Women's lived experience of recovery from childhood sexual abuse, and their perception of the role of mental health services.

"We won't be shoved under the carpet or buried in the sand."

(Sue, participant)

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[1] Anonymous name, Greek ἀλθος *althos*, "healing"

ABSTRACT

Background: The scale of childhood sexual abuse (CSA) in the UK is larger than previously believed. Evidence shows a lack of research surrounding women's experience of recovery from CSA. Furthermore, the role of mental health services within this experience has largely been ignored. The aim of this research was to explore how women who were sexually abused as children understand their experience of recovery and the role they perceived mental health services to have had throughout.

Method: Semi-structured interviews were conducted with seven women who had experienced CSA and accessed support from statutory mental health services. Interviews elicited narratives regarding perceptions of recovery and the role of mental health services. Transcripts were analysed using Interpretative Phenomenological Analysis to identify themes.

Results: Four superordinate themes were identified: 'the on-going, unfinished journey of recovery'- capturing the nature of the process of recovery; 'the power of being silenced by others'- encompassing the influence of others inhibiting their ability to speak out and the related consequences; 'acknowledging the past and uniting it with my life'– describing vital internal processes experienced during recovery; 'I can't do this alone: ingredients for connections with others'– specifying that recovery is better experienced in unison with a supportive other.

Conclusion: Results were considered in light of existing evidence and psychological theory. This provided an evidence-base to inform the development of services for women who have experienced CSA, and outline a number of clinical recommendations that could aid recovery. Recommendations for future research, and dissemination approaches are also discussed.

Keywords: *Child sexual abuse; Women; Recovery; Qualitative; Interpretative Phenomenological Analysis; UK.*

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LIST OF ABBREVIATIONS

ACC.   Accident compensation corporation

Abbreviation	Meaning
ACC.	Accident compensation corporation
BPD.	Borderline personality disorder
BPS.	British psychological society
CASP.	Critical appraisal skills programme
CJS.	Criminal Justice System
CPTSD.	Complex posttraumatic stress disorder
CSA.	Childhood sexual abuse
HCPC.	Health care profession counsel
HIV.	Human immunodeficiency virus
IPA.	Interpretative phenomenological analysis
IWM.	Internal working model
MASGH.	Multi-agency safeguard hub
MDT.	Multidisciplinary team
NAPAC.	National association for people abused in childhood
NHS.	National health service
NICE.	National institute for health and care excellence
NSPCC.	National society for the prevention of cruelty to children
NZ.	New Zealand
PTG.	Posttraumatic growth
PTSD.	Posttraumatic stress disorder
R&D.	Research and development
REC.	Research ethics committee
SAFE.	Survivors of abuse: freedom and empowerment
SR.	Systematic review
TREM.	Trauma recovery and empowerment model
UK.	United Kingdom
USA.	United States of America
WG.	Welsh government

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INTRODUCTION

"Imagine a childhood disease that effects one in five girls and one in seven boys before they reach the age of eighteen; a disease that can cause erratic behaviour and even severe conduct disorder among those exposed; a disease that can have profound implications for an individual's future health by increasing the risk of substance abuse, sexually transmitted diseases and suicidal behaviour, a disease that replicates itself by causing some of its victims to expose future generations to its debilitating effects. Imagine what we, as a society would do if such a disease existed. We would spare no expense. We would invest heavily in basic and applied research. We would devise systems to identify those affected and provide services to treat them. We would develop and broadly implement prevention campaigns to protect our children. Wouldn't we? Such a disease does exist – it is called child sexual abuse."

(Mercy & Vibolo-Kantor, 2016)

Positioning the reader: Context overview

Despite growing recognition that childhood sexual abuse (CSA) should be identified as a public health priority (Hudson & Barnett, 2015) the National Association for People Abused in Childhood (NAPAC) claim the mental health needs of adult survivors of childhood abuse are still not being met by the national health service (NHS; NAPAC, 2017). Currently, CSA is estimated cost the UK 3.2 billion a year (Saied-Tessier, 2014). Since the recent media coverage on CSA within youth football in the UK there has been a tenfold increase in need for NAPAC's support groups as a result of the upsurge in disclosure rates. Other notable increases in disclosure rates were reported after the announcement of the Independent Inquiry into CSA, and the media coverage on the Savile scandals (Sanderson *et al.*, 2015). Such coverage tends to focus on the criminal aspects of CSA, such as, how perpetrators are managed. While this is important, it draws attention away from what happens to people after they have been abused and how society supports survivors. There is a risk that this approach is reinforcing an assumption that 'historic abuse' is 'finished business' and something that can naturally moved on from (Hudson & Barnett, 2015). The Board of the UK Psychological Trauma Society considers that failure to address some of the impacts of CSA will result in intergenerational health consequences, and further compound social and economic costs (Cloitre *et al.*, 2012).

Services and professionals working with survivors of CSA need to be well informed about the current understanding of trauma and associated interventions to keep up with the rising demand (Bateman *et al.*, 2013). In 2015, the Government provided a new victims' fund of nearly £5million for organisations to offer support to survivors specifically in response to the surge in disclosures mentioned. While increased funding in a period of austerity appears

positive, this money should be viewed in the context of the anticipated cost of the Independent Inquiry, which is likely to be in excess of £260million (Smith *et al*., 2015). If the new 'victims' fund' reflects the value placed on supporting survivors then it is greatly outweighed by the investment in an inquiry focusing on perpetrators and prosecutions. Indeed, the office of the Children's Commissioner suggests that much more is known about the perpetrators of abuse than about survivors of abuse (Horvath *et al*., 2014).

Current literature focusing on survivors of CSA recovery tends to be informed by professional perspectives rather than by survivors' views (e.g. Chouliara *et al.,* 2014). More specifically, international research focuses on the impact of CSA and/or professionals' perspectives of their clients' experiences and predominantly focuses on resilience and coping strategies (Bogar & Hulse-Killacky, 2006; Chambers & Belicki, 1998; Daigneault *et al*., 2007; Dufour *et al.,* 2000; Dufour & Nadeau, 2001; Himelein & McElrath, 1996). Although survivors of CSA perspectives have drawn more research interest (Merrill *et al.,* 2001), there is still a "striking lack of evidence available about adult CSA survivors in the UK" (Smith *et al.,* 2015, p. 3). The lack of research is problematic as without robust evidence, the effectiveness of strategies to support survivors of CSA to recover is hindered (Smith *et al.,* 2015). In this context, the current study was developed to gain an understanding of CSA survivors' experience of recovery generally, and to develop awareness to how mental health services in the UK have played a role in this. The overall aim is to further the evidence base to aid the development of local and national service provision for this population who are seldom heard.

