PORTFOLIO FOR PROFESSIONAL DOCTORATE IN COUNSELLING PSYCHOLOGY (DPSYCH)

An Exploration of the Experience of Women Attending a Specialist Psychotherapy Service for Survivors of Childhood Sexual Abuse

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City, University of London Declaration

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Preface

This doctoral portfolio represents three individual pieces of work which relate to my training both as a researcher and a Counselling Psychologist. It also demonstrates my developing interest in the field of counselling psychology and reflects the breadth of research and clinical knowledge gained over the past three years. The three pieces of work are associated with childhood trauma and neglect and are directly applicable to the field of Counselling Psychology.

This portfolio also depicts my journey of working with adult survivors of childhood sexual abuse ("CSA") prior to and throughout my Dpsych training. I have had the opportunity to work with and provide therapy to adult survivors of CSA in a number of different settings, including charities, GP surgeries, specialist services and hospitals. I have also been given the opportunity to present my research topic and raise awareness about working with adult survivors of CSA amongst professionals in a variety of settings. This journey has provided me with the opportunity to gain knowledge, awareness, and skills that have enabled me to understand the intricacies and sensitivities that accompany working with this population. Throughout my journey, I have often reflected on what it might mean for clients who are survivors of CSA to experience therapy. Furthermore, following a rigorous literature review, I found that while there is a large amount of research conducted on adult survivors of CSA in general, there is a limited amount of literature on the experiences of adult survivors of CSA attending specialist services, notably from their perspective. This fuelled my interest in conducting a study on this particular topic.

The first part of my doctoral portfolio comprises of a qualitative research study that explores the experiences of women attending a specialist service for adult survivors of CSA. The second part of my portfolio explores a clinical case study that depicts my work with a client who experienced childhood trauma and the difficulties in her patterns of relating to self and others as an adult. The final part of the portfolio consists of a journal article summarizing my research study which will be submitted to the *Child Abuse & Neglect Journal: The International Journal* for their publication should they chose to. Despite the fact that all three pieces of work are independent, they have a common theme that links them together. All of them explore attending therapy due to childhood trauma - the key difference between the Doctoral Research and related Publishable Article relative to the Clinical Case Study is the approach to the analysis and understanding of the individuals' cases. The Doctoral Research approaches this subject using Interpretative Phenomenological Analysis ("IPA"), while the Clinical Case Study approaches it using the Cognitive Analytic Therapy ("CAT") framework. Furthermore, another link that can be drawn between the Doctoral Research and the Clinical Case Study is that CAT uses an integrative approach, which partly relies on observations, rather than solely psychodynamic interpretations, as well as exploring current experiences.

Part A: Doctoral Research

The aim of the research study is to explore in depth the lived experience of women attending a specialist psychotherapy service for survivors of CSA. The essence is to capture the women's experience of attending a specialist psychotherapy service for CSA and the meaning they make of their experience, as well as implications this may have on their existence, from their own perspective and voice. The research study is the key component within the doctoral portfolio. The study employed the use of semi-structured interviews to gather data. The accumulated data was analysed using IPA, as this approach attempts to understand the subjective experience of an individual in relation to their life, and how that individual makes sense of that experience. The findings of this study were explored with regard to the existing literature and psychological theories. The implications, limitations and contributions to the field of Counselling Psychology are also identified and explored.

Part B: The Professional Practice – Clinical Case Study

The Clinical Case Study represents a piece of work with a client ("Lucy") who attended time-limited CAT for a six-month period. Her reason for seeking therapy was to understand her entrenched relational difficulties and persisting symptoms of depression and anxiety. Given her difficulties and presenting problems, CAT seemed to be a suitable fit for Lucy as she wanted to get a better understanding of her relationship patterns that she had been struggling with for a while. This case study furthermore helped me recognise my passion for integrating both analytic and cognitive ways of thinking and formulating, which fits with my identity as a counselling psychologist. My rationale for presenting my work with Lucy is influenced by my strong interest in CAT, as well as the progress she made and challenges I faced during our sessions. Furthermore, some of the areas explored during our sessions, such as understanding early childhood difficulties and interpersonal relationships, wove a thread throughout the therapeutic experience that links directly to my doctoral research. Although Lucy did not experience CSA, the case study considers the way in which childhood neglect and emotional disconnection is experienced at the hands of formative caregivers. It further highlights how these experiences can shape and impact the mind of an individual, causing deep insecurities, mistrust and fear. Given CAT therapy places a lot of emphasis on early childhood attachment relationships, it appeared to be the most suitable approach to take with her. As CAT is heavily informed by attachment theory, a further link can be made in relation to my doctorate research which explores attachment theory and its link to childhood sexual abuse in further detail.

Part C: Publishable Article

The Publishable Article is an abridged version of the Doctoral Research with the aim of being published in the *Child Abuse & Neglect: The International Journal ("the Journal")*. The formatting

of the text is in adherence with the journal guidelines. This Journal was selected as it has a particular interest in child protection in general and is widely used within the Literature Review section of the doctoral research. The Journal seeks contributors and welcomes readers interested in children's safety in the settings of everyday life, including homes, day care centres, schools, playgrounds, youth clubs, health clinics, places of worship, and so forth. It also invites the engagement of social scientists and humanists whose studies may contribute to an understanding of both the "evolution of concepts of and strategies for child protection" and "the responsibilities of adults and the institutions of which they are a part to ensure children's safety and their humane care" (Elsevier, 2016). While the Doctoral Research is focused on adults, they are all survivors of childhood sexual abuse. This article can serve to illuminate readers of this journal on some of the complex long-term impacts that abuse during childhood can have on a person's latter life, notably from their own perspective. The publication of this article within this journal would allow its dissemination to practitioners from a wide and diverse range of disciplinary fields such as medical, behavioural, health and social sciences who also have a shared interest in childhood sexual abuse and therapy for survivors of CSA. The article aims to provide an overview on the prevalence of CSA, its ties to Attachment Theory, the aims, design and method of my research, some of the key findings within one of the super-ordinate themes, and clinical implications and limitations for the practice of Counselling Psychology.

A note on the terms used in the portfolio

The terms "Counselling Psychologist", "therapist", "psychologist" and "clinician" are used interchangeably throughout this portfolio. The term "childhood sexual abuse" is often abbreviated to "CSA". The term "survivor" is used to describe women who have experienced childhood sexual abuse. The terms "Woman's Service" and "Service" are both used interchangeable to refer to the UK National Health Service ("NHS") Woman's Service on which this study was conducted. Further details on the actual name of this service have intentionally not been disclosed to maintain anonymity. All names and identifying details of all participants who volunteered for this research study have also been changed to preserve anonymity. Acronyms and abbreviations are sometimes redefined in full in the text at the beginning of new sections to assist the reader.

Part A: Doctoral Research

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An Exploration of the Experience of Women Attending a Specialist Psychotherapy Service for Survivors of CSA

Supervisor

Dr. Jacqui Farrants

Abstract

For most survivors of childhood sexual abuse ("CSA"), seeking and receiving help to manage their difficult experiences of abuse are known to be complex, long and a difficult process (Gavey, 2003; Frenken & Van Stock, 1990). The experience of using such services has seldom been explored from a survivor's perspective (Chouliara et al., 2012). The aim of this study is to explore in depth the lived experience of women attending a specialist psychotherapy service for survivors of CSA. The essence was to capture the women's experience while attending a specialist psychotherapy service for CSA and the meaning they make of their experience, as well as implications this may have on their current lives. This study uses a qualitative research design paradigm. The data was collected from a small sample of women attending a UK National Health Service ("NHS") specialist service for survivors of CSA. Semi-structured interviews were employed to gather information from participants. The accumulated data was analysed using Interpretive Phenomenological Analysis ("IPA"). The three super-ordinate themes that emerged from the data included: Forming the Therapeutic Alliance, The Therapeutic Journey and Experience of Finding Their Voice. The narratives within these themes revealed the therapeutic journey which first began with the difficulties they first encountered when they felt misattuned with their therapist, continued to the forming of the therapeutic alliance, and through to the ending of the therapy relationship, drawing light on some interesting findings within each of these stages of the therapeutic process. Implications for the clinical practice of Counselling Psychology, limitations of this study, as well as recommendations for future research are considered within.

Chapter 1

Introduction & Literature Review

1.1 Introduction

This research was carried out with the aim of exploring women's experiences of attending a specialist service for adult survivors of CSA and the impact of the therapy on their current lives. Numerous studies carried out in the last few decades have focused on the overarching topic of CSA and its long-term impact on adult survivors, many of which have been conducted from the perspectives of a therapist or clinician (Way et al., 2007). This study aims to provide an insight into the lived experiences of adult women attending a psychotherapy service specifically for survivors of CSA from their own perspective, giving voice to a difficult to reach population.

For most survivors of CSA, seeking and receiving help to manage their difficult experiences of childhood sexual abuse are known to be complex, long and a difficult process (Gavey, 2003; Frenken & Van Stock, 1990). The experience of using such services has seldom been explored from a survivor's point of view or perspective (Chouliara et al., 2011). As a result, knowledge on the topic shows an unclear picture on whether CSA survivors view their needs and service provisions similarly to clinicians and whether their needs are addressed in these clinical settings (Draucker & Oetrovic, 1997). Chouliara and colleagues (2011) argue that there is a lack of published research obtaining the views and experiences of survivors of CSA and professionals who work with survivors of CSA, notably in Scotland and the United Kingdom.

While each survivor's experience is unique and personal, I believe that their stories can be important in highlighting different experiences and ways to support and assist survivors seeking therapy. Previous research has indicated that survivors of CSA find it difficult to leave unproductive therapy relationships (Shannon, 1996). Shannon's (1996) study interviewed female survivors of CSA and adopted a feminist, narrative research method to interview them about their efforts toward recovery and their views of the psychotherapy relationship. She suggested an idea for future research would be to explore the impact of power dynamics in the therapy relationship and whether or not service users needs are appropriately and adequately met. My study aims to provide an element of clarity and understanding of the individual experiences of users from their perspective, as well as the change and challenges they may face in therapy. This in turn can prove to be useful for therapists, psychologists and other mental health practitioners and health professionals by illuminating the complexities and sensitivities involved with this population. This chapter introduces the contextual overview and background on the prevalence of CSA and existing literature on this topic. The choice of literature used was based on a conventional literature search using terms that include 'sexual abuse', 'childhood

sexual abuse', 'adult survivors of childhood sexual abuse', 'therapy experiences of adult survivors of childhood sexual abuse', 'recovery', and 'qualitative experiences'. Additional searches were conducted by combining the terms stated above and the Boolean operators 'OR', 'AND' and phrases such as 'psychological intervention', 'counselling psychology', 'clinical psychology', 'psychotherapy', 'therapeutic work', 'Attachment Theory', 'Psychodynamic psychotherapy', 'group therapy', 'art therapy', and 'therapy relationship'. The databases used to search the relevant literature included the City, University of London Database (16 underlying databases in relation to psychology), PsycARTICLES, PsycBOOKSPsycEXTRA, PsycINFO, Psychology and Behavioural Science Collection, and CINAHL. No exclusions were made with reference to date range for papers.

Following an introduction to the topic, I discuss the psychological and physical impact of CSA on survivors. Subsequently, I discuss Attachment Theory and its relationship to working with adult survivors of CSA. In the ensuing section I explain my reasons for focusing on Attachment Theory over other theories or models in the context of my study. I then go on to explore the therapy experiences of adult survivors' of CSA in relation to the different therapies offered at the specialist service, as well as the therapeutic relationship with context to working with adult survivors of CSA. Finally, I introduce the Woman's Service on which I conducted this study in order to provide a background and contextualize the study. I end by exploring my rationale for carrying out this research study as well as the relevance for the field of Counselling Psychology.

1.2 Overview and Prevalence of CSA

Child maltreatment is of fundamental importance to the practice of psychology and our society (Bottoms & Quas, 2006). The abuse of children perpetrated through neglect, physical, emotional or sexual abuse is an issue that is severe and long established. Every year, over a million children are reported to have been maltreated and this represents only a portion of the total amount as many cases go unreported (Bottoms, Rudnicki, & Epstein, 2007; Pipe, Lamb, Orbach, & Cedarborg, 2007).

Child maltreatment is defined as:

> "All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (Butchart, Putney, Furniss, and Kahane, 2006, p. 9).

A considerable minority of children experience severe maltreatment and abuse at home, in school, and in the community, from both adults and from their peers (Brown & Tessier, 2015). A report by the National Society for the Prevention of Cruelty to Children ("NSPCC") in 2015 estimated that the prevalence at which severe maltreatment occurred was at 5.9% of under 11 year olds (6.1% of

females and 5.8% of males), 18.6% of 11 to 17 year olds (19.0% of female and 18.2% of males) and 25.3% of 18 to 24 year olds (30.6% of females and 20.3% of males). Findings from the above study revealed that the percentage of parental neglect was 9.9% in 2009 compared to 9.4% in 1998. That said, a general decline in children's experiences of harsh physical and emotional punishment, as well as a drop in a number of experiences of sexual and physical violence was observed. In addition, a significant reduction in the prevalence of physical violence from 13.1% in 1998 to 9.8% in 2009 was noted. The experience of prolonged verbal aggression at home, school or elsewhere also reduced significantly over time (from 14.5% in 1998 to 6% in 2009). Though CSA is not an explicit occurrence within the broader context of child maltreatment, it still warrants specialist attention due to the associated harmful psychological impact on children and teenagers, as well as the long-standing effects that are transferred on into adulthood (Harvey & Taylor, 2010; Brent et al., 2002; Nelson et al., 2002).

Over the past several decades, CSA, which was formerly seldom discussed or acknowledged, has garnered an increase in attention and is no longer seen as a subject of taboo. CSA is defined as "any sexual contact with a child through the use of force, threat or deceit to secure the child's participation" (Finkelhor, 1994). It also represents a violation and manipulation of a person who is more vulnerable by another person who holds greater power. In instances of CSA, the child is not just physically and emotionally violated- he/she also experiences "a breach of trust, a breaking of boundaries, and a profound violation of the sense of self" (Davis, 1991, p. 13). For the purpose of this study the following definition specified by the World Health Organisation (2002) is used:

> "Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person."

It is difficult to state an accurate prevalence of CSA as most of it is unreported or not disclosed. Radford et al. (2011), as part of the NSPCC, carried out their most recent study on the prevalence of child sexual abuse and established that 16.5% of 11 to 17 year olds reported having experienced sexual abuse, of which 4.8% had experienced contact child sexual abuse. These figures rose to 24.0% and 11.3%, respectively, within the 18 to 24 year old age bracket (Brown & Tessier, 2015).

A prevalence study across Europe was carried out by Lampe (2002) and he found overall prevalence rates of 6% to 36% in girls and 1% to 15% in boys under 16. The Council of Europe states that "available data suggest that 1 in 5 children in Europe are victims of some form of sexual violence" (Council of Europe, 2014). In spite of the ambiguity around the prevalence statistics, a variety of

findings reveal that CSA affects a substantial percentage of the population (Brown & Tessier, 2015). In 2011, it was argued by the NSPCC that, "By not addressing child sexual abuse as a public health problem we are failing our children" (NSPCC, 2011).

Neglect and abuse is believed to be problematic and unique not only to the UK, but poses a worldwide problem that has significant consequences for public health (Krug et al., 2002). CSA is a global problem- statistics from recent research among a nationally representative sample of youth and children suggested that approximately 6% of the sample size experienced some form of sexual offence and 1.4% reported experiencing sexual offences within the previous year (Finkelhor et al., 2015). In addition, 16.4% of girls represented the highest rates of sexual offences between the ages of 14 to 17 (Finkelhor et al., 2015). Statistics from an older research study conducted by Molnar, Buka and Kessler in 2001 suggested that approximately 1 in 4 (i.e. 26.6%) of girls and 1 in 20 (i.e. 5.1%) of boys have experienced some form of sexual abuse as children. A meta-analysis of the predominance of CSA in adults using 65 articles from 22 countries reported that 7.9% of men and 19.7% of women had experienced sexual abuse before the age of 18 (Pereda, Guilera, Forns, & Gómez-Benito, 2009). While both girls and boys are vulnerable to CSA, girls are considered to be at a higher risk (Conklin, 2012). That said, the long term impacts of health and social indicators were similarly harmful to both genders (Dube et al., 2005). A prevalence study by Lundqvist, Hansson & Svedin (2004) revealed that between 15% to 30% of women have been sexually abused as children. These figures illustrate that CSA is an issue that is highly prevalent in our society, and therefore reinforces the importance of exploring the long-term and psychological impact on survivors.

Throughout this study the term 'survivors', rather than 'victims', is used because the study attempts to follow previous practice (e.g. Clarke & Llewellyn, 1994; Hall & Lloyd, 1993; British Psychological Society Report 1990). The term 'survivor' infers re-framing the client's position in relation to their past, whereby implying that they can access and develop their strengths from a previously victimized or powerless state (Ryan et al., 2005). Due to the lasting effects on the survivor's mental and physical health that are carried on into adulthood, CSA is seen as an important public health concern (Maniglio, 2009; Wegman & Stetler, 2009). Given the above statistics and despite the variety of research carried out on CSA, survivors of CSA still warrant specialist clinical attention, especially with regard to their mental health. The following section will discuss the physical and psychological effects of CSA on adult survivors.

1.3 Psychological and Physical Impact of CSA

A growing body of research has indicated that CSA has profound short and long-term psychological, social and physical effects on its survivors' lives (Briere & Scott, 2015; Kamiya, Timonen & Kenny, 2015; Collishaw et al., 2007; Hetzel-Riggin, Brausch, Montgomery, 2007; Browne & Finkelhor,

1986). Adult survivors of CSA have a considerable and a greater risk of developing long-term mental health difficulties and physical health problems in contrast to the overall population (Liu et al., 2013; Anda et al., 2004). Fergusson et al. (2008) reported that individuals with a background history of CSA experienced mental health disorders 2.4 times higher than those who were not exposed to CSA. His study cohort also disclosed that CSA accounts for roughly 13% of the mental health difficulties encountered (Taylor & Harvey, 2010). Violence and abuse contribute to fundamental mental health problems: there are a significant number of men survivors and approximately 70% or more women service users that are survivors of CSA (NHS Confederation, 2008). Unhealed CSA experiences can cause physical symptoms and psychological problems that are carried into adulthood (Jacobs et al., 2012; Norman et al., 2012). Previous findings have further indicated that higher incidences of CSA are prevalent amongst women who seek clinical treatment for various mental health problems (Callahan, Price, & Hilsenroth, 2003).

A clinical presentation of the fundamental core difficulties can be found amongst the varied CSA symptomology and associated mental disorders. These core difficulties that are seen include issues with cognitive distortions, impulse control, sense of self, interpersonal relationships, affect regulation, and feelings of vulnerability (Psychiatric Association, 2013; Cloitre et al., 2012; Putnam, 2003). Furthermore, Ullman (2006) and Kessler et al. (2003) identified five emotional symptoms common to CSA women survivors. They include self-blame, self-destruction, low self-esteem, anxiety, and social maladjustment. Additionally, they are likely to further experience challenges with parts of emotional functioning such as control, safety, self-esteem, trust, and intimacy (Shipherd et al., 2006). Female CSA can also result in adulthood re-victimization, a degree of self-blame, PTSD and maladaptive coping (Fillipas and Ullman, 2006). A longitudinal study by Molnar et al. (2001) analysed the relationship between CSA and developing subsequent substance, mood and anxiety disorders. One of their findings suggested that 15.6% of women with a history of CSA were more likely to endure lifetime alcoholic dependence in comparison to only 7.6% prevalence amongst those who did not report CSA. However, their study was faced with a potential limitation due to the accuracy of retrospective recall. In addition, a follow-up study carried out by Cutajar et al. (2010) explored participants' experiences between 12 to 43 years after CSA had occurred and established that CSA is a significant risk factor for a series of mental disorders carried into adulthood. Their study was also faced with a similar limitation which applies to the retrospective design adopted, which makes the assumption that there is a close correspondence between actual events in childhood and the history of abuse given in adulthood. Bhandari et al. (2011) conducted a retrospective cohort study comparing the relationship between 'family dysfunction' on sexually abused and non-abused participants and the findings supported the notion of 'family dysfunction' as a long-term effect of CSA. However, their study was limited by their measure of the severity of sexual abuse and it required further assessment of its precision and validity (Bhandari et al., 2011).

Although the above studies are confronted by limitations, the findings reveal a significant correlation between CSA and psychopathology for both women and men. Researchers have also found that individuals with abuse histories are more likely to have an earlier onset and history of comorbid disorders compared to participants with no history of CSA. The existence of post-traumatic stress disorder ("PTSD") in the general population is between 5% and 10% (Kessler et al., 2003; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). However, trauma that occurs during childhood is specifically linked with a higher risk in developing PTSD (Sigurdardottir, 2012). Studies by Beitchman et al. (1992) & Browne and Finkelhor (1986) found subsequent adult development of depression, PTSD, dissociative disorders, interpersonal difficulties, anxiety disorders and other disruptive symptoms have a direct link with CSA. Furthermore, Schore (2001) emphasised that abuse occurring in children generates a high level of stress and is therefore linked with a negative impact on brain development. There is a significant link between childhood trauma and development of adult traumatic experiences and the presence of post-traumatic and dissociative phenomena (Sar et al., 2009; Tamar et al., 2008; Watson et al., 2006). Furthermore, a recent study by Gaon et al. (2013) explored the existence of undiagnosed PTSD among patients in out-patient mental health clinics and their most important finding was the huge impact of childhood trauma, especially sexual abuse, on latter life. This study suggested that childhood trauma and sexual abuse has an impact on the long-term psychopathology of an individual. Therefore, prevention, early detection and treatment of child abuse is crucial in preventing long term psychopathology and must be further emphasized.

Additional concerns mentioned in the literature include interpersonal issues such as difficulty with trusting others, feelings of isolation, impairment in sense of self such as poor self-esteem, and identity disturbances amongst survivors of CSA (Putnam, 2003; Nelson et al., 2002; Nuemann, Houskamp, Pollock, & Briere, 1996). Based on a 15-year prospective, a longitudinal study by Jaclyn et al. (2009) examined the self-reports of traumatic sexual and physical experience of adolescence and young adult females occurring subsequent to substantiated CSA, such as re-victimization. They highlighted that sexually abused females were almost twice as likely to be physically and sexually re-victimized compared to the group that did not experience CSA. Other research supported the notion that there is an increased risk of further victimization later in life for sexually abused females (Bramsen, Lasgaard, Koss, Shevlin, Elklit, & Banner, 2013; Easton, Coohey, O'leary, Zhang, & Hua, 2011).

Studies have further recognized that childhood trauma interferes with neurobiological development and therefore is associated with physiological dysregulation and increased risk for chronic health problems such as liver and heart disease, stroke, cancer, diabetes and skeletal fractures in adult survivors (Rich-Edwards et al., 2012; Sargent, 2009; Briere, 1992). In addition, there is other recent evidence suggesting that CSA is associated with long-term medical and health problems, such as poor general health, gastrointestinal problems, obesity, gynecological and cardiovascular symptoms, and

immune system disorders (Chen et al., 2010; Irish, Kobayashi, & Delahanty, 2010; Wilson, 2010; Maniglio, 2009).

Lastly, one of the most baffling, yet common threats to health includes worrying physical symptoms, for which neither a medical explanation nor an organic cause can be agreed, labelling them as 'medically unexplained symptoms' ("MUS") (Nelson et al., 2012). Adults who have been sexually abused appear at a disproportionately high risk of conditions, such as chronic pelvic pain, irritable bowel syndrome, respiratory dysfunctions, fibromyalgia non-epileptic seizures, and chronic fatigue syndrome (Nelson et al., 2012). Nevertheless, given the above research and statistics, I would note that the presence of any of these conditions does not automatically state that the individual has been sexually abused. A study carried out by Erbes & Harter (2005) notes that not all adults who have experienced CSA suffer from the above difficulties (Erbes & Harter, 2005).

1.4 CSA and Attachment Theory

"The human condition is far too complex for any single theory to suffice." (Scharff & Scharff, 1998, p. 63). Over the years, many different theoretical conceptualisations have endeavoured to explain the difficulties that accompany childhood trauma and abuse. As a trainee counselling psychologist, keeping in mind that the heart of our training lies within an integrative framework, I appreciate the need to integrate propositions from different theoretical perspectives that have clinical relevance. There are several theories and numerous models that have been used to understand the relational aspects and long-term implications of CSA including, but not limited to, Interpersonal Schema Theory, Contextual Behvaioural Perspective, Traumagenic Dynamics Theory, Affect Regulation Theory by Shore, and Developmental Psychopathological Model. These models have been proposed to understand the various effects encountered as a result of CSA and implications on the development and subsequent functioning of interpersonal relationships. I have chosen, however, to focus particularly on Attachment Theory, the concept of the secure base and its link to psychodynamic literature. My reason for this is because the service upon which I conducted this research study is primarily a psychodynamic service which is heavily informed by Attachment Theory. As a result I believe the accompanying Analysis and Discussion is most applicable to consider in the context of Attachment Theory.

Attachment Theory provides a useful conceptual framework for understanding the long term effects of CSA (Hooper et al., 1997). Attachment Theory has been found to contribute largely to the understanding of emotional distress and interpersonal issues that result from CSA, as well as provide an underlying perspective on the development of relationship difficulties, psychopathology and affect dysregulation (Karakurt & Silver, 2014). This idea that early disruption to the mother-infant relationship can be a pre-cursor for emotional difficulties (Bowlby, 1944) makes one curious about

the impact of the primary caregiver relationships on clients' latter lives. Although psychoanalysis from its inception suggested that maladaptive developmental pathways during childhood may result in difficulties in latter life, it lacked a good theory of normal development (Marrone & Cortina, 2003). Thus, Bowlby developed Attachment Theory as an attempt to link psychoanalysis with the larger world of evolutionary theory and ethology (Holmes, 2015). This section explores the long term effects of CSA on a survivor's latter life from an Attachment Theory perspective. In the next section I also explore further the contribution of Attachment Theory to the healing process in a therapeutic relationship, in particular with CSA survivors and to Counselling Psychology in general. Attachment Theory in relation to CSA is discussed in detail from a psychodynamic lens given participants at the service whom this study is based on received psychodynamic psychotherapy.

It has been recognised that individuals are far more likely to experience profound emotional disturbance when the abuser in the context of CSA is an attachment figure (Main and Hesse, 1990). Insecure attachment patterns are commonly found amongst children who have experienced abuse or neglect (Alexander, 1992) and on the other hand, secure attachment in infancy is often associated with greater competence and functioning latter in childhood (Mikulincer & Shaver, 2007). Although early attachment experiences are important in shaping the child's internalised support system, attachment needs continue throughout life (Hopper et al., 1997). However, as not all experiences are uniform, Attachment Theory suggests that variability may exist as a result of the context of childhood experiences, the meaning the abusive relationship occupies in the child's attachment network, and/or the nature of the abuse (Hopper et al., 1997). Consequently, not all children are affected in the same way and attachment theory can only account for some of the differences.

Attachment Theory with reference to internal working models is useful in understanding some of the characteristics of CSA in adult survivors (Hooper, Koprowska & Mc Cluskey, 1997). Researchers postulate that attachment patterns formed during childhood get transferred into attachment patterns in adulthood (Alexander, 1993). Studies have further shown the effects of attachment style that are passed into adulthood can influence peer and romantic relationships, as well as parenting (Kim, Trickett, & Putman, 2011; Bartholomew & Shaver, 1998). Therefore Bowlby developed the concept of internal working models to explain how attachment patterns can be carried on throughout life (Bowlby, 1988). Traumatic experiences during childhood, especially in relation to their primary caregivers, may affect the development of their internal working models. These experiences may be excluded from the child's consciousness, subsequently forming what may appear to be incoherent internal working models or multiple models (Main, 1991; Bowlby, 1988). For instance, they may continue to see others as untrustworthy and not reliable because their ability to form relationships might have been inhibited by distorted perceptions due to their relationship with their early caregivers (Herman, 1992). Research indicates that poor interpersonal boundaries and difficulties with trusting others appropriately are found amongst survivors of CSA (Blume, 1990). Insecure attachments

commonly lead to excessive and unproductive focus on negative emotions, leading to inappropriate emotional regulation (Moran et al., 2008). Thus, insecure individuals might also find it difficult to form trusting relationships in therapy and often doubt their therapist's regard for them (Mikulincer & Shaver, 2007).

Self-Concept

> "One's experience of relations with others becomes a feature of one's relations with oneself." (Peter Hobson, 2002, p.180).

The concept of the self is a central idea in a number of theories on lifestyle development, and in particular, the development of children (Cassidy, 1990). According to Cassidy (1990), individuals require knowledge that is portable about themselves and the world in order to function effectively. They develop an understanding of such knowledge from their past experiences and memories and this knowledge is utilized to make predictions and judgements about their present and future experiences. A principal assumption of Attachment Theory is that in the interest of survival, humans develop close emotional bonds. These bonds enable the development and maintenance of mental representations of the self and others, or 'internal working models', which assist individuals with predicting and understanding their environment, engaging in survival promoting behaviours such as proximity maintenance, and establishing a psychological sense of 'felt' security (Bretherton, 1985; Sroufe & Waters, 1977). Bowlby also theorises that mental representations of the self and others are moulded in the context of a child-caregiver relationship. This mental representation formed during one's childhood years is carried into adulthood and has an impact on their feelings, thoughts and behaviours. These models or mental representations combine two distinct, yet interconnected cognitive schemas: a self-model encompassing elementary perceptions of one's own competence, self-worth, and lovability and the other model representing core expectations concerning trustworthiness, the essential goodness, and dependability of significant others in one's collective world (Lopez, 1998). Bowlby (1988) suggests that an individual's internal working models, once shaped in early childhood, function as a reasonable template for their consequent intimate relationships. Young infants and children develop an understanding of the self and others as they experience relationships. Their most significant relationship is their care-giver or parent who becomes their main attachment figure. Therefore, an individual learns about the self through being in a relationship with the other and an understanding of one's self comes with an understanding of the other. These bonds, behaviours and interactions become mentally represented by the child and form an internal working model (Howe et al., 1999). These internal working models formed during childhood have a significant bearing and impact on how an individual understands and views the self, others and interaction with the world.

Bartholomew (1990) extended Bowlby's definition of internal working models to consider the impact of a disruption in the early childhood relationships. He maintained that positivity or negativity within either the self-model or the other-model could outline four different attachment archetypes. He continues to suggest that high positivity of the self-model would indicate an individual's internalisation of a sense of own self-worth from caregiver relationships, while high negativity of the self-model would be associated with self-blaming (Griffin & Bartholomew, 1994). High positivity of the other-model would be embodied by an individual's anticipation of others to be available and supportive, whereas high negativity of the other-model would manifest in an individual's expectation of others to be indifferent.

Howe et al. (1999) hypothesize that internal working models contain beliefs and expectations about one's own and other people's behaviour, the lovability, worthiness and acceptability of the self and the interest and emotional availability of others and their ability to provide protection. These internal working models and representations usually develop from infancy up to the first few years of the child's life, particularly as they get to learn and know the behaviour of the significant attachment figure. Established by the learning and understanding of his/her care-givers behaviour and patterns of relating to them, the child develops behavioural strategies to ensure that his/her needs are met optimally given the characteristics of his/her care and carers (Howe et al., 1999). However, a change in the social environment and alteration in other's responsiveness can 'disconfirm' and alter the child's internal working models, resulting in changes in his/her developmental pathways for both good or bad. Given that a child's attachment relationships become psychologically internalised, the quality of the child's social experiences becomes a mental property of that child. An intensely negative affect comprising of feelings of powerlessness and fear are observed in children who are raised in maltreated environments. The experience of childhood maltreatment can have a profound effect on self-perception, self-regulation and interpersonal functioning. In comparison to children who were not maltreated, they display divergent patterns of emotion expression and recognition, and heightened behavioural reactivity to stress (Cicchetti & Valentino, 2006). An impoverished awareness of their own internal states and diminished social interactions have been seen in children who are maltreated (Shields & Cicchetti, 1997). These difficulties and experiences can cause physical symptoms and psychological problems that are carried into adulthood (Jacobs et al., 2012; Norman et al., 2012). Attachment Theory and maltreatment research provide some signs and approaches as to how the cycle of abuse can end and how survivors of childhood adversity can move toward better psychological and physical health (Dube, Felitti, & Rishi, 2013; Egeland, Jacobvitz, & Sroufe, 1988).

This has seen to take place typically in terms of establishing new relationships with a partner or therapist, by attaining psychological coherence, and a sense of balance among emotional regulation (Main et al., 2008). Individuals who have been exposed to childhood adversity can overcome their

difficult patterns of relating and move toward better health by establishing relationships and social ties that are supportive (Dube et al., 2013).

1.5 Attachment Theory, Secure Base and the Healing Process

From an Attachment Theory perspective, repeated trauma during childhood forms and deforms the child's personality, as they experience a feeling of betrayal from a trusted caregiver or parent on whom they depend. Children who develop in an abusive environment of domination develop pathological attachments to those who neglect and abuse them (Herman, 1992). Feelings of betrayal and rejection also manifest themselves through insecure attachment patterns. Therefore, growing up in an environment where a child cannot depend on their caregiver for protection, care and love, might make the child turn inward and seldom express his/her feelings of fear and pain, forming an avoidant or dismissive attachment pattern, and resistant to forming a secure base in therapy (Farber & Metzger, 2010). Clients during therapy are inhibited by their distress, anxiety and early attachment patterns and this prevents the exploration of new thoughts and behaviours (Hopper et al., 1997). Freud's discovery of 'repetition compulsion' helps us understand how patterns of relating acquired during childhood that were particularly difficult repeat themselves in latter life (Kahn, 2001). As a result, internal working models are not only related to or influenced by past relationships but also function in a reciprocal process with current relationships (Kobak & Hazan, 1991).

Ainsworth (1967) made a further contribution to Attachment Theory, as she conceptualised core features of the psychoanalytic process with the concept of the secure base. When caregivers or parents provide an environment of safety and security, "a child's threshold for fear of the unfamiliar is raised and increases their confidence to use the caregiver as a base for exploration" (Ainsworth, 1972 p. 117). Attachment Theory suggests that over time the survivor can rewire their internal working models by engaging in non-abusive relationships which can help them regain safety, trust and connection with others (Hopper et al., 1997). Main and Solomon (1996,1990) applied the term 'disorganised' to describe infant attachment and behaviour of infants who were disorganised with respect to Ainsworth's classification system of patterns of infant behaviour with the parent in the 'Strange Situation' (Main & Solomon, 1986, 1990). Unresolved attachment is conceived as a representational form of disorganised attachment in adolescents and adults (George, West, & Pettem, 1997). Disorganised attachment, as postulated by Main (2000), is a situation where the attachment figure is simultaneously not only experienced as the safe haven, but also a source of danger. In moments of alarm, a child is pre-programmed to turn to their parents and is faced with contradictory impulses to avoid and approach the parent. It is a situation that is untenable from which the child's dependency on the parent is unavoidable. Main (2000) theorises that disorganised attachment is an outcome of the child experiencing the parent both as 'frightening' and 'frightened'. The outcome of this 'biological paradox' is disorganisation or disorientation (Wallin, 2007). Main and Hesse (1999)

further go on to postulate that this 'fright without a solution' can lead to a collapse (or absence) of an attentional and behavioural strategy for coping with stress (Hesse and Main 1999).

A leading discovery in attachment research is the strong relationship between caregivers' unresolved memories of traumas or losses, leading to 'unresolved' Adult Attachment Interview classification, and disorganization of early attachment in their children (Main & Hesse, 1990; Main & Solomon, 1990). Mary Ainsworth's laboratory study for observing infants' internal models in action classified a fourth group of infants as disorganised or disoriented as they exhibited seemingly undirected behaviour such as hand clapping, freezing and head banging and a desire to escape the situation even in the presence of the caregiver (Fonagy, Gergely, Jurist, Target, 2005). A study carried out by Carlson et al. (1989) found that 82% of infants were classified as disorganised as a result of maltreatment by their parents in comparison to 18% of a matched controlled group. Furthermore, a disproportionate representation of disorganised attachment was exhibited in infants from high-risk samples that involved families that were weighed down by psycho-social stressors such as psychiatric illness, poverty and substance abuse. Infants that display disorganised attachments are a significant risk factor for psychopathology from childhood onward (Wallin, 2007). For example, patients with borderline personality disorders often exhibit disorganised attachment (Dozier, Chase, Stoval, & Albus, 1999; Schore, 2002; Fonagy et al., 2005).

In summary, a biological driven interaction with a caregiver may register psychologically as a mental representation that is carried on into adulthood and can continue lifelong to shape behaviour and subjective experience even if the original caregiver is not present physically (Wallin, 2007). In the context of a therapeutic relationship, the therapist's role is essential in establishing a safe environment for the client to explore and uncover childhood experiences and the emotions associated with it (Bowlby, 1988). Faber et al. (1995) suggested that therapists usually function as attachment figures for their clients. However, a therapist's role is significantly different from that of a parent. Recovery cannot occur in isolation and can only take place within the context of relationships (Herman, 1992). The concept of the secure base can be linked to therapy with survivors of sexual abuse. Survivors of abuse may be faced with the difficulty of trusting the other, and Bowlby suggests that the therapist should serve as a secure base, as it enables the client to explore and make their own decisions and restore control over their environment rather than continue to remain an interpreter of their experiences (Farber & Metzger, 2010). This said, the need for security in a therapeutic relationship is an idea that has existed since the beginning of psychoanalysis. The concept of an 'unobjectionable' positive transference (Freud, 1912), the notion of containment by Bion, as well as Winnicott's concept of the holding environment suggests the need for a 'safe place' in psychotherapy (Havens, 1989). Theorists further argue whether or not the concept of the secure base is distinguishable from Rogers' (1957) necessary core conditions i.e. empathy, genuineness and unconditional positive regard. Dozier et al. (1994, 1998 & 2002) theorise that there is something distinctive about the

therapist as a secure base because they go beyond the Rogerian core conditions by gently and respectfully challenging client's internal working models. Furthermore, D. W. Winnicott, trained by Klein, developed the concept of mother-child relationship based on observation which can be linked to the idea of a secure base. He postulated that in order for an infant to develop an optimal feeling of self-worth, 'good enough mothering' (Winnicott, 1956) is necessary- i.e., the infant has to see himself mirrored in his mother's effect (Winnicott, 1965). Winnicott's theory is applicable to Attachment Theory as it posits environmental failure and the infant's reaction to it (Winnitcott, 1963).

With context to the therapeutic relationship, although there is reason to accept that clients who have had difficult childhood experiences with their caregivers might be able to establish a secure base with their therapist, there is no reason to believe that this will be a foregone conclusion. Thus, using an attachment framework, via an assessment of attachment style, a therapist may be able to predict the kind of transference i.e. positive or negative transference, a client may engage in (Eagle & Wolitzky, 2010). This is another way in which Attachment Theory further helps in exploring the experiences of CSA because it assumes that existing representations are carefully passed from one relationship to the next and transference is easily integrated into it (Tolmacz, 2003).

1.6 CSA and the Therapy Relationship

Long after CSA ends, many survivors still look to make sense of their abuse experiences (Park, 2010; Simon, Feiring, & McElroy, 2010; Wright, Crawford, & Sebastian, 2007; Silver, Boon, & Stones, 1983). Making sense of the abuse supports the individual in reflecting upon how the abuse experiences are incorporated into representations of the self, others, and the world (Park, 2010; Joseph & Linley, 2005; Janoff-Bulman, 1995).

Several authors have noted that there are a variety of challenges that mental health therapists face whilst working with adult women survivors of CSA such as self-mutilation, dissociative and eating disorders and antisocial behavior (Wise, Florio, Benz, & Geier, 2007). In addition, professionals are at risk of empathy fatigue that comes with listening to the stories of trauma survivors (Stebnicki, 2008) and secondary trauma (Lev-Wiesel, 2008; Etherington, 2000). Research suggests treatment for CSA survivors requires multi-problem intervention strategies because of the vast number of symptom possibilities (Lev-Wiesel, 2008), as well as peer supervision for the therapist to pay attention to boundary issues and promote personal self-care (Stebnicki, 2008). A study carried out by Chouliara et al. (2012) strongly highlighted "the importance of the therapeutic relationship for survivors, as well as challenges involved in developing and maintaining such relationship when working therapeutically with CSA survivors" (p. 159).

For survivors of trauma and sexual abuse, experiencing the asymmetries of power in the psychotherapy relationship may evoke a pattern of dominance and submission inherent in the societal

structure of sexual oppression and in the situation of abuse (Waites, 1993). Therefore, how therapists use the power in the therapeutic relationship has a significant bearing on whether or not the relationship is considered healing. Giving voice to the situation of abuse will challenge the inherent submission in the societal structure of sexual oppression. A qualitative narrative study conducted by Nelson (2007, 2009) highlighted that staff who were non-judgemental, caring, respectful, and have an established understanding of the effects of CSA were found to contribute more towards helping survivors of CSA. Furthermore, Draucker & Petrovic (1997) revealed that findings from their qualitative study of male survivors via unstructured interviews discovered that therapist traits such as being 'informed about male sexual abuse issues, informing the client about therapeutic process, respecting the client's process, connection to the client, going the distance, and letting client go at the appropriate time' proved to be beneficial for the client. Acknowledging the importance of the therapist's role during recovery process is vital and it is essential the survivor is the author of her own recovery. Judith Herman (1997) believed that interventions that take power away from the survivor, even though they appear to be in the best interest of the individual, cannot foster recovery. Therefore, validating the client's experience, helping them take control over their behaviour and empowering them will help nurture recovery. Koehn (2007), in his qualitative study using semi-structured interviews, found 'approach to power and control' were the main themes uncovered. Sub-themes such as 'willingness to offer choices', 'response to client as an equal or with honour', 'flexibility with agenda', 'response to criticism', 'sexual interest', 'approach to client's suggestions', 'expectations regarding forgiveness', and 'consultation with alter identities (in dissociative identity disorder)' were identified.

