needed in order for conclusions to be drawn on its applicability to the effects of CSA. Other frameworks that have been considered in this research include Attachment Theory (Alexander, 1992). This theory highlights the relationship between issue of betrayal by a significant person and the short and long-term negative effects such as distorted adult relationships, chronic negative effects, re-victimization, and disturbances in self-concept. Developmental Theory (Celano, 1992; Cole & Putnam, 1992) was also considered as it furthers the understanding related to the stages of development in which the child was abused, the context of the abuse and subsequent behaviour in adulthood, including the relationship between oral sexual abuse and various personality and addictive disorders in adults (Lev Wiesel, 2008).

1.5. Service utilisation and help-seeking amongst survivors of CSA.

This section will provide an overview of the literature related to help seeking behavior, and service utilization patterns amongst survivors of CSA. Challenges associated with this process will also be discussed, and a particular emphasis will be put on discussing its influence on survivor's experiences and perceptions of therapy.

1.5.1. Service utilisation

There is contradictory evidence in the literature regarding the uptake of health care amongst CSA survivors. Some studies report a high use of services (Grimstad & Schei, 1999) whilst others report a under-use or avoidance of health care services (McGregor, Jülich, Glover, & Gautam 2010). For instance, findings from a national survey of nearly 400 survivors examining the support needs of CSA survivors in the UK (Smith, et al., 2015), showed that survivors utilise a variety of support services. More specifically, it was found that counselling, mental health and GP services were amongst the most commonly used, with over half of survivors using these services for the effects of CSA. Other commonly used services included voluntary sector abuse and support services and psychotherapy services, followed by the police, the Samaritans and Accident and Emergency, and Secondary health services. Social services were the least used, with less than a fifth of survivors using these services. In general, survivors used on average between four or five services a year over a ten-year span, between the first service accessed and the most recent service used (Smith et al., 2015).

In UK services where the medical model prevails, such as the NHS, diagnosis is often used as a means to categorise client's mental health symptoms, subordinating their experience of CSA (Allnock et al., 2009). However, NICE guidelines appear to have conflated treatment for survivors of CSA within the PTSD guidelines, without taking into account the additional complexity of issues survivors often present with (Putnam, 2003). Consequently, studies have highlighted that services for CSA survivors have an adherence towards the medical model, characterised by a focus on prescribing rather than on individual needs of survivors (Survivors West Yorkshire, 2006), furthermore, that mainstream services are often not able to meet the complex needs of survivors, and that there is a lack of understanding of the nature and long-term effects of adult survivors of CSA (McGregor et al., 2010). The importance of third sector organizations, in particular specialist services, has been recognised in a number of policies and strategies (HM Government, 2009; WAG, 2010).

These services play a crucial role in providing a range of abuse specific services, signposting to other key services, as well as enhancing understanding and practice in statutory sectors (Itzin, 2006). In fact, a recent report by the Survivors trust (2010) found that the statutory sector relies heavily on third sector services as it accounted for approximately 71% of all the referrals made. Providing a comprehensive evaluation on the literature relating to service provision for survivors of CSA is outside the scope of this study. However, it is important to note that existing research highlights a number of challenges related to survivors' experience of accessing and utilising specialist services (Smith et al., 2015). As such it is important to consider the impact of the wider use of services amongst survivors, and how this relates to and impacts on the experiences of help-seeking and psychological therapy.

1.5.2. Help-seeking behavior amongst survivors of CSA

Survivors of CSA have described difficulties disclosing their experiences of abuse due to shame, self-blame, fear of not being believed, or not knowing the abuse had an effect on their presenting symptoms (McGregor et al., 2010). In fact, many survivors lack awareness of the relationship between their experiences of abuse, and presenting mental health difficulties (Lothian & Read, 2002; Wurr & Partridge, 1996), and some studies indicate that survivors only seek formal support following years of trying to overcome shame, fear and denial (Robinson, 2000), and tend to access services in the context of an increased awareness of personal patterns in relationships, or at different developmental markers (Courtois, 1999), or during a life crisis (Dale, 1999). In addition, a lack of information about available services and difficulties in accessing specialist services can exacerbate these problems (HM Government, 2007; Sanderson, 2006; Survivors Trust, 2010).

In fact, a number of studies have indicated that survivors experience specific barriers to accessing specialist services (Chouliara et al., 2011; Smith et al., 2015; Monahan & Forgash, 2000). For instance, Palmer, Brown, Rae-Grant, and Loughlin, (2001) study on survivors' experience of obtaining treatment in Canada found that survivors reported long wait periods,

available therapy being unaffordable, and professionals not having specialised abuse training. Furthermore, many described feeling judged by their therapist, or said that the duration of treatment was insufficient in length. In contrast, findings from a national survey of nearly 400 adult survivors of CSA in the UK, showed that satisfaction with services was associated with the treatment of survivors, including basic qualities such as whether they made survivors feel listened to, believed and respected (Smith et al., 2015). Overall, research has indicated that positive service responses can lead to improved outcomes in relation to survivors functioning, coping and mood, as well as result in survivors reaching a point of recovery sooner (Smith et al., 2015). Unhelpful experiences on the other hand can negatively affect future help-seeking behavior, as it can lead to survivors being suspicious of healthcare professionals in general (Monahan & Forgash, 2000), as well as create barriers to future help-seeking (Chouliara et al., 2011). More research is therefore needed in order to understand factors that might hinder or assist disclosure and help-seeking for survivors and how this relates to experiences and utilisation of therapy.

1.6. Psychological therapy and interventions for women survivors' of CSA

This study aimed to explore women survivor's experiences of psychological therapy. It is therefore important to consider the psychological therapy and interventions that are available to CSA survivors. The present section aims to provide a review of recent Meta- analysis and empirical outcome studies, comparing the efficiency of psychological therapy for adult survivors of CSA, with a particular focus on the effectiveness of interventions on well-documented effects of CSA. In addition, a number of treatment considerations that have been identified as important when working with survivors of CSA will be reviewed, along with qualitative studies exploring the experience of psychological therapies amongst survivors of CSA.

1.6.1. Effectiveness of treatment: Meta Analysis studies

Meta analyses related to the experience of CSA survivors generally cover the long-term effects of CSA, effectiveness of treatment of children who have been victimised in childhood, as well as effectiveness of treatment for symptoms commonly experienced by CSA survivors. However, comprehensive meta-analysis comparing the efficiency of psychological therapy for adult survivors of CSA is limited. Two meta-analyses studies, which provide a review of treatment for CSA survivors specifically, include Martsof and Draucker (2005) study as well as a meta-analysis by Taylor & Harvey (2010) and Ehring et al. (2014). These studies will be reviewed in the following section.

Martsof and Draucker (2005) reviewed and synthesised results from 26 studies and two meta-analyses on the effectiveness of abuse focused psychotherapy techniques for adult survivors of CSA. This included evaluating individual, group and combined treatment formats, with pre/post test, quasi-experimental or randomised control designs. Accumulated research findings suggested that abuse focused psychotherapy, (including Cognitive Behavioral Therapy, Eye Movement Desensitisation and Reprocessing and Emotion focused therapy) for adult survivors of CSA is generally beneficial in reducing psychiatric distress, depression, and trauma specific symptoms, regardless of the specific therapeutic modality or technique used. Martsof and Draucker (2005) concluded that no therapeutic approach was found to be more superior than the other and there was little evidence about the effectiveness of individual versus group therapy, but both were more effective than no treatment at all. Furthermore, no evidence was found on the optimal treatment duration. However, they found a number of limitations to studies that had been conducted, including a lack of randomised control studies, as well as inadequate use of control groups (i.e. utilising pre/post designs without a comparison group or utilising a quasi-experimental design with natural wait list groups as control). As such, the authors concluded that the interpretability of studies were limited.

In order to address the limitations of previous studies Taylor and Harvey (2010), reviewed 44 studies comprising of 59 treatment conditions, which were analyzed to evaluate the effectiveness of a variety of psychological treatments at reducing negative outcomes of CSA, with a particular focus on psychological effects. Results showed a medium effect size for Post Traumatic Stress Disorder (PTSD) symptoms, externalizing, self-esteem, interpersonal functioning as well as global functioning symptoms following treatment for CSA. Interpersonal functioning had an inconsistent effect size across the study design. The results showed that overall, psychological treatment is beneficial for adult survivors of CSA and that the effects are maintained at least six months following treatment. However, different characteristics of therapy were found to moderate the effectiveness of interventions. Treatment modality was a clear moderator of PTSD/trauma symptoms outcome, and there was no evidence to support the effectiveness of group interventions for any of the six outcomes measures. Furthermore, it was hypothesised that certain characteristics of the client and their abuse experience also function as a moderating factor in treatment. Although this review provided useful information about the effectiveness of treatment for adult survivors of CSA there were a number of limitations affecting the results, including heterogeneity of effect sizes and treatment approaches affecting interpretation of the data. The authors concluded that there is a need examine what aspects of treatments are most effective, such as specific interventions, treatment modalities, and optimal duration of treatment (Taylor & Harvey, 2010).

Ehring et al. (2014) carried out a meta-analysis focusing on studies evaluating the efficacy of psychological interventions for PTSD in adult survivors of CSA. Sixteen robust randomized control trial studies met the inclusion criteria, and these were sub-divided into trauma-focused CBT (TF-CBT), non-trauma-focused CBT, Eye Movement Desensitization and Reprocessing (EMDR) and other treatments (interpersonal, emotion-focused). Results showed that psychological interventions are effective for PTSD in adult survivors of CSA.

Additionally, trauma focused treatments (i.e. TF-CBT and EMDR) were more effective than non-trauma focused interventions, and treatments including individual sessions showed greater improvements in client outcomes than pure group treatments. Additionally, there were similar levels of drop-out from trauma and non-trauma focused interventions. The authors concluded that the best effects could be achieved with individual trauma focused treatments. The authors also suggested that these findings do not support concerns that it is not safe to use trauma-focused treatments in clients suffering from high levels of symptom complexity.

1.6.2. Effectiveness of treatment interventions: Empirical findings

A number of therapeutic interventions have been utilised in the treatment of adult survivors of CSA, including group and family counselling, Cognitive behavioural interventions (Kessler, White, & Nelson, 2003), including trauma-focused or exposure based treatment (Cloitre, Stovall-McClough, & Levitt, 2004; Follette & Ruzek, 2006; Putnam, 2009) as well as Emotion focused therapy (Cohen, 2008). In the UK Statutory provision encourages the delivery of trauma focused CBT and EMDR therapy. This preference is associated to the vast efficiency studies and evidence base related to the effectiveness of these interventions (Hetzel-Riggin, Brausch, & Montgomery, 2007; Silverman et al., 2008; Wethington et al., 2008), and as a result it is seen as the 'gold standard' of provision for symptoms associated with CSA, including depression, anxiety and PTSD (National Institute for Health and Clinical Excellence, 2008; National Institute for Health and Clinical Excellence, 2011). Other common interventions provided in the UK include play therapy and Psychodynamic therapy, and counselling. However, the evidence base for these therapies is limited (Wethington et al., 2008). This section will provide an overview of psychological interventions for survivors of CSA. A particular focus will be put on the adequacy of these interventions in treating the effects of CSA.

1.6.2.1. Cognitive Behavioral Therapy interventions

A study by McDonagh et al. (2005) has provided some support for the effectiveness of exposure and cognitive techniques for the treatment of CSA-related PTSD. In a randomised clinical trial of CBT interventions for the treatment of PTSD in adult female survivors of CSA, McDonagh et al. (2005) compared the efficacy of CBT; specifically prolonged imaginal exposure, in vivo exposure, cognitive restructuring, psycho-education, and breathing techniques to present-centred therapy (PCT) which focuses on coping styles, problem-solving skills, psycho-education and journal writing, and a waiting-list control group. At follow up, both CBT and PCT were more effective in treating PTSD in comparison to the waiting-list control group. Furthermore, improvements were found in the severity of PTSD symptoms, anxiety and trauma-related cognitive schemas. There were no significant improvements in symptoms associated to CSA, including dissociation, depression, hostility, anger and quality of life, when compared to the waiting-list control group.

In addition, findings showed that CBT participants had the highest drop-out rate (41%) among the three treatment modalities, particularly amongst participants with psychiatric issues, such as depression and anxiety. Based on these findings, McDonagh et al. (2005) concluded that individuals with complex clinical presentations might not tolerate and benefit from CBT as well as those with PTSD alone. These results emphasise that some versions of CBT might be more effective than others, and that CBT may have positive effects, but not on all outcomes. Despite the usefulness of these results in highlighting the effectiveness of CBT for the treatment of PTSD that is secondary to CSA, the use of exclusion criteria (i.e. use of medication, existing relationship with an abusive partner, current substance use, pregnancy and cardiovascular disease) raises issues regarding the generalisability of these findings to clients with multiple presenting problems.

Another CBT study (Moller & Steel, 2002) investigated the effectiveness of 'Cognitive Restructuring' in a sample of 26 female adult survivors of CSA. Participants were assessed

for depression, state anxiety, state anger, state guilt, and self-esteem. Participants completed 10 weekly sessions of group rational-emotive behaviour therapy and an 8-week follow up was conducted following completion of treatment. The pre to post treatment results showed that Cognitive Restructuring was effective in reducing anxiety, depression and anger, but was less effective in reducing guilt and low self-esteem. Furthermore, findings from the survey of personal beliefs showed that the relationship to the perpetrator and pre-treatment irrational evaluation beliefs were found to be the best predictor of treatment outcome. More specifically, poor treatment outcomes were associated with the perpetrator being a close family member, and with more 'other directed shoulds', in contrast, recovery was associated with the perpetrator being a friend or stranger, and with more 'awfulising', 'self-directed shoulds' and negative self-worth beliefs.

Chard (2005) explored the effectiveness of Cognitive Processing Therapy (CPT) adapted treatment for CSA survivors, to a wait list control group and found promising results. 71 women were assigned to either a CPT-SA group or a control, receiving 17 weeks of group and individual therapy. CPT interventions incorporated information processing, developmental and attachment theories. The results showed a significant reduction in PTSD, depression and dissociation symptoms for participants in the CPT-SA group compared to the control group. Similarly, mindfulness based treatments, such as Acceptance and Commitment Therapy (ACT, Hayes, Luoma, Bond, Masuda, & Lillis, 2006, Mindfulness Stress Reduction (MBSR), (Kabat-Zinn, 1982) as well as Dialectical Behavioral Therapy (DBT), (Linehan, 2000) have also shown to be effective in the treatment of CSA survivors.

For instance, Steil, Dyer, Priebe, Kleindienst, and Bohus, (2011) conducted an uncontrolled study to examine the acceptance, safety and effectiveness of Dialectical Behaviour Therapy (DBT) for CSA survivors suffering from post-traumatic stress disorder (DBT-PTSD). The authors treated 29 women with chronic CSA-related PTSD plus at least one other comorbid

diagnosis, using principles from DBT and trauma focused CBT approaches. The results showed that DBT–PTSD has promise for reducing severe and chronic PTSD after CSA. In addition, the authors concluded that there was a high acceptance of treatment as it had a low drop-out rate, and did not appear to exacerbate PTSD, other symptoms, or cause any form of crisis. Overall, strong test changes were identified in PTSD between the baseline and follow-up. However, the study did not allow for determination related to how DBT components contributed to treatment outcomes specifically and the CBT, limiting effectiveness comparisons across modalities.

Similarly, Kimbrough, Magyari, Langenberg, Chesney and Berman (2010) examined the effectiveness of an eight-week mindfulness meditation based stress reduction (MBSR) program, and daily home practices of mindfulness skills in 27 adult survivors of CSA. Assessment of depressive symptoms, PTSD, anxiety and mindfulness showed an improvement in all outcomes post MBSR. More specifically, symptoms of avoidance and numbing were the most greatly reduced in the PTSD symptom criteria, whilst compliance to attendance at home practice was high, indicating that interventions were safe and acceptable for survivors. In addition, improvements were largely sustained following 24 weeks.

1.6.2.2. EMDR, Sensorimotor Psychotherapy, Schema Therapy, Narrative Therapy and Psychodynamic Therapy interventions.

Studies examining treatment outcomes for therapy for CSA survivors, other than CBT are limited. Nevertheless, Edmond, Rubin, and Wambach (1999) found support for the effectiveness of Eye Movement Desensitization and Reprocessing (EMDR) therapy in reducing trauma symptoms among adult female survivors of CSA. The authors randomly assigned 59 female CSA survivors to one of three treatment conditions: 1) Individual EMDR treatment 2) routine individual treatment and 3) a delayed treatment control group. Survivors

received six weekly 90-minute individual treatments sessions focusing on the effects of CSA that were identified as most troubling by the participants. The therapy in the routine treatment condition utilised an 'eclectic' approach to therapy, consisting of a variety of techniques and theories, that were incorporated into an approach that would best meet the therapeutic needs of each participants. The results from the standardized instruments (i.e. the State-Trait Anxiety Inventory, the Impact of Events Scale, the Beck Depression Inventory, and the Belief Inventory) indicated that both EMDR and routine individual therapy were effective in reducing trauma symptoms in comparison to the control condition (i.e. delayed treatment). Furthermore, EMDR was found to be equally effective in reducing target symptoms compared to routine individual therapy. However, at a 3-month follow up, the EMDR participants displayed significantly better outcomes in comparison to those in the routine individual treatment group, on two of the four measures, including trauma specific anxiety and depression. The routine individual therapy participants however demonstrated clinically significant symptoms of anxiety or depression, whilst the EMDR group did not. Edmond et al. (1999) concluded that these results suggest that EMDR might be effective in producing more enduring trauma resolution than routine individual therapy. Edmond and Ruby (2004) conducted a follow-up study in order to investigate whether the therapeutic gains demonstrated by participants who received EMDR treatment in Edmond et al.'s (1999) study would be maintained 18-months post treatment. The results showed that the EMDR group maintained their therapeutic gains, but also showed slight improvements on every standardized measure, while the control participant's scores deteriorated slightly. Although none of these changes were statistically significant, these findings were still interpreted as evidence of EMDR's ability to produce long-term improvements in trauma symptomology.

Langmuir, Kirsh, and Classen (2012) conducted a pilot study, investigating the effectiveness of Sensorimotor Psychotherapy (SP) on female survivors of childhood abuse. Ten women with a history of childhood abuse participated in 20 weekly sessions of SP informed group

therapy, and were assessed at pre-treatment, post-treatment, and at 6-month follow up. The results demonstrated a significant improvement in body awareness, dissociation and receptivity to soothing. The authors concluded that the results provide preliminary evidence of the effectiveness of SP in reducing trauma related symptoms amongst clients with a history of childhood abuse. However due to limitations such as low number of participants, more studies are needed in order to draw conclusions on the effectiveness of this approach in treating symptoms associated to childhood abuse.

Cloitre, Cohen, and Scarvalone (2002) examined the use of Interpersonal Schema Therapy for survivors of CSA, and showed some promising results. The authors examined the effectiveness of treatment amongst a group of female survivors of CSA who experienced revictimisation in adulthood, and compared these individuals to women survivors of CSA, that were not revictimised. The results from the Interpersonal Schema Questionnaire (ISQ) showed a significant difference in the interpersonal schemas between survivors that were re-victimised in adulthood, and those who were not victimised in adulthood, and women who had never experienced abuse of any kind. More specifically, the authors highlighted that both victimised women and non-victimised women significantly generalised their predominant parental schemas to current relationships and differed only in the content of the schemas. Re-victimised women viewed others in a parental role as hostile and controlling, whilst women that had never experienced abuse viewed others as warm and non-controlling. Women abused only in childhood held schemas of parents as hostile but not controlling, and did not generalise from parental to current schemas. The authors concluded that the tendency to generalise observed in the first two groups suggests that "repetition compulsion" is not limited to those who were traumatised and are psychologically distressed.

Some studies have indicated that Narrative Approaches to treatment, such as letter-writing and externalisation of abuse may be helpful for survivors of CSA. Batten, Follette,

Rasmussen, Hall, and Palm (2002) examined the physical and psychological effects of the written disclosure of CSA experiences. 61 women completed bi-weekly telephone interviews for 12-weeks after writing, as well as at a week 12 follow-up. The results indicated that the intervention of writing the abuse story on its own was not effective in providing physical and psychological health benefits, however when used in conjunction with other forms of treatment, it may be beneficial. The authors provided some suggestions to assist the process of telling abuse stories, including considering the level of trust and comfort between the victim and the person they considered sharing their stories with, as well as finding allies, such as other abuse victims. Furthermore, the authors suggested that writing the abuse story down can be used as a first step of breaking the silence, even if the survivor does not share what he or she has written with anyone, as there is power in writing and sharing the story outside of the self (Batten et al., 2002).

Price, Hilsenroth, Petretic-Jackson and Bongec (2004) examined the effectiveness of Psychodynamic Psychotherapy for adult survivors of CSA. The authors evaluated the effectiveness of individual short-term psychodynamic psychotherapy, with a naturalistic sample of adult survivors of CSA. The findings from self-report measures and clinical rating scales demonstrated significant improvements in survivors' symptomatic distress, level of functioning, and dynamic personality variables. More specifically, survivors formed positive therapeutic alliances, comparable to the non-abused clinical samples, and these effects remained throughout treatment. Based on these findings, the authors concluded that CSA survivors demonstrated a similar response to treatment as non-abused clients, with the potential for a greater change in feelings about the self. Furthermore, they concluded that these findings indicate that psychodynamic psychotherapy may be useful for CSA survivors experiencing depressive and interpersonal difficulties.

Similarly, Lampe, Hofmann, Gast, Reddemann, and Schüßler (2014) examined the long-term

effectiveness of an inpatient treatment based on psychodynamic-orientated trauma therapy amongst 43 survivors of CSA. The findings from a two- year follow up global system load (GSA), PTSD, depression and self-soothing ability scale, showed significant improvements in comparison to the admission status. However, no change was found in dissociative symptoms. Furthermore, 40 % of participants showed reduction in depressive, dissociate and PTSD symptoms in long- term outcome. Patients with good outcome showed more previous inpatient treatment. The authors concluded that inpatient treatment has the potential to lead to significant symptom reduction in women with severe childhood abuse and that treatment effects remains stable following two years, under further outpatient psychotherapy.

1.6.2.3. Group Psychotherapy interventions

A number of group interventions have been proposed to be effective for the effects of CSA. For instance, in a large Randomised control trail (RCT), Lau and Kristensen (2007) found that systematic group therapy was more effective then non-manualised analytic therapy, over a treatment period of 12 months for psychological distress following CSA. However, such effects disappeared at one-year follow up (Elkjaer, Kristensen, Mortensen, Poulsen, & Lau, 2014). Classen et al. (2001) non-blind RCT study on the other hand, reported that manualised group trauma-focused treatment of psychodynamic orientation was equally effective as present-focused group treatment of CBT orientation for trauma and interpersonal difficulties in survivors of CSA. There is also evidence to support the effectiveness of person-centered group therapy for survivors of CSA (Payne, Liebling-Kalifanib & Joseph. 2007).

Similarly, Karatzias, Ferguson, Gullone and Cosgrove (2015) provided evidence on the effectiveness of group psychotherapy, based on trauma recovery and empowerment model, for psychological distress in adult survivors of interpersonal trauma. 71 female patients from five NHS boards in Scotland participated in the study. The findings from a number of self

rated measures (PLC, CORE, SCL-90), DES and RSES) were used at baseline, mid-intervention and post intervention and three month follow up. The findings showed a small to medium effect size across measures and assessment at post treatment and follow up. The authors concluded that group psychotherapy might be useful for a proportion of participants, especially for symptoms of dissociation and self-esteem. Furthermore, they suggested that survivors of interpersonal trauma should be offered a choice of individual or group treatment modalities in order to reduce drop-out rates and maximize outcome.

In summary, studies investigating the effectiveness of various forms of individual and group psychological modalities and interventions for survivors of CSA. However, factors such as limitations in methodology and design, as well as varying result in the literature on the effectiveness of these approaches, indicate that more research is needed in order to be able to generalise findings.

1.6.3. Treatment considerations for CSA survivors

Up until now, this study has shown that the literature regarding treatment for survivors of CSA is limited, and no specific treatment model has been suggested to be superior than the other (Kessler, Nelson, Jurich, & White, 2004). Despite this, researchers have provided suggestions and important considerations for counseling psychologist and other therapist to consider. This section will provide an overview of these considerations, with a particular focus on CBT frameworks, as well as important aspects related to the therapeutic relationship.

1.6.3.1. CBT frameworks

Psychological treatment for survivors of (CSA) has traditionally involved Cognitive Behavioral interventions, including individual, group and family counselling. Interventions that have shown particular promise include trauma-focused or exposure based treatment, (Cloitre, et

al., 2004a; Folette & Ruzek, 2006; Putnam, 2009), including anxiety management, exposure, and cognitive restructuring (Foa et al., 1999). Despite the evidence to support the effectiveness of these approaches in treating symptoms associated to the effects of CSA, including reducing depression and trauma specific symptoms. These treatments have not shown consistent improvements in the interpersonal or social functioning symptoms of clients (Cloitre et al., 2004a; Martsof & Draucker, 2005). Furthermore, personal improvements in sessions have been difficult to transfer to daily life and sustain over time, and dissociative experiences and post-traumatic stress symptoms among those with a history of CSA remain high compared to survivors of other forms of trauma (Van Den Bosch, Verheul, Langwland & Van Den Brink, 2003), suggesting that the patient needs remain unmet by existing treatments modalities (Lev-Wiesel, 2008).

Some authors have therefore argued that there might be a need to adapt conventional trauma-focused therapies, which are often aimed at individuals that have experienced single traumatic events in order to address the multifaceted needs associated with the effects of CSA (Lev-Wiesel, 2008). For instance, Clotire, Konen, Cohen, and Han (2002) proposed the need to consider certain patient characteristics of CSA survivors that might impact on the outcome of exposure work, including difficulty tolerating distress/feelings and tolerating the interpersonal nature of therapy, as well as vulnerability to dissociation. Furthermore, that adding training in affect and interpersonal regulation prior to exposure therapy might increase survivors' ability to tolerate and benefit from exposure work (Clotire, Konen, Cohen, & Han, 2002). The need for adaptation of interventions is further highlighted by Cohen (2008) who argues that the long-term effects of CSA are inherently different than adult rape or other traumatic events experienced in adulthood, and that research on treatment of adult victims of trauma should not be generalised to CSA clients. Cohen suggests that when treating individuals with complex PTSD using CBT principles, therapists should examine the clients developmental and attachment needs, both of which can be negatively impacted with the

experience of CSA. Due to the potential alterations of CSA on a child's development, Cohen (2008) further suggests the utilisation of developmental and attachment theories (such as Bowlby's Theory of Attachment) when working with survivors.

Studies with more feminist standpoints of trauma (Roth, Newman, Pelcovitz, Van der Kolk, & Mandel, 1997; Van Der Kolk, Mcfarlane, & Weisaeth, 1996) have highlighted that PTSD and its first line trauma focused treatments does not adequately explain the powerlessness, stigmatisation and betrayal that is associated to the experience of CSA. Furthermore, that the relational and dissociative somatic and affect regulation problems are not given proportional attention, considering that these have been identified as particular characteristics of the survivors' early onset and interpersonal trauma. Similarly, Briere, Woo, McRae, Foltz, and Sitzman, (1997) highlighted that symptoms such as dissociation, overeating, substance abuse, indiscriminate sexual activities and self-harming behaviours are used to block out painful memories or feelings, and that therapists should therefore not problematise such behaviours of survivors. Instead, symptoms should be regarded as understandable patterns of coping, given their circumstances. In light of these findings, the therapist might benefit from having treatment ideas readily available to utilise in addition to CBT techniques, such as developmental, emotion focused, and feminist approaches.

Psych-education has been proposed to be effective when working with survivors of CSA. According to Blumer, Papaj, and Erolin (2013) providing the survivor with knowledge and assertiveness skills might empower the survivor to take back control over their lives. This is of particular importance in light of findings which highlight that a long history of CSA and learnt helplessness creates fears related to loosing personal control and that this is particularly difficult to challenge, as the survivors identity is immersed in this fear (Bass & Davis). Blumer et al., (2013) further suggest that steps can be taken towards assisting the survivor in gaining personal control through assertiveness training. For instance, Clotiere

Cohen and Koenen (2006) suggest that this might include teaching survivors assertiveness skills such as using “I” statement, making requests, and saying “No”. Blumer et al. (2013) also argues that normalisation should be a key component in treatment with survivors of CSA, as it can contribute to a sense of empowerment in a survivors healing. In particular they highlight that survivors often feel that they are not normal or that they process a character flaw due to their experiences of CSA. Therefore, normalising and acknowledging their feelings as being part of the healing process from CSA trauma might be helpful (Williams & Poijula, 2002).

Literature on treatment considerations concerning therapeutic modalities other than CBT are limited, however a number of researchers have highlighted the value of an integrative approaches when working with survivors of CSA. For instance, in a review of research on interventions for CSA survivors, Lev-Wiesel (2008) argued that treatment for CSA survivors requires multi-problem interventions, due to the large number of symptom possibilities, as well as interventions that address the unique experiences of survivors of CSA, relating to the separation of body and soul, and the perception of the body as ‘worthless, weak, and helpless’. Similarly, in a report by Itzin, Taket, Barter-Godfrey and DoH (2010) looking at the perspectives of ‘experts’ regarding the most effective treatment for survivors of CSA, it was found that out of 70 respondents, there was a unanimous agreement amongst professionals who believed that 1) there is no single therapeutic approach that works best for every CSA victim/survivor (69) 2) that the approaches used should be needs-led and victim/survivor centered’ (69 respondents) and 3) that ‘behavioral and cognitive approaches on their own are insufficient to meet CSA survivors’ needs’ (67 respondents). Furthermore, the authors concluded that a majority position could be identified, which pointed to the endorsement of person-centered approaches that were believed to be flexible and responsive to survivors’ needs, readiness and experience of clients. The above findings point to the usefulness of an integrative approach to therapy, as this will allow for exploration and treatment of survivors’

multifaceted needs.

Studies with more feminist frameworks (Blumer et al., 2014) have highlighted the importance of creating a sense of safety for building rapport, and that this is especially important in cases of treating women survivors of CSA, due to their histories with trauma, betrayal and mistrust. Ways to create safety for the survivor might according to Levenson and Morin (2001) include non-forcing or rushing of disclosure of CSA history, ensuring physical safety from the abuser or other external threats, and facilitating comfort in sessions, including sitting at a distance, bringing in a security blanket or a soothing object or sitting in a comfortable position (Blumer et al., 2013). Another aspect that might be important to consider is the empowerment of the survivor. A number of suggestions have been provided in which this can be facilitate, including supporting the survivor to redefine their sense of guilt, shame and self-blame, including their identification of self as victim as opposed to that of a survivor (Blumer et al., 2013). This also includes redefining cognitive distortions surrounding feelings or recollections of the abuse, or relationships that involve the abuser, or others who might be taking advantage of the survivor's vulnerability (Koenig, 2007). Additionally, validation has also been identified as an empowering technique to utilise when working with survivors of CSA (Blumer et al., 2013; Margolin, 1999). Blumer et al. (2013) argues that when practicing validation it is important not to minimize the survivors' experience of trauma. Furthermore, that caution must be taken when validating survivors experiences of abuse, in order to avoid encouraging the self-destructive thoughts and behaviors associated to these experiences. Blumer et al. (2013) therefore suggest that validation might best be utilised when the survivor question their sense of power, and to offer reassurance that they possess power to heal from the trauma.