Overall chapter outlines

The current research study is presented in four chapters. Each chapter contains a number of subheadings to direct the content of the chapter. Each chapter will begin with an overview of the content within the chapter to situate the reader. In summary, the chapter contents are as follows:

- **Chapter one** is divided into three core parts. Overall, the chapter provides an introduction of the literature surrounding the current research topic (Part one) along with a systematic review (SR) of the relevant literature to help inform the current study (Part two, divided into Section a, b & c). Finally, an outline of the aims and objectives of the current study is provided (Part three).

- **Chapter two** details the methodological approach taken in the current study and rationales for the choices made. A description of the analytical approach taken is also provided.

- **Chapter three** presents the findings of the current study.

- **Chapter four** situates the findings in relation to previous research, describes the implications of the findings, and comments on the strengths and limitations of the research. Thought is also given to the dissemination approaches that could be adopted.

Chapter one overview

The current chapter is presented in three parts:

- **Part one** provides a synopsis of the relevant literature regarding CSA along with current national and local guidelines applicable to the current study.

- **Part two** is divided into three core sections (Section a, b & c) that present a SR of the literature exploring women who have experienced CSA perception of recovery.

- **Part three** discusses evidence regarding survivors of CSA perception of support services and discusses the gaps within the current UK literature. Together this forms the basis of the rationale and aims for the current research. The rationale will also be supported by the discussions in Part one and Part two.

<div align="center">**PART ONE**</div>

What is childhood abuse?

Childhood abuse can take multiple forms (Higgins & Mccabe, 2001; Richmond *et al*., 2009). The National Society for the Prevention of Cruelty to Children (NSPCC) outline the following four pertinent categories:

- **Physical abuse**: Any act causing physical harm. Physical harm can include when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

- **Emotional abuse:** Persistent emotional maltreatment that causes severe and persistent adverse effects on emotional development. It can include imposing developmentally inappropriate expectations, including overprotection and limitation of exploration and learning. It may involve serious bullying (including cyber bullying) or the exploitation or corruption of children. All acts that result in the child feeling frightened, or in danger.

- **Neglect:** Persistent failure to meet a child's basic physical and/or psychological needs (including during pregnancy).

- **Sexual abuse (CSA):** Defined in detail below.

Several authors suggest separately considering the specific subtypes of child abuse (Afifi & MacMillan, 2011; Domhart *et al*., 2015) since the association between exposure to abuse and outcomes may vary (Ehring *et al*., 2014; Price-Robertson *et al*., 2013). Indeed, as has been noted, "Childhood trauma, particularly sexual abuse, may set in motion chain reactions of trauma across the life cycle" (Banyard *et al*., 2001, p. 698). Thus, aggregating types of maltreatment likely confuses conclusions drawn regarding impact. This may be especially true for CSA with its specific features such as betrayal, stigmatization, or early traumatic sexualization that distinguish it from other types of maltreatment (Finklehor & Browne, 1985). However, many children who are abused experience more than one form of maltreatment across many life domains (poly-victimisation), and are more likely to be exposed to other environmental risk factors, such as parental separation, or living with disadvantage or poverty (Donfg *et al*., 2004; Finkelhor *et al*., 2005; Finkelhor *et al*., 2007; Scott-Storey, 2011; Sneddon *et al*., 2016; Turner *et al*., 2010). With this in mind, although

neglect is the most common type of abuse in Wales (Welsh Government; WG; 2015) it should be considered a potential predictor for other types of abuse, such as CSA.

Childhood sexual abuse

CSA is a relatively recent umbrella term describing a complex life experience (Campbell, 1988); it is not a diagnosis or a disorder. There is no universal definition of CSA and agreement with what it entails varies throughout history (Collin-Vézina *et al.*, 2013; Hacking, 1991; Smart, 1998, 2000). Current definitions used in England, Northern Ireland, Scotland and Wales are similar. The HM Government guidance for professionals 'Working together to safeguard children' (DCSF, 2010) describe CSA as:

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

(HM Government, 2015: p.93).

CSA is commonly broken down into three criteria (Radford *et al.*, 2011):

- **Non-contact abuse**: a range of acts, including inappropriate sexual solicitation or indecent exposure.

- **Contact abuse**: touching and/or fondling.

- **Intercourse:** oral, anal and/or vaginal intercourse.

As a whole, most definitions of CSA agree that it typically includes unwanted and inappropriate sexual solicitation of, or exposure to, a child by an older person; genital touching or fondling; or penetration in terms of oral, anal or vaginal intercourse or attempted intercourse (Sneddon *et al.*, 2016). Either an adult or another young person can commit CSA (Hackett, 2011). There is disparity between the age of sexual consent across nations. For example, the ability to have sexual consent can be as young as 12 or 13 (e.g. Tonga, Spain) to

17 or 18 years of age (e.g. some states in the USA, Australia) (Collin-Vézina *et al*., 2013). In almost all European jurisdictions, sexual relations are legal from age 16 onwards.

Difficulty obtaining a universal definition of CSA is echoed in the academic literature. An awareness of this issue is important when reviewing literature on CSA in countries that hold different views concerning CSA. The current study assumes the HM Government's definition of CSA, and the age of consent being 16 years.

Historical context of CSA

CSA sits in a historical backdrop of oppression against women (García-Moreno *et al*., 2015). In part, this seems to have shaped approaches to researching CSA, for example, differences between male and female samples are commonly documented. As a result, focus of the current research is specifically on the female population.

Violence against women is a global health phenomenon that has historically been hidden, ignored, and accepted (Blume, 1990; García-Moreno *et al*., 2015; Mullender & Hague, 2005). Freud's decision to reject the seduction theory, which uncovered the tip of prevalence rate of CSA, in favour of theories of fantasy and the Oedipus complex that placed blame on the child for their behaviour, is considered to have been highly influential in creating the stigma surrounding CSA and violence against women (Holmes *et al*., 1997). As a result of sustained advocacy and organising of women's movements such discrimination and silencing has gradually reduced (Delap, 2007; García-Moreno *et al*., 2015). Conversely, the validity of CSA disclosures continues to be questioned. Survivors are often blamed for their experiences, and the consequences of CSA are often trivialized or discounted by the majority (family, friends, police, legal officials and mental health professionals) (Marx, 2005).