A study by Draucker & Petrovic (1997), on the other hand, indicated that negative incidences of the therapy relationship between therapist and patient also do occur. Judith Herman (1997) writes that, when an individual in adult life experiences repeated trauma, the structure of the personality already formed gets eroded; however, when a child is faced with repeated trauma during childhood, their personality is formed and deformed trying to face the formidable task of adaptation in an abusive environment. Individuals who have suffered CSA are forced to develop extraordinary capacities that are both destructive and creative to survive their pathological environment of abuse. As a result, the environment nurtures the development of abnormal state of consciousness where at times, the individual is no longer able to hold ordinary relations of body and mind, knowledge and memory and imagination and reality. The brain washing effects of trauma can impact the adult survivors by making them accustomed to doubting their own feelings, memories and bodily sensations leaving them to believe that the therapist's version of the truth is more believable than their own (Shannon, 1996). According to Flax (1990), being aware of the relational and unconscious aspects of therapy gives rise to the objectivity of the clinical situation. Whilst working with victims of abuse, the psychological impact it can have on therapists is particularly intense. Therefore it is not surprising that the therapist can experience the same feelings of helplessness, rage, terror and despair as the patient,

but to a smaller degree. This is known as traumatic countertransference (McCann, Pearlman, 1990). This phenomenon may sometimes cause therapists to emotionally withdraw from their clients. Unless therapists' adverse reactions are contained and understood, it could potentially lead to disruptions in the therapeutic alliance with patients. This present study provided service users an opportunity to raise their concerns and communicate their needs more clearly, which in turn may contribute to the accessibility and effectiveness of the service. It can also serve to contribute to the ethical recommendations of therapists having to educate clients about their role and to discuss the limitations of their knowledge and the impact of their subjectivity on the therapy process.

Positive changes have been recognised and documented in literature, philosophy and religion following adversity (Tedeschi & Calhoun, 1995). Several survivors of CSA continue to search to make meaning of their childhood abuse experiences long after the abuse ends (Park, 2010). Meaning made from the abuse experiences can echo how these experiences can be integrated into representations of the self, others and the world (Joseph & Linley, 2005). Not undervaluing the deleterious nature and effects of childhood sexual abuse, survivors report positive psychological change and growth after traumatic events (McElheran et al., 2012). Post- traumatic growth ("PTG") is defined as experiencing positive psychological change after going through traumatic life events (Calhoun & Tedeschi, 2006). The component of 'growth' within this concept refers to an individual's subjective perception of the benefits received from coping and dealing with trauma and its aftermath (Zoellner & Maercker, 2006). The leading theory of PTG is established on the notion that individuals develop a set of assumptions and beliefs about the world that offer a structure to guide their actions and develop a sense of meaning in their lives (Tedeschi & Calhoun, 1996). An individual's views of self, others, belief systems, their future and including the way they identify the world become instable when faced with trauma. A certain form of cognitive restructuring takes place after the event to consider the fact that traumatic events do occur (Hartley, et al, 2016). One possible effect of this is that the individual's beliefs become more resilient to future trauma, and this is experienced as 'growth' (Hartley et al; 2016). Woodward & Joseph (2003) highlighted results from a study based on individuals who were physically, emotionally or sexually abused as children, which showed that nearly all participants described positive change in self-perception, approximately two-thirds described positive change in their world philosophy, and one-fifth reported change in their relationships for the better. Adults with a history of childhood sexual abuse have shown positive changes in self-belief, improvement in personal strength, adopted better coping mechanisms, protected themselves as well as their children from danger, changed their interpersonal beliefs about intimacy, support and empathy, as well as changed beliefs and views about the world that highlight a better appreciation for life, growth in relation to religion and a greater sense of purpose (Hartley et al., 2016). However, it does not mean that adult survivors of CSA who report post traumatic growth are more resilient and feel less distressed in relation to their trauma (Tedeschi & Calhoun, 2004). As a matter of fact, a majority of survivors report, together with their ability to reflect on the psychological

benefits of dealing with trauma, that they are still dealing with the distress and suffering that comes from its aftermath (Tzadok & Arad 2016).

1.7 Psychotherapy Approaches at the Specialist Service for CSA

> "The new information that science has offered in recent decades makes it clear that something can be done to alleviate many social and mental health problems" (Gerhardt, 2004, p. 217).

This section outlines therapies that have been used to treat participants at this particular Woman's Service where the present study was conducted. Although there are a number of approaches to treat CSA, which include Schema-focused therapy, EMDR, Art therapy, Group Therapy, Psychodynamic Therapy, Person-Centred Therapy, Cognitive Behaviour Therapy, Family Therapy, Feminist Therapy, and Cognitive Analytic Therapy, amongst others, this section focuses in detail primarily on Psychodynamic, Art and Group therapy. The reason for this funnelled view is because this particular Service offers these treatments to their users. Each form of therapy offered at the Service is explored in detail, followed by the strengths and limitations of these therapies.

Rose, Freeman & Proudlock (2012) state that given the vast amount of research on the exposure to traumatic events and childhood trauma being an important precursor to developing a variety of serious and chronic mental health problems – "it appears that within the British National Health Service at least, this is not particularly addressed within the British NHS mental health services" (Rose et al., 2012). Nevertheless, documents published in 2008 looked into changing this. In March 2008, the Department of Health ("DH") published practice guidelines entitled "Refocusing the care programme: Approach and Practice Guidelines", which became policy in October 2008. The relevant section states that ''Childhood experience of sexual and other abuse is known to be more frequent in the histories of individuals with both mental illness and personality disorders'' (Department of Health, 2008, p. 28). In addition, the DH policy has incorporated appropriate training for staff and all mental health assessments involved in the exploration of abuse and violence. As discussed above, due to the non-specific psychopathological risk factor for CSA, it is expected that they are likely to require social, medical and psychological counselling services (Chouliara, 2012).

Given the statistics and prevalence discussed in the prior sections, along with the mental health difficulties encountered in particular to this population group, the significance and requirement of implementing effective treatments is urgent and necessary. While abuse-focused therapy depends on the well-known principles and standards of practice that inform generic psychotherapy, more than a handful of authors, including Meiselman (1994), propose that the treatment of the long-term effects of CSA vary from generic therapy. "Traditional schools of therapy offer ideas about how to confront some aspects of this complex treatment challenge, but none seems adequate by itself" (Meiselman, 1994, p. 92). A variety of authors suggest that due to the nature of CSA, which usually comprises of

interpersonal betrayal during childhood, and includes varying levels of confusion, shame, blame and physical pain, working with this population can be challenging (Briere, 2002; Herman, 1992).

When working with survivors of CSA, it is essential to consider therapeutic boundaries because their personal limits were violated growing up, often before they had the adequate knowledge to understand the limits of interpersonal relationships, thus restricting their ability to make appropriate judgements about themselves or others. A study by Harper (2006) highlighted the importance of recognizing 'how boundary decisions are made and understanding the effects of these decisions on the survivor, therapist, and therapeutic relationship'. A complex issue for both survivors and therapists is exercising choice. In order to help therapists develop a safer and contained therapeutic environment, issues that affect boundary decisions and the negotiation processes need to be recognized and appreciated.

Furthermore, generalised and deeply embedded childhood trauma, over time, can render working with adult survivors particularly vulnerable to therapy errors (McGregor, 2001; Dale, 1999). Taylor & Harvey (2010) conducted a meta-analysis of the treatment outcome for survivors of CSA. Their research included 44 studies and 59 treatment conditions. There were a few limitations to their research, such as the interpretation of data was affected by the heterogeneity of effect sizes and there was a suggestion of evidence bias in their independent sample status. As a result, their research did not take into account the percentage of individuals who did not engage in therapy or the ones who did not find therapy beneficial. However, based on their overall findings, they concluded that psychotherapy approaches for the psychological effects for CSA on adult survivors were found to be beneficial and these effects were maintained for at least six months following therapy (Taylor & Harvey, 2010).

There have been a number of narrative reviews that sought to evaluate the outcome of therapy with adult survivors of CSA (Chouliara et al., 2012; Marsoft & Draucker, 2005; Kessler et al., 2003; Cahill et al., 1991). Findings from the above studies suggest that abused-focused therapy have shown to reduce symptoms of depression, improve functioning and have an overall positive effect on well-being. In addition, they have also noted that there is a further need for research to explore which aspects of treatment modalities, client characteristics, negative aspects of therapy and what optimal durations have a positive effect on outcome. In keeping in mind the gap in literature that has been identified by Marsoft & Draucker (2005), McGregor et al. (2005) and Chouliara et al. (2012), to name a few, this research study attempts to address an aspect of this by exploring the experiences of women attending a specialist psychotherapy service for survivors of CSA from their own direct perspective.

1.8 Psychodynamic Approaches and Empirical Research

> "Psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by an overwhelming force. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning" (Herman, 1997, p. 33).

As more research is carried out to explore the developmental, complex interpersonal and the relational impact of CSA on the adult survivors, the advantages of psychodynamic treatment for adult survivors continue to rise. Early psychoanalytic thinking mainly focused on attempting to reconstruct trauma, however, contemporary psychoanalytic thoughts no longer emphasize this but rather aim to work with survivors of CSA within a relational framework. This implies the co-creation of a transitional space, whereby the patient and therapist act freely by re-creating the relational matrices of the patient's early life and creating context and meaning (Davies & Frawley, 1994). In addition, Nemiroff et al. (2000) argued that general trauma theory remains too constricted to adequately look at the traumagenic sequelae of CSA survivors; conversely psychodynamic theory identifies that "the material of dissociation as well as the process of dissociating become fundamental aspects of the survivor's sense of identity and of self- they become characterological" (p. 666). Psychodynamic theorists are still in disagreement on a variety of matters related to CSA. However, they agree that understanding the development of dissociated parts of self is essential and must be brought into closer communication (Spermon et al., 2010).

In addition, exploring the transferential relationship in relation to the developmental history is another key element for psychodynamic theorists (Tummala-Narra, 2011; Spermon et al., 2010; Kudler et al., 2009). The relational treatment model acknowledges that 'neutrality' is difficult within the therapy relationship. Therapists are usually drawn towards the transference and countertransference feelings and can sometimes be caught up within it (Davies & Frawley, 1994). In particular, a mutual factor that arises across all psychodynamic approaches is the "awareness of the therapist's own emotional reactions to the patient within the treatment situation," labelled countertransference (Spermon et al., 2010, p. 5). The consciousness of the impact of transference and the healing power of the relationship between client and the psychodynamic therapist is one of the most significant aspects of the traumagenic sequelae that adult survivors of CSA experience.

The Diagnostic and Statistical Manual of Mental Disorders 5 ("DSM 5") echoes this in the intrusive cluster of PTSD whereby an individual suffering from PTSD behaves or feels as though the traumatic experience recurs. For over a century, psychodynamic psychotherapy has been evolving to treat the traumagenic sequelae related to CSA and its principles "can facilitate treatment across a broad range of approaches, psychodynamic or otherwise" (Spermon et al., 2010; Kudler et al., 2009, p. 346). Apart from the PTSD symptoms stated in the International Classification of Mental and Behavioural

Disorders 10 ("ICD-10"), PTSD associated with CSA also elicits issues with emotional regulation, interpersonal relationships and self-concept. Herman (1992) refers to this as 'complex trauma'. She further expanded the description of six categories of symptoms that have been adopted by many in the field including van der Kolk et al. (2005). These include alterations in: affect regulation, consciousness, self-perception, perception of the perpetrator, relations with others, and systems of meaning.

Abbas & Macfie (2013) carried out supportive and insight-oriented psychodynamic psychotherapy for PTSD in an adult male survivor of sexual abuse and found that the improvement that occurred during psychodynamic psychotherapy was the ability to gain mastery over the trauma and regain mastery over his life. Furthermore, they state that reintegration takes place when the creation of meaning surfaces and the trauma survivor can incorporate the trauma into his or her self-concept (Abbas & Macfie, 2013). Although their study focused on one male survivor, rich detailed accounts of his symptoms were outlined. A study conducted by Lampe et al. (2014) looked at the long-term course of 43 female survivors of CSA after receiving psychodynamic-orientated trauma therapy in an in-patient setting. The findings of their study revealed a clear alleviation of symptoms after 6 weeks of being hospitalized. Some of these effects also lasted two years after hospitalization and continuing therapy.

While a number of psychodynamic clinicians have endeavoured to provide a framework for the healing and stages of recovery for the adult CSA survivor (Tummala-Narra, 2011; Matthews & Chu, 1997; Wells et al., 1995; Herman, 1992), the fact is that psychodynamic treatment process for adult survivors of CSA is complicated and has various dimensions to it, and thus may not follow a structure or framework of stages.

There is evidence to show that psychodynamic psychotherapy has been seen for its contributions to treating depression, self-esteem and interpersonal problems as well as problems associated with presentations of complex trauma in adult survivors of CSA (Schottenbauer, Arnkoff, Glass, & Gray, 2008; Price, Hilsenroth, Callahan, Petretic-Jackson, & Bonge, 2004). The main element that psychodynamic therapy is recognised for is establishing a strong therapeutic alliance in therapy. Although a positive alliance between the therapist and adult survivors of CSA was identified early on in therapy in a study by Price et al. (2004), psychodynamic empirical research is narrow, and this limitation has been acknowledged as a consequence of psychodynamic researchers facing substantial problems using conventional research paradigms to assess their work (Kudler, Krupnick, Blank, Herman, Horowitz, 2009). Supplementary research examining psychodynamic psychotherapy for the treatment of adult survivors of CSA is required (Schottenbauer, Arnkoff, Glass, & Gray, 2008).

Foa et al. (2009) debated that psychodynamic therapy offers a capacity to develop stronger motivation, insight into psychological mindedness, and distress tolerance. However, for individuals with certain symptoms associated with trauma and PTSD, the symptoms may present as a limitation

while seeking psychodynamic therapy. They conducted a study to assess the effectiveness of short-term psychodynamic psychotherapy with adult survivors of CSA (Price et al., 2004). Their study comprised of 27 participants that were consecutively admitted at a community outpatient psychological clinic. They were categorised into two groups: 15 patients without a history of CSA and a group of 12 patients with a history of CSA. The length of treatment varied based on collaborative decisions of the patients' and clinicians' recommendations as well as client progress. The average duration was 26 sessions over a period of six-months. Short-term psychodynamic treatment was provided once or twice a week (Price, Hilsenroth, Callahan, Petretic-Jackson, & Bonge, 2004; Blagys & Hilsenroth, 2000). Findings indicated that survivors of CSA demonstrated a significant improvement in the level of functioning and symptomatic distress according to clinical rating scales and self-report measures (Price et al., 2004). Positive therapeutic alliances were developed amongst adult survivors of CSA, in comparison to the non-abused group. The response to treatment were similar to both groups, however, adult survivors of CSA displayed a greater potential for change with regard to feelings about the self. Although the findings seem promising, potential limitations must be considered. As the history of their CSA was not taken and participants did not seek treatment for CSA particularly, these findings cannot be generalised to individuals explicitly pursuing treatment for CSA. However, these findings show that for this specific group of CSA survivors, psychodynamic psychotherapy was beneficial and can be useful for those with CSA, presenting with interpersonal difficulties and depressive symptoms.

Similarly, a review for the effectiveness of individual therapy for the treatment of survivors of CSA was carried out by Price, Hilsenroth, Petretic-Jackson, and Bonge (2001). Results of their study showed that between 1989 and 1999, only a single study which integrated psychodynamic treatment approach was found. In addition to the above, a study was carried out to investigate a long-term case to exemplify a psychodynamic perspective in relation to childhood sexual trauma. This study explored and identified difficulties that are inextricably interwoven in the client's experience of trauma that has an impact on the therapeutic alliance. Although the study explored the success and difficulties that take place in the therapeutic relationship, the findings from this study are difficult to generalise as it was a single case study. According to a case study by Krupnick (2002), following the occurrence of a single traumatic event, brief psychodynamic therapy has been useful in treating individuals suffering from PTSD. The outcome of the case study demonstrated a reduction in PTSD symptoms and improved psychosocial functioning and coping ability after a six-month follow-up.

Randomised controlled trials are required to verify and strengthen the efficacy of psychodynamic psychotherapy for PTSD and CSA survivors (Woller, Leichsenring, Leweke, & Kruse, 2012; Schottenbauer, Glass, Arnkoff, & Gray, 2008). Even though individuals with PTSD exhibit high drop-out rates, it has been argued that psychodynamic approaches assist with addressing essential symptoms of trauma and PTSD (Schottenbauer, Glass, Arnkoff & Gray, 2008).

1.9 Art Therapy and Adult Survivors of CSA

Art therapy is defined by Tessa Dalley (1984) as "a form of psychotherapy which utilizes art in mental treatment and stimulates patients to express their feelings through artistic expression". Art therapy sits under the umbrella of creative therapies. It provides us with a framework that is unique, which makes working with uncomfortable memories attainable through the use of imagery. For most people accessing painful and uncomfortable memories is a process that is inherently difficult and a number of strategies are used to avoid engaging with these memories. Several studies have associated the concept of avoidance or escaping unhealthy emotions and memories with psychopathology (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Often times a client is able to engage with the process when an image is produced, thus enabling an interaction with parts of self that were previously vague and indescribable (Huprich, 2008; Ramm, 2005). Art therapy appears to provide richness to the therapy process by attempting to give access to parts of self that are hidden, encouraging creativity where talk therapy may not (Wadeson, 2000).

According to Howard (1990), visually encoded memories are difficult to describe using words. He further points out that such memories can be accessed through the visual process of creating artwork. Traumatic imagery that has been embedded in the unconscious can be accessed by the pictographic method of story-telling that art therapy provides. In addition, art gives survivors an avenue to express metaphors of their experiences, which in turn can help validate their traumatic past. Art therapy also serves as a vessel for accessing hidden childhood trauma and the inner conflict that comes with it, whilst providing an environment that is safe and containing for the survivor as their story emerges.

Art therapy has proved to be useful amongst individuals who have who have undergone sexual trauma (Pifalo, 2002, 2006; Backos & Pagon, 1999). Analysis from studies highlight that art therapy is predominantly beneficial in treating chronic PTSD, especially popular among adult survivors of CSA (Collie, Backos, Malchiodi, & Spiegel, 2006). A study by Collie et al. (2006) looked at a conceptual foundation for research about art therapy as a treatment for combat-related PTSD. This was carried out by situating art therapy within the context of other PTSD treatments. Their study of art therapy within a group setting was carried out in three stages. They recommended that art therapy clinicians working with combat-related PTSD patients be given extensive and specialist training with relation to PTSD theory and trauma invention.

A pilot study carried out by Pifalo (2006), which integrated Cognitive Behavioural Therapy ("CBT") interventions along with art therapy, revealed that participants reported a reduction in PTSD symptoms. These participants experienced CSA between the ages of 8 to 16. Forty-one participants received therapy for 8 weeks and were divided in small groups. Participants conveyed a decrease in symptoms of depression, anxiety, PTSD, anger and dissociation, subsequent to treatment. While this study preliminary supports the use for integration of CBT and art therapy with sexually abused

individuals, it was short of a control group. Henderson, Rosen, and Mascaro (2007) compared trauma focused mandala art therapy with trauma-focused art therapy with a control art therapy condition. Their study comprised of 36 undergraduate females and males. A trauma history was reported by all participants, however, all the trauma was not specific to CSA. Participants' symptoms were investigated using the Beck Depression Inventory ± Second Edition (BDI-II), Posttraumatic Stress Disorder Scale (PDS), and the State-Trait Anxiety Inventory (STAI), separately. No significant difference was found post treatment; yet, the trauma-focused mandala group at the one month follow-up had a reduced amount of severe symptoms of PTSD compared to that of the control group. An obvious limitation that stood out in this study was the small sample size. Furthermore, it also lacked a direct comparison between the two groups. However, despite the limitations, the findings suggest that trauma-focused art therapy can be beneficial in decreasing PTSD symptoms.

In addition, Schorre (2001) stressed that adult survivors of abuse commonly experience a difficulty in finding words to describe or explain emotional stress associated with childhood experiences. He argued that structurally defective right side of brains are developed by children who experience dysfunctional attachments during early childhood due to trauma. The part of the brain that encodes CSA memories is the right hemisphere (Shorre, 2001). The hampered development of the right hemisphere in the brain due to poorly formed attachments by children can develop inadequate coping mechanisms with regard to recognising emotions in faces, coping with negative affectivities and a tendency to have a low self-esteem. As a result, meaning-making and affect regulating pathways in a lot of abused children fail to develop. Thus, as art therapy is an imagery-based and symbolic technique, it may be valuable whilst working with adult survivors of CSA. Furthermore, it can help encourage articulation of trauma in a non-verbal symbolic manner. Many survivors were manipulated as children into trusting others and people in authority (Pifalo, 2007). Therefore they learn that they cannot rely on people in authority or adults who claimed to be trustworthy, thus limiting their verbal communication (Pifalo, 2007).

A pilot study conducted by Becker (2015) explored the feasibility of integrating art tasks within group therapy for adult survivors of CSA experiencing PTSD. Findings from the this study revealed that participants reported a reduction in PTSD symptoms after nine weeks of treatment and a one month follow-up, and also indicated that taking part in the art treatment group may have contributed towards improving PTSD symptoms. A systematic review by Schouten et al. (2015) was conducted to evaluate and identify research on art therapy in association with adults who have experienced complex trauma. Findings from one study suggested a significant decrease in depression, and the treatment groups reported a significant decrease in psychological trauma symptoms. In addition, a case study conducted by Skeffington & Browne (2014) revealed that change is expected in an art therapy environment, and is most likely to occur in a way that is 'meaningful to the individual rather than in an expected

pattern'. This suggests that art therapy is beneficial in overcoming avoidance in the therapy relationship.

It has been recognised that art therapy can be beneficial whilst working with adult survivors of CSA; however further research in the field is much required as there are many unanswered questions that remain. A consistent limitation in the literature with regard to art therapy is the absence of control groups and small sample size, highlighting the need for further research to be conducted within the field.

1.10 Group Therapy and Adult Survivors of CSA

Group psychotherapy is gaining popularity amongst adult survivors of CSA as a treatment of choice (Richter, Snider, & Gorey, 1997; Alexander, Neimeyer, Follette, Moore, & Harter, 1989). Recently, its popularity is also largely attributed to the cost-effective aspect of group therapy. Research indicates that group psychotherapy among women with a CSA history is a valuable treatment, and studies reveal the progress or maintenance in the results during follow-up periods with relation to PTSD symptoms, psychological distress and psychosocial functioning (Taylor & Harvey, 2010; Peleikis & Dahl, 2005). Yet, there are not many randomized controlled trials that study their effectiveness and more information is required concerning which type of group psychotherapy is most beneficial and has the maximum durable effect (Lau & Kristensen, 2007; Spiegel, Classen et al., 2005; Alexander, Neimeyer, Follette, Moore, & Harter, 1989).

A study carried about by Lau & Kristensen (2007) suggested that for adult survivors of CSA, group therapy is effective and linked to improvements in psychiatric symptoms, betterment in quality of life and psychosocial functioning. Their study measured the outcome of analytic and systemic group therapy with 151 women who experienced CSA. The 151 participants were randomly allocated to each group. Pre and post-test designs were adopted to evaluate participants at assessment, at the start and the at end of therapy. The treatment effects that were measured at all three stages were flashbacks, quality of life, psychological distress, relational problems and psycho-social functioning. Both the groups showed a reduction in symptoms in these women. The outcome of the systemic group, however, was superior in comparison to the analytic group. The systemic group conveyed that they appreciated the structure and active role the therapist played in therapy in comparison to the analytic group. That said, participants in both groups valued feeling safe during therapy.

Similarly, Coulsen and Morfett (2013) published a study that was based on Irvin Yalom's integrative approach, making use of the qualitative feedback from group members described in his work "The Theory and Practice of Group Psychotherapy". They highlighted that 'the power of group work was an important element in a person's recovery, because magic happens' and by that they meant the women would understand and listen to one another, challenge each other's beliefs about self-blame,

guilt and shame in a way that was different from individual therapy (Coulsen & Morfett, 2013). In addition, Calvert et al. (2015) carried out a study that aimed to evaluate the effectiveness of group cognitive analytic therapy ("GCAT") which is also an integrative approach for female survivors of CSA who were highly distressed in clinical practice. The findings of their study suggested GCAT can be an effective approach for individuals finishing therapy as an additional care treatment that is provided in secondary care settings.

Furthermore, Ryan et al. (2005) conducted a study that looked at the efficiency of both individual and group therapy for female adult survivors of CSA and found a highly significant positive treatment effect for both individual and group therapy conditions. Their findings are both clinically and statistically significant. For instance, both treatment groups in their study indicated an average improvement on the Beck's Depression Inventory scale comparing before and after treatment of 12.4 points, thus representing a clinically significant shift in the levels of depression. A quantitative outcome study that included 26 studies by Parker, Fourt, Langmuir, Dalton, and Classen (2007) revealed that both individual and group therapy were effective in the overall reduction of PTSD symptoms. In addition, group therapy assists members in making sense of their own experiences and behaviours by helping them recognise others' experiences to trauma. This in turn can decrease feelings of disconnection, isolation and self-blame from others. Group therapy can also be beneficial as it needs members to support and attend to the needs of others in the group whilst providing themselves with an opportunity to be accepted and valuable to others (Fritch & Lynch, 2008).

Research carried out by Ellis (2012) was aimed at demonstrating the effectiveness of group therapy programmes for 59 adult survivors of CSA, through the use of "The Butterfly Programme", i.e. a group programme developed using a variety of therapeutic methods running over a period of eight weeks. Results from her study were measured using questionnaires, which were completed at the start and the end of the treatment programme. The Rosenberg self-esteem, self-report measure of global self-esteem and a reliable ten-item scale were employed to assess the effectiveness of the programme. The findings suggested positive effects from the Butterfly programme group therapy, indicating that the women were able to speak about difficult emotions linked to their experience of CSA and improve their interpersonal relationships. This in turn also facilitated a reduction of their dependency on 'peripheral' medical services and helped them advance their employment and education prospects.

Additionally, a study by Sigurdardottir et al. (2016) aimed to present a description of the Wellness-Program, another group program, for female CSA survivors. Findings from their study indicated a considerable improvement of health and well-being of the women who engaged with the programme. The wellness-program ran for a period of 10 weeks and consisted of 20 hours per week with an organised scheduled. Participants described an increase in self-confidence, a reduction in the feelings of guilt, blame and self-loathing and furthermore an ability to learn to love themselves through the

process of therapy. However, the study acknowledged that further assessment of the programme is necessary before it is made available to healthcare systems (Sigurdardottir et al., 2016).

Although the above studies indicate the effective use of group therapy with adult survivors of CSA, there still remains a debate over the success of it with this population. This is particularly true in relation to psychologists receiving different theoretical training, and using group therapy for a varied number of mental health difficulties (Ellis, 2012). One of the clear disparities between group and individual therapy is the amount of people attending therapy in one session. Groups are often convenient for services as they are cost effective, and in many cases, clients rarely have the choice of engaging in individual therapy instead. Research carried out on the efficacy of group therapy by psychologists has discovered that there are a number of benefits that accompany group therapy that may not always be dealt with in individual therapy (Ellis, 2012). Equally, though, it has been established that certain individuals did not gain from group therapy.

1.11 The Woman's Service and Rationale for Research

A detailed plan about developing specific therapeutic interventions and appropriate support for women in the NHS is provided by the department of health policy on mainstreaming gender and women's mental health (2003). However, there is evidence of limited and patchy provision of specialist psychological therapy services for women in the UK who are survivors of CSA (Smith, Pearce, Pringle, & Caplan, 1995). The experience of using such services has seldom been explored from a survivors' point of view or perspective (Chouliara et al., 2011). Thus, we have an unclear picture of whether or not CSA survivors perceive their needs and service provisions similarly to clinicians or whether their requirements are catered to in clinical settings (Draucker & Oetrovic, 1997).

Despite the variety of studies carried out on adult survivors of CSA, Chouliara et al. (2011) argue that till date, there is a significant lack of research published discussing the views and experiences of survivors and professionals who work with survivors, particularly in Scotland and the United Kingdom. Notably, there is a lack of information from a survivor's perspective (Chouliara et al., 2012). It has been further identified that lack of research in the area is partly due to the "gate keeping attitudes" of professionals working in the field, in addition to the already existing sensitive nature and stereotype surrounding the topic, often causing low functioning or high co-morbidity of participants (Chouliaria et al., 2009; Way et al., 2004).

A variety of psychological, relational, social, sexual and physical difficulties ranging in severity are likely to be experienced by survivors of CSA (Michaud et al., 2001; Kessler et al., 1995). As a result, adult survivors are more likely to access social, medical and psychotherapy and counselling services (Chouliara et al., 2012). Furthermore, research has well established that amongst CSA survivors, the

long-term damage caused by CSA is evident. Equally, a variety of studies mentioned above have addressed effectiveness of several treatment modalities targeting the psychological sequelae related to such abuse. Nonetheless, in spite of the recent rise in the awareness of different psychological therapies offered within the field of psychology, a scarce amount of studies have sought to explore the efficacy of specialist services for CSA from a survivors perspective.

The NHS Specialist Service upon (which I refer in this study interchangeable with "The Woman's Service" or "The Service", and have intentionally not disclosed further details on to maintain anonymity) was established 14 years ago and has been successfully operating since then. An early audit that was carried out in the first two years after the service opened, as well as a service report prepared by the service from 2008-2009, showed that the Woman's Service had been effective in providing specialist treatment which helped reduce the need for patients to engage in further services following discharge (Amar, 2009). The results indicated that most patients did not require any additional involvement with health services and therefore maintained an overall improved level of functioning. More recently, an unpublished quantitative service audit was carried out by Wieliczko (2013), which indicated that overall, 61.1% of clients had reliably improved after therapy, using the Core-OM as a measure of testing the outcome. Among those, 38.9% had also improved clinically. Since then, no further studies have been conducted on this Service.

Thus, in view of the above findings on the Woman's Service, as well as the highlighted gap in the literature, I became interested in carrying out a more detailed and in-depth analysis to explore the clients' individual experience of therapy at service. The aim of my study is to capture a qualitative illustration of the experiences and perspectives of women attending a specialist service for female CSA survivors. I hope it can be accretive to the field of psychology when assessing the effectiveness of psychodynamic, art and group therapy, the three main approaches used at this service, to treat survivors of CSA. In view of the research mentioned above i.e. (Chouliara et al., 2012; Hilden et al., 2004; Smith, Pearce, Pringle, & Caplan, 1995) this study can also contribute to the further development of specialist services in the UK for women who are survivors of CSA, which in turn can benefit the overall field of counselling psychology. It can also be of general interest to psychologists, psychotherapists, social workers, researchers and others practitioners/providers interested in the field of CSA.

1.12 Research Question

How do women experience attending a specialist psychotherapy service for survivors of childhood sexual abuse?

Chapter 2

Methodology & Procedures

2.1 Research Aims

The aim of this research study is to explore in depth the lived experience of women attending a specialist psychotherapy service for survivors of childhood sexual abuse ("CSA"). The essence of the study is to capture the women's experience of attending a specialist psychotherapy service, as well as the meaning and implications this may have on their existence after experiencing childhood sexual abuse, from their own perspective and voice.

2.2 Research Question

How do women experience attending a specialist psychotherapy service for survivors of childhood sexual abuse?

2.3 Research Design

This study uses a qualitative research design. The data was collected from a small sample of women attending the Woman's Service referenced in the prior chapter. Semi-structured interviews were employed to gather information from participants. The accumulated data was analysed using Interpretive Phenomenological Analysis ("IPA") (Smith et al., 2009), as this approach attempts to understand the subjective experience of an individual in relation to their life and how each individual makes sense of that experience by describing phenomena as it presents itself to them.

2.4 Rationale for Chosen Paradigm

Understanding experiences is the key basis of qualitative methodology. Qualitative researchers are concerned with meaning-making, subjectivity and experience (Willig, 2013). Qualitative research involves a process of rigorous and careful inquiry into aspects of the social world and it intends to establish an understanding of how the world is constructed (McLeod, 2001). The underpinning of a qualitative study recognises that understanding objects is not the same as understanding experience. Therefore, I employed a qualitative methodology as this study aims to explore the individual experience (i.e. concerned with the quality and texture of experience) of attending a specialist service for childhood sexual abuse. According to McLeod (2005), our personal, social and relational world is layered and complex and can be viewed from different perspectives. This research attempts to understand participants' experiences in a particular context and how they make sense of their world.

Finlay & Ballinger (2006) propose that the process of carrying out qualitative research is like embarking on a 'quest', giving us the sense that an 'adventure' lays ahead (Willig, 2001). The findings of this adventure can potentially help inform others in similar situations to seek appropriate help and perhaps make a difference in other people's lives.

This research study does not rely on a quantitative methodology because it does not look for a cause-effect relationship. It does not aim to work with predefined variables before the research process starts, is not scientific in nature, and nor does it warrant the use of statistical analysis. Mainstream psychology is still dominated by the underpinnings of a positivist standpoint where knowledge and social facts are believed to be uncovered (Langdridge, 2007). As this research is interested in the experiences, thoughts, feelings and emotions, a quantitative methodology may not provide us with these answers. That said, the merits of one methodology over the other are not the most obvious in the field of psychology. While qualitative methods are gaining an increase in popularity in mainstream psychology and the British Journal of Social Psychology and Journal of Health Psychology are starting to increase their numbers of qualitative psychologists on their editorial boards (Willig & Stainton-Rogers, 2008), clear and simplistic distinctions between the research methods are far from being adequate and prove to be highly problematic (Denzin and Lincoln, 2005; Crotty, 1998). Qualitative research supports the belief that knowledge is always socially constructed to an extent and is intersubjective (Langdridge, 2007). It can be used to further examine areas where little information is known or where much is known in order to gain different understandings (Stern, 1980). A pluralistic framework is a common core principle to both counselling psychology and qualitative research. It identifies that there is no one way to study a world that is diverse (Kasket & Rodriguez, 2011). As argued by Cooper (2007), the main principle of a pluralistic framework is that psychological difficulties might have various causes and it is unlikely that there is one correct or right therapeutic method that might be appropriate in all situations. This might suggest that different chosen methods will certainly discover different things (Willig, 2001). Willig (2013) postulated that there are different types of knowledge: realist knowledge, phenomenological knowledge, and social constructionist knowledge. She suggested that the research methodology that one employs should be guided by the type of knowledge they are seeking. A positive bi-product of qualitative research is that it can lead to a rich diversity in underlying findings. It moves beyond a positive outlook on reality and views all knowledge as changeable, thus allowing phenomena and experiences to be seen in their many forms (Langdridge, 2007). McLeod (2002) points out that the super-ordinate research approach within counselling psychology should be methodological pluralism, which is incorporating both qualitative and quantitative methodologies. Given that a wealth of quantitative research is already existent in the field of CSA, I believe that focusing on a purely qualitative approach may contribute to the methodological pluralism of the research body.

McLeod (2003) further notes that another aim of qualitative research is to illuminate and clarify the meaning of social actions and situations in order to gain understanding rather than explanation. Thus, qualitative research can help in gaining a deeper understanding of a topic, which can be a valuable avenue of information and contribute to the field of counselling psychology by further informing our therapeutic practice. As a result, it is proving to be a popular method of enquiry for human based psychological research (Kasket & Rodriguez, 2011).

2.5 Philosophical Underpinnings of IPA

Interpretative Phenomenological Analysis ("IPA") is "a qualitative research approach committed to the examination of how people make sense of their major life experiences" (Smith, Flowers and Larkin, 2010). IPA is interested in understanding how individuals view and experience their world, with sufficient acknowledgement that it is impossible to gain direct access into an individual's personal world (Willig, 2011). IPA is a recently developed method that has been gaining popularity and is rapidly growing in the field of psychology, becoming a chosen method for many counselling and clinical psychologists. Although originally best known in psychology, it is now a well-established method for those working in other disciplines such as social, human and health sciences (Smith et al., 2009).

Phenomenology, hermeneutics and idiography are the three main pillars that form IPA's theoretical underpinnings. In the ensuing sections, I explore in detail the foundations of phenomenology, assess the role that hermeneutics play, explore the influence of idiography, and finally describe some of the key elements of an IPA framework.

Phenomenology

Kvale (1996, p. 53) describes:

> "Phenomenology is interested in elucidating both that which appears and the manner in which it appears. It studies the subjects' perspectives of their world; attempts to describe in detail the content and structure of the subjects' perspectives of their world; attempts to describe in detail the content and structure of the subjects' consciousness, to grasp the qualitative diversity of their experiences and to explicate their essential meanings".

Phenomenology aims to explore the individual's personal experience as it appears, by setting aside or 'bracketing' our assumptions about the object of inquiry. A phenomenological researcher believes that it makes no sense to think of the world as subjects and objects that are separate from our experience of them (Willig, 2011). The main focus is on how a person, object or event is made sense of and experienced in the context of our lived world (Finlay, 2009; Langdridge, 2007). As IPA is

largely interested in exploring the individual experience of a person in a particular context, it would be incomplete not to examine Husserl's attempts to construct a philosophical science of consciousness. Husserl (1970, 1982) was largely interested in understanding how objects or things appear and "present themselves to us in our consciousness" (Spinelli, 2005, p. 6). Husserl phenomenology was particularly concerned with examining our everyday experience by stepping out of our 'natural attitude'. He formulated transcendental phenomenology in the early 20th century which was interested in the way the world presents itself to us. Phenomenology in its original form is focused largely with the philosophical belief that human beings have an intentional and conscious relationship with their world and this concept underlines the descriptive transcendental method. One of its main principles was to set aside or bracket our assumptions that we might have about them. However, phenomenological researchers in psychology claim that it is not always possible to suspend biases and assumptions in contemplating a phenomenon. Husserl used the term 'intentionality' to explain the relationship between the process occurring in consciousness and the object of attention for that process (Smith, 2008). As phenomenology is concerned with the way the world appears to us, our experience through practical engagements with objects and others in the world and the reality in which we live in, is inherently meaningful (Smith et al., 2009), and any human experience can be subjected to phenomenological analysis. As a result, this approach is also of interest to psychological researchers. However, there are dissimilarities in emphasis and focus between phenomenological method in psychology and the transcendental phenomenology as a philosophy. Phenomenological psychology is more interested with the variability and diversity of human experience rather than the identification of essence according to Husserl (Spinelli, 1989). IPA researchers have drawn upon the work of Husserl to mainly focus on the process of reflection (Willig, 2011). Thus, my research study is embedded in a phenomenological approach as it involves an exploration of the participants' perception of their experience of attending a specialist service for adult survivors of CSA, rather than producing an objective record of the experience or event itself. Though Husserl was interested in finding the essence of experience, IPA is more concerned with attempting to capture particular experiences of individuals as they appear in a particular context (Smith, 2009), which is what I attempt to do in this study.

Hermeneutics

Hermeneutics, unlike Phenomenology, claims that understanding is always from a perspective and the researcher can never be free of the 'prejudices' that might come about from being a part of culture and using language (McLeod, 2001). In essence, it is the theory of interpretation. Heidegger, a student of Husserl, highlighted his divergence from him in relation to this subject (Smith, Flowers & Larkin, 2009). His aim was to bridge both the concepts of phenomenology and hermeneutics. His phenomenological approach notes the shift from the descriptive transcendental project to laying the

foundations for the beginning of the existential and hermeneutic impact in phenomenological philosophy. Hermeneutics began with interpreting biblical texts and grew to establish a broader concern with the process of interpretation (Packer & Addison, 1989). The goal of hermeneutics is to understand the lived experiences of individuals i.e. the very nature of being-in-the-world. It takes into account the implication of the researcher's own world view, as well as the type of interaction between the individual and the researcher. The phenomenological concept of 'intersubjectivity' refers to the overlapping, shared and relational nature of our engagement in the world and "experience and knowledge are always intersubjective and temporal" (Smith et al., 2009, p. 16). Heidegger's perspective on 'intersubjectivity' highlights the fact that we are relational beings and are constantly involved in a process of communication with and making sense of the other. A Heideggerean (1962) perspective posits that it is not always possible to describe simply what we see, as language mediates and shapes our experience and perceived realities (Ricoeur, 1996). Our dependence on language iterates that there can never be complete transparency or direct access to our experiences (Polt, 1999; Ricoeur, 1996). The Hermeneutic interpretation that underpins the theoretical foundations of IPA in essence is more than just a re-description of the material. It aims to capture the quality and texture of the individual experience. However, it acknowledges that experience is never directly accessible to the researcher (Willig, 2011). Given IPA acknowledges that it is impossible to gain direct access into an individual's world, it highlights the importance of the researcher's role in trying to make sense of the participant making sense of their world (Smith & Osborn, 2008). Thus, the researcher is engaged in a 'double hermeneutic' or two stage interpretation process, with the researcher "trying to make sense of the sense-making activities of the participant" (Langdridge, 2007, p. 68). Therefore, IPA is an interpretation of the participant's experience, wishing to capture the quality and texture, although identifying that such an experience is never directly available to the researcher (Willig, 2013). Heidegger re-evaluates the role of bracketing with relation to the interpretation of qualitative data by unpacking the relationship between interpretative work and the fore structure of our understanding (Smith, 2009). This further helps us understand that bracketing is something that can only be achieved partially. In this study, the interpretation on the participants' narratives relies on the researcher making it a two stage interpretation process, which is dependent on the researcher's perspectives that are required to make sense of the participants' personal world which the researcher is not a part of.