1.6.3.2. The therapeutic relationship

Regardless of the therapeutic modality, the therapeutic relationship has been found to be a

particularly important component of therapy when working with survivors (Cohen, 2008). For instance, Cloitre, Stovall-McClough, Miranda and Chemtob (2004), found an effect size of .47 between the therapeutic alliance and post-treatment PTSD symptoms in women who had experienced child abuse. This effect size was considerably higher in comparison to other studies that found an effect size of .22 between alliance and treatment outcome obtained in a meta analysis of 79 studies, supporting the notion that the therapeutic alliance might be a particularly important component for child abuse related PTSD. Nevertheless, studies have consistently shown that CSA experiences impact interpersonal functioning, including the ability to trust and establish intimacy in relationships, including those with the therapist (Dale, 1998; Chouliara et al., 2012; DiLillo, 2001).

Some authors have therefore suggested that CSA survivors might benefit from learning new ways of relating to and being in relationships. This includes modifying negative beliefs about trust and intimacy, or developing new inner working models of the self and others (Bowlby, 1988). In particular, survivors might believe that they are unloved, and have fears about being abandoned by the people that are important to them, impacting their behaviour (Briere, 1989). Additionally, survivors might be particularly attuned to, and look out for signs of a lack of empathy, understanding, and/or the ability to cope with hearing about CSA histories (Dale 1999). A therapist that is perceived as lacking in these areas might contribute to the experience of further betrayal for the survivor (Van der Kolk et al., 1996). Survivors of CSA might also have disrupted relational boundaries, and re-enact earlier traumatic dynamics in adult relationships (Harper & Steadman, 2003). It has therefore been argued that therapist need to be aware of the importance of the therapeutic relationship for survivors, and that they might be harmed by dual-role relationships or blurred boundaries, as these dynamics might replicate the characteristics of abuse (Dalenberg, 2000). Furthermore, requires a solid framework, and a shared understanding that both the client and the therapist cannot overstep each other's boundaries (Briere, 1996; Meiselman, 1990).

Abused focused therapy has criticised traditional therapy models for assuming the role of the 'expert', being cold and aloof, and for not sharing their knowledge and creating power imbalances in the relationship (Briere, 1992, 1996; Herman, 1992; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Furthermore, traditional therapy that advocates therapist objectivity can be counterproductive in abuse-focused work with survivors (Briere, 1992). For instance, Herman (1992) argued that for clients that have experienced chronic victimisation at an early age, adopting a neutral or non-judgmental stance might not be sufficient. Therefore, in order to foster self-acceptance on the part of the client, the therapist should adopt a position of moral solidarity with the survivor, allowing them to view the therapist as an ally (Herman, 1992). Similarly, Fosha (2006) highlights the importance of 'being with' rather than bearing witness to the clients' experience, in order to convey to the survivor that although they were alone in their experience of the abuse, they no longer have to re-experience it alone.

Abuse-focused therapy guidelines also highlight the importance of establishing relationships that facilitate the client with a sense of control, and empowerment (Briere, 1992; Courtois, 1999). According to McGregor, Thomas, and Read (2006), this might involve working in partnership with the survivor, and for the therapist to inform survivors about the strategies they intend to utilize and why (McGregor et al., 2006). Furthermore, Resick, Nishith, and Griffin (2003) argues that clinical guidelines for abuse-focused therapy should be used within a flexible approach as studies have show that therapist who are strictly committed to one modality can disadvantage their clients (Meiselman, 1990, as cited in Resick et al., 2003). Abuse-focused therapy guidelines also highlight the importance of establishing relationships that facilitate the client with a sense of control and empowerment (Briere, 1992; Courtois, 1999). According to McGregor et al., (2006), this might involve working in partnership with the survivor, and for the therapist to inform survivors about the strategies they intend to utilise and why (McGregor et al., 2006). Furthermore, Resick et al., (2003) argue that clinical

guidelines for abuse-focused therapy should be used within a flexible approach as studies have shown that therapists who are strictly committed to one modality can disadvantage their clients (Meiselman, 1990, as cited in Resick et al., 2003).

A qualitative study by McGregor et al. (2006) explored survivor's perspectives on helpful and unhelpful aspects related to the building of the therapeutic relationship. Although no therapeutic modality was specified in the study, the authors identified five key issues for therapists to consider when working with survivors of CSA, including 1) Importance of giving information about the process of therapy, including informing survivors about their rights and responsibilities at the onset of therapy. 2) The therapist should actively work towards establishing an equal and collaborative relationship, this was considered of particular importance due to survivor's previous experiences of disempowerment as children. 3), The importance of building rapport, which was described by survivors as feeling carefully listened to, respected and understood and lastly, 4) survivors valued therapists that conducted effective assessments, particularly in relation to the effects of CSA, and assisted them to work through these effects. McGregor concluded that when these aspects of therapy were absent, a number of participants reported dissatisfaction with therapy. The findings of this study shed light on important factors that might facilitate the development of the therapeutic relationship when working with survivors of CSA.

1.6.3.4 . Summary

In summary, when working with survivors, it is important that treatment incorporates multi-problem interventions that address the large number of symptom possibilities, as well as the unique experience of survivors, including the experience of interpersonal and relational difficulties. Furthermore, the use of affect regulation skills prior to initiating trauma-focused work might be useful, in order for treatment to be beneficial and more manageable for survivors. As previous research has suggested that PTSD and other first line trauma focused

treatments do not adequately explain the powerlessness, stigmatisation and betrayal that is associated to the experience of CSA. The incorporation of other modalities might be beneficial in conjunction with CBT, including narrative therapy, family therapy, art therapy, action methods and Eye Movement Desensitisation and Reprocessing (EMDR) (Briere, 1992), as this will allow the exploration and treatment of survivors multifaceted needs. Additionally, studies have shown that the therapeutic relationship is of key importance when working with survivors of CSA. Therefore, therapists should ensure that the therapeutic relationship is collaborative, and client led, and that survivors are consulted on the pace and focus of therapy, including meaning of their traumatic material (Briere, 1992).

1.6.4. Experience of therapy: client perspectives

Although research into the effectiveness of different psychological therapies has increased in recent years, the experience of using such services has rarely been explored from a survivor's perspective (Chouliara, et al., 2012) As a result it is unclear whether survivors of CSA perceive their needs and service provision in the same way as clinicians or whether their needs are met by existing psychological approaches (Macdonald, MacArthur, Frazer, 2012). The following section will provide a review of research on therapy experiences amongst women survivors of CSA. The studies that are most related to the present study will be presented at a greater depth, and a particular emphasis will be put on qualitative studies on survivors' perspectives of therapy.

A study by Dale, Allen and Measor (1998) involved both qualitative and quantitative methodologies. 53 respondents took part in in-depth interviews, based on phenomenological principles of enquiry, and analysed using grounded theory. Out of the 53 respondents, 23 respondents also provided written narrative material relating to their experiences, and this was augmented by written material from a further 12 respondents that were not interviewed. Client participants were recruited through advertisements in national and local newspapers,

whilst counselor respondents were recruited via personal contact and by advertisement at a number of training events. Counselors abused as children were recruited through both sources. Ages ranged between 25-61 years old. The questionnaire was designed to record respondent's assessment of their counselling experiences, which was defined as a specific sequence of sessions with the same counselor. The majority of participants (90 %) had more than one experience of counseling; others had a range of between one and ten experiences. Respondents reported experiencing a variety of child abuse including sexual abuse (70%), emotional abuse (74%) and physical abuse (49%).

The findings indicated that there were many similarities between what abused clients, and the general client population perceives to be helpful and unhelpful in counseling. Similarities included the benefit of a safe therapeutic context, an understanding and accepting relationship in which the client could feel understood, and able to talk openly, and create meaning for their experiences. Analysis from the qualitative data showed that respondents reported the benefits of counseling to be reflected in four main areas, including improved general day to day coping with life, ability to express and contain feelings, changes in relationships, particularly with their own children, families and partners, as well as the development of understanding and meaning for abuse experiences.

Nevertheless, Dale et al. (1998) concluded that there are certain aspects of the therapeutic relationship which appear to be particularly challenging for CSA survivors, especially those with limited prior knowledge or experience with counseling. This includes challenges related to 1) becoming 'ready' for counseling, in the context of associated barriers to help-seeking. 2) Challenges in establishing effective working alliance, 3) clients being vulnerable to and feeling overwhelmed by abuse related cognitions, imagery and affect. 4) Clients inhibition of communication regarding shameful inner experiences, and feeling of dissatisfaction with counselors. 5) Deciding if, when and how to talk about abuse experiences, and whether the abuse needs to be discussed in detail. 6) Searching for reasons regarding why the abuse

occurred, and the impact of the abuse on clients sense of identity. 6) Concerns around clients memory processes. 7) Dilemmas around what constitutes 'resolution' of the effects of abuse, and its impact on family relationships. 8) Fears around the influence of abuse on clients abilities to parent their own children successfully.

Based on these findings, Dale et al. (1998) concluded that there was a diversity of experiences and views within the group as a whole. As such, it was argued that CSA survivors should not be considered a unitary group with predictable problems, needs and aspirations. Furthermore, that attitudes and reported experiences of survivors suggest that effective counseling with CSA survivors may be essentially similar with research on helpful and unhelpful therapy experiences in counseling/psychotherapy as a whole. However, Dale et al., (1998) stressed that CSA survivors may face specific challenges in counseling, and that there is a need for training, accreditation/registration and commissioning bodies to offer guidelines on the sufficient level of theoretical knowledge and good-practice principles, by professionals working within this field of work. Furthermore, Dale et al. (1998) highlights the need for public education related to issues of good and bad practice, in order to better equip and prepare survivors to monitor and evaluate counseling that they receive, allowing a more informed perspective.

Another study by Allnock (2015) explored the retrospective accounts of CSA survivors' experience and perspectives of therapy received before the age of 18. A total of 299 participants took part in the study, ages ranging between 18 to 35 years old. The participants received therapy covering a range of approaches including play therapy, psychodynamic therapy, individual counseling, group counseling, cognitive behavioral therapy, and art therapy. The findings from the survey demonstrated that therapeutic factors such as therapist characteristics, and interpersonal communication were of key importance in informing their perception of therapy received. Positive experiences were related to the therapist's ability to make them feel cared for, and listened too. Additionally, therapists showing respect and

interest were also valued. Survivors also liked therapists that were friendly and down to earth. Negative experiences were related to therapeutic factors such as waiting times, therapist skills, characteristics or therapeutic preferences, or to external factors such as intervening circumstances in the survivor's life. Survivors also wished for therapy to have been more flexible, and some felt that the type of therapy received did not compliment their preferred method of expression. Based on these findings, Allnock (2015) concluded that survivors express themselves in different ways, and identified a preference for a flexible approach. Furthermore, that it is uncommon that one therapeutic experience will be the 'magic bullet', which solves all problems for the survivor. Allnock (2015) highlighted that the survivor might need to find the right therapeutic environment that will offer meaningful engagement, supporting them to develop positive coping skills and relieve feelings of self-blame and guilt. Furthermore, that this can be facilitated by therapists that respond to clients needs, so that they feel listened to, cared for and believed. Lastly, Allnock (2015) proposed that therapists should maximise the information gathered in assessment, and show sensitivity to particular circumstances clients might be experiencing outside of therapy sessions.

In a systematic review by Chouliara et al. (2012) that reviewed and synthesized research about the perspectives and experience of psychological therapy from a survivors perspective, focused on addressing three overall research questions, including 1) positive and negative experiences of survivors therapy experiences, 2) survivors perceptions on effectiveness of treatment and adjustment post treatment and 3) the views and experiences of survivors regarding disclosure of CSA in therapy. The authors identified nine studies that met the inclusion criteria for the review. Studies were rated based on quality, where three studies were rated as 'high' quality studies, whilst four were rated as poor, and two as moderate. Findings from Chouliara et al. (2012) review showed that most studies included both positive and negative reports of survivors' therapy experiences. For instance, positive experiences of psychological therapy included the importance of a safe therapeutic

relationship; based on respect, equal power, participation and flexibility as well as the importance of awareness and professional competence regarding issues of CSA and trauma. Negative experiences on the other hand included therapists taking a sexual interest in clients, dealing ineffectively with errors, including being passive or non-responsive, exaggerating objectivity, and the prescription of heavy medications.

Chouliara et al. (2012) concluded that findings from the systematic review highlighted the importance of the therapeutic relationship for survivors, including challenges related to developing and maintaining such relationships when working therapeutically with CSA survivors. Furthermore, that the therapeutic relationship plays a central role in survivors' narratives, in particular issues of power, inclusion and equality, which according to Chouliara et al. (2012) might suggest a need for a more relational model of training and practice for the mental health professionals in this field. The author added that this could equip professionals to attend to and utilise the therapeutic relationship as a tool for change and recovery.

Although the systematic review added to the understanding of the experiences of psychological therapy amongst survivors, Chouliara et al. (2012) highlighted that existing research in this field was characterised by a number of methodological limitations, including selection bias, ill-described samples in relation to CSA history and current psychological status, inconsistencies in recruitment and procedure (i.e. different methods used across participants within the same study, or different types of interviews used within one study such as telephone and face-to-face interviews or group or individual interviews). In addition to this, it was found that there was a lack of a balanced account of negative as well as positive experiences from services (Edmond, Sloan, and McCarty, 2004; Nelson & Phillips, 2001 as cited in Chouliara et al. 2012). As a result of these findings, Chouliara et al. (2012) argued that "we cannot conclude as to which approaches survivors might find more beneficial, at what stage of their recovery, and for what level of trauma severity and complexity" Chouliara et al. (2012, p. 156). More research is therefore needed in order to shed light on the

experience of psychological therapy amongst survivors, in order to better understand challenges involved, as well as assisting factors impacting on survivors' therapy experience.

The study by Chouliara et al. (2011), aimed to address the gap of previous literature, by conducting a study investigating the perspectives amongst 13 adult survivors' (all female) of CSA as well as 31 professionals (six male and 21 female) regarding helpful and hindering experiences of therapy, and the perceived satisfaction of needs. Demographic information on participants' age, ethnic background, or the abuse itself was not collected, in order to minimize intrusion and increase acceptability of study by services. The range of therapeutic approaches that were reported to best describe the professionals' allegiance included CBT (N=12), Person centered therapy (n=14), art therapy (n=1), Cognitive analytic therapy (n=2), compassionate mind therapy (n=1), dialectic behavioral therapy (n=3), interface intervention model (n=1), and solution focused therapy (n=1). However, most professionals described utilising an 'eclectic' approach, where they did not utilise one single approach at all times, but rather, combining elements of different approaches to fit the needs of individual clients. Using Interpretative Phenomenological Analysis, the study identified two main themes; benefits from talking therapies, and challenges of the therapeutic process. The benefits of Psychological therapy to participants were mainly found in six areas, including; 1) The importance of a trusting therapeutic relationship, in particular participants identified conditions required for the development and maintenance of such a relationship, including confidentiality, lack of judgment, safety, transparency, flexibility about time of sessions, and willingness of therapists to listen. 2) Feeling safe to disclose abusive experiences was identified as beneficial: lack of judgment in particular, was highlighted as a significant factor, contributing to a safe environment for disclosure of abuse. 3) Breaking isolation and silence; participants described feeling less isolated as a result of accessing talking therapies, and valued having a safe place to access support. 4) Enhancing self-esteem and sense of self; participants described gradually feeling better about themselves as a result of therapy, including developing better self-care practice and a better sense of self. This resulted in

fewer symptoms, and an increased sense of freedom and control of their lives, including social functioning. Other helpful aspects included 5) importance of normalizing and contextualizing the abuse through acceptance of the experience and reducing stigma, in particular survivors highlighted the need to understand the impact of the abuse on different aspects of their lives and make links between past and present. 6) The importance of recovery was identified as one of the most important benefits in their therapy experience. This included learning to live with what happened, managing traumatisation and reducing the frequency and intensity of an acute episode.

Challenges of using services related to 1) Difficulties of trauma focused work, in particular, participants identified challenges related to choosing the appropriate timing and depth of such work, which differed for each survivor. 2) Maintaining contact between appointments or when on a waiting list was identified as a positive experience for survivors. This offered reassurance and contributed to a reduction in isolation and feeling cared for. Time restrictions on the other hand, were described as a barrier, impacting survivors' engagement and willingness to fully engage and benefit from talking therapy 3) Ensuring continuity and consistency of therapy/services, including working with the same professional for the duration of their talking therapy was identified as important for building a trusting relationship, as well as establishing safety. Continuity was also important as it made the survivors feel they were valued, and given option and flexibility. 4) Accessibility of services, particularly during acute episodes was also identified as important. Participants described being considered 'too complex', when in crisis, and therefore being denied therapy. As a result, survivors could experience long periods without access to therapy, despite their willingness to be in therapy. Other challenging issues related to: 5) Dealing with child protection issues; survivors expressed finding child protection issues 'scary', and expressed a preference to be involved in the process, and not to take the issue entirely out of their control. 6) Resource availability and service accessibility; some survivors described that living in certain areas affected their ability to access service, where one participant stated

that living in a remote area meant no one could 'entertain' her, which she did not think was right. 7) Most professionals highlighted that hearing and managing survivors' disclosures was a challenging and difficult experience, due to the nature of the stories.

Based on these findings, the Chouliara et al. (2011) concluded that there was an overall consensus between participants and professionals accounts of therapy across the statutory and voluntary sector. Both survivors and professionals provided a balanced account of both positive and negative experiences of each sector. The authors provided a number of recommendations in order to improve aspects of clinical practice for survivors, In particular, the authors argued that a "fit for purpose", service will be able to respond to the multiple needs of CSA survivors, furthermore, that services for survivors of CSA need to be attentive and considerate to professionals and the challenges that exist in this field of work. Although this research provided useful insight into the perceived effectiveness of psychological therapy amongst adult CSA survivors, methodological issues such as lack of information on history of abuse, ethnic background and age of survivors, suggests the need for further investigation in order to increase understanding about this under-studied population in the literature, as well as to shed light on the perceived effectiveness of psychological therapy amongst a culturally diverse population, allowing for generalisations to be made.

In summary, although the above studies provided useful insight into the perceived effectiveness of psychological therapy amongst adult CSA survivors, methodological issues such as a lack of information on the history of abuse, ethnic background and age of survivors, suggests the need for further investigation in order to increase understanding about this under-studied population in the literature. More research is therefore needed in order to understand the unique therapy experiences of survivors, as well as to shed light on the perceived effectiveness of psychological therapy, allowing for comparisons to be made and to better meet survivor's needs.

1.7. Rationale for study

There is an array of studies that highlight the negative outcomes of CSA in adulthood (Bhandari et al., 2011; Cashmore, & Shackel, 2013; Chouliara et al., 2011; Mullen & Fleming, 1998; Van Der Kolk, McFarlane, & Weisaeth, 1996). However, evidence based treatments for adult survivors of CSA are limited, with several meta-analysis studies indicating that there is a lack of evidence to support the superiority of any one psychological approach or intervention when working with survivors of CSA (Martsolf and Draucker, 2005; Taylor & Harvey, 2010). As a result the adequacy of psychological therapy for survivors of CSA remains unclear. Key questions arising from the literature relate to treatment needs and experiences and expectations of clients. As trauma focused work and other psychological therapies do not appear to meet the multifaceted needs of CSA survivors (Lev-Wiesel, 2008) and there is some support for needs-led and survivor-centred treatment (Itzin et al., 2010) more research is required into the type of psychological therapy that would be most adequate in meeting the needs of survivors. In light of the above findings, as well as research, which show that it is relatively rare for survivors of CSA to be asked about their experiences of therapy (Dale, 1999). This study aims to explore CSA survivors' experience of psychological therapy, with a particular focus on hindering and assisting aspects of therapy. The implications of this research relate to developments in best practice guidelines for working with survivors of CSA, as well as to the improvement of clinical practice and delivery for survivors.

2. METHODOLOGY

“IPA is a creative process. It is not a matter of following a rule book”

(Smith, 2009)

2.1. Introduction

This chapter describes the methods and procedures employed in order to answer the research question: How do women survivors of Childhood Sexual Abuse (CSA), experience Psychological Therapy? It begins with outlining broader epistemological assumptions, followed by the qualitative methods used. Next, procedural and research design descriptions will be provided, including the development of the interview schedule, the recruitment process, and the conducting of interviews. The process of analysis of the data will be explained, including the steps that have been taken to ensure that high quality, validity and ethical standards have been maintained. Finally, the use of reflexivity will also be discussed along with a conclusion.

2.2. Epistemology, Methodology & Method

Epistemology as outlined by Cardinal Hayward and Jones (2004) is concerned with the way knowledge is generated and how we make sense of the world around us. ‘Methodology’ on the other hand, is concerned with the overall approach to studying research techniques whilst ‘Method’ relates to the specific research techniques used (Cardinal et al., 2004). This section will discuss the epistemological position held by the researcher, as well as the method and research design that have been used in order to answer the research question.

2.2.1. Rationale for using qualitative research design

This study used a qualitative, semi-structured interview based design, adopting Interpretive Phenomenological Analysis (IPA). Qualitative research refers to a wide variety of methods. The most common approaches used in social sciences include ‘Grounded Theory’, ‘Interpretative phenomenological Analysis’, ‘Foucauldian Discourse Analysis’ and ‘Narrative

Analysis' (Dicks, Soyinka, and Coffey 2006; Moran-Ellis et al., 2006). These qualitative methods share a number of core assumptions, including the underlying belief that there is no 'objective' reality or universal truth, and that knowledge and the process of acquiring knowledge are context-specific (Willig, 2001). In addition, qualitative research is founded on the premise that the researcher and participants, in combination with ideologies and social structures make up significant parts of the context and the phenomenon being investigated (Coyle, 2007). However, despite sharing key underlying assumptions, qualitative research is not considered to be a homogeneous field. The vast methods in qualitative research are based on different paradigms and philosophical assumptions, which shape not only how psychological knowledge is produced but also influence the scientific goals and the guidelines for good practice (Coyle, 2007; Willig, 2001). More specifically, these philosophical assumptions refer to different beliefs about the world, including how we know and the relationship between the knower and the known (Epistemology), the nature and reality and all that exist within it (Ontology), and how we gain knowledge of the world (Methodology) (Hesse-Biber 2010).

As discussed, previous studies have consistently shown that there is limited knowledge about the experience of therapy amongst women survivors of CSA. It therefore seemed appropriate to utilise a qualitative research design, in order to learn from and remain rooted in the participants' experience of therapy. Furthermore, exploring the subjective experience of these individuals is likely to contribute to a multi-dimensional insight into survivors' therapy needs, and thereby assist clinical practice. In addition, the humanistic theoretical basis of counselling psychology highlights the ideographic approach to human experience, which further highlights the importance of qualitative enquiry. The present research therefore aimed to enhance understanding of the therapy experience of this understudied population group, using a qualitative research design; this also fits the researcher's epistemological stance and worldview.

2.2.2. Epistemological stance

Critical realism presupposes that the credibility of science's explanatory approach is enhanced when the underlying ontology epistemology and methodology have been stated. Critical realism is primarily concerned with ontology, which relates to questions about what exist (Bergin Wells & Owen, 2008). It distinguishes between three different levels of knowledge, including 'the real', the actual' and the 'empirical'. The focus of Epistemology on the other hand relates to its beliefs and the way in which knowledge is generated and understood (Scotland, 2012). It asks questions about what it means to know (Scotland, 2012) and considers the process of thinking (Lincoln, Lynham & Guba, 2011).

The critical realist standpoint acknowledges that there is a reality 'out there', independent of the observer. In contrast to a naïve realist epistemology, which assumes that reality can be readily accessible, the realist standpoint argues that an understanding of the world is generated and understood by a combination of different mechanisms, including one's own experiences and perceptions (Schiller, 2016). Furthermore, critical realism also differs from positivism and constructivism, as positivism promotes the limitation of 'reality' to what can be empirically tested, and constructivism views reality as entirely constructed through human knowledge or discourse (Schiller, 2016). However, despite the differences and opposing views between the different epistemological perspectives, they all share the perspective that reality is reduced to human knowledge, whether in the form of a lens or vessel for reality (Schiller, 2016).

Nevertheless, the critical realist contrasting view states that there is a deeper reality (i.e. the real domain), which is not always directly observable, but that underpins what we can observe and experience (i.e. the actual domain), including what we can know or interpret (Fairclough, Jessop, & Sayer, 2004). The role of research is to develop conceptual theories and models, in order to explain the social phenomena that are experienced in the empirical field (Norris, 1999). As such, critical realism acknowledges that there is a social world that

can be studied and understood through science. However, they underline that some knowledge is closer to reality than other knowledge (Danermark, Ekström, Jakobsen, & Karlsson, 2002). Additionally, critical realism advocates the use of theories that can assist us to get closer to reality, including causal mechanisms underlying social events or phenomena, through the use of rational judgment of these social events (Archer, Bhaskar, Collier, Lawson, & Norrie, 1998).

An important aim of critical paradigm research is to liberate and expose social injustice, therefore the search for 'truth' is not a goal of this perspective, and reality is assumed to be 'representational' rather than 'truthful' (Hesse-Biber, 2010). This paradigm is particularly relevant in relation to investigating women CSA survivors' experience of therapy as women are more likely to experience social and health inequalities than men (WHO, 2004, World Bank Group, 2015; Mathews, 2015). A critical realism framework takes an analytical and critical stance to the social phenomenon studied, but also to the existing theories that explain such practices (Sayer, 2000; Martin, 2007). It therefore allows the exploration of how inequalities and power dynamics serve to generate a given set of meanings about social reality and lived experiences for these women. In comparison, the philosophical limitations of positivism and constructivism can lead to certain information being overlooked or missed during the research process, including factors that are not measurable, invisible to existence, or not expressed by the individual being researched (Wainwright & Forbes, 2000).

Critical realist authors have advocated qualitative methods of research as a way to explore and understand experiences and events (Lipscomb, 2008). Qualitative methods allow the exploration of aspects of reality, whilst acknowledging that knowledge is not confined to the identification of such concepts (Lipscomb, 2008). Guided by a critical epistemological and realist ontological framework, this study utilised qualitative research methods in order to investigate women survivors' experience of psychological therapy, and the meanings they ascribe to these experiences. The emphasis on explanation and causal analysis in critical

realism, as opposed to engaging in a descriptive approach of a text makes it particularly useful for analysing survivors' experiences of therapy, as well as suggesting solutions for change.

2.2.3. Method: Interpretive Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is theoretically rooted in critical realism (Bhaskar, 1978) and social cognition paradigm (Fiske & Taylor, 1991). This approach aims to 'gain a better understanding of the nature and quality of phenomenon as they present themselves' (Willig, 2008, p, 56). IPA provides an opportunity to explore participants' experience, understandings, perceptions and views (Brocki & Wearden, 2006), and predominantly employs a qualitative methodology, utilising interviews or other text accounts of the participants' experience as basis for exploration (Smith & Osborn, 2003). Additionally, IPA puts a particular emphasis on the meaning that people hold of their experience, whilst acknowledging that these meanings are products of a particular situation in the social world (Willig, 2008).

According to Smith, Jarman, and Osborn (1999) the key purpose of IPA is to gain an insider perspective of the phenomenon being studied, whilst acknowledging that the researcher is the primary analytical instrument. Therefore the researchers beliefs are not seen as biases, but rather a necessary component for making sense of the experience of other individuals. According to Smith and Eatough (2007) access to the participants experience involves a complex process, involving the researcher's own conceptions through a process of interpretative activity. Smith and Eatough (2007) refer to this as a 'double hermeneutics' where a two-stage interpretation process takes place. Firstly, as the participant is engaged in making sense of his/her experiences, the researcher's role is to make sense of how the participant is trying to make sense of his/her world (Smith & Eatough, 2007). In addition, IPA allows the researcher to make both empathic interpretations as well as critical interpretation (Smith & Eatough, 2007) where the researcher can take a critical stance to the material that

is analysed. Combining these two styles of enquiry can contribute to a richer analysis and provide greater justice to the person as a whole (Smith & Eatough, 2007).

2.2.4. Theoretical Paradigms Underpinning IPA

There are three major philosophical underpinnings in IPA: Phenomenology, hermeneutic Phenomenology and Ideography (Smith, Flowers & Larkin, 2009). The following section will discuss these in more detail, including how they relate to IPA.

2.2.4.1. Phenomenology

Phenomenology can be described as both a philosophical approach as well as a range of methods to the study of experience (Brocki, & Wearden, 2006). It is concerned with the way things appear to us in experience, and puts a particular emphasis on things that are inherently meaningful and constitute a person's lived world (Smith et al., 2009). Phenomenology is derived from two important historical phases, the transcendental and the hermeneutic or existential (Smith et al., 2009). Transcendent phenomenology is grounded in the ideas of Husserl who put forward a radical change to the nature of philosophy, by focusing on the perception of the world as it appears to people, through experience and conscious acts (Langdridge, 2008; Brocki, & Wearden, 2006; Smith, et al., 2009).

At the core of Transcendent phenomenology, is the commitment to identifying essential core structures of a given experience, through a process of methodological reductions (Smith, Flowers & Larkin, 2009). According to Husserl (1927 as cited in Smith et al., 2009, p. 12), phenomenology involves a detailed exploration of human experience, with a particular emphasis on creating space for individuals to accurately identify the essential qualities of their own experience of a given phenomenon (Smith, Flowers & Larkin, 2009). Husserl (1927) argued that once a person's 'essential features' have been identified, this would transcend the particular circumstances of their experience and could inform a given experience for others (as cited in., Smith et al., 2009, p. 12). Husserl's (1927)

phenomenology called for the intentional effort to step outside of our everyday experience, or 'natural attitude', in order to examine that everyday experience. This involved adopting a phenomenological attitude, which required reflexivity around our inner experiences, including thoughts, values, goals. This according to Husserl's (1927) could only be revealed 'through reflection' (as cited in., Smith et al., 2009, p. 12).

In order to achieve the phenomenological attitude, Husserl developed a 'phenomenological method' with the aim to identify the core structures and features of human experience. This approach aimed to identify and bracket off our assumptions, related to context, culture, history (Smith et al., 2009). Husserl's (1972) described this process of bracketing out as 'shutting out from the phenomenological field the world as it exists for the subject in simple absoluteness; its place however, is taken by the world as a given in consciousness' (perceived, remembered, judged, thought, valued etc.)' (as cited in Smith et al., 2009, p. 13). This method employed a methodological reductionist approach, whereby a series of 'reductions' offered a different lens, enabling a different way of thinking and reasoning about the phenomenon at hand (Smith et al., 2009). The ultimate aim of Husserl's reductionist approach was to bracket off the distraction of a person's own assumptions and preconceptions and shift this towards the essence of their experience of a given phenomenon (as cited in Smith et al., 2009, p. 13). The means to achieve this included the use of 'eidetic reduction', which involved the techniques required in order to get at the essence, as well as 'transcendental reduction', which intended to look at the nature of the consciousness per se –the thing that underlies and makes possible our consciousness of anything at all.

2.2.4.2. Hermeneutics

The second major theoretical influence of IPA is hermeneutics. It is described as the theory of interpretation and has its origin in the ideas of philosophers such as Heidegger, Sarte and Merleau, who further developed the ideas of Husserl (Langdridge, 2008). Hermeneutics was

originally used as a foundation for the interpretations of biblical texts. Subsequently, it developed as a philosophical underpinning for the interpretation of a number of historical texts and literary works (Smith et al., 2009). At the core of Hermeneutics is the concern with existence and human nature. Its influence from phenomenology still remained in that it focused on understanding 'the things in their appearing', and employed the use of phenomenological methods (Smith & Eatough, 2007). However, the main distinction lied in the greater recognition of the 'life world', which is concerned with the way that all experience must be understood in the context of the person having the experience and the way they see the world (Langdridge 2008). According to (Heidigger (1927/1962), Sarte (1943/2013) and Merleau-Ponty (1945/1962) as cited in Langdridge, 2008), Transcendent phenomenology failed to consider experience in the context of the embodied and situated subject (Langdridge, 2008). IPA derives from Hermeneutic thinking through its particular focus on eliciting meaning and processes as opposed to events and their causes (Smith & Eatough, 2007).