Adopting the principles of feminist ideology Herman (1992) developed her Trauma Theory with an aim to encourage a movement away from the stigma surrounding the trauma faced by women, such as sexual violence and CSA. The theory arose from the conceptualisation of Post Traumatic Stress Disorder (PTSD) to create a language and method for understanding difficulties commonly described by war veterans (Tseris, 2013). Herman (1992) describes how this theory provided an opportunity to use this diagnosis as a way to also understand trauma in women. Trauma Theory is heavily guided by feminist values that challenge the oppressive conceptualisation of mental health and the interventions used, particularly for women dating back to the era when psychoanalytic theory dominated psychiatry (Herman, 1992). The theory favours a socio-political understanding of women's lives by suggesting that

trauma symptoms are the expression of coping with a particular trauma event. However, historians have shown that this perspective is rarely favoured within court hearings involving CSA (Cox, 2003). As a whole, it appears that mainstream Trauma Theory is no longer centred on feminist values, having become preoccupied with medically oriented issues concerning diagnosis and standardized treatment (Berg, 2002; Burstow, 2003; Gilfus, 1999; McKenzie-Mohr, 2004; Worell, 2001). For example, there is a growth in research surrounding the impact, and particularly the neurodevelopment, of people who have experienced trauma (Zaleski *et al.*, 2016). The focus on reductionist conceptualisations such as this seem incongruent with feminist goals of empowering women and resisting pathologizing understandings of their experiences (Naples, 2003). Priority still seems to be placed on assessing and treating the effects of trauma, rather than on examining issues of context and experience (Tseris, 2013).

Giving a voice to 'the silenced population' through research

In recent years there has been increased attention given to the victim's perspective of abuse (e.g., Phillips & Daniluk, 2004; Hunter, 2010; London *et al.*, 2005). However, many comment on the significant lack of survivor's of CSA voices within official documents and research surrounding CSA and recovery from CSA (Bingham *et al.*, 2016; Glaister & Abel, 2001). This narrative is especially true in the NHS where value is placed on quantitative findings (McDonald, 2003; Stuart, 2016). Grossman *et al.* (1999) discuss the limitations of an exclusive reliance on questionnaires and statistics that hide the unique texture of individual lives. They discuss the importance of being able to give a voice to those who are too often silenced, and recognise the value of the knowledge they can impart to society.

Providing survivors of CSA a voice through research presents numerous ethical and regulatory constraints (Veenema *et al.*, 2015). One prominent factor is that CSA is a highly sensitive topic surrounded with stigma, which is likely to influence funding and whether ethical approval is granted (Veenema *et al.*, 2015). Some express concern regarding the possibility of opening 'Pandora's box' by exploring sensitive topics. There is a fear of intense reactions that include anger, uncontrollable crying, extreme anxiety, and flashbacks during the interview, as well as nightmares and sleeplessness in the aftermath. Although no cases of long-term harm have been reported in the literature (Jaffe *et al.*, 2015). Others have also expressed a fear of the implications or repercussions of their research conclusions (e.g., Marx *et al.*, 2001; Rind *et al.*, 1998). This highlights the unique qualities that a Trainee Clinical Psychologist can offer due to their training in engaging and managing emotionally intense situations, and conducting and communicating research. Despite this, the researcher found it

difficult to identify research specifically on CSA recovery conducted by Clinical Psychologists.

Research suggests that the benefits of confiding a traumatic experience to a trustworthy other seem to outweigh the immediate distress that accompanies discussion of painful experiences (Draucker, 1999; McClain & Amar, 2013). Individuals who respond to questionnaires, or participate in interviews, are often more concerned with providing a meaningful narrative related to their traumatic experiences than they are in avoiding emotional distress (Pennebaker & Susman, 1988). Pennebaker and Susman (1988) argue that "actively avoiding thoughts and feelings surrounding a trauma and/or not discussing a trauma is a particularly insidious form of inhibition" (p. 327). More recently, literature surrounding post-traumatic growth (PTG) emphasises the importance of rumination as a key cognitive process for growth (Tedeschi & Calhoun, 1995, 1996; Tedeschi *et al*., 2016). Overall, research opportunities can be viewed as providing a platform for survivors of CSA to be heard, which counteracts the historical backdrop in which CSA belonged. However, this is only possible if the results are disseminated in form that will reach appropriate audiences.

The extent of CSA

CSA is a global phenomenon (Pereda *et al.*, 2009) that is not typically experienced as isolated or short-term episodes (Smith *et al*., 2015). Rather than being random, opportunistic assaults, the risks of CSA are better understood as being concentrated among certain children who are repeatedly abused by someone close to the child [2](Radford *et al*., 2011; Smith *et al*., 2015). The most commonly cited statistic regarding the prevalence of CSA based on adult retrospective accounts is one in four girls and one in six boys (Centres for Disease Control and Prevention, 2005; Finkelhor *et al*., 2014), with rates increasing to 35–75% in clinical populations (Chu & Dill, 1990).

There is no single source of data on the scale of CSA in the UK, however estimates commonly reported suggest one in 20 children in the UK have been sexually abused (Bentley *et al*., 2016; Radford *et al*., 2011). Whilst in Wales it is estimated that 10% of children have experienced CSA (Public Health Wales, 2015). Statistics can be derived from three main sources: 1) self-report abuse and neglect studies; 2) the child protection system (child protection plans/registers); and 3) recorded crime statistics on sexual offences. All of these sources have their own limitations. Core limitations include the terminological ambiguity

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[2] 70% of children in the UK are sexually abused by a close family member or someone close to the family (Smith *et al*., 2016).

regarding definitions of CSA; not accounting for trends in the data likely to reflect increased public awareness and changes in policing (Bentley *et al*., 2016); the lack of disclosure of CSA[3] (Radford *et al*., 2011; Smith *et al.,* 2015); low rates of conviction and crime statistics only incorporating statistics on actual convictions. The NSPCC (2015) describe that more accurate numbers of CSA can only be obtained through submitting a Freedom of Information Act request to individual police forces. Despite these methodological challenges reports still consistently suggest alarming prevalence rates (Smith *et al*., 2016).

Overall, females are more likely to experience CSA (Pereda *et al*., 2009), however this is often conflicted by suggestions that males face more stigma surrounding CSA which therefore reduces the likelihood of disclosing (O'Leary & Barber, 2008*)*. However, most people who have experienced CSA will not disclose their experience until adulthood (Sneddon *et al*., 2016). The presence of a disability is also thought to increase the likelihood of being abused (Horner-Johnson & Drum, 2006), as well as family adversity, substance abuse and social isolation (Wolfe, 2007). Recent population-based studies suggest that, amongst other factors, living in poverty is a predictive factor for children to be subjected to both physical and sexual abusive experiences (Bellis *et al*., 2014; Bellis *et al*., 2015; MacMillan *et al*., 2013).