Phenomenology and hermeneutics form two of IPA's main theoretical underpinnings and it is believed that they are "the roots of all qualitative research" (McLeod, 2002, p. 56). This study merges phenomenology and hermeneutics and strives to "focus on the life world", and simultaneously maintains "the interpretation of meaning as its central theme" (Kvale, 1996, p. 38).

Idiography

Idiography is the third major influence on IPA which is focused primarily on the particular. Gorden Allport (1962) is the founding father of idiography. He is recognised for his interest in the unique experience and behaviour of an individual and an individual being studied as a unique case (Smith, 2008). Whilst general psychology is 'nomothetic' in nature i.e. concerned with making generalisations at a group or population level, IPA is idiographic in nature, exploring the interpersonal and subjective involvement of human thought, emotion and action with an attempt to gain a deeper understanding of the phenomena under investigation (Smith, 2008). It is committed to understanding how people in a particular context experience a particular phenomenon i.e. a process, relationship or event. An idiographic approach focuses on the interplay of factors which are specific to the individual (Smith, 2008). This study employs an idiographic approach as it attempts to look at the subjective experiences of the individual participants and discover the underlying meaning of their experience.

Key Elements of the IPA Framework

IPA's main focus is to give consideration to each participant's account, and therefore, sample studies tend to be small as that allows detailed analysis of each case (Pietkiewicz & Smith, 2014). While there is no firm rule on the number of participants that should be included, it depends partly on whether the researcher aims to focus on an individual case or present a more general account of a specific group or population. Given the aim of this study is focused on a particular group, the latter of these was more relevant for this study. Smith et al. (2009) suggests that at a professional doctorate level research study, a range between 4 to 10 interviews is recommended. Usually, researchers employing IPA aim for a fairly homogeneous sample. Given that psychological similarities and differences are typically analyzed within a group that has been defined according to pre-determined characteristics (i.e. women with a history of childhood sexual abuse attending a specialist service), it's not deemed appropriate to select a random sample when interviewing so few participants. In ordinary circumstances, data collection within the IPA methodology is based on purposive sampling (Willig, 2013). This allows the researcher to find a defined group for whom the research problem has relevance and personal significance (Pietkiewicz & Smith, 2014).

Semi-structured interviews are the most commonly used tool to collect data in a qualitative research study employing IPA. The reason for its popularity is because it is easier to arrange compared to other forms of data collection and is compatible with several methods of data analysis (Willig, 2011). In-depth semi-structured interviews are a well-suited method of data collection because IPA researchers aspire to analyse in detail how participants make sense of things that happen to them. Semi-structured interviews elicit stories, thoughts, and feelings about the phenomena and give the participants an opportunity to provide a detailed, rich, and personal account of their experiences (Smith et al., 2009).

In addition, this form of interviewing also allows the participant and researcher to engage in a dialogue where the initial questions are altered accordingly to a participant's responses and the researcher is able to probe important and interesting areas that might come up during the interview (Smith, 2008). IPA requires rich data and this means participants should be given the chance to talk freely and tell their stories reflectively and at length (Smith et al., 2009). Semi-structured interviews allow for a more flexible approach to the interview process. Although researchers might use an interview schedule for topics that are predetermined, the flexibility of the structure provides an opportunity for unanticipated responses and issues to emerge through the use of open-ended questioning (Tod, 2006).

IPA interviews try to gain information about the research question indirectly as it is not always effective to approach the topic directly. Smith et al. (2009, p. 58) posit that "IPA interviews attempt to come at the research question 'sideways'. The interview schedule is used mostly as prompts for the IPA researcher; it does not aim to dictate the direction of the interview, and is mainly participant led. The interview questions are asked in an order that might seem most suitable and appropriate for the participant (taking into account the potential sensitive nature of the topic).

2.6 Rationale for using IPA

The aim of my research is to gain a deeper understanding of the experience of women attending a specialist service for childhood sexual abuse. IPA offers the ideal research tool to conduct this study given the combination of its methodological rigour and essential simplicity. Although IPA has prominent resemblances with several other qualitative methods such as certain versions of grounded theory or discourse analysis, it was chosen primarily because the epistemological position of my research question matches with the overall stand point of IPA over these other methods (Smith et al., 2009). My epistemological stance matches my ontological standpoint that reality is created by the individual; therefore the experience that is communicated is an interpretation of the individual's experience. One of the assumptions that IPA researchers make is that the analyst is interested in learning something about the participants' psychological world (Smith, 2008). Smith and colleagues (2009) argue that the kernel of IPA is its analytical focus and is therefore directed towards an attempt to make sense of the participants' experience. The aim is to try and understand the content and complexity of those meanings. This might involve the researcher engaging in an interpretative relationship with the data (Smith, 2008). Smith & Osborn (2008) also note that IPA emphasizes on the importance of trying to understand the content and complexity of the meaning as opposed to measuring the frequency. It is believed that through continual engagement and a process of interpretation with the text, the researcher attempts to capture the meaning of the individuals' experience and discover various aspects of their world. I believe IPA enables me to capture the

quality and the texture of the individual experience, giving voice to these participants' thoughts, feelings and opinions in order to adequately answer the research question

My rationale for choosing IPA over grounded theory is because unlike IPA, grounded theory consists of a comparative, systemic inductive and interactive approach to inquiry with several key strategies for conducting inquiry (Charmaz, 2006). Grounded theory usually sets out to produce a theoretical account of a particular phenomenon; this often involves work of a considerable scale, as well as a particular approach to sampling (Smith et al., 2009). It also depends on reasoning about experience to entertain all conceivable theoretical explanations for the data and then proceeding to check explanations through further experience- its methods can therefore be abductive in nature (Rosenthal, 2004; Deely, 1990; Peirce, 1938). IPA, in comparison, allows more freedom for creativity and collecting and analysing data. This study is not aimed at developing a theory or for a process to emerge from social-contextual processes, but rather gaining a deeper understanding of women's personal experiences of attending a specialist service for childhood sexual abuse survivors. Abbreviated grounded theory and IPA have many common similarities. For instance, both set out to create a sort of cognitive map that represents a person or a group of people and their view of the world (Willig, 2011). However, IPA was created to gain an insight into the individual's inner psychological world. In contrast to IPA, grounded theory is more likely to push towards a more conceptual explanatory level based on a larger sample size (Smith et al., 2009). By using grounded theory researchers would set out to generate a more generalised theoretical account of CSA survivors rather than the experience of a group of women attending a specialist service for CSA.

Discourse Analysis ("DA") in recent years has been split into discursive psychology and Foucauldian Discourse Analysis ("FDA") (Willig, 2011). However, both approaches share some important features. Discourse Psychology is concerned with what people do with language as well as highlights the performative qualities of discourse. Discourse psychologists are also concerned with references to concepts like identity and memory within a text or talk that occurs naturally and the consequences and functions of such references (Willig, 2011). Additionally, they are also interested in how participants use language to manage and negotiate social interactions in order to achieve interpersonal objectives. Discourse psychology is also interested in achieving interactive ends using available cultural resources (Potter & Wetherell, 1987).

Although IPA may primarily be concerned with understanding the individual experience, language and culture are inevitably enmeshed (Smith et al., 2009). However, this does not necessarily mean that IPA and DA share the same deconstructive aims. Particular attention is given to the action–orientation of talk by discourse psychologists. They are interested in the ways in which people manage issues of stake and interest (Willig, 2011). The reason why DA did not seem the most appropriate method for this study is because the aim of my research is not concerned with understanding how the participants use language as a tool to construct their experience or the

performative value of language. Furthermore, my aim is also not to question the value of the category of the experience (Willig, 2011). In line with IPA, my epistemological position assumes that talk can help us understand something about a "reality" of a person's world. DA, similarly to FDA, seeks to understand ways in which particular versions of the phenomena are constructed through language rather than understanding the true nature of psychological phenomena (Willig, 2013). FDA is carried out 'wherever there is meaning' (Parker a d tbe Bolton Discourse Network, 1999). It does not necessarily incorporate an analysis of only words, but FDA can be conducted on any symbolic system (Willig, 2013). FDA does recognise subjective realities and points to the role of dominant discourses in terms of both creating and shaping them. Within discourse analysis, a 'subject position' is identified as "a location for persons within the structure of rights and duties for those who use that repertoire" (Davis and Harre 1999, p. 35). DA constructs subjects and objects and therefore makes accessible positions within networks of meaning that speakers can take up. Links are attempted to be made between the discursive constructions used by participants and their implications for subjective experience (Willig, 2013).

2.7 Epistemological Considerations

Flew (1989) argues that epistemology is the exploration of how we know, what we know and whether or not we can know. The primary aim of qualitative research is to gain an understanding of how the world is constructed (Willig, 2011). One of the key roles of a qualitative researcher is to reflect on how they see and understand, as well as reflect on the process of knowing itself. The process of knowing includes a practical method that is originated from 'an epistemology' (i.e. the theory of knowledge) which in turn is grounded in 'an ontology' (i.e. the set of assumptions about the nature of life) (Mcleod, 2001). IPA aims to produce knowledge that gives us insight into the participant's view and experience of the world. IPA further makes an assumption that our data can give us an insight into an individual's orientation and involvement towards the world and how they make sense of it (Smith, Flowers & Larkin, 2009). The main focus of this research is on the participants' experience and how they make meaning of it; thus no direct claim is made about whether what they are telling us is a 'fact' in the outside world, and assumes a relativist ontological position. An extreme relativist position is not chosen because I am unable to produce an accurate account of participants' subjective experience, even though participants' accounts are mediated through culture, power and language. Only an insight into their experiences of reality is presented (Forrester, 2010).

This study also endorses a social constructionism claim (Eatough & Smith, 2008) that sociocultural and historical processes are essential in relation to how we understand and experience our lives. It is interested in identifying various ways of constructing social reality that are present in a culture to trace their implications for human experience and social practice (Willig, 2011). IPA "sits at what might be called the light at the end of the social constructionist continuum maintaining that seeing the

individual's lifeworld merely as a linguistic and discursive construction does not speak of the empirical realities of people's lived experiences and their sense of self" (Eatough & Smith, 2008 p. 184). In this form, social constructionism views identity and the self as constructed within a social situation. As this research study attempts to generate knowledge of how and what people think about the phenomena under investigation, only using language as a mediator of these experiences and not constructing their experiences, I am unable to separate my own experiential views from the data and produce an accurate account of participants experiences. Therefore, I am inclined to use a critical realist lens to view knowledge production (Willig, 2011). An extreme realist acknowledges that actions and events represent reality, but does not take into account the impact of the researcher's experiential self on the data, therefore this research study doesn't follow this approach.

2.8 Reflexivity

Reflexivity refers to the researcher engaging in a reflection in order to generate awareness about their actions, feelings, and perceptions (Hughes, 2014; Anderson, 2008). It also helps to promote transparency in the researcher's role with regard to analysing data and conducting research, as well as ensures that the researcher makes the essential changes to ascertain the credibility of their findings (Finley and Ballinger, 2006). Henwood and Pidgeon (1992) identify that one out of the seven characteristics for a good qualitative research is reflexivity. He argues that the role of the researcher needs to be acknowledged and recorded in the write up of the research. Smith (2006) points out that the tone of writing up a report needs to be confessional rather than purely realist. Reflexivity is a continuous process that begins from the start of the study and carries on till the end (Gilgum, 2006). It enables the researcher to reflect on their assumptions, thoughts and expectations (Finlay, 1998). This allows researchers to become consciously aware of how these thoughts and actions might influence the research process. Mcleod (2001) argues that qualitative research is a personal activity that involves a personal struggle to challenge assumptions and achieve understanding. Additionally, it involves entering a meaningful relationship with participants. The identity and experience of the researcher has an influence on the final findings. Willig (2011) further highlights the importance of reflexivity in qualitative research and thus claims that there are two types of reflexivity i.e. *personal* and *epistemological* reflexivity.

Personal Reflexivity

My interest in this project originates from both a personal, as well as from a professional standpoint. From a personal point of view, having experienced domestic abuse in the past and overcoming it, I was drawn to work with people experiencing domestic violence. In turn, I was exposed to work with a large number of clients who have also experienced childhood sexual abuse. Having worked with

survivors of CSA since I started my MA in Psychotherapy and Counselling Psychology at Regents University, my passion in this area has grown tremendously, and fuelled my interest to learn more about their experience of therapy and how these individuals experience the therapeutic relationship. The therapeutic situation is known to possess the capacity to activate power and the complexity that can be accounted for in the mere presence of the therapist (Zerubavel & Wright, 2012). The paradigm of the wounded healer sits very closely to the use of self in therapy. Therefore the paradigm posits that within each healer lies deep an inner wound that plays an essential role in contributing to the healing of the patient, as well as an important part in choosing our vocation as therapists (Zerubavel & Wright, 2012). I am aware of my personal experiences with regard to my topic and how it might potentially impact the interviews; therefore, I decided to use prompts during my interview schedule, as well as before the interviews. This enabled me to bracket my own experiences, try and be aware of the assumptions I might be making during the process and stay with my participants' experience rather than mine, which is a similar thought process I had during individual psychotherapy. In addition, my personal experiences enabled me to further attune to my participants, perhaps making the process more comfortable. The notion of the wounded healer helped drive my insights and keeping a journal for myself has assisted in helping me understand what my experiences were during this process, the impact it had on me and guided me to continuously try to revaluate the process that was unfolding. Shannon (1997) writes, survivors offer a wealth of knowledge about their experiences, views and struggles in therapy and thus through this project, I learnt about and discovered a richer understanding of their experiences in therapy.

Epistemology Reflexivity

With reference to epistemological reflexivity I am keen to revisit Husserl's founding principle of phenomenological inquiry where experience is examined the way it appears. Husserl's phenomenology is concerned with stepping out of our 'natural attitude', our everyday experience, so we are able to examine that everyday experience (Smith et al., 2009). The phenomenological method employs the rule of Epoche or bracketing i.e. suspension of presuppositions and assumptions, judgements and interpretations to allow ourselves to become fully conscious of what is before us (Willig, 2011). Although I have been influenced largely by Husserl's work i.e. phenomenology that is interested in the careful examination of human experience, it is virtually impossible to close off my existence. Therefore, it required that I remain very attentive to my role and involvement in this research.

The Husserlian perspective of seeing things as they 'appear' and the concept of Epoche has been an invaluable contribution to my research experience. In addition, Heidegger's concept of phenomenology i.e. appearance has a dual quality and it is explicitly an interpretation activity and has links to hermeneutics, also influenced my thinking during this research study. Although I was aiming

to represent my participants' voice and stay as close as possible to their experience at first, later during the process of analysis, I began to understand the process of giving meaning and making an interpretation of what the participants were reporting. I realised the importance of my role (the researcher) in my research study. As alluded to earlier, the researcher is said to have an active and dynamic role in the process of IPA where they try and make sense of the individual construction of their world, thus making it a two-stage interpretation or the researcher engaging in a double hermeneutic. The researcher is also said to be engaged in a hermeneutic circle, which means one goes back and forth through a range of different ways of thinking about the data, rather than a step by step procedure, highlighting IPA's iterative stance (Smith, 2009).

2.9 Recruitment Strategy

Overview of the Woman's Service

The Woman's Service upon which this study is conducted is a part-time dedicated NHS psychotherapy service intended to provide specialist therapy and support for women survivors of childhood sexual abuse. The service is a secondary care service which means that women contacting the service already have a mental health diagnosis and a history of CSA, having been referred by specialist secondary care services, GP services, the community mental health services or via internal referrals within the trust. This service offers a comprehensive range of treatments such as a Psycho-Education Group, followed by a support group, Art and Psychodynamic individual psychotherapy (draws upon Attachment Theory), Psychoanalysis, Group psychotherapy, young women's group and couples psychotherapy. A typical course of individual psychotherapy treatment lasts for a minimum of 12 months. Clients are given an opportunity to move through complex stages of recovery facilitated within different psychotherapy modalities over a number of years. This is tailored according to the individual client's needs and difficulties. In addition to receiving therapy once a week, on-going support is offered to women using the service by a support worker if needed. These support sessions are provided to assist women who are waiting for therapy, sometimes during therapy and after finishing a course of their therapy. While there is no explicit limit on the maximum duration or length of time a client can receive treatment, in practice, the lead clinician will discuss and negotiate an appropriate ending date with the client. Clients at the service have to undergo a review session with the lead clinician and support worker once they have completed a course of psychotherapy.

I joined the Woman's Service as a trainee psychologist. My primary role was to see clients for individual therapy. During the course of my placement, having attending a number of team meetings, I learned that there was a lack of research conducted on the service. As noted in the introductory chapter, a prior study by Wieliczo (2013) noted that an idea for future research would be to explore in-depth the experience of women attending this service, as results of her study noted an improvement

in symptoms after therapy. These two points, coupled with my strong interest in working with adult survivors of CSA, fuelled my interest in carrying out this research study. Consequently, I expressed my interest to the lead clinician and team at the service, and in turn, we approached the Research Manager of the Trust to see if this idea was feasible before obtaining ethical approval.

Sampling Conditions

This study focused on ten women, all of whom were users of the Woman's Service and had recently ended their therapy. In line with requirements of IPA described above, my group of participants were homogeneous as they shared the experience of a particular situation. They were recruited by working carefully with the lead clinician and by screening and selecting individuals who were suitable for the study i.e. the aim was to select participants that would illuminate my research question, and develop a full and interesting interpretation of the data. All service users have a background history of childhood sexual abuse and the participants matched the criteria for my study (i.e. women who have experienced childhood sexual abuse). All participants were required to be above 18 years of age, as well as have attended individual therapy for a minimum of one year. The reason I recruited participants aged 18 and over is because of issues of informed consent. The reason I required participants to have undergone one year of individual therapy is because I anticipated that this would enable me to elicit a robust and in depth understanding of their experience of attending the service. I believe one year is sufficient time for the client to establish a relationship with the therapist and potentially feel safe enough to explore their abuse (one of the reasons why they were referred). I am aware I may have likely attracted participants who have engaged in therapy for a whole year with good attendance, as opposed to participants with poor attendance or those who had a negative experience of therapy. I explore this limitation in further detail in the Discussion chapter. In addition, participants were required to have ended therapy no longer than three months prior to their research interview because the service requires clients to have their exit interview within this time period of their final therapy session. Therefore, in collaboration with the service, it was deemed appropriate for participants to have their research interview within this time-frame. This ensured that they still had contact with the service, having not been discharged as yet, and also meant that they could access support sessions if they wished.

Given the qualitative nature of the method used to carry out the study, a small sample size was sufficient. Participants who I had previously worked with were excluded from the study in order to avoid therapeutic collision, as well as the possibility of clients feeling obliged to take part or unable to speak freely during the interview process. Clients who I had worked with may have affected the results if they felt the need to want to please me. Their narratives may not have reflected their actual experience as they might not have been able to be as open and honest with me, thus impacting on the power dynamics of the relationship. Participants who were still in therapy during the time of my

research were also excluded from the study in order not to disrupt or interfere with their current therapy process. One of the participants (Participant 11) who was selected for the study had not received individual therapy, and as a result, I was unable to include this participant's narratives in the analysis of the results as it would not have been consistent with my homogenous sample. Nonetheless, it was important for me to disclose this fact as it would not have been ethical for me to exclude her from my study. As the recruitment process was done collaboratively by the lead clinician, the support worker and I, there may have been an oversight from our part to not have explained to this participant what constituted individual therapy. This participant had received support sessions from the support worker and assumed that this might qualify as having undergone individual therapy. Although I did employ a rigorous screening process with my participants, I was only able to get a better understanding of the kind of therapy this participant had when I started my interview. In discussion with my supervisor, we agreed that it would be best not to include the data from this participant in the main analysis, but rather reflect on it broadly and note any differences or similarities that may exist as a result of not having individual therapy. This way I was able to retain my homogeneity of the sample in terms of the data analysed, but also ensure that the data was used in some way, thus honouring my contract with the participant.

Recruitment Procedures

During their end of therapy review interview with the support worker, participants were verbally informed about the study, given a copy of the Study Advert (see **Appendix A),** and asked to contact me if they wished to participate (my contact details were on the Study Advert). I believe this gave them a choice of whether or not they wanted to take part and didn't make them feel obligated to do so. Although the service provided an information sheet to a number of participants, only a proportion reached out to me. Participants began contacting me via either a phone call or a text message. A total of eleven potential candidates contacted me. I screened the candidates over the phone by asking them a number of questions, including: "How long had they received therapy at the service?", "Had they received individual therapy for over a minimum of 1 year?", Confirmed they had a history of CSA, and re-confirmed their interest to participate in the study. Given all 11 candidates responded in a way that suggested they fit the criteria, I ended the conversation by arranging potential interview dates which would take place at the service. I informed them that travel expenses would be paid for if required, although none requested for any reimbursement. As mentioned above, one of the candidates did not meet the precise criteria and this was realised only during the interview process.

The interviews were conducted at the Woman's Service due to the nature of the topic and the potential sensitivities that might arise as a result of the interview. On the day of the interview, participants were handed out an Information Sheet (see **Appendix B)** and a Consent Form (see **Appendix C)** before the interview. They were re-explained what the purpose of the study was and

also given an opportunity to ask any questions. In order to ensure participants were as comfortable as possible with exploring their experience at the service, I informed them that the research is part of the service and they would need to give me informed consent on the basis that I will be feeding back a general overview of the findings to the service. I also informed them that that all identifiers would be anonymised, that any general findings arising from the research will use only collective findings (i.e. won't focus on individual's responses to questions), and that they wouldn't be identified. No identifying material would be disclosed and participating in the research was voluntary and would not affect their treatment in the service. Refreshments were also offered to the participants before and after the interview. We ended the interview with debrief forms (see **Appendix D**) which consisted of information about the study and my contact details again if they wished to contact me or my supervisor. After the interview, each participant was offered a follow up support session with the support worker at the service. Precaution and care was taken not to feedback to the service about the participants who took part in the study in order to respect the confidentially and anonymity of the participants. A thank you card was given to each participant at the end for participating in the project.

Interview Schedule & Pilot Interview

Semi-structured interviews were conducted, in line with the recommendations of IPA. While I pre-prepared my interview topic guide (see **Appendix E**), I only used it as a guide to shape my interviews. Although my questions served more as a trigger to assist the participant to talk about a particular aspect of their life, it is important to acknowledge that they were driven by my research question (Smith, 2008). Smith & Osborn's (2003) guidelines were used as a guide to structure the interview questions. With the guidance of my supervisor I aimed to design questions that were neutral, non-directive and open ended. According to Sampson (2004), it is useful to initially carry out a pilot study, as it provides the researcher the chance to review the interview process, reflect on the draft interview questions and highlight potential shortcomings regarding ethics and validity. Thus, these questions were informally tested on a colleague and I also conducted one pilot interview with the first participant that came forward to take part in the study. Initially, I thought my questions and interactions were clear and encouraged the participant to speak openly about her experience. However, after transcribing my first interview and discussing it with my supervisor, I was able to alter the way I might respond to my participants in the future. This was not only invaluable in helping me reflect on the draft questions and potential concerns, but also as my role as a researcher and how important it was for me to be neutral, non-judgemental and non-directive in my responses. For subsequent interviews, my interview schedule, as well as my responses, were modified in light of my participants' responses and were used mostly as a guide. The interviews generally lasted between 40 to 90 minutes, and the material generated was remarkably rich. This may have been as a result of the participants' eagerness to share and disclose their experience.

Recordings and Transcriptions

The interviews were audio recorded on a digital voice recording device. The data was then uploaded onto my personal computer and stored on a cloud-based storage service. The data was then deleted from my personal computer hard drive and a backup flash drive with the original recordings was stored in a secure filing cabinet. The verbatim record of the data collected is an important aspect of IPA. Kvale and Brinkman (2009) argue that transcription is an interpretative process and requires it explicit reporting. However, it also does not necessitate the transcription of prosodic aspects of the recordings (Smith et al., 2009). All the recordings were transcribed directly by me. My aim was to ensure that, as far as possible, I capture and reflect the interviews in their truest form. The transcripts included non-verbal communications, as well as broken words and any vocal utterances (i.e. hmm... arhhh... ahh... etc.). Once the data was listened to and transcribed, all information collected was stored in a locked filing cabinet.

Participants

This study is based on ten participants. As this is a difficult to reach population, I initially thought I would struggle with finding participants to take part in the research project. However, I was surprised by the response I received and chose to interview all the women who came forward, even though ten is a relatively large sample for IPA. All participants experienced contact CSA. Of the ten participants, all ten had been involved in long-term psychodynamic therapy and six out of the ten had received group therapy in addition to their individual therapy. Summary information on ten participants who took part in the study is included in **Table 1.**

Table 1

#	Name	Individual Therapy at the Service	Group Therapy at the Service
1	Pearl	Yes	No
2	Bella	Yes	No
3	Jo	Yes	Yes
4	Lara	Yes	No
5	Doris	Yes	No
6	Emma	Yes	Yes
7	Terry	Yes	Yes
8	Tia	Yes	Yes
9	Macy	Yes	Yes
10	Betty	Yes	Yes

2.10 Ethical Considerations

The ethical implications and the risks involved in carrying out this research study were carefully considered during the initial stages of the study. The research study aims to follow the BPS and HPCP codes of ethics and conduct (2009, 2012). Full ethical approval was obtained by the Research Head of the Oxleas department, as well as the Department of Psychology at City, University of London Ethics Committee (see **Appendices F and G**). The important issues to consider particularly were confidentiality, informed participant consent, as well as debriefing. All participants were informed about the true nature of the study and received information about the research on a written consent form, as well as a verbal explanation about the purpose of the research. They were also given the option to contact me (the researcher) before and after the interview should they wish to ask any questions about the research. I have ensured that the information collected conceals any personal identities and all names and identifying details have been changed to protect the confidentiality of the participants. In order to further ensure confidentiality all data was stored carefully on a cloud-based storage service that is password protected. Participants were informed that data will be used for the sole purpose of research and it would be written up as a research project for a Doctorate in Counselling Psychology. All material collected was treated confidentially and participants were informed that the study may be published. Participants were also informed about their right to withdraw from the study at any stage and were debriefed about this at the start and end of each interview.

2.11 Adverse Effects of Participating in the Research Study

The participants' well-being was kept in mind at all times. I was aware of the potential anxiety that might take place during and after the interview due to the emotional and sensitive nature of the focus of the study. Therefore, extra care was taken to make sure that the participants had clearly understood the nature and aim of the research, and could make an informed choice of whether or not to participate. A support session with a support worker or lead clinician was available to all participants on the day of their interview as highlighted before, I ensured that I adequately informed all the participants about the overall process involved to conduct this study, and reassured them that their confidentiality would be protected at all times.

2.12 Validity

There has been a substantial discussion about assessing the quality or validity in qualitative research amongst researchers over the years. IPA sits with the idea that the concept of reality and truth are subjective in nature and the individual's perspective of the world is unique and different. Yardley (2008) suggests that individual's perception on reality is shaped by our surroundings such as

activities, culture, and context, and as a result, each individual will have a very different perspective on reality. Yardley (2000) proposes four main dimensions be employed to assess the validity of studies using qualitative methods: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. These recommendations have been used as a guide whilst considering the validity of this research project, and a more comprehensive evaluation of how these broad principles have been met are discussed below.

Sensitivity to Context

According to Yardley (2000), she posits that demonstrating sensitivity to context is an essential element of good qualitative research. She suggests that this can be represented in a variety of ways such as showing sensitivity to the current literature on the topic, the data gathered from the participants and the socio-cultural background in which the study is situated within. I conducted a detailed literature search and review to ensure that my study is pertinent to the field of Counselling Psychology. However, I also strived to ensure that my study would be focused on the subjective experience of the participants in the study by focusing on them. The interview process enabled me to exhibit empathy towards the participants through ensuring that they were at ease, and allowing them to have as much control as possible during the interview process. For instance, due to the sensitive nature of the topic, it was decided that it would be appropriate for the interviews to be held at the Woman's Service itself which the participants were familiar with given they had undergone therapy there for over a year. I, the researcher, disclosed my own experience of working with adult survivors of CSA and the use of semi-structured interview questions that were mostly open-ended helped to facilitate disclosure. Throughout the analysis process, sensitivity to context was established by paying attention to the raw material. As suggested by Smith et al. (2009), "considerable number of verbatim extracts from the participants'" material were kept to support the argument being made, thus giving participants a voice in the project and allowing the reader to check the interpretations being made" (p. 180-181). Furthermore, sensitivity was demonstrated by remaining as close as possible to what is described with the help of quotes from the interviews to back up my analysis.

Commitment and Rigour

Yardley's second broad principle is demonstrating commitment and rigour. This was taken into consideration by engaging in rigorous data collection and a thorough engagement with the process of analysis within the topic (Yardley, 2008). Shinebourne (2011) discusses that within IPA, commitment is shown throughout all stages of the research process. I was able to demonstrate this by interviewing all participants who volunteered, rather than a small sub-set which would have been acceptable and adequate for a qualitative IPA study. During the research interview, this was further demonstrated by

engaging with participants throughout the duration of the interview. Subsequently, I was able to show commitment by carefully and sensitively analysing each of the ten transcripts in detail to ensure that I was able to capture the individual voice of each participant, whilst keeping in mind the interpretative stance of IPA. The in-depth interviewing process during this study demonstrates rigour, which Smith et al. (2009) argue is essential in order to get an in-depth view of the individuals lived experience. I was able to further demonstrate commitment and rigour by recruiting a homogenous sample. This is discussed in further detail in the recruitment strategy section of this chapter.

Transparency and Coherence

Yardley's third broad principle suggests that transparency in the research study be considered by carefully describing the recruitment process. My attempt at ensuring this is discussed in detail under the recruitment strategy section of this chapter. I highlighted in this section the oversight made during the recruitment process while recruiting a participant who did not fully meet the recruitment criteria, and her subsequent exclusion from the study (Participant 11). Her interview is nonetheless broadly explored in the Discussion chapter. This enabled me to retain the homogeneity of the sample and honour my contract with this participant. In addition, I have attempted to make this study coherent by maintaining a consistent aim and approach throughout the various stages of the process, including participant recruitment, analysis, reflection on the findings, and drafting of my study.

Impact and Importance

Lastly, Yardley's (2008) final principle, impact and importance, should be taken into consideration. Yardley (2000) purports that although research is conducted well in terms of the other validity criteria, impact and importance constitutes "the decisive criterion by which any piece of research must be judged" (p. 223). Keeping in mind the principles of IPA, as the researcher, I attempted to highlight through this study the experience of women attending a specialist service for childhood sexual abuse by reflecting on their therapy experience. This study can prove to be insightful to survivors who have had no experience of therapy and might find it informative in terms of what they can expect from therapy, particularly within a NHS specialist service. Likewise, this study can prove to be beneficial for clinicians, therapists, health care professionals and researchers working in this field, whether directly with clients or seeking to recruit clients for a study, by creating awareness about the intricacies, sensitivities and complexities involved whilst working with this population.

2.13 Criteria for Evaluation of Qualitative Research

As noted by Willig (2010), qualitative research is interested in meaning making within a particular situation or context. It comprises of engagement and involvement with the interpretation of data. This suggests that qualitative research acknowledges a subjective component during the process of research. A number of educational researchers who participate in qualitative research have recommended several sets of criterion for evaluating qualitative research.

Henwood and Pidgeon (1992) further offer seven attributes that comprise of good qualitative research. These attributes are concerned with the parallel process of ensuring rigour whilst acknowledging creativity and idiosyncrasies within the research process. They are as follows:

Keeping Close to the Data: The Importance of Fit

One of the basic requirements of qualitative research is the analytic categories produced by the researcher should fit the data well. During my research process, comprehensive accounts of the reasons for categorizing themes in a certain way were established. My categories and participants' accounts were kept as close as possible to the original data that emerged from my interviews.

Theory Integrated at Diverse Levels of Abstraction: Integration of Theory

Henwood and Pigeon suggest that good theory needs to be complex, rich and dense and integrated at diverse levels of generality. Integration of theory at diverse levels should be apparent. During the process of analysis, I was able to make clear links between the units of analysis and their integration at different levels of generality, as well as their rationale.

Reflexivity

As aforementioned, qualitative research is primarily concerned with meaning making, therefore, the research process is invariably a joint product of the data and the researcher engaging with the data. The role of the researcher needs to be sufficiently acknowledged. I have attempted to keep in mind the reflexive nature of qualitative research and thus addressed reflexivity in the *Method* section of the portfolio. I have aimed to address both personal, as well as epistemological reflexivity. Furthermore, a general account of the process of research and the impact of my role as the researcher on the process of research has also been explored in the *Discussion* section of the portfolio.

Documentation

It is suggested that a reflective journal be kept throughout the process of qualitative research. The journal should comprise of an account of what is done and why it was carried out during the research process. Researcher's thoughts, feelings, assumptions and values during the process of research and how they might change throughout the research need to be documented. I kept a live journal throughout the research process in which I documented my assumptions, feelings, thoughts and values. This is also explored in the reflexivity section in the *Discussion* section of the portfolio.

Theoretical Sampling and Negative Case Analysis

It is recommended that the researcher continues to seek to modify and extend emerging theory (Willig, 2010). During the process of analysis, themes that did not fit with the emerging analysis arose within the data and they were adequately explored.

Sensitivity to Negotiated Realities

The interview process enabled me to exhibit empathy towards the participants through ensuring that they were at ease, and allowing them to have as much control as possible during the interview process. Throughout the analysis process, sensitivity to context was established by paying attention to the raw material so the data is readily recognisable to the participants in the study providing the information. The researcher is recommended to attend to the ways in which the research is interpreted by the participants who created the data (Willig, 2010).

Transferability

Within qualitative research, sampling decisions have not been carried out on statistical grounds and it has been suggested that researchers talk in terms of transferability rather than generalizability of findings. The findings of this study can be applied to contexts similar to the context from which study was derived from. For instance, other specialist services within the NHS, as well as charities, can benefit from the findings from this study. This study will also inform health care professionals working within this population about the complexities involved and ways of approaching and dealing with them.

2.14 Analytic Strategy

During the initial stages of analysis, the data was transcribed, read, re-read and studied. I also listened to the interviews whilst I was reading. A broad range of notes which reflect the initial observations and thoughts that I, the researcher, held in response to the text were produced (Willig, 2013). It has been suggested that 'descriptive, linguistic and conceptual' comments be used in order to highlight abstract notions that might assist the researcher in making sense of the participant's account (Smith et al., 2009). After reading the transcripts of recorded interview several times, initial notes were taken, as show in **Appendix H.** Descriptive, exploratory and linguistic comments were noted. Emergent themes from these notes from each transcript were consolidated into a table as shown in **Appendix I**. These emergent themes were clustered into common themes by establishing connections between them as shown in the example in **Appendix J.** After conducting this analysis on every participant's transcript and creating a summary table for each, patterns across cases were identified and common clusters across the transcripts were then grouped together under as shown in **Appendix K**. Clusters were then organized under broad emerging themes, as shown in **Appendix L**. Through the process of analysis, I went back and forth, revisiting the patterns and themes which I saw emerging from the data to identify more concrete sub-themes. Finally, related sub-themes were integrated together to form super-ordinate themes, and these are summarized in a table in **Appendix M**. These themes reflect the experience of participants as a whole (Smith et al., 2009; Willig, 2013). Smith & Osborn discuss dropping themes that do not fit well within the emerging data and themes that are not particularly rich in evidence within the transcripts (Smith and Osborn, 2008). There was a list of themes that emerged that did not have any particular relevance to my research study. In the process of identifying and highlighting themes that were relevant to my research question, an emergent sub-section of 'homeless' themes which did not fit well within my data evolved. For instance, themes that were more associated with the practical aspects of attending therapy (i.e. the location of the service, duties of the receptionist, speculation around the trust losing funding) were considered peripheral to the topic of interest and thus were dropped from the analysis.

The analysis emerged through various layers of interpretation. I began from looking at participants' accounts on a descriptive, contextual and linguistic level, to the relationship between different accounts in the same interview, and eventually to the super-ordinate themes that were discovered. The levels of interpretation are concerned with the 'dynamic relationship between the part and the whole' on a number of levels (Smith et al., 2009). The analysis is unavoidably a joint product of the researcher and the individual. In addition, the final findings are a result of how I, the researcher, made sense of the participant making sense of their experience, thus engaging in a 'double hermeneutic' (Smith et al., 2009). Deciding on which themes to focus on is challenging and requires prioritising of and reducing the data by the analyst (Smith & Osborn, 2008). Keeping in line with Smith & Osborn, I was able to prioritise my data and list of themes based not only on their prevalence within my data,

but other factors such as the richness of particular parts of my transcripts and how certain passages highlighted other themes. For instance, the final themes were selected based on the aim to provide an illuminative, rich and detailed insight into the complexity of the lived experiences of these women who have a background experience of childhood sexual abuse. They also served to answer the study's research question of how these women experience attending a specialist service for adult survivors of childhood sexual abuse. My final themes aimed to highlight the significance, relevance and meaning it held for the participants. Throughout the analytic procedure, I moved to and from a range of different ways of thinking about the data, thus engaging in a hermeneutic circle (*see Epistemological Reflexivity*). IPA researchers also try to understand what an experience is like from the participant's perspective. As a result, IPA research studies may encompass features of both types of interpretation, creating a richer and more comprehensive analysis (Pietkiewicz & Smith 2012).

Chapter 3

Analysis

3.1 Introduction

As discussed in the prior chapter, the Interpretative Phenomenological Approach to data analysis was employed with the attempt to explore an in-depth experience of women attending a specialist psychotherapy service for adult survivors of CSA. A detailed and thorough analysis of each case and across cases was carried out. Through this, it was evident that a number of interesting and common themes emerged across the transcripts. Although each woman's experience and journey was unique and individual, there were a variety of themes that were shared across the interviews. Through the process of analysis, this chapter aims to provide an insight into the experience of the interviewed participants at the Woman's Service.

As outlined, the analytic process involved a thorough reading and re-reading of the transcripts and emerging themes and patterns were identified and explored. Emergent themes across each case characterised illustrations of higher order concepts. Although there was substantial areas of overlap amongst the themes, a few themes resonated more closely, shining light on one another, thus providing a deeper and richer understanding of the individual phenomena under investigation.

Due to the extensive quantity of data gathered and keeping in mind the need to prioritise the information, not all aspects of the participants' narratives can be communicated. As an interpretative account of the participants' experience was developing, I have focused on the themes that appeared most pertinent in relation to answering my research question, covering areas that seem to give voice to participants' experience of attending a specialist service. However, another researcher might have prioritised or chosen different experts and themes. This chapter attempts to steer the reader through aspects that are most prevalent and pertinent to responding to the research question. The process of analysis revealed a number of themes that describe participants' experiences. The section below will discuss these themes that emerged from the data under three wider super-ordinate themes. The super-ordinate themes include**: "Forming the Therapeutic Alliance", "The Therapeutic Journey",** and **"Experience of Finding Their Voice".** The three aforementioned themes cover aspects of the most meaningful excerpts that answer my research question and appeared as an outcome of the analytic process, designed to represent the data clearly. The purpose of these themes is to postulate and capture a rich depiction of the extensiveness and complexity of the experience of attending therapy within a specialist psychotherapy service for adult survivors of CSA. It is imperative to bring to the reader's notice the fact that these super-ordinate theme categories are not essentially dissimilar but have

considerable overlap between and within themselves (Smith et al., 2009). Therefore, acknowledging that overlap between themes is to be expected when describing the data.

All sub-ordinate themes are illustrated and described using verbatim citations from the participants' interviews. Empty brackets in these citations represent material that has been omitted to focus on more relevant portions of the narrative. The three full stops after a phrase or sentence reflect when the participant paused for a moment. Pseudonyms are used to refer to participants throughout this section and going forward. The sources from which the citations are obtained are from the original transcripts and are signposted by line reference numbers and pseudonyms.

This section describes the interpretative element of the analysis including looking at links between the accounts; however, no further theoretical discussions or incorporation of the literature are included as I believe it will take away attention from the participant's in-depth lived experience. The next chapter, Discussion, will aim to summarize key findings and include theoretical incorporation of the literature. Essentially, while attempting to highlight a genuine presentation of a phenomenon, I have also made an effort to maintain a holistic representation of the women's accounts, through reflection of personal interconnections between themes; as a result, creating the multifaceted exploration of meaning or 'double hermeneutic' (Smith & Osborn, 2003) which is representative of IPA.

3.2 Overview of Super-Ordinate Themes

The first super-ordinate theme titled "**Forming the Therapeutic Alliance"** describes the therapy relationship between the therapist and client. This theme aims to cover how participants are able to establish a therapeutic alliance with their therapists as well as the repercussions of misattunement they experience in the therapy relationship. This can be seen at the beginning of their therapy journey where participants begin to form a relationship with their therapist and their response to the framework of therapy. The second super-ordinate theme "**The Therapeutic Journey"** captures the participants' experience of the re-discovery that has occurred within them as a result of the journey of therapy. This super-ordinate theme reflects the client's journey towards change and the discovery of new parts of themselves. Finally, the third super-ordinate theme **"Experience of Finding their Voice"** presents an account of the significance of the childhood sexual abuse and the impact it has on their current day-to-day life. It draws the reader's attention to the gratitude they experience for getting specialist help from the service, the stigma they experience associated to mental health difficulties, and the desire to reach out to other women in similar situations by sharing their journey.