2.2.4.3. Idiography

The third major influence of IPA is ideography, which is concerned with the particular and the development of detailed and systemic analysis (Smith et al., 2009). Ideography is committed to understanding how a particular phenomenon or event has been experienced or understood by a particular individual in a particular context. In terms of analysis, IPA is therefore committed to an idiographic level of analysis, which has a particular focus on the particular, rather than on drawing generalisations (Smith et al., 2009). In Ideography, the process of analyzing data can refer to a detailed reading and development of a single case, or as part of larger study involving a detailed analysis of a number of single case studies making up the larger study, which can be developed into more general claims (Smith et al., 2009; Smith & Eatough, 2007). Ideography therefore allows a more cautious way of developing generalisations, by locating them in the particular. This allows for the development and understanding of generic themes in the analysis, related to worldly and

relational phenomenon, which are not restricted to the understanding of an individual. Simultaneously, it provides a possibility to explore the individual narrative of a particular person's experience (Smith & Eatough, 2007). This dual interpretation is possible, because an individual can provide a personal account of their relationship to, or involvement in the phenomenon (Smith et al., 2009).

2.2.5. Rationale for choosing IPA

IPA aims to explore the experiences and meanings of participants and identify key themes (Smith, 1996; Smith & Osborn, 2003). It was considered to be the most suitable theoretical approach to data collection and analysis due to a number of reasons. Firstly, in comparison to other theoretical approaches, the primary concern of IPA is to explore the links between how people describe their experiences, their cognition and their behavior (Smith, 1996). In addition, Scotland (2012) highlights that IPA is 'especially useful for research in applied Psychology, and mental health, due to the shared similarities of the realist ontology to the social cognitive paradigm. It was therefore felt that this would be a useful approach in order to explore experiences of therapy amongst survivors.

Nevertheless, It is well known that IPA shares similarities with other qualitative approaches, in particular grounded theory (Willig, 2001). For instance, grounded theory aims to develop theories of basic social processes through the examination of the six Cs (causes, contexts, contingencies, consequences, covariance's, and conditions) of social processes (Brocki & Wearden, 2006). Given the limited information on the experience of psychological therapy for CSA, IPA was believed to be the most suitable approach in order to build an understanding of both individual and shared perspectives of survivor's experience; IPA was therefore chosen over the theory building approach of grounded theory. Other qualitative approaches that were considered includes, Discourse analysis which is concerned with language –in-use, and how individuals accomplish personal, social and political projects through language. It offers a way to scrutinize how individuals account for and make sense of themselves and their

social world (Schotter, 1993), making it less suitable for this study as its preliminary focus is on the subjective experience of survivors. Narrative analysis on the other hand, focuses on the way individuals present their accounts of themselves, and considers self-narrations as constructions and claims of identity (Linde, 1993). The aim of this research was to gain an understanding of the experience of psychological therapy from the perspective of the survivor. IPA was felt to be the methodology most consistent with the research aim of this study, and narrative analysis was therefore not chosen.

Similarly, quantitative research methods were not selected due to their emphasis on objective measurement, causal relationships, and generalisations. The phenomenological focus of IPA allows the exploration of lived experiences of the participants; it highlights and captures their expertise, and how they have experienced psychological therapy, and what their views and perspectives are (Scotland, 2012). Furthermore, the ideographic approach of IPA, allows the exploration of phenomenon on a case study level, bringing in the perspective of the individual as well as the wider group of CSA survivors (Flowers, Davis, Hart, Rosengarten, Frankis, & Imrie, 2006). Lastly, IPA was considered the most suitable approach due to its critical realist stance (Shinebourne, 2011) as this is in close alignment with the researchers epistemological position

2.3. Procedure and Research Design

2.3.1. Semi structured Interviews

IPA aims to investigate and develop in depth analysis of participant's experience. Semi-structured interviews have been the preferred approach to collect such data (Smith et al., 2009). Semi-structured interviews are a set of questions that aim to guide the course of the interview, rather than dictate it. According to Smith et al. (2009) interviewing provides an opportunity for the researcher and participant to engage in dialogue that is influenced and modified by the participants responses, and thereby provides an opportunity to enquire about areas of interest that might come up during the interview. (Smith et al., 2009). In this sense,

participants are considered as experiential experts of the phenomenon being studied (Smith & Osborn, 2003). The aim of the interview is to facilitate a comfortable interaction that allows in-depth investigation into the experience in question in a sensitive and empathic manner, recognizing that it is a human-to-human interaction (Fontana & Frey, 2000). IPA interviews can in practice develop from a structured interview in the form of an interview schedule, to a more unstructured format, as the emphasis is put on the participant as a storyteller, as opposed to a respondent (Smith & Eatough, 2007). According to Smith et al. (2009), interview questions should be open and expansive, in order to encourage the participant to talk at length. In addition, Interviews should typically move between sequences that are more narrative or descriptive, and those that are more analytic and evaluative (Smith et al., 2009).

2.3.2. Participants

A total number of 6 participants were recruited in this study, using purposeful sampling. Participants were selected based on their particular perspective on their experience of therapy for the effects of CSA. According to Smith et al. (2009) there is no right answer for the number of participants required in IPA studies. This partly depends on the level of commitment to the level of analysis and reporting on a case study level, as well as the organisational constraints one is operating under. This is mainly because IPA is primarily concerned with a detailed account of individual experience (Smith et al., 2009). However, for doctoral research, a number of four to ten interviews have been recommended as a reasonable sample size (Smith et al., 2009). Constraints relating to the requirement of participants contributed to the sample size. Many services that were contacted felt they were not able to advertise the study due to service restrictions, confidentiality issues, or because participants did not meet the inclusion criteria (See procedure section for further details). Nevertheless, six participants were ultimately felt to be sufficient as participants provided in-depth accounts of their lived experience, as required by the IPA method (Willig, 2013).

Criteria for participating in this study included; adult women survivors of CSA, who were over

the age of 18 years at the time of the study, and able and willing to give informed consent to participate following a description of the study. For the purposes of this study, the broad definition of CSA was used: 'unwanted sexual contact' without describing specific behaviours, which has also been the most widely used definition in population studies (Chouliara et al., 2012). Participants were recruited from voluntary services and existing CSA survivor support groups. Only clients that had had at least six therapy sessions for the effects of CSA were included in this study. This was to ensure that participants had sufficient therapy experience to comment on, and has shown to be sufficient in previous research with this population group (McGregor, 2003). In addition, only clients that were not in therapy at the time of this research were included in this study. This was to avoid interrupting the therapy relationship for participants that were in therapy, as well as to avoid the potential of positive selection bias by professionals (i.e. professional advertising the study only to clients that are at advanced stages of recovery, and/or have recovered very well from the effects of CSA, and/or have been satisfied with their experience of professional help). Exclusion criteria included participants that were undergoing a legal court case at the time of the study, which was related to the experience of sexual abuse, as well as participants that reported having suicidal or self-harm thoughts.

Participants will be referred to by pseudonyms, and will be called Tina, Jane, Amy, Margarette, Caroline and Annette. They are all over 18 years old, with ages ranging between 19 to 53 years old. Five of the participants are white British, and one participant is of an Asian nationality. The majority of participants had more than one experience of therapy (4 out of 6), whilst two participants only had one experience of therapy. The participants had very varied and mixed experiences of therapy. This included both general therapy, as well as trauma-focused therapy. Whilst no specific theoretical orientation was specified, all participants had undergone at least six sessions of therapy for survivors of CSA and its effects.

2.3.3. Research materials and resources

A digital audio recorder was used to record participants' account of their therapy experience. The research utilised semi-structured interviews, and an interview schedule was used with areas of interest to guide the interview (See Appendix A). The costs associated to this research included standard computer printing expenses and travel expenses for accessing participants.

2.3.4. Interview schedule guide

As guided by Smith et al. (2009), the first section of the semi-structured interviews focused on asking open-ended descriptive questions about participants' experience of the process of finding/accessing therapy. It then moved on to questions requiring more analytic answers about participants' experiences and perceptions of their therapist and how therapy was conducted, with a particular focus on assisting and hindering experiences as well as anything they might have wished could have been different. The second section of the interview explored participants' overall therapy experience, including their experiences of the therapeutic setting, as well as abuse specific aspects of therapy. The third section of the interview explored how participants' experience of therapy had impacted lives and wellbeing (Appendix A). The role of the researcher involved exploring, clarifying and probing the participants' experience of therapy. Guided by Smith et al. (2009) considerations were made in order to choose questions that do not make too many assumptions about the participants' experience, as this could lead participants to particular answers. Each semi-structured interview lasted between 60-90 minutes, and participants were informed that the face-to-face interview would not include questions about their actual CSA experiences, but rather on the experience of utilising therapy, for the effects of CSA. Participants were also informed that they could withdraw their participation at any point in the interview.

2.3.5. Procedure

2.3.5.1. Piloting and recruitment

Prior to the study, a piloting of interview questions was conducted, consisting of two colleagues from the professional doctorate course. The interviews were adapted to focus on general therapy experiences, and were used in order to clarify and amend any identified problems and misunderstanding with the interview questions. The pilot interview proved to be valuable, as the researcher decided to re-frame certain questions on the basis of the feedback provided from the two participants. It was also helpful to practice how to actively listen to participants' experiences, whilst asking follow-up questions in order to explore areas that were of interest. The pilot interview also provided the researcher with an opportunity to ask about feedback relating to their interviewing style, and to improve this accordingly.

The recruitment process turned out to be a challenging process. Participants were recruited through a recruitment advert and information leaflet (Appendix B) distributed to relevant professionals in voluntary service as well as survivor support groups. A number of services across London were initially contacted through email and phone. However, the majority of services did not respond, whilst some responded, but felt that they would not be able to advertise the study to their service users, due to service restrictions and confidentiality issues. After several attempts, and a number of setbacks the researcher was informed about a voluntary organization, which provides specialized support to survivors of CSA. The name of the service will not be provided in order to preserve anonymity of participants (i.e. staff or other individuals not being able to identify participants based on information provided in the research). The researcher contacted the manager over email, and they agreed to advertise my research study on their website, as well as contact potential clients directly, and provide them with information about my study. The first phase of the screening process involved asking mental health professionals with relevant expertise to identify survivors that met the inclusion criteria. They were asked to advertise a leaflet, informing participants about the study (Appendix H). Mental health professionals were asked to refer clients who were robust enough to participate in the study, capable of understanding the study, and able to provide informed consent. Participants who were deemed vulnerable and not robust (i.e. participants

that had expressed suicidal or self-harm thoughts, or that were in a social or health crisis) were excluded from the study. In addition, participants that were undergoing a legal court case and currently in therapy were also excluded from the study.

2.3.5.2. Conducting Interviews

Those participants who expressed an interest in the study went through to the second phase of the screening process in order to schedule face-to-face interviews. Participants were initially screen by mental health professionals in order to establish whether they met the inclusion criteria. The researcher scheduled an initial phone conversation with the participants in order to provide more information on the research, establish their willingness to participate following an explanation of the research as well as establish whether they met the inclusion criteria. Participants were asked to attend a one-off, one-to-one interview and were provided with a choice of venues where the interviews could take place. This was done in order to provide clients with more control over the process, whilst ensuring the safety of participants and the researcher, and to make it as comfortable as possible, which has shown to strengthen credibility of the research process (Chouliara, Kearney, Worth, & Stott, 2004). Two interviews were conducted in a private study room at City University, whilst the remaining four interviews were conducted in the service in which the participants were referred from.

The next stage involved the researcher meeting with the participant. Clients had already been screened for risk by the mental health professionals that had referred them to the study, as well as over the phone by the researcher, no additional risk assessment in the form of questions on suicidal or self harm thoughts was conducted at this stage, and no clients expressed these risks at the time of the research. Participants were informed about the nature, purpose and anticipated consequences of research participation, and individual written informed consent was obtained prior to each interview (Appendix C). The six interviews were conducted using principles of sensitive interviewing, and were flexible in

nature, so that when participants showed signs of psychological distress, they were able to pause the interview at any time, and to resume once ready. Once the interviews had been completed, participants were debriefed, and the nature of the study was fully explained to them (Appendix D). The researcher answered questions or queries participants had, as well as thanked them for their participation. All participants were provided with a comprehensive list of local community psychological resources (Appendix E), if they required assistance as a result of any potential distress that might have occurred as a result of the study. Additionally, contact details of the researcher and supervisor involved in the study were provided, to allow participants to discuss any concerns that have come up during the course of the study.

2.4. Transcription and Analysis

The analysis followed the process outlined by Smith and Osborn (2003). The interview was transcribed in verbatim, including false starts and the notation of pauses '(pause)' and other significant features '(laughter)' as recommended by Smith and Osborn (2003). Additionally, as guided by Atkinson and Heritage (1984) line numbers and noted emphasis: 'emphasised', were used. During transcription, the researcher kept a record of initial thoughts, comments and points of potential significance. This was used at a later stage to return to and check against interpretations during analysis. Secondly, the transcript was read several times, noting points of interest and significance on the right hand margin, including the use of particular language styles or form, initial interpretations based on what the participants had said, as well as convergences and contradictions in their narrative. (Smith & Eatough, 2007).

The next stage involved noting themes of a higher level of abstraction. This involved returning to the transcript and making notes on the left margin, whilst preserving a link back to the original account. This stage required the use of psychological concepts and abstractions (Smith & Eatough, 2007), as the researcher attempted to identify the psychological quality within the initial notes and in the participants' narrative. According to Smith (2004) it is important to stay connected to the participants' account, which should be

kept at the forefront of the analysis. Furthermore, that psychological theory should only be drawn on if triggered by the personal account. As guided by Smith and Eatough (2007), a particular emphasis was put on ensuring that the connection between the participants' own words and the researchers interpretation was maintained. For instance Jane described wishing that her therapist had facilitated exploration into the 'root cause', of her difficulties, as she felt that this would have allowed her to 'trace back' her difficulties to her experiences of CSA earlier. This was interpreted as a 'missed opportunity for exploration and discovery'.

Thirdly, establishing connections between the preliminary themes and grouping them into clusters, reduced data further. A summary table was developed providing each superordinate theme and the themes that comprise it, as well as the line numbers to the corresponding quotes that aim to capture their quality (Smith & Eatough, 2007). In accordance with the ideographic element of IPA, each transcript was looked at individually, before moving on to the next interviews to identify themes. Once the analysis was completed for each participant, a cross-case analysis was carried out and a final table of superordinate themes was developed in order to represent the whole data set. Themes that did not relate to the overall question, and/or did not have strong enough evidence base were omitted. For instance, the majority of participants had highlighted the importance of a 'non-judgmental stance', in being able to 'communicate freely'. This was initially developed into the theme "Ability to speak freely without judgment". However, upon looking at the cross-case analysis, it was evident that this theme was not present and/or did not have a strong evidence base across all participant narratives. As a result, this theme was replaced by a broader theme "Relational qualities of the therapist", which encompassed all participants' experiences, and included an account of the importance of a non-judgmental stance in being able to communicate freely. Exemplar of the analytic process has been presented in the appendix (See appendices F - G).

The write-up of a narrative account of the analysis, involved an interplay between the

interpretive activity of the researcher and the participants' account of their experience in their own world (Smith & Eatough, 2007). As guided by Smith and Eatough, (2007), an emphasis was put on providing a close textual reading of the participants' account, whilst moving between different levels of interpretation, at all times ensuring differences between account and interpretation were made. Furthermore, enough data was presented for the reader to evaluate the usefulness of the interpretations (Smith & Eatough, 2007). In order to stay true to the ideographic commitment, Smith and Eatough (2007) proposes that the researcher should attempt to convey some of the details of the individual experience of participants, even when presenting an analysis from a number of participants (Smith & Eatough, 2007).

2.5. Ethical Considerations

This research was conducted in line with BPS (2009) Code of Ethics and Conduct guidelines (See appendix I). Prior to each interview, individual written informed consent was obtained (Appendix C). Additionally, clear records were kept of when, how and from whom consent was obtained, using a numbering system to ensure anonymity of participants. All names and identifying information was changed to preserve anonymity of participants, whilst recordings and transcripts were encrypted, stored securely, and will be destroyed once they are no longer needed for research purposes. Participants were informed that their participation was voluntary, and that they could withdraw their participation at any time. The researcher was mindful of the sensitive nature of the topic, and the possibility that some of the questions might have contributed to participants experiencing emotional distress. Measures were therefore put in place to provide appropriate support to participants following the completion of the interview, if necessary, including sufficient time to ask questions about the study and to process and get support with any difficult emotions that might have come up. The majority of participants stayed to ask questions about the study, but none of the participants showed any evidence of distress as a result of the interview. Nevertheless, details of counselling community and psychological resources local to each participant were provided to all participants (See appendix E). The researcher's personal safety and wellbeing was attended

to by appropriate use of supervision in order to protect against possible psychological distress.

2.6. Assessing validity and quality of research: Yerdley's (2000) criteria

A number of guidelines for assessing quality and validity in qualitative research have been developed. The approach by Yardley (2000) was chosen for this study, as it has a sophisticated and pluralistic stance for assessing qualitative researches. This approach has been recommended by Smith et al. (2009) who highlight two main advantages of this approach, including the suggested criteria being broad ranging, and offering a variety of ways of establishing quality. Secondly, it offers criteria, which can be applied irrespective of the particular theoretical orientation of qualitative research (Smith et al., 2009). Yardley (2000) presents four main principles for assessing the quality of qualitative research. This includes 'sensitivity to context', 'commitment and rigour', 'transparency and coherence' and 'impact and importance'. This section will provide an overview of each criterion, and how it relates to the present research.

2.6.1. Sensitivity to context

Yardley (2000) argues that good qualitative research should demonstrate sensitivity to context. According to Smith et al. (2009) IPA research demonstrates sensitivity to context throughout the research, including the socio-cultural milieu in which the study is situated, the existing literature on the topic as well as the material obtained from the participants. One way in which this study demonstrated sensitivity to context is through obtaining quality data, by showing empathy, facilitating a comforting environment, as well as having awareness of interactional dynamics and power differential that exist between participant and researcher. Additionally, as guided by Smith et al. (2009) sensitivity to context was also demonstrated through the analytical process, by showing immersed and disciplined attention to the participants' accounts. Additionally, Smith et al. (2009) argues that a strong IPA study will demonstrate sensitivity to the raw material being worked with. By including verbatim extracts

from the interview in order to support the argument being made, and thereby giving participants a voice in the project. Additionally, Yardley (2000) highlights that one has to show sensitivity to context of theory. A literature review was therefore carried out on relevant literature, as well as the research method, providing an understanding of relevant literature, including previously related empirical work as well as research on the method itself, showing further sensitivity to the context (Smith et al., 2009).

2.6.2. Commitment and rigour

Yardley (2000) second principal 'commitment and rigour' can be demonstrated in a number of ways. According to Smith et al. (2009), commitment refers to the appropriateness of the sample to the question at hand, the quality of the interview, and the completeness of the analysis undertaken. The researcher demonstrated commitment through showing sensitivity and care to the data, including showing attentiveness to participants during the data collection process, as well with the analysis of each interview (See Methodology chapter). Rigour on the other hand was demonstrated by considering the appropriateness of the sample to the question at hand. The sample was selected carefully, ensuring it was as homogeneous as possible. Analysis was conducted thoroughly and systematically guided by principles set out by Smith et al. (2009), including extracts from participants in order to illustrate themes showed commitment to ideographic principles. Additionally, an effort was made to ensure analysis was sufficiently interpretive, moving beyond simple description when interpreting the meaning of data.

According to Yearly (2000) triangulation can be used to demonstrate commitment and rigour. Triangulation refers to the use of multiple researchers, research methods, sources, or theories in order to assess the consistency of findings (Flick, 1991; Tindall, 1994). Yardley (2000), argues that triangulation of analysis can provide a rounded, multi-layered understanding of the research topic. For this research, a fellow colleague was asked to look at the analysis in order to generate themes. These were compared to the themes generated

by the researcher, and were found to be similar. Although triangulation may result in a more 'full' level of analysis, it does not necessarily contribute to a more objective one (Fielding, 1986). As such, the researcher recognises that the nature of IPA is interpretive, and that biases might exist (See reflexivity section for further discussion).

2.6.3. Transparency and coherence

Yardley's third principle is transparency and coherence. According to Smith et al. (2009), transparency refers to the way in which the stages of the research process are described in the write-up of the study. As guided by Smith et al. (2009), the researcher demonstrated transparency by explicitly demonstrating the analytical procedure (See Methodology chapter), ensuring transparency regarding decisions, as well as using reflexivity to ensure that the researcher showed awareness of the impact of their own subjective experiences, thoughts and attitudes and how it might impact the analysis (See reflexivity section). According to Smith et al. (2009), in order to demonstrate coherence the researcher needs to ensure that the themes fit together logically, and that coherent arguments are presented. The researcher included exemplar of the analysis process (See Appendices), in order to demonstrate how the themes were generated. Additionally, the researcher acknowledges that the insights generated from the research are interpretations of the participants' experiences, and not absolute truth, thereby showing further coherence (Smith et al., 2009).

2.6.4. Impact and importance

Yardley's (2000) final principle impact and importance, highlights that the test of 'real validity', lies in ensuring that the research informs the reader about something interesting, important or real (Smith et al., 2009). This research aimed to increase the understanding of experiences of psychological therapy amongst women survivors of CSA. The importance of these findings relate to clinical implications, as it aims to inform therapists about survivors' unique experiences of therapy, in order to better meet survivors' needs, and inform clinical practice.

2.7. Reflexivity

My interest in this topic dates back to when I worked in residential mental health crisis service for women. During my time in the service, I worked therapeutically with women suffering with enduring and complex mental health problems, and was able to understand that for many of these women, the experience of CSA was a prominent and contributing factor to their mental health difficulties. I also witnessed the lack of sensitivity to the effects of gender many clients experienced in relation to accessing mainstream mental health services. These services often failed to acknowledge the additional mental health needs of women, particularly those needs arising from experience of CSA and violence, care responsibilities, social isolation and the need for safety. I therefore began to wonder whether these difficulties were extended to women's CSA survivors' experience of being in therapy, and the general adequacy of therapy for survivors of CSA.

As I began to do a literature search in this area, I was surprised by the lack of research in outcome studies on effectiveness of therapy/interventions for survivors of CSA, furthermore, that there were very limited studies investigating experiences of therapy, from survivors' perspectives. I therefore wanted to conduct a qualitative study, to shed light on this issue. The main aim of this study was therefore to explore adult women CSA survivors' experience of psychological therapy, particularly hindering or assisting aspects of therapy, as well as experiences relating to the therapeutic relationship. My main hopes with conducting this research was to shed light on survivors' unique experiences of therapy in order to better meet the multifaceted needs of survivors and inform clinical practice.

According to Banister, Burman, Parker, Taylor and Tindall (1994) it is insincere to claim to be neutral in research, as research is always carried out from a certain position. I therefore acknowledge that my experience, in combination with existing theoretical knowledge of working with this client group, might have impacted on the outcome of this research in a number of ways. In relation to interviewing participants about their experience of therapy,

having past experience of working therapeutically with CSA survivors allowed me to promote rapport and trust with participants, by utilising core conditions such as empathy, unconditional positive regard and congruence. Additionally, this might have also aided the identifying of themes. However, having theoretical knowledge and experience might have also acted as a barrier to interpreting participants' experience without imposing my own meaning and worldview in the interview as well as in the analysis stage, including the interpretation of themes.

According to Moustakas (1994) reflexivity enables the formal acknowledgment of the researchers' interpretive role. Reflexivity can therefore be used to 'bracket out' researchers' preconceptions (Moustakas, 1994). In order to address the above limitations, reflexivity was used throughout the development and completion of this research. During the analysis process a reflective diary was kept in order to become more aware of my own perspectives, opinions, attitudes and worldviews and to assist self-analytical practice. I was able to go back to the reflective diary to understand, and identify how the above biases might have impacted the analysis process, in particular the development of themes. As a result, I was able to amend themes that were felt to be influenced by my own biases and perspectives in order to ensure that the themes developed were closely connected to the participants accounts, providing a more credible analysis. Some researchers have argued phenomenological research should engage participants in the reflexive techniques, in order to stay true to the method (Caelli, 2001). Due to ethical considerations, participants' validity checks of transcripts were not requested, as it was felt that this could potentially cause psychologically harm to participants, as it could bring up difficult traumatic memories and reminders. A second researcher assisted in the co- analysis of themes, in order to aid the development and accuracy of themes.

2.8. Conclusion

This chapter has critically discussed the key epistemological standpoint, as well as the used Methodology and Method, and their adequacy in addressing the research aims of this study. It has provided an overview of the theoretical underpinnings of IPA, including key developments in phenomenology, Hermeneutics and Ideography, and how these relate to IPA. This study has also discussed key ethical considerations underpinning this research, and demonstrated its use in the planning and development of this study, along with a demonstration of how validity and quality of research was demonstrated. The importance of reflexivity has been addressed through an account of the researchers beliefs and assumptions about the phenomenon being studied, and how this might have impacted the research. In conclusion, qualitative research, in particular IPA offers an opportunity to gain an in-depth understanding of participants' inner world. It is particularly beneficial in psychological research, as it offers a methodology that is philosophically informed and systemic, whilst focusing on the willingness to enter into, and respond to the participants' world.

3. ANALYSIS

3.1. Introduction

The purpose of this qualitative study was to explore women CSA survivors' experiences of Psychological Therapy. Interpretive Phenomenological Analysis (IPA) was utilised in order to understand women's lived experiences of therapy, with a particular focus on facilitative and hindering aspect of therapy. The data analysis from the semi-structured interviews revealed four superordinate themes, which are listed below:

1. The help-seeking journey
2. The development of the therapeutic alliance
3. Salient therapeutic experiences
4. Healing as a process

Each superordinate theme also has a number of inter-related sub-themes. All participants did not express these sub-themes, however the superordinate themes were present in all participants' narratives. The table of themes (See appendix G) illustrates the identified themes, along with the presence of particular themes across participants. The themes are inter-connected, and therefore share commonalities, and aim to capture the survivors' experiences of utilising therapy. It is recognized that these themes are subjective interpretations of the researcher; and that other researchers might have identified alternative themes from the participants' narratives.

The following chapter will describe these themes with the use of direct quotes to illustrate their quality. Minor changes have been made to improve readability; repetitions and utterances such as 'erm', have been removed, unless deemed relevant. All identifying information has been removed or changed, and pseudonyms have been used in order to preserve the anonymity and confidentiality of participants.

3.2. Findings from the IPA

3.2.1. Superordinate theme 1: The help - seeking journey

The first superordinate theme ‘The help-seeking journey’ aims to capture participants’ experiences of seeking and accessing therapy. This is characterised by women’s accounts and experiences of inner pain and awakening at the time of seeking therapy, including the effects of CSA, and their journeys of gaining awareness and insight of these effects on their presenting problems, which seemed to have been a key contributing factor to help seeking. Women also described a number of pre- therapy experiences and expectations. These were often varied and complex, and seemed to have had a profound impact on women’s experiences and overall perception of therapy.

3.2.1.1. Inner pain and awakening

All participants interviewed reported a number of social and psychological difficulties in their adult lives, at the time of seeking therapy. These responses relate to the well-documented effects of CSA (See chapter 1), including depression and anxiety, problematic relationships and re-victimisation, as well as difficulties with intimate relationships and intimacy. Participants also spoke of having outbursts of ‘aggression’, ‘feeling numb’, detached’, or ‘dissociating’. In addition, women reported struggling with substance abuse, and noted histories of self-harming and suicidal ideation and behaviour. The majority of participants described seeking therapy in the context of a triggering and/or increased severity of symptoms, and perceiving that their existing coping strategies were no longer effective.

Jane emphasises this:

“I sort of was really struggling with my studies, some of them sort of like were a bit close to the trauma I had suffered (....) some of the stuff I had been reading, and it was beginning to cause me PTSD and flashbacks, and caused me to get quite upset really, at times I just couldn’t deal with it

really, I just needed to do something about it, otherwise I was going to fall into pieces” (1; 12-17).

Jane seems to describe a deep sense of helplessness and despair, and a lack of inner resources to cope with her feelings, which seems to have had a profound impact on her. It appears that she had an awareness of the link between symptoms triggered by the course material and her trauma. She recalls that she ‘couldn’t deal with it’, and that she ‘had to do something about it’, as she would otherwise ‘fall into pieces’. There is a strong sense of fragility and despair in her account, almost as if she was on the verge of breaking down and desperately trying to hold herself together. Therapy seemed to have been experienced as a last option, or perhaps a lifeline, in order to alleviate her feelings of despair, and to prevent further breakdown. Jane’s account also highlights the susceptibility to on-going psychological effects of CSA, which was a theme shared across all participants.

Margarette described the role of guilt, in contributing to her decision to seek therapy:

“ I allowed myself to be treated so badly, feeling guilty all the time, so what made me cause my counselling, guilt, feeling so guilty” (1: 26-27).

The awareness and insight into the relationship between CSA experiences and their difficulties varied. The majority of women reported lacking an awareness of the continued impact CSA had on their adult lives and presenting problems. Some women reported not having clear memories about the abuse. These women described struggling with their lives as a result of not knowing, and reported feeling overwhelmed when they experienced flashbacks or memories of the abuse. Others reported having some awareness into the potential link between their difficulties and experiences of CSA, and wanted to explore this further in therapy.

Amy recalls this moment:

“ So it was obviously on my mind for years and years, and the relationship I was in (....) the relationship wasn’t going very well. I was very stuck, and I’d discuss with my partner, he knew my history, and I’d discussed with him, how I felt so incredible numbness, when we talked about the emotive things, that we were gonna split up, and I felt nothing, I had been like that in previous relationships, so just kind of felt, maybe it’s a result of my childhood (....) yea I kind of how I felt like, its time to start and try unravel what had happened, and also to kind of have reassurance that the impact of my childhood had on how I am today, yea” (1:11-23).

Amy’s account seems to suggest that she is reflecting on important issues that led her to linking her difficulties to her childhood experiences. She seems to reflect on her experiences within a wider context. On the one hand, she is aware that her experiences of ‘numbness’ related to talking about ‘emotive’ things in her relationship, were different, and seems to locate these in the context of previous relationship patterns, and perhaps also other people’s experiences. This seemed to have encouraged her to start looking for answers, and to find out if these difficulties were a result of her ‘childhood’. Perhaps she also wanted assurances from therapy that there was a root cause of her difficulties, as she might have felt fundamentally different or flawed as a result of the abuse experienced as a child.

3.2.1.2. Pre-therapy experiences and expectations

Participants’ attitudes and expectations about therapy varied. Some participants’ entered therapy believing it was an opportunity to receive help for their difficulties, and wanted to get answers regarding the ‘root cause’ of their problems. Others entered therapy with a lack of awareness of their need for therapy, some described not knowing what to expect.

Participants also spoke of wanting therapy to help them to 'make links', and 'increase awareness' of the relationship between past and present experiences and difficulties.

Jane recalls this:

"I think I kind of wanted to figure out why I had suddenly gone like from being really passive to really aggressive and I didn't understand what had caused that, so I think I kind of hoped that we'd explore what had caused these things so that I could actually deal with them in future" (2:60-63)

Amy on the other hand, described lacking memories of the abuse, and wanting to find answers through therapy:

"I have some memories of what happened, but not complete (...) so my main kind of hope was that I be able to access memories and have a definitive idea of what went on, cuz' at the moment I just have signposts to suggest that I was abused (...) and also to have discussion around how I am now and how I've grown up, how I have become to be now" (1:26-31)

It appears that Jane and Amy did not understand how the experiences of abuse continued to impact on their presenting difficulties. Jane highlighted wanting to 'explore what had caused' her behaviour, whilst Amy wanted to 'access memories' and have discussions around how she has 'become to be now'. Although there were differences in their recollection and memory of abuse, it seems that both highlight the importance of learning how, and the extent to which the abuse had impacted on them and their presenting difficulties, in order to perhaps be able to begin to address, and deal with these effects.