The economic impact of CSA

Saied-Tessier (2014) was first to confront the critical issue of estimating the overall cost of CSA in the UK. All previous studies were conducted within the USA or Australia. Since the health and social care systems are different across countries it would be inappropriate to use such estimates within the UK. Estimating such costs enables policy makers to put spending on CSA in the context of other costly public health issues. There are many difficulties calculating the cost of CSA for any country, for example the low rates of disclosure and the substantial uncertainty around the factors that affect the cost of CSA. Therefore Saied-Tessier's (2014) estimate was intended to draw attention to the 'possible cost' with the hope that it will ignite further discussion and understanding.

Table one is the estimated annual cost of CSA in the UK broken down into the areas chosen by Saied-Tessier (2014). It was acknowledged that this list does not encompass all the costs associated with the impact of CSA. Those that were chosen were due to the evidence-base available and the accessibility of gaining information about the service.

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[3] It is estimated that the true incidence is 30 times that identified in cases officially confirmed by government agencies (Stoltenborgh *et al*., 2011).

2012/2013 area of spending	Specific area	£ million
Health	Child mental health- depression	£1.6
	Child suicide & self-harm	£1.9
	Adult mental health-depression & PTSD	£162.7
	Adult physical health- substance misuse	£15.4
	Total	**£182**
Criminal Justice System (CJS)	Perpetrator	£89.9
	Adult victim of CSA	£5808
	Total	**£149**
Services for children	Children social care	£93.9
	NSPCC service cost	£7.7
	Total	**£124**
Labour market	Lost productivity	£2,700
Total cost		**£455**

Table one: Estimate annual cost of CSA in the UK.

The total cost of CSA on health was £182million, almost £150million on the CJS and £124million on overall children social services. The highest estimated cost was on lost productivity due to unemployment and low earning potential at a total of £2,700million. As a whole these estimates were suggested to be conservative. However, the inclusion of the estimate for human and emotional suffering suggests that the overall cost is significant. The use of such estimates is important for policy makers to be aware of as they are considered to reflect the 'true cost' of CSA (Saied-Tessie, 2014)[4].

Caution should be taken when applying the above estimates as these are based on the UK average and are not Welsh specific. The NHS in Wales is different to other UK countries. For example, Welsh Government has a 10-year strategy for mental health and wellbeing, Together for Mental Health (2012). This aims to promote everyone's mental wellbeing and, where possible, prevent mental ill health from developing. At the heart of the strategy is the Mental Health (Wales) Measure (2010), which places legal duties on health boards and local authorities to improve support for people with mental ill health. These differences could play a role in the economic impact of CSA; therefore a study specifically focusing on the economic impact in Wales is warranted.

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[4] While many feel it is not possible to put a figure of human pain and suffering, health economists have the relevant skills to do this, for example, such estimates have also been used in domestic violence research.

Potential outcomes

Generally childhood maltreatment is suggested to account for 45% of the population attributable risk for childhood onset psychiatric disorders (Teicher & Samson, 2016). There is widespread acknowledgement that CSA is a risk factor for a myriad of negative outcomes (Aydin *et al.,* 2015; Collin-Vézina *et al.,* 2013; Read & Bentall, 2012), many of which are identified within a variety of psychiatric diagnoses. Universally, exposure to CSA, and other adverse life experiences are suggested to have a dose-response relationship, in that increased exposure results in an increase in negative outcomes (Bassani *et al*., 2009; Bellis *et al.,* 2015; Brown *et al*., 2009; Cecil *et al*., 2017; Felitti *et al.,* 1998; Hughes *et al*., 2016), which are likely to persist into adulthood (Widon, 1995; Kendler *et al*., 2000; Felitti *et al*., 1998). Attention has been drawn to the complexity of this relationship among CSA survivors (Briere & Jordan, 2009) due to heterogeneity between their experiences (Bentley *et al.,* 2016; Finkelhor, 1990). Studies typically indicate greater negative consequences for those with poly-victimisation experiences compared to a single type of abuse type or occurrence (Boxer & Terranova, 2008; Lacelle *et al*., 2012; Turner *et al*., 2010). Taken together, CSA may be associated with greater detrimental outcomes than other types of abuse, but that the high rate of poly-victimisation among CSA victims may partially explain the greater negative sequelae.

Some research suggests that the needs and concerns of CSA survivors are different from that of other types of abuse as a result of its nature (Fergusson *et al*., 2008). For instance, Lewis *et al*. (2016) controlled for poly-victimisation and found that CSA is a unique contributor to symptoms over time. It was suggested that the effects were related to CSA being associated with traumatic sexualisation, and feeling powerless, betrayal, coercion to keep their experience a secret, stigmatisation, and attributions of responsibility, guilt and shame (Finklehor & Browne, 1985; Lewis *et al*., 2016). Others highlight that these unique effects may be related to CSA being a taboo subject in society, often occurring for extended periods of time, and occurring in the early stages of development (Allnock, 2010; Draucker 1992). However, these suggested unique effects are not consistently found (e.g. Vachon *et al*., 2015). These mixed findings may be related to methodological shortcomings such as, sampling and measurement differences across studies, or stem from the variations in factors such as: the number of maltreatment types assessed; the type of control group recruited; the analytical strategy employed; and the type of covariates included (Arata *et al*., 2007; Higgins & McCabe, 2001; Petrenko *et al*., 2012). Overall, it is widely accepted that the experience of CSA can be detrimental both to the developing child and later in life (Wohab & Akhter, 2010).

While a thorough review of the impact on CSA on developing children and adults is beyond the scope of this research Table Two outlines some of the more commonly published adult outcomes associated with CSA. The outcomes were drawn from current reviews and large-scale prospective cohort studies due to their suggested level of scientific rigour. Overall, as well as actual poor health people also have poorer perception of their health (Sneddon *et al.*, 2016). The health-related consequences of CSA are relatively similar despite geographic and cultural differences (Meursing *et al.,* 1995). The only geographically based difference in health sequelae identified relates to increased HIV transmission in regions where HIV is endemic (Forjuoh & Zwi, 1998; Haffejee, 1991). It should be acknowledged that there is a vast amount of evidence detailing the possible outcomes, only an overview has been provided here. Please refer to the citations provided for further details.