Super-Ordinate Themes	Sub-Themes
I. Forming the Therapeutic Alliance	A. Misattunement with Therapist B. Connection with and Validation from Therapist C. Feeling Accepted in Therapy D. Holding Environment of Therapy
II. The Therapeutic Journey	E. Discovering Self and Breaking Through Emotions F. The Role of Time in Breaking the Silence G. Experience of Therapeutic Ending
III. Experience of Finding Their Voice	H. Impact of Childhood Sexual Abuse I. Sharing the Journey With Others J. Stigma Around Accessing Mental Health Services

3.3 Super-Ordinate Theme I: Forming the Therapeutic Alliance

The first super-ordinate theme captures the participants' experience of forming the therapeutic relationship and their responses to the boundaries and framework that therapy entails. It encompasses participants' desire of wanting to feel secure, safe and a sense of connection towards the therapist. As the therapy process is a journey that is seldom easy, participants describe the importance of having a connection with and validation from their therapists. They further describe the impact of misattunement in the therapy relationship and how sometimes it can re-create their difficult emotional experiences and memories. The impact of the healing relationship facilitates change, self-discovery and learning to cope with these difficult emotions. Within this super-ordinate theme, four sub-ordinate themes were identified**:** A. Misattunement with Therapist, B. Connection with and Validation from Therapist, C. Feeling Accepted in Therapy, and D. Holding Environment of Therapy.

A. Misattunement with Therapist

The first sub-theme, Misattunement with Therapist, aims to capture the participants' experience of misattunement with their therapist and the emotions and impact generated as a result of it. An experience of misattunement or "therapeutic impasse" is defined as both the therapist and client feeling more alone and isolated, less connected with each other and one where neither can see how to move on from these feelings of disconnection (Stiver, 1992). Undesirably, when the less powerful person in the relationship is unable to communicate their feelings, or when they receive a response of

denial or indifference, they begin to keep 'aspects of themselves out of the relationship' (Miller & Stiver, 1997). The participants' narratives throughout suggest the difficulty in relating to and connecting with the therapists that they perceived as cold, unfamiliar, silent, dismissive, robotic or lacking in therapeutic skills. The quote below describes how difficult Betty found it to engage with her therapist:

> *"There was one women who I went to who was very cold and sort of like a robot and I didn't feel that was helpful... but for me... I think I need to feel that there was a human talking to you... rather than anyone sitting on the chair and being just robotic... Sitting there frowning and taking notes... I think it is very important for people to feel comfortable with a therapist... you feel... otherwise you can't open up to someone... and sometimes just to have somebody even just to nod and say yeah I understand or... something... but then she made me feel awful... I didn't want to actually go there anymore..."* (Betty, 286-302)

Betty found her therapist to be 'unhelpful' due to her 'cold and robotic' style which she perceived to be un-engaging. Her narrative suggests her therapist may have acted in a manner as if she understood her, however, it didn't feel real and this sense of falseness in the relationship made Betty feel 'awful'. The lack of connection made her experience of therapy feel a lonely one, largely due to her therapist's style of being unresponsive and not approachable. It appears that for Betty, her therapist came across as being pre-programmed, with automatic responses, and not actually taking her individual and specific experience into consideration. This perhaps draws attention to her childhood experiences where her feelings were neglected. Sharing parts of oneself for Betty in therapy is a difficult and vulnerable process, and this can only be achieved if she feels a sense of 'human' connection or bonding with the therapist, suggesting a need for warmth, emotion and communication. Pearl, like Betty, found it difficult to relate to her therapist who did not communicate much, highlighting her difficulty with facing uncertainty during therapy:

> "*It can be awkward... I was just thinking will she sit there and say anything...? I thought to myself I don't want to be coming here like once a week to be playing games in a room with somebody... but that's how it felt... I mean I found myself asking the service what kind of qualifications does this lady got? Am I the first person that she's worked with... or what kind... because to me... she's just... Not right... I do not know whether it was her or me."* (Pearl, 128-132)

Pearl was perplexed by her therapist's manner towards her, suggesting the different expectations she had from her. She felt misunderstood by her therapist. The notion that the therapist may be 'playing

games' with her gave her the impression that her therapist was not taking her session seriously or having fun at her expense, making her question the therapist's qualifications for the role. Her tone suggests that this approach by the therapist led her to a state of confusion where she was unable to think clearly and felt disoriented and began to doubt herself. This led to Pearl automatically thinking the misattunement was something to do with her. The lack of communication from her therapist was difficult to interpret and did not feel 'right', making her uncomfortable and unsettled in the presence of her therapist, as she imagined therapy to be a two-way process. Tia, similarly to Pearl, had a certain expectation from therapy and found the silence in the therapy room a 'strange situation' and difficult to engage with:

> *"I found it so difficult to say things... And I just found it a very strange situation to be honest... To be with somebody else in a room who is not really saying anything and expecting me to talk about thing... And half the time I was there I just didn't say anything... Because I didn't know how to say things... hmm... I would be very anxious..."* (Tia, 115-128)

Tia describes finding it difficult and 'strange' to sit with the silence from her therapist. Ainsworth (1970) devised the concept of the "Strange Situation" which has profound effects of attachment on behaviour. She carried out a study to observe the behaviour and responses of children in a situation where they were briefly separated from their mothers and then reunited with them, and assessed their reactions to this situation. Although Tia does not refer explicitly to Ainsworth's "Strange Situation", her experience of lack of familiarity led to a sense of discomfort and lack of attachment and bonding with her therapist. Tia interpreted her therapist's silence as an unspoken expectation that she should do the talking in therapy thus, making it an 'anxious' situation where she felt nervous, unsettled and uncomfortable. Expressing feelings of discomfort is easier when you are an adult because you can use words that you have learned. However, this is not the case with children who are still in the process of learning a language. In this situation, it appears as if Tia felt very much like an infant where she was unable to express herself, still in the process of learning how to communicate with her therapist. In a similar way to Tia, Doris found her relationship with her therapist challenging as she was unable to effectively communicate her difficult emotions towards using art in therapy:

> *"The only time I found our relationship difficult was when she was trying to get me to use the art... Ahmm... And I just really struggled with doing that... I think... s-some of it was like... It was almost like an embarrassment... That kind of thing when I was growing up and was in school... I was always told I wasn't good enough... So to have to use art materials and stuff was something that I had not got on well with and was always criticised for... Bought up too much... That I couldn't deal with... And I also wasn't able to turn around and say... this is*

what it was doing it me... You always feel very much on your own... and... By not saying something to somebody... Even if it is a therapist... And you know you can trust this person... you're still leaving yourself open to the criticisms and the put downs... " (Doris, 223-239)

Although Doris mentions that a therapist is someone she should trust, her experience suggests that she was unable to reach that level of trust with her therapist. There appears to be an element of shame and embarrassment associated with expressing difficult feelings towards art as she fears criticism from her therapist similarly to when she was a child- assuming that if she didn't use the art materials, she would be criticised. It could be interpreted that by not disclosing her difficult feelings to her therapist, she felt safer and less vulnerable to criticism, but had to suffer the consequences of feeling alone in therapy. This suggests the misattunement between herself and the therapist caused her not to share parts of herself. She further notes that even if it is a therapist, she still felt at risk of being ridiculed by her, iterating the significance of the impact of her past criticism, lack of trust and disconnection with her therapist. Furthermore, it sounds as if the experience of the art therapy echoed or mirrored her disempowering experiences as a child

In summary, this theme highlights instances of the impact of therapist misattunement with clients' emotions and psychological well-being and the consequential impact on the therapeutic relationship. All participants expressed that therapists who exhibited a silent and un-engaging manner were a hindrance to their therapy process. They also expressed a difficulty in relating to a therapist who was cold and 'robot- like'. This suggests the importance for these women to feel a connection and a sense of comfort in order to be able to engage in therapy. The topic of childhood sexual abuse is a sensitive one and therefore it is essential for them to feel supported and engaged adequately for their story to be told. It also appears that it is equally important for them to feel empowered, rather than disempowered, as the latter is what they've experienced in their abusive pasts. The aspect of connecting effectively with the therapist is explored in the second sub-theme of "Connection with and Validation from Therapist".

B. Connection with and Validation from Therapist

Forming the therapeutic relationship becomes easier as participants express how they are able to create a connection with the therapist and the role that validation plays in this. They highlight the significance of being shown empathy, warmth and validation in developing and building a therapeutic alliance. This is an important aspect of their therapy relationship as it seems to be a precursor for healing to take place within their therapeutic journey. Pearl describes how she was able to develop a sense of connection with her therapist as a result of her demonstrating both empathy and a desire to listen:

> "*I mean she was a nice lady and she showed empathy... She you know... Listened... She conversed back... Hmm... She conversed back in a way... Where... I would come out thinking I can't believe I thought like that or thought about that... That's right... That is it... you know... And it is like... You spend years trying to get an answer... To something... And in a room suddenly the answers appear... something that maybe you have never thought before... and that's what... and that happened quite a few times...*" (Pearl, 146-154)

Communication and relating to the other seems to be an important aspect in therapy for Pearl. According to her narrative, Pearl sought feedback and validation during therapy, which can only take place through conversing or connecting with the other. Her experience illustrates the power of communication in helping her find 'answers'. Her therapist's ability to connect with her, and facilitate thinking about her situation led to her experiencing 'light bulb' moments during therapy. This is evidenced when she says 'suddenly the answers appear'. Bella, below, interestingly describes that in addition to empathy, it was her therapist's reliability in always being there, as well as emotional robustness which made it possible for her to establish a connection:

> *"...And what I really appreciated that my therapist was... She was a really strong robust person... With so much empathy and understanding... so... She was able to... Come alongside me... And enter painful places with me... but... hmm... I suppose it is difficult to describe... I knew she was there with me throughout all the difficult moments []...What she was teaching me was about a safe wholesome good relationship and one where if cried... I wouldn't be punished and if... I wouldn't be punished... so she helped me to learn how to be... myself."* (Bella, 75-86)

Bella's experience captures the importance of having a 'robust' therapist- someone who is strong enough to enter difficult places with her given her fragile state. Bella's story suggests that as a child she would be punished for expressing negative emotions and therefore she grew up learning not to express them. Therapy served to re-parent her by teaching her to be 'herself'. At times she found it 'difficult to describe' the emotions and feelings she felt during her relationship, suggesting it may be something she's never experienced before. Bella's use of the word 'wholesome' can be interpreted as an inference made towards food suggesting that her relationship was nourishing and leading to better health. As her inter-personal relationships were violated as a child, she was unable to experience a 'wholesome good relationship'. Terry, similarly to Betty, describes how she was able to connect with her therapist as a result of her coming across as trustworthy and someone she felt 'safe' to express herself to:

"But for me I felt like I was talking to someone I felt comfortable and safe enough to share everything with... I knew it wouldn't go outside...[ ] I feel such a connection with that lady before I left... I thought what... Maybe she's been through something similar... No wonder she understands." (Terry, 198-303)

Terry's experience signifies the importance of trust where she says 'it wouldn't go outside', highlighting her idea of a perceived 'inside' and 'outside' world. Her connection with the therapist and the therapy room was 'inside', signifying a warm, safe and contained environment as opposed to the unknown and uncertainty she experiences in the outside world. She mentions feeling a 'connection' with her therapist before the ending of her sessions, suggesting that the sharing of painful emotions in therapy can contribute towards building a connection with the therapist. Furthermore, Terry expresses feeling a deep sense of affection for her therapist, and it led her to question if her therapist has gone through something similar given her ability to understand her well. There appears to be a connotation again of the therapist feeling like an 'insider' or from the same team, someone who has experienced something similar. Lara, similar to Terry, felt connected to her therapist as she gave her the impression that she was 'on her side':

"And her kindness and her gentleness...Was so important... Makes me feel calm just thinking about it... Just being with her... You know... The actual just being with that person... It was... It was... A lovely experience... I really felt like she was on my side... and that has had a profound effect on me... and I will carry that I am sure throughout my life... You know that feeling of support...and...hmm...That is very special to me... and it kind of gives me a buoyancy buoyancy... that I can take with me..." (Lara, 55-59)

The kind and gentle approach by the therapist in this scenario made Lara feel that she was on her side and left her with a feeling of buoyancy. Lara uses the word 'calm' to describe her experience, giving further weight to her notion of being 'buoyant', or floating with support. The approach taken by the therapist had an intense and deeply felt impact on Lara, which made her feel supported by just 'being' in the presence of the therapist. Lara's tainted and restrictive childhood experiences are in stark contrast to her feelings when in the presence of her therapist. Thus, she felt the need to iterate how she felt 'special' suggesting that there was something unique and precious about her experience that she would like to hold on. Perhaps this was something she did not feel growing up, implying her desire to 'take with' her this new sense of security and safety.

In summary, this theme explored the connection participants encountered with their therapists during therapy and the importance of being validated. Their ability to express their difficult and painful emotions during therapy was made easier to achieve due to the therapist's warm, reliable, trustworthy,

robust and engaging manner as opposed to the 'cold and robotic' style experienced in the previous sub-theme. This enabled participants to build a rapport and a therapeutic alliance with more ease, as compared to when they felt disconnected and disengaged at the onset due to misattunement. In addition, sharing vulnerable parts of one-self can be very difficult, especially when one's boundaries have been violated during childhood. Therefore it is particularly important that participants feel 'safe' enough in order to disclose these difficult feelings. For some of the participants, the ability to communicate freely with their therapist, without judgement, seemed to be an important aspect in helping them feel cared for and adequate. This leads us to the third sub-ordinate theme, "Feeling Accepted in Therapy", where forming the therapeutic relationship is continued.

C. Feeling Accepted in Therapy

Having explored aspects of the therapeutic alliance, including the possibility of misattunement at the onset, as well as the importance of connection and validation from the therapist, I explore particular aspects of the therapy relationship where participants felt accepted and how this had an impact on the nature of the relationship. Participants expressed developing a healthy therapeutic alliance is not always easy and it is important for them to feel accepted when seeking professional help. Bella's quote illustrates the particular ways her therapist helped her feel more accepting of herself:

> *"What was amazing... that I realised that I didn't know how to play... And one of the techniques that she used with me around myself as a child was... When I think to myself as a child... When I look back what do I see... And I didn't see a child when I looked back... I saw an adult...so... She suggested that we looked at photographs as me as a child in the period that was the most painful period of my life and suggested that I brought photos of my children at that age as well..."* (Bella, 93-98)

Bella was able to recognise the loss of her ability to 'play', suggesting that as a child she was robbed of the freedom to explore and engage with activities that were free-spirited. Bella suggests that her childhood was adulterated and 'taken away' from her, where her innocence was lost and it was made to feel false or even impure. By helping her get in touch more profoundly with her experience when she was a child, specifically through looking at older photographs of this period, her therapist assisted her with revisiting and accepting the difficult parts of herself emanating from her childhood. It appears as though bringing photographs of her and her children at similar ages helped her recognise the disparity in affection for herself when contrasted to that of her children. Betty, like Bella, was able to further explore her emotions in therapy as a result of her therapist giving the impression of taking away the pressure from her during the sessions:

"It was a wonderful feeling... it takes off so much pressure and it makes you feel you know... somebody feels you're not worthless... You feel a lot better... It easies the pressure... you are able to reveal more about yourself...[]" (Betty, 476-480)

The use of the word 'pressure' suggests a physical force or a stressful situation which, in Betty's case, she was accustomed to facing in her life which may have contributed to eroding her self-confidence. Her therapist, by first showing her that she accepted her for who she was, helped ease this mounting pressure. She explained somebody believing in her and allowing her to be herself helped her develop a sense of usefulness and value. Before therapy, Betty had the impression that nobody believed in her abilities, which had given rise to her feelings of worthlessness. Lara, below, describes how unconditional kindness made her feel comfortable enough to think about herself:

"Yeah... It was like having medication or something.... it's like having that kind of zoomed in... Kindness...[] It kind of gave me permission to kind of... spend time on myself and think about things..." (Lara, 163-168)

Lara describes her experiences of therapy being like 'medication', which is used to alleviate or prevent pain. She uses this interesting metaphor to describe therapy and how it may have helped heal and cure her, suggesting she was in distress before therapy. She also uses the word 'zoomed in' to depict her experience of therapy, inferring the importance of having someone focus their attention on her. Her therapist's desire to take a closer look at the minute details of Lara's life also served to give importance to her experience in her eyes. Her example also suggests an element of guilt she felt when thinking about her individual needs because she didn't feel *worthy* enough. She expresses how therapy gave her 'permission to spend time' on herself, suggesting that she needed approval from someone who was perceived as a person in authority much like how a child would feel. Spending time on herself points to her desire to take care of herself and relax as opposed to 'using time' to accomplish tasks. It seems like spending time on herself in the presence of her therapist who exhibited kindness gave her the confidence to believe it was acceptable for her to think about herself without feeling judged. Terry, like Lara, was able to open up to her therapist only after her therapist guided her and asked her the questions at first, tailoring therapy specifically to her case:

"I really liked her and trusted her... hmmm... I think that was as far as the relationship went... because... as far as it should go... but she was very good at bringing us back on track... And stopping us from deviating too much... and talking about non-sense... and talking about what we should have been talking about... But she was also very good at recognising the ones that

were struggling... Struggling when they needed to say something... When they needed to be left alone..." (Terry, 576-580)

Terry's experience of group therapy was a fruitful one for her. Terry's use of the word 'deviating' & 'nonsense' suggests that during therapy she felt the conversation had moved away from a predicted or expected path into something more irrelevant with no meaning. Her quote suggests that they 'should have been talking' about things that were relevant to them, such as their childhood abuse and the impact of the abuse on their current lives. Her narrative suggests the tendency of people in her group to avoid talking about difficult feelings and painful situations during therapy, and how a skilled therapist can bring them 'back on track' through asking tailored questions. It also suggests that she values the importance of freedom, where she highlights her therapist was able to recognise 'when they needed to be left alone', thus putting no pressure on them to contribute. Tia below further describes an interesting element similar to Terry, where her therapist was able to help her understand her body's reaction to stress by contextualizing her experience:

"I think what helped mostly was the understanding why you behave in a certain way and why your body behaves in a certain way because what's happen to you and how to recover from it in terms of things like the relaxation and meditation and that sort of thing if I had been told those things many years ago or I had the same support system many years ago I wouldn't be here now... but hopefully people coming along now in the future will know that this is a really useful thing and we have to have such a service." (Tia, 409-415)

Tia felt that this approach to therapy helped her in trying to understand the physical symptoms she had been experiencing. She was able to understand her symptoms better and believed that this assisted in her recovery. It highlights the sense of difficulty that she had with the unknown, where it can cause a sense of fear and panic within herself. Tia expresses how she does not need support today and probably wouldn't have needed it for so long had she been better informed years ago. This highlights her difficulty with seeking support, perhaps due to the stigma associated with CSA or just as importantly whether this kind of specialised help was available to her years ago. Although she received support only in the latter years of her life, she has a desire for other people to be helped in the same way as her.

In conclusion, this theme summarises the impact of making clients feel accepted during therapy and various ways that it was successfully achieved by different therapists. The lack of acceptance during their childhood perhaps accentuated the need of feeling accepted during therapy. The participants' accounts demonstrated the impact of this on a number of occasions, both from individual and group therapy. It seems as though the acceptance, often as a result of tailoring therapy to their individual

circumstances and needs, gave them an experience where they were made to feel 'special' and cared for, facilitating healing within therapy. Forming the therapeutic relationship continues with participants describing the holding environment of therapy that enabled them to feel safe enough to open up about their experiences.

D. Holding Environment of Therapy

Having described aspects of the therapeutic relationship and the importance of feeling accepted in therapy, I explore the importance of the holding environment of therapy. Therapy can evoke different emotions and feelings within participants, and therefore they express the importance of the holding environment in which they feel safe and contained whilst exploring vulnerable parts of themselves. Betty's quote below expresses the validation she receives from other members in her therapy group and highlights the importance of this surrounding environment during therapy:

> *"And I felt like I was the failure but listening to everybody else you realise that it is not like that at all and you realise it is more about what has happened to you in the past has made you the way you are and it helped make more sense of everything really..."* (Betty, 373-376)

Betty experienced both individual and group therapy at the service and her words highlight the positive impact of listening to others in group therapy. Betty considered herself a 'failure'- implying she was somebody who never experiences success and loses regularly. However, 'listening to others' led her to feel protected enough to become aware that her negative self-perceptions and 'feelings of failure' were as a result of her past. It is as though validation from people who have gone through similar experiences brings her an added sense of feeling held and contained. This sense of feeling held paved the way for greater self-awareness in an uncontaminated environment to recognise the detrimental effects of her abuse. Macy, similarly to Betty, found the sharing of ideas in a group setting conducive to self-reflection:

> *"[ ]...in actual fact in some ways... For me anyway... The group was probably an improvement to one to one..Because it actually initiated more conversation... Because you are like a ping pong... Bouncing off everyone else in the group... Around people come up with things that you have not thought of... oh... you know... Ways of dealing with things... oh you know I have never thought of that... Looking at it that way or whatever you know."* (Macy, 99-105)

Macy describes feeling like a 'ping pong', which gives the impression of something that echoes, resonates, or bounces off something else. This is exactly how sharing ideas with others in a group therapy setting feels to her, which she describes as an 'improvement' to being in one to one therapy. It also suggests that the combination of both listening to and contributing towards a conversation in a group can facilitate an increase in awareness, generate feelings of usefulness, and potentially bring about healing. Moreover, the group setting can bring about a new way of thinking or approaching a situation that one may not have thought about before. Tia experiences similar feelings to Macy where she also had an experience of group therapy and talks about the importance of not being judged within a group environment:

> *"I suppose being able to talk about things and nobody blaming you... And nobody else blaming you... or making you feel bad about yourself... because of it... []...I suppose... The continuity of always having the meeting at the same time, every day I think that is my time and forget about everything else..."* (Tia, 235-237 & 313-319)

It seems to be important for Tia to be able to express herself freely, in a non-judgemental group setting, which was something that was alien to her. It seems as though the consistent environment that was created and its associated stability was something she did not experience as a child. Her experience also suggests that Tia was made to feel regret and blame and took responsibility of the abuse she faced as a child. Her use of the word 'forget' almost implies the group sessions took her into a parallel world where she focused on herself, perhaps suggesting that outside of therapy she was unable to do so. Bella shares similar sentiments with Tia in the context of individual therapy.

> *"My therapist consistently being there... Building up a lot of trust... And I really felt cared for by her and nurtured by her... And it is through... And through that relationship that I was able to move from the place I was in emotionally to a completely different place... It was incredibly painful journey and there were times when I thought I can't do it... And it is so painful..."* (Bella, 124-130)

Bella explains that her therapist was 'consistently' there for her in a systemic manner which enabled her to construct and develop a trusting relationship.. Her narrative indicates a sense of journeying with her therapist and a strong relationship that developed over time through trust, which started originally from a place of pain. Her use of the words 'painful journey' describes the distress and discomfort she experienced during therapy by coming face to face with her abuse. The pain could only ease over time in the presence of a trusting counterpart who was consistently available for her.

Throughout this theme participants expressed their experience of a contained environment where they were able to establish a sense of trust with their therapist that in turn enabled them to explore the vulnerable parts of themselves. Their experiences point out the importance of the environment, setting boundaries and maintaining professionalism for clients to form that important therapeutic alliance, which is an essential precursor for recovery to take place. There seems to be an element of safety associated with consistency, as well as comfort in hearing other people face similar experiences as themselves. This takes us into exploring the second super-ordinate theme of how once the therapeutic alliance has been formed, participants were able to discover parts of themselves through "The Therapeutic Journey".

3.4 Super-Ordinate Theme II: The Therapeutic Journey

This super-ordinate theme, The Therapeutic Journey, seeks to explore what changes have occurred within the participants during therapy and how they have re-positioned their inter-personal relationships with themselves, others and the broader world. It also explores how participants break through and understand the difficult emotions they experience as a consequence of the abuse. This theme further investigates the role that time plays in helping participants open up about their abuse and the impact of therapeutic endings. On the whole, it aims to encapsulate the impact of the past and how it formed an unconscious pattern that contaminated and coloured the participants' present experience and image of themselves, and subsequently how it led to the discovery of the hidden parts of themselves.

E. Discovering Self and Breaking Through Emotions

In sub-theme E, Discovering Self and Breaking Through Emotion, I explore how participants' narratives capture the changes that have occurred during therapy and the process of discovering and re-discovering parts of themselves. I also assess how participants express an element of self-awareness and responsibility towards caring for themselves and understanding and recognizing the impact of childhood abuse. The theme serves to depict the journey of therapy by participants' accounts, of breaking through and discovering emotions towards self and others during the therapy process. The narratives highlight how for many women the journey of discovering and working through emotions has been a painful one. Many of them have been dissociated from their emotions and the process of therapy helped them unlock many of these suppressed feelings. Bella's excerpt highlights her realisation of her ability to connect with her emotions and feelings during therapy, something that she was unable to do previously:

> *"I realise that I had not known how to love... I thought my laughter and I thought my emotions and I didn't feel them... And I was dissociated... definitely, and when you do not realise something until you experience something different... So I suppose going from someone with a completely low self-esteem and sense of self-loathing to someone who can actually say I do feel the love for myself... and I value myself... and I am a lot happier..."* (Bella, 118-124)

Bella's account shows her awareness of her ability to start loving again, suggesting it was an area that was unexplored and something she had not consciously realized. Her description of 'thinking' about her laughter demonstrates the rational use of laughter, suggesting a practical connotation and idea that is produced by her mind rather than her ability to 'feel' it, further confirming her disconnection from the emotional sensation produced by it. Bella uses the word 'dissociation' to illustrate her feelings, implying she was separate from, ceased and broken away from feeling her emotions to cope with or minimise her pain. From a psychological perspective feeling 'dissociated' is usually triggered by trauma and it is a mechanism to cope with pain or stressful situations. Her ability to 'feel' love for herself adds to this notion of how an emotion for her had turned into something physical that she can touch and feel, which she could only get in touch with the emotional aspect of as a result of therapy. Her expert also suggests her ability to discover and draw comparisons of her emotions before and during therapy, suggesting her ability to recognise the difference within herself. Lara, like Bella, was able to demonstrate feelings of sadness and compassion towards herself in therapy:

> *"She just kind of facilitated it... and I do not know how she did it... I was able to take pity on myself... and... that sadness kind of channelled into this poor little thing that I was... so poorly abused... and not just sexually... but in so many other ways... and hmm... Horrific... Horrible... Awful..."* (Lara, 342-346)

Lara describes learning to show 'pity' towards herself, a feeling of compassion and sympathy she was unable to express towards her childhood suffering before therapy. Her concept of self appears to have shifted from feelings of contempt, the opposite of pity, towards a more compassionate understanding of self. Her discovery of how 'poorly abused' she was further highlights her different feelings of sadness and sorrow for her misfortune which presumably she was unable to do so before therapy. She senses an emotional change within herself and it feels as if her eyes were opened to her 'horrific' past that she was once blinded by. Towards the end of the quote her tone becomes stronger which suggests that she was able to really connect with and communicate the 'horrific and awful' abuse which she had endured. Interestingly, she goes on to describe how change within her occurred in an unconscious manner over time, which she did not realize:

"It's kind of changed things within me... In a kind of subliminal way... It is not conscious things... it is just... There have been shifts within me and... hmm... kind of given me... It has changed in the way I think about things... So the stuff that was bothering me... it is not so... dominant... and I am thinking about me and my future and moving on... In a different way... well I didn't think in those terms before but it's... just kind of... that is how it has changed me... things like colour is so important to me... and how it has been diminished in my life... hmm.. I just... kind of exploring the parts of me that have been kind of closed off... because I had to and... The joy of bringing those things out... I didn't even know it was there... Just lovely to be able to move on in a way that I never anticipated... didn't know it was in me... didn't know that what was going to happen at the end of therapy... and so what it does... it has not made stuff go away but the focus goes away from it... it makes it less important and less dominant in your life..." (Lara, 19-35)

Lara's expert above demonstrates an interesting experience where she able to discover change in a sub-conscious manner that surprised her. Her narrative suggests that she expected something different from therapy, where perhaps change would have occurred in a physical way that she would have actively seen. Her use of the words 'shifts within' and 'subliminal' can be interpreted as change from one place to another in a way that is almost abstract or metaphysical, analogous to how one would perceive a cosmic shift. She was able to discover and connect with parts of herself that had been 'closed off' and begin to bring out parts of herself which she didn't believe existed, simultaneously astonished by her ability to do so. The re-discovery of her love for colour and her awareness of its diminishing presence gave her a sudden burst of life with almost a different sense of excitement, much like that of a child who has found new meaning for it. Jo, below, describes her experience of having strong feelings of self-blame and how these were explored during therapy:

"If you needed it... and you could talk in there without feeling ashamed and it also helped to take away the guilt... that we all felt and the blame that we all felt... the self-blame and the guilt... and actually that we were not actually in the wrong... somebody else was and when you were on your own, you get sucked into feeling it was your fault." (Jo, 459-464)

For Jo, the self-blame, guilt and responsibility carried on until she was able to express herself freely in group therapy in the presence of other people who had been through a similar experience. The shared and common understanding of these feelings gave Jo a sense of discovery and validation not only from the therapist, but also from other women, which helped 'take away the guilt'. She was able to realise that she was carrying a burden for something she didn't do through reflection from others. The nature of childhood abuse appeared to have made Jo feel alone where she was unable to talk about or understand her feelings with another, which lead to her feeling 'sucked' into blaming herself, giving

the impression that she was drawn in by a force that was out of her control. This kept her away and deserted her from people and activities.

This sub-theme highlights participants' ability to discover certain emotions during therapy. Their stories shed light on a renewed ability to connect with and discover lost parts of themselves due to their childhood abuse, in certain instances, sub-consciously. What is apparent is through their journey of therapy and processing their childhood abuse they were able to understand and become aware of the adverse effects of it. Their experiences suggest that therapy was able to provide them with a space that helped them facilitate the discovery of these difficult and painful emotions. This leads us next to explore the theme of the role of time in breaking this silence.

F. The Role of Time in Breaking the Silence

The Role of Time in Breaking the Silence captures participants' experience of the process of therapy and the role that time plays in it. Their accounts suggest that being able to establish a relationship and begin to open up with the therapist is a process that takes time. Participants' accounts describe the feelings of talking to a new person. Although the person in the role may be a professional therapist, it can still be a daunting experience to open up, especially when it involves exploring childhood abuse and the various risks associated with opening up such as feeling vulnerable and experiencing pain again. Therefore, it appears that talking about such experiences in therapy requires time and a certain level of patience and consistency from the therapist to facilitate this process. Bella expresses these sentiments in her expert below:

> *"And when I first saw her I told her in quite a detached way... It was only when we started to deal with the really deep painful stuff when I really had learnt to trust her... Hmmm those things were not just spoken about but felt for and it was a lot of very personal and intimate detail and I would feel incredibly vulnerable and very small during those times and she was always able to hold me... And it took me a long time to believe her and a long time to actually trust her enough to cry with her and express some of those natural lovely human emotions that I couldn't access... I couldn't reach them..."* (Bella, 442-448)

Bella's extract describes that talking about painful emotions in therapy has two sides – one where she was able to articulate her experiences in a practical way, one where she did not feel connected to them, i.e. with a sense of detachment, and the other, where over time, she was able to feel a deeper connection and relate to the trauma from her past. She explains feeling held by her therapist when she felt 'incredibly vulnerable and very small', perhaps maybe like a child, highlighting that it takes time in therapy to 'grow' to trust her therapist. In comparison, a child learns to develop trust in the care-

giver when they are attended to towards both good and bad needs, and Bella's experience resonates with this. Overtime, similar to that of a child and a care-giver, Bella learnt to trust her therapist. Terry, like Bella, explores the role of time in helping her feel adequately safe to explore painful emotions and experiences:

> *"Time you know... I think you know it is great... it made me feel confident enough... she gave me enough confidence to believe her and want to work with her... I didn't want to work with on this before... But over time... I just thought... Well it is me... and I felt sorry for myself all the time... She actually showed me the mirror on quite a few things...*" (Terry, 236-242)

Whilst talking about the abuse was not her intention when first attending therapy, her therapist's patient approach, which built up her confidence, enabled Terry to be able to talk through her difficult emotions over time. She uses the word 'mirror' to describe her experience, which gives the visual image of herself being reflected back to her by an object or person. Terry's therapist was able to reflect back to Terry certain things she was unable to see. Unless we use a mirror we cannot see parts closest to ourselves, and it appears as though the therapist acted as a mirror to show Terry these parts. Lara, similarly to Terry, was able to change her perspective on her therapeutic relationship over time as she developed a different kind of sadness towards herself:

> "*Yeah so we did over time and it was... hmm... Yeah it was painful... And it made me sad... Sad in a different way... Sad in a here and now sad... And it kind of... Kind of... galvanized... It kind of... The feelings were depressing and horrible and to kind of talk about it... One bit particularly stands out... and I hadn't thought about that... It was just...That I was cold all the time when I was a child and feeling... Feeling cold... And sore... From the abuse... And that was something I never really thought about."* (Lara, 273-281)

Lara's previously associated feeling 'sad' to feeling 'cold'. Her new description of 'sadness' in her quote developed over time illustrates her realisation and awareness of the true pain and sorrow she experienced as a child, coupled with different feelings of empathy towards herself, rather than the numbness associated with feeling cold. The ability to feel sad for herself in a 'different' way helped her realise that she had been 'cold and sore' from the abuse. It 'galvanised' her into action, giving the impression that she was 'shaken' into realisation. It may suggest that through her therapist's warmth and empathy, which had been lacking in her life previously, she was able to over time realize and reflect on the difference between feeling cold and feeling sad.

This sub-theme explores the role of time in the process of therapy. For most people talking about vulnerable feelings in therapy is difficult and this process requires time, particularly with relation to

abuse. For adult survivors of abuse their accounts show the difficulty in trusting the other with difficult emotions, highlighting that the process of developing this trust occurs over a period of time. However, a consistent approach over time can help strengthen the survivor's ability to begin to separate their different emotions and realize the difference between what they thought they were feeling and what they were actually feeling. For some of the participants even though they were able to process some difficult emotions, they found that even one year of therapy was not sufficient to process the complexities and intricacies that are accompanied by abuse. This leads us the experience of therapeutic endings, the final sub-theme that completes their journey of therapy.

G. The Experience of Therapeutic Endings

The final sub-theme depicts participants' experience of the end of therapy. Engaging in the process of therapy and establishing a healthy relationship with the therapist takes time and participants' accounts iterate this. A significant part of the journey of therapy involves the process of ending. Given that developing a therapeutic relationship takes time, ending a year long relationship is complex. Participants' narratives express the process of ending and how it can be bittersweet. Bella's narrative depicts a sense of sadness to leave her therapist, while at the same time she's gained the confidence to be able to separate and feels ready to end her therapeutic journey:

> *"Yeah I miss her terribly... I really miss her... hmm... but I don't feel... I don't feel... I am not fearful when she is not around... which I was... It was almost like a... that kind of attachment that quite a young child might have... when mum goes off somewhere... but having had that and having Harriet [pseudonym] come back again and come back again... it conformed to me that she was not going to leave me and now I feel I am kind of alright if she did..."* (Bella, 327-335)

It appears that an ending within the therapeutic relationship is quite a significant process with a deeper impact on participants than may appear on the surface. Bella's inner child still seems to hold a place in her present life. Due to her past abuse and different childhood experiences, Bella found it hard to believe that her therapist wouldn't abandon her. Through the process of therapy, however, she was able to conquer this fear. When Bella was ready to end her therapy relationship, she indicates feeling 'kind of alright' when her therapist could not see her anymore, suggesting therapy re-created her childhood attachment 'almost like a mother and child', where she was able to feel safe enough to express her fears of her therapist leaving. This in turn enabled her to develop the confidence not to feel 'fearful' when her therapist was not going to see her anymore. Her transition of not feeling fearful 'anymore' was a powerful one, illustrating the impact of therapy on her being able to re-parent her emotions. Her therapist being there for her consistently helped her recreate and model a safe

relationship - one that was different from her childhood experiences. There was an element of doubt about her therapist leaving her initially, and these feelings seemed to have shifted towards the end of therapy. Betty, similarly to Bella, describes her strong attachment and affection for her therapist and how she found the ending difficult:

> *"Hard... Hard... She got me through a lot... And... Been with me for a long time and it was hard parting with her... And I would love to know how she is keeping and everything... But I would not want to embarrass a professional by being a nuisance... Just I felt her as much as I could... Hmm you know I do not think... The professionals that do this kind of work actually realise... Just how much... Errr... I hate the word patients or clients but us are grateful... But when you get to the point that you do not want to live anymore... And suddenly you feel... That somebody... Has helped you get to where you are... You can't help but feel gratitude... Yeah... so... I am grateful..."* (Betty, 510-521)

Betty's account expresses a sense of affection towards her therapist, as well as a sense of hardship due to the ending of therapy. It appears as if she wants to connect with her therapist again, implying an attachment and bonding with her, but at the same time is aware of the boundaries of therapy. It is apparent that she feels undeserving of this kind of help where she refers to herself as a 'nuisance', implying that she is a bother of some kind or someone that disturbs her therapist. Conceivably, the impact of her abuse left her feeling undeserving of this kind of help and this is shown in her strong sense of gratitude towards her therapist. Betty also strongly highlights the significant and powerful impact her therapist had on her and suggests that perhaps her therapist may not be aware of the extent of her attachment and gratitude towards her. The tone in her narrative suggests a deep level of attachment towards her therapist that she had formed which had lasted even after therapy. Lara, like Betty, found it difficult to end therapy, but was able to use the inner strength she acquired to look at her progress from therapy and the 'hope and joy' she gained from it:

> *"It was a wrench... It made me a bit nervous... It was kind of... I know a year seems a long time... But of course... We... You know... All this stuff has been at this end of the therapy... And all this positive stuff that is coming out... Now... You know... And going out and living this experience of therapy... And over a long period of time... So I suppose a year isn't that long... It has changed me... Hmm... But you know it is ok... She has given me so much... so much hope and joy..."* (Lara, 364-373)

Lara uses the word 'wrench' to describe the ending of therapy. It seems to suggest that ending felt like a sudden jerk or pull to her that she was unprepared for, which caused pain or anguish as it was taken

away abruptly. Conversely, the ending appears to have a bittersweet sensation as she was able to recognise her progress, as well as feel comfortable enough to talk about the anguish involved with ending. It also appears that one year of therapy was not sufficient to deal with sensitive and painful issues that arise from childhood abuse. However, Lara was able to recognise that 'it has changed me', illustrating her ability to believe that something good had come out of therapy. Terry shares similar sentiments to Lara where she found it 'too sad to finish' with her therapist, but at the same time, was able to establish a connection with her therapist that made her feel 'special':

> *"I was so sad... and I think we had such a connection that I didn't come to the last one because I was too sad to finish and then I wrote an email to the service saying I really feel awful I didn't say good bye properly and is there anywhere I can see her but she had left the service... But you know what she felt enough... Cause we did have such a connection and she said you know you are very special to me... I have left the service and I work somewhere else now but I would like to see you... So she came back to see me... It was so nice..."* (Terry, 111-119)

What is apparent is Terry's difficulty with ending the therapeutic relationship, which resulted in her deciding not to turn up for the last session. Ending therapy was a difficult process for her, which perhaps originated from her fear that it may re-trigger difficult emotions of her past, where she felt rejected. Conceivably, the ending of therapy felt like another abandonment and rejection for her. Terry felt awful about not being able to say goodbye properly to her therapist, but at the same time, recognized that a 'connection' that she had developed made it safe for her to request another ending session.

This second super-ordinate theme covers the participant's experience of their therapeutic journey. This experience includes the process of breaking through difficult emotions in therapy, often sub-consciously, the role that time plays in breaking the silence of abuse, and coping with the ending of therapy. Participants' accounts take us through the journey that a childhood sexual abuse survivor faces between uncovering their difficult emotions at the beginning and end of therapy, with a special emphasis on the role that time plays in facilitating the process of opening up and viewing their emotions with further clarity. This directs us to the third and final super-ordinate theme, which explores participants' experience of finding their voice through their journey of therapy.

3.5 Super-Ordinate Theme III: Experience of Finding Their Voice

The final super-ordinate theme explores participants' experience of the impact of their childhood abuse on their present life and how it affects their patterns of relating to others. It also examines their

experience of being able to 'find their voice' as therapy has given them the confidence to express themselves freely and their desire to reach out to other people in similar situations. This newfound ability has also given them the assurance to explore the stigma attached to mental health and the restrictions and silence they felt due to childhood abuse.