In fact, the majority of respondents described wanting therapy to help them to 'move on' from their experiences. Caroline emphasise this:

“ I hoped that it would work in the sense that I could feel that I could move on because, you can’t ever forget what’s happened (pause), its always gonna be there for anybody who has been through that...” (1: 29 -31).

Caroline described wanting therapy to help her to ‘move on’. She notes that ‘you can’t ever forget what’s happened’, in reference to the abuse. It appears that there is a sense of acknowledgment that the abuse will have a continued and lasting impact on her life, and that ‘moving on’ might involve having to learn to live with what had happened to her, or perhaps find new ways of relating to her experiences, in order to be able to reduce its negative impact.

Participants’ pre-therapy experiences were varied and unique. The majority of women described a number of obstacles and challenges related to receiving therapy. These related to both service barriers as well as participants’ personal circumstances. In particular, participants described experiencing financial constraints leading to restrictions in the choice of therapy. They also reported obstacles to accessing sufficient therapy; service regulations and/or funding deficits appeared to have had a significant impact on both availability of services, as well as the way in which therapy was delivered.

Tina highlights this:

“The first time when I really wanted to do therapy, at the time I did not have a lot of money, so the natural thing was to seek therapy through the NHS, and it was this waiting list (...) it took a year to even get to go for an assessment (...) and was then told you are too high risk, you wouldn’t be able to manage the kind of stuff that might come up and I was really, really upset because at that point it was me who wanted to do it, and I was being denied doing that” (2: 75-81).

Tina's account illustrates a sense of frustration with the service that she felt had let her down. Tina's frustration at being denied therapy becomes evident when she recalls how she was 'really upset', as she at that point 'wanted to do it', perhaps feeling that choice or control had been taken away from her. This sense of control or choice being taken away seems to bear a strong resemblance to the difficulties Tina recalls later on in the interview, when her parents and other professionals made the choice for her to start therapy, which might have been particularly damaging in her experiences with the service. This account also raises questions regarding the provision of therapy for survivors of CSA, as similar to Tina's account, service regulations were consistently noted to have contributed to delays in receiving sufficient therapy. This was particularly evident for women accessing therapy within the NHS, where they were denied therapy, or/and it was felt that the staff was not adequately equipped to work with their complex histories and presenting problems.

Annette described a similar experience, in which deficiencies in therapy funding appeared to affect both the consistency and perceived benefits of therapy. She recalls:

"They referred me to x (name of therapy service), when I was 16, it took three years to get funded. I had an interim therapist whilst I was on the waiting list, I didn't find that helpful" (1: 26-28).

Annette describes the negative impact of financial funding deficiencies on her therapy experiences. It appears that being given an interim therapist whilst on the waiting list was experienced as unhelpful, perhaps feeling that she could not fully connect with and develop a relationship with the 'interim' therapist, as she was aware that this therapy would have to come to an end. This highlights the importance of providing continuous support to survivors, including them not having to change therapist during the course of treatment, as this might impact engagement negatively, as well as the perceived benefit of therapy.

Participants also reported a number of factors facilitating help-seeking. Margarette described that her GP played a key role in being able to access therapy. She noted how she had ‘conveyed enough of a story’ to her doctor, who was then able to recognise that she “*needed counselling*” and referred her for therapy (1: 38-41). Availability of local services specialising in CSA, was also consistently considered to assist help-seeking.

Jane emphasise this:

“Having a group that was so open about what they deal with, was actually quite good for me because it meant that I knew that actually when the issue started rearing, then sort of saying I am having these flashbacks, I am not dealing as well with this as I thought I was, it’s not as buried as I thought it was, having a group that was publically open about what they help with made it easier to just walk through the door” (3: 134-140).

Jane described how having access to a service that was open about working with the effects of CSA was experienced as valuable. It seems that this allowed her to feel safer to open up about her difficulties, perhaps feeling she would not be judged, or that these professionals would show greater understanding and be able to help her with her difficulties. This seemed to have promoted help-seeking, and made it easier to make contact with the service. Margarette and Jane’s accounts further highlight the importance of having access to knowledgeable healthcare professionals and therapist that are able to identify and work with the symptoms of CSA, including having access to local services specialising in CSA, which seem to promote help-seeking and service utilisation for survivors.

The majority of participants were initially offered a period on the waiting list prior to being given their first appointment with the therapist. Although they were aware and accepting that waiting lists were part of the process, they described experiencing a number of challenges

during this process, including professionals showing inflexibility to their needs and preferences, such as type, frequency and time of appointments offered, which were felt to be unhelpful. In addition, some participants reported being contacted at inappropriate times, or by different people, impacting them negatively.

Jane emphasise this:

“A lot of the child victim support lines phoned me up at really bad points, (...) and they didn’t seem to be willing to sort of like communicate in any other way then trying to phone me up, sort of nine to five and most of the time, nine to five was a really bad time, so I was like I can’t talk, and you are offering me counselling over the phone which is lovely, in theory but actually it is not particularly helpful, because of the time you could offer me, are not particularly conducive” (5:555 -564)

Amy also noted an unhelpful encounter over the phone:

“So the person, whoever it was, was like hello is Amy there, are you ok to talk, and it was all totally normal, and as soon as I went yes its fine I can talk, their tone of voice changed to oh, are you all right, and I really didn’t like that, that switch ...”

“What was it about the switch, what did it mean to you?”

“I suppose it was cuz’ it was quite loaded, and then it is a reminder of like (Pause), I know it is x (name of service) that rung up, but it’s a real reminder of kind of I don’t know how to say (Pause) like really putting on to me that there might be something wrong with me, do you know what I mean, (...), it didn’t really sit well with me whereas prior to me saying it is fine I can talk, it was just a normal like, hi so and so here, and it was as all, and then it shifted, and in that shift, that didn’t resonate with me” (2: 58-70).

Amy highlights a shift in the professionals 'tone of voice', which seemed to have had a profound impact on her. She initially describes it as being 'quite 'loaded'', but the level of hesitation, seems to signify that she struggles to make sense of this experience. She goes on to say that it was a 'reminder' of something, but hesitates, as this doesn't seem to capture what she experienced. She eventually describes it as if the professional was 'putting it on me', that there might be 'something wrong with me', perhaps perceiving it as a judgment of her as 'different' or 'abnormal'. It seems that Amy has come to understand that her experiences of CSA reveals something about her that others consider different, or perhaps shameful. The professional may not have judged her, but for Amy even just the thought of being judged seems to have had a profound impact on her. Later in her account, Amy describes perceiving this shift as if the professional was 'feeding that victim stage' (2:80-81). There is a sense that the 'victim' label carries judgment. Amy seems to feel that it is an invalid interpretation of her experiences, perhaps perceiving that such labelling implies a sense of weakness, or possibly makes her feel like the professional was pitying her, which seems to have been perceived as particularly damaging in her encounter with the service. Amy's account indicates that CSA could be considered a highlight stigmatising experience, contributing to perceptions of the self as abnormal or different, which might have a negative impact on help-seeking and service utilisation. It is therefore important to show consideration to these issues, and how they might impact therapy and help-seeking.

3.2.2. Superordinate theme 2: The development the therapeutic alliance

The second superordinate theme 'Development of the therapeutic alliance' aims to capture participants' experiences of developing and maintaining a therapeutic alliance. It appears that the majority of survivors experienced challenges in their initial contact with the therapist, this was related to issues of safety, and trust in the therapeutic alliance. Additionally, survivors highlighted both qualities they attributed to therapists, as well as to the therapeutic interaction, including aspects related to the negotiation of the therapeutic alliance to have

been of significant importance for the development of a trusting therapeutic alliance and outcome.

3.2.2.1. Therapeutic alliance and trust

All participants highlighted the importance of trust in therapy, but it was described in different and multifaceted ways. Nevertheless, the development of trust in the therapeutic alliance seemed to have been important in order for participants to be able to open up and express themselves in therapy, as well as for the development of safety in the therapeutic alliance. The development of trust seemed particularly important in survivors' initial therapy experience and/or contact with therapist, which was challenging for the majority of participants. Issues relating to trust, and seeking safety in the therapeutic alliance seemed to have underpinned these difficulties. For instance, participants spoke of feeling 'terrified', 'worried', 'nervous, or 'hesitant' in their first contact with their therapist. Some participants described 'lacking choice', when entering their first therapy. For these women, social care professionals got involved as a result of CSA being disclosed/detected, and directed them towards therapy. However, these participants stated that although their first therapy felt 'forced', subsequent therapy experiences were more their own choice.

Tina emphasise this:

"The very first time I started therapy I was seventeen years old and I had very recently tried to kill myself because the sexual abuse was still happening at the time, that was my way of getting away from it, social services got involved and then I happen to have a father that is a therapist so the natural thing was when this thing came out it was of course you must be in therapy, it was sort of it wasn't entirely by choice, it was more social services felt it was needed, my family felt it was needed and I complied since then I have been much more choosing to do it, but the very first

experience was more, family pressure” (1: 9 -17).

Tina describes attempting to commit suicide as a way to escape the abuse, which was still happening at the time. It was perhaps a feeling of desperation and a lack of resources leading to her to believe that the only way to stop the abuse from happening was to commit suicide. She describes the subsequent referral to therapy as a ‘natural’ response, and links this to having a father that was a therapist, perhaps feeling there was no other alternative. It appeared that her feelings about starting therapy were not explored. The use of the word ‘complied’ implies that perhaps she was feeling like she was giving up ‘choice’, or going along with the family decision, at the expense of her own wishes and needs. It makes one wonder, what her preferences were the time, and whether her experiences of therapy would have been different if she was consulted and included in the decision making process related to her needs and preferences arising from her traumatic experience.

Tina later describes experiencing a sense of apprehension about therapy, and in particular about the prospect of exploring her experiences of abuse. This provides some insight into how she might have felt about therapy at the time of being referred, and in particular how her experiences of therapy not being entirely by ‘choice’, might have influenced her perception of therapy.

She recalls this moment:

“I was quite apprehensive about doing it, I’d never been to therapy before (....), I didn’t have any personal experience of talking about, because I had been keeping everything secret for such a long time that I didn’t really want to, I didn’t, I still didn’t really know that I could talk about it because it was brand new to me, even though everyone knew it happened” (1: 19-25).

Tina highlights the role of secrecy in contributing to her feelings of apprehension about therapy. It seems that having to keep the abuse secret continued to impact on her as an adult. In particular this seemed to have contributed to doubt and confusion about whether she was allowed to talk about these experiences. It appears that although her family knew about the abuse, it was to be addressed and spoken about for the first time in therapy. It might be that the family responded inadequately to the detection of abuse, or perhaps not in accordance with her wishes and needs, which might have reinforced her feelings of doubt/shame, and contributed to an increased sense of apprehension, and perhaps vulnerability related to exploring her experiences of abuse in therapy.

Women who lacked the choice to start therapy consistently described a lack of engagement with therapy. This seemed to have caused a sense of frustration and resistance to therapy.

Jane recalls this:

"I was very upset at the fact that I had been forced to go to these sessions, I didn't really have anything to say, cuz' nothing was really bothering me, there was nothing pressing about going, there was no reason for me to be there" (1: 49-51).

Annette describes a similar experience:

"I didn't really seek therapy at all, I kept getting referred there, I didn't really engage with them until I was like 16, but then again I didn't seek that, it was the care home I was in, they didn't give much choice" (1: 4 -6).

Annette and Jane illustrates a pattern of disengagement with therapy and being re-referred to therapy, which was a common theme among those survivors who experienced external pressure to start therapy. It seemed that the disengagement described by the participants

was directly related to them lacking choice to start therapy, perhaps feeling that the referral was inappropriate, or that therapy did not take into account their needs and circumstances which led them to be in therapy. This hypothesis is partly supported by further accounts provided by these women, who continuously highlighted how the nature of support available did not seem to take into account their underlying difficulties, circumstances and needs.

Jane highlights this:

"It felt like the biggest waste of my life, (....) I just didn't feel angry or bothered by anything and I was like I am not an angry person, I just had an angry outburst. I spent six sessions there, not doing very much, didn't really talk about anything (...). He just sat there with his sort of laid back and just didn't say anything, didn't really interact with me and never really asked me anything to kind of get the bottom of why I had been angry and just told me that I shouldn't get angry about stuff" (1: 35-44).

Jane describes perceiving her initial therapy as lacking benefit. This seemed to have stemmed from perceptions of the therapist's as lacking engagement and understanding of her life circumstances and needs, which seemed to have caused disengagement, and a sense of not feeling understood or supported by her therapist. She emphasised the lack of interaction by the therapist as particularly damaging, and highlighted both verbal and non-verbal communication to illustrate this. This seems to have contributed to her needs not being explored in therapy, impacting negatively on her perception of therapist, as well as the perceived benefit of therapy.

Tina described a similar experience, but highlights the impact of external factors on therapy:

"I spent a lot of time in the first part of therapy just talking about completely irrelevant things, cuz' I was just not ready to really do therapy (....) it was a

tricky one, it was complicated with the fact that it was going to be a court case against the person who committed the abuse, and so the therapist wasn't allowed to coach me, in anyway, of kind of help me you know to bring up memories, or anything that could sort of change what my testimony might have been like, so it was a little restricted in that sense, that that the therapist then when I started talking about irrelevant things, they couldn't particularly steer me back to talking about the stuff that happened" (1: 26 -36).

Tina illustrates the conflicting perspectives and agendas of therapy between the client and therapist. Tina perceived that the therapist showed a lack of consideration to her needs arising from experiences of abuse/effects of CSA, which was described as restrictive. Although this seemed to have been a result of the restrictions imposed by the court case, the lack of collaboration and disagreement on the focus of therapy seemed to have further contributed to her feeling that her needs were not being addressed or met in therapy. However, Tina also highlights that she was 'not ready' to be in therapy at time, indicating that she perhaps made a conscious decision to avoid threatening topics, and that she was aware how this might have contributed to her not being able to benefit from therapy fully. Tina and Jane's account highlights the importance of showing consideration of survivor's circumstances and context, as well as underlying difficulties and needs related to CSA experiences, when providing therapy. These aspects seem to be important in order to facilitate engagement, development of a trusting therapeutic alliance as well as for the perceived benefit of therapy.

There was also a strong awareness by some of the participants that challenges related to subsequent therapy experiences were associated to damaging first and/or past experiences of therapy. This experience was shared by Tina who recalled how past experiences of

involuntary endings, impacted on how she interacted with her future therapist.

She recalls:

“ I was really open with what had happened with my previous therapist, and why that had come to an end, I didn’t want to risk her not understanding that I can become quite high risk, and I needed her to know that because I couldn’t afford to work with someone for five years and be told sorry, we cant cope with you, its like my biggest fear” (5: 229 -233).

It appeared that for Tina, experiencing difficult and involuntary endings in the past, contributed to a belief that relationships could not be expected to last. Perhaps she felt she needed to take steps to ensure this would not happen with future therapist. The disclosure of risk with subsequent therapists might illustrate an attempt to develop a sense of trust in the relationship, or to regain some control over the situation, and to perhaps reduce her feelings of fear related to potentially being abandoned as a result of the therapist’s perceived inability to cope. This highlights the importance of the therapist considering previous experiences of therapy, including existing biases or attitudes, which might impact on the therapeutic relationship and overall experience of therapy.

The majority of participants described a change in their therapy over time. When women started therapy by choice, the relationship with the therapist appeared to have strengthened over time, which contributed to increased self-exploration and benefits. For instance, many women described feeling confused about, or resistant to the therapeutic process in the initial contact with their therapist. Some expressed not understanding and being dismissive of the interventions put forward by their therapist.

Amy describes this:

“Because she’s very yes really buoyant (...), I suppose you just felt quite

full on (...), I've never been to counselling before and sort of don't know what to expect, and she was trying to resource me by kind of giving me this alter ego, kind of thing which I can totally understand why, where she was coming from, it just felt like oh god, really cringing" (2: 95-102).

Amy illustrates how she initially felt overwhelmed by her therapist's approach, and highlighted both the therapist characteristics and use of intervention to illustrate this. Amy describes having a physical reaction to the intervention (*"it just felt like oh god, felt cringing"*), to emphasise her discomfort with the intervention proposed by her therapist. One gets the feeling that she experienced overpowering feelings of unease or perhaps felt self-conscious in response to the intervention. She might have felt that the intervention was inappropriate, or not in accordance with her preferences and needs. It appears that not having had any previous experience of therapy contributed to a sense of uncertainty about therapy, perhaps adding to the perception of this intervention as uncomfortable, and/or overpowering.

Amy describes how this intervention was perceived later on in the interview. She also recalled how the relationship with the therapist evolved over time, but this required time:

"Because of time, that was a few months down the line and yea, that's what I just felt we had built up more of a relationship, and I knew I could say, yea that was a bit strange (laughter) yea" (6: 248-250).

Amy described how she was able to feedback her dissatisfaction with the intervention proposed by the therapist, but this required time. The development of comfort and safety in the therapeutic relationship appeared to have been a key factor in being able to communicate openly and honestly in sessions. This was consistently described by other participants, who emphasised the role of a trusting relationship in contributing to a positive

change in their therapy experience over time.

Caroline emphasise this:

“Obviously it is always the unknown (...), you don’t know what to expect and you are a bit nervous it’s almost like you are in a job interview sometimes, but once she started (...) I found this particular lady, quite warming, and its almost like when I was explaining everything to her, she was actually feeling everything that I had felt and that makes a big difference...”

“In what way did it make a difference?”

“Because its almost like she understands to the deepest part of me, what happened to me, and how I feel abut it, and how much it hurt me, and how it affected me really, and the way I think” (3: 118-130).

Caroline describes how the initial contact with her therapist was accompanied by a lot of anxiety and apprehension. It appeared that the therapist’s ‘warming’ approach allowed her feel more comfortable, and to experience a positive change in therapy. In addition, the therapist ability to empathically listen to and understand her experiences seemed to have been of particular importance. It might be that she was feeling that her therapist was sharing the experience, or going on journey with her, which perhaps enabled them to meet at a level of relational depth, impacting therapy positively.

Tina described ‘testing’ her therapist; this was also associated to trust:

“I still tested her like crazy, the first two years (laughter), you know to make sure she was real”

“In what way would you be testing her?”

“Just through little things like you know, how does she react if I tell her this, and would she freak out if I say that, and, I think when you’ve been through abuse, and also you have some kind of, unsteady upbringing in general, you get very used to looking after yourself you don’t easily rely on anyone else, or at all, in any sort of way, so when you go to therapy and it’s all about trust, that is a massive challenge to the whole way of thinking that ok I am suppose to trust this person and share things, and before we do that you just have to you know put little feelers out to see, but can they be trusted” (6: 247 -258).

Tina describes ‘testing’ her therapist, as a way to see her therapist reaction to what she was bringing to sessions, perhaps she wanted to find out if the therapist could cope or be trusted with her story. She links this to experiences of CSA, more specifically, the notion that when coming from an “unsteady upbringing’ trust needs to be developed, rather than being present from the start. She portrays a picture of becoming fiercely self reliant, and not trusting anyone as a result of the abuse. The feeling that the therapist is able to cope with her problems therefore seems to have been particularly important for Tina, as it seemed to have facilitated a sense of confidence and trust in the therapist, which also seemed crucial in being able to share, and open up in therapy. This highlights the importance of emphasising trust for the development of a therapeutic alliance with survivors. This includes the therapist’s ability to cope with and respond sensitively to survivor’s experiences, which might facilitate sharing in therapy, as well as a trusting therapeutic alliance.

3.2.2.2. Therapist characteristics

The majority of participants identified a number of therapist characteristics that seemed to have impacted on their engagement in therapy as well as the therapeutic alliance.

Participants made a number of distinctions in the therapist characteristics, including those therapist that were perceived as 'formal' or 'informal'. In particular, 'formal' therapists were perceived as prescriptive' and 'doctor' like. This appeared to have caused distance and hindered engagement and self-expression as well as challenged the therapeutic alliance. In contrast, informal therapists seemed to have contributed to participants feeling "comfortable", and they compared these therapists to the experience of 'talking to a friend', this was described as positive, and appeared to improve engagement as well as assist the therapeutic alliance.

Caroline highlights this:

"The last therapist was very much more open, her body language was more open, her body, the way we talked and communicated, made me feel safe, in being able to express things (...), If I was going to say well my last therapist was more of a friend then the one before was sort of more of a doctor" (6: 264 -269)

Caroline illustrated a perspective shared by most of the participants, namely the difficulty in engaging with and trusting therapist that was perceived as doctor like or authoritative, whilst informal therapists appeared to be perceived as more authentic and trusting, which assisted engagement and a sense of comfort and sharing. Caroline highlights the therapist body language, stating that it was 'open', as well as feeling that the therapist was more of a 'friend', which seemed to have reinforced her feelings of safety. Participants also described valuing therapist that that were flexible/open in both their interaction and way of working. This seemed to contribute to participants feeling 'safer, and 'freer' to open up and express themselves in therapy. In contrast, therapist that were considered to be 'rigid', were perceived as un-attuned to their clients needs, which resulted in participants feeling "restricted" and "holding back "in therapy.

Tina highlights this:

“If you are seeing someone who is willing to be flexible, who is willing to work with you in a way that works for you as opposed to being very rigid, in this is how I train, it becomes then restrictive, whereas if you work with someone who has trained in therapy type A, but is willing to take a few extra courses, you know test a few different things, that becomes something much more explorative and you feel freer to find different ways of expressing yourself” (3: 134 -143).

Tina illustrates how flexibility in therapy was considered helpful, and assisted engagement and self-expression. In particular, she emphasises the collaborative nature of their work, which enabled her to explore and identify what works for her, as well as use a variety of therapeutic interventions to meet her needs. This seems to have provided her with a sense of involvement and inclusion, and perhaps contributed to a more equal relationship, further assisting self-expression and sharing. Tina’s account might point to the value of a pluralistic approaches to therapy, in which a range of effective therapeutic methods and interventions are embraced and incorporated in treatment, based on each individuals needs.

The influence of therapists’ professional expertise appeared to have also impacted on participants’ engagement and perception of therapy.

Amy emphasise this:

“I felt reassured that she wasn’t new to her game, that she knew what she was doing, you know kind of wholeheartedly trusted she was a really good therapist.”

“Why was that important to you?”

“I suppose cuz’ I was looking, cuz’ I needed support, and if I’d have any

sort of hesitation or felt that not quite sure then I wouldn't have been able to speak so freely, I don't think, I know that she could work with everything that I was saying (...), like I said I felt reassured" (4 -169-178).

Amy described the importance of knowing that her therapist was experienced and able to deal with what she was bringing to sessions. The perceived expertise appeared to have facilitated a sense of trust and strengthened her confidence in the therapist. This in turn seemed to have allowed her to speak more freely in sessions. It seems that perceiving that the therapist was able to work with "everything" that she was saying, further reinforced her feelings of trust and safety. Perhaps she felt that her therapist could cope and be trusted with her story, without fear of being rejected or perhaps abandoned by her therapist inability to cope. A similar experience was described by Caroline who recalled a situation in which she had an initial hesitation about the intervention proposed by her therapist, but describes how her perception of the therapist as 'competent' seemed to have strengthened her confidence and trust in the therapist, allowing her to continue with, and benefit from this intervention.

She recalls:

"At first I thought I am talking to an empty chair, its almost like I have turned into a "nutter", almost like I had lost my mind, but I thought I needed to be open minded, she is qualified and she is trained, she has probably been doing it for a little while as well she has some experience, so I went with it. I did what she asked me to do and then it was really weird. I cant explain the feeling (...), if you want to be descriptive I would say that the clouds had been parted in my head and the sun had come out in my head, it was like I was seeing clearly again, and I could move forward" (4: 182-192).

Most participants did not describe therapist demographic characteristics such as race or

gender as significant in their therapy. Margarette, however, stated that her therapist made her feel very 'comfortable' and 'able to talk', and attributed this to the therapist 'being a woman', stating that it made a 'difference'. (3: 107-111). Participants also identified a preference for working with a therapist of the opposite gender of their abuser. Caroline highlights this:

"I think it is significant, as to its probably easier to speak to the opposite sex of the person that abused you, you gonna think that they, well I don't think that they will take their side necessarily, because everyone are different, everyone have different opinions, but it just makes it harder to talk about because they are the same as them, in the sense that they it sounds strange but I think personally that it is significant, and its a lot easier to talk to somebody that isn't the same to probably somebody that's done it to you, because there is no significance there, there is no relation there" (7: 340-348).

Caroline highlights a preference for working with a therapist that is the opposite sex of the abuser. There is a clear level of uncertainty in this narrative that suggests that Caroline remains undecided about this aspect of her experience. The hesitant language ('*you gonna think that they*' and '*well I don't think that they will take their side*') might suggest an on-going difficulty in knowing where to position herself in relation to her perception of working with a male therapist. Although there is a sense that she is suggesting that the therapist could potentially identify with the abuser, it seems to be more of a feeling that she describes, rather than tangible evidence of its occurrence. She eventually notes that it is easier to talk to someone that 'isn't the same' to someone 'that's done it to you', as there is 'no significance there'. Perhaps this expresses a wish to eliminate the possibility of any characteristics that might be a reminder of the abuser. This seemed to have been of key significance, in order to assist a safe exploration of issues. This might indicate the need to consider transference processes when working with survivors of CSA, and the importance of offering choice related

to the gender of the therapist, as this might have a profound impact on survivors ability to open up and share their experiences in in therapy.

3.2.2.3. Relational qualities of the therapists

Participants described a number of relational qualities of the therapists to have impacted on their therapy experience. Participants highlighted the importance of feeling understood, believed, and empathetically listened to by their therapist. These qualities seemed to have contributed to a sense of safety and acceptance as well as assisted sharing and self-expression. In particular, participants seemed to value therapists that exhibited human qualities, including therapists that were perceived as warm, genuine, sensitive, and having empathic concern.

Caroline highlights this:

“Just that significant point really, where everything was said. I felt like she was, she wasn’t just listening, she was feeling it to, like I think makes all the difference probably to everybody it made me feel like she really understood everything that I felt and when I felt it, and why” (5: 256-258).

Caroline highlighted the significance of empathic listening. She describes her therapist ‘feeling’ as opposed to ‘just listening’ to her experiences, perhaps feeling that she had a genuine connection with her therapist, or that she felt listened to and understood at a level of therapeutic depth. This seemed to have been of profound importance; perhaps it allowed Caroline to communicate more freely and openly in sessions.

Participants also emphasised qualities that conveyed a sense of sincerity and care as described by Annette:

“Like really blunt and really straightforward. And she didn’t really give a shit if it was ethical, just told you how it was, which I like, like she actually had

emotional reactions to what I was saying, and that she also had some kind of emotional attachment to me, which I think matters, like all the experiences of therapy I've had, that have actually worked have been dependent on that" (2: 61-65).

Annette illustrates the therapist's qualities and approach as important factors. In particular, she highlights the therapist 'blunt' and 'straightforward' approach as valuable, perhaps experiencing her as congruent, and authentic. This seemed to have been of key significance in facilitating engagement. However, it appeared that having an "emotional attachment", to her therapist seemed to have been a condition required for therapy to work, and perhaps for this type of interactions to be useful.

Participants also highlighted the value of a non-judgmental stance in creating safety to open up and communicate freely.

Amy describes the value of this:

"Because it allowed me to say absolutely anything, things that I have you know never been able to talk about before, and knowing that there is no judgment, no kind of like, yea, that didn't happen, none of that at all, so I just felt completely, just totally at ease, to say absolutely anything, which yea, real liberating experience, when you haven't felt able to do that, so to have someone that is just wholeheartedly there to listen and to help you sort of, guide you, yea its fantastic" (4: 154-164).

Amy illustrated the value of the therapist assuming a non-judgmental stance. It appeared that the therapist ability to convey a sense of acceptance allowed her to open up about things she had previously been holding back. Being believed, and not judged by her therapist seemed

to have been key for being able to express herself freely. She described this experience as 'liberating', indicating that it might have been of particular importance in light of previous experiences of not feeling able to talk, possibly due to previously being shamed or judged when talking about or attempting to talk about their experiences.

Participants also emphasised the value of a non-judgmental stance in normalising their experiences. This was particularly evident for those survivors who reported feeling 'different', or 'shamed' as a result of their experiences and lifestyles. Similar to Amy, Jane highlights the value of a non-judgmental stance in normalising her experiences; this was associated to an increased sense of acceptance and self-expression:

"I am often made to feel like I am a bit strange or a bit weird (...) I don't fit in a box at all, I am often made to feel guilty or bad about the fact that I don't fit in, I don't conform easily, so actually having someone who I could talk to about my life and my current relationships and my viewpoints and things and being made to feel actually that that was ok, that my lifestyle choices and my personality and everything were absolutely fine, and perfectly normal, it was sort of quite big to be able to open up like that and not have someone go well that is a bit weird you know so, a lot of acceptance as well, but being able to trust, being accepted for who I was, without fear of judgement" (7: 324-335).

Participants also described a number of unhelpful relational qualities, including non-responsive therapists, therapists not showing any interest or warmth, or silent or passive therapists. These qualities led to participants feeling unable to open up, holding back or censoring themselves in therapy. In addition, it appeared that these qualities also contributed to challenges in the therapeutic alliance.

Jane highlights this:

“Counsellors who literally just, sat in a room, looking at me, I did spend 45 min in silence, because I had nothing to say, and they were not interested in starting a conversation, and once you get past the colours of the wall, you kind of, just sat there.”

“How did that feel, that silence?”

“It was awful, because I basically sat there with my own head, thinking, and all I kept thinking was, surely somebody else could benefit from this, there must be somebody out there who needs these counselling session” (10: 483-490).

Jane describes how her therapist seemed to lack interest and engagement in her therapy, which was considered unhelpful. She emphasised the role of silence in reinforcing her negative perceptions of the therapist and dissatisfaction with therapy. This seemed to have impacted negatively on the therapeutic alliance as well as the adherence to and perceived benefit of therapy.

Annette described a similar experience in which a perceived lack of engagement from her therapist contributed to a sense of frustration and resistance to therapy:

“She was a proper Psycho-analyst, she was really cold, and really, silent. I was very silent and none of us would budge, so we literally sat there for like five months and didn’t speak to each other. We got really pissed off with each other I think...”

“How did you feel in that setting, with your therapist?”

“I found her quite inhumane” (1: 49 -55).

Annette illustrates a recurrent pattern in which participants often described the unhelpful experiences with the therapists as events and where therapeutic modality, relational qualities, and interventions were intertwined, and contributed to participants overall perception of the therapist. Annette seemed to compare the therapist interaction against desirable 'human qualities', and when these were perceived as lacking, it seemed to have contributed to a negative perception of the therapist. The word 'inhuman', to describe her therapist, gives one a feeling of someone that lacks compassion and is unkind, which seemed to have been considered particularly unhelpful, impacting engagement and outcome negatively.

Tina, who described the therapist assuming a 'blank canvas' stance, illustrates a similar experience:

"Some therapist are very traditional, where you, you know, sort of the blank canvas approach where they will not say anything back to you, and you know, the idea is to frustrate you, I get that, but it is also frustrating to a point, that it hinders something in my view (...) I think its about when I experience a therapist as being very rigid in their way of working with me, it then makes me very stubborn, and you kind of going back to the same place again and again, without moving forward, because the therapist isn't going to change their way of working and you are not getting what you are wanting so it becomes incredibly frustrating and stops the process of healing" (4: 152-163).

Tina describes her therapist as 'traditional, and utilising a 'blank canvas approach', which seemed to have generated feelings of frustration, and was experienced as hindering. It

appears that the therapists rigid approach coupled with the lack of collaboration between her and the therapist, contributed to her feeling stuck and like she was not moving forward in therapy. This gives one a feeling of being trapped, and having limited influence over decisions in therapy, causing further frustration with therapy. This also seemed to have impacted therapy outcome negatively, as she describes that it 'stops the process of healing'.