Mental health	Physical Health	Maladaptive behaviours
Anxiety disorders	Gastrointestinal problems (e.g. irritable bowel syndrome)	Substance use/misuse/abuse
Depression	Gynaecological symptoms (e.g. chronic pelvic pain)	Poor sexual functioning, risky and sexualised behaviour (sex trading), unplanned pregnancies, number of sexual partners
Eating disorders	Pain (such as headaches, backaches, muscle aches and joint pain)	
Post-traumatic stress disorder (PTSD)	Cardiopulmonary symptoms	
Sleep disorders	Obesity	
Suicide attempt/ideation	Increased number of physical health related visits to doctors	
Psychotic disorders		
Low self-esteem		
Personality disorders		

Table Two: Summary of adult outcomes drawn from the following reviews: Amado et al. (2015); Chen et al. (2010); Devries et al. (2014); Irish et al. (2010), and the following cohort studies: Fergusson et al. (2013).

Efforts to identify specific pathways from CSA to negative outcomes, or a specific syndrome of symptoms have not resulted in any uniform or consistent findings across samples (Kendall-Tackett *et al.*, 1991). This may be due in large part to the heterogeneous and diverse nature of CSA experiences, contexts of abuse, and potential moderating and mediating factors (Paolucci *et al.*, 2001; Putnam, 2003). Some suggest CSA survivor experience 'sleeper effects' showing little distress initially then followed by increased psychopathology over time (Briere, 1992; Gomes-Schwartz *et al.*, 1990). However, children who have experienced sexual abuse and interpersonal violence often lose a sense of trust and safety with others (Briere & Runtz, 1993). A number of empirical studies have identified difficulties in forging and maintaining relationships in those who experience CSA (e.g. Kia-Keating *et al.*, 2010; McGregor *et al.*, 2006). It has been argued that a significant contributing issue to this range of difficulties is the loss of a belief in the security of key relationships. Furthermore, recent

evidence suggests that CSA may alter brain development trajectories as an adaptive response to their environment (Teicher & Samson, 2016). Although there is some suggestion that this relationship is causal and dose-responsive (Teicher & Samson, 2016) the specific impact this has on an individual is highly complex, and requires future research.

Complex PTSD

Some psychiatric disorders are more commonly discussed in relation to CSA more than others, such as post-traumatic stress disorder (PTSD). The distinct components of trauma developed throughout childhood has led to the proposal of a new diagnosis, 'Complex PTSD' ([CPTSD]; Ford & Courtois, 2013; Herman, 1992). Others have used the terms developmental trauma, attachment trauma, or relationship trauma (Sar, 2011; van der Kolk, 2001). In addition to the classic PTSD symptoms of re-experiencing, experiential avoidance, and hyper arousal, individuals with CPTSD may have difficulties with chronic affect deregulation, self-harming behaviours, dissociative problems, somatisation, and distortions in concepts of self and others (Ford & Courtois, 2013; Herman, 1992). There is a significant overlap between the symptoms of CPTSD and borderline personality disorder (BPD). People meeting criteria for BPD commonly report having experienced sexual, emotional and physical abuse as a child. 75% of 214 consecutive in-patients with severe BPD had a documented history of reported CSA (McFetridge & Coakes, 2010). This high comorbidity has been reported across cultures (Zhang, *et al.,* 2012). A closer examination of the nature of symptoms can, however, distinguish BPD from CPTSD. BPD presents a greater risk of self-harm, frequent suicidal behaviours and a shifting sense of self (as opposed to one that it is pervasively negative as in CPTSD). There is also often an intense fear of abandonment that is not evident with CPTSD (Maercker *et al.,* 2013).

Unlike PTSD, there is no current NICE guideline or Cochrane review of the effectiveness of psychological and pharmacological interventions for CPTSD within the UK. Overall, the focus of the current study is not on a specific outcome associated with CSA, and effort is made to move away from labelling the outcomes of people's lived experiences.

Protective factors

It is suggested that up to 50% of survivors of CSA do not exhibit the most severe long-term psychiatric disorders, such as CPTSD, and between 15% and 47% show few or no symptoms in adulthood (Sneddon *et al*., 2016). These individuals may be classified as resilient (see below). Glaister and Abel (2001) suggest that survivors of CSA make up a significant portion

of the clinical populations receiving some type of healthcare. The current study focuses on the latter population, however, briefly, the following table outlines core protective factors [5] experienced in childhood that are thought to buffer against the outcomes described above (Sneddon *et al.*, 2016). Despite the growing evidence-base surrounding protective factors associated with the impact of CSA few reviews have focused on specially the protective factors associated with CSA, a majority focus on child abuse as a general concept.

Table Three is an amalgamated summary of protective factors associated with context and personal qualities. Due to their methodological robustness the most recent cohort study (e.g. Dube & Rishi, 2017) and reviews (e.g. Dufour *et al.*, 2000; Domhardt *et al.*, 2015) specifically associated with CSA were drawn upon.

Contextual factors	Personal qualities
Educational engagement and/or attainment	Optimism and hope
Social and emotional support and/or positive adult role model (family, community)	An internal locus of control and control beliefs
Engagement in leisure and cultural activities	High self-efficacy
Socioeconomic status (the higher the more protective)	Education and schooling (being more sure of educational goal, higher academic performance and positive attitudes towards school)
Social role satisfaction and positive sense of community	Emotional intelligence, interpersonal competence, and trust
Positive parenting when a child (perceived maternal acceptance, positive parenting and emotional bond between child and mother)	High self-esteem and sense of self-worth
	Being able to find meaning and a sense of personal growth in response to the abuse
	Active coping
	Externalising blame, trauma-related beliefs, and cognitions
	Social attachment (peer or family member)
	Religiosity and spirituality

Table Three: Protective factors drawn from Dube & Rishi (2017); Dufour et al. (2000); Domhardt et al. (2015).

In addition to the above factors, features related to the CSA experience also seem important. For example more severe, enduring outcomes are related to longer abuse duration and frequency, the use of force during abuse, abuse occurring at a younger age, and being related

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[5] Protective factors can be referred to as characteristics of the individual and the environment that modify, ameliorate, or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome (Rutter, 1985).

to the perpetrator (Hutchinson, 2015). Furthermore, there is some evidence to suggest that the response to disclosure may be the most predictive factor of later negative outcomes (Sneddon *et al.*, 2016). Obviously, the relationship between CSA and negative outcomes is complex and multifactorial, which is reflected in the mixed evidence within the literature.