H. Impact of Childhood Abuse

This sub-theme captures the experience of the impact of childhood sexual abuse on the survivor's adult life and their growing awareness of it. It also encompasses the women's experience of the long-term consequences of CSA and the difficulties faced whilst trying to cope with them. It highlights their struggle to protect themselves from getting intimate, both emotionally and physically, with others as they still fear rejection and hurt. Betty speaks about her experience of the realisation of the childhood abuse and her inability to recognise the extent of it until after therapy:

> *"You're so used to being in that sort of environment... Where you feel you are worthless and you are damaged goods and everything and you believe it... And therefore you act in that way as well and don't realise you are doing it until you meet someone else who has also... And you think hang on a minute... That person has behaved like I have done and then you suddenly realise... How timid and scared you have been... It is only till you really talk with other people that you really find out more about yourself..."* (Betty, 53-60)

Betty describes 'so used to being in that environment' which highlights a notion of familiarity, where the consequences of abuse have become second nature to her and are only open to being questioned in therapy. She uses the metaphor 'damaged goods' to describe her feelings, suggesting that due to her childhood abuse she feels blemished, ruined, broken or marred by imperfections. She had been unable to recognise the manipulation and coercing from her abuser and had accepted the strong feelings of fear within her without questioning them. There is also a strong sense of validation from people which gave her the courage to recognise her timid self, further indicating she was previously fearful and overly cautious because of her sense of worthlessness. For Tia, similarly to Betty, due to the damaging effects of childhood sexual abuse as an adult, she had been unable to express her emotions to others:

> *"I find it quite difficult to talk about my feelings because a lot of the time I feel if I allow someone to know my feelings then they can use it to hurt me so... hmm I mean... I have various aspects in my life where I haven't solved the problems... My own husband always*

says that I never say I love him to him... And my children even because I am scared of saying it..." (Tia, 439-444)

Tia's association of sharing emotions and linking it with people hurting her stems from the impact of her past. Her childhood experiences perhaps led her to believe that sharing parts of herself will leave her feeling exposed, vulnerable and susceptible to being 'hurt' by others. Therefore, as an adult, she remains cautious about expressing herself freely within relationships, both intimate and non-intimate. She has this difficult with both her husband and children, and her tone suggests it is because she feels it may leave her vulnerable and susceptible to being hurt again, and therefore, it is almost safer for her to keep things within. Emma, like Tia, was fighting to cope with the long-term consequences of childhood abuse and only realised through therapy that she had been burying her emotions until they finally erupted:

"I tried for many years and I carried on... I had a good job... And all that kind of stuff and things just happened... And that kind of thing... then you crumble, because I crumbled big time and you can't keep fighting it... And hiding from it... You can't... Because it starts to ruin your life and make your life a mess and you end up like I did one day... That I didn't want to live anymore... Because I was fed up of fighting... And taking the blame for somebody else and how bad it made me feel..." (Emma, 506-513)

Emma describes surviving for many years and working to cope with her difficult feelings, highlighting that she had been suppressing the impact of her abuse to find a semblance of normalcy in her life. She uses the word 'crumble' to describe how it felt when these emotions could no longer be held together. Carrying this 'blame' for many years, led her to feel like she was unable to 'fight' or keep up anymore with this conflict within herself. It is almost as if she was living parallel lives to cope with the consequences of her abuse and that confused her state of mind. The impact of 'carrying' this secret for years suggests she was holding onto something for another person and the heaviness of this secret over the years weighed her down, until she no longer could cope. Lara, like Emma, depicts suppressing her past in order to cope with her present, especially for her children:

"Hmm I suppose I was just feeling so down... And tearful a lot of the time and hmm... and I was finding it hard to cope with bringing up the kids and keeping my job... It was just... I was finding life hard... I think I have said this before... Just the way I kind of bagged everything off to kind of cope... to present this kind of very capable person competent and independent to the world..." (Lara, 97-100)

Lara explains how she had 'bagged' everything to cope with her difficulties, metaphorically implying she had stored away and locked up difficult emotions in order to cope better. It also suggests she had been burdened with carrying this baggage of suppressed emotions throughout her life. Her anecdotes also bring to light the shame associated with facing the past and the need to put a brave front to the world outside. There is a sense of real struggle in her tone as she had to battle with this double process.

In summary, this sub-theme serves to highlight the struggle these women have faced by not being able to open up about their abuse and almost having to live two parallel lives in order to cope. In certain instances, they actually had been unaware of the consequences that CSA has had on their lives until they were explored during therapy. Throughout their narratives they also express a degree of fear and shame of sharing their experiences of childhood abuse and emotions with significant others. This points towards the damaging and toxic effects of childhood sexual abuse and its long-term impact on individuals. However, these women appear to conquer in part the negative and harmful effects of their childhood abuse through exploration and support received from therapy and validation from others in similar situations.

I. Sharing the Journey With Others

The experience of finding their voice continues with the women wanting to share their journey with others and the desire for their story to be told. It is as though the silent nature of abuse has been broken and the women want their voices to be shared, heard and documented. Throughout their experts they mention their strong desire and need to help other women with similar histories to them. There is a sense of freedom expressed amongst these women and the longing to share it in order to free other women, who are assumed to be captive of their past. Emma, in her anecdote, states the importance in furthering research and providing avenues to survivors to open up on their abuse:

> "*Hmm... Because we're not going to get anywhere... hmm... unless there's research done... I still think that a lot of the times... Abuse... And violence against women in a lot of the cases still gets pushed under the carpet... And then sometimes we have got to keep the messages out there and I also care about other people who have been through the same... thh... Thh... there just needs to be a hand out there somewhere... There are a lot of women that still won't talk about it..."* (Emma, 64-67)

Emma feels very strongly about participating in research, believing that in order to 'get anywhere' research needs to be conducted. In her mind it appears as though participating in research will help make known the difficulties she has encountered. There is a confirmation of the silence she experienced with relation to abuse when she says it 'gets pushed under the carpet', showing her

awareness of the clandestine nature of abuse in the world today and her determination to be heard. There is also an element of strength in her tone when she talks about reaching out to other women, suggesting she feels strongly about helping women in her situation as she is able to identify with their difficulties. Emma has been able to find her voice and break through the silence after attending therapy and has a desire to share her journey with other people affected by childhood abuse. Lara shares similar sentiments to Emma where her account suggests she would like to help women in her situation:

> *"I manage a service and I know the importance of outcomes... hmm... and I have got so much out of my counselling... but... so... I thought I would like to offer up the findings for you to be able to use... hmm... fine... so... hmm... as I say I wanted to... because it has been so amazing I wanted it to be documented and hmm... You know... for it to help other people...*" (Lara, 375-379)

Lara describes having an added awareness and knowledge of the 'the importance of outcomes' as she manages a service. She feels a strong sense of gratitude towards the service, conveying her warmth and appreciation for the help she has received. She would want to 'document' her experience to make it official and valuable, to be used by others. Lara did not initially anticipate receiving specialist help in this capacity and feels a desire to reach out to people in similar situations by taking part in research.

This sub-theme encapsulates the strength and desire of these women to help and reach out to other people with similar histories. There appears to be a real sense of unity and courage to spread the awareness of the impact of childhood abuse and break through its silence and secret nature. For most of these women participating in research before therapy appeared to be a frightening prospect and with the help of therapy they want their newfound confidence to be shared and documented in order to free other women from the captive nature of abuse. There is also a suggestion that sharing their experiences with others offers a sense of healing in itself. This leads us to explore final sub-theme, the stigma attached to mental health and the women being able to voice their experiences of it.

J. Stigma Around Accessing Mental Health Services

This sub-theme covers participants' concerns around and acknowledgement of the stigma associated with childhood sexual abuse and discussing mental health in general. It's important to explore this area because the stigma has prevented many from being able to voice and express their difficulties, and it is evident that therapy has given them the confidence to be able to get more comfortable in doing so over time. It has also increased their general awareness of the topic, including making them realize how widely prevalent childhood sexual abuse is, which in turn has made them more comfortable when speaking about their own experiences. Emma below speaks about the experience of

other women in similar situations to herself, and specifically, how much more difficult it is when the abuse happened a long time ago:

> *"There are a lot of women that still won't talk about it... there is very few people that I know... know what I went through... cause there are some women who still won't talk about it... I think... it is still seen in shameful way... and all the guilt... and everything that you... who knows... In fact it is harder for somebody who was abused 30-40 years ago... than those who were abused last week... you got all those near you... burying it and hiding from it... and not having anybody to go to... taking years and years and years to be able to get any kind of therapy..."* (Emma, 338-341)

Emma's narrative reaffirms how speaking about childhood abuse is something that is still not openly done and gives us the impression that there is still guilt and shame directed at oneself because of it. Emma goes on the say 'it is still seen in shameful way' implying that even today she feels there is an element of dishonour and regret associated with abuse. Her story also suggests that it was harder for women like her abused many years ago due to the lack of help, the secret nature and perhaps lack of awareness of abuse, forcing survivors to carry the burden alone. Bella, similar to Emma, grapples with the stigma associated with abuse, more so because she explains how being the head of her department at a social care service makes her feel more uncomfortable while seeking help for her mental health difficulties:

> *"For me personally I found it quite difficult to come to sessions in the mental health service... hmmm the stigma is still there for people and although I do not have a diagnosed mental health problem... hmm... coming to the service means I am coming into a mental health resource and the reason that it is more sensitive for me because perhaps I am head of services in social care in *******... so I am local and some of the staff that work in this building are... They are not my staff but they are staff to my colleagues..."* (Bella, 207-214)

There appears to be an element of 'stigma' attached to her using mental health resources, especially for someone who is the head of a department and perceived as a person of authority. Bella almost suggests that her position makes it such that her colleagues may look up to her, and attending a session for mental health may be perceived as a sign of weakness or a flaw. She uses the phrase 'coming into a mental health resource', in a tone which has a poignant negative connotation associated with the action, almost as to imply she is undeserving of it. Her narrative also suggests a general negative connotation attached to accessing mental health services, regardless of the context.

The third super-ordinate theme covers the participant's experiences of 'finding their voice'. These experiences included their awareness of the impact of childhood abuse even on their adult life. Their

experience of finding their voice continues with them being able to express and share their experience of therapy and wanting to reach out to other women in need. Participants' accounts suggest that they are aware of the secret nature of abuse and would like to make their experiences public so they can be heard. Finally it appears that therapy has given them the courage to be able recognize and voice the obstacles and stigma attached to accessing mental health services create for other survivors.

Chapter 4

Discussion

4.1 Overview

The vast majority of prevailing research studies on CSA have adopted quantitative methodologies which have contributed tremendously to the understanding, knowledge, and awareness of its impact and long-term effects. They have served to identify and establish cause-effect relationships. In the current era, however, qualitative research has been increasing in popularity, particularly amongst counselling psychologists. Keeping in mind the words of McLeod (2002), where he advocates strongly for the case of methodological pluralism, this present qualitative study contributes to research in the field by shining light on the meaning-making and lived experiences of women attending therapy at a specialist service for survivors of CSA within the UK, from their own perspective.

In this chapter I assess some of the key findings and conclusions that have emerged from the analysis of the participants' interviews conducted in this study. I have attempted to accomplish this by identifying recurring patterns and themes within the three larger super-ordinate themes, which are **"Forming the Therapeutic Alliance", "The Therapeutic Journey",** and **"Experience of Finding Their Voice"** and thus grouped the key findings within these three. I then make reference to existing literature which is most applicable to the key findings and assess how findings from this study differ from or support findings in existing literature. Subsequently, I explore the limitations of this study, and finally, I discuss clinical implications of this study to the field of Counselling Psychology and my views on where further research on this topic can be accretive. In keeping in line with the transparency and coherence principals of Yardley (2008, 2000), I make broad references to Participant 11, who was omitted from the analysis having not undergone individual therapy. While not the core basis for the findings highlighted in this study, her narratives are used in a broader, complementary sense.

4.2 Super-Ordinate Theme I: Forming the Therapeutic Alliance

The therapeutic alliance can be described as a concept that explains the working relationship between client and therapist (Allnock et al., 2013). The first super-ordinate theme, Forming the Therapeutic Relationship, covers several interesting findings on how this alliance is formed between therapist and the participants in the study. The first of these is the importance of the initial engagement between a therapist and the participants. The various accounts, directly from participants' perspectives, would suggest they found their therapists unable to successfully engage with them, often times more prevalent at the very beginning. We see this in the narrative of participants who experienced their

therapists to be un-engaging and 'robotic' or others who found the silence in the room 'awkward', leading one participant to question the qualifications of the therapist. Some participants didn't know 'how to say things' and thought they would receive further help. This 'misattunement' at the onset can put clients off from seeking therapy for childhood sexual abuse. Given the nature of CSA, there is perhaps an added level of importance on how a new relationship, in this case with a therapist, is developed at the onset and held during therapy, and the manner with which the therapist approaches it. In many instances, survivors may be put off by the initial experience and may never re-explore therapy which could have been beneficial to them.

The general possibility of misattunement is supported by previous studies where participants found it difficult to establish a relationship with their therapist as they perceived them as un-engaging, un-empathic and non-responsive (Mc Gregor et al., 2006). Mc Gregor et al.'s study highlighted the challenges encountered amongst CSA survivors, where many experienced difficulties with openness, safety, trust, and interpersonal relationships. Perhaps not highlighted in previous studies is the acuteness with which this occurs amongst survivors of CSA and the resulting impact on their ability to want to connect in therapy again. Childhood trauma can generate vulnerability with relation to therapy errors (McGregor, 2001; Dale, 1999; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994; Herman, 1992; Kluft, 1990). Pearl, for instance, began to question her therapist's skills due her sense of discomfort and lack of connection that she felt. Initial interactions with a therapist are likely to be fundamental for the effectiveness of therapy (Dale, 1999) and findings of this study support the importance of this. Dale (1999) also suggested some survivors observe the therapist closely and intensely for signs of a lack of understanding, empathy, and their ability to manage hearing about their CSA disclosures. Must a therapist be perceived to be lacking in any of the above, they may experience this as a sign of further betrayal (Chouliara, 2012; van der Kolk et al., 1996; Salter, 1995). Participants' expressions of self-doubt, attributing the lack of connection to themselves, are consistent with some of the common emotions experienced by adult survivors of CSA (Cloitre et al., 2006). But perhaps specific to childhood sexual abuse, this is an area where therapists can be even more sensitive to the initial interactions as it can have a detrimental impact on the overall relationship. In the case of the participants in this study, they were fortunate to have been offered a second chance with a different therapist. In ordinary circumstances, they may not be given this chance or have the desire to give therapy another try.

Herman (1992), in her analysis of Trauma and Recovery: The Aftermath of Violence, compared the consequences of trauma on three social groups: adult survivors of CSA, domestic violence victims and military personnel injured in combat. She found considerable differences in the long-term sequalae between these groups. The differences were attributed to factors such as the number of traumatic events and perpetrators, early onset of age and public recognition of the reality of the trauma (Bird, 2015). It was acknowledged that the consequences of CSA were observed to be far

more difficult to address and complex than combat trauma. She suggested the reason for this to a certain extent is a child's account is less likely to be believed by the general public when compared to that of armed services involved in action which are reported extensively in the media and news (Bird, 2015). As a result, Herman highlighted varies degrees of complexity may exist within post-traumatic stress disorder (PTSD), whereby childhood trauma, for instance, may require more time to recover from and is harder work as it needs more support in comparison to other PTSD. Coping mechanisms developed during childhood are harder to replace in adulthood as they may become deeply embedded and repressed by the child over the years. These findings by Herman support the notion that chances and the extent of misattunement are increased when working with survivors of CSA given the complexities of the trauma involved, which is also seen in this current study.

Attachment Theory (Bowlby, 1973), which is discussed in detail in the Literature Review (Chapter 1), also provides some insight into the current study's findings. It provides a framework for understanding how early interactions with primary caregivers can impact one's experience of relating as an adult. It informs us that the way a child is responded to or treated by their parents or caregivers can have a significant influence on their development. Anxious attachment is a result of the primary caregiver being emotionally or physically unavailable, which predisposes the individual to anxiety and dependency. This anxiety and dependency can serve as a function of protection in relation to attachment (Alexander, 1992). Attachment Theory may also serve to partially explain why the chances of misattunement are likely to be more prevalent amongst adult survivors of CSA seeking therapy.

Participants in this study also expressed observing when their therapist's didn't seem 'human', and it felt like they were speaking to a 'robot', which made them question their reasons for coming to therapy. This finding is in line with previous research where some authors caution that because therapists are frequently asked to bear witness or adopt a 'neutral stance' to a crime, and traditional approaches use the 'blank screen' approach with survivors of CSA, it can give the impression of rejection to those looking for empathy and understanding (Dalenberg, 2000; Herman, 1992; Maroda, 1991). Prior research has identified that survivors first and foremost want a warm human being to help them with their difficulties (McNay et al., 2012). Likewise, a study carried about by Armsworth (1989) explored therapists' attitudes or practices that were considered harmful to the client. It was discovered that lack of validation, blaming the survivor, using rejecting responses, victimisation and exploitation were found to be unhelpful to the clients. The first of these, i.e. lack of validation, ties in directly with the blank screen approach reported to have been experienced by participants in this study. The study also supports these existing findings which found that participants want to 'connect with a human' during therapy. However, while existing literature has described this notion from a therapist's perspective, this study offers the unique perspective of the clients themselves, giving them

a voice. We learn from their direct perspective how they feel and react when faced with a situation such as this, providing further depth to existing findings.

The importance of trust in therapy is essential to any individual seeking therapy (Brown & Lent, 2008), however, this group in particular, found a robotic, un-engaging and non-communicating manner during therapy more difficult to trust. This could be for a variety of reasons explored previously in the literature, such as re-creating traumatic memories in therapy, or survivors seeking nurture from therapists but having this need unmet due to the vicarious re-traumatisation (Herman, 1992). This further suggests the challenges of regular therapy differ from that of abuse-focus therapy (Meiselman, 1994). It appears as though in order to facilitate disclosure and exploration of the abuse in particular to this group, trust, safety and clear communication is paramount. This study found that a more relational therapy experience is important as participants described the need to feel validated, heard and supported with warmth and empathy.

A second interesting finding within this theme is how participants describe ways or reasons by which they were able to connect successfully with their therapist. Throughout this sub-theme, there is an overarching pattern of therapists being able to connect better with their clients when they demonstrate a deeper level of empathy, come across as trustworthy, and interestingly, also show a level of robust emotional strength that perhaps offers a client the adequate support structure to open up or promote disclosure during therapy. Interestingly, therapists who came across as robust and able to explore difficult experiences with the participants were perceived as helpful. The importance of perceiving the therapist as resilient is an interesting finding. This conclusion is also closely linked to the value that clients attach to feeling accepted during therapy explored above. It appears that therapists who were able to successfully connect with their clients within this group did so by offering validation, belief and acknowledgement of their abuse, putting no added pressure on them to delve into details prematurely, or interestingly, tailoring therapy specifically to their needs at hand. This was illustrated in one case where a therapist used photographs of a participant's childhood to make her think about the period when she was abused, and this turned out to be a breakthrough session for her.

Previous research (Chouliara et al., 2011, 2012; Phillips & Daniluk, 2004) supports the importance for participants to establish a safe, trusting, and empathic relationship based on equal communication, participation and respect with their therapists. Unique to this study is the qualitative experience of participants highlighting the importance of the therapist coming across as emotionally strong, patient, and acknowledging of the abuse which encouraged participants to feel comfortable enough to challenge them. Herman (1992) suggests that a client who is traumatized is looking for nurture and rescue from her therapist. Perhaps adding to her findings is how participants were seeking emotional ‘nourishment’ at the same time which may have been diminished during their childhood. According to Sartre (1956), the perception of ourselves develops from our understating of the perceptions others

have of us. This study gives meaning to this statement when clients describe successful therapists helped them not feel worthless and recognised where they were struggling or needed to be left alone.

Existing research also suggests the importance of trustworthiness in a broader sense (Horvath & Greenberg, 1989), lucid communication (Price & Jones, 1998) and accurate interpretation (Ogrodniczuk & Piper, 1999; Crits-Christoph, Barber, & Kurcias, 1993). The essential components of empathy comprise of affirmation (Najavits & Strupp, 1994), helping (Coady & Marziali, 1994), and warmth/friendliness (Saunders, Howard, & Orlinsky, 1999; Bachelor, 1991). What the present study suggests is that from a client's perspective, they specifically recognized and appreciated some of these characteristics of a therapist that they can hold onto even after therapy ended. Participants' narratives suggest that opening up for them only became easier when they could confirm their therapist was trustworthy. For some, being left alone or not being put under pressure to speak at a particular point is a sense of affirmation of the struggle they are facing. Existing research mentioned above also suggests that participants appreciate the importance of journeying with the therapist during the exploration of abuse, rather than them taking a neutral or blank stance.

A study by Middle & Kennerley (2001) found that survivors of CSA emphasised more on the importance of the therapist's qualities in the relationship, whereas their non-abused participants placed more importance on the therapeutic techniques and process (Middle & Kennerley, 2001). Participants described that therapy helped them contextualise their abuse. Across nearly all narratives in this study, the focal point when discussing forming the therapeutic alliance is around the participants' experience and observations of their therapist's qualities. The direct perspective of the participants, however, helped put this into context where every subtle quality of a therapist can be perceived as a positive or a negative, not just the general approach.

Finally, another conclusion that stands out within this super-ordinate theme is the importance of the environment in which a client engages in therapy, and how different settings can lead to breakthroughs for different clients. A client unable to connect during individual therapy may find a completely different experience if engaged in art therapy or if sharing experiences within a group therapy setting. Participants describe how listening to other people in a group setting helped them normalize, validate and reduce the stigma or feelings of being alone in this experience.

Even within the context of individual or group therapy, the approach taken by the therapist can create different environments which are more or less conducive to creating a successful therapeutic relationship. For instance, participants allude to a therapist always being there for them at a particular time every day, suggesting how a reliable and repetitive pattern can be important to them. Perhaps this was something alien to them during their childhood. They also refer to a therapist's regularity and ability to be themselves during the sessions, suggesting consistency, as well perceived openness are important to them. This finding has meaningful implications for therapists who after several sessions

with a client continue to find no breakthrough or improvement. They may attempt to change the setting or approach that they take in trying to form the therapeutic alliance with their client. As highlighted in the Literature Review, Nelson (2007, 2009) suggested the importance of a therapist creating a non-judgemental, caring and reliable environment. Harper (2006) also emphasized that in order to help therapists develop a safer and contained therapeutic environment, issues that affect boundaries needed to be recognized and appreciated.

For adult survivors of CSA, the process of breaking the silence can be a difficult one. It is essential that there is a space where individuals can explore their childhood difficulties safely and express their victimization, pain and the voice of their survival (Herman, 1997). Not only has individual therapy appeared to be useful whilst working with adult survivors of CSA, but group therapy has proved to be just as effective (Coulson & Morfett, 2013). Findings from the current study supports previous research findings where participants were able to feel accepted and held within a group therapy environment. As discussed in the Literature Review, Ellis (2012) carried out a case study to research the effectiveness of group therapy (The Butterfly Programme) for adult survivors of CSA. He explored various venues where the program could be delivered and used pre- and post-therapy measures to assess various levels of effectiveness. His study concluded that for individuals who have experienced CSA, group therapy is highly beneficial. In a group setting it was found that the stigma attached to CSA, as well as feelings of guilt, shame and secrecy were reduced. These findings are in line with the present study where participants described the benefits of group therapy where they felt adequately supported and found it easier to share their difficulties. Perhaps not appreciated before is the overall environment, even within a group setting, and how the therapist approaches each client, can also have an impact. On the other hand, literature suggests the downside of group therapy is that sometimes it doesn't provide the depth of exploration as many clients are hesitant to share their highly personal and emotional issues with a broader group. In addition, some clients are reluctant to face their past as it can be threatening and evoke painful emotions (Voight & Weininger, 1992; Carver et al., 1989).

Participants in this study described feeling safe during group therapy, knowing everyone there had experienced some form of childhood sexual abuse. They felt supported by other members who helped them realise that their abuse was not their fault. Ellis (2012) concluded that women who engaged in the Butterfly programme were able to explore their emotions in relation to CSA, and therapy helped them reduce their dependency on other medical services. The Butterfly programme, however, consisted of only eight weeks of therapy. This study suggests that these positive experiences can also benefit participants who have been engaging in longer term therapy, in this case, at least one year.

Findings from the present study also illustrated the importance of group therapy in helping participants reduce their feelings of self-blame. Their accounts suggest their ability to connect with each other, as well as the therapist, whilst getting in touch with their painful childhood experiences

and the impact it has on them today. This finding is in line with the study conducted by Coulson & Morfett (2013). Coulson & Morfett (2013) described women's experiences of overcoming their feelings of shame and isolation by sharing their story in a safe space during group therapy. The findings of their study highlighted the power of group therapy as an important factor in an individual's recovery, because "magic happens" (Coulson & Morfett, 2013). Here the women were able to listen to and understand others' experiences, as well as challenge other members' and their own beliefs about shame, guilt and self-blame in way that was experienced differently from individual therapy. What's interesting to note in the present study is what specific elements during the therapy can enable this 'magic to happen' in the participants' own voices. For one participant it was listening to the fact that she was not the only one who had suffered abuse. For another it was the inherent patience and comfort of being in a setting where having to speak is more optional rather than mandatory when compared to individual therapy. For a third participant it was others validating her experience. These are interesting insights that could inform therapists on specific aspects that were effective for this particular group.

4.3 Super-Ordinate Them II: The Therapeutic Journey

The second super-ordinate theme, focused on The Therapeutic Journey itself, provides us with another set of interesting findings. The first is related to the process through which participants discovered aspects of themselves and broke through their emotions. A very salient point this study makes is how this process can be an 'unconscious' one. One participant described realizing how 'she had not known how to love'. She 'thought her laughter' and was dissociated, until she went from someone with completely low self-esteem and sense of self-loathing to someone who could actually say she felt love for herself. She had *sub-consciously* forgotten how to love, and had to *think* about her laugher. Another described realizing after years of therapy that things had changed within her in a 'subliminal way' and that she witnessed shifts within her, which were not conscious. She further went on to say that she didn't know these things existed, and they were all coming out in a way that she had not anticipated. These are very powerful messages that the participants shared. I was struck by how participants described their experience of therapy as an 'unconscious process' that brought about change in their lives. Unconsciously, over time, perhaps even years after initially going to therapy, survivors of CSA within this group began to discover parts of themselves that had changed without even realizing it. For a therapist looking for more immediate or timely affirmation of change or improvement within a client, this finding suggests while change may not be happening in an apparent way during the therapeutic relationship, subliminal shifts within the client could still be taking place within. This finding is further complemented by one of the recurring sub-themes, which was the role that time played in uncovering these emotions, which is covered more explicitly in the *Analysis* section. The findings explored above are in line with previous research that refers to how survivors

seek to make meaning from their abuse experiences and echo how the meaning from these experiences can be integrated into representations of the self, others and the world (Joseph & Linley, 2005).

Prior research suggests that during one's childhood, when faced with events that are traumatic, the child is more likely to carry these events as part of their identity into adulthood and quite possibly throughout their lives. Thus, this forms a platform that shapes the way they think, perceive and react to various life events (Tedeschi & Calhoun, 1995). For adult survivors of CSA, some self-concepts are more likely to be familiar, for instance, feelings such as blame and shame, which leads them towards a more problem-saturated rather than strengths-based life (Bhuvaneswar & Shafer, 2004). Therefore, it is not surprising that children internalise their blame and shame and develop a strong sense of self-loathing (Cloitre et al., 2006). The study by Cloitre, Cohen, and Koenen (2006) suggests that sexually abused children typically believe that it is their own intrinsic badness or their fault that they were abused. Participants in this study describe not understanding the 'extent of their abuse' as they led normal lives to push their feelings aside. They were under the impression that carrying on with life and trying to cope was the best approach, suggesting they were not able to fully comprehend the extent of their abuse. But what we learn is that subconsciously and even unconsciously, over time, under the right conditions, shifts in the way of thinking can occur to alter their negatively established beliefs. One participant uses a very specific example to describe this change when she says she was able to express a 'different kind of sadness and pity' towards herself, something she was unable to do prior to therapy.

A study by Blumer et al., (2013) concluded that CSA survivors are often either extremely aware or completely unaware of how their experiences of sexual abuse affect their current problems in life (Blumer et al., 2013). Their study looked at the importance of Feminist Family Therapy ("FFT") whilst counselling survivors of CSA. They found that FFT was an effective way to connect with and validate their feelings by bringing about normalization and change with regards to the lack of power in their lives. This was fostered through an environment that empowered the survivor to be an advocate for herself (Blumer et al., 2013). Another interesting element of the current study is participants describing when they realized that, rather than feeling emotions, they consciously thought about them. They explained that they 'thought' about their love and laughter in a 'rational' way, feeling disconnected or dissociated from their emotions. This realization also suggests a shift in their way of thinking that occurred during the course of therapy.

Saha, Chung & Thorne (2011) conducted a retrospective qualitative study that explored the evolution of the sense of self after intensive therapy with participants who experienced childhood sexual abuse. A narrative analysis was conducted on four women's experiences who completed a course of group therapy for sexual abuse. Findings from this study indicated that participants had a 'traumatised self' characterised by shame and guilt, leading to self-perceptions of being insignificant and undeserving.

After therapy, participants showed an overall positive improvement of their sense of self, characterised by an increase in self-confidence, awareness and acceptance. Furthermore, they were able to externalise their abuse by shifting responsibility from themselves to the abuser. While the work by Saha et al. (2011) highlights the increased awareness that participants faced directly after engaging in therapy, this current study suggests there is a layer of awareness that was lacking that is deeply rooted within this participant group and only increases sub-consciously over time.

Another very interesting finding within this theme is the importance of the therapeutic ending. We learn some interesting points that could be highly accretive to existing literature on this topic. Participants described being nervous towards the lead up to the ending and fearful of their therapist not being around after. The ending was described as 'hard' and felt like a 'wrench'. One participant didn't even attend her final session because she was too sad to finish. Participants also described how they were interested in knowing how their therapist was keeping post their therapy relationship ending, without being a 'nuisance' to them. One participant highlighted that she had developed 'a kind of attachment that quite a young child might have'. She further went on to describe how she felt professionals in this sector might not actually realize how much clients like her are grateful for the work they do. The more immediate takeaway from this is how the process of ending the therapeutic relationship is an uneasy and a bittersweet experience. However, the more intriguing point is the significance and relevance of the ending process and how it is experienced by this particular group. The anxieties they faced ahead of it, during it and after it in their own words, is not an area explored in detail within the existing literature. This study illuminates these women's anxieties with regard to ending therapy. As the women presented in this study were sexually as well as emotionally abused, it appears that their primary relationships and internal working models developed during their childhood were abusive and deleterious. As a result, there are faced with the risk of being abused or mis-treated again, similarly to when they were children, and as adults they may struggle to let go of a 'wholesome' therapy relationship which had become such an important part of their emotional well-being.

Ending the therapeutic relationship is a process that is highly significant in therapy. Usually the therapist ensures that the therapeutic ending takes place at a meaningful time and the timing of it is a decision that is collaboratively made by both the client and the therapist. There are a variety of books that emphasize the process of endings from an analyst's perspective (Schlesinger, 2005; Cummings, 2001; Murdin, 2000; Rennie, 1998). However, there is limited research conducted from a client's perspective (Etherington & Bridges, 2011). Stiles et al. (2008) and Barkham et al. (2008) explained that therapists and clients are able to make suitably responsive decisions about when to end therapy if a review has been successfully implemented. This is consistent with Perrin et al. (2009) who suggested that "the precise number of sessions seemed less important than how the ending was conducted" (p. 245). A study carried out by Etherington & Bridges (2011) revealed that clients with

abuse histories described the therapeutic importance of mutuality and negotiation in decision making about endings. However, I found that existing literature on the intricacies of the ending process itself and its impact on clients, in specific those with a history of CSA, is very limited. It focuses on the timing and process of therapeutic endings in general, but not on the actual feelings it generates amongst clients who have child abuse histories. Notably, this study seems to suggest that the ending process has a more significant impact on and causes more uneasiness within survivors of CSA.

4.4 Super-Ordinate Theme III: Experience of Finding Their Voice

The last super-ordinate theme, Experience of Finding their Voice, gives us the final set of findings discussed in this study. The first of these is how common and prevalent it was to find participants who had generally lacked awareness about their abuse and its long-lasting impact on them. Many had swept it away under the carpet, and felt a numbness towards it until they finally crumbled. Participants mentioned acting in ways they didn't realize until they met someone else who made them aware of it. Some of them indicated that they only found out more about themselves through speaking to other clients during group therapy sessions. One participant related to this sentiment outside of therapy when describing her relationship with her husband and children. Her husband pointed out to her that she never expressed her emotions to him, something she never realized. Participants described finding it difficult to cope with managing their day-to-day activities such as their jobs and family/children commitments. They had to stifle or avoid their emotions in order to continue to function in an ordinary way. The common theme here is participants not realizing the impact that the abuse had on them as they tried to suppress it for many years, without realizing it was actually gnawing into their daily lives in the background and waiting to erupt.

Prior studies have explored the phenomenon of how coping plays an important role in helping adult survivors of CSA mitigate the effects of their experience of abuse on their adult life (Steel, Sanna, Hammond, Whipple, & Cross, 2004; Bal, Van Oost, De Bourdeaudhhuji & Combez, 2003). Furthermore, research indicates that avoidant coping strategies predict poor adjustment outcomes (Negrao et al., 2005; Steel et al., 2004; Bal et al., 2003; Gibson & Leitenberg, 2001), however they remain to be a main coping theme used for survivors (Perrott et al., 1998; Sigmon et al., 1996). Children learn ways to protect themselves during sexual abuse by separating parts of them from the direct physical and temporal experience (Willis, Canavan & Prior, 2015; Hawkins, 2007). What's not evident in the research is that many participants lack the general awareness that they've been 'coping' for all this while, an interesting finding in the current study.

A study by Phanichrat & Townshend (2010) explored the coping experiences of seven adult survivors of CSA using IPA. Their findings highlighted the coping strategies that survivors used on their way to recovery. Semi-structured interviews were used to gather the data and the analytic process identified

two main clusters such as avoidant coping strategies and problem-focused strategies. Their analysis revealed that participants went through a gradual dynamic process from initially adopting avoidant coping strategies to gravitating toward problem-focused coping strategies over a period of time. Their study showed a healthy process of coping with sexual abuse involved optimistic thinking, seeking support, cognitive engagement, self-acceptance, and seeking other meaningful strategies. Their study highlights that problem-focused coping strategies should be encouraged as part of a therapeutic intervention. The findings from the present study are in line with the findings of Phanichrat & Townshend (2010) where all participants expressed suppressing and avoiding the effects of abuse until they sought therapy. Therapy helped them engage in more problem-focused coping strategies. However, the current study further contributes to existing research as participants described from their own experiences the specific interventions used in therapy that helped them become aware of the impact of their abuse.

The other interesting finding that this theme shed light on was the general desire of participants to want to share their experiences and journey. The sharing not only addressed their concerns with the overall stigma associated with CSA and mental health in general, but in a sense, also served to further ignite their healing and almost empower them. One participant described that ‘we have got to keep the messages out there and I also care about other people who been through the same’. She went on to say ‘there just needs to be a hand out there somewhere’. It's powerful to realize how a survivor of CSA herself can evoke such an empowering emotion to be in a position to want to help others. Participants were keen to offer up their narratives to be used for this study and wanted them to be documented, again highlighting a role of reversal where a participant was thinking about other abuse victims. There is also a general desire to address the stigma around CSA. One participant described how ‘there are still many women that still don't want to talk about it’ and another explained how ‘the stigma is still there for her’ when she accesses mental health services. The tone of both suggests a desire to address this. These findings can be linked to post-traumatic growth. It is suggested that adults with a history of childhood sexual abuse showed positive changes in self-belief. Participants in this study report a deep sense of change within patterns of relating to self as well as others. They further go on to mention the desire and need to reach out to people in similar situations suggesting an increase in their ability to empathise with self and others.

This finding is in line with previous research where a study by McClain & Amar (2013) found that female survivors of childhood sexual abuse found their voice through participating in research. Although the current study highlights that participants had a positive experience of participating in research, they also expressed a desire to give back to the service as they have benefitted from therapy. It appears as though participating in research gave them an opportunity for their voices to be heard, which in itself was both healing and empowering, as it challenged the stigma associated with childhood sexual abuse (Becker-Blease & Freyd, 2006).

Participants' narratives demonstrate an ability to discover an element of strength and control by voicing their past abuse, which consequently, diminishes the power of the abuser. A study by Draucker et al., (2011) supports this finding where their study suggested that participating in research can mean an element of healing as survivors begin to engage in and participate in different activities and altruistic behaviours they previously have found difficult. This study can further add to previous research by informing future researchers carrying out studies on adult survivors of CSA about the positive aspects generated through participating in research.

Lastly, the topic of abuse for adult survivors of CSA often gets silenced due its sensitive nature and re-creation of traumatic memories. However, this study also provides some insight to future researchers by taking into consideration the process of carrying out research sensitively, ethically and providing the participants with additional support after their research interview.

In summary, this study aimed to shed light on the lived experience of women who have attended a specialist psychotherapy service for adult survivors of CSA from their own perspective. Findings from this study suggest that due to the nature of trauma caused from childhood abuse, there is a degree of complexity that participants seeking therapy for it faced when forming the therapeutic relationship. Misattunement seems to be a recurring pattern. Findings also suggest that specific experiences and instances facilitated these women's ability to feel a sense of acceptance in order to successfully connect with their therapists. For instance, they experienced the use of certain techniques or interventions or found aspects of the environment that were created conducive to making them feel more comfortable to engage with their therapists. Findings also suggest an interesting phenomenon that occurs within clients over the course of therapy whereby the discovery of certain emotions and change occurs 'unconsciously' or via 'subliminal shifts', which has interesting implications on how therapists can assess improvements in their clients over time. The experience and impact of ending the therapeutic relationship for this group in particular is also one that sheds light on some interesting conclusions for therapists and for other survivors seeking therapy. It appears that the ending process has a deeper meaning and impact on this particular group. Another interesting finding is the apparent lack of awareness that clients have about the impact that CSA had on them and the extent of the consequences on their present lives, as well as, the role that therapy has played in increasing their awareness of it. Lastly, interestingly, participants in this study were keen to share their journey with others and challenge the stigma associated with the topic and mental health services in general, a process which seems to empower them and may even contribute to their healing process.

4.5 Research Claims

Having explored some of the key findings generated from this study, I explore some of the limitations it faces. One limitation that stands out is that the sample size of the study is relatively small and therefore its implications and conclusions have to be considered with some perspective. Within qualitative research, as discussed above, researchers speak in terms of transferability, rather than generalising findings, as sampling decisions have not been carried out on statistical grounds. The findings of this study can be applied to situations similar to the context from which the study was derived. For instance, other specialist services within the NHS, as well as charities, can benefit from the findings from this study. This study can also inform health care professionals working within this population about the complexities involved and ways of approaching and dealing with them. Despite carrying out research on a small scale, the material gathered from the interviews provided some data rich in quality with a relatively large sample size for an IPA study. It suggests that the women participating in the study were able to be open and courageous enough to reveal their experiences in depth.

A limitation of this study is that it only involved participants who had undergone a minimum of one year of individual therapy. There are many cases of survivors of CSA undergoing shorter periods of therapy, and thus, implications of the findings may differ for such a population. It is also important to take into consideration the experience of survivors who did not complete their therapy or who were not willing to take part in the research as this study does not reflect their experiences.

Participants who stepped forward to volunteer were likely to have had a positive experience of therapy to have wanted to spend another 45 minutes to 1 hour to speak about it. I tried to address this by asking all participants about their negative, as well as positive experiences of therapy. I also tried to employ a transparent and inclusive process of recruitment by providing all potential participants with as much information that was deemed appropriate and ethical about the study. This included not collecting participants' history of abuse in order minimize any form of intrusion. It could be argued that whilst recruiting for volunteers to take part in research, all researchers only have access to those who are willing to talk about or share their experiences. This aspect is shared by all researchers and is perhaps not unique in particular to adult survivors of CSA, even though they are a more difficult population to reach. This said, it is important to take into consideration the experience of survivors who were not willing to take part in the research. In addition, this service is a specialist NHS service and this does not take into account the women who do not have access to it. It would be interesting to explore the experiences of women and men in general across the UK in other services to see if there are any differences and similarities between them, or if specific aspects of this particular service had any bearing on the conclusions.

Although a rigorous recruitment procedure was carried out, the study was also subject to an oversight in the recruitment procedure. As there were several people involved in the recruitment process, including the lead clinician, the support worker and myself, there happened to be a participant ("Participant 11") that expressed interest in participating in the study who did not meet the inclusion criteria. This was only realised when she attended the interview. Therefore, given IPA requires a homogenous sample, she was excluded from the main study. However it would be unethical not to mention this oversight or completely exclude her from the research. Insights from her interview were broadly explored and are summarized below.

Participant 11 shared her views on the initial misattunment she experienced in the context of group therapy. She suggested that 'a bit more prompting from the facilitators [group therapist]' would have been helpful, especially when there were long and short periods of silence where clients were finding it difficult to share. This said, she found the group environment to be safe, like some of the other participants expressed. She elaborated by highlighting that clients in a group therapy session were keen to help a newly joined member by sharing as much from their own experiences. She described being 'protective' of a new member and wanting to 'take them under your wing'. Lastly, when speaking about the ending process of her group therapy, she described being 'angry' and confused, because she didn't know why it was ending. It led her to theorize on the reasons for this, thinking it might have something to do with lack of government funding for mental health services.

Although this is a collective experience of women attending a specialist service for adult survivors of CSA, it is important to consider that their experiences may not represent all women who have experienced CSA that have undergone therapy.

4.6 Clinical Implications

While carrying out this research study I have attempted to keep in mind the implications of the findings to the field of Counselling Psychology. In my view, this study has shed light on some new findings, but also with regards to findings that are not completely new to established literature, they have been uncovered from a different perspective. This perspective is that of the survivors themselves, in their own voice, which offers powerful insight. As a trainee counselling psychologist, reflecting on the experience of survivors attending a specialist service, where their inner dialogues and use of strong metaphors highlight different perspective of healing and recovery, has proved to be both insightful and informative.