3.2.2.4. Negotiating the therapeutic alliance

Based on participants' stories, it is evident that issues related to the negotiation of the therapeutic alliance, including the development of therapeutic boundaries, opportunity for involvement and collaboration in therapy, as well as the importance of choice, had a profound impact on survivors overall therapy experience as well as for the development of the therapeutic alliance and sense of safety in therapy.

For instance, Tina highlighted the value of having sound therapeutic boundaries; this seemed to have been associated to safety.

She recalls:

"The boundaries make me feel safe, because I know she's not gonna overstep anything, which is really important to someone that has suffered abuse, because that all about the boundaries being kind of trampled all over, so she is very clear on these sort of boundaries, but she'll also check how does this boundary feel for you, and do we need to look at where it needs to sit for things to work between us" (9:393-399)

Tina illustrates the importance of having strong therapeutic boundaries, in making her feel safe. She particularly emphasised the need of boundaries for people that have experienced abuse where boundaries had been 'trampled over'. Tina portrays a picture of violation and belittlement resulting from the abuse and the importance of the therapist in ensuring clear

boundaries exists in sessions. It appeared that establishing these boundaries in collaboration with her therapist reinforced her feelings of safety, which also seemed significant for the development of an effective therapeutic alliance. Tina also stressed the importance of the therapist being able to maintain time boundaries.

She recalls this:

“Sometimes you wish, I wished there was extra ten minutes, twenty minutes whatever, but I also know that if she was someone who sometimes run longer, then that would, loose the sort of safety within these are my fifty minutes, so that’s really important: (9: 436-441)

It appeared that the therapist’s ability to maintain time boundaries, allowed for security to be developed within sessions. Tina notes that although she sometimes wished that her therapist had allowed the sessions to run longer. This would have contributed to a reduced feeling of safety within the sessions, as she would have broken away from these boundaries. Perhaps the therapist’s ability to withstand her wishes showed further evidence of being protected, and cared for by her therapist.

Participants also emphasised the value of working in collaborating with their therapist. For instance, Jane described her experiences of making “active choices” and its positive impact on therapy:

“I got to make the choices, and I got to have a say in how my sessions were structured, and what we talked about, so that was quite important, being able to sort of make a plan with my counsellor, and really feel like it wasn’t just me being guided, it was me making active choices about what we were going to talk about” (10: 461-465).

Jane describes being involved in therapy decisions, and highlights the value of 'having a say' in deciding the structuring and content of her sessions. Working in collaboration with the therapist seemed to have been significant in being able to experience a sense of involvement in therapy, perhaps contributing to an increased sense of equality and empowerment or control in therapy, which seemed to have been important. However, the same participants described an encounter with a different therapist, where she seemed to have lacked control, this was experienced as unhelpful:

"But before it was basically, it felt much more rigid and, I think the power genuinely was in the counsellors hand, it wasn't in my hands to explore things (...). I was being asked to talk about things that I didn't know what I needed to talk about, but at the same time I didn't have the power or the dynamic, because they were the ones in control of the room, they were the ones who controlled the situation and I didn't really have the ability to say, how about you help me figure out why I have been angry, or what it is that keeps putting me in situations that I end up feeling vulnerable and I leave myself open to further abuse, what is it that causes these behaviour patterns" (5: 238-248).

Jane seems to have experienced a sense of frustration related to lacking power, and not having control or influence over her own session. It appeared that the awareness of the power imbalance, between her and the therapist, further reinforced her perception of herself as lacking control, contributing to feelings of disempowerment and vulnerability. This appeared to have contributed to not being able to express her needs in therapy, leading to important aspects being missed, and not explored in therapy, impacting outcome negatively.

Caroline also identified choice as being important in therapy. She recalls:

"She sort of left it open, she said we can try this if it doesn't work we'll do

something else, so she sort of left it open really (...), I think that's probably what maybe helped me to be more open minded about the whole exercise really because I thought well, this is a bit strange but I will give it a try, if it doesn't work we can see what else can be done..." (9: 444-451).

Caroline highlights how her therapist was facilitating choice in her therapy. In particular, she described how her therapist did not restrict therapy to a particular modality, which seemed to have been valued. It appears that the therapist's open and collaborative approach strengthened her confidence and trust in the therapist's judgment, and allowed her to become more open minded and inclined to try out interventions proposed by her therapist, despite having experienced initial doubt, and hesitation towards this intervention.

3.2.3. Superordinate theme 3: Salient therapeutic experiences

The third superordinate theme 'Salient therapeutic experiences', relates to a number of general aspects of therapy that participants described as having impacted on their therapy experience. This included the importance of experiencing a sense of safety in therapy, having a sense of continuity and consistency in therapy, as well as important abuse specific factors and their impact on the overall perception of therapy. Participants also described deficiencies in therapy related to missed or unmet needs, as well as provided suggestions for improvement.

3.2.3.1. Sense of safety in therapy

The importance of experiencing a sense of safety in therapy was a recurrent theme amongst survivors. Women did not describe one single factor that contributed to an increased sense of safety. In fact, experiences of the therapy room appeared to have been closely linked to their perceptions of the therapist and the therapeutic interaction, which all seemed to have impacted on their experience of safety in therapy.

Jane emphasises this:

“Every experience I had, they would sort of sit across a big room from me, and they were very distant but actually here the last one it was really close and quite intimate, so it didn’t feel like I had to kind of shout my problems across the room, it was small and cosy and I just sit and have a conversation with someone about it.”

“... and why was that important?”

“I think just made me feel supported, it made me feel more like I was having a conversation with someone, then sitting on a counselling session” (4:178-186).

Jane highlights the importance of physical attributes of the therapy room, in facilitating a sense of comfort. In particular, she highlights how ‘close’ and ‘intimate’ environments added to the feeling of not having to ‘shout’ out her problems’, perhaps experiencing the setting as confidential and safe which seemed to have been valued. She goes on to say that this made her feel like she was having a ‘conversation with someone’, rather than ‘sitting in a counselling session’. It might be that this environment was experienced as more intimate, contributing to her feeling supported and perhaps cared for by her therapist. Interestingly, these experiences were described in contrast to her initial experience of therapy, where she was ‘sitting across a big room’, from her therapist, who she seemed to have perceived as ‘distant. This further highlights the importance of intimacy in facilitating a sense of comfort and safety in therapy.

Tina’s response echoed a similar experience:

“She’s got her own furniture you know, it’s a little bit of her in there, and also some of my paintings, that she put up, and she asked me to do some

paintings for her room, which is really nice. It adds to the feeling that this is not you know her office, It's our, our therapy room. It's not mine, its not hers, It's our joint space" (11:494-501)

Tina describes the benefit of a personalised therapeutic environment. In particular it seemed that objects in the therapy room provided a sense of her therapist's personality and care for her. In addition, being asked to add objects to the therapy room that had personal meaning to Tina seemed to have contributed to a sense of inclusion or 'joint space' in therapy, and perhaps contributed to her experiencing an increased sense of equality in the therapeutic alliance, which seemed to have been valued.

The role of the environment also extended to women's experiences with the service in which the therapy was held. Women described qualities about the therapeutic environment, which provided them with an increased sense of safety, anonymity and privacy.

Annette emphasises this:

"It was like a bubble kind of so we didn't just have therapy and then go home to be alone, you had therapy and then you had meetings to talk about your therapy. The whole system was set up so that it was as safe as it could possibly be. And also, when I was at an adolescent unit that was like really safe but for different reasons because, just because I physically couldn't get out, and I couldn't physically hurt myself, so they would restrain me, so there was a lot more trust at the castle to keep yourself safe, but both settings were good" (4: 187 -193).

Annette described two sets of environments that seemed to have provided her with an increased sense of safety, but in different ways. She compares the first therapy experience

to being in a 'bubble', perhaps experiencing it as being secluded from the outside world and maybe also her own external struggles. She also notes having access to continuous support there, including not being left on her own and having meetings to talk about therapy, which seemed to have reinforced her feelings of safety and security in the therapy. In contrast, she notes a different therapy environment, in which the experience of physical boundaries, in the form of a 'secluded environment', prevented her from 'physically hurting' herself, which also provided her with a sense of safety. However, she highlights that there was more 'trust' in the castle to 'keep yourself safe', suggesting she experienced a sense of responsibility to maintain the trust that had been developed with 'the service' to keep herself safe. This highlights the important role of trust in survivors being able to maintain own safety.

Amy described a similar experience:

"On coming here, coming into the building for me, 'I always came in and out of the side door, I felt I could hide, that was really good" (8:354-355).

Amy illustrates how having access to a side door entrance, made her feel like she could 'hide', perhaps providing her with a sense of anonymity or privacy, which seemed to have been valued. Tina on the other hand, identified a preference for seeing therapists working from their private practice, as opposed to someone working from 'from home'. She recalls:

"I was so aware that I was in someone's (Therapists) home (...) I could hear her husband coming home at six o'clock, and know that he can call out honey I am home, because she was in session, and I felt very aware of my impact on you know, being in the house, on their family life, and that was a challenge I do feel more comfortable working with someone, who doesn't work from home, and has their own practice somewhere different" (10: 483-488).

Tina illustrates the challenge she experienced in relation to seeing a therapist that was working from home. She described how the possibility of hearing her therapists husband, made her aware of her presence and impact on being in the house, and on her therapists family life. It might be that she felt like she was intruding or perhaps that it felt too intimate, causing feelings of discomfort. She identifies a preference for seeing her therapist in her own private practice, as opposed to someone working from home. This might also signify a preference for wanting clear boundaries in therapy and making clear distinctions between personal and professional roles, which might have been experienced as more blurred when she had to see a therapist in her home environment.

3.2.3.2. Continuity and consistency in therapy

Participants emphasised the value of having continuity and consistency in therapy. In particular they highlighted the value of being able to receive follow up support, to have contact between sessions, opportunity to extend sessions and not having to change therapist for the duration of treatment. This seemed to have been experienced as positive for the therapy process and healing.

Amy emphasised this:

"I cant remember if it was six or twelve, If it had just been those initial hours that wouldn't have been enough, so yea that was good to have the opportunity for more to be put on, definitely, and without having to sort of go back to the beginning through the whole waiting process just to kind of roll..."

"Why was that important?"

"...Because I think that would have just sent me back again (...) it was like you started something and you are going with it, you are working with it all the way through" (8: 380-388).

Amy illustrates the benefit of having the opportunity to extend sessions as it meant that she did not have to start therapy 'all over again'. It seems that if this option had not been available it would have diminished the progress she had made (*'that would have just sent me back again'*), and was considered unhelpful. There is a sense of determination and commitment related to wanting to work through whatever she had started in therapy, perhaps experiencing that this commitment would be lost, or difficult to regain, if she had to start therapy all over again.

Jane on the other hand described finding the initial period following discharge as particularly challenging. She noted how having access to support during this time, made her feel less isolated. It seemed that having a 'safety net' contributed to an increased sense of self – resilience and use of internal resources and coping strategies.

She recalls:

"For me actually that first week after I stopped counselling, was one of the hardest weeks in my life, I felt like I was literally going to fall back over the edge at any point (...) all my partners had to keep reminding me that actually if I needed it there was a phone line, I wasn't completely on my own here, was this safety net still there, and I could go back and use the safety net if I needed it, you know..."

"What did that mean knowing that you had that safety net?"

"It meant I could sort of sit there and, while I was having a bad day, I could analyse whether I needed to talk to someone, or whether it was just a bad day, and actually I would be ok if I'd just took few deep breaths, and had a cup of tea or you know took a break or just, stopped" (9: 412-419).

Tina describes the value of having contact with her therapist in between sessions:

“Sometimes in sessions, I wasn’t able to say things, and it would pop up at home, and then I found it really hard in the beginning, (...) to contact her over the weekend, or in-between sessions. She really encouraged me to say that’s ok, because I can check my emails when I want to (...) so there were boundaries, but there were also a lot of encouragement to use all the tools in the box, and not just the actual session time, and that was a really good way of building the relationship, it made it feel more natural”

“What did it mean to you, being able to contact her in between sessions?”

“It meant that I guess, that she really cares, you know, she doesn’t work twenty four seven, but she is willing to be contacted twenty four seven”

(6: 281-294).

Tina described valuing that the therapist was open and encouraging about having contact in between session, which contributed to a ‘better flow’ in therapy. This seemed to have also assisted self-expression as well as facilitated the development of a therapeutic relationship. Tina’s account also relates to aspects of flexibility in therapeutic boundaries. It seems that the therapist’s flexible and accommodating approach seemed to have showed evidence of authentic caring which was considered important for both the therapeutic alliance as well as for an experienced sense of continuity in therapy.

3.2.3.3. Abuse specific aspects in therapy

A frequent occurring experience reported by survivors related to important abuse specific aspects in therapy. Women described an interplay of factors which impacted on their ability to communicate openly about their abuse experiences. This related to intrinsic factors, as well as life circumstances and context and the dynamic of the therapeutic relationship. For instance, Margarette described not wanting to talk about her experience of abuse because it

would have meant she had to go over it in her mind again, and did not *'want to keep voicing it'* (7:311-313). It seems that talking about her experiences of abuse contributed to a sense of having to re-live the abuse in her mind, which seemed to have been experienced as difficult and unhelpful.

Participants also described using a number of interpersonal tools in therapy, in the form of distraction or avoidance in therapy. These seemed to assist them in dealing with the discomfort arising from engaging in discussions around abuse histories, which was experienced as particularly challenging.

Annette describes using a type of interpersonal tool that she refers to as a *'weapon'*:

"I kind of felt like lost, like It became a weapon that I could use I am not really sure how it makes sense but that, something I knew about, and the other person was guessing about, and I could drop hints, it kind of put me in control" (3: 134 -137).

Annette seems to describe a game-like exchange, in which she compares *'it'* (her abuse experiences) to a *"weapon"*, and something she *'knew about'*, and the other person was *'guessing about'*. There is a sense that she is trading secrets with her therapist, and that Annette only feels comfortable or able to talk about these experiences, if the therapist engages in this game-like exchange. There is also a sense that talking about her experiences of abuse contributes to profound feelings of disempowerment and lack of control. It seems that she used these interpersonal tools to regain a sense of control, as well as to cope with the discomfort of talking about the abuse. The hesitant language (*"I am not really sure how it makes sense"*) possibly mirrors the hesitation she experienced about talking about her abuse experiences, which was understandably a challenging and perhaps also frightening topic. Another hypothesis is that this interpersonal tool was used as a way to

test her therapist's ability to cope with her story, which perhaps provided her with an increased sense of safety within the relationship, and perhaps further facilitated a sense of control in session.

The same participants described a different situation in which she was unable to control discussions of abuse experiences and other difficult experiences, which seemed to have been experienced as challenging, but beneficial. She recalls:

"I couldn't manipulate the situation in order to feel in control. I just couldn't do that because the staff would talk to each other and could see very clearly that I was doing that and call me up on it..."

"Could you tell me a bit more?"

"I didn't really do that as much in x (name of therapy service), but by the time I was eighteen I kind of picked up on this habit, where if I found something difficult, then I could create undercurrents of the situation, and like try and don't know how to describe it (...) I think the only reason that the x (name of therapy service) worked, is because I had to stick in therapy with these same people who now knew what I would do and how I tried to, like make myself more strong and powerful" " (4: 207 -227).

Annette illustrates a common pattern in participants' accounts, in which certain aspects of therapy were considered simultaneously helpful and unhelpful, depending on context. Annette seemed to acknowledge the role of intrinsic factors, in particular her attempts to avoid talking about her abuse experiences as she experienced this as challenging or difficult. However, being in a service, where she lacked the ability to 'manipulate the situation' in order to make herself 'strong', and 'powerful', seemed to have been perceived as significant in being able to experience progress and for therapy to work.

Tina described a similar experience in which an ongoing court case prevented her therapist from 'probing' her about her experience of abuse. She noted that although it felt 'restrictive' it was also a 'relief' at the time. It appeared that the restriction provided her with a sense of control over the way in which her abuse experiences were discussed. This was experienced as positive, as she did not feel ready to explore these experiences in therapy.

" I think to be honest, at the time it was almost a relief because it was an excuse to not talk about things, I knew that they were not allowed to pressure me to open up about anything, and so I could always choose to talk about what happened and they gave me whatever, and then you wouldn't be able to steer me back to anything difficult that I wasn't ready to talk about, so it was kind of, it was quite safe in a way, at the time because I wasn't ready to look at things, so yea" (2: 51-59)

Talking about the abuse in therapy was generally seen as a challenging experience. This related to choosing appropriate timing and depth of such work, but also the right type of therapy forum. The majority of women emphasised the value of being involved in establishing how and when they would talk about these experiences, including having the choice to opt out when they were finding it too difficult.

Jane highlights this:

"Having that choice meant a lot, because it meant I had control, I have the control for the probably first time in my life about, how I let the abuse affect me, and that was that was really quite ground-breaking, cuz it basically meant I was able to be a like, today it's not going to affect me, today I am just going to ignore it, and I am ok with that, and then next week if I am feeling stronger we can talk about it then" (14: 679-684).

Jane illustrates how being given choices provided her with a sense of control over how the CSA would affect her. She described this experience as “ground breaking”, as ‘for the first time’ she could choose, if and when it would affect her. Being able to postpone the exploration of abuse to when she feels stronger within herself seemed to have been particularly valued. Perhaps it was experienced as empowering in light of previous experiences of being abused, in which she lacked the ability to control or stop the abuse from happening. Caroline described a similar experience; in particular, she describes the value of being offered a choice of different types of treatments. This seemed to have had a significant impact on her willingness to explore abuse experiences in therapy

She describes this:

“ She did ask me if I wanted to go to group sessions and I said no (...) I think personally if somebody been through something like this whether it is an isolated incident or not, if it is sort of random nobody, then yea group therapy, I think its fine because they are all the same as you, but if it has been more personal and it’s been somebody that is related to you or is a family member or a very close friend, it’s very, very difficult, because you feel ashamed you don’t want to share that with everybody, you don’t want to share that with other people, you feel that you need to go on a journey on your own to get rid of whatever it is that’s holding you back” (2: 96-104).

Caroline seems to make a distinction between her and ‘others’ abuse experience. In particular, she emphasised how being abused by a relative, versus somebody that is not a family member, was experienced as more ‘difficult’ and seemed to contribute to greater feelings of shame causing her to not want to share these experiences with ‘everybody’. It seems that this perceived distinction in abuse experiences played a significant role in her decision to start one to one therapy over group therapy. It might be that she felt that other survivors would not understand, or share her experiences, or perhaps judge her. She adds

that it felt like she needed to go on her “own journey”, perhaps feeling that being with other survivors in therapy would interfere with her healing journey.

3.2.3.4. Missed or unmet needs

Participants highlighted a number of inadequacies with aspects of therapy that appeared to be missing or not meeting their needs. These aspects related to both the treatment and the therapist's inability to identify appropriate interventions to meet their needs. This appeared to undermine participants' confidence in therapy, as well as challenge the therapeutic alliance. For instance, some participants described perceiving their therapist missed important issues, or failed to see the seriousness of their problems, or choosing interventions that did not match their developmental needs as described by Caroline:

“I thought this is more child-like, and I am an adult. I don't see how this is going to work, maybe if I was 12-13 years old, yeah I think it could have probably worked (...) but because I am a grown woman with children of my own it just didn't feel significant if you like” (6: 281 -290).

Caroline illustrates the lack of usefulness of a ‘paper work’ exercise. In particular she emphasised how this intervention was perceived as “child-like’ and inappropriate for her age. It seems that she perceived that her therapist had misjudged the usefulness of this exercise, which was experienced as particularly unhelpful and contributed to her needs not being met. Margarette describes a similar experience. In particular she describes how her therapist seemed to have failed to see the seriousness of the negative impact of her difficulties; this appeared to undermine her confidence in her therapist's judgment.

She recalls:

“What he did say to me, don't waste your life, try not to waste your life. It's easier said than done, when you don't know what to do” (2: 90-92).

Jane on the other hand described how her therapist's lack of exploration prevented exploration and increased awareness of difficulties.

She recalls:

"I could have traced it back to the sexual abuse earlier, instead I kind of blocked all of that as being in the past, so it doesn't matter. I think if somebody literally picked apart those initial behaviours that caused me to get go to counselling in the first place. I could have probably done all this years ago" (2: 84-88).

It seems that there is a sense of a missed opportunity in Jane's account. In particular, that the therapist's lack of exploration of her presenting problems, resulted in lost time and had the therapist facilitated this exploration; she could have made these links sooner, and perhaps made progress sooner, which seemed to have been considered important for healing.

Similar to other participants Amy described experiencing that her preferences were not sufficiently taken into consideration. She recalls:

"Like for me wanted to be able to access the memory, so when I first spoke to my initial contact here, she said they have a hypnotherapist. When I was on the waiting list, it was my understanding was that that's where I was going (...) so then when my counsellor did ring up, I did say are you a hypnotherapist and she said no, she's not, I was mislead a bit, you know that's what I wanted to get out of it, so I am still in the same situation as where I was in that we didn't act, we couldn't get to access memories, but obviously we worked through a load of other stuff" (5: 212 -221).

Amy described how she initially had requested to see a “hypnotherapist”, as she wanted to “access memories” of her abuse. However, it seems that she felt misled about the treatment that was offered. This seemed to have prevented her from being able to address important issues in therapy and contributed to unresolved issues, which seemed to have been experienced as negative. However, she acknowledges that despite this, she was able to work through ‘a load of other stuff’, which seemed to have been experienced as positive.

Tina on the other hand, described how perceived restrictions in therapy contributed to challenges in the therapeutic alliance, causing her to terminate therapy.

She recalls:

“ She was going to basically allow me to carry on in therapy where you can talk about everything apart from feeling suicidal, because obviously that was something she couldn’t deal with, so I had to actually make the decision, I learnt a huge amount from working with her (...) I also realised that I was ready to go further, and look at the reasons why and she wasn’t (...) and I just kind of had to you know move over to see someone else” (15:691-697).

Tina illustrates her therapist’s lack of willingness to talk about her suicidal feelings in therapy, as this was something she could not ‘deal with’. This seemed to have contributed to Tina’s decision to terminate therapy. Although this seemed to have been experienced as difficult, it also appeared to have contributed to an increased awareness and learning about herself. In particular it seemed to have contributed to insights regarding her readiness to explore these experiences in more depth, which seemed to have been experienced as valuable.

Although perceived deficiencies related to ‘missed or unmet needs’ in therapy were a

recurrent theme amongst the majority of participants, there was also an acknowledgment of changes in the perceptions of therapy over a period of time. In particular, Annette spoke of being able to see the benefit of treatment, despite initially feeling that their needs and preferences were not being considered or met. She recalls:

“At the x (Name of therapy service), they often used to focus on things I didn’t get, I didn’t get why it was important, and actually a lot of the Psychoanalytical ones that I have had, not sure if I can complain, as it worked in the end” (3: 119 -122).

Annette describes how she initially did not seem to understand the focus and reasoning for interventions put forward by her therapists, and seemed to question their significance and value. However, it appeared that with time and retrospectively looking at her experiences and how therapy was beneficial for progress, she was able to see the usefulness of this therapy.

3.2.3.5. Suggested improvements

This refers to aspects of therapy that participants felt were missing from therapy or things that could improve their therapy experience. Participants described improvements related to therapy, such as providing follow up appointments following discharge, or to the therapist interaction, including improvements related to relational qualities or responses of the therapist, as described by Jane:

“ I genuinely would have liked him to try having a conversation even if you know I sort of siting there and he didn’t think I was willing to engage in the process, which is probably what he was thinking, for 45 minutes, while this person just don’t want to engage in the process and I am sitting there thinking this process is ridiculous, it is not going anywhere or doing anything, even if he just said you know, so what hobbies are you into... talk

like a general conversation, just, maybe even try and get to know me a bit or something, actually in six weeks I don't think he knew who I was more than I knew who he was " (11: 506 -511).

Jane describes wanting her therapist to have started a conversation with her, despite her giving off an impression of not wanting to engage. Jane seems to be critical of her therapist, and seems to communicate a sense that therapy would not be of any benefit to her. She expresses that she had wished that her therapist used general communication skills (*"if he had just said, what hobbies are you into"*) as a potential way to get to know her better. It seems that she wished to have had experienced a greater connection with the therapist, or perhaps a greater sense of intimacy in the therapeutic alliance. Not being able to experience this connection seemed to have caused disengagement in therapy and impacted the therapy process negatively. Although there is insufficient information to draw a conclusion on Jane's earlier experiences, it is likely that previous experiences with mental health professionals have been perceived as unaccommodating, and perhaps unresponsive to her preferences and needs. This might have contributed to wider experience of therapy as well as influence her perception of the as unhelpful.

Participants also identified suggested improvements related to the termination/end of therapy. This included wanting clarification regarding the therapist's decision making process, or wanting follow up support as described by Amy:

"I think it would be nice to then say, we have a follow up in two or three months, just to sort of touch base, and see if anything would come up, in that time where you living and you are functioning on your own, without support if you know (...) I don't know, to maybe reassurance kind of thing, then if anything has arisen in that space where you haven't got that

dedicated person” (6:305-311).

Amy suggested and describes the value of having a follow up appointment following discharge. This was a recurrent theme amongst participants who like Amy, felt that having a follow up session, would have offered them some reassurance during the transition period; going from being supported to functioning on their own. It might be that the initial time following discharge was experienced as a period of particular uncertainty and vulnerability and that a follow up session could offer some reassurance and support, which was considered to be of particular value.

Tina also provided a suggestion for improvement; this included wanting clarification regarding therapist’s decision-making process and therapy content.

She recalls:

“How can therapy work if there are specific things that you cannot talk about, because it scares your therapist so much (...) We did used to have quite a lot of trust but then after that, it was broken, it was broken by something that I did, because it scared her when I did that, and I understand that part of it, but I just wish we could have talked about a bit more. Yea I felt to me to decide to end that therapy” (15: 702 -709).

Tina highlights aspects of the therapeutic relationship, which seems to have contributed to her decision to terminate therapy. In particular she emphasises the therapist’s lack of willingness to talk about ‘specific things’ as this ‘scared’ her therapist. This lack of willingness to explore these issues seems to have contributed to a loss of trust in the therapeutic alliance. Tina seems to acknowledge her role in contributing to trust being broken, but notes how she had wanted her therapist to engage in a joint conversation about these issues.

However, when this was perceived as lacking, it seemed have contributed to her decision to terminate therapy. Tina's decision to end therapy might also suggest that she was trying to protect herself from potential rejection and abandonment, as it might have felt safer to reject her therapist, before she anticipates being rejected herself.

Tina elaborates on this later in the interview:

"I don't have a problem completely disagreeing with someone I don't mind that at all, but someone who is genuine, you know, who will have the discussion with and meet me and agree or disagree but at least talk about everything, that makes me want to stay in therapy" (15: 722 – 725).

Tina notes how working with therapists that are genuine, and open to engaging in honest discussion of these issues is of key importance for wanting to stay in therapy. This highlights the importance of transparency and collaborative decision-making when working with survivors of CSA abuse. This might increase adherence to and perceived benefit of therapy.

There was awareness amongst some participants that aspects missing from therapy were related to intrinsic factors within themselves, hindering exploration.

Margarette highlights this:

"I didn't know if Mary did actually know, that there was more, she must have done because she was a counsellor. But of course there is a limit to how far a counsellor can push you because you have to get there on your own. and if she dropped any seeds I would have just completely walked over them because they just didn't exist. I don't know they did" (6: 270 - 274).

Margarette seems to be reflecting on whether her therapist had been aware of any important underlying issues related to her experiences. However, she also seems to have an insight

into her role in preventing the exploration from deepening. There seems to be a contradiction in Mary's account of this particular experience. On the one hand it seems that she felt that she lacked awareness of important issues and would therefore not have picked up any interpretations or 'seeds' from the therapist. An alternative hypothesis might be that Mary was aware of the importance of her abuse experiences, but did not feel ready to explore these aspects in therapy, and therefore felt she would have to 'walk all over them', indicating an intentional dismissal or avoidance of issues. This highlights the importance of considering intrinsic factors related to abuse experiences, which might impact on a survivor's ability to explore these issues in therapy.

3.2.4. Superordinate theme 4: Healing as a process

The last superordinate theme refers to participants' accounts of healing as an ongoing process, characterised by increased insight and development of new meaning. Participants also highlighted a number of healing responses, which seemed to have facilitated therapeutic change and healing. Participants also described aspects of personal development and growth, which was considered important for this process.

3.2.4.1. Insight and new meanings

Participants reported achieving increased insight and development of new meanings as a result of therapy. This included gaining an increased awareness of abuse related issues as well as new perspectives on unhelpful coping strategies and their impact. It appeared that gaining this awareness was key in enabling a therapeutic change to occur and for the experience of healing. For instance, many women described the value of being able to make connections between past experiences and present difficulties. This appeared to have facilitated acceptance as well as the management of symptoms.

Jane highlights this:

“Yes, I think I have gained a much better understanding of what somehow some of my behaviour patterns have formed from that initial abuse (...) and how that lead to me into other abuse relationships and how that’s impacted on who I am today (...) A real understanding which has helped me kind of, you know accept that it is ok to be angry about some of that stuff, and it is ok to feel these things, and it’s about not controlling the emotion but controlling the impact of the emotion, so it has been really helpful” (19: 901-909).

Jane illustrates the value of gaining an increased awareness into the relationship between CSA experiences, behavioral patterns and subsequent abuse and re-victimisation. This seemed to have enabled her to be more accepting of displaying her emotions, particularly her feelings of anger. It might be that making connections allowed her to understand that there was a reason for her feelings of upset and anger. It seems that this increased insight allowed her to shift her focus in how she managed these emotions. In particular, she highlights that it allowed her to be more accepting of her emotions, which seems to have been considered particularly helpful for progress and healing.

Participants also spoke of therapy contributing to them gaining an insight into aspects of themselves, which they had not previously been aware of, as described by Annette:

“It’s kind of every layer you peel off, revealed another layer of fucked up. I was initially referred because I was self-harming, I was being self-destructive, but when you peel that away you get the way I look at the world, and then when you peel that away you get why I look at the world the way I look at the world” (6: 306 -309).

Annette likens her therapy to the experience of 'peeling off' layers. She notes how every layer seemed to have contributed to a deeper level of reflection and understanding about herself, including how she thinks about and relates to the world and why. However the tone of Annett's account to describe what she discovered as a result of 'peeling off' these layers might indicate that although this process was experienced as necessary, it was also experienced as profoundly challenging. The use of words 'fucked up', to describe the revelations might also indicate something personal about her own challenges struggles in coming to terms with her experiences and difficulties.

Another similar example comes from Tina:

" I've had a huge amount of space to start exploring things but there are always more to explore, and as you explore those areas sometimes you stumble up on a new area (...) and then it opens a new venue to go into, and have a look and see what's gonna happen there, so I wouldn't say that I've had closure on anything I have worked on, but I have more patterns, of the fact that these are the things that I have dealt with, these are the things I have struggled with, and here is the space I can do it" (18-849-860).

Tina also highlights the value of making links between past and present experiences, and describes how this seemed to have allowed her to access new parts of herself. She emphasises the notion of healing as a process, rather than a designated destination. In particular, she notes that she has not had any 'closure', but that therapy has allowed her to integrate a new meaning of her experiences, as well as a space to continue exploration, which seems to have been valued.