There are a number of methodical weaknesses that should be held in mind when identifying possible protective factors related to the outcomes identified above. For example, most research focuses on child samples rather than investigating populations across the life span to gain an understanding of possible patterns of resilient functioning, there is a lack of research exploring the influence of combinations of protective factors, and the cut-off criterion that identifies resilience and/or outcome domains varying considerably across studies (Sabina & Banyard, 2015).

What is recovery, and how is it different from resilience?

Separately, the definitions and measurements of resilience and recovery in relation to CSA are widely debated (Chouliara *et al.,* 2014; Kaplan, 2005; Sneddon *et al.*, 2016), criticised for being vague and ambiguous (Beresford, 2015; Smith-Merry *et al.*, 2011), and often convoluted within the literature (Bonanno, 2008). For the purpose of the current study the author attempts to clearly differentiate between the two concepts to aid the applicability and implications of the current study's findings.

Generally, the difference between recovery and resilience relates to the psychological functioning trajectories after exposure to trauma (Sneddon *et al.*, 2016). Commonly the recovery trajectory is characterised by a significant decline in wellbeing immediately after a traumatic event(s) and a rise in pathological symptoms. Subsequently, there is a gradual improvement in functioning and a reduction in pathology until the individual achieves a level of functioning and wellbeing that is equivalent to that which they evidenced prior to the trauma (Sneddon *et al.*, 2016). Recovery may not be a smooth linear process, and can be associated with negative turning points that can lead to a temporary loss of adaptive functioning. On the other hand, positive turning points can accelerate recovery. Notions of recovery represent a long-term process or 'journey' based on positive aspects such as hope, resilience, involvement, participation, inclusion, meaning, purpose, control and self-management (Repper, 2000; Stickley & Wright, 2011). Although stages of recovery have been identified, the process is unique for each individual (Sneddon *et al.*, 2016).

Recovery is often defined as mental health symptom remission (i.e. clinical recovery) and/or a personal journey over time to reach a meaningful sense of life post-abuse (i.e. personal recovery) (Chouliara *et al.,* 2014; Pilgrim, 2008). Most research exploring recovery focuses on measuring either a decrease in symptoms related to mental health difficulties (Koss & Figueredo, 2004) or indications of positive life changes after a trauma (Frazier *et al*., 2004). Davidson & Roe (2007) argue that it has become a conflation of two ideas: clinical recovery, or 'recovery from'; and a person focused definition, or 'recovery in'. Recovery concerns personal and existential dimensions of recovery rather than simply symptom remission. The uniqueness of this experience highlights the need to adopt subjective and self–evaluative methods of data collection to explore experiences of recovery (Roberts & Wolfson, 2004). However, the move away from the concept of clinical recovery in mental health has been met with fears in regards to UK NHS providers using it as an excuse to make cuts in support (Bird *et al*., 2014; Roberts & Boardman, 2013).

Resilience on the other hand refers to the ability to sustain relatively normal functioning after exposure to a traumatic event. The concept of resilience has been scientifically studied for over four decades and has had various definitions and conceptualisations applied to it (Cicchetti, 2010; Luthar *et al*., 2000). Peter Fonagy succinctly defined resilience as normal development under difficult conditions (Fonagy *et al*., 1994). There is a growing consensus to consider resilience as a two-dimensional construct that encompasses both aspects of an individual's life circumstances and evidence of positive adaptation (Luthar *et al*., 2000). Masten and colleagues (1990) recall three phenomena related to resilience: (1) an adequate level of functioning despite the presence of risk factors; (2) effective coping to restore or maintain functioning after a significant threat; and (3) recovery from prolonged or severe trauma when the immediate danger is reduced. The first two definitions of resilience refer to the population of individuals who despite being exposed to CSA demonstrate positive outcomes or show few long-term negative outcomes (Collishaw *et al*., 2007; Marriott *et al*., 2014). The first two definitions provide a clearer understanding of the difference between resilience and recovery, whilst the last definition resembles the description of recovery provided above. The current study adopts the use of the first two definitions of resilience, which reflects previous research (Banyard & Williams, 2007).

PART TWO

Theoretical models of recovery from CSA

Literature surrounding protective factors from CSA and resilience are useful in gaining some perspective regarding the recovery process from CSA (Chouliara *et al*., 2014). Several psychotherapeutic theories and approaches within the general CPTSD literature attempt to describe the process of recovery in adulthood (Courtois & Ford, 2009; Proulx, 2009). Some models relate to a range of different traumas; others are specific to CSA. A majority are based on clinical observations and concentrate on recovery via psychotherapy (Chouliara *et al*., 2014). Therapeutic models alone are prone to over-emphasising the impact of psychotherapeutic factors in recovery and overlook the impact of factors external to the therapy context (Chouliara *et al*., 2014).

A handful of studies have been carried out with adults who have experienced CSA using qualitative methods to explore their perspectives of healing or the recovery process, both inside and/or outside of a therapeutic setting. A majority of these studies have attempted to develop a theoretical model of recovery. To explore these studies in a robust manner a systematic review (SR) was conducted.

Systematic review

Aims and overview

The following section outlines the process undertaken to conduct a SR aiming to uncover the connections among many empirical findings regarding recovery from CSA in adulthood by reviewing, summarising and synthesising available peer-reviewed research knowledge.

To provide structure to Part two of the current chapter it will be split into three core sections:

- **Section a** provides information regarding the SR's overall methodology (meta-ethnography), and search process.

- **Section b** specifies information on the quality review of the SR (quality will be assessed using the Critical Appraisal Skills Programme Qualitative Research Checklist [CASP, 2010] framework).

- **Section c** outlines the synthesis of the SR.

Throughout, key information will be presented in tables for ease of reading. From the detailed review and synthesis undertaken future research directions are communicated and provide part of the rationale for the research question in the current study.

- Section a. -

Method

Meta-ethnography approach

The value of synthesising qualitative research to facilitate effective and appropriate healthcare is growing (Thomas & Harden, 2008). Meta-ethnography, originally developed by Noblit and Hare (1988), is the most widely used approach to integrate qualitative findings (Hannes & Macaitis, 2012) that has been applied to research syntheses in healthcare, particularly for questions relevant to patient experiences (e.g. Campell *et al*., 2003) (Atkins *et al*., 2008). Noblit and Hare (1988) suggest seven non-discrete overlapping steps to conducting meta-ethnography that offers an approach for combining studies akin to methods used to analyse primary qualitative data (see Appendix One). The approach is explicit in terms of how studies are compared and outlines the formation of higher-order constructs from individual research findings; it adopts an objective idealism epistemological stance focusing on commonalities across studies to form a holistic conceptual representation (Noblit & Hare, 1988). Campbell *et al*. (2011) caution that this approach is highly interpretive and requires considerable data emersion. For these reasons a meta-ethnography approach was chosen to answer the following SR question.