A variety of research has been carried out with reference to therapists' experiences of working with adult survivors of CSA (Hodges & Myers, 2010; Way et al., 2007; Way & VanDeusen, 2006). However, there is a limited amount of research from the clients' perspectives of attending therapy within specialist services for adult survivors of CSA (Chouliara, 2011, 2012). Chouliara (2012) in fact

suggests that research across gender, as well as survivors' negative therapy experiences, requires further exploration. Thus, this study aimed to partially bridge this gap in the literature.

Seeking therapy can be a difficult process for any individual, more so for adult survivors of CSA. Specifically, due to the risk of feeling re-traumatized, misrepresented or even wanting to avoid the feelings generated when processing painful experiences, it is difficult to gain access to a sample set like this for research. This study can prove to be insightful to survivors who have had no experience of therapy and might find it informative in terms of what they can expect from therapy, particularly within the NHS. Likewise this study can prove to be beneficial for clinicians, therapists, health care professionals and researchers working in this field, whether directly with clients or seeking to recruit clients for another study. Although therapy courses and counselling and clinical psychology doctorate programmes provide training on how to work with adult survivors of CSA, being reminded of the sensitivities and complexities that accompany working with this population is of paramount importance. Findings from this study are an important contribution to the field of counselling psychology as they draw attention to the sensitivities and intricacies involved in forming a therapeutic relationship with adult survivors of CSA. Some of these include how to minimize chances of misattunement at the onset, what techniques or interventions facilitate connection with clients, how the holding environment of therapy can impact the therapeutic alliance, how changes within survivors of CSA can occur sub-consciously, the lack of awareness many survivors have on the impact of their abuse, the importance of therapeutic endings, and the empowerment that survivors of CSA can gain from sharing their experiences.

Interesting to note, the way that this particular service was set up gave clients another chance at therapy with a different therapist. This is because every client seeking treatment at this service was provided with the optional use of a support worker, alongside their lead therapist. As a result, in instances where a client found it difficult to form a therapeutic alliance with a particular therapist, the support worker was able to intervene, support them, and also offer them a different therapist. This added level of sensitivity and opportunity at a second chance is perhaps a broader aspect to be explored further for survivors seeking therapy for CSA and service providers. One of the implications that can be considered for this service is to further explore or take note of the reasons for a client not getting on with a particular therapist and wanting a change, perhaps via seeking feedback from them. In addition, the service provided their clients with the opportunity to receive therapy via a different approach if the first was not suitable. This could mean a client struggling with individual therapy having the opportunity to then explore group or art therapy, and vice-versa. The implication here is that just like most individuals may have to 'shop around' to find the right therapist for them, for this particular population, this point may be even more applicable given the sensitivities around their abuse history.

The study found that participants preferred longer-term therapy and expressed that one year of therapy was not sufficient for them to explore their history of abuse. Participants were also able to connect better with their therapists when they received consistent messages and found them to be emotionally robust enough to be relied on as a support structure. A 'relational' and engaging therapist was more effective than one who adopted a 'blank screen' approach or non-communicative style. Perhaps offering training or running seminars/works shops for therapists which highlight the evidence suggesting misattunement can occur due to the lack of validation and communication can create an added sense of awareness and knowledge amongst therapists. The environment in which a client engages in therapy can have a material impact on the likelihood of a positive outcome from the experience. The therapist may also not visually recognize the changes occurring within a client given its often unconscious in nature. Moreover, therapeutic endings can be an emotionally taxing process to clients, in particular to this group.

While there might be apprehensions about causing added trauma in carrying out research with survivors of CSA, this study is consistent with the understanding that participating in qualitative research for survivors of CSA can provide some benefits such as finding the research interview healing, empowering and generating positive feelings towards talking about their experiences (McClain & Amar, 2013). Lastly, participants indicated that while therapy had helped reduce their feelings of self-loathing and blame, their experience of childhood abuse would be something they would never be able to forget and it would always remain a part of them. The childhood victimisation feelings, however, were no longer dominant. This has interesting clinical implications for therapists as it enables them to have an idea of which areas they can have the most meaningful impact on within the therapeutic relationship.

Healing is an on-going process (Herman, 1992) and participants in this study demonstrate this. The strong connection between their childhood sexual abuse and the long-term impact on their present lives is important to keep in mind whilst working with them therapeutically. As some may have been silenced and whilst many of them carry the blame and burden of their abuse, it is important to consider that their early attachment relationships have been disrupted. NICE (2014) guidelines rely more heavily on therapies that produce evidence-based research to be rendered successful. Therefore, as counselling psychologists, bridging the gap between quantitative and qualitative research is a potential route into integrating methodologies and producing meaningful data that is relevant to practice and powerful enough to be recognised by professional bodies, a combination that is influential (Frost, 2011).

4.7 Future Research

As discussed in the Literature Review, findings from Sigurdardottir et al.'s (2016) Wellness-Program for female CSA survivors indicated a considerable improvement of health and well-being of the women who engaged with the programme. Nonetheless, the study acknowledges that further assessment of the programme is necessary before it is made available to healthcare systems (Sigurdardottir et al., 2016). While the present study differs in the duration of treatment for adult survivors of CSA, the improvement aspects experienced by the participants are similar. For example, participants described an increase in self-confidence, a reduction in the feelings of guilt, blame and self-loathing and furthermore an ability to learn to love themselves through the process of therapy. However, a consideration for future research would be to explore their experiences after a few more years of therapy to see if they have been able to maintain these lifestyle and emotional changes. It would be also interesting for future research to consider participants that dropped out of therapy earlier, participants who found it difficult to participate in research, or even include a different demographic such as males to explore if findings differ from the ones discovered in this study. Although prior research indicates that the female population is faced with a higher ratio of childhood sexual abuse (Chouliara et al., 2011; Polit & Tatano Beck, 2008), the male population, and their unique experiences of attending specialist care cannot be ruled out. It would be interesting to carry out further research with the male population and compare the differences in experience, if at all, they exist.

As discussed in the Clinical Implications section, an interesting aspect to explore further, especially with this particular population, is the general benefit of a service that offers more flexibility in terms of course of treatment. This could mean offering different durations of treatment, type of treatment (individual vs. group vs. art), or providing additional support (i.e. a support worker) which could be valuable in engaging this group further in therapy. Additionally, given this study was conducted on participants who were attending a specialist service for CSA, it would be interesting to compare the results of clients who received therapy for CSA at a general practice, as opposed to a specialist practice.

Another interesting element that can be explored further is the positive experience that participants experienced as a result of participating in this research. This can inform future researchers about the positive effects for adult survivors of CSA as a result of participating in research. Perhaps speaking about their experience during research offers them a chance to break the silence that they haven't been able to over the years. This may further generate healing and validation, and as discussed before, be an empowering experience.

Finally, given the large amounts of research conducted in this field has either been quantitative in nature or qualitative, a study which combines both methods could also be very accretive to this topic.

4.8 Reflexivity

I consider in this section of the chapter my personal engagement and implications on the research process. This part attempts to take into consideration my own personal assumptions and experiences that might have shaped or influenced this research. As Willig (2001) posits, a large part of qualitative research includes acknowledging the influence on the process of the researcher on the research and vice-versa. The Methodology chapter described in detail my interest in this topic and my position as a researcher. I feel fortunate to have had the opportunity to interview the women who participated in this study and grateful to them for their openness, courage and honesty in sharing their experiences of attending therapy. As a result of their braveness, I have been able to consciously think about my work with adult survivors of CSA to a greater degree than before. Having been a part of this service as a trainee and learnt a tremendous amount from the clinicians, I have been able to better understand the complexities that accompany working with this population. Studying their transcripts in detail and immersing myself in the gathered data, I was able to further understand with depth the impact of their childhood abuse on their current life, notably because I have not experienced it myself. I hope to use this acquired knowledge to further develop my clinical practice with adult survivors of CSA.

As this is my first doctoral qualitative research project I was faced with many anxieties. Reflecting on this process in supervision and personal therapy helped me engage with the process of research in a more confident and self-affirming manner. At times, the process of research was overwhelming; however, my supervisor helped me put things into context which curbed my anxieties. Before undertaking this research project, I did not anticipate the level of pleasure I would gain from it. I have thoroughly enjoyed using the IPA approach to analyse my data. I initially struggled with coming to terms with the interpretative part of the IPA, however, with the use of supervision, I was able to appreciate that research is a process which takes time, patience and reflection to undertake. I was struck by the depth of richness that was present within my data. I have attempted to be as transparent and open as possible to allow the voices of my participants to come through. However, it would be impossible to state that my own assumptions, experiences and professional development in the field have not had a significant influence on the research process.

Prior to conducting the interviews with the participants, I had certain expectations of how the interviews may unfold. For instance, I expected that the participants would mainly speak about the positive aspects of their therapy relationship and not divulge much detail on their struggles in therapy. However, the very first sub-theme that emerged from the transcripts was the degree of 'misattunement' that participants had experienced and the resulting emotional distress that it had caused them. Right away, this lead the interview process in a direction different to the one I had anticipated. As I went through the various interviews, another fascinating phenomena occurred which caught me by surprise. It appeared that in the process of reflecting and speaking about their

therapeutic relationship, participants began to realize aspects about themselves and their healing that they had not noticed in an explicit way. For instance, when Lara mentioned discovering change in a 'subliminal way', she actually came to that realisation during our interview process- not during therapy, as one would have imagined. This led me to realize, as I completed my research, that the opportunity to participate in this study contributed to their awareness of their healing process, which was a powerful revelation to me.

As this is a sensitive and complex subject to explore within research I was under the assumption that participants would be hesitant or reluctant to share their life experiences with me freely. As a trainee in this field, I was surprised by the willingness of my participants to divulge details on their negative therapy experiences. It appeared that perhaps they were comfortable speaking about the negative aspects because their overall experience had been a positive one. I wonder if their ability to be as transparent would have been different if they had encountered a different experience. At times, some of their narratives were emotional and vivid, which further enlightened my perspective and understanding of their experiences. Discussing these experiences and keeping a reflective diary (see **Appendix N**) enabled me to engage with and make better sense of them. Listening to participants' narratives on their therapeutic journey towards recovery was insightful, captivating and a fascinating research exercise.

4.9 Concluding Remarks

Having undergone therapy at a specialist NHS service for adult survivors of CSA, participants in this study provided a very detailed and enlightening depiction of their experiences. They embarked on a journey which began with the difficulties that they first encountered when meeting their therapist, continued to the forming of the therapeutic alliance, and through to the ending of the relationship. Participants expressed the value of being able to explore and discover their past, finding their voice during their healing journey. Moreover, the research indicated the significance of participants being able to share their journey and experiences with others. The findings in this study can provide useful insight into the unique experience of women with a history of CSA who have attended therapy within a specialist service. They can enable psychologists and therapists working in the field to make considerations and develop interventions that are appropriate for this population. I believe this study can be a valuable contribution to the field of Counselling Psychology as it offers valuable knowledge to both prospective clients with a history of CSA and therapists who are working in the field of CSA, a growing worldwide problem that has significant consequences for public health (Krug et al., 2002).

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Appendices

Appendix A

Study Advert

CITY UNIVERSITY LONDON

PARTICIPANTS NEEDED FOR RESEARCH

I am looking for volunteers to take part in the following study:

An exploration of the experience of women attending a specialist psychotherapy service for survivors of childhood sexual abuse

This is a study for individuals who have had an experience of childhood sexual abuse and have attended a year of psychotherapy at the *[name deleted]* Woman's Service. I am looking for volunteers willing to share their experience of therapy at the Service. Your participation and support will really help improve specialist services for women who have experienced sexual abuse as well as encourage women with similar experiences to seek appropriate help.

If you wish to participate in the above study, you will be invited to a one-off face to face interview at the *[name deleted]* Woman's Service with the researcher to discuss the topic. The interview will last any time between 50 minutes to an hour, in which you can leave at any time you wish. Your personal information will be kept **confidential at all times** during the research and the information will be destroyed upon completion of the study.

In appreciation of your time, refreshments will be provided on the day of the interview and at the end you will receive a token for participating in the study in appreciation for your time.

If you have had an experience of childhood sexual abuse and attended therapy at the *[name deleted]* Woman's Service and would like to take part or if you are interested in further information about the study please contact:

Rhea Williams, Trainee Counselling Psychologist

By Email: Rhea.williams.1@city.ac.uk

Or

By Phone: 07887498613
Supervisor – Dr. Jacqui Farrants
Email: J.Farrants@city.ac.uk

Appendix B

Information Sheet

CITY UNIVERSITY LONDON

Title of study

An exploration of the experience of psychotherapy for women attending a specialist service for survivors of childhood sexual abuse.

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. Please do not hesitate to ask me if there is anything that is not clear and if you would like more information.

What is the purpose of the study?

The aim of this research is to understand the experience of female survivors of childhood sexual abuse in therapy at this particular service. In view of the study carried out by Smith, Pearce, Pringle, & Caplan (1995), this research will contribute to the development of specialist services in the UK for women who are survivors of childhood sexual abuse as well as encourage women in similar situations to seek appropriate help. The proposed duration of the above study is one year and a half. The study is undertaken as part of a Doctorate in Counselling Psychology at City University London.

Why have I been invited?

You are being invited to participate because you have received therapy at the *[name deleted]* Woman's Centre.

Do I have to take part?

Participation in the project is voluntary, and you can choose not to participate in part or the entire project. You can withdraw at any stage of the project without being penalized or disadvantaged in any way. You are also free to withdraw at any time, without giving a reason. If you do decide to take part, you can choose not to answer any questions that you consider to be personal or intrusive and you are assured that this will not affect any future treatment you might receive.

It is up to you to decide whether or not you would like to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

If you decide to participate in the above study, you will be asked to attend a 50-60 minute interview with the researcher, which will be audio tape recorded. Your active participation in the study will last for about 50-60 minutes.

During your meeting with the researcher you will be asked about your experience of therapy in mostly an open ended way. The research method being used in the above project is IPA (Interpretative Phenomenological Analysis). The research interview will take place at the *[name deleted]* Woman's Service.

Your interview will be audio recorded by the researcher and information will be stored securely.

Travel expenses to and from the *[name deleted]* Woman's Service will be covered. Refreshments will be offered before and after the interview.

What do I have to do?

You will be asked to talk about your experience of therapy at the service with the researcher for about 50 minutes to an hour. The interview will be audio-recorded and all information will be strictly confidential. The interview will be semi- structured, asking you about your experience of therapy at the service and your relationship with your therapist.

What are the possible disadvantages and risks of taking part?

The possible disadvantage of taking part is that you may feel some distress at talking about personal issues.

What are the possible benefits of taking part?

- The possible benefits of taking part are that this research will contribute to the further development of specialist services in the UK.
- *[name deleted]* Women's Service will potentially benefit by improving the service they provide to their service users in the future.
- This may lead to other women feeling encouraged to talk about their difficulties and seek appropriate help.

What will happen when the research study stops?

The collected data will be anonymized and analyzed confidentially. The data will be stored securely and retained for 5 years in accordance with the recommendations of the British Psychological Society, (BPS).

Will my taking part in the study be kept confidential?

- All information will be anonymized in order to protect confidentiality and no information that is identifiable will be included in the findings reported.
- Audio recordings will be stored securely by the researcher.
- All personal information will be changed or anonymized.
- All information collected will be destroyed after 5 years.
- There may be certain instances in which I may need to break confidentiality agreement, for example, if I believe you were at risk of attempting suicide, self-harm or harm to others or if there are grave concerns regarding a child's safety. If, for the reasons above, confidentiality needs to be broken, I will make every effort to discuss this with you beforehand.

What will happen to the results of the research study?

The results of the study will be used to provide an executive summary for the [name deleted] Womens' Service and the results may also be published in academic journals. All personal identifying information will be removed or anonymised and confidentiality will be protected at all times. I would like to assure you that you will not be able to be identified from the information contained in these

reports. Data will be retained for a period of 5 years, in accordance with the recommendations of the British Psychological Society (BPS).

What will happen if I don't want to carry on with the study?

Your participation is voluntary which means you have the right to terminate the interview at any stage if you wish to do so, without giving a reason and without incurring a penalty.

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: An exploration of the experience of psychotherapy for women attending a specialist service for survivors of childhood sexual abuse.

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

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]*

Further information and contact details

Rhea Williams – Rhea.williams.1@city.ac.uk, Telephone number (Mobile) – 07887498613

Supervisor of Project – Dr. Jacqui Farrants - J.Farrants@city.ac.uk
Telephone : 020 7040 0172

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

Appendix C

Consent Form

CITY UNIVERSITY LONDON

Title of Study

An exploration of the experience of psychotherapy for women attending a specialist service for survivors of childhood sexual abuse

Ethics approval number: PSYCH (P/F)14/15 149 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 • making myself available for a further interview should that be required	
2.	This information will be held and processed for the following purpose(s): For the data to be transcribed; To be analysed for themes relating to the research topic 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. The data will be retained for 5 years in accordance with the recommendations of the British Psychological Society, (BPS).	
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.	

Rhea Williams

_____	_____	_____
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

CITY UNIVERSITY LONDON

An exploration of the experience of psychotherapy for women attending a specialist service for survivors of childhood sexual abuse

DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it's finished I would like to explain the rationale for the research.

This study aims to explore the individual experience of therapy for women who are survivors of childhood sexual abuse and current users of the [name deleted] Women's Service. In addition, it also aims to provide a deeper understanding about how clients might experience this service, particularly their relationship with their therapist and how they might have felt about talking about their concerns in this context. This will enable the research to make recommendations to the service about ways to enhance the service in terms of the therapy and support they might offer to clients, possibly improve therapist training as well as understand from clients about their actual experience of therapy. It is hoped that the research will provide an in depth understanding of the therapy experiences at the service which will contribute to the improvement of the service and development of specialist services in the UK. It is also hoped that the research might encourage women in similar situations to seek appropriate help.

It is possible that you may have found speaking about your experiences today upsetting. A support session with the support worker from the [name deleted] Woman's Service will be offered to all women who participate in the study after completion of the interview to help you with any concerns that may have arisen for you.

I hope you found the study interesting. If you have any other questions please do not hesitate to contact me on the details provided below:

Rhea Williams - rhea.williams.1@city.ac.uk

Telephone number: 07887498613

Supervisor of Project – Dr. Jacqui Farrants - J.Farrants@city.ac.uk

Telephone number: 020 7040 0172

I would like to thank you very much for your valuable time and for participating in the study.

Ethics approval code: *PSYCH (P/F)14/15 149*

Appendix E

Indicative Interview Topic Area Guide

Consistent with an IPA approach (Interpretative Phenomenological Analysis), I anticipate that the questions will evolve across the interviews, allowing flexibility for participants' lived experiences to emerge. I shall also discuss the wording of questions during my ongoing research supervision prior to data collection. The below is an indicative list of the areas that might be addressed in the interview.

Experience of therapy Relationship with therapist

- I am wondering what your reasons are for choosing to take part in this research?(In order for me to help understand motivations)
- How long have you had therapy?
- How many courses of therapy have you had and if yes, how long did you have to wait for your next course?
- What type of therapy have you had with the women's service? (This is because the women services offers a range of different therapies)
- How would you describe your relationship with your therapist?
- What did you find helpful in your time together with your therapist?
- What did you find unhelpful in your time together with your therapist?
- When you wished it could have been different were you able to discuss it openly with your therapist?
- Describe your reasons for seeking therapy?
- Describe your reasons for ending therapy?
- What does the word sexual abuse mean to you?
- Does it relate to your experience? & if so how?
- What is it feel like to tell me about your experience?
- Have you explored the abuse in therapy? If so what was the experience like for you? If not, what were your reasons for not doing so?

Relationship with the service

- If you were sick and needed to cancel, would you feel comfortable calling the service to inform them about the cancellation?
- Did you feel supported by the service during therapy? If so or not could you elaborate your experience?
- Can you describe any positive aspects of the service?
- Before we bring our session to a close, is there anything you would wish to raise?
- What has it been like to talk to me about your therapeutic relationship?

Appendix F

Service Evaluation Project (SEP) Approval Notification

Oxleas NHS Foundation Trust

Service Evaluation Project (SEP) Approval Notification

This notification confirms that the SEP named below has been **approved** by the Research and Development Office of Oxleas NHS Foundation Trust:

Title:	*An exploration of the experience of women attending a specialist psychotherapy service for survivors of childhood sexual abuse*
SEP investigator:	*Rhea Williams*
SEP supervisor:	*Maggie Schaedel*
Dated:	*03/02/2015*
Approved by:	*Anthony Davis, Research and knowledge manager*
Signed:	

Review by an NHS Research Ethics Committee is **not** required because:

- *Study aims to elicit the experiences and perceptions of users of a local women's service and does not meet the definition of research as defined within the Research Governance Framework*

This SEP may therefore be undertaken. Please note that approval is **contingent upon the following**:

- The SEP investigator will **immediately notify** the Research and Development Office of the Trust should any changes be made to the original SEP Proposal Form as any deviations will render this approval notification void.
- The SEP investigator will send an **executive summary** of the findings of this SEP to the Trust's R&D Office for uploading to the Trust's intranet.

For further information please contact:

Anthony Davis, Research and knowledge manager
Oxleas NHS Foundation Trust, Pinewood House, Pinewood Place, Dartford, Kent DA2 7WG
Tel 01322 625700 x5032
Fax 01322 625711
Email anthony.davis@oxleas.nhs.uk

R&D Office, Oxleas NHS Foundation Trust, February 2010

Appendix G

City University Psychology Department Standard Ethics Application Form

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

8th May 2015

Dear Rhea Williams

Reference: PSYCH (P/F)14/15 149
Project title: An exploration of the experience of psychotherapy for women attending a specialist service for survivors of childhood sexual abuse

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.

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 (anna.ramberg.1@city.ac.uk), 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.

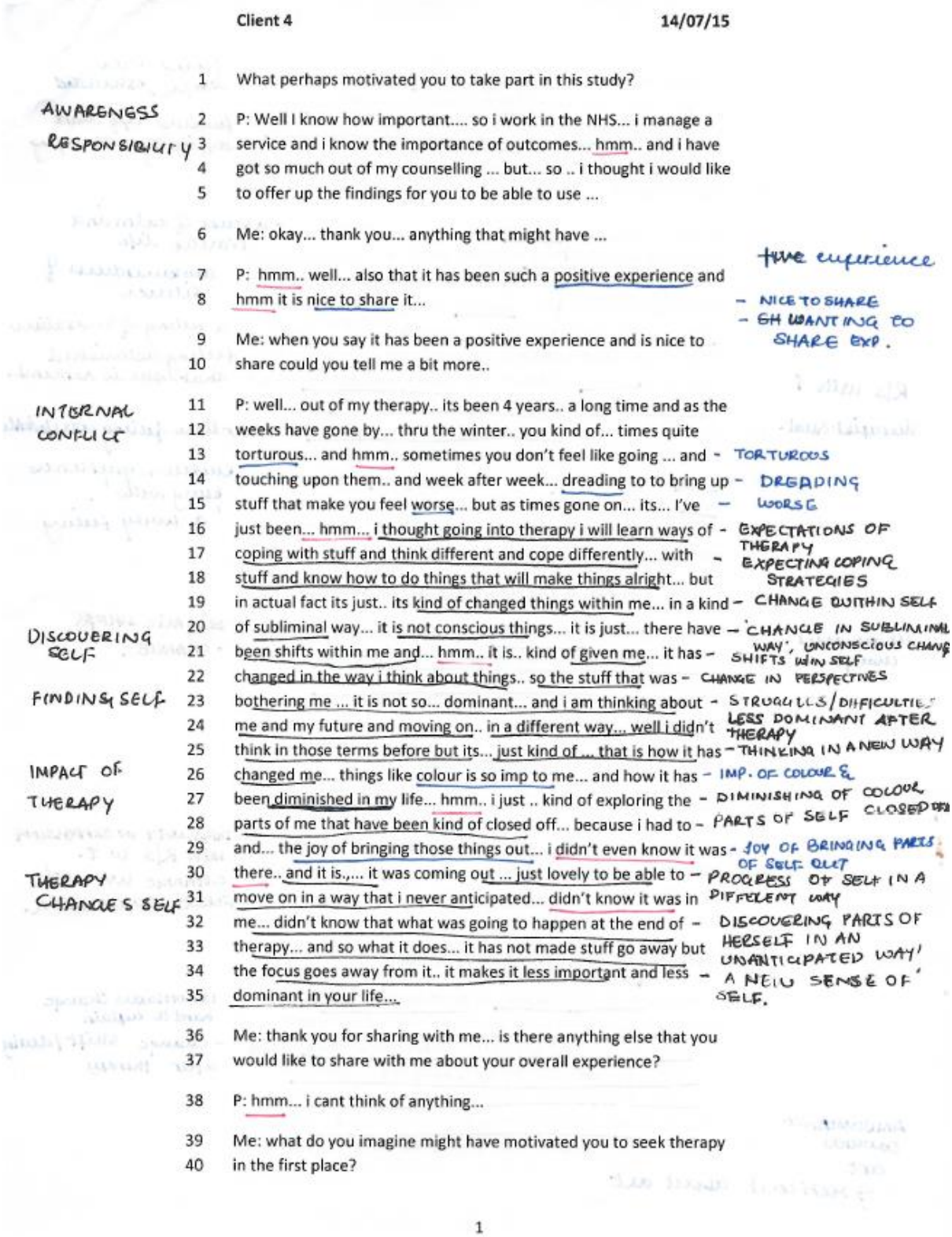
Kind regards

Karen Hunt
Departmental Administrator
Email: karen.hunt.1@city.ac.uk

Katy Tapper
Chair
Email: katy.tapper.1@city.ac.uk

Appendix H

Analysis Stage 1 Example: Initial Noting on Transcript



Client 4 **14/07/15**

1 What perhaps motivated you to take part in this study?

AWARENESS RESPONSIBILITY

2 P: Well I know how important.... so i work in the NHS... i manage a
3 service and i know the importance of outcomes... hmm.. and i have
4 got so much out of my counselling ... but... so .. i thought i would like
5 to offer up the findings for you to be able to use ...

6 Me: okay... thank you... anything that might have ...

7 P: hmm.. well... also that it has been such a positive experience and
8 hmm it is nice to share it...

9 Me: when you say it has been a positive experience and is nice to
10 share could you tell me a bit more..

INTERNAL CONFLICT

11 P: well... out of my therapy.. its been 4 years.. a long time and as the
12 weeks have gone by... thru the winter.. you kind of... times quite
13 torturous... and hmm.. sometimes you don't feel like going ... and
14 touching upon them.. and week after week... dreading to to bring up
15 stuff that make you feel worse... but as times gone on... its... I've
16 just been... hmm... i thought going into therapy i will learn ways of
17 coping with stuff and think different and cope differently... with
18 stuff and know how to do things that will make things alright... but
19 in actual fact its just.. its kind of changed things within me... in a kind
20 of subliminal way... it is not conscious things... it is just... there have
21 been shifts within me and... hmm.. it is.. kind of given me... it has
22 changed in the way i think about things.. so the stuff that was

DISCOVERING SELF

FINDING SELF

23 bothering me ... it is not so... dominant... and i am thinking about
24 me and my future and moving on.. in a different way... well i didn't
25 think in those terms before but its... just kind of ... that is how it has

IMPACT OF THERAPY

26 changed me... things like colour is so imp to me... and how it has
27 been diminished in my life... hmm.. i just .. kind of exploring the
28 parts of me that have been kind of closed off... because i had to
29 and... the joy of bringing those things out... i didn't even know it was
30 there.. and it is.,... it was coming out ... just lovely to be able to

THERAPY CHANGES SELF

31 move on in a way that i never anticipated... didn't know it was in
32 me... didn't know that what was going to happen at the end of
33 therapy... and so what it does... it has not made stuff go away but
34 the focus goes away from it.. it makes it less important and less
35 dominant in your life...

36 Me: thank you for sharing with me... is there anything else that you
37 would like to share with me about your overall experience?

38 P: hmm... i cant think of anything...

39 Me: what do you imagine might have motivated you to seek therapy
40 in the first place?

1

- positive experience
- NICE TO SHARE
- SH WANTING TO SHARE EXP.
- TORTUROUS
- DREADING
- WORSE
- EXPECTATIONS OF THERAPY
- EXPECTING COPING STRATEGIES
- CHANGE WITHIN SELF
- 'CHANGE IN SUBLIMINAL WAY', UNCONSCIOUS CHANGE
- SHIFTS WITHIN SELF
- CHANGE IN PERSPECTIVES
- STRUGGLES/DIFFICULTIES
- LESS DOMINANT AFTER THERAPY
- THINKING IN A NEW WAY
- IMP. OF COLOUR &
- DIMINISHING OF COLOUR
- PARTS OF SELF CLOSED OFF
- JOY OF BRINGING PARTS OF SELF OUT
- PROGRESS OF SELF IN A DIFFERENT WAY
- DISCOVERING PARTS OF HERSELF IN AN UNANTICIPATED WAY!
- A NEW SENSE OF SELF.

P: hmm I suppose i was just feeling so down.. and tearful alot of the time and hmm.. and i was finding it hard to cope with bringing up the kids and keeping my job... it was just.... I was finding life hard...

feeling down tearful, exhausted
finding life hard difficulty with coping

Me: okay... maybe could you describe to me your relationship with your therapist?

P: hmm.. it was ... very calming... you know... in a life where everything was very frantic with me... hmm... I .... you know to go into a room where you can hear the clock ticking... it was a bit... err.. in the beginning i felt a bit... awkward talking because of the silence... but as the time went on... i began to ... find it... relaxing... being in that situation and err... I always found it astonishing how much my therapist remembers... err.. .you know... every week she kind of seemed to remember... and kind of bring it to my attention.... and er... so over a period of time.. .you know.. i thought... i was sort of getting very comfortable with her... and her kindness and her gentleness... was so important... makes me feel calm just thinking about it... just being with her... you know... the actual just being with that person... it was.. it was.. .a lovely experience...

- a sense of calm in a frantic life
awkwardness of silence
a feeling of relaxation
feeling astonished that she is rememb.
R|s with T
Therapist Qual.
- over time feeling comfortable
kindness, gentleness being with
a lovely feeling

Me: could you tell me a bit more about your experience with her?

P: hmm.. it was just amazing the way... she would just point little things out... and yet... didn't seem to be doing very much... but the these seismic shifts were occurring in me... hmmm... and ...

unconscious change.
SEISMIC SHIFTS - CHANGE.

Interruption.... room change...

I think she was saying at 5 we had to leave...

Me sorry about that

P: hmm... so it was like... what has happened... it is so hard to put into words... it didn't feel forceful... it astonishes me how much i got out of it... with her just kind of guiding and ... yeah,,, it was hard to explain really... i cant...

DIFFICULTY IN EXPRESSING HER R|S W T.
CHANGE WAS W/O FORCE, GUIDING HER.

Me: what part are you finding hard to explain

P: the way it wasn't conscious... it didn't feel like i was doing anything./// you know when you have a task you got to do this that and the other... but it didn't feel like I was doing anything,.. doing any tasks... but obviously something was going on inside and externally.. and doing the art stuff was hilarious as i was really reticent about it in the beginning. But then you know... she told me you do not have to do it... but if you feel like doing it .... you can...

UNCONSCIOUS CHANGE hard to explain
- change shift / during after therapy

AMBIVALENCE towards art → reticent about art

and then she would put thee stud out and then i would not want to stop... so hmm.. that was interesting... and stuff came out thru the art work... and it was fascinating... the overwhelming feeling i had from being with my therapist was just calm... safe... kind... environment.. there was kindness there and understanding and support for me... hmm.. you know 100 percent support for me ... which was a really weird feeling... im not used to people being on my side.. in that way...

Me: what was that like for you

P: oh it was lovely... when i realised what was happening i was like this is a weird experience.. to have someone routing for me and er... when i express all this negative stuff it is kind of... nice for her to support me and explain things ... talk me thru it and make me see that it s not my fault... and it wasn't anything that i did... and... it was therapeutic itself to just have that...

Me: could you tell me a bit more about what else you might useful

P: hmm.. i didn't really know where the art thing was going... but for some reason... out of nowhere or the other.. colour has seen to come out of it ... colour seems to be important and i have ... i think i have said this before.. just the way i kind of bagged everything off to kind of cope... to present this kind of very capable person competent and independent to the world.... there this you know... there is these wired colours coming along... these pinks and blues and golds... welling out and coming out... and I.... I love colour...

Okay: sounds like you found the colour useful but I cant explain it... it feels like weird.. i do not know why.. .but it just has.. it is in my dreams... and i have become more experimental with what i wear... and thats great.. lovely..

Me: you find that working with t1 colour has made you more experimental...

P: yes and i am using colour a lot more into my life and i bring colour more into my life... whether i have... i do not know why.. i just have.. blanned everything off.. my natural love of colour was always there.. it wasn't present in my life... i know it sounds really weird but it is important ..

Me: i know ... with art therapy sounds like colour is a very important part of therapy... it is very interesting to hear that colour has an impact on you and i would like to know more...

feeling safe calm supported 100%. not used to this support. overwhelmed weird feeling listened to. "being on my side".

weird feeling & emp & lovely to be cared for. "routing for me helping Dr 4/s it was not her fault - unconditional support knowing the ivcs

presenting diff self - colour

ways of coping old self was closed new self discovery

colour is imp bagged everything to cope. - presenting a capable person competent / independent

- colour

like us more colourful rediscovery self

new discovery of colour rediscovery self acknowledging the importance

Appendix I

Analysis Stage 2 Example: Developing Emergent Themes

Transcipt 4		
Themes	**Line Numbers**	
Awareness	2,3	T4
Responsibility	3-4	T4
Internal conflict about therapy , feeling torturous,	11-13	T4
Ambivalence towards therapy , dreading to bring up stuff	13-16	T4
Expectation of therapy eg. Coping strategies	16-18	T4
Discovering self during therapy	18-22	T4
Impact of therapy -Change during therapy	20-24	T4
Joy of discovering self	26-30	T4
Unconscious change	30-35	T4
Subliminal change	30-35	T4
Therapy transforming self	26-35	T4
Progress of self in a different way	30-33	T4
Unanticipated change	31	T4
Ways of coping before therapy (feelings before therapy)	41-43	T4
Calming relationship w3ith T	46-48	T4
Awkwardness of silence	48-51	T4
Role of time	50	T4
Feeling comfortable overtime	51-55	T4
Feeling cared for, feeling special	55-59, 83-86, 230-235	T4
Feeling of therapy being a 'lovely experience'	58-59	T4
Seismic shifts during therapy	61-63	T4
Difficulty in expressing her relationship with T in words	67-68,69-70	T4
Feeling astonished by her gain from therapy	68-69,	T4
Unconscious change	72-77	T4
Ambivalence during the start of therapy	75-77	T4
reticent with Art	76-78	T4
Loss of childhood		T4
Feeling overwhelmed	81-82	T4
Discovering parts of self	95-102,109-113	T4
Bagged everything to cope	97-100	T4
Presting a 'capable' self to the world	99-100	T4
Loss of parts of self	117-123	T4
Awareness of loss of colour growing up	118-121,131-134,	T4
New exciting feeling of discovering herself	126-128,	T4
Need for freedom	138-144,	T4
Colour - Importance of colour	117-119	T4
Feeling safe	79-86, 82,144-150,150-154	T4
Indulging in alone time	150-154	T4
Valuable	154	T4
Therapy like medication	162-164,	T4
Zoomed in view of relationship	162-164	T4
Feeling heard,	158-164	T4
Feeling acknowledged, supported	158-161	T4
Feeling contained	158-164	T4
Therapy giving her 'permission' to spend time on herself	168-169	T4
Thinking of self in a relational way	160-164	T4
Denying self due to guilt / feeling unworthy	171-173, 174-178,200-205,	T4
Disclosure to GP was a 'big thing'	194-196,	T4
Change is astonishing (Stopping medication naturally) unconsciously stopping medication	208-221	T4
Zoomed in view of relationship		T4
Therapists guidance, suggestions and non-defectiveness	228-230	T4
Therapist on her side	230-231,	T4
Profound effect	232-235	T4
Non-judgemental attitude	226-228	T4
Feeling special and supported	231-235	T4
Touched / overwhelmed	237	T4
Weird / incredible experience of therapy	239	T4
Wanting to know more	242-243	T4
Unearthing the truth	243-245	T4
Unable to articulate difficult feelings of therapy process	251-255	T4
Loss of childhood	273-276	T4
Feeling sad	274-277,290-294	T4
Cold sore feeling	278-283, 284-289	T4
Sense of belonging after therapy		T4
Deep empathy for self	282-284	T4
Bringing painful emotions to surface	282-287	T4
Unable to express negative emotions as a child	290-297, 297-300	T4
Feeling a nuisance as a child	294-296	T4
Stronger sense of self	299-301, 309-310,	T4
Learning to be kind to herself	300-301,	T4
Feeling valid as a person	310-312,	T4
Feeling confident empowered	316-323,327,	T4
Knock on effect of therapy	315-325,331-334	T4
Therapy unlocking supressed feelings	340-342	T4
Therapy working like magic	343	T4
Rich experience of therapy	343-345	T4
Giving voice to inner parts of self	340-345	T4
Grateful for therapy	343-345	T4
Therapy has given so much	352-358	T4
Wrench of ending therapy	364-366	T4
Feelings towards the ending of therapy	366-371	T4
Gratitude / pain of ending	364-371	T4
Bitter / sweet ending		T4
Sadness / Joy / Hope towards ending		T4
Feeling equipped to face the world		T4
Want to share experience		T4
Want to be documented / heard	375-377	T4
Want to help others / want to give back	376-378	T4
Independent self to the world/ competent self		T4
Closed off parts of self		T4
Presenting different self		T4

Appendix J

Analysis Stage 3 & 4 Example: Identifying Common Themes & Clustering

Experience of Attending Specialist Service for CSA

Positive Experience of Service

Incredible experience of service	6-7	T2
Wanting the service to be replicated in the country	7-9	T2
Positive experience of service	10-13	T2
Impossible to find a service like this in the NHS	10-13,13-19	T2
Gratitude to service	5-9, 32-34, 37-39,	T2
Wanting to be heard / documented	6-15	T2
Want the whole country to replicate this service	15-19, 32-34,	T2

Supportive Service

Feeling supported by service	55-61	T2
Benefit of couples therapy at service	43-46	T2
Service supportive of her husband	46-52	T2
Asense of support for her and her husband by the service	59-66	T2

Stigma around accessing MH Services

Stigma around accessing MH services	207-214, 216-227	T2
Private Service like the Women's Service	232-236	T2
A snese of anxiety accessing MH services	218-223	T2
Sense of being found out by colleagues	222-227	T2

Journey of Therapy

Therapy Bringing about change

Grown in confidence after therapy	66-67	T2
Change in self	66-70	T2
Learning to value herself	67-68	T2
Ability to take control after therapy	69-71	T2
Low confidence vs increase in confidence after therapy	71-72	T2
Learning to love self	70-72	T2
Unable to cry before therapy	78-81	T2
Recreating her childhood expereinces	373-376	T2
Making her childhood experiences safe	373	T2
Able to trust eventually that therapist would come back	375-377	T2
Gradually grwoing to feel secure in herslef	383-385	T2
No more great fears of sepation	385-389	T2

Exploring difficult parts of therapy

Exploring the difficult parts of therapy	404-407	T2
Thinking about acting out testing thoughts	353-356	T2
Talking to therapist about wanting to test her	357-359	T2
Alien experinece of talking to therapist	358-360	T2
Ability to express to therapist that she didn't like her going away	364-367	T2
Testing therapist	352-357, 357-371	T2

Therapy bringing out strong emotions

Self-loathing	66-70	T2
Feeling a lot happier within self	70-72	T2
Disliking that child part of her during the abuse	115-117	T2
Disliking self vs learning to like self	114-119,456-467,482-483	T2
Realization through therapy	120,121,122-124	T2
Learning to express difficult emotions during therapy	91-94, 300-302	T2
Self - blame	483-494	T2
At times it was unbearable	471-474	T2
Parts of self that blocked the abuse	463-467	T2
Shame	478-	T2
Exploring the abuse at her pace	472-474	T2
Feeling responsible for everything she did	481-483	T2
hiding parts of self	480-481	T2
Shifting the blame	478-480	T2
New exp of loving herself	480-482	T2
Not questioning her child like fantasis	485-489	T2
Childlike fanatasy of power beleiving that it was her fault	487-490	T2
People Pleasing	491-495	T2
Feeling of not being good enough	491-495	T2
Realisation of being closed off from emotions	528-534	T2
Aware of not being able to laugh	494-499	T2
Her emotional self was shut down	499-503	T2

Ending Therapy

Difficult emotions around breaks in therapy	276-282, 292,339	T2
Ending therapy	302-315,318-322, 324,325,327-333	T2
Preparing for the ending	305-309	T2
Therapy endings interupted by therapist illness	307-315	T2
Not feeling anxiety about the ending towards the end	324-325	T2
Not fearful anymore that she is not around	328-330	T2

Journey of Therapy

The commitment of therapy	22-24	T2
Trust	26,27, 296-301,442-445	T2
Journey of Therapy	43-57	T2
Building a relationship over time	76-77	T2
Therapy as a painful journey	128,129, 130-133	T2
Reliving bits of abuse	438-442	T2