3.2.4.2. Healing responses and therapeutic change

Based on participants' narratives, it is evident that there were a number of therapeutic responses that seemed to have had profound and lasting impact on participants' healing journey. In particular, they highlighted the important role of the therapist in offering validation and modelling of experiences, which seems to have facilitated an insight, instilled a sense of hope, provided alleviation of guilt and self-blame and enabled them to move forward in their healing journey. For instance, the majority of participants appeared to have felt restricted by their experiences of abuse/injustice as they contributed to feelings of self-blame, shame and confusion. The role of the therapist in acknowledging and validating their experiences appeared to have been instrumental for therapeutic change to occur. It seems that having their experiences accepted as valid allowed them to internalise the therapist's voice, which seems to have reduced the negative effects of these experiences.

Caroline highlights the value of ascribing blame to the abuser, and the role of the therapist in being able to do so. She recalls:

"The exercise that she'd done (...) put the blame where it needed to be and that was the most important part, because that's what she said, we need to get the blame where it needs to be, and at that moment it's not where it needs to be, and I knew that, and obviously she knew that as well"

"What did that mean to you, hearing that?"

"I felt I was getting somewhere that I could actually, this could work"

(6: 322-331).

Caroline illustrates the active role of the therapist in promoting awareness, through acknowledgment and validation, which seems to have shifted the responsibility of abuse to the perpetrator. Gaining this insight seems to have been important for lifting self-blame, experiencing a sense of progress and strengthening adherence to therapy.

Another example comes from Margarette who emphasised the importance of her therapist in being able to make sense of her experiences of abuse. This seems to have contributed to reduced feelings of self-blame.

She recalls:

“I hadn’t realised that I had a narcissistic mother once the therapist had explained it to me, I was able to make sense of it all, if that makes sense. I understood it better, so it wasn’t my fault. Still feels as if it was, but it wasn’t my fault. I had bad parental guidance, I had no, I had no moral guidance, at all” (10: 141-151).

Margarette illustrates how the therapist helped her to make sense of her experiences of abuse. It appeared that this allowed her to view her experiences within a context. In particular, Margarette highlights the role of her absent mother who appeared to have had a passive involvement in the abuse, through a lack of guidance and protection, or perhaps by not preventing the abuse from happening. The therapist’s acknowledgment and validation of these experiences seems to have allowed her to move from feeling ‘at fault’ for what happened, to gaining more insight of her experiences of abuse and thereby alleviated feelings of self-blame.

Being validated was also considered beneficial for Amy; in particular, she describes the role of the therapist in being able to move her forward in her healing journey:

“I can’t recollect the actual incident but sort of strong signposting to it, so she said yea we are just gonna take it that you were, and then at that point that was just like (sight), that was a real turning point (crying) ... yea that she said what I have said that it sounded like I had been (abused), and just

in her saying that, yea we are going to take it that you had been abused, it was a huge relief (...) absolutely like yea a big weight had been lifted because my thing had been for all those years, I just been like, did it happen, didn't it happen, going mad in my head no knowing... and for someone to go yea Ok, it looks like you were, it was kind of like, I could let go of some of that did it happened, didn't it happen you know (crying)" (6:259-276).

Amy illustrates the distress she experienced in attempting to uncover her lost memories of abuse. She described how not being able to uncover these memories had contributed to an endless search for answers and not being able to move on. The therapist appeared to play a significant role in acknowledging and validating her experiences of abuse. She emphasised a turning point in which her therapist's validation of abuse experiences, seemed to have acted as a confirmation that the abuse had happened. She describes this experience as 'a huge weight' being lifted to illustrate her sense of relief related to being able to 'let go' of her search for definite answers. One gets the feeling that 'not knowing' was experienced as a significant burden or weight that she had to carry with her and that being able to let go of her search for definite answers (i.e. '*Did it happen, didn't it happen*') was therefore significant in her being able to experience therapeutic change and move forward in her healing journey.

Participants also described how their therapist was able to model appropriate emotional reactions and responses. This seemed to have contributed to participants feeling more confident in their ability to identify and express their own emotions.

Tina highlights this:

"I feel like because I am not always really good at knowing what the feelings are, it makes me feel like, well if she feels that it was sad, and it

makes her angry that that happened, then maybe its ok that I feel angry about something. Those kind of things are really important” (17: 785-788)

Tina illustrates how her therapist modelled appropriate emotional responses. In particular she emphasised her difficulties in identifying emotions or ‘knowing what the feelings are’. Therefore seeing her therapist displaying her emotions in therapy seems to have allowed her to feel more accepting of displaying her own emotions, including her feelings of anger related to the abuse. There is a sense that sharing these emotions can be intimidating or perhaps unsafe and that the therapist lessened the intimidating nature of this experience, which seems to have been considered important for both progress and healing.

Annette described a similar experience:

“ So the therapist I had between the ages of 16 and 18, was, it’s a really weird thing to say but I kind of, think she kind of taught me how to, almost re-parented me in a way. Before that stage I was, like I didn’t have any experiences of relationships of any sort where people gave a shit or kind where caring or things like that. I think if I didn’t have that experience I would have gone into adulthood. It was like a last chance, like I was in an age where if I hadn’t experience it then it would’ve never sunk in if that makes sense.... she made a big difference in my life”

“Could you tell me a bit more about that?”

“Because, eh, she genuinely cared like I genuinely believed that. She went out of her way to help me, and, she had like very normal emotions about things like she, I remember I would just talk about things quite causally and she would be like why are you joking about that, it’s not funny, I don’t know, I was quite shut off and she made me a lot less shut off.” (3: 97-110).

Annette describes perceiving that her therapist 're-parented' her. She emphasises not having had any experience of trusting relationships, or feeling cared for in the past and that this experience therefore made a 'big difference' in her life. Annette's sentences appear disorganised and become confused in places. This may represent her current emotional state and difficulties in trying to provide a coherent narrative of her own mental health difficulties. It seems that her therapist was able to model appropriate emotional responses, which seems to have assisted her to share her own emotions, having a profound impact on her life. However, it appeared experiencing a sense of genuine caring from her therapist coupled with the therapist displaying 'normal emotions' increased the therapist authenticity, and played a crucial role in being able to receive and internalise her therapist's healing responses and for therapeutic change and progress to occur.

3.2.4.3. Personal development and growth

The majority of participants described a positive change in their lives, as a result of being in therapy. These changes related to aspects of personal development and growth, including how they viewed themselves and the way they interacted with the world and others, as well as their relationships. This seems to have contributed to the positive changes in their daily lives.

Annette highlights this:

“ I kind of came full circle because, when I was 16, I was a version of myself that was very vulnerable and easily like taken advantage. So I hated that version of myself, and became totally the opposite of that, and almost convinced myself that I was a psychopath so that no one could ever hurt me and I spent 4 years in x (name of therapy service) reversing that till I eventually come back to the point when I was 16, where I was like maybe it's a bit better to be vulnerable and occasionally get hurt than to become

what I became..." (6: 312-317).

Annette described coming full circle and appears to acknowledge the personal development and progress she had made in therapy. She describes hating aspects of herself that were considered 'vulnerable' and 'easily taken advantage' of. She therefore seemed to strive to become the opposite of that. The use of word "psychopath" to describe the person she had become, gives a picture of someone that is unstable, lacks compassion and is able to hurt others. However, becoming this person was perhaps viewed as necessary in order to be able to protect herself from being hurt. It seems that she associates her progress with having been able to embrace aspects of herself that she considered vulnerable; at the expense of not reverting back to what she 'had become'. Although this was experienced as challenging, it was in hindsight described as worthwhile in light of the profound progress and growth that she had achieved.

Participants experiences of personal development and growth also related to a sense of having value, not being at fault, being more confident and empowered, as well as gaining an increased sense of self-acceptance and self-worth.

Margarette's response echoes this:

"I still find it hard (clears throat), to think that I let myself do it. That it happened to me. How would I know any other way? Yea I have let go of it, it's done. I don't hate myself for it now, I don't like it, I don't like the fact it actually happened" (9: 434-437).

Margarette seems to describe her journey of coming to terms with what had happened to her, and its impact on her view of herself. It appeared that although she continued to struggle with feelings of self-blame related to the abuse, she had managed to 'let go of it', to some extent. It appeared that taking into account that she was a child at the time (*'How would I*

know any other way”), lifted some of her feelings of self-blame and shifted this blame to the abuser or perhaps another important authority figure in her life. This appeared to have been of key importance for her process of healing.

Caroline described a similar experience in which therapy helped her to view her experiences in past tense, which seems to have been key in reducing the impact it was having on her. Caroline recalls *this*:

“ What it can do is like she said, it can put the blame where it needs to be, but I still carry a small amount of shame, but I don’t think I am ever going to get rid of that (...) it helps you deal with it in the sense that you don’t dwell on it anymore, its just something that happened, so you can look at in past tense, you don’t even have to think about it anymore, you know it happened but you don’t need to think about, it’s not important anymore” (11: 550 -560).

Caroline highlights how therapy helped her not to ‘dwell’ on her abuse experiences. It appeared that distancing herself from these experiences, and recognising that these experiences were part of her history and not of her current life, made a profound impact on her life, assisting growth and healing. Similar to Caroline, most women felt that they had made positive improvements in therapy, however, they also acknowledged that they continued to experience difficulties in some areas in their lives. For instance, Jane described experiencing continued challenges related to poor self-care, as a result of her experiences.

She recalls:

“It has been massive improvement, I mean there are still things I am quite flaky about, my self-care is pretty poor some days (...) but my self-esteem has improved, I am much more kind to myself (...). I used to very negative about myself, I used to push myself to a level of excellence which I

probably just don't have the energy for most of the time, so being able to sit there and go actually, you are doing ok today, and ok is good enough, it's quite important I think so" (18: 854-862).

Jane emphasised the notion of healing as a process. In particular, she acknowledges areas in which she has made progress, as well as areas that continued to be a struggle, including her poor self-care. It appeared that being more accepting and kinder to herself, including being less self-critical and perfectionist ideals, was considered important for therapeutic growth and healing.

Participants also identified practical implications of their therapy, this included changes related to how they related to and interacted with others, including their relationships.

Amy describes this:

"The relationship I was in, and I was in a very stuck place, and, we split up, we split up just before Christmas, and it was kind of I don't know halfway through therapy maybe, would I have got to that point without counselling, I don't know, but having that opportunity to talk about everything, enabled me to speak my truth and to have the confidence in that relationship, to say you need to step up, so that yea" (10:451-456).

Amy described being in a 'stuck place' and seems to highlight her relationship as a contributing factor to these feelings. She describes ending this relationship, and seems to highlight the importance of therapy in being able to take this step. In particular, she notes that therapy allowed her to talk about and process important issues and that this enabled her to 'speak her truth'. It seems that therapy provided her with an increased sense of empowerment and self-worth, which allowed her to make positive changes in areas of her life that she was dissatisfied with, which was experienced as positive.

3.3. Summary of findings

This chapter has provided an IPA of the interview transcripts of six women. Four superordinate themes were identified to describe the women's experiences of therapy, including 'The help-seeking journey', 'the development of the therapeutic alliance', 'salient therapeutic experiences', as well as 'healing as a process'. Each superordinate theme had a number of sub themes. These themes seem to be interconnected and influenced one another. Overall, the findings indicate that there are a number of serious and on-going gaps in service provision, particularly in relation to accessing and receiving sufficient therapy for survivors. Additionally, it highlights the importance of an individually tailored approach to therapy, encompassing the unique experiences related to the effects of CSA, including a complex interplay of various intrinsic and contextual factors related to these experiences.

4. DISCUSSION

4.1. Introduction

This study set out to explore the experience of psychological therapy amongst women survivors of CSA. Something that became apparent during the analysis and write up process was that the themes that were generated were often overlapping and various quotes could be placed under a number of superordinate themes. However, this overlap of themes was considered to highlight the complexity of therapy experiences of survivors, rather than viewing it as a limitation in the analysis process. Therefore, the themes that are discussed in this chapter are interconnected and aim to capture the richness of the lived experiences of CSA survivors' therapy experiences. This chapter will discuss the findings of the study in relation to the initial aims of the research as well as the context of wider literature. In addition, it will discuss the strengths and limitations of the research, including methodological and analysis consideration, along with reflections on the impact of the researcher on the study. Additionally, implications for clinical practice and policy will also be discussed, along with suggestions for further research and a conclusion.

4.2. Study aims and findings

The findings of this study identified four superordinate themes to describe survivor's experiences of therapy, including 'The help-seeking journey', 'Development of the therapeutic alliance', 'Salient therapeutic experiences' as well as 'Healing as a process'. These themes are not mutually exclusive but provide a framework in which to discuss the findings of this study. Overall, survivors identified both benefits and challenges related to their experiences of accessing and utilising therapy and highlighted organisational aspects of therapy and service delivery, as well as interpersonal and intrinsic factors that impacted this process. The majority of survivors emphasised the significance of a trusting therapeutic alliance. In particular, they identified specific characteristics and relational qualities of the therapist, including aspects related to negotiation of the therapeutic alliance to have been key for the development of a working alliance, therapeutic process and outcome. Women

also identified salient therapeutic experiences including the importance of safety in the therapeutic environment, having access to continuous and consistent therapy, as well as important abuse specific aspects of treatment. Perceived deficiencies in treatment were also identified. These related to missed or unmet needs, as well as suggestions for improvement. The experience of healing was discussed as an on-going process and was characterised by increased insight and new meanings of experiences and abuse. Women also identified a number of healing responses in facilitating therapeutic change, as well as alleviating feelings of self-blame shame and guilt. Women also described changes related to aspects of personal development and growth, including an increased sense of confidence and self-worth and the alleviation of feelings of self-blame. This section will discuss these findings under four main themes, each theme will be discussed separately, with a particular focus on the way the literature was supported or built upon by the present finding.

4.3. Discussion of findings in context

4.3.1. The- help-seeking journey

The women of this study had experiences of utilising a range of mental health services and were able to indicate what aspects of services provision they experienced as assisting or hindering when seeking therapy. The effects of CSA were discussed in the context of these experiences. The problems identified by the women are consistent with previous literature in this field, linking CSA with a range of psychological, social and physical problems (Kaysen, Resick & Wise, 2003; Ruggiero et al., 2004). In particular, women described suffering from depression and anxiety, experiencing flashbacks, dissociating or feeling detached. Some women noted histories of self-harming, substance abuse, and suicidal behaviour. Women also described difficulties with interpersonal relationships and re-victimisation. For instance, Jane described being in an abusive relationship at the time of seeking therapy, whilst Amy noted experiencing difficulties with intimate relationships and intimacy. Margarette recalled struggling with overpowering feelings of guilt related to the abuse and described having a vague understanding of how the effects of CSA continued to impact her adulthood. Caroline

on the other hand reported lacking memories of the abuse and experiencing difficulties as a result of not knowing, which goes in line with previous findings (McGregor et al., 2006). These findings highlight the complexity of the problems experienced by CSA survivors, including variations in symptomology and severity of symptoms that may exist.

The importance of these findings relate to literature surrounding the detection and disclosure of abuse, including its impact on service provision. It is evident that the women were in high levels of distress at the time of being referred to or seeking therapy, despite most being in contact with other mental health or medical professionals. This might indicate that their distress was not recognised in the earlier stages, possibly due to a lack of understanding of symptoms associated to CSA. Other explanations might include findings, which have shown that survivors might experience a lack of willingness to disclose CSA experience, due to feelings of shame or fear of not being believed (McGregor et al., 2010; Robinson, 2000). Additionally, if survivors are not able to link the symptoms to the CSA, they might not be able to articulate their problems to professionals which can lead to delays in receiving treatment, impacting outcome negatively (McGregor, 2003). As a result, it has been suggested that mental health professionals should place particular focus on CSA when performing clinical assessments, treatment plans and case conceptualisation (McGregor et al., 2006). However, given that CSA is associated to feelings of shame, guilt, and secrecy, this study supports previous research which suggested that assessment should be regarded as an ongoing process, rather than a single one-off intervention (Briere, 1992). This is also consistent with abused focused therapy guidelines which suggest that that a full assessment of harmful experiences and effects will take time and rapport building (Briere, 1996; Courtois, 1997). Furthermore, that it is expected that new issues are likely to surface throughout therapy, as trust in the therapeutic relationship deepens (Briere, 1996; Herman, 1992). It is therefore important that the therapist is mindful of factors that might impact disclosure, as well as to develop an environment that facilitates disclosure.

The findings of this study indicate that survivors' help-seeking journey, characterised by patterns of disclosure and pathways for support, is a complex and unique process. However, all women in this study described seeking therapy in relation to or as a direct consequence of being exposed to CSA. For instance, Amy, Margarette, and Caroline described seeking therapy as a result of an increase in severity of symptoms and perceiving that their own coping strategies of managing these symptoms were no longer effective. This is a factor commonly affecting all individuals' decision to seek therapy regardless of whether they have experienced CSA (Manthei, 2005). These women sought therapy in services specialising in CSA with CSA as the presenting issue, questioning previous research, indicating that survivors are more likely to seek therapy with a 'disguised presentation' rather than for their abuse experience (Gelinas, 1983; Herman, 1992). In contrast, Tina, Jane and Annette described lacking choice when entering their first therapy. This was a result of CSA being detected and social services getting involved or as a result of police involvement. These women raised issues of inadequate responses from mental health services; this was particularly evident for women seeking therapy within the NHS where they described organisational and financial founding obstacles, including being denied therapy as a result of not fitting the profile for these services. This goes in line with previous research (Chouliara et al., 2012), which reported procedural/organisational barriers to accessing and utilising services amongst survivors. Women also identified factors that seemed to facilitate help-seeking, including Margarette who identified her GP as essential in being able to identify symptoms of CSA and subsequently refer her to counselling. For others, the availability of local services specialising in CSA and being open about working with the effects of CSA seemed to have helped them to make contact with the service for support.

There has been little research into factors that affect help-seeking, however, previous research by O'Brien, Bateman, and Henderson (2007) indicated that negative experiences associated with this process include long waiting lists, survivors being told they are not a priority, being put on hold, reaching answering machines when making telephone contact,

feeling rushed and not being heard. Additionally, O'Brien et al. (2007) found that participants wanted frontline staff to show understanding to their sensitivity and background. Furthermore, that they were highly sensitive to rejection and that any indication of impatience or diffidence would cause them not to approach the service. This goes in line with the findings of this study, where women described professionals showing inflexibility to their needs and preferences, such as type, frequency and time of appointments offered which were felt to be unhelpful. In addition, some participants reported being contacted at inappropriate times or by different people, impacting them negatively. For instance, Jane described how victim support lines often called at inappropriate times. It appeared that these services showed a lack of flexibility and consideration of her care responsibilities, as the appointment times that were offered were felt to be unfavourable. This study adds to the understanding of help-seeking experiences and shows the impact of intrinsic factors on this process. For instance, Amy described an unhelpful encounter over the phone in which a shift in the professional's tone of voice was experienced as damaging. It seemed that what concerned Amy were the therapist response and beliefs about what her experiences of CSA signifies about her. In this sense CSA experiences could be understood as a highly stigmatising. It is therefore important that service providers have an understanding of the issues that might impact help-seeking for survivors and to show sensitivity to these issues when interacting with survivors. The importance of these findings relates to studies, which has shown that previous negative experiences of therapy, might impact future therapy experiences negatively (Chouliara et al., 2011). More research is therefore needed in order to shed light on factors which might encourage engagement and utilisation of therapy amongst survivors.

4.3.2. The development of the therapeutic alliance

Similar to previous research, this study highlighted the importance of the therapeutic alliance, for the development of trust, safety, self-expression, as well as healing (Chouliara et al., 2011; McGregor et al., 2010; Dale, 1999; Middle & Kennerley, 2001). More specifically, this

study found that women described a number of challenges in their initial therapy experience; this was particularly related to difficulties in the development of trust and safety in the therapeutic alliance. This goes in line with previous studies which show that challenges might occur in relation to establishing effective therapeutic relationships with survivors who have particular tendencies towards a lack of trust (Dale, 1999). Studies have consistently identified that the development of trust is of significant importance when counseling survivors of CSA (Allnock, 2015; Chouliara et al., 2011; Dale et al., 1998; McGregor et al., 2010), as survivors learn at a very early age to be wary of their surroundings and those in it (Leahy, Pretty & Tenenbaum, 2004) and may be cautious of their counselors for a number of reasons (Scaer, 2001). This is consistent with the findings of this study, where women described 'testing' their therapist. This seemed to have been associated to their experiences of abuse, as well as previous damaging experiences related to involuntary endings where trust had been broken. Additionally, talking about their experiences of abuse seemed paradoxical to some, as experiences related to the abuse were characterised by secrecy and mistrust. For instance, Tina highlighted how having to keep the abuse secret had a continued impact on her as an adult. More specifically, talking to her therapist about the abuse seemed to have been an unknown concept characterised by uncertainty and worry. This illustrates the importance of addressing the client's previous experience of therapy, as well as attitudes and biases related to their experiences of abuse, which might contribute to challenges in the development of a trusting therapeutic alliance.

This study adds to the understanding of the development of a trusting therapeutic alliance, and highlights the role of therapist characteristics and qualities, which seemed to have been of key significance for the development and maintenance of the therapeutic alliance, as well as for progress and healing which confirms findings from earlier studies (Allnock, 2015; Middle & Kennerley, 2001). This study indicates that participants found certain therapist characteristics to have facilitated engagement and their ability to communicate openly in session. In particular, facilitative therapy was described as informal rather than formal or

prescriptive. These therapists were flexible, collaborative and inclusive, rather than rigid and directive. This is consistent with previous studies which have shown that survivors identified a preference for a flexible approach over a rigid program of therapy (O' Brian et al., 2007). Generally, helpful therapists were perceived as more authentic and trusting which seemed to facilitate engagement, as well as assisted the therapeutic alliance and healing. In contrast, unhelpful therapists were perceived as authoritative which seemed to have caused distance as well as hindered engagement, self-expression and challenged the therapeutic alliance. Although the value of helpful therapist characteristics for the building of therapeutic alliance has been identified with participants in the general population (Ackerman & Hilsenroth, 2003), this might be of particular importance to survivors of CSA. For instance, Schachter, Stalker, Teram, Lasiu, and Danilkewich (2008) suggest that survivors might show particular mistrust towards authority figures, which might stem from having been betrayed by trusted adults during childhood. It is therefore important that therapists are sensitive to this and take active and ongoing steps in order to demonstrate their trustworthiness by interacting with survivors in ways which facilitate engagement and the development of a trusting therapeutic alliance.

Furthermore, participants identified that they trusted therapists that were perceived as qualified, knowledgeable and confident. This seemed to have strengthened their confidence in the therapist, as well as facilitated adherence to treatment. Similar phenomenon has been found by Schachter, Radomsky, Stalker, and Teram (2004) who found that survivors of CSA expressed a wish for professionals to be understanding and knowledgeable about abuse issues, including showing attentiveness to boundaries and the effects of trauma experiences on the body, as well as the prevalence and sequence of violence. Additionally, some participants in this study identified a preference for working with a therapist that was of the opposite gender of their abuser. This may relate to Barber's (2012) research, which indicates that female survivors who consulted male professionals reported dissatisfaction with their

experience and reported experiencing discomfort disclosing their experiences of abuse. However this is also likely to be related to transference processes, in which feelings and issues from the past might be transferred or projected onto the therapist (Howard, 2000). These transference reactions have specific implications for survivors of CSA, who may perceive the therapist as threatening or abandoning in the same way as the perpetrator of the abuse. Conversely, survivors may idealise the counselor, seeing him as the warm and loving parent they always wanted. It is therefore important that therapists are aware of these processes and how they might impact therapy (Howard, 2000).

In addition, survivors in this study also identified specific relational qualities of the therapist to be of significance for both the development of a therapeutic alliance, engagement and outcome. This has been identified as important with many client groups in the general population (Mikulincer, Shaver & Berant, 2013; Ackerman & Hilsenroths, 2003), as well as with survivors of CSA (Allnock, 2015). However, survivors of CSA appeared to value specific relational qualities in order to move towards healing. In particular, participants seemed to value therapists that exhibited human qualities, including therapists that were warm, genuine, sensitive and had empathic concern. They also highlighted the importance of feeling understood, believed and emphatically listened to by their therapist and this was positively associated to self-expression, engagement and the development of a working alliance, as also identified by previous findings (Allnock, 2015; McGregor et al., 2006; Chouliara et al., 2011). The significance of therapist qualities for survivors is further highlighted by Middle and Kennerly (2001) study, which explored the experience of the therapeutic relationship in clients with and without histories of CSA. It was found that survivors placed more importance on the qualities of the therapist, including the therapist's commitment, being believed and the therapist not showing negative reactions. In contrast, the non- abused clients focused more on the therapeutic techniques and process. The authors suggested that these differences might have reflected particular interpersonal schemas, which could be addressed in therapy.

In particular, by identifying specific beliefs that influence the therapeutic relationship it could assist the identification of universal interpersonal schemas held by survivors. Furthermore, that the therapeutic relationship could provide a means of challenging these schemas and their consequent cognitive distortions. Further research is therefore needed in order to understand the influence of therapist relational qualities on the development of the therapeutic alliance and the process of healing.

Women in this study also highlighted the importance of the therapist assuming a non-judgmental stance. Generally, assuming a non-judgmental stance has been identified as valuable when working with survivors of CSA, who have most likely been judged and further shamed when discussing or attempting to discuss their experiences in the past (Sanderson, 2006). Being believed and not judged has been found to be crucial in whether a therapist was trustworthy and worthy enough of hearing their stories (Anderson & Hiersteiner, 2008; Chouliara, et al., 2011; McGregor et al., 2006). This is reiterated by the findings of this study, where women described the value of a non-judgmental stance in facilitating sharing and self-expression. In addition, the findings of the present study adds to this understanding and indicates that assuming a non –judgmental stance can also be beneficial due to its normalizing effect. For some women, the non - judgmental stance of the therapist seems to have offered reassurance and facilitated a sense of acceptance, which seemed to have been equally valuable for its normalising effect as psycho-education, both in reducing the negative effects of CSA as well as for the development of a trusting therapeutic relationship and facilitated the healing process.

Participants' perspectives are consistent with person centered/humanistic therapy approaches which are underpinned by six conditions, including three core therapist principles: unconditional positive regard, congruence and empathy (Rogers, 1959). From a theoretical perspective, being in an accepting, non-judgmental and empathic environment,

characterised by the therapist's unconditional positive regard towards the client, may bring the incongruent client to begin to accept herself and thereby experience the healing necessary to live a more functional life (Phillips & Daniluk, 2004). A study by Murphy (2009) provides further evidence of the value of this approach. A positive outcome was found in the use of person centered therapy with an adult male survivor of childhood trauma was found, including increased self-worth and sense of being respected, as well as improvements in the ability to engage with employment and maintaining relationships with friends and family. As a result, some researchers have advocated relational models of training and practice for professionals working with survivors of CSA (Chouliara et al., 2012), this is also in line with the findings of this study.

The findings of this study suggest that therapeutic alliance, including the characteristics and interpersonal approach of the therapist, appeared more important to the process of healing than the therapeutic modality, as identified by previous studies (Martin et al., 2000). In particular, it highlights the detrimental effects of unhelpful qualities, such as therapists showing a lack of interest, engagement and judgment. This seems to have contributed to participants holding back or censoring themselves in therapy, as well as causing ruptures in the therapeutic relationship which is consistent with other studies (Chouliara et al., 2012; Dale, 1999; McGregor et al., 2010; Allnock, 2015). Although unhelpful relational qualities have been shown to negatively affect the therapy process with clients in general therapy (Ackerman & Hilsenroth, 2003). This might be of particular importance to survivors who might have experienced previous negative responses to disclosure. For instance, studies have found that survivors who disclose are often disbelieved or blamed by those they tell (Jonzon & Lindblad, 2004; Schachter et al., 2008). Furthermore, that because abuse undermines an individual's personal boundaries and autonomy, survivors might be sensitive to any indication of disrespect or dismissal (Sachacher et al., 2008). It is therefore important that survivors feel accepted and heard by their therapist and that they are not judged. Sachacher et al. (2008)

also suggests that therapists should avoid using false assurances that might be perceived as dismissive or indicate a lack of understanding or their concern. The importance of the present findings relate to evidence –based informed recommendations in which the therapeutic alliance and relational qualities are not necessarily highlighted as key factors for effectiveness of treatment (NICE, 2005), which has been identified as of fundamental importance when working with survivors of CSA (Middle & Kennerley, 2001; Chouliara et al., 2011; Chouliara, et al., 2012; Edwards & Lambie, 2009; Middle & Kennerley, 2001; Sanderson, 2006). It is therefore important that therapists are aware of the importance of relational qualities and characteristics as these seem to be as equally important for the effectiveness of treatment as the therapeutic model and techniques. This study highlights specific characteristics and qualities that assist with the development of a positive working alliance when working with survivors, which can broaden the understanding of effectiveness of treatment, as well as contribute to positive outcomes for survivors.

The findings in this study also emphasises the importance of recognizing how decisions are made relating to the negotiation of the therapeutic relationship and the effect of these decisions on the survivor, the therapeutic alliance and the overall therapy experience. Women in this study highlighted the importance of sound therapeutic boundaries. This related to issues around time and contact between sessions, which provided safety and seemed to facilitate confidence in treatment and the relationship, which is consistent with previous studies (O'Brien et al., 2007; Sanderson, 2006; Schachter et al., 2008). It is suggested that setting boundaries is important for survivors of CSA, as the survivor experienced fundamental violations of their mind, body and spirit (O'Brien et al., 2007; Sanderson, 2006; Schachter et al., 2008). Providing clear boundaries may facilitate the development of trust and safety in the therapeutic relationship (Sanderson, 2006). This was consistent with Tina's account which emphasised the need of having sound therapeutic boundaries, specifically for women that have experienced abuse. She also stressed the

importance of working on collaboration with the therapist in order to establish these boundaries which seemed to reinforce her feelings of safety. Additionally, Tina described the damaging effects of therapists lacking boundaries, including the therapist running over the allocated appointment time, which seemed to contribute to a lack of safety within sessions and was considered unhelpful. This is similar to the findings by Wilcoxon, Remley, Gladding, and Huber (2007) who highlighted the potential impact of a lack of recognition and practicing of professional boundaries. In particular, the authors suggest that this can cause harm to both the survivor as well as the therapeutic relationship by a lack of protection of the client's welfare, reversing the roles of the therapists to the clients, leading to the clients having to care for the therapist and hindering the clients growth as a result of the impairment of the therapist. It is therefore important that therapists manage positive professional boundaries. This can involve a discussion around what mental health professionals can and cannot do and the client's rights and responsibilities (Sanderson, 2006). Furthermore, it can be assisted through regular supervision, as well as the use of personal therapy, in order to address personal issues and process issues that might emerge in therapy (Sanderson, 2006).

The present findings support existing literature on the benefit of client led practice (McGregor et al., 2006; Palmer, Brown, Rae-Grant, & Loughlin, 2001; Schachter et al., 2008). In particular, it was found that survivor's valued therapists that involved them in the treatment decisions, including providing opportunities for making active choices in the structuring of sessions. This seems to have contributed to an increased engagement and adherence to therapy. Client lead therapy has been identified as beneficial, as it allows survivors to feel that they have some control of the treatment (Saakvitne, Gamble, Pearlman, Tabor & Lev, 2000). Participants seemed critical of therapists that did not follow these practices which also seemed to have contributed to resisting the interventions proposed by the therapist, thereby also leading to ruptures in the therapeutic alliance. Mills and Daniluk (2002) suggest that professionals working with survivors of CSA have traditionally embraced more directive

approaches characterised by the provision of instructions, recommendations and explanations in order to promote coping and adaptive behavioral responses. However, some authors suggest that such approaches might contribute to feelings of hopelessness and helplessness and may re-traumatise survivors (Mills & Daniluk, 2002). This is believed to be due to a tendency for survivors to enter therapy with difficulties associated with issues around control, trust, safety and interpersonal relationships (McGregor et al., 2006). This further highlights the need for the client's active involvement in treatment and collaboration with the therapist for increased engagement and outcome.