Table Four outlines the seven steps suggested by Noblit and Hare (1988) and how these are represented within the current SR. Despite the apparent rigidity of the approach more recently others have cautioned against this in favour of a more flexible stance (Campbell *et al*., 2011). The 'focus of the SR steps' are discussed in more detail at the beginning of each preceding section and incorporate ideas suggested by Campbell *et al*. (2011).

Focus of the SR steps	Noblit and Hare (1988) steps	Description and how communicated (*italics*) in current SR
Identifying literature and assessing the quality.	**Step one** Getting started	Involves choosing an area to explore i.e. developing a SR question, which can be based on previous literature recommendations. *Section a.*
	Step two Deciding what is relevant to the initial interest	Exploring the scope of the review, not always involving an exhaustive SR of the literature, however the current SR did undertake an exhaustive SR using relevant databases. Quality review of the papers selected to answer the SR question using CASP framework. *Section b.*
Synthesis of findings.	**Step three** Reading the papers	All papers that were quality assessed to identify the main concepts. *Section c.*
	Step four Determining how the studies are related	Common reoccurring concepts are identified through creating lists. Concepts are judged as to whether they are similar or contradictory. *Section c.*
	Step five Translating the studies into one another	Key to the meta-ethnographic approach the concepts in the previous stage are translated into each other, which is akin to constant comparison methodology. The outcomes should be considered one possible translation from a number of possible translations. *Section c.*
	Step six Synthesising translations	Interpretations are developed from the translations of the concepts identified to develop third-order constructs. *Section c.*
	Step seven Expressing the synthesis.	Presenting the synthesis in regard to the audience *Section a, b & c.*

Table Four: Outline of seven steps to conducting meta-ethnography (Noblit & Hare, 1988)

Getting started

A brief overview of previous SRs related to the above SR question helped contextualise the current evidence-base and provide a rationale for the decisions made regarding the current SR's focus. Personal correspondence with experts in the field of CSA and recovery were also made to guide the development of the current SR question and identify relevant literature (personal correspondence with Dr Zoe Chouliara, March 2016).

Previous Systematic Reviews (SR) and rationale for current SR question

Conducting a scoping exercise to explore SRs surrounding CSA and recovery (using PsychINFO) revealed two SRs of relevance: Domhart *et al.* (2015) and Draucker *et al.* (2009). Reviewing these two papers provided the basis for the current SR.

In brief, firstly, Domhart *et al.*'s (2015) SR explored protective factors associated with resilience following CSA. This study was deemed non-specific to recovery based on the definition of recovery outlined in the previous section ('What is recovery…'). Specifically, resilience was conceptualised as the absence of psychopathological symptoms and presences of adaptive functioning, thereby focusing on relative resilience. Furthermore, only quantitative studies were included, which is against Roberts and Wolfson (2004) suggestion that subjective and self–evaluative methods of data collection are required to explore experiences of recovery. Of more relevance was Draucker *et al.*'s (2009) meta-synthesis, which specifically analysed qualitative papers exploring sexual violence experienced by adults, as adults or children, in the USA. The essence of healing was described as:

- **Managing memories of the sexual violence:** being able to reach a point when you can control whether you evoke memories related to sexual violence and they do not become overwhelming.

- **Relating to important others:** sexual violence involves the violation of basic trust, therefore there is a need to re-establish relationship boundaries that allowed but also limited the access of others.

- **Seeking safety:** the attempt to learn to take reasonable precautions whilst confronting the inevitable danger, which allows you to create some type of security, there is acknowledgement that the world is never completely safe.

- **Re-evaluating the self:** both trying to rid yourself from the impact of sexual violence, and/or refusing to accept that the experience has had an impact. Overall, it is the ability to repair the damage the experience had caused.

Drauker *et al.* (2009) concluded that the overall synthesis fits with quantitative findings of recovery from sexual violence in terms of types of coping. It extended current knowledge by suggesting that healing factors are not dichotomous (i.e. positive or negative), but rather reflect opposing responses that when synthesised form 'healing'. However, this meta-synthesis was one component of a larger project (e.g. Women's and Men's Responses to

Sexual Violence), which was intended to develop a midrange theory explaining women's and men's responses to sexual violence experienced as an adult and/or child. Thus, some studies reviewed only sampled from a male population and involved people who had not specifically experienced CSA. Overall, neither of the previous SRs explored recovery from CSA in accordance to only women's perspectives. Gaining an understanding of the available literature aided the specificity of the current SR question. Therefore the following SR aimed to answer this question:

How do adult female survivors of CSA describe their experience of recovery from CSA?

Search strategy

The following section outlines the search process applied to retrieve the most suitable research papers to answer the above SR question.

The search strategy for the current SR was informed by the work of Booth (2016). In accordance to published literature on CSA the following five electronic databases were searched in October, 2016 using the search terms outlined below [6] : Web of Science; PsycINFO; CINAHL; EMBASE; and OVID, Medline (Choulier *et al*., 2009; Draucker *et al*., 2009).

Greenhalgh *et al*. (2005) described how within their SR study search only 30% of primary sources were found by using a predefined search strategy. Other methods, such as reference, footnote and citation tracking collected 51% of their final studies to review. Complementary search methods such as this are particularly important to compensate for any deficiencies in retrieval terms (Grayson & Gomersall, 2003; Papaioannou *et al*., 2010). Guidance on meta-ethnography advocates conducting complementary searches alongside topic-based database searching to minimise the risk of missing studies (Campbell *et al*., 2011). Therefore, a variety of search strategies (e.g., footnote chasing, citation searching, author searching, and subject searching) were employed in the current SR until saturation was reached (Dixon-Woods *et al*., 2006; Ogilvie *et al*., 2005; Papaioannou *et al*., 2010). These strategies were also employed on three documents classified as 'grey literature' published in the UK (e.g. Sanderson *et al*., 2015; Smith *et al*., 2015; Sneddon *et al*., 2016). However, Campbell *et al*. (2011) explained that due to the nature of the meta-ethnography approach if one study is omitted from the analysis it is unlikely to have an impact on the overall outcomes.

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[6] Automatic email alerts were set up on each database until March 2017 to notify the researcher when new papers had been published that matched the search criteria. No new relevant papers were identified in this time period.