Discovery of Self during therapy

Not knowing how to cry	80-82	T2
Learning that it is okay to cry	89-92	T2
Unable to play	94-98	T2
Unable to recognise her childhood as a 'child'	98-102	T2
A sense of being an adult not a child	98-102	T2
Discovery of her not being able to love/ Learning to love	118-120	T2
Unable to feel emotions because of abuse	119-121	T2
Feeling dissociated	119-121	T2
Amazed by the workshe would need to do	112-123	T2
Therapy meeting unmet needs	341-352,384-389	T2
Realising how much she hates herself	462-467	T2
discovering new feelings of hate & anger towards self	461-464	T2
Trying to understand self	246-247	T2
Trying to better manage her relatinolship thru therapy	246-248	T2
Trying to get as much help / support from therapy	248-250	T2
Inidvidual therapy for both her n husband really helped	252-258	T2
Able to address her self hate and understand it thru innerchild work	464-467	T2
Inner child work, talking about self in third person	469-474	T2
Parts of self that blocked the abuse	469-474	T2
Took a lot of work and effort to feel her inner child	469-471	T2
Able to express difficult feelings	515-519	T2
Able to discover her inner child	506-509	T2
Discovering self	78-81, 118-121,373-381,478-483, 495-519,521-534	T2

Breaks in Therapy

Difficulty in coping with breaks / separation	278-282	T2
Separation was extremely painful	284	T2
Gut wrenching and a dread	284-286	T2
Coping with breaks by preparing for it	286-293	T2
Not beleiving tht therapist would come back	290-293	T2
Doubting therapist will come back	290-293	T2
After 3 years of thewrapy breaks were okay	294-296	T2
Therapist kept coming back	331-333	T2
Feeling alight now if therapist leaves	333-	T2
Knowing therapist would be there helped	341-345	T2

New Life /New Discovery

Discovering new self - feelings of laughter'belly laugh'	506-515	T2
Re-discovering what she missed	521-523	T2
New life/ New birth	525-530	T2
Re-discovering what she missed	521-525,530-534,	T2
Feeling robbed of emotions	528-533	T2
Lovely to express natural emotions like crying	301-304	T2

Therapuetic Alliance

Importance of the therapy relationship

Relationship as 'key'	75-86	T2
Feeling that the therapist was on her side	83-84	T2
A sense of belonging in therapy	84-86	T2
Therapist entering painful places with her	84-86	T2

Feeling attachment towards therapist

Attached to therapist like a child	329-331	T2
Missing therapist a lot	327-328	T2

Significance of therapuetic alliance

Therapist being there	125	
Building trust in the therapy relationship	125-126	T2
Feeling cared for / feeling nurtured by therapist	125-127	T2
Through the therapy relationship she was able to move to different place	127-129	T2
Feeling reassured by therapist	131-133	T2
Therapist was committed to her	134-135	T2

Therapuetic Techniques whilst working with adult survivors

Feeling Validated by T

Feeling vulnerable talking about abuse	446-449	T2
Feeling held contained and safe when tallking about abuse	451-454	T2
T acknowledging the abuse	448-452	T2
Never felt bad or terrible for expressing her needs	456-459	T2
Trust	351-353	T2
Feeling brave	353	T2
Validation	448-454	T2

Tailoring Therapy to individual needs

Contact in between sessions	148-149	T2
Therapy twice a week initially	153-158	T2
Feeling special, supported	161-165	T2
Abuse around bed time	175-179	T2
Therapist tailoring therapy to her needs	179-187	T2
Feeling contained and safe	186-189	T2
Therapy totally individual to her needs	191-194	T2
Therapist did not prescribe a type of approach	193-194	T2
Therapist knowledge and skill of working with CSA helped	196-198	T2
Feeling special, supported	134-135,156-161,131-136,360-362	T2
Tailoring therapy to her needs	131-136, 165-169, 176-189,191-194,246-253	T2

Therapuetic Techniques

Looking at Photos of the most painful period as a child with T	99-103	T2
T asked about her children	104-109	T2
Used this technique to explore her experience with self	109-113	T2
Photograph of when she expreinced the most awful abuse	113-115	T2
Therapist knowing her in and out	360-362	T2
Inner child work during therapy	116-118	T2
T challenging her negativity towards herself	459-463	T2

Therapists Qualities / Skills

Therapist bringing her up emotionally/psychologically	387-389	T2
Non-collusive attitude of therapist	394-395	T2
Therapist stronger minded than her	395-397	T2
Firm but caring	398	T2
Broundried but skilled	399	T2
Able to clarify with therapist	404-408	T2
Therapist willing to explore and clarify with her	408-410	T2
Therapist exploring the power dynamics	408-410, 417-421	T2
Therpist being human,open,transparent	410-413	T2
Therpaist acknowledging and apologsing when she didn't get something right	414-416	T2
Saying sorry when there was genuine error only	414-416	T2
Accepting each other for theirs faults	416-419	T2
Therapists qualities (being there, robust, empathy, understanding)	82-86,196-198,394-399,404-421	T2
Therapist a part of healing process	89-91,124-128,130-133,134-135,187-189	T2

Impact of Childhood Sexual Abuse

Childhood

Loss of childhood	95-101	T2
Childhood memories	96-100, 110-113	T2
Revisiting Childhood abuse memories	113-114,437-444,469-474	T2

The Gravity of abuse

understanding the gravity / impact of the abuse	68-69	T2
Still not fully aware of the extent of work she needs to do	123-125	T2
Understanding the impact of each others abuse	259-263	T2
Did not think that her own experience caused trouble	241-243	T2
Talking about abuse in a factual way	429-436	T2
Awareness of adult survivors of abuse	9-12	T2

Expressing Needs

Punished as a child for having / expressing needs	346-349	T2
Therapy allowing her to express her needs	350-352	T2

Relationship with Husband

Experiencing Relationship difficulties w husband	232-236	T2
Her husband was also a surivior of CSA	43-45	T2
Repressing herself in her relationship with husband	244-245	T2
Experiencing Relationship difficulties	240-245,262-263	T2

Research

Research Interview

Feelings around research interview	538-543,578-583	T2
Comfortable research experience	538	T2

Appendix K

Analysis Stage 5 Example: Clustering Across Cases

I. SIGNIFICANCE OF THERAPUETIC ALLIANCE/ UNCONSCIOUS CHANGE

A. Aspects of the Therapuetic Experience

Difficult relationship with Therapist 1

Difficult relationship with therapy	55-60	T1
Difficulty with articulating feelings	73-78	T1
Therapy not working for her	88-89	T1
Going to therapy for a reason	104-106, 204-207, 236-239,	T1
Therapy being a purpose	102-104	T1
Question self (is it me ?) vs is it her ?	105-106, 122-124,241-244,	T1
Relationship with T1 as problematic	111-113, 210-217, 227-228, 236-239	T1
Apprehensive about therapy / service	117-119,121-122	T1

Difficult Feelings generated in her by therapist

feeling dismissed by therapist	55-59	T1
Lack of acknowledgement by therapist	60,62-65,75,76,82,	T1
Cold feeling and unfamiliar feeling from T	62-65	T1
Self-Doubt in relation to therapy	44-47, 106,122-123,	T1
Feeling of being told off by T	69-71	T1
Difficulty in understanding what is going on with therapist	73-76	T1
Feeling awkward in room with T	111-112	T1
feeling of being played with by T	112-114	T1
Expectation of therapy (therapy means help)	102-106, 203-207, 206,207	T1
feeling undignified by therapist	205-207,	T1
T being under familiar	210-212	T1
Therapist not saying Hello'	212-214	T1
Trying to make sense of T behaviour towards her	215-220,	T1
Theapy making her feel uncomfortable	227-228	T1
Struggled before therapy experience with T2	409-424,427-432, 567-580,588-595 , 644-647	T1
Testing therapist /acting out in therapy	91-94	T1
Difficulty with silence	89,91-94,111-113, 230-232	T1

Caring Relationship with T2

Worked well with T2	138	T1
Feeling cared for by T2	139	T1
Feeling of needing therapist	140	T1
Relationship with T2 a different experience	134-135, 138-140,146-161,163-165, 195-196	T1
Therapist showing her empathy	146	T1
Feeling listened to by T	147	T1
Feeling heard, feeling of being able to converse with T2	148	T1
Her other therapist acknowledged her (she said hello to me)	77-80	T1

Relationship with individual therapist

Difficulty in sitting in a room with someone and to talk	115-117	T8
Strange situation	116-118, 125-127	T8
Silence	118-120	T8
Role of time	121-123,	T8
Not knowing how to say things to T	119-123	T8
Time to settle into therapy & talk	122-123	T8
Not a very successful year in therapy	122-124	T8
Wanting to hide in corner all her life	127-131	T8
Isolation	129-134,	T8
Difficult to deal with someone in a room once a week	131-135	T8

Importance of the therapy relationship

Relationship as 'key'	75-86	T2
Feeling that the therapist was on her side	83-84	T2
A sense of belonging in therapy	84-86	T2
Therapist entering painful places with her	84-86	T2

Feeling attachment towards therapist

Attached to therapist like a child	329-331	T2
Missing therapist a lot	327-328	T2

Significance of therapuetic alliance

Therapist being there	125	T2
Building trust in the therapy relationship	125-126	T2
Feeling cared for / feeling nurtured by therapist	125-127	T2
Through the therapy relationship she was able to move to different place	127-129	T2
Feeling reassured by therapist	131-133	T2
Therapist was committed to her	134-135	T2

Talking about abuse during therapy

Talking about abuse for the first time	11-14	T5
Non-disclosure of abuse	11-14	T5
Talkingwas upsetting at first	23	T5
Grew more confident with time	23-25	T5
Easier with time	24-25	T5
Feeling partly there after therapy	14	T5
Talking about feelings with therapist	20-21	T5
Focusing on the abuse	294-296,	T5
Role of time	76-80,175-178,	T5

Importance of Relationship with Therapist

Importance of being able to identify with T	131-134,	T10
Professional relationship	142	T10
Feeling cared, contained	143-144,215-216,	T10
Feeling cold	145,	T10
Feeling attended to	145-146,	T10
Feeling suicidal	146-148	T10
Feeling grateful gratitude for help	148-151,153,	T10
Wanting to help me as a result	148-151	T10
Feeling helped	153,155-162,	T10
Importance of feeling comfortable with T	296-301,	T10
Someone who is human/ someone you can relate to	294,298-301,	T10
Refreshing to talk to therapist who wasn't a robot	304-308,	T10
Huge impact of therapy on her	312-313, 313-328, 331-333	T10
Given so much by individual therapist	425-426,430-433	T10
Individual therapy giving her tools to climb the next step	430-434	T10
Feeling wonderful to have therapist support	463-466	T10
Therapy making her feel unintentionally self absorbed	464-466	T10
Strong sense of gratitude towards T	523-531	T10
Therapy helped her make a choice between life and death	518-521	T10
Therapy giving her a purpose in life	523-526	T10
A sense of affection and love towards therapist	526-529	T10
Feeling loved cared and special by therapist	526-531, 533-538	T10
Therapists professional manner	533-536	T10

Difficult relationship with T

Feeling guilty for expressing difficulty with T	286-291	T10
Cold and robot like manner from therapist	391-296	T10
Bad experience with therapist	602-613	T10
Wanting to be liked by this therapist	602-613	T10
She was so grateful that someone was taking her seriously	613-615	T10
She bought the T flowers	613-617	T10
Therapist reaction rtowards flowers eally upset her	615-621	T10
Felt rejected by therapist	617-621	T10
Unable to identify with T1	131-134,	T10

Feelings generated by Therapist 1

To start to express grief	107	T3
Sharing a lot with T1	110-112	T3
Feeling young in T1 presence	95-99, 147	T3
Sharing her younger child emotions helped	126-128	T3
Feeling safe, nurtured	133-134	T3
Allowing herself to be the child with T1	138-140	T3
Felt closer to T1	143	T3
More of an emotional connection with T1	229,233	T3
Therpist 2 as a mother figure	280-285	T3
Relationship growing in time	284-286	T3
Different experience of therapy with t1	21,22,26,27,31,34,42-43, 92-98,103,104, 107-108,126-128,133-134	T3
Therapist seen as a mother figure	280-281, 312-314, 424-428,432-440	T3
At the time her intervention was helpful	185-187	T3
In retrospect it was not helpful	180-186	T3
Thrown back talking about the abuse with me	394-400	T3
Explored abuse with T1	406-409	T3

Feelings generated by therapist 2

Feeling more adult like with T2	96-101,148-149	T3
Expressed more feelings with T2	103-105	T3
Feeling like she moved on more with T2	111-112	T3
Taking more responsibility of self with T2	114-116	T3
feeling like an adult with T2	139-141	T3
Feeling more responsible	141-142	T3
Stronger boundry w T2	141-143,236-237	T3
Feeling close to T2 in a different way	143-145	T3
T2 being more deft at picking things out	204-207	T3
T2 giving her options and not what she wanted to hear	206-209	T3
Felt she would object with T2	207-209	T3
Able to explore being unhappy with therapist 2	213-215	T3
Exploring feeling patronised	215-220	T3
Able to challenge t2	224	T3
Affection	298-305	T3
Different experience of therapy with t2	27-29,34-38,40-41,98-101,104-105,139,142,144-145,234-236,	T3
Therapist seen as equal	283-288, 315-325,	T3
Hugging was a different exp with T2	298-305, 307-309	T3
Explored it differently with T2	411-418	T3
Addressing her relationship difficulties and ways of thinking with t2	414-419	T3

Feelings towards relationship with therapist

Calming relationship w3th T	46-48	T4
Feeling comfortable overtime	51-55	T4
Feeling cared for, feeling special	55-59, 83-86, 230-235	T4
Feeling of therapy being a 'lovely experience'	58-59	T4
Seismic shifts during therapy	61-63	T4
Difficulty in expressing her relationship with T in words	67-68,69-70	T4
Feeling astonished by her gain from therapy	68-69,	T4
Unconscious change	72-77	T4
Feeling safe	79-86, 82,144-150, 150-154	T4
Valuable	154	T4
Therapy like medication	162-164,	T4
Zoomed in view of relationship	162-164	T4
Feeling heard,	158-164	T4
Feeling acknowledged, supported	158-161	T4
Feeling contained	158-164	T4
Therapy giving her 'permission' to spend time on herself	168-169	T4
Thinking of self in a relational way	160-164	T4

Feelings generated during therapy

Sympaphy is like mocking	295-296	T7
Sympathy being cruel	295-298	T7
Empathy being more genuine	316-317	T7
Sympathy equals pretending	319-321,	T7
Wanted therapy to be longer	330-332	T7
Feeling suicidal during therapy	333-336	T7
Expectation of therapist not being sympathetic but empathic	298-301	T7
Grooming	598-600,606-609,	T7
Guilt from abuse	600-601,604-606,	T7
Insecure	625, 634-638,	T7
Being too trusting	625-632	T7
Being naive	634-638	T7
Feeling loved	642-654,	T7
Wanting to be directed	667-671	T7

Significance of therapuetic alliance

Connection with individual therapist	106-107,	T7
Feeling special	116-119,	T7
Feeling understood by therapist	120-121	T7
Identifying with therapist	126-136,	T7
Feelings towards therapist initially	143-143-148, 154-155,	T7
Process of therapy	172-184,236-247	T7
Feeling played with	184-191,193-195,	T7
Feeling safe	198-199,200-202,309-314,	T7
Trust	203,626-632,	T7
Empathy vs sympathy	213-214, 215-224,295-301	T7
Process of therapy	172-184,236-247	T7
Feeling played with	184-191,193-195,	T7
Feeling safe	198-199,200-202,309-314,	T7
Trust	203,626-632,	T7
Empathy vs sympathy	213-214, 215-224,295-301	T7
Wanting to be cared for	270-276	T7
Understanding the her current patterns of beh thru therapy	80-83	T7
Understanding the impact of abuse thru therapy	80-86	T7
Confidence growing over time	202-204	T7
Process of therapy	172-184,236-247	T7
Feeling played with	184-191,193-195,	T7
Feeling safe	198-199,200-202,309-314,	T7
Trust	203,626-632,	T7
Able to be open with t eventually	207-210	T7
Feeling understood by therapist that she thought T had an exp of CSA	126-136	T7
Feeling for the therapist	132-133	T7
Assuming therapist had been thru something similar	133-136	T7
Feelings towards therapist initially	143-143-148, 154-155,	T7
Difficulty with opening up	38-40,	T7
Bubbled out information in session 1	40-44	T7
Therapist teaching her how to be kind to self	249-253	T7

Relationship with Art Therapist

New therapist (Art therapy)	132-134	T8
Warmth of therapist	136,	T8
Conversing back in therapy room	137-138,	T8
T asking about her feelings	137-140,	T8
Conversing led to opening up avenues to her feelings	136-141	T8
Art as strange initially	141-146,	T8
Art therapy helping her talk	140-146	T8
Art therapy was more useful	144-146, 164-166	T8
Time to settle into therapy	149-151,	T8
Strange feeling of talking to someone about feelings	149-152	T8
Struggle to articulate feelings	151-152,	T8
Therapist facilitating the process of getting in touch with feelings	152-155	T8
T using colour and visualisation to as a tool to bring up her feelings	155-159,	T8
Colour	161-162,	T8
Colour making everything better	161-162	T8
Finding individual therapy useful	164-166	T8
Sad feelings towards endings	166-170	T8

Struggle with Individual Art therapist

Individual therapy did not suit her	592-594,595-599,600-605	T6
Feeling frightened about art and individual therapy	600-605,607-609,	T6
Benefitted from previous 1-1 therapy before service	611-614,	T6
Struggle with relationship with therapist and Art	178-184,	T6
Unable to express difficulty with t about Art	178-183	T6
Art bringing up difficult memories	185-193, 195-196,	T6
Feeling embarrassed when doing art	182-183	T6
Association of art & Criticism	198-206, 198-206,	T6
Art bringing up difficult childhood memories	184-190	T6
Art triggering anxiety and panic	188-193,	T6
Difficulty with criticism	202-206	T6
Unable to discuss the feelings of criticism with T	210-212,213,214-216,	T6
Feeling alone in art therapy	218-220,222	T6
Feeling vulnerable in art therapy	223-227,	T6
Feeling pushed in therapy	273-276	T6
Individual therapy did not suit her	592-594,595-599,600-605	T6
Individual therapy was a waste of time	592-593	T6
May have got something but not a lot	595-599	T6
Feeling frightened about art and individual therapy	600-605,607-609,	T6
Seeing pen and paper when thinking about Indi, PT	600-605	T6

Indi / Gt experience

Feeling comfortable in both therapies	437-445	T10
Ech therapy helpful in their own way	433-434	T10
Talking about different things in both group and individual	439-449	T10
Group focus is shared and focus keeps shifting	443-449	T10
Privileged to talk in one to one therapy	452-460,	T10
Feeling terrified as well to talk in one to one	452-460	T10
Focus on her was hard in indi therapy	455-460	T10
Attention on self difficult process and scary exp	455-460	T10

Silence

Struggle with silence	175-177,	T9
Getting used to silence	177,178-186,	T9
Thinking differently about silence	179-183	T9

Difficult experience with Individual Therapist

Difficultly with T saying nothing for an hour	111-116,125-126,152-154,218-231,	T9
Entertaining herself during the therapy hour	119-123,167-171,	T9
Playing guessing games about what scarf she was going to wear	119-123	T9
Feeling faffed around by individual T	152-154	T9
Feeling stuck with one person in room	158-160	T9
Only benefitted slightly from indi T	167-171	T9
A feeling of getting nothing out of her individual therapy	228-231	T9
Here for a reason	238-241,	T9
Putting everything they got into therapy	237-240	T9

B. The Effect of Therapists Qualitiies / Skills on the relationship

Therapists Skills / Qualaties

Zoomed in view of relationship		T4
Therapists guidance, suggestions and non-defectiveness	228-230	T4
Therapist on her side	230-231,	T4
Non-judgemental attitude	226-228	T4
Feeling special and supported	231-235	T4
Touched / overwhelmed	237	T4
Weird / incredible experience of therapy	239	T4

Therapist lacking skills/ Expressing difficulty with Support worker

Lacking in therapeutic skills	69-71,129-130-132	T1
Question the therapists Counselling Skills	84-86, 129-132,	T1
Something lacking from her therapist / lack of empoathy	69-71	T1
Strong feelings towards T	241-244	T1
Expressed her difficulty to support worker	248-250,256-259	T1
Still persisting with Therapy for 6 months more	261-268	T1
Difficult therapy experience	256-259, 261-268	T1

Therapists Skills and Qualities

Therapists approach	31-33	T5
Drawing helped	31-33	T5
Feeling guided by therapist	119-122	T5
Non-judgemental attitude	135-136	T5
Interaction with Therapist helped	144-154	T5
Able to let her feelings of nervousness out	159-161	T5
Role of therapist	31-33,67,69,114-116,118-121,138-139,144-154,159-160,244-249,	T5

The Effect of Therapists Qualities / Skills on the relationship

Not being led by therapist	175-180	T7
Therapists non-direction	180-184	T7
Therapists non-disclosure	183-187	T7
Therapists non-disclosure annoying her	185-189	T7
Felt therapy was confidential	199-202	T7
Therapists empathy	213-216	T7
Empathy vs sympathy	213-214, 215-224,295-301	T7
Coping mechanisms helped	221-222	T7
Understanding trigger points helped	222-224	T7
Therapist mirroring her emotions and feelings	240-241	T7
Therapist mirroring her patterns of behaviour	241-243	T7
Picking up therapist feeling of failing her	335-340	T7
Opening up more after therapist expressed this to her	340-350	T7
Opening up	330-350,392-393,	T7

C. Tailoring Therapy to Survivors' Needs

Feeling Validated by T

Feeling vulnerable talking about abuse	446-449	T2
Feeling held contained and safe when talking about abuse	451-454	T2
T acknowledging the abuse	448-452	T2
Never felt bad or terrible for expressing her needs	456-459	T2
Trust	351-353	T2
Feeling brave	353	T2
Validation	448-454	T2

Tailoring Therapy to individual needs

Contact in between sessions	148-149	T2
Therapy twice a week initially	153-158	T2
Feeling special, supported	161-165	T2
Abuse around bed time	175-179	T2
Therapist tailoring therapy to her needs	179-187	T2
Feeling contained and safe	186-189	T2
Therapy totally individual to her needs	191-194	T2
Therapist did not prescribe a type of approach	193-194	T2
Therapist knowledge and skill of working with CSA helped	196-198	T2
Feeling special, supported	134-135,156-161,131-136,360-362	T2
Tailoring therapy to her needs	131-136, 165-169, 176-189,191-194,246-253	T2

Therapuetic Techniques

Looking at Photos of the most painful period as a child with T	99-103	T2
T asked about her children	104-109	T2
Used this technique to explore her experience with self	109-113	T2
Photograph of when she expreinced the most awful abuse	113-115	T2
Therapist knowing her in and out	360-362	T2
Inner child work during therapy	116-118	T2
T challenging her negativity towards herself	459-463	T2

Therapists Qualities / Skills

Therapist bringing her up emotionally/psychologically	387-389	T2
Non-collusive attitude of therapist	394-395	T2
Therapist stronger minded than her	395-397	T2
Firm but caring	398	T2
Broundried but skilled	399	T2
Able to clarify with therapist	404-408	T2
Therapist willing to explore and clatify with her	408-410	T2
Therapist exploring the power dynamics	408-410, 417-421	T2
Therpist being human,open,transparent	410-413	T2
Therpaist acknowledging and apologising when she didn't get something right	414-416	T2
Saying sorry when there was genuine error only	414-416	T2
Accepting each other for theirs faults	416-419	T2
Therapists qualities (being there, robust, empathy, understanding)	82-86,196-198,394-399,404-421	T2
Therapist a part of healing process	89-91,124-128,130-133,134-135,187-189	T2

Appendix L

Analysis Final Stage Example: Organizing by Sub-Ordinate/Sub-Themes

I. Aspects of the Healing Relationship/Forming the Therapeutic Alliance

A. Misattunement with Therapist

Difficult relationship with therapy	55-60	T1
Difficulty with articulating feelings	73-78	T1
Therapy not working for her	88-89	T1
Going to therapy for a reason	104-106, 204-207, 236-239,	T1
Therapy being a purpose	102-104	T1
Question self (is it me ?) vs is it her ?	105-106, 122-124,241-244,	T1
Relationship with T1 as problematic	111-113, 210-217, 227-228, 23	T1
Apprehensive about therapy / service	117-119,121-122	T1
feeling dismissed by therapist	55-59	T1
Lack of acknowledgement by therapist	60,62-65,75,76,82,	T1
Cold feeling and unfamiliar feeling from T	62-65	T1
Self-Doubt In relation to therapy	44-47, 106,122-123,	T1
Feeling of being told off by T	69-71	T1
Difficulty in understanding what is going on with therapist	73-76	T1
Feeling awkward in room with T	111-112	T1
feeling of being played with by T	112-114	T1
Expectation of therapy (therapy means help)	102-106, 203-207, 206,207	T1
feeling undignified by therapist	205-207,	T1
T being under familiar	210-212	T1
Therapist not saying Hello'	212-214	T1
Trying to make sense of T behaviour towards her	215-220,	T1
Theapy making her feel uncomfortable	227-228	T1
Struggled before therapy experience with T2	409-424,427-432, 567-580,588	T1
Testing therapist /acting out in therapy	91-94	T1
Lacking in therapeutic skills	69-71,129-130-132	T1
Question the therapists Counselling Skills	84-86, 129-132,	T1
Something lacking from her therapist / lack of empoathy	69-71	T1
Strong feelings towards T	241-244	T1
Expressed her difficulty to support worker	248-250,256-259	T1
Still persisting with Therapy for 6 months more	261-268	T1
Difficult therapy experience	256-259, 261-268	T1
Difficulty in expressing her relationship with T in words	67-68,69-70	T4
Therapists approach	31-33	T5
Feeling guilty for expressing difficulty with T	286-291	T10
Cold and robot like manner from therapist	391-296	T10
Bad experinece with therapist	602-613	T10
Therapist reaction rtowards flowers eally upset her	615-621	T10
Felt rejected by therapist	617-621	T10
Unable to identify with T1	131-134,	T10
T1 did not express a lot	107	T3
T1 telling her what she wanted to hear wasn't helpful	168-172	T3
In retrospect it was not helpful	180-186	T3
Unhelpful aspect of therapy	168-179,190-196, 207-209	T3
Feeling played with	184-191,193-195,	T7
Feeling played with	184-191,193-195,	T7
Feeling played with	184-191,193-195,	T7
Difficulty with opening up	38-40,	T7
Symapathy is like mocking	295-296	T7
Sympathy being cruel	295-298	T7
Empathy being more genuine	316-317	T7
Sympathy equals pretending	319-321,	T7
Expectation of therapist not being sympathetic but empathi	298-301	T7
Empathy vs sympathy	213-214, 215-224,295-301	T7
Previous therapy had been on and off for years as she neev	62-66	T7
Process of changing therapists before women's service	62-74,	T7
Felt like she was repeating her story again & again	67-69	T7
Felt like nobody was listening	69-73	T7
Disadvantage of group therapy	671-683,986-690	T7
Group therapy not long enough	660-690	T7
Everyone having their own agenda	660-690	T7
Everyone talking about casual things outside of abuse	660-690	T7
Feeling like it was a waste of time at times	6670-690	T7
Unable to discuss the feelings of criticism with T	210-212,213,214-216,	T6
Struggle with relationship with therapist and Art	178-184,	T6
Unable to express difficulty with t about Art	178-183	T6
Individual therapy did not suit her	592-594,595-599,600-605	T6
Feeling frightened about art and individual therapy	600-605,607-609,	T6
Unable to discuss the feelings of criticism with T	210-212,213,214-216,	T6
Feeling alone in art therapy	218-220,222	T6
Feeling vulnerable in art therapy	223-227,	T6
Feeling pushed in therapy	273-276	T6
Individual therapy did not suit her	592-594,595-599,600-605	T6
Individual therapy was a waste of time	592-593	T6
May have got something but not a lot	595-599	T6
Feeling frightened about art and individual therapy	600-605,607-609,	T6
Seeing pen and paper when thinking about Indi, PT	600-605	T6
Difficultly with T saying nothing for an hour	111-116,125-126,152-154,218	T9
Entertaining herself during the therapy hour	119-123,167-171,	T9
Playing guessing games about what scarf she was going to v	119-123	T9
Feeling faffed around by individual T	152-154	T9
Feeling stuck with one person in room	158-160	T9
Only benefitted slightly from indi T	167-171	T9
A feeling of getting nothing out of her individual therapy	228-231	T9
Here for a reason	238-241,	T9
Questioning security in group due to facilitator	329-331	T9
Disruption due to change in facilitators	344-352	T9
Feeling criticised by facilitator 1	394-397	T8
Change in facilitator	200-204, 205-212	T8
A sense of disruption due to change in group	200-206	T8
Difficulty in sitting in a room with someone and to talk	115-117	T8
Strange situation	116-118, 125-127	T8
Not knowing how to say things to T	119-121	T8
Time to settle into therapy & talk	122-123	T8
Not a very successful year in therapy	122-124	T8
Difficult to deal with someone in a room once a week	131-135	T8

B. Connection with and Validation from Therapist

Feeling cared for by T2	139	T1
Feeling of needing therapist	140	T1
Relationship with T2 a different experience	134-135, 138-140,146-161,163-165, 19	T1
Therapist showing her empathy	146	T1
Feeling listened to by T	147	T1
Feeling heard, feeling of being able to converse with T2	148	T1
Her other therapist acknowledged her (she said hello to me)	77-80	T1
Worked well with T2	138	T1
Feeling that the therapist was on her side	83-84	T2
A sense of belonging in therapy	84-86	T2
Therapist entering painful places with her	84-86	T2
Attached to therapist like a child	329-331	T2
Missing therapist a lot	327-328	T2
Therapist being there	125	T2
Feeling cared for / feeling nurtured by therapist	125-127	T2
Through the therapy relationship she was able to move to di	127-129	T2
Feeling reassured by therapist	131-133	T2
Therapist was committed to her	134-135	T2
Feeling cared, contained	143-144,215-216,	T10
Importance of being able to identify with T	131-134,	T10
Feeling attended to	145-146,	T10
Feeling grateful gratitude for help	148-151,153,	T10
Wanting to help me as a result	148-151	T10
Feeling helped	153,155-162,	T10
Importance of feeling comfortable with T	296-301,	T10
Someone who is human/ someone you can relate to	294,298-301,	T10
Refreshing to talk to therapist who wasn't a robot	304-308,	T10
Huge impact of therapy on her	312-313, 313-328, 331-333	T10
Given so much by individual therapist	425-426,430-433	T10
Individual therapy giving her tools to climb the next step	430-434	T10
Feeling wonderful to have therapist support	463-466	T10
Strong sense of gratitude towards T	523-531	T10
A sense of affection and love towards therapist	526-529	T10
Feeling loved cared and special by therapist	526-531, 533-538	T10
Therapists professional manner	533-536	T10
Wanting to be liked by this therapist	602-613	T10
She was so grateful that someone was taking her seriously	613-615	T10
She bought the T flowers	613-617	T10
Relationship as 'key'	75-86	T2
Therpist being human,open,transparent	410-413	T2
Non-judgemental attittude	135-136	T5
Allowing herself to be the child with T1	138-140	T3
Felt closer to T1	143	T3
Feeling more adult like with T2	96-101,148-149	T3
Expressed more feelings with T2	103-105	T3
Feeling like she moved on more with T2	111-112	T3
Taking more responsibility of self with T2	114-116	T3
Stronger boundry w T2	141-143,236-237	T3
Feeling close to T2 in a different way	143-145	T3
T2 being more deft at picking things out	204-207	T3
T2 giving her options and not what she wanted to hear	206-209	T3
More of an emotional connection with T1	229-233	T3
Therpist 2 as a mother figure	280-285	T3
Relationship growing in time	284-286	T3
Different experience of therapy with t1	21,22,26,27,33,34,42-43, 92-98,103,104	T3
Therapist seen as a mother figure	280-281, 312-314, 424-428,432-440	T3
Feeling like an adult with T2	139-141	T3
Able to explore being unhappy with therapist 2	212-215	T3
Affection	298-305	T3
Therapist seen as equal	283-288, 315-325,	T3
Sharing a lot with T1	110-112	T3
Sharing her younger child emotions helped	126-128	T3
At the time her intervention was helpful	185-187	T3
Connection with individual therapist	106-107,	T7
Feeling special	116-119,	T7
Feeling understood by therapist	120-121	T7
Identifying with therapist	126-136,	T7
Therapists empathy	213-216	T7
Feeling loved	642-654,	T7
Wanting to be directed	667-671	T7
Feeling safe	198-199,200-202,309-314,	T7
Wanting to be cared for	270-276	T7
Feeling for the therapist	132-133	T7
Assuming therapist had been thru something similar	133-136	T7
Feelings towards therapist initially	143-143-148, 154-155,	T7
Understanding the her current patterns of beh thru therapy	80-83	T7
Understanding the impact of abuse thru therapy	80-86	T7
Warmth of therapist	136,	T8
T asking about her feelings	137-140,	T8
New therapist (Art therapy)	132-134	T8
Facilitator helping them understand and address difficulties	216-219,221-225,	T8
Facilitator giving them techniques to leran how to relax	221-225	T8
Facilitator helping her understand herself better	225-231	T8
Feeling special and supported	231-235	T4
Touched / overwhelmed	237	T4
Feeling safe	79-86, 82,144-150,150-154	T4
Feeling heard,	158-164	T4
Feeling acknowledged, supported	158-161	T4
Feeling contained	158-164	T4
Calming relationship w3ith T	46-48	T4
Feeling of therapy being a 'lovely experience'	58-59	T4
Feeling cared for, feeling special	55-59, 83-86, 230-235	T4

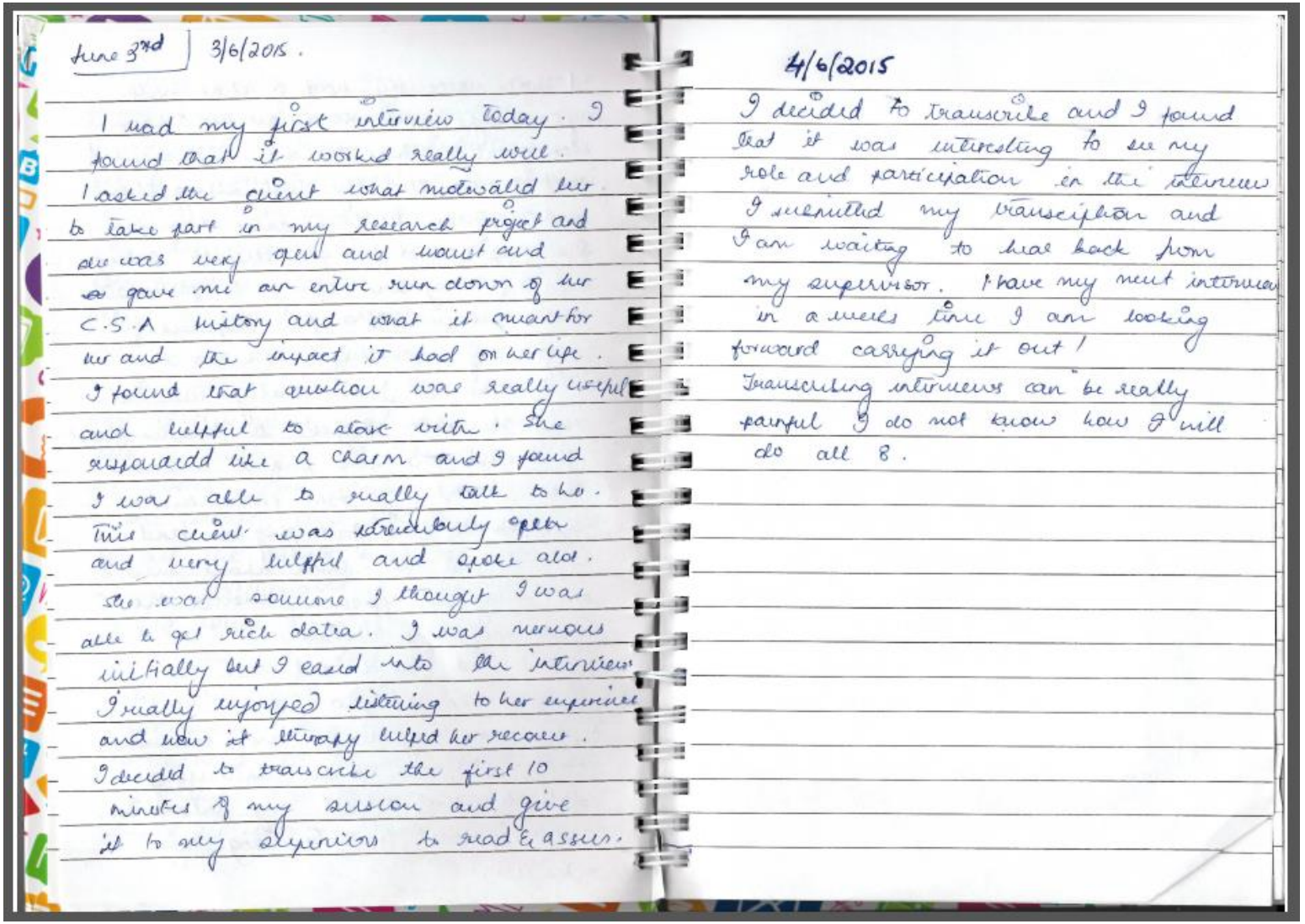
Appendix M

Summary Table of Super-Ordinate & Sub-Themes

Super-Ordinate Themes	Sub-Themes
I. Forming the Therapeutic Alliance	E. Misattunement with Therapist F. Connection with and Validation from Therapist G. Feeling Accepted in Therapy H. Holding Environment of Therapy
II. The Therapeutic Journey	H. Discovering Self and Breaking Through Emotions I. The Role of Time in Breaking the Silence J. Experience of Therapeutic Ending
III. Experience of Finding Their Voice	K. Impact of Childhood Sexual Abuse L. Sharing the Journey With Others M. Stigma Around Accessing Mental Health Services

Appendix N

Extract from the Reflective Diary



June 3rd | 3/6/2015.

I had my first interview today. I found that it worked really well. I asked the client what motivated her to take part in my research project and she was very open and honest and so gave me an entire run down of her C.S.A history and what it meant for her and the impact it had on her life. I found that question was really useful and helpful to start with. She responded like a charm and I found I was able to really talk to her. This client was incredibly open and very helpful and spoke alot. She was someone I thought I was able to get rich data. I was nervous initially but I eased into the interview. I really enjoyed listening to her experience and how it strongly helped her recover. I decided to transcribe the first 10 minutes of my session and give it to my supervisors to read & assess.

4/6/2015

I decided to transcribe and I found that it was interesting to see my role and participation in the interview. I submitted my transcription and I am waiting to hear back from my supervisor. I have my next interview in a weeks time I am looking forward carrying it out! Transcribing interviews can be really painful I do not know how I will do all 8.

Appendix O

Psychology Department Risk Assessment Form

Date of assessment: 29/4/15

Assessor(s): Rhea Williams, Jacqui Farrants

Activity: Doctorate in Counselling Psychology research - Lone Working

Date of next review (if applicable):

Hazard	**Type of injury or harm**	**People affected and any specific considerations**	**Current Control Measures already in place**	**Risk level** Med High Low	**Further Control Measures required**	**Implementation date & Person responsible**	**Completed**
Therapy rooms at the mental health charity (Oxleas NHS [name deleted] service) to conduct the research interviews.	Personal security/safety compromised Violent or threatening persons	Researcher (Myself)	- My mobile number will be given to a safety contact. - I will notify the safety contact of the date, time and location of the meeting with the participant. -I will call the safety contact before and after the meeting so they know I am is safe. - I will be seated closest to the exit should they need to exit in an emergency. -Obstacles obstructing the exit will be moved.	Low	If I feel that my safety is at risk, the interview will be terminated immediately and I will remove myself from the situation.	Rhea Williams	

			- I will have relevant emergency telephone numbers on quick dial should it be needed in an emergency. - I will be carrying a personal alarm at all times.				
Premises where I am working is out of sight or hearing range of colleagues (e.g. therapy rooms at the mental health charity.	Aggressive/threatening persons Theft of personal property An accident such as a trip, slip or fall	Researcher & participant	-A visitor control system is in place (e.g. signing in and out book). -Effective communication systems in place for the researcher to summon help or to raise an alarm. -CCTV systems. - Interview rooms are arranged in a way that all exits routes are clear. -Good internal and external lighting. -Security guards. -Heavy carrying and lifting activities will be avoided. -Computer equipment will be placed so as to avoid trip	Low	If I feel that my safety is at risk, the interview will be terminated immediately and that I will remove myself from the situation.	Rhea Williams	

			hazards and provide enough space to work comfortably. -The researcher will not take unnecessary expensive equipment or valuables into the room.				
Desktops and other electrical equipment	Electric shock	Researcher & Participant	-All electrical equipment will be visually checked for signs of damage or overheating prior to each use. -Ventilation/cooling vents on electrical equipment will not be obstructed.	Low		Rhea Williams	

Please note that it is the responsibility of the PI or supervisor to ensure that risks have been assessed appropriately.