4.3.3. Salient therapeutic experiences

A key finding emerging from the participants' accounts is the need for a sense of safety in therapy, including the need to work collaboratively with the therapist regarding treatment decisions and the therapeutic environment. Experiencing a sense of safety in therapy has been identified as important in treatment of complex trauma (Brand et al., 2012). For survivors, however, the experience of a sense of safety seems to have been related to practical issues surrounding the therapeutic environment, which contributed to feelings of comfort, safety and feeling cared for and protected. Although this theme shares similarities to the theme 'negotiating the therapeutic alliance', it was felt that this theme, 'safety in the therapeutic environment', was more related to experiences of general aspects of therapy. For instance, based on participants' accounts, qualities about the therapeutic environment which provided them with a sense of confidentiality and anonymity, seemed to have been important for the development of safety. Jane described this in terms of not having to 'sit across a big room' from her therapist and feeling like she didn't have to 'shout out her problems', or experiencing it as though she was 'having a conversation with someone', rather than being in a counselling session. Additionally, the therapist's ability to work collaboratively with the survivor, as well as facilitate a sense of inclusion and equality in the therapeutic relationship was also considered important. For instance, Tina described the benefit of being able to add

personalised objects to the therapy room and how this added to the feeling of it not just being the therapist office but their 'joint space'. This is consistent with previous research (McGregor et al., 2006), which has highlighted the value of consulting survivors over the structure, pace and focus of therapy. Additionally, being treated as equals, listened to and consulted about meanings, contributed to clients feeling empowered. Furthermore, McGregor et al. (2006) found that some clients reported feeling disempowered when they were not treated this way. The findings of this study adds to the understanding of collaborative practice and shows that implicit in the idea of working collaboratively in a safe therapeutic relationship, is the idea of inclusion as well as the therapist's ability to be flexible and respectful of survivors' perspectives, preferences and needs related to the therapy that they receive, as well as the therapeutic environment. This seems to have facilitated a sense of safety and feeling cared for and protected by their therapist which was considered important. Other aspects of the therapeutic environment which seemed to have facilitated a sense of safety includes Annette's description of being in an environment where she couldn't 'physically hurt herself', or having the opportunity to use a side door entrance, as described by Amy. Tina on the other hand, highlighted challenges associated to seeing her therapist in a 'home' environment, which contributed to feelings of discomfort. This further highlights the importance of utilising a collaborative approach and showing sensitivity to such factors and to find ways to apply and negotiate these issues with survivors, in order to facilitate a sense of safety in therapy.

The findings of this study support previous research, highlighting the importance of consistency and continuity in therapy with survivors of CSA (Chouliara et al., 2011). In particular, participants highlighted the value of being able to receive follow up support, the opportunity to extend sessions and not having to change their therapist for the duration of their treatment. In addition, participants who had the opportunity to contact their therapist in between appointments, when on the waiting list or following discharge, identified this as a

positive experience, this also seemed to have facilitated the therapeutic alliance and healing, as it made them feel valued and cared for, as well as supported. One woman (Annette) described the damaging effect of organisational barriers. More specifically, financial funding deficiencies, which contributed to uncertainty related to the availability of the therapist and therapy. This seemed to have impacted on her ability to utilise therapy effectively. The findings of this study highlights the importance of considering factors which might impact on the continuity of therapy for survivors, including organisational barriers as well as issues related to the structuring of sessions and contact with therapist, as these have shown to be important for both the development of the therapeutic alliance, as well as the overall experience of therapy (Chouliara et al., 2011).

Previous research has shown that when talking about CSA experiences, survivors have identified the value of having a therapist that is knowledgeable about abused focused therapy, able to normalise the effects of CSA and able to listen to accounts of CSA, including providing client-directed therapy (McGregor et al., 2006). The current study adds to the understanding and shows that survivors engaged in overt and covert processes in order to gain a sense of control over the way in which their abuse experiences were talked about in therapy. For instance, Annette described engaging in a game like interaction with the therapist, in which she would 'drop hints' about something she knew (i.e. her abuse history) and that the therapist did not know and was 'guessing about', which seemed to have contributed to an increased sense of control for Annette. This might relate to Howard's (2000) observation, which suggests that the survivor's feelings about themselves might also affect the relationship. More specifically, Howard (2000) argued that many survivors experience shame, low self-esteem, self-blame and guilt related to the abuse. This may lead to attempts to distract the therapist from abuse-related issues so that they are not discussed or examined. Therefore, Howard (2000) recommends that the therapist should be aware of and prepared for possible responses of this sort and work to bring them to the client's

attention for discussion (Howard, 2000). Another possible explanation might be that some participants might have used these processes as a way to exercise control, which was in contrast to their abuse experiences, where control has been taken away from them. According to Harper (2006), having a sense of control in therapy is crucial for survivors of CSA as these have often never experienced their own agency in terms of having control. Therefore, some authors have suggested that therapy should involve opportunities in which CSA experience power and control within therapy (Drauker, 2000), as this can allow the client to begin to develop their self-knowledge and choices (Malmo & Laidlaw, 1990). Other aspects of abuse related treatment that were considered helpful included being involved in establishing how and when to talk about their abuse experiences, including having a choice to opt out, as described by Jane. Caroline highlighted the value of being offered a choice in the type of treatment in which she would be discussing her abuse history. It seemed that she perceived her experiences as different to other survivors and related this to the fact that her abuser was a relative, which contributed to greater feelings of shame. These findings further highlight the importance of fostering dynamics which facilitate choice and control over the way in which abuse experiences are worked with.

Participants highlighted a number of inadequacies with their experiences of therapy related to missed or unmet needs. This related to both aspects of treatment and the therapist's ability to identify appropriate interventions or responses. For instance, Caroline believed that a particular intervention proposed by her therapist was unhelpful, to the point where she felt it was inappropriate for her age. It appears that the therapist failed to tailor the proposed interventions to Caroline's individual needs or circumstances. It is therefore important that suggested interventions or strategies are offered in accordance with what the survivor feels comfortable with and will benefit from (Barber, 2012). In addition, some participants described perceiving that the therapist was missing important issues or failing to see the seriousness of the problems. Jane described the negative impacts of her therapist's lack of

exploration. This seems to have led to a sense of missed opportunity for exploration and increased awareness of difficulties. The use of 'meta dialogue' might be useful in order to ensure that the survivor's needs are being met. Studies have shown that talking about the process and experience of therapy, including pace, intensity, helpful and unhelpful strategies, including suggested improvements, have been found to be beneficial (Farber, Khurgin-Bott & Feldman, 2009; McGregor et al., 2006). Some participants also described experiencing that their preferences were not taken into consideration which seemed to have contributed to unresolved issues. Tina on the other hand, described how the presence of suicidal ideation and her therapist's perceived lack of willingness to work with these issues, seemed to cause a rupture in the therapeutic alliance and ultimately led to the decision to end therapy. Studies have shown that providing opportunities to raise and discuss the therapeutic relationship, including possible miscommunications or errors in therapy, is considered beneficial for survivors (Courtois, 1999; Dale et al., 1998). However, although this may facilitate an effective working alliance, it might be intimidating for the survivor who, due to the dynamics of the abuse, might be accustomed to complying with others in fear of rejection or judgment (Dale et al., 1998). The findings of this study highlight the importance of the therapist being aware of the challenges and conflicts that survivors of CSA may experience and to discuss these in sessions. The therapist ability to identify and address these challenges seem to be critical to early engagement as well as for the development of a positive working alliance

Survivors also provided suggestions for improvement. These improvements related to the overall therapy experience, including having access to follow up appointments following discharge, as well as having the opportunity to discuss miscommunication and disagreements with treatment. Whilst this is likely to be important for clients in general therapy, these experiences seem to be related to the dynamics that are related to abuse. For instance, Tina highlighted the need for openness and transparency in the therapeutic relationship, which has been found to be essential when working with survivors of CSA

(O'Brien et al., 2007; McGregor et al., 2006), due to the dynamics of abuse, which are characterised by secrecy. Other suggestions provided by survivors related to the therapist's relational qualities and the need for a sense of intimacy, which is also considered important in other studies with this population group (Middle & Kennerley). Margarette on the other hand acknowledged the role of intrinsic factors in contributing to her needs being missed or unmet, it seems that issues related to the dynamics of CSA, including avoidance related to discussions around abuse history seemed to have been a key factor impacting on therapy.

The present findings also highlight the importance of survivor involvement in the development and delivery of service provision. In fact, studies have shown that drawing on survivors first-hand experience is important in order for staff to gain an increased understanding of survivor –defined outcomes, as well as the long term effects of CSA (Seddon et al., 2012). One such study by Smith et al. (2015) looked at experiences of abuse, satisfaction with services and the availability of information about services, amongst 400 survivors in the UK. It was found that there was a sharp contrast between voluntary and independent sector organizations. More specifically, over 70 % of survivors were more satisfied with the voluntary sector than with statutory sector services, whilst less than 20 % rated statutory services over voluntary services. Furthermore, satisfaction with services was linked to interpersonal qualities and treatment of survivors, including whether professionals made survivors feel listened to, believed and respected. This study also found that poor service experiences could represent as a barrier to further service use, as dissatisfaction with service experiences may cause delays in accessing new services. Additionally, that failing to find satisfying services may lead to survivors utilising more services over a longer period of time than those who receive helpful service responses at the onset. This further highlights the importance of a qualitative exploration of survivor perspectives on therapy.

4.3.4. Healing as a process

Findings from the present study suggest that the experience of healing was described as an ongoing process, which supports previous findings (Barringer, 1992). Survivors described a number of factors that appeared to facilitate this process. In particular, they described gaining an increased insight and understanding of their experiences, allowing them to make sense of the abuse and to relate to oneself in new and more adaptive ways. Women also described experiencing growth through the development of new perspectives and relationships with others. This goes in line with previous research which showed that adults who experienced child abuse, have identified positive change processes related to making sense of the abuse (Woodward & Joseph, 2003). The present study extends these findings and suggests that gaining an understanding of experiences through therapy might potentially be more important to the process of healing, than trauma resolution or symptom management, as found in previous meta analysis reviews exploring healing for sexual violence (Draucker et al., 2009). In particular, women highlighted how therapy enabled them to gain insight into new aspects of themselves that they had previously not been aware of. This allowed survivors to gain a deeper level of understanding of 'the self', others and the world, which was considered helpful. These findings support research that questions the use of symptom measures as the primary assessment of therapy outcome (e.g., Levitt, Stanley, Frankel & Raina, 2005). It might therefore be useful to develop evaluations of therapy that take into account broader ways of defining outcome. This is consistent with the Counselling Psychology, which emphasises the role of subjective experiences and a holistic approach to practice.

However, for some of the women, psycho-education related to abuse experiences was also perceived as valuable as it allowed them to make links between CSA and their difficulties, which appeared to normalise their feelings and behaviours and assisted with coping and healing. In particular, this research has highlighted the importance of providing psycho-

education on the symptoms and behavior associated to CSA and how these symptoms might be manifested, making connections between past experiences of abuse and presenting problems as well as providing alternative ways of thinking about experiences. This allows the survivor to be able to make sense of and understand their experiences, be more accepting of their symptoms, as well as ways to manage these, which is consistent with findings from previous studies (Blumer et al., 2013), highlighting the important role of psycho-education for survivors. Survivors' perspectives are also consistent with CBT models of PTSD (Harvey, Bryant & Tarrier, 2003), which highlights the value of psycho-education in legitimising trauma reactions and the role of anxiety management training in facilitating coping skills and the management of symptoms.

Women also highlighted the value of healing responses in facilitating therapeutic change. In particular they highlighted the important role of the therapist, in facilitating this change. Based on participant's stories, it is evident that the validating and accepting approach of the therapist appeared to have brought confidence in the therapeutic alliance as well as reduced the negative effects of abuse. Generally, validation has been identified as an important intervention tool when working with survivors of CSA. Experiencing genuine validation and acceptance has been shown to be important for change (Woodward & Joseph, 2003). Acknowledging and validating experiences can also maintain engagement in the therapeutic process (Sanderson, 2006), as well as reduce negative effects of abuse (Margolin, 1999; Blumer et al., 2013). Added to the understanding of validation is its role in facilitating self-value and elimination of blame, as validated by the therapist and integrated by the self. In particular, it seems that having their experiences validated, enabled women to consider alternative ways of thinking about their experiences of abuse and reduced feelings of guilt and self-blame by shifting the responsibility of the abuse to the perpetrator. From this perspective, validation might be considered as an offering of alternative interpretations, in order for clients to re-evaluate and thereby withstand the negative effects of abuse.

Sanderson (2006) argued that survivors, who perceive their therapist as invalidating, are likely to have their feelings of betrayal reinforced. This further highlights the value of the present findings in furthering the evidence on the role of validation in reducing negative effects of CSA, including the interpersonal exchanges between the clients and the therapist, as well as the specific variables involved. It is therefore important to employ such principles when working with survivors of CSA.

The current study supports theoretical discussions related to post-traumatic growth (Grossman, Cook, Kepke, & Koenen, 1999) defined as “the individual's experience of significant positive change arising from the struggle of a major life crisis” (Calhoun, Cann, Tedeschi, & McMillan, 2000). Participants’ reports of personal development and growth related to significant shifts and improvement in functioning as well as change in self-perception. This included, perceiving themselves as having value, being able to accept what happened, as well as forgiving themselves for their behaviors, was also dominant among women’s reports of growth. Women also described gaining new perspectives on life as a result of healing. In particular being able to consider their experiences within a context, as well as acknowledging that the abuse was part of their history, and not their current life, which seemed to have reduced the negative effects of CSA, particularly related to shame and self-blame. These findings are consistent with Johnco, Hofmeyr and Berry (2016) research exploring post-traumatic growth with adult survivors of CSA. In particular they found that growth was complex and multifaceted in this group of participants and involved elements of making sense of the abuse, and learning ways of relating to oneself in new and more adaptive ways as well as through experiencing healthy relationships with others.

The findings of this study extend these results to emphasise the role of shame and self-blame which contribute to continued difficulties in the survivors’ lives. In particular, women described positive changes associated to and being able to move away from positions of self-blame and shame and assign blame to the perpetrator. The importance of this is further

highlighted by Lev-Wiesel's (2000) qualitative study. Findings from an analysis of 52 adult survivors of CSA revealed that those who attributed blame to the offender reported more a positive adjustment and higher self-esteem than those who assumed blame or blamed situational factors. The present findings also suggest that positive changes related to development and growth also occurred in conjunction with an increased sense of empowerment, self- acceptance and self-worth. This highlights the importance of psychological interventions that focus on empowerment and the development of self- acceptance and self-worth in order to enhance the process of healing and growth, following CSA experiences, as opposed to those interventions solely focusing on symptom management. For instance, Schachter et al. (2008) suggests that survivors should be supported with developing core skills, such as decision making, building self- esteem, assertiveness and asking for help. Additionally, issues surrounding the establishment of healthy boundaries and self –nurturing should also be supported.

The women in this study also associated their experiences of development and growth to positive changes in self -care practices, being less critical of the self and recognising the progress that they had made. In addition, positive changes in their interactions with others, including their relationships, were also considered to assist healing; this is consistent with other studies (Joseph & Linley, 2005). In particular, this was related to learning to assert their needs, as well as having the confidence to end relationships that were perceived as harmful. However, although participants recognised the growth they had made, the majority of participants described healing as an ongoing process and highlighted the need for further treatment. This goes in line with previous research (Banyard & Williams, 2007; Schachter et al., 2008) which suggests that healing should not be recognised as a linear process and that ongoing support may be required (Schachter et al., 2008). It is therefore important to provide opportunities for continuous support, as well as to show sensitivity to factors which facilitate healing for survivors.

4.4. Recommendations for clinical practice and policy

A number of practical implications related to policy and clinical practice can be drawn from the findings of this study. The following section aims to summarise the key findings from the survivor's narratives, under three main headings; 1) the help-seeking journey, 2) clinical implications, including assessment and psychological interventions and 3) policy implications. It is hoped that this will provide a useful framework for informing recommendation for the clinical practice, policy and service provision.

4.4.1 The help-seeking journey

The findings of this study highlight the importance of acknowledging survivors' individual help-seeking journeys, which are often unique and complex. In general, present service provision seems to be inflexible and lack responsiveness to survivors' life circumstances, personal preferences and needs, resulting in their needs being missed or unmet. Derived from the survivors' narratives are a number of organisational and service barriers impacting help-seeking, and the utilisation of therapy, causing delays in receiving treatment as well as impacting on survivors' ability to receive sufficient therapy. This included ineffective and inappropriate referrals, limited treatment options, as well as a lack of involvement and choice when accessing therapy, contributing to a sense of powerlessness and disengagement with therapeutic services. Financial funding deficiencies and service restrictions contribute to further challenges for survivors. The importance of services specialising in the effects of CSA in assisting help-seeking was recognised by survivors. Staff being able to recognise the symptoms of CSA and make appropriate referrals for support, was also considered to facilitate help-seeking.

The findings of this study highlight key areas that the organisations and service provision for survivors might be improved. This includes the need to address financial funding deficits in

order to increase access to specialised services for survivors, particularly in the NHS. The need for more secure funding for services delivering therapeutic treatment to survivors of CSA is essential, as this will ensure that survivors receive sufficient and continuous support that will facilitate healing. Whilst specialist services might be better able to meet the needs of survivors in the current economic climate, it is unlikely that resources will materialise to fund their growth to the required level (Allnock et al., 2009). It is therefore important to recognise that a therapist without specialised training will work with survivors of CSA. As a result, it is important to strengthen the partnership between statutory and third sector organisations, including the establishment of robust referral protocols and pathways as this can reduce delays in the provision of therapy, provide continuity in treatment, as well as address issues related to service restrictions. If frontline staff are aware of existing support services available to survivors and utilise established referral and signposting pathways to direct survivors to appropriate services, this can improve service delivery for survivors. A particular emphasis should be put on establishing relationships with services specialising in CSA, including third sector organisations, as survivors have identified these services as particularly useful. Partnerships working across key agencies will also allow providers to share their knowledge and skills and thereby improve service practice for survivors.

Additionally, there is a need to offer more flexibility in delivery of service and accommodate different preferences and needs of survivors. This includes providing a range of appointment times, as well as treatment modalities and types of therapy. Survivors should be actively involved in deciding what therapy will best meet their needs and their life circumstances should be taken into account and the implications of this should be acknowledged and discussed in therapy. Lastly, in order to improve some of the obstacles highlighted by survivors related to the current service provision, future training should increase awareness and knowledge related to organisational or practice barriers that might exist for survivors, in order to improve service provision and encourage joint working across agencies.

4.4.2 Clinical implications

4.4.2.1. Assessment

Survivors reflected on their expectations of therapy services in wanting the therapist to assist them in making sense of their childhood experience, including making links between past and present difficulties. In addition, survivors described wanting to address negative behavioural patterns, as well as learn to move on from their experiences of abuse. Despite having clear goals and preferences for therapy, their initial therapy experiences did not seem to effectively meet their needs, particularly those needs arising from their experiences of CSA. In addition, many women did not disclose their experience of abuse in their initial therapy experience, whilst others sought therapy several years after the abuse had taken place. This is consistent with previous research by Read, McGregor, Coggan and Thomas (2006), which showed that survivors of CSA are often reluctant to spontaneously tell professionals about their experiences of abuse. More specifically, of the 191 women who had received counselling for CSA, the average time taken to disclose their abuse was sixteen years.

The findings of this study suggest that experiences of CSA should be an integral part of practice when Counselling Psychologists and other mental health professionals assess clients, derive formulations of clients presenting problems and needs, as well as make treatment plans. Based on the Ackurland Health Board (2000) the best practice document for trauma and sexual abuse, in New Zealand two guiding principles have been provided to ensure effective routine mental health assessment, that incorporates exploration of trauma history, including 1) ensuring assessments of clients including questions about possible trauma and sexual abuse in order for appropriate therapy to be made available. 2) Clinicians should routinely ask about the history of trauma, especially trauma that might have occurred during childhood (Auckland District Health Board, 2000). Furthermore, Young, Read, Barker-Collo, and Harrison (2001) survey of psychologist and psychiatrist exploring the most

appropriate time to ask about abuse history, found that 62 % of professionals chose to ask about abuse history 'once rapport had been established', 47 % chose to ask "usually on admission/initial assessment, unless the client is too distressed". More research is needed on the experience of disclosure amongst survivors, including identifying helpful and unhelpful practices in order to facilitate disclosure.

Although the findings of this study indicate the importance of routinely asking abuse history, in order to be able to incorporate this in formulation and treatment plans and to effectively address the client's needs. Given that experiences of abuse are often associated with shame, guilt, secrecy and self-blame, this study supports research which suggests that assessment should be regarded as an on-going process and not as a one-off intervention (Briere, 1992). This also goes in line with abuse focused therapy guidelines, which suggest that a full assessment of harmful experiences and effects require time and rapport building (Briere, 1996; Courtois, 1997), furthermore, that new information and issues are likely to surface throughout therapy, as trust in the therapeutic relationship strengthens (Briere, 1996; Herman, 1992). Mainstream mental health services should also begin to record abuse history, as part of the assessment process. More specifically, recording should indicate the professional's response, including referrals that might have been made, or reason for lack of response. This will inform services of the scope of the CSA population utilising services, provide an understanding of demand experienced by mental health services, as well as allow for follow up interventions to be taken and for therapeutic support to be made available that meets the particular needs of survivors (Seddon et al., 2012)

4.4.2.2. Psychological interventions

The findings of this study highlight the value of an integrative approach to therapy when working with survivors of CSA. Findings suggest that therapy should be client led and

psychological interventions should be employed based on each survivors needs. Furthermore, it might be useful to provide psycho-education to clients about the nature of CSA and its effects, and work collaboratively in order to integrate new learning into their overall perspectives. The experience of gaining understanding of feelings and experiences and a subsequent greater sense of management over symptoms is similar to the CBT model (see Harvey et al., 2003), which might be particularly useful in normalising experiences as well as reducing negative effects of abuse. Furthermore, Counselling Psychologists should discuss topics related to self- blame, shame, guilt, self, relationships, as well as the impact of trauma on survivors' lives and healing. In addition, the findings of this study highlights the value of validation, as provided by the therapist in normalising survivors' experiences of abuse and reducing the negative effects of CSA, particularly related to feelings of self-blame, guilt and shifting blame to the abuser. In fact, previous studies have shown that interventions that seek to address self –blame can have a positive impact on post- traumatic symptomology and functioning (Daigneault, Hebert, & Tourigny, 2006). In addition, the modelling of appropriate responses by the therapist, might work to facilitate the expression of feeling, increase self –confidence and promote healing. Other interventions that might be helpful include self-care practices, discussions around risk and ways to keep safe.

It has been argued that CSA survivors are particularly vulnerable in therapy due to the power differential between therapist and clients (Sanderson, 2006). This is consistent with the present findings. It is therefore important that power, powerlessness and control should be central issues of exploration during the recovery process with survivors. Furthermore, therapists should aim to assist their clients in regaining a sense of power, including exploring ways to exercise power in an effective way (Sanderson, 2006). Schachter et al. (2008, p.18) provides further suggestions on this topic. They argue that a central aspect of abuse experiences is the loss of control over one's body, having a sense of control is crucial for the development of safety. Schachter et al. (2008) therefore highlights the importance of using

therapeutic contracts as a tool for articulating goals, clarifying roles and responsibilities and defining the parameters of the therapeutic relationship. Furthermore, that these issues should be explicitly discussed as part of the treatment plan in order to minimise miscommunications and misunderstandings and increase trust. Survivors should also be encouraged to actively participate in decisions regarding their treatment (Schachter et al., 2008).

The development of a trusting therapeutic alliance should be of primary importance when working with survivors of CSA, as described by the participants in this study. A trusting therapeutic alliance depends on the therapist's ability to respond empathically, show understanding and have a non-judgmental approach. In addition, certain therapist characteristics and qualities also seem to be important for the development of a trusting therapeutic alliance, including those therapists that were perceived as flexible, inclusive, congruent and those that were facilitating choice and involvement in treatment. These responses mirror the principals of humanistic and person centred modalities, characterised by three core conditions of empathy, unconditional positive regard and congruence (Rogers, 1959). It might therefore point to the usefulness of relational models, when working with survivors of CSA. Furthermore, whilst some participants noted the benefit of specific techniques used in therapy, most survivors identified 'non-specific' factors of therapy to be of most importance for the therapeutic process and healing, which has also been found in previous research in treatment with the general population (Chatoor & Krupnick, 2010). Greater transparency related to the therapist's decision making process and ways working might also be useful, including discussions around process issues and intrinsic and extrinsic factors that may impact therapy. In fact, studies have shown that transparency is essential when working with survivors of CSA (O'Brien et al., 2007; McGregor et al., 2006), due to the dynamics of abuse, which are characterised by secrecy. It has therefore been argued that therapist should explain the process of therapy, set clear therapeutic boundaries, and

explore the survivor's expectations of therapy. Additionally, providing information about the therapeutic process at the onset is considered to be of value as it might decrease anxiety about engaging in therapy (McGregor et al., 2006; O'Brien et al., 2007; Schachter et al., 2008).

The perspectives of survivor's experiences of therapy are consistent with a range of treatment modalities, including CBT, Pluralistic, Psychodynamic and Humanistic theory and treatment. Current NICE guidelines on treatment for PTSD recommend evidence-based treatments such as CBT and Eye Movement Desensitization and Reprocessing (EMDR) therapy. However, these treatments on their own might not be able to address the complexity of symptoms experienced by CSA survivors. Instead, an integrative approach to therapy may be more adequate in meeting the unique needs of survivors. Additionally NICE guidelines recommends 8 -12 sessions to be offered. However this does take into account the time required to develop a therapeutic relationship, as studies have shown that survivors might face particular challenges in establishing therapeutic relationships (Dale et al., 1998). Integrative treatment modalities that might be helpful include, Schema therapy and theory, which integrates aspects of Psychodynamic, Cognitive Behavioural and Attachment theories (Young, Klasko & Weishar, 2003). DBT, which uses principles of DBT and trauma focused approaches, has also shown to be effective. In particular, DBT for PTSD aims to assist clients in reducing fear of trauma associated primary emotions, question secondary emotions such as guilt and shame as well as radically accept trauma facts (Steil, Dyer, Priebe, Kleindienst, & Bohus, 2011). Overall, this study highlights the importance of adopting an integrative approach to therapy, ensuring that sensitivities related to intrinsic and contextual factors are considered, as well as ensuring that decisions around therapy are collaborative and chosen based on the survivors needs.

4.4.3 Policy implications

4.4.3.1. Increasing awareness

The findings of this study highlight a number of gaps in current service provision for adult survivors of CSA. A number of implications related to policy can be drawn. Firstly, it is important to increase awareness and understanding of the effects of CSA. This should be included in routine mental health training as well as accredited training across health and social care professionals (NHS Highland Council). Some useful guidelines exist, including 'Survivor Scotland', which is a national strategy for CSA (Scottish Executive, 2005). Survivor Scotland aims to enhance the health and wellbeing of survivors by raising awareness of CSA and its long-term outcomes, as well as investing in the continued improvement and expansion of services, including overseeing a national training programme for frontline staff. In addition Nelson and Hampson (2008) "Yes you can" guideline as well as Sneddon, Wager and Allnock (2016) evidence review '*Responding sensitively to survivors of Child Sexual Abuse*' also provides valuable guidelines for professionals working with survivors of CSA. Despite the usefulness of these guidelines, there is a lack of existing training materials as well as professional development programs across the UK. Professional conferences devoted to the discussion of proposed reforms and treatment options are also needed in order to increase awareness of the effects of CSA, and improve service provision for survivors. Additionally, It is essential that training and awareness rising of the effects of CSA, including appropriate treatment responses are integral to supervision as well as professional development courses across social and healthcare professionals (Seddon et al., 2012).

In addition, studies have highlighted that knowledge gaps and misconceptions about CSA are not limited to social and healthcare professionals. The lack of knowledge about CSA is widespread amongst the general public (Cromer & Goldsmith, 2010; Fontes & Plummer, 2010) as well as professionals, and opinion leaders (Shackel, 2008) Yet, increased

awareness of CSA is essential for both recognition and prevention strategies. At the individual level, awareness must be developed in the survivors themselves; this includes increasing the awareness of the effects of CSA, as well as the connection between experiences of abuse and presenting problems. It is also essential to increase awareness of CSA amongst professionals in education, law enforcement, social welfare, and other organisations, as these are often the trusting adults that survivors disclose to, and seek support from (Mathews & Collin-Vézina, 2016). At an institutional level, it is important for managers of social and health organisations to develop an understanding of CSA and its impact, and to establish clear policies regarding abuse identification, prevention and responses, including the establishment of robust referral pathways (Mathews & Collin-Vézina, 2016). At a societal level, awareness is necessary in religious and community leaders, government and judicial organisations as well as the general public. The key components of awareness-building efforts should include, what CSA is and its prevalence, the effects of CSA on survivor's social physical and mental health functioning, as well as the non-tendency of and barriers to disclosure. Enhanced public awareness through media campaigns should also be a priority (Mathews & Collin-Vézina, 2016), and there is also a need for a national strategy for survivors of CSA in England (Seddon et al., 2012).

4.4.3.2. Survivor involvement

Survivors of CSA should be actively involved in assessing the effectiveness of therapeutic services and other service provision and policies. Survivors' perspectives are crucial in the development of effective service provision, as well as for the development of the evidence base related to the effectiveness of therapeutic services and support (Seddon et al., 2012). To date, there have been limited national initiatives exploring survivors' perspectives of services. However, a recent national survey 'The focus on survivors' developed by Smith, Dogaru and Ellis (2015), as part of survivors in transition and the survivor's trust, provide useful information on survivors' perspectives on services. In particular the survey explored experiences of abuse, satisfaction with services and the availability of information of

services. Despite the usefulness of this study, more research is needed in order to gain a better understanding of survivor's experiences of therapeutic services and to inform the clinical practice.

4.4.3.3. Visibility and partnership working across agencies

Partnership working across agencies is essential in order to provide effective support for survivors. Pathways of care that connect primary care services, statutory and voluntary services will allow for effective treatment aimed at survivors to be integrated into existing service provision (Seddon et al., 2012). More specifically, it will allow for appropriate signposting, to more intense therapeutic support and specialised services for those survivors that have been identified as requiring specialist support or deemed as not fitting into the profile of a particular service. In addition, working in partnership with local services, including GPs, which are often the first point of contact for survivors seeking help, as well as other services specialising in CSA is essential (Scottish Executive, 2003; Seddon et al., 2012). In addition, the visibility of service working with survivors of CSA is important. Psychological services should make it explicit that they provide support for survivors of CSA and this should also become an integral part of performance management for mental health services.

4.5. Methodological and Analysis considerations

4.5.1. Methodological considerations

This study has contributed to furthering the understanding of women survivors' experience of psychological therapy. However, a number of limitations need to be considered in relation to the design and procedure of the study. Specifically, although information on ethnicity, age and duration of therapy was collected for each participant, information on history of abuse, including duration of and type of abuse, age at which the abuse occurred or relationship to the abuser was not recorded. It was believed that such information would be too intrusive,

and possibly affect willingness to participate in the study. However, studies have shown that these moderating factors may impact outcome, the generalisation of findings is therefore limited. Additionally, this study consisted of female survivors of CSA, and the majority of participants were of white British nationality. Thus, generalisability cannot be made for other gender, ethnic and cultural groups. Secondly, this study used a number of exclusion criteria, which might have impacted the findings. More specifically, participants that were not in therapy at the time of the study, had an on-going court case related to the abuse or expressed suicidal or self-harm thoughts were not included in this study. Thus, generalisability of findings to clients with multiple presenting problems might be questionable. However, the purpose of this research was not to obtain knowledge that can be generalised but rather an in depth understanding about the phenomena under investigation

The selection procedure involved therapists identifying appropriate clients, which might have contributed to selection bias. More specifically, some therapists might have had some concerns that the research was an evaluation of their skills as a therapist, which might have led to them choosing clients that were further along in their healing journey or selecting certain clients over others. However, to minimise such bias, this study only recruited participants that were not in therapy at the time of the interview and interviewed participants about a vast range of therapy experiences. The participants in this study provided a balanced account of both helpful and unhelpful experiences of therapy, which might indicate that the therapists did not only refer clients they deemed had been 'successful' in therapy. Another limitation of this study relates to the use of qualitative interpretation. Although the researcher made every attempt to carry out an objective analysis, (i.e. following validity and quality guidelines for qualitative research, including the use of triangulation) an implicit bias might have been present in the interpretive process (See Methodology chapter for in depth discussion). Other researchers might have interpreted and identified different themes in the data. However, the nature of qualitative research and in particular IPA, does not claim

complete objectivity, rather it sees the researcher as an integral part of this process (Smith & Osborn, 2003). This study explored retrospective experiences of therapy, with a reconstruction of past events from memory. Therefore, there might have been a memory bias in the recall of experiences, depending on participants' state of mind. However, all participants interviewed had come far along their healing journey and did not report high levels of distress at the time of the interviews, and thus were more likely report their experiences from a more reflective stance.

4.5.2 Analysis considerations

Willig (2013) describes three main limitations of IPA research, including the role of language, the suitability of accounts and explanation versus description. This following section will discuss these limitations in more depth, and how it relates to this specific study. According to Willig (2013), phenomenological analysis relies upon the representational validity of language. This study utilised semi structured interviews in order to collect data. As such, language was the means participants communicated their experience to the researcher. According to Willig (2013), it can be argued that language constructs, rather than describes reality. This means that language cannot give expression to the experience; rather, it adds meanings that reside in the words themselves, which makes having direct access to someone else's experience impossible. From this perspective, an interview transcript tells more about the way in which an individual talks about a particular experience within a particular context, than about the experience itself. According to Willig (2007), the conceptualisation of language in much phenomenological research can be criticised for lack of sufficient engagement with its constitutive role.

Secondly, Willig (2013) highlights that the aim of IPA is to capture the experience and meanings of a particular phenomenon, rather than to identify the individual's opinions about

it. As such, it raises the question, to what extent a participants' account constitutes a suitable material for phenomenological analysis (Willig 2013). Furthermore, according to Willig (2013), the phenomenological research method is not suitable for the study of the experiences of those who are not able to sophisticatedly articulate them, as required by the method. As such this limits applicability of the phenomenological method. The participants in this study varied in educational level and ethnic background. However, all participants showed a high level of sophistication in their accounts, and provided in depth descriptions of their lived experiences.

Lastly, Willig (2013) highlights that phenomenological research aims to describe and document the lived experiences of participants, rather than explain it. Furthermore, that in order to move beyond sharing an experience with the participants and to understand their experiences, one needs to be aware of the condition that gave rise to these experiences. Furthermore, that without concern for their cause or origin, this limits understanding of the phenomenon. Such conditions might according to Willig (1999) be found in past or recent histories, or the social and material structures within the individual's lives (Willig 1999). Despite some potential limitations, one of the strengths with IPA research relates to its recognition of the impact of contextual factors on how meaning is constructed by an individual. This was considered particularly valuable for exploring women survivors' experience of therapy, as it allowed for reflections on the influence of social, contextual and cultural factors and how these related to participants experiences of therapy.

4.5.3 Impact of researcher on study

This section will discuss the impact of the researcher on this study. It will consider the issues identified in the initial reflexivity of this research (See Methodology chapter) and how it relates to the study that was conducted. According to Brocki and Wearden (2006) there is a

lack of advice on how much interaction the researcher should have with the participants, including when interpreting data within the interview which has led to variations in the amount of quality and depth of the information provided. Although the researcher experienced challenges related to setting up an interview schedule, particularly in relation to avoiding the presence of interpretive suggestions that are in accordance with the researcher's experiences and worldview, the final interview schedule seemed open and free from suggestions. However, during the interview itself, suggestions ("Did that have an impact on how you experienced therapy") and interpretations ("it sounds like it was more of a collaborative approach") seemed to have been provided. Although this might have been related to the researcher's clinical and theoretical knowledge of working therapeutically with survivors, it is believed that this was largely due to the lack of experience of conducting IPA interviews. It is also likely that the researcher's experiences, beliefs, standpoints and worldview impacted on the analysis procedure, interpretation and development of themes. According to Smith (2009), analysis should be informed more by general psychological interest, rather than being approached from pre-existing formal theoretical positions. This was a particular challenge experienced by the researcher during the initial stages of analysis process, as the researcher seemed to have approached interpretation from pre-existing theoretical positions. However, upon familiarisation with the transcripts, and bringing to the fore participants accounts, the researcher was able to understand the participants' lived experiences in a phenomenological sense, and was able to identify themes that were close to the participants' accounts.

4.6. Future directions for research

This study focused on the experience of psychological therapy amongst women survivors of CSA. Future studies should explore male therapy experiences, in order to compare differences/similarities across gender. Similarly, the sample of this study consisted mainly of participants from white British backgrounds, with the exception of one participant who was of

an Asian background. Previous research has indicated that racial, cultural and religious factors may relate to differences in CSA disclosure (Alaggia, 2001; Ramos-Lira, Koss, & Russo, 1999). Furthermore, that survivors from other 'non-white' ethnic groups might present with specific needs related to familial dynamics (Gilbert, Gilbert & Sanghera, 2004), the pressure to marry (Ayyub, 2000), and issues related to gender hierarchical relationships in the family (Sonuga-Barke, Mistry, & Quereshi, 1998). Future research should therefore include participants from varied ethnic and religious background, in order to be able to generalise findings to survivors from other ethnic and religious groups. The findings of this study highlight the unique experiences of CSA survivors, in contrast to studies that have focused on therapists' perspectives. Research suggests that survivors' perspectives of therapy may differ from those of therapists working with survivors of CSA (Chouliara et al., 2012). Future research should therefore explore multiple perspectives of therapy, incorporating both survivors' and professionals' perspectives, which may contribute to a more comprehensive understanding of CSA survivor experiences in therapy.

Lastly, the findings of this study identified the therapeutic alliance as an important component in therapy for survivors of CSA. However, these findings also indicate that there might be a number of client variables that can assist or hinder the therapy process. Thus, future research on the experiences of therapy should explore factors which may mediate therapy experiences and outcome, including the role of intrinsic factors arising from participants' abuse experiences, such as experiences of shame, self-blame, and guilt, and how these relate to the utilisation of therapy. Furthermore, factors such as previous negative experiences of therapy and the presence of organisational barriers, and their influence on subsequent help-seeking behaviour and therapy experiences should also be explored.

4.7. Final thoughts

The experience of carrying out this research has been a challenging, but more often insightful and rewarding experience. My aim with this research was to gain an in-depth understanding of women survivors' experience of psychological therapy. When I embarked on this journey I had limited knowledge about the unique experiences and needs of survivors. However, my previous experience of working with this client group became a useful tool in this process. In particular, I was aware of the sensitive nature of this topic, as well as the need to approach the recruitment and interviewing process with care, and a sense of responsibility and confidentiality. The majority of women expressed a genuine interest and engagement in the interview stage. They shared both helpful and unhelpful experiences of therapy, and provided in-depth and emotional accounts of their therapy journeys. However, some challenges occurred during this process. In particular, it was challenging to find a balance between asking about participants' experiences of 'talking about abuse history' in therapy, without going into descriptions of the actual abuse. I therefore paid close attention to the women's responses, in order to steer back focus towards the experiences of therapy in instances where it was felt that women were sharing specific details about the abuse. I noticed that many women were reluctant to provide in-depth answers related to this question, which indicated to me that it was a particularly difficult and challenging experience to share in the interview. I therefore asked limited follow-up/probing questions, as I wanted to allow women to only share experience they felt comfortable with. This was received well, and participants did not seem to show any signs of distress when talking about this section of the interview. However, some women did cry during other stages in this process, often in response to expressing the gratitude they felt towards the services and therapists that provided them with support at a time in need. This was a very impactful experience, both for the survivors, but also for me as a researcher, as it highlighted the crucial and often life-saving role therapy had on their lives.

The final section of the interview focused on how the women felt therapy had impacted on their current lives. This question was designed to assist the participants to re-connect with their strengths and to acknowledge the progress they had made. I was struck by the strength and resilience many of these women had shown in the face of very difficult and traumatic experiences. Survivors were also asked about their experience of participating in the research. The women expressed that it had been a beneficial and rewarding experience, and the majority also noted that it had had a therapeutic value, as they were able to consider how much they had achieved throughout their therapeutic journeys. The last question that was included provided women with an option to share some words of advice to other survivors that were looking to start therapy. Their responses were wide ranging. However, I was struck by participants' level of insight, emotional content, and drive in sharing advice in relation to their experience of therapy. This not only confirmed my belief in the importance of engaging survivors in the evaluation and development of therapy, but also strengthened my commitment to ensuring that client feedback is an integral part of my practice as a Counselling Psychologist.

In summary, whilst this study has shown how complex and often challenging therapy can be, it also highlighted how valuable therapy can be for survivors. I would like to conclude this section by sharing some words of advice provided by the women to other survivors who are seeking to start therapy. Many highlighted the important role of the therapist in this process.

This can be summed up in the words of Margarete:

"Don't be scared, feel the warmth coming from your counsellor, because it is warmth that comes from the counsellor, and just talk. Just talk, and the counsellor will usually guide you if you are going in the wrong direction; they usually push you back on course, that kind of thing. Just listen to your counsellor and like yourself"

4.8. Conclusion

This study has contributed to the understanding of adult women survivors' experiences of psychological therapy. It has highlighted the challenges related to seeking and accessing therapy. In particular, services were often perceived as inflexible and non-responsive to survivors' lived experiences, preferences and needs. Inappropriate referrals, financial constraints, and delays in receiving sufficient therapy further contributed to challenges associated with this process. Factors assisting help-seeking included professionals being able to identify symptoms and make appropriate referrals for therapy, and the availability of local services specializing in CSA was also considered to assist help-seeking.

This study suggests that the initial therapy experience and/or contact with therapist was challenging for the majority of respondents. This included challenges in establishing a therapeutic alliance. Issues relating to trust and seeking safety seemed to have underpinned these difficulties. Furthermore, it highlights that past negative experiences of therapy may contribute to challenges in future therapy experiences, creating potential barriers for future support. A number of therapist characteristics and qualities were identified as significant; being believed and not judged was considered important in order to be able to open up in therapy. This was also central for the development of a positive working alliance, and for the survivors' individual process of healing.

Women also identified salient therapeutic experiences related to their general therapy, including the importance of safety in therapy, having a sense of continuity and consistency in treatment, as well as important abuse-specific aspects of therapy. Perceived deficiencies related to missed or unmet needs were also identified, as were suggestions for improvement. The healing journey, as characterised by increased insight and understanding, healing responses and therapeutic change, as well as personal development and growth, were

complex and unique. Nevertheless, the majority of survivors described healing as an ongoing process, and women described requiring further therapy for the effects of CSA. Overall, this study highlights the importance of an individually tailored approach to treatment, encompassing the unique experiences related to the effects of CSA, including a complex interplay of various intrinsic and contextual factors related to these experiences.

4.9. References

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**It can be consulted by Psychology researchers on application at
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APPENDECIES

Appendix A

Interview schedule guide

Demographic Information:

- Age, Gender, Ethnicity
- Duration of therapy for the effects of CSA,
- Time passed since ending/completing therapy

Before therapy:

1. **What motivated you to participate in this study?**

2. **Could you please tell me what first led you to seek therapy?**
 - How did you feel at the time?
 - Did you have any hopes or expectations about therapy prior to starting? If so what hopes/expectations did you have?

- **Could you describe the process you went through of finding or being referred to a therapist.**
 - What was this experience like?
 - Was there anything that was particularly helpful or unhelpful about this process, if so what?

During therapy

3. **I would like to explore your experiences of the therapists you met?**
 - The initial contact with the therapist, what was it like?
 - How did you feel?
 - How would you describe your therapist's style/approach in therapy?
 - How did you feel about his/her approach
 - What did you find most helpful in your time together with your therapist
 - What did you find most unhelpful in your time together with your therapist
 - Why was that helpful/unhelpful?
 - Did you talk about your experiences of CSA in therapy; if so, how did you feel about the way your experience of CSA were addressed/talked about in therapy?

4. I would like to find out about your experiences of being in therapy as a whole?

- Was there anything you found particularly important about therapy, if so what?
 - Why was that important?
- How did you feel about the setting in which the therapy was conducted?

After therapy:

5. I would like to move on to exploring how you feel therapy has impacted on your life in general?

- Do you feel that the areas/difficulties you initially sought therapy for changed during therapy, if so in what way?
- Do you feel that any other areas that were affected, if so how?
- If yes, what do these changes mean to you?

6. Looking back at your therapy experience, what advice would you give to other survivors who are looking to start therapy?

7. Lastly, what has it been like to share your experiences of therapy today?

Appendix B

Information sheet



Title of study: The most important thing in therapy is the relationship: *Women survivors of Childhood Sexual Abuse describe their experiences of psychological therapy*

I would like to invite you to take part in a research study. 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 us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

My name is Adela Mrkaljevic, and I am a Doctorate student on the Professional Doctorate course in Counselling Psychology at City University. I am conducting an interview-based study to learn about women survivors' of child sexual abuse, experience of using Psychological therapy, and would like to request your participation in this study. You have been chosen because you have received therapy for the effects of child sexual abuse, and have expressed an interest in this study.

Do I have to take part?

Participation in the project is voluntary; it is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. You can choose to stop the interview at any time, or skip any questions you don't want to answer. You can withdraw at any stage of the project without being penalised or disadvantaged in any way. There are no right or wrong answers, and some topics may be difficult to discuss, but many women have found it useful to have the opportunity to talk about their experiences.

What will happen if I take part?

If you agree to take part, you will be given a choice of venues in which the interview will take place. The interview will take approximately 60-90 minutes to complete, and the study will be fully explained at the end of the interview. The interview will be audiotaped and used for the write up of this study. Your participation is completely voluntary, but your experience could be very helpful to other women survivors of childhood sexual abuse.

Will my taking part in the study be kept confidential?

Personal information will not be released or viewed by anyone else other than the researcher and the supervisor involved in this study. The data collected as part of this research project will be reported anonymously, and all identifying information will be changed to preserve confidentiality. The recordings and transcripts of this study will be stored securely and destroyed once research has been completed. The information that you provide is confidential, and no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. The

recordings and transcripts of this study will be stored securely and destroyed once research has been completed.

What if there is a problem:

If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee. 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 '*The most important thing in therapy is the relationship: Women survivors of Childhood Sexual Abuse describe their experiences of psychological therapy*'

You could also write to the Secretary at:

Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [REDACTED]

Who has reviewed the study?

This study has been approved by City University London Psychology Department Research Ethics Committee, approval number *[insert approval number here]*

If I have any questions about the study, you can contact the researchers at the email address below. If you have any concerns about the study, or your treatment as a participant, you can contact the member of staff supervising the project.

Further information and contact details:

Researcher:	Adela Mrkaljevic	Email:	[REDACTED]
Supervisor:	Dr. Sara Chaudry	Email:	[REDACTED]

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

Appendix C

Statement of Consent



Title of Study: "The most important thing in therapy is the relationship: *Women survivors of Childhood Sexual Abuse describe their experiences of psychological therapy*"

Ethics approval number: [PSYETH (P/F) 15/16 20]

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • Being interviewed by the researcher • Allowing the interview to be audiotaped	
2.	This information will be held and processed for the following purpose(s): analysing and write up of results. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

Name of Researcher Signature Date

Name of Participant Signature Date

When completed, 1 copy for participant; 1 copy for researcher file

Appendix D
Debrief information



Title of study: *The most important thing in therapy is the relationship: Women survivors of Childhood Sexual Abuse describe their experiences of psychological therapy.*

DEBRIEF INFORMATION

Thank you for taking part in this study! Now that it's finished we'd like to explain the rationale behind the work. This study set out to explore adult women's survivors' experience of psychological therapy, with a particular focus on the positive and hindering aspects of therapy. Previous research has shown that although the long-term effects of Childhood sexual abuse (CSA) are well documented, little attention has been paid to the treatment of women survivors of CSA, in a manner that is sensitive to the unique needs of the survivor. In fact, studies have consistently shown that there is a distinct lack of research looking at experience of therapy, from a survivor perspective. Furthermore, that existing research is characterized by a number of methodological limitations, including inconsistencies and wide variability in methodology and focus, which makes findings difficult to compare and weakens the generalizability of results.

Due to the limitations of previous research, it is unclear whether CSA survivors perceive their needs and service provision in the same way as clinicians or whether their needs are met in clinical settings. The overall aim of this research is therefore to give voice to women survivors' unique experiences of therapy, in order to better meet the multifaceted needs of survivors and to inform clinical practice. I hope you found the study interesting. If you have any questions about the study, you can contact the researchers and/or supervisor involved in this study, at the email address below. We realize that some of the questions asked may have provoked strong emotional reactions. As researchers, we do not provide psychological support and we will not be following up with you after the study. However, we want to provide every participant in this study with a comprehensive and accurate list of clinical resources that are available, should you decide you need assistance at any time. Please see information pertaining to local resources at the end of this form.

Thank you for your participation!

Appendix E

Community Resources and Psychological support

Community services

- **Solace Women's Aid**
Provides safe and supportive temporary accommodation to female victims of Domestic abuse. The refuge staff provides advice and advocacy on housing issues, welfare benefits and legal remedies that will empower women to move on to independent and safe living. An outreach service for women and children who are living independently within the community is also available through Women's Aid. This includes work with children and young women who have either witnessed domestic violence and/or experienced domestic Violence
<http://solacewomensaid.org/get-help/>
Tel: 020 7619 1360
- **Women and Girls Network:** P.O. Box 13095. NW. Tel: 0207610 4345
- **Maya Centre:** Eastgate Building, 131b St. John's Way, N19 3RQ.
Tel: 0207 281 2673
- **Samaritans** - A 24 hour phone line offering emotional Support www.samaritans.org.uk
Tel: 08457 90 90 90

Self Help Material

- **Get self-help** – A range of self-help material, worksheets to help manage a variety of common mental health problems. <http://www.getselfhelp.co.uk/>.
- **Northumberland and Tyne Self Help Booklets** – A range of self help CBT booklets on common mental health problem. <http://www.ntw.nhs.uk/pic/selfhelp>
- **Living Life to the Full:** http://www.lltff.com/index.php?section=page&page_seq=8

Appendix F

Exemplar of the analysis

Transcript 1

1 I: Ok, so thank you so much for participating in this study, (Pause) erm I 2 want to start of with asking what motivated you to participate in the 3 study? 4 P: Erm, when I read about the study it just seemed like something that 5 would really interest me, because I have been in therapy quite a few 6 times, and I have always been really interested in (Pause) how useful 7 <u>therapy is, cuz'</u> I have always found it <u>really useful</u>, a lot of what people 8 say, and there is <u>no evidence</u> for it, I wanted to take part to say this is 9 <u>how it has helped me</u>, that is the main reason. 10 I: Erm, could you tell me what first you led you to seek therapy? 11 P: Erm, the very first time I started therapy I was seventeen years old 12 (Pause) and I <u>had very recently tried to kill</u> myself because the sexual 13 abuse was still happening at the time, <u>that was my way of getting away</u> 14 <u>from it</u> (Pause) social services got involved and then I happen to have a 15 father that is a therapist so the natural thing was when this thing came 16 out it was of course <u>you must be in therapy</u>, it was sort of (Pause) <u>it</u> 17 <u>wasn't entirely by choice</u>, it was more social services felt it was needed, 18 my family felt it was needed and I <u>complied</u> (nervous laughter) since 19 then I have been much more choosing to do it, but the very first 20 experience was more, <u>family pressure</u>. <u>Later experience / choosing self.</u> 21 I: mmm, OK, and at the time did you have any expectations or hopes for 22 therapy? 23 P: Erm, that time I think (Pause) I was quite apprehensive about doing 24 it, I'd never been to therapy before I didn't you know, I didn't have any 25 personal experience of talking about, because I <u>had been keeping</u> 26 <u>everything secret</u> for such a long time that I didn't really want to, I 27 didn't, I didn't, I still didn't really know that I could talk about it. 28 I: mmm 29 P: ... because it was brand new to me, even though everyone knew it 30 happened, so I spent a lot of time in that <u>first part</u> of the therapy just 31 <u>talking about completely irrelevant things</u>, cuz' I was just <u>not ready</u> to 32 <u>really do</u> therapy, I was going to therapy, but I <u>wasn't really doing</u> 33 <u>therapy</u> if that make sense, so erm, (Pause) yea, it was a tricky one, it 34 was complicated with the fact that it was going to be a court case 35 against the person who committed the abuse, and so the therapist 36 weren't allowed to coach me in anyway sort of, kind of help me (Pause) 37 you know even bring up memories or anything that could sort of, 38 change what my testimony might have been like, you know, when it 39 came to trail, <u>so it was a little bit restricted</u> in that sense, that the 40 therapist then when I started talking about irrelevant things, they 41 couldn't particularly easily then steer me back to talking about this stuff 42 that happened. 43 I: Was it explicitly said that you couldn't talk about that, because of that 44 reason? 45 P: Yea that was made explicit to me, that basically I could use therapy in 46 whichever way I wanted to 47 I: mmm 48 P: ... <u>but they weren't allowed to probe me</u> cuz, erm, I was still a <u>minor</u>, I 49 was seventeen so I was <u>nearly not a minor</u>, but I was <u>technically a</u>	<i>Interest</i> <i>choice or force</i> <i>lack of evidence.</i> <i>Before therapy</i> <i>harm or evidence. perspective?</i> <i>Suicide as a way to escape avoided / sense of desperation hopelessness.</i> <i>Natural step because or dad</i> <i>lack of involvement choice</i> <i>Complicated - went along w/ family.</i> <i>Apprehension / An-avoidance not T.</i> <i>Secretly</i> <i>Not knowing if she can talk about it.</i> <i>Continued impact</i> <i>Avoiding threatening topics / abuse?</i> <i>Not ready - worry abt what might happen? complication?</i> <i>Court case restricting experience</i> <i>Restricting what?</i> <i>Restrictions provide sense of control perhaps? over how abuse is talked abt?</i> <i>Therapist showing lack of consider. - "probe" of abuse? (eval. term.)</i>
--	---

(Control)

① Perpetrator ③ Court case

② Family ④ Therapy

50 minor, and for that reason, you were not allowed to question a child
 51 more than once then. Law might have changed, but at the time it was
 52 the law, so obviously if the therapist was asked kind of leading
 53 questions, probing questions that could be understood, that could
 54 undermine the court case because then, erm, the defence might have
 55 argued that she's been coached into saying all of those things, and she
 56 hadn't said those before....

57 I: How was that experience for you, so being told that you can talk
 58 about whatever you want, but that there were restrictions, how did you
 59 find that?

60 P: I think to be honest, at the time it was almost a relief because it was
 61 an excuse to not talk about things,
 62 I: mmm

63 P: ... you know, I knew that they were not allowed to pressure me to
 64 open up about anything, and so I could always you know, I could choose
 65 to talk about what happened and they gave me whatever, and then you
 66 wouldn't be able to steer me back to anything difficult that I wasn't
 67 ready to talk about, so it was kind of, it was quite safe in a way, at the
 68 time because I wasn't ready to look at things, so yea...

69 I: ...and you mentioned that particular time, you were referred by social
 70 services, erm (pause) could you tell me about, describe how, erm kind
 71 of the process of being to referred to or finding a therapist, so maybe
 72 not that particular one, other experiences....

73 P: Other experiences are sort of self referred as an adult, I have both self
 74 referred to a therapist, and found out myself, erm I have sought therapy
 75 and been turned down for it, and this has been through NHS because I
 76 was deemed to be too high risk, and I have also been referred through
 77 other NHS service to counselling as well, so I have kind of had all the
 78 different experiences both family steering me towards it, and social
 79 services telling me that's what you should do, then having other kind of
 80 NHS services saying I think you need to do this, and then finally
 81 eventually when I was ready making the decision myself that I needed
 82 therapy and I am ready to actually work with my experiences. (3x ready)

83 I: How do you feel about the different, erm ways of finding therapy that
 84 process what was that like?

85 P: Erm, the first time when I really wanted to do therapy, erm at the
 86 time I did not have a lot of money, so the natural thing was to seek
 87 therapy through the NHS, and it was this waiting list you know like I
 88 don't know how long it took, it took like a year to even get to go for the
 89 assessment, and have that assessment and was then told you are to high
 90 risk, you wouldn't be able to manage the kind of stuff that might come
 91 up, and I was really really upset because at that point it was me who
 92 wanted to do it, and I was being denied, doing that....

93 I: How did you feel about it being denied?

94 P: It was really really hard, because when you finally want to start
 95 making changes, and someone tells you you can't, that is difficult to deal
 96 with, it was really upsetting, at the time I was seeing a counsellor
 97 through a different NHS service, erm, and she told me that it was going
 98 to be eight sessions, but it ended up being nine months (laughter) you

Therapist not able to probe
Initial T.
Restriction providing sense of safety
- Not feeling ready
Therapy being safe
Sense of control over topic?
Hindering / assisting factors influencing help seeking
Initial exp lacking choice - disengagement
Later experience having choice increased engagement
Financial sit causing restriction in choice
Restriction of service - denied therapy
Sense of rejection vs safety

Experience looked at from a legal perspective
2nd person narrative looking back?
Restriction a relief providing control / choice safety?
Not feeling ready start exp?
Referring to abuse but not naming it.
Varied experience!
Medical terminology which is the
Initial experience pressure / force
vs
Choosing to start therapy later on
Restriction in choice due to financial sit.
High risk
Not able to manage
Really Really - emphatic upon
2nd person narrative
Laughter expecting outcome complicity?

Appendix G

Table of themes, with appearance of theme for each participant

Theme	Participants who displayed this theme	Participant, page, line number
1. The help-seeking journey	All participants	
1.1. Inner pain and awakening	All participants	Tina: 1; 9-12 Jane: 1; 12 -17 Amy 1: 11-23 Margarette: 1: 26-27 Caroline: 1: 15-18 Annette 1: 8
1.2. Pre-therapy experiences and expectations	All participants	Tina: 2: 75-81 Jane: 2: 60-63; 3:134-140;5:555-564 Amy: 1:26-31; 2:58-70 Margarette 1: 38-41 Caroline: 1: 29 -31 Annette: 1: 26-28
2. The development of the therapeutic alliance	All Participants	
2.1. Therapeutic alliance & Trust	All Participants	Tina: 1: 9-17; 1:19-25; 1: 26 -36; 5: 229-233; 6:247-258 Jane: 1: 49-51; 1: 35-44 Amy: 2: 95-102; 6: 248-250 Margarette: 3: 144-148 Caroline 3:118-130 Annette: 1: 4 -6.
2.2 Therapist characteristics	All participants	Tina: 3: 134 -143 Jane: 6: 264 -269 Amy: 4: 169-178 Margarette: 3: 102:111 Caroline: 6:264-269; 4: 182-192; 7: 340-348 Annette: 3: 145 -147
2.3. Relational qualities	All participants	Tina: 4: 151-163 Jane: 7: 324-335; 10: 483-490 Amy: 4: 154-164 Margarette: 2: 84-89 Caroline: 5: 256-258 Annette: 2: 61-65; 1: 49 -55
2.4 Negotiating the therapeutic alliance	4/6 (apart from Margarette & Amy)	Tina: 9:392-399; 9:436-441; Jane: 10: 461-465; 5: 238-248 Caroline: 9: 444-451 Annette: 6: 282 - 284
3. Salient therapeutic experiences	All participants	

3.1. Sense of Safety	5/6 (Apart from Margarette)	Tina: 11:494-501; 10:483-488 Jane: 4:178-186 Amy : 8:354-355 Caroline: 8; 379 -383 Annette: 4: 187 -193
3.2 Continuity and consistency	All participants	Tina: 6:282-294 Jane: 9: 412-419 Amy: 8: 380-388 Margarette: 8: 373 -376 Caroline: 9: 432-436 Annette: 1: 35 -39
3.3 Abuse specific aspects of therapy	All Participants	Tina: 2: 51-59 Jane: 14: 679-684 Amy : 8: 423-436 Margarette: 7:311-313 Caroline: 2: 96-104 Annette: 3: 134 -137; 4: 207 -227
3.4 Missed or unmet needs	All Participants	Tina: 15: 691-697 Jane: 2: 84-88 Amy: 5: 212 -221 Margarette: 2: 90-92 Caroline: 6: 281 -290 Annette: 3: 119 -122
3.5 Suggested improvements	4/6 (apart from Caroline & Annette)	Tina: 15: 702 -709; 15:722-725 Jane: 11: 506 -511 Amy: 6:305-311 Margarette: 6: 270 -274
5. Healing as a process	All participants	
5.1 Insight & new meanings	All Participants	Tina: 18:849-860 Jane: 19: 901-909 Amy : 6:259-276 Margarette: 9: 424 - 426 Caroline: 10: 504 -505 Annette: 6: 306 -309
5.2 Healing responses & therapeutic change	All Participants	Tina: 17:785-788. Jane: 8:865 -871 Amy : 6:259-276 Margarette: 10: 141-151 Caroline: 6: 322-331 Annette: 3: 97-110
5.3 Personal development and growth	All Participants	Tina: 20: 804-811 Jane: 18: 854-862 Amy : 10:451-456 Margarette: 9: 434-437 Caroline: 11: 550 -560 Annette: 6: 312-317

Appendix H

Recruitment leaflet

Department of Psychology
City University London



Have you ever consulted with a mental health professional about sexual assault experienced as a child or adolescent?

Are you over 18 years of age?

If 'yes', then please read on...

If you have experienced Childhood Sexual Abuse (CSA) and spoken (or attempted to speak) to a therapist about it, then we would like to hear from you.

We are interested in your experience/s of being in therapy and speaking with a therapist about the issues of CSA. If you would like to share this with us, it would be conducted as an informal 1:1 interview, lasting between 60-90 minutes.

This is an opportunity for you to contribute to furthering the education and practice of therapists and mental health professionals, which may lead to an improvement in services for survivors.

If you would like to participate in this study or would like further information, then please contact the researcher: Adela Mrkaljevic on [REDACTED] (mobile) or via email at [REDACTED] and kindly leave a contact number and convenient time to be contacted.

Please note: This study is solely about your experience with therapy and not about your actual experience of CSA. Privacy and confidentiality is strictly adhered to in accordance with ethical guidelines.

This study has been reviewed by, and received ethics clearance through the Psychology Research Ethics Committee, City University London: PSYETH (P/F) 15/16 20.

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email: [REDACTED]

Thank You!

Appendix I
Ethics Approval Letter



Psychology Research Ethics Committee
School of Arts and Social Sciences
City University London
London EC1R 0JD

18th January 2016

Dear Adela Mrkaljevic and Nicole Scheiner

Reference: PSYETH (P/F) 15/16 20

Project title: *The most important thing in therapy is the relationship: Women survivors of Childhood Sexual Abuse describe their experiences of psychological therapy.*

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Recruitment leaflet

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

- (a) Recruit a new category of participants
- (b) Change, or add to, the research method employed
- (c) Collect additional types of data
- (d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee [REDACTED], in the event of any of the following:

- (a) Adverse events
- (b) Breaches of confidentiality
- (c) Safeguarding issues relating to children and vulnerable adults
- (d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Hayley Glasford
Student Administrator
Email: [REDACTED]

Katy Tapper
Chair
Email: [REDACTED]