Contacts

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University Safety Manager: Mohammad Torabi, safetyoffice@city.ac.uk

Part B: Professional Practice –

Client Case Study

CITY, UNIVERISTY OF LONDON

DEPARTMENT OF PSYCHOLOGY

RHEA WILLIAMS

A Collaborative Participation Towards Change

May 2017

Part C: Publishable Article

CITY, UNIVERISTY OF LONDON

DEPARTMENT OF PSYCHOLOGY

RHEA WILLIAMS

An Insight Into the Experience of Women Survivors of Childhood Sexual Abuse Attending a Specialist Psychotherapy Service: An Interpretative Phenomenology Analysis

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Abstract

For most survivors of childhood sexual abuse ("CSA"), seeking and receiving help to manage their difficult experiences of abuse are known to be complex, long and a difficult process (Gavey, 2003; Frenken & Van Stock, 1990). The experience of using such services has seldom been explored from a survivor's perspective (Chouliara et al., 2012). The aim of this study is to explore in depth the lived experience of women attending a specialist psychotherapy service for survivors of CSA. This study uses a qualitative research design paradigm. The data was collected from a small sample of ten women attending a UK National Health Service ("NHS") specialist service for survivors of CSA. Semi-structured interviews were employed to gather information from participants. The accumulated data was analyzed using Interpretive Phenomenological Analysis ("IPA"). One of the three super-ordinate themes that emerged from the data was Forming the Therapeutic Alliance. The focus of this article is on this theme. The narratives within this theme revealed, from these women's own perspectives, the therapeutic journey which first began with the difficulties they first encountered when they felt misattuned with their therapist, continued to connection and validation from the therapist, and through to the importance of the holding environment of therapy, drawing light on some interesting findings within each of these stages of the therapeutic process. Implications for the clinical practice of Counselling Psychology, limitations of this study, as well as recommendations for future research are considered within.

Key Words

'Childhood sexual abuse', 'Therapy experiences' 'Counselling Psychology', 'Specialist service', 'Qualitative research'

Funding Sources

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1. Introduction

1.1 Background

Over the last several decades, childhood sexual abuse ("CSA"), which was formerly seldom discussed or acknowledged, has garnered an increase in attention and is no longer seen as a subject of taboo. It is difficult to state an accurate prevalence of CSA as most of it is unreported or not disclosed. Radford et al. (2011), as part of the NSPCC, carried out their most recent study on the prevalence of child sexual abuse and established that 11 to 17 year olds reported 16.5% of them had experienced sexual abuse, of which 4.8% had experienced contact child sexual abuse. These figures rose to 24.0% and 11.3%, respectively, within the 18 to 24 year old age bracket (Brown & Tessier, 2015).

A prevalence study across Europe was carried out by Lampe (2002) and he found overall prevalence rates of 6% to 36% in girls and 1% to 15% in boys under 16. The Council of Europe states that "available data suggest that 1 in 5 children in Europe are victims of some form of sexual violence" (Council of Europe, 2014). In spite of the ambiguity around the prevalence statistics, a variety of findings reveal that CSA affects a substantial percentage of the population (Brown & Tessier, 2015). In 2011, it was argued by the NSPCC that, "By not addressing child sexual abuse as a public health problem we are failing our children" (NSPCC, 2011).

Neglect and abuse is believed to be problematic and unique not only to the UK, but poses a worldwide problem that has significant consequences for public health (Krug et al., 2002). Statistics from recent research among a nationally representative sample of youth and children suggested that approximately 6% of the sample size experienced some form of sexual offence and 1.4% reported experiencing sexual offences within the previous year (Finkelhor et al., 2015). In addition, 16.4% of girls represented the highest rates of sexual offences between the ages of 14 to 17 (Finkelhor et al., 2015). Statistics from an older research study conducted by Molnar, Buka and Kessler in 2001 suggested that approximately 1 in 4 (i.e. 26.6%) of girls and 1 in 20 (i.e. 5.1%) of boys have experienced some form of sexual abuse as children. A meta-analysis of the predominance of CSA in adults using 65 articles from 22 countries reported that 7.9% of men and 19.7% of women had experienced sexual abuse before the age of 18 (Pereda, Guilera, Forns, & Gómez-Benito, 2009). While both girls and boys are vulnerable to CSA, girls are considered to be at a higher risk (Conklin, 2012). That said, the long term impacts of health and social indicators were

similarly harmful to both genders (Dube et al., 2005). A prevalence study by Lundqvist, Hansson & Svedin (2004) revealed that between 15% to 30% of women have been sexually abused as children. These figures illustrate that CSA is an issue that is highly prevalent in our society, and therefore reinforces the importance of exploring the long-term and psychological impact on survivors of it.

A growing body of research has indicated that CSA has profound short and long-term psychological, social and physical effects on its survivors' lives (Briere & Scott, 2015; Collishaw et al., 2007; Hetzel-Riggin, Brausch, Montgomery, 2007; Browne & Finkelhor, 1986). Adult survivors of CSA have a considerable and a greater risk of developing long-term mental health difficulties and physical health problems in contrast to the overall population (Liu et al., 2013; Anda et al., 2004). Violence and abuse contribute to fundamental mental health problems; there are a significant number of men survivors and approximately 70% or more women service users that are survivors of CSA (NHS Confederation, 2008). Unhealed CSA experiences can cause physical symptoms and psychological problems that are carried into adulthood (Sweig, 2011). Research and clinical experiences have indicated that CSA makes people vulnerable to an array of both physical and mental ill health difficulties (Kamiya, Timonen & Kenny, 2015; Maniglio, 2009; Felitti et al., 1998). Previous findings have further indicated that higher incidences of CSA are prevalent amongst women who seek clinical treatment for various mental health problems (Callahan, Price, & Hilsenroth, 2003). There is a significant link between adult survivors of CSA and increasing mental health difficulties as compared to the general population.

1.2 CSA and Attachment Theory

"The human condition is far too complex for any single theory to suffice." (Scharff & Scharff, 1998, p. 63). Over the years, many different theoretical conceptualisations have endeavoured to explain the difficulties that accompany childhood trauma and abuse. As a trainee counselling psychologist, keeping in mind that the heart of our training lies within an integrative framework, I appreciate the need to integrate propositions from different theoretical perspectives that have clinical relevance. There are several theories and numerous models that have been used to understand the relational aspects and long-term implications of CSA including, amongst others, Interpersonal Schema Theory, Contextual Behvaioural Perspective, Traumagenic Dynamics Theory, Affect Regulation Theory by Shore, and Developmental Psychopathological Model. These models have been proposed to understand

the various effects encountered as a result of CSA and implications on the development and subsequent functioning of interpersonal relationships. I have chosen, however, to focus particularly on Attachment Theory, the concept of the secure base and its link to psychodynamic literature. My reason for this is because the service upon which I conducted this research study is primarily a psychodynamic service which is heavily informed by Attachment Theory. As a result, I believe the accompanying Analysis and Discussion is most applicable to consider in the context of Attachment Theory.

Attachment Theory provides a useful conceptual framework for understanding the long term effects of CSA (Hooper et al., 1997). Attachment Theory has been found to contribute largely to the understanding of emotional distress and interpersonal issues that result from CSA, as well as provide an underlying perspective on the development of relationship difficulties, psychopathology and affect dysregulation (Karakurt & Silver, 2014). This idea that early disruption to the mother-infant relationship can be a pre-cursor for emotional difficulties (Bowlby, 1944) makes one curious about the impact of the primary caregiver relationships on clients' latter lives. Although psychoanalysis from its inception suggested that maladaptive developmental pathways during childhood may result in difficulties in latter life, it lacked a good theory of normal development (Marrone & Cortina, 2003). Thus, Bowlby developed Attachment Theory as an attempt to link psychoanalysis with the larger world of evolutionary theory and ethology (Holmes, 2015).

1.3 Therapy Experiences of Adult Survivors of CSA

A detailed plan about developing specific therapeutic interventions and appropriate support for women in the NHS is provided by the department of health policy on mainstreaming gender and women's mental health (NHS, 2003). However, there is evidence of limited and patchy provision of specialist psychological therapy services for women in the UK who are survivors of CSA (Smith, Pearce, Pringle, & Caplan, 1995). For most survivors of CSA, seeking and receiving help to manage difficult experiences of sexual abuse are known to be complex, long and a difficult process (Gavey, 2003; Frenken & Van Stock, 1990). The experience of using such services has seldom been explored from a survivor's point of view or perspective (Chouliara et al., 2011). Thus, we have an unclear picture of whether or not CSA survivors perceive their needs and service provisions similarly to clinicians or whether their requirements are catered to in clinical settings (Draucker & Oetrovic, 1997).

Despite the variety of studies carried out on adult survivors of CSA, Chouliara et al. (2011) argue that till date, there is a significant lack of research published discussing the views and experiences of survivors and professionals who work with survivors, in particular in Scotland and the United Kingdom. Notably, there is a lack of information from a survivor's perspective (Chouliara et al., 2012). It has been further identified that lack of research in the area is partly due to the "gate keeping attitudes" of professionals working in the field, in addition to the already existing sensitive nature and stereotype surrounding the topic, often causing low functioning or high co-morbidity of participants (Chouliaria et al., 2009; Way et al., 2004).

A variety of psychological, relational, social, sexual and physical difficulties ranging in severity are likely to be experienced by survivors of CSA (Michaud et al., 2001; Kessler et al., 1995). As a result, adult survivors are more likely to access social, medical and psychotherapy and counselling services (Chouliara et al., 2012). Furthermore, research has well established that amongst CSA survivors, the long-term damage caused by CSA is evident. Equally, a variety of studies conducted in the past on this topic have addressed the effectiveness of several treatment modalities targeting the psychological sequelae related to such abuse. Nonetheless, in spite of the recent rise in the awareness of different psychological therapies offered within the field of psychology, a scarce amount of studies have sought to explore the efficacy of specialist services for CSA from a survivor's perspective.

1.4 Present Study

The NHS Specialist Service upon which study was carried out (which I refer in this study interchangeable with "The Woman's Service" or "The Service", and have intentionally not disclosed further details on to maintain anonymity) was established 14 years ago and has been successfully operating since then. An early audit that was carried out in the first two years after the service opened, as well as a service report prepared by the service from 2008-2009, showed that the Woman's Service had been effective in providing specialist treatment which helped reduce the need for patients to engage in further services following discharge (Amar, 2009). The results indicated that most patients did not require any additional involvement with health services and therefore maintained an overall improved level of functioning. More recently, an unpublished quantitative service audit was carried out by Wieliczko (2013), which indicated that overall, 61.1% of clients had reliably improved after

therapy, using the Core-OM as a measure of testing the outcome. Among those, 38.9% had also improved clinically. Since then, no further studies have been conducted on this Service.

Thus, in view of the above findings on the Woman's Service, as well as the highlighted gap in the literature, I became interested in carrying out a more detailed and in-depth analysis to explore the client's individual experience of therapy at service. The aim of my study is to capture a qualitative snapshot of the experiences and perspectives of women attending a specialist NHS service for female CSA survivors in their own voice. I also hope it can be accretive to the field of psychology when assessing the effectiveness of psychodynamic, art and group therapy, the three main approaches used at this service, to treat survivors of CSA. In view of the research mentioned above (e.g. Chouliara et al., 2012; Hilden et al., 2004; Smith, Pearce, Pringle, & Caplan, 1995) this study can contribute to the further development of specialist services in the UK for women who are survivors of CSA, which in turn can benefit the overall field of counselling psychology. It can also be of general interest to psychologists, psychotherapists, social workers, researchers and others practitioners/providers interested in the field of CSA.

2. Method

2.1 Research Design

This study uses a qualitative research design. The data was collected from a small sample of women attending the Woman's Service. Semi-structured interviews were employed to gather information from participants. The accumulated data was analysed using Interpretive Phenomenological Analysis ("IPA") (Smith et al., 2009), as this approach attempts to understand the subjective experience of an individual in relation to their life and how each individual makes sense of that experience by describing phenomena as it presents itself to them.

2.2 Procedure

In ordinary circumstances, data collection within the IPA methodology is based on purposive sampling (Willig, 2013). As a result, the group of participants were homogeneous as they shared the experience of a particular situation, a requirement for IPA methodology. Participants were recruited by working carefully with the lead clinician, and screening and selecting participants who were suitable for the study. Clients at the service have to undergo a

review session with the lead clinician and support worker once they have completed a course of psychotherapy which lasts for a minimum of one year. Participants were approached during their end of therapy review interview by the support worker, and were informed about the study and asked to contact me (the researcher) if they wished to participate. I believe this gave them a choice of whether or not they wanted to take part and didn't make them feel obligated to do so. They were informed that no identifying material would be disclosed and participating in the research was voluntary and would not affect their treatment in the service. The service provided an information sheet to a number of participants and only a proportion took part in the study. Precaution and care was taken not to feedback to the service about the participants who took part in the study in order to respect the confidentially and anonymity of the participants. Once the participants expressed an interest in participating in the study, I assessed their suitability for the study via a phone call. Subsequently, I arranged for an interview date to be set up at a time and date that was most convenient to the participant. The ten participants attended a semi-structured interview. The interviews lasted between 40 to 90 minutes in the service where the women attended their therapy. This location was chosen due to the sensitive nature of the topic and it was deemed appropriate to carry out the interviews in an environment that was safe, confidential and non-threatening for the participants. All the interviews were recorded on an audio-phone. They were then transcribed by myself and analysed.

2.3 Participants

The study is based on ten participants. As this is a difficult to reach population, I initially thought I would struggle with finding participants to take part in the research project. However, I was surprised by the response I received and chose to interview all the women who came forward, even though ten is a relatively large sample for IPA. All participants experienced contact CSA. Of the ten participants, all ten had been involved in long-term psychodynamic therapy and six out of the ten had received group therapy in addition to their individual therapy.

2.4 Data Analysis

As aforementioned, the Interpretative Phenomenological Approach to data analysis was employed with the attempt to explore an in-depth experience of women attending a specialist psychotherapy service for adult survivors of CSA. A detailed and thorough analysis of each

case and across cases was carried out. Through this, it was evident that a number of interesting and common themes emerged across the transcripts. Although each woman's experience and journey was unique and individual, there were a variety of themes that were shared across the interviews. All the themes were listed on a spreadsheet to capture the quality of meaning and experience of what was being described. Emergent themes sometimes formed clusters together, in turn creating the sub-themes. After conducting this analysis on every participant's transcript and creating a summary table for each, these sub-themes were integrated across participants to establish super-ordinate themes that had developed.

3. Analysis

3.1 Overview

Three wider super-ordinate themes emerged from the data, which include: **"Forming the Therapeutic Alliance", "The Therapeutic Journey",** and **"Experience of Finding Their Voice".** Due to the expansive amount of data generated in this study, this article focuses only on the first of these super-ordinate themes, Forming the Therapeutic Alliance. This theme refers to the participants' reflection of their experiences of different aspects of the therapeutic alliance. This theme is discussed in detail because it revealed two different aspects of the experience of attending a specialist service for CSA. It covers aspects of some of the most meaningful excerpts that answer the research question and appeared as an outcome of the analytic process.

3.2 Forming the Therapeutic Alliance

This super-ordinate theme captures the participants' experience of the therapeutic relationship and their responses to the boundaries and framework that therapy entails. As the therapy process is a journey that is seldom easy, participants describe the importance of having a connection with and validation from their therapists. They further describe the impact of misattunement in the therapy relationship and how sometimes it can re-create their difficult emotional experiences and memories. The impact of the healing relationship facilitates change, self-discovery and learning to cope with these difficult emotions.

Misattunement with Therapist

The first sub-theme, Misattunement with Therapist, aims to capture the participants' experience of misattunement with their therapist and the emotions and impact generated as a result of it. An experience of misattunement or "therapeutic impasse" is defined as both the therapist and client feeling more alone and isolated, less connected with each other and one where neither can see how to move on from these feelings of disconnection (Stiver, 1992).

> *"There was one women who I went to who was very cold and sort of like a robot and I didn't feel that was helpful... but for me... I think I need to feel that there was a human talking to you... rather than anyone sitting on the chair and being just robotic... Sitting there frowning and taking notes... I think it is very important for people to feel comfortable with a therapist... you feel... otherwise you can't open up to someone... and sometimes just to have somebody even just to nod and say yeah I understand or... something... but then she made me feel awful... I didn't want to actually go there anymore..."* (Betty, 286-302)

Betty found her therapist to be 'unhelpful' due to her 'cold and robotic' style which she perceived to be un-engaging. Her narrative suggests her therapist may have acted in a manner as if she understood her, however, it didn't feel real and this sense of falseness in the relationship made Betty feel 'awful'. The lack of connection made her experience of therapy feel a lonely one, largely due to her therapist's style of being unresponsive and not approachable. It appears that for Betty, her therapist came across as being pre-programmed, with automatic responses, and not actually taking her individual and specific experience into consideration. This perhaps draws attention to her childhood experiences where her feelings were neglected. Sharing parts of oneself for Betty in therapy is a difficult and vulnerable process, and this can only be achieved if she feels a sense of 'human' connection or bonding with the therapist, suggesting a need for warmth, emotion and communication. Pearl, like Betty, found it difficult to relate to her therapist who did not communicate much, highlighting her difficulty with facing uncertainty during therapy:

> "*It can be awkward... I was just thinking will she sit there and say anything...? I thought to myself I don't want to be coming here like once a week to be playing games in a room with somebody... but that's how it felt... I mean I found myself asking the*

service what kind of qualifications does this lady got? Am I the first person that she's worked with... or what kind... because to me... she's just... Not right... I do not know whether it was her or me." (Pearl, 128-132)

Pearl was perplexed by her therapist's manner towards her, suggesting the different expectations she had from her. She felt misunderstood by her therapist. The notion that the therapist may be 'playing games' with her gave her the impression that her therapist was not taking her session seriously or having fun at her expense, making her question the therapist's qualifications for the role. Her tone suggests that this approach by the therapist led her to a state of confusion where she was unable to think clearly and felt disoriented and began to doubt herself. This led to Pearl automatically thinking the misattunement was something to do with her. The lack of communication from her therapist was difficult to interpret and did not feel 'right', making her uncomfortable and unsettled in the presence of her therapist, as she imagined therapy to be a two-way process. Tia, similarly to Pearl, had a certain expectation from therapy and found the silence in the therapy room a 'strange situation' and difficult to engage with:

"I found it so difficult to say things... And I just found it a very strange situation to be honest... To be with somebody else in a room who is not really saying anything and expecting me to talk about thing... And half the time I was there I just didn't say anything... Because I didn't know how to say things... hmm... I would be very anxious..." (Tia, 115-128)

Tia describes finding it difficult and 'strange' to sit with the silence from her therapist. Ainsworth (1970) devised the concept of the "Strange Situation" which has profound effects of attachment on behaviour. She carried out a study to observe the behaviour and responses of children in a situation where they were briefly separated from their mothers and then reunited with them, and assessed their reactions to this situation. Although Tia does not refer explicitly to Ainsworth's "Strange Situation", her experience of lack of familiarity led to a sense of discomfort and lack of attachment and bonding with her therapist. Tia interpreted her therapist's silence as an unspoken expectation that she should do the talking in therapy thus, making it an 'anxious' situation where she felt nervous, unsettled and uncomfortable.

In summary, this theme highlights instances of the impact of therapist misattunement with clients' emotions and psychological well-being and the consequential impact on the therapeutic relationship. All participants expressed that therapists who exhibited a silent and un-engaging manner were a hindrance to their therapy process. They also expressed a difficulty in relating to a therapist who was cold and 'robot-like'. This suggests the importance for these women to feel a connection and a sense of comfort in order to be able to engage in therapy.

Connection with and Validation from Therapist

Forming the therapeutic relationship becomes easier as participants express how they are able to create a connection with the therapist and the role that validation plays in this. They highlight the significance of being shown empathy, warmth and validation in developing and building a therapeutic alliance. This is an important aspect of their therapy relationship as it seems to be a precursor for healing to take place within their therapeutic journey. Pearl describes how she was able to develop a sense of connection with her therapist as a result of her demonstrating both empathy and a desire to listen:

> "*I mean she was a nice lady and she showed empathy... She you know... Listened... She conversed back... Hmm... She conversed back in a way... Where... I would come out thinking I can't believe I thought like that or thought about that... That's right... That is it... you know... And it is like... You spend years trying to get an answer... To something... And in a room suddenly the answers appears... something that maybe you have never thought before... and that's what... and that happened quite a few times..."* (Pearl, 146-154)

Communication and relating to the other seems to be an important aspect in therapy for Pearl. According to her narrative, Pearl sought feedback and validation during therapy, which can only take place through conversing or connecting with the other. Her experience illustrates the power of communication in helping her find 'answers'. Her therapist's ability to connect with her, and facilitate thinking about her situation led to her experiencing 'light bulb' moments during therapy. Bella, below, interestingly describes that in addition to empathy, it was her therapist's reliability in always being there, as well as emotional robustness which made it possible for her to establish a connection:

> *"...And what I really appreciated that my therapist was... She was a really strong robust person... With so much empathy and understanding...so... She was able to... Come alongside me... And enter painful places with me...but...hmm... I suppose it is difficult to describe... I knew she was there with me throughout all the difficult moments []...What she was teaching me was about a safe wholesome good relationship and one where if cried...I wouldn't be punished and if... I wouldn't be punished... so she helped me to learn how to be... myself."* (Bella, 75-86)

Bella's experience captures the importance of having a 'robust' therapist- someone who is strong enough to enter difficult places with her given her fragile state. Bella's story suggests that as a child she would be punished for expressing negative emotions and therefore she grew up learning not to express them. Therapy served to re-parent her by teaching her to be 'herself'. At times she found it 'difficult to describe' the emotions and feelings she felt during her relationship, suggesting it may be something she's never experienced before. Bella's use of the word 'wholesome' can be interpreted as an inference made towards food suggesting that her relationship was nourishing and leading to better health. As her inter-personal relationships were violated as a child, she was unable to experience a 'wholesome good relationship'. Terry, similarly to Betty, describes how she was able to connect with her therapist as a result of her coming across as trustworthy and someone she felt 'safe' to express herself to:

> *"But for me I felt like I was talking to someone I felt comfortable and safe enough to share everything with... I knew it wouldn't go outside...[ ] I feel such a connection with that lady before I left... I thought what... Maybe she's been through something similar... No wonder she understands."* (Terry, 198-303)

Terry's experience signifies the importance of trust where she says 'it wouldn't go outside', highlighting her idea of a perceived 'inside' and 'outside' world. Her connection with the therapist and the therapy room was 'inside', signifying a warm, safe and contained environment as opposed to the unknown and uncertainty she experiences in the outside world. She mentions feeling a 'connection' with her therapist before the ending of her sessions, suggesting that the sharing of painful emotions in therapy can contribute towards building a connection with the therapist. Furthermore, Terry expresses feeling a deep sense of affection for her therapist, and it led her to question if her therapist has gone through

something similar given her ability to understand her well. There appears to be a connotation again of the therapist feeling like an 'insider' or from the same team, someone who has experienced something similar.

In summary, this theme explored the connection participants encountered with their therapists during therapy and the importance of being validated. Their ability to express their difficult and painful emotions during therapy was made easier to achieve due to the therapist's warm, reliable, trustworthy, robust and engaging manner as opposed to the 'cold and robotic' style experienced in the previous sub-theme. This enabled participants to build a rapport and a therapeutic alliance with more ease, as compared to when they felt disconnected and disengaged at the onset due to misattunement.

Feeling Accepted in Therapy

Having explored aspects of the therapeutic alliance, including the possibility of misattunement at the onset, as well as the importance of connection and validation from the therapist, I explore particular aspects of the therapy relationship where participants felt accepted and how this had an impact on the nature of the relationship. Participants' interviews expressed developing a healthy therapeutic alliance is not always easy and it is important for them to feel accepted when seeking professional help. Bella's quote illustrates the particular ways her therapist helped her feel more accepting of herself:

> *"What was amazing... that I realised that I didn't know how to play... And one of the techniques that she used with me around myself as a child was... When I think to myself as a child... When I look back what do I see... And I didn't see a child when I looked back... I saw an adult...so... She suggested that we looked at photographs as me as a child in the period that was the most painful period of my life and suggested that I brought photos of my children at that age as well..."* (Bella, 93-98)

Bella was able to recognise the loss of her ability to 'play', suggesting that as a child she was robbed of the freedom to explore and engage with activities that were free-spirited. Bella suggests that her childhood was adulterated and 'taken away' from her, where her innocence was lost and it was made to feel false or even impure. By helping her get in touch more profoundly with her experience when she was a child, specifically through looking at older photographs of this period, her therapist assisted her with revisiting and accepting the

difficult parts of herself emanating from her childhood. It appears as though bringing photographs of her and her children at similar ages helped her recognise the disparity in affection for herself when contrasted to that of her children. Betty, like Bella, was able to further explore her emotions in therapy as a result of her therapist giving the impression of taking away the pressure from her during the sessions:

> *"It was a wonderful feeling... it takes off so much pressure and it makes you feel you know... somebody feels you're not worthless... You feel a lot better... It easies the pressure... you are able to reveal more about yourself...[]"* (Betty, 476-480)

The use of the word 'pressure' suggests a physical force or a stressful situation that in Betty's case she was accustomed to facing in her life, which had been eroding her self-confidence. Her therapist, by first showing her that she accepted her for who she was, helped ease this mounting pressure. She explained somebody believing in her and allowing her to be herself helped her develop a sense of usefulness and value. Before therapy, Betty had the impression that nobody believed in her abilities, which had given rise to her feelings of worthlessness. Lara, below, describes how unconditional kindness made her feel comfortable enough to think about herself:

> *"Yeah... It was like having medication or something.... it's like having that kind of zoomed in...Kindness...[] It kind of gave me permission to kind of... spend time on myself and think about things..."* (Lara, 163-168)

Lara describes her experiences of therapy being like 'medication', which is used to alleviate or prevent pain. She uses this interesting metaphor to describe therapy suggesting that it helped heal and cure her, implying she may have been in distress before therapy. She also uses the word 'zoomed in' to depict her experience of therapy, inferring the importance of having someone focus their attention on her. Her therapist's desire to take a closer look at the minute details of Lara's life also serve to give importance to her experience in Lara's eyes. Her example also suggests an element of guilt she felt when thinking about her individual needs because she didn't feel *worthy* enough. She expresses how therapy gave her 'permission to spend time' on herself, suggesting that she needed approval from someone

who was perceived as a person in authority. Spending time on herself points to her desire to take care of herself and relax as opposed to 'using time' to accomplish tasks.

In conclusion, this theme summarises the impact of making clients feel accepted during therapy and various ways that it was successfully achieved by different therapists. The lack of acceptance during their childhood perhaps accentuated the need of feeling accepted during therapy. The participants' accounts demonstrated the impact of this on a number of occasions, both from individual and group therapy.

Holding Environment of Therapy

Having described aspects of the therapeutic relationship and the importance of feeling accepted in therapy, I explore the importance of the holding environment of therapy. Therapy can evoke different emotions and feelings within participants, and therefore they express the importance of the holding environment in which they feel safe, secure and contained whilst exploring vulnerable parts of themselves. Betty's quote below expresses the validation she receives from other members in her therapy group and highlights the importance of this surrounding environment during therapy:

> *"And I felt like I was the failure but listening to everybody else you realise that it is not like that at all and you realise it is more about what has happened to you in the past has made you the way you are and it helped make more sense of everything really..."* (Betty, 373-376)

Betty experienced both individual and group therapy at the service and her words highlight the positive impact of listening to others in group therapy. Betty considered herself a 'failure' - implying she was somebody who never experiences success and loses regularly. However, 'listening to others' led her to feel protected enough to become aware that her negative self-perceptions and 'feelings of failure' were as a result of her past. It is as though validation from people who have gone through similar experiences brings her an added sense of feeling held and contained. This sense of feeling held paved the way for greater self-awareness in an uncontaminated environment to recognise the detrimental effects of her abuse. Macy, similarly to Betty, found the sharing of ideas in a group setting conducive to self-reflection:

> *"[ ]...in actual fact in some ways... for me anyway... the group was probably an improvement to one to one... because it actually initiated more conversation... Because you are like a ping pong... bouncing off everyone else in the group... around people come up with things that you have not thought of... oh... you know... ways of dealing with things... oh you know I have never thought of that... looking at it that way or whatever you know."* (Macy, 99-105)

Macy describes feeling like a 'ping pong', which gives the impression of something that echoes, resonates, or bounces off something else. This is exactly how sharing ideas with others in a group therapy setting feels to her, which she describes as an 'improvement' to being one to one with a therapist. It also suggests that the combination of both listening to and contributing towards a conversation in a group can facilitate an increase in awareness and potentially bring about healing. Moreover, the group setting can bring about a new way of thinking or approaching a situation that one may not have thought about before. Tia shared similar feelings to Macy where she also had an experience of group therapy and talks about the importance of not being judged within a group environment:

> *"I suppose being able to talk about things and nobody blaming you... And nobody else blaming you... or making you feel bad about yourself... because of it... []...I suppose... The continuity of always having the meeting at the same time, every day I think that is my time and forget about everything else..."* (Tia, 235-237 & 313-319)

It seems to be important for Tia to be able to express herself freely, in a non-judgemental group setting, which was something that was alien to her. It seems as though the consistent environment that was created and its associated stability was something she did not experience as a child. Her experience also suggests that Tia was made to feel regret and blame and took responsibility of abuse she faced as a child. Her use of the word 'forget' almost implies the group sessions took her into a parallel world where she focused on herself, perhaps suggesting that outside of therapy she was unable to do so.

Throughout this theme participants expressed their experience of a contained environment where they were able to establish a sense of trust with their therapist that in turn enabled them to explore the vulnerable parts of themselves. Their experiences point out the importance of the environment, setting boundaries and maintaining professionalism for clients to form that

important therapeutic alliance, which is an essential precursor for recovery to take place. There seems to be an element of safety associated with consistency, as well as comfort in hearing other people face similar experiences as themselves.

4. Discussion

4.1 Summary Findings

In this section I assess some of the key findings and conclusions that emerged from the analysis of the participants' interviews conducted in this study. This was accomplished by identifying recurring patterns and themes within the larger super-ordinate theme.

The therapeutic alliance can be described as a concept that explains the working relationship between client and therapist (Allnock et al., 2013). This super-ordinate theme, Forming the Therapeutic Relationship, covers several interesting findings on how this alliance is formed between therapist and the participants in this study. The first of these is the importance of the initial engagement between a therapist and the participants. The various accounts, directly from participants' perspectives, would suggest they found their therapists unable to successfully engage with them, often times more prevalent at the very beginning. We see this in the narrative of participants who found their therapists to be un-engaging and 'robotic' or others who found the silence in the room 'awkward', leading one participant to question the qualifications of the therapist. Some participants didn't know 'how to say things' and thought they would receive further help. This 'misattunement' at the onset can put off clients from seeking therapy for childhood sexual abuse. Given the nature of CSA, there is perhaps an added level of importance on how a new relationship, in this case with a therapist, is developed at the onset and held during therapy, and the manner with which the therapist approaches it. In many instances, survivors may be put off by the initial experience and may never re-explore therapy which could have been beneficial to them.

The general possibility of misattunement is supported by previous studies where participants found it difficult to establish a relationship with their therapist as they perceived them as un-engaging, un-empathic and non-responsive (Mc Gregor et al., 2006). Mc Gregor et al.'s study highlighted the challenges encountered amongst CSA survivors, where many experienced difficulties with openness, safety, trust, and interpersonal relationships. Perhaps not highlighted in previous studies is the acuteness with which this occurs amongst survivors of CSA and the resulting impact on their ability to want to connect in therapy again. Childhood

trauma can generate vulnerability with relation to therapy errors (McGregor, 2001; Dale, 1999; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994; Herman, 1992; Kluft, 1990). One participant, for instance, began to question her therapist's skills due her sense of discomfort and lack of connection that she felt. Initial interactions with a therapist are likely to be fundamental for the effectiveness of therapy (Dale, 1999) and findings of this study support the importance of this. Dale (1999) also suggested some survivors observe the therapist closely and intensely for signs of a lack of understanding, empathy, and their ability to manage hearing about their CSA disclosures. Must a therapist be perceived to be lacking in any of the above, they may experience this as a sign of further betrayal (Chouliara, 2012; van der Kolk et al., 1996; Salter, 1995). Participants' expressions of self-doubt, attributing the lack of connection to themselves, are consistent with some of the common emotions experienced by adult survivors of CSA (Cloitre et al., 2006). But perhaps specific to childhood sexual abuse, this is an area where therapists need to be even more sensitive to the initial interactions as it can have a detrimental impact on the overall relationship.

Herman (1992), in her analysis of Trauma and Recovery: The Aftermath of Violence, compared the consequences of trauma on three social groups: adult survivors of CSA, domestic violence victims and military personnel injured in combat. It was acknowledged that the consequences of CSA were observed to be far more difficult to address and complex than combat trauma. She suggested the reason for this to a certain extent is a child's account is less likely to be believed by the general public when compared to that of armed services involved in action which are reported extensively in the media and news (Bird, 2015). As a result, Herman highlighted varies degrees of complexity may exist within post-traumatic stress disorder (PTSD), whereby childhood trauma, for instance, may require more time to recover from and is harder work which requires more support in comparison to other PTSD. Coping mechanisms developed during childhood are harder to replace in adulthood as they may become deeply embedded and repressed by the child over the years. These findings by Herman support the notion that chances and extent of misattunement are increased when working with survivors of CSA given the complexities of the trauma involved, also seen in this current study.

A second interesting finding within this theme is how participants describe ways or reasons by which they were able to connect successfully with their therapist. Throughout this sub-theme, there is an overarching pattern here of therapists being able to connect better with their clients when they demonstrate a deeper level of empathy, come across as trustworthy,

and interestingly, also show a level of robust emotional strength that perhaps offers a client the adequate support structure to open up or promote disclosure during therapy. Interestingly, therapists who came across as robust and able to explore difficult experiences with the participants were perceived as helpful. The importance of perceiving the therapist as resilient is an interesting finding. This conclusion is also closely linked to the value that clients attach to feeling accepted during therapy explored above.

A study by Middle & Kennerley (2001) found that survivors of CSA emphasised more on the importance of the therapist's qualities in the relationship, whereas their non-abused participants placed more importance on the therapeutic techniques and process (Middle & Kennerley, 2001). Participants described that therapy helped them contextualise their abuse. Across nearly all narratives in this study, the focal point when discussing forming the therapeutic alliance is around the participants' experience and observations of their therapist's qualities. The direct perspective of the participants, however, helped put this into context where every subtle quality of a therapist can be perceived as a positive or a negative, not just the general approach.

Finally, another conclusion that stands out within this theme is the importance of the environment in which a client engages in therapy, and how different settings can lead to breakthroughs for different clients. A client unable to connect during individual therapy may find a completely different experience if engaged in art therapy or if sharing experiences within a group therapy setting. Participants describe how listening to other people in a group setting helped them normalize, validate and reduce the stigma or feelings of being alone in this experience.

Findings from the present study illustrated the importance of group therapy in helping participants reduce their feelings self-blame. Their accounts also suggest their ability to connect with each other, as well as the therapist, whilst getting in touch with their painful childhood experiences and the impact it has on them today. This finding is in line with the study conducted by Coulson & Morfett (2013). Coulson & Morfett (2013) described women's experiences of overcoming their feelings of shame and isolation by sharing their story in a safe space during group therapy. The findings of their study highlighted the power of group therapy as an important factor in an individual's recovery, because "magic happens" (Coulson & Morfett, 2013). Here the women were able to listen to and understand others' experiences, as well as challenge other members' and their own beliefs about shame, guilt and self-blame in way that was experienced differently from individual therapy. This finding

is in line with the study conducted by Coulson & Morfett (2013). What's interesting to note in the present study is what specific elements during the therapy can enable this 'magic to happen' in the participants' own voices.

4.2 Clinical Implications

A variety of research has been carried out with reference to therapists' experiences of working with adult survivors of CSA (Hodges & Myers, 2010; Way et al., 2007; Way & VanDeusen, 2006). However, there is a limited amount of research from the clients' perspectives of attending therapy within specialist services for adult survivors of CSA (Chouliara, 2011, 2012). Chouliara (2012) in fact suggests that research across gender, as well as survivors' negative therapy experiences, requires further exploration. Thus, this study aimed to partially bridge this gap in the literature.

Seeking therapy can be a difficult process for any individual, more so for adult survivors of CSA. Specifically, due to the risk of feeling re-traumatized, misrepresented or even wanting to avoid the feelings generated when processing painful experiences, it is difficult to gain access to a sample set like this for research. This study can prove to be insightful to survivors who have had no experience of therapy and might find it informative in terms of what they can expect from therapy, particularly within the NHS. Likewise this study can prove to be beneficial for clinicians, therapists, health care professionals and researchers working in this field, whether directly with clients or seeking to recruit clients for another study. Although therapy courses and counselling and clinical psychology doctorate programmes provide training on how to work with adult survivors of CSA, being reminded of the sensitivities and complexities that accompany working with this population is of paramount importance. Findings from this study draw attention to the sensitivities and intricacies involved in forming a therapeutic relationship with adult survivors of CSA. Some of these include how to minimize chances of misattunement at the onset, what techniques or interventions facilitate connection with clients, and how the holding environment of therapy can impact the therapeutic alliance.

Interesting to note, the way that this particular service was set up gave clients another chance at therapy with a different therapist. This is because every client seeking treatment at this service was provided with the optional use of a support worker, alongside their lead therapist. As a result, in instances where a client found it difficult to form a therapeutic alliance with a

particular therapist, the support worker was able to intervene, support them, and also offer them a different therapist. This added level of sensitivity and opportunity at a second chance is perhaps a broader aspect to be explored further for survivors seeking therapy for CSA and service providers. One of the implications that can be considered for this service is to further explore or take note of the reasons for a client not getting on with a particular therapist and wanting a change, perhaps via seeking feedback from them. In addition, the service provided their clients with the opportunity to receive therapy via a different approach if the first was not suitable. This could mean a client struggling with individual therapy having the opportunity to then explore group or art therapy. The implication here is that just like most individuals may have to 'shop around' to find the right therapist for them, for this particular population, this point may be even more applicable given the sensitivities around their abuse history.

4.3 Research Claims & Further Research

Having explored some of the key findings generated from this study, I explore some of the limitations it faces. One limitation that stands out is that the sample size of the study is relatively small and therefore its implications and conclusions have to be considered with some perspective. So while an IPA study requires between 4 to 10 participants (Smith et al., 2009), the relatively small sample size makes it such that one cannot use findings in this study to generalize about a broader group of survivors of CSA. Despite carrying out the study on a small scale, the material gathered from the interviews provided some data rich in quality. It suggests that the women participating in the study were able to be open and courageous enough to reveal their experiences in depth. Another limitation of this study is that it involved participants who had undergone a minimum of one year of individual therapy. There are many cases of survivors of CSA undergoing shorter periods of therapy, and thus, implications of the findings may differ for such a population. It is also important to take into consideration the experience of survivors who did not complete their therapy or who were not willing to take part in the research.

Another limitation of this study is the inherent self-selection process of the participants in this study. All participants volunteered to take part in the research study with the knowledge that aspects of their experience would be discussed. Moreover, participants who stepped forward to volunteer were likely to have had a positive experience of therapy to have wanted to spend another 45 minutes to 1 hour to speak about it. This was addressed by asking all participants

about their negative, as well as positive experiences of therapy. A transparent and inclusive process of recruitment was employed by providing all potential participants with as much information that was deemed appropriate and ethical about the study. This included not collecting participants' history of abuse in order minimize any form of intrusion. It could be argued that whilst recruiting for volunteers to take part in research, all researchers only have access to those who are willing to talk about or share their experiences. This aspect is shared by all researchers and is perhaps not unique in particular to adult survivors of CSA, even though they are a more difficult population to reach. This said, it is important to take into consideration the experience of survivors who were not willing to take part in the research.

A consideration for future research would be to explore the experiences of participants after a few more years of therapy to see if they have been able to maintain these lifestyle and emotional changes. It would be also interesting for future research to consider participants that dropped out of therapy earlier, participants who found it difficult to participate in research, or even include a different demographic such as males to explore if findings differ from the ones discovered in this study. Another interesting aspect to explore further, especially with this particular population, is the general benefit of a service that offers more flexibility in terms of course of treatment. This could mean offering different durations of treatment, type of treatment (individual vs. group vs. art), or providing additional support (i.e. a support worker) which could be valuable in engaging this group further in therapy. Additionally, given this study was conducted on participants who were attending a specialist service for CSA, it would be interesting to compare the results of clients who received therapy for CSA at a general practice, as opposed to a specialist practice, to see if there are any differences and similarities between them, or if specific aspects of this particular service had any bearing on the conclusions. It would also be interesting to explore further the positive experience that participants experienced as a result of participating in this research. This can inform future researchers about the positive effects for adult survivors of CSA as a result of participating in research. Finally, given the large amounts of research conducted in this field has either been quantitative in nature or qualitative, a study which combines both methods could also be very accretive to this topic.

4.4 Concluding Remarks

Having undergone therapy at a specialist NHS service for adult survivors of CSA, participants in this study provided a very detailed and enlightening depiction of their

experiences. They embarked on a journey which began with the difficulties that they first encountered when meeting their therapist, continued to the forming of the therapeutic alliance, and through to the ending of the relationship. Participants expressed the value of being able to explore and discover their past, finding their voice during their healing journey. Moreover, the research indicated the significance of participants being able to share their journey and experiences with others. The findings in this study can provide useful insight into the unique experience of women with a history of CSA who have attended therapy within a specialist service. They can enable psychologists and therapists working in the field to make considerations and develop interventions that are appropriate for this population. I believe this study can be a valuable contribution to the field of Counselling Psychology as it offers valuable knowledge to both prospective clients with a history of CSA and therapists who are working in the field of CSA, a growing worldwide problem that has significant consequences for public health (Krug et al., 2002).

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