Search terms

Current Cochrane guidance on qualitative SRs does not specify an appropriate alternative search tool to PICO (Population/problem, Intervention/exposure, Comparison, and Outcome), which is commonly used in SRs drawing on quantitative findings (Noyes *et al*., 2011). Regardless, one alternative suggested is a SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) framework (Cooke *et al.,* 2012). Therefore this structure was used to formulate and focus the literature search.

Main key terms were identified after a scoping search of the above databases, which included 'narrowing' and 'expanding' terms. This was done with the support of a Subject Librarian at Cardiff University. The search strategy involved four layers of search terms combined using Boolean operators (e.g. AND, OR). Table Five outlines the search terms. The search terms within a column were combined in the search using the OR operation, and rows were then combined using the AND operation.

Adult female	Survivors	Recovery	Childhood sexual abuse
Female*	Survivor*	Heal*	Child* abuse, sexual/
Adult/	Victim*	Recover*	Sex* Child* Abuse*
Wom?n	Suffer*		Child* Molestation*
	Adult survivor* of child* sex*		Sex* Maltreatment
	Survivor* of child* sex*		Incest
			Child* sex* assault

*Table Five: Search categories and terms used within search databases to retrieve suitable research papers for the current SR; *- wildcard symbol for search term truncation; ?- Characters converted to spaces in search queries (no translation will be performed); /- MeSH/Subheading combinations.*

Inclusion/exclusion criteria

Following guidance (e.g. Centre for Reviews and Dissemination, 2009; Higgins & Green, 2011) the following inclusion/exclusion criteria were applied. Studies were included if they fulfilled the following criteria:

- *Published in peer-reviewed journal after 1980.*

The cut-off criterion regarding publication year was chosen to reflect observed changes in publication rates focus, as well as theoretical and clinical developments in the area in the last 30 years (Chouliara *et al*., 2014).

- *Published and disseminated in English.*

This was due to the limitations in language speaking expertise of the researcher, and the lack of translation resources available.

- *Explored recovery from CSA in adulthood.*

Recovery was defined in accordance to Part one's section 'What is recovery?'. Studies exclusively focusing on recovery within therapy that explored how the specific therapeutic approach had an influence on a specific area of life, e.g. identify, were excluded. This was decided based on the recent SR conducted by Parry and Simpson (2016) who explored the influence of talking therapies (discussed in detail in 'Survivors perspectives of mental health services').

Childhood sexual abuse was defined in accordance to Part one's description of CSA.

- *Included an adult female survivors perspective.*

Adult female survivors' perspectives were classified as any qualitative data obtained through the researcher directly seeking their thoughts as opposed to professional's perspectives of survivor's thoughts. If only male's perspectives were used then the paper was excluded.

- *Adopted a qualitative methodology.*

Qualitative studies were defined as studies derived from "empirical research with human participants conducted in any research paradigm that used what are commonly viewed as qualitative techniques for sampling, data collection, data analysis, and interpretation" (Sandelowski & Barroso, 2002, p. 154).

If a mixed methods study met all the above inclusion criteria, and the qualitative methodology could be separated from the quantitative elements of the study, then this study was included (Centre for Reviews & Dissemination, 2009). This was a similar approach taken by Domhart *et al*. (2015) and Drauker *et al*. (2009).

Search process

After conducting the searches across the specified databases a total of 2,984 articles were identified. Mendeley Desktop was used to organise the search process. Word documents were also created to save references that were of relevance but did not fit the SR inclusion criteria. Before the researcher reviewed the titles and abstracts of articles identified all duplicates were removed (1,020). Articles were excluded at this stage for obvious violations of the inclusion criteria including: unrelated subject matter, papers other than original research. 330 papers remained after this process.

Some articles remained due to the information in the abstract not allowing suitability to be determined, or because no abstract was immediately accessible. After reviewing the abstracts, and excluding inappropriate papers (274), 56 full texts were then reviewed. Appendix two outlines the notes made during each exclusion stage, and detail the reasons for excluding papers.

Hand searching of the five included studies and relevant grey literature identified three additional potential studies. The reference lists of the SR detailed above were also reviewed, but no additional studies were found. Figure One outlines the search process described.

Web of Science (*n* = 931)	OVID, Medline (*n* = 1009)	PsychINFO (*n* = 210)	EMBASE (*n* = 748)	CINAHL (*n* = 86)

Identification

Screening

Articles found through electronic databases (*n* = 2,984)

Duplicate publications (*n* = 1,020)
Excluded by title review (n = 1,634)
Excluded abstract review (*n* = 274).

See Appendix two

Eligibility

Full text articles retrieved for review (*n* = 56)

Excluded by full-text review (*n* = 51)

See Appendix two

Included

Articles retained (*n* = 5)

Additional articles found through reference searching (*n* = 3)

Articles included in systematic review (*n* = 8)

Figure One: Outline of the search process conducted to selected research papers for SR.

Summary of the research papers reviewed

A detailed summary of each study included in the SR can be found in Appendix three. References for the studies included in the review can be found in the overall reference list, they are highlighted by an *.

Section b. -

Assessing research quality

The following section outlines an assessment of the quality of the research papers found in the search process. A critical appraisal of the quality and credibility of the research findings were conducted for all eight studies identified. Checklists can play an important role in suggesting the quality of qualitative research and in convincing potential sceptics of its 'thoroughness' (Hoddinott & Pill, 1997; Popay *et al*., 1998; Seale & Silverman 1997). A variety of checklists have been developed to assess quality in qualitative research, however there is no consensus to 'what makes a good study' (Murphy *et al*., 1998; Toye *et al*., 2014) or whether a study should be excluded due to not meeting a certain standard (Daly *et al*., 2007; Dixon-Woods *et al*., 2006; Sandelowski, 2006). The CASP (2010) was selected to appraise the studies in the current SR due to its clarity, and recommended use in public health practice (Ciliska *et al.,* 2008) (The CASP, 2010, criteria used are presented in Appendix four).

The CASP contains a 10-item checklist to review studies. It begins with two screening questions that enquire whether the aims are provided and whether a qualitative methodology was appropriate. Eight questions considering the sampling strategy, data collection, researcher's reflexivity, ethical issues, data analysis, findings, and the value of the research then follow. The studies were scored for each item to give an indication of overall quality. Two independent raters (Trainee Clinical Psychologists) obtained the study's quality scores. Boland *et al*. (2014) recommend that an independent rater should rate 20-25% of selected studies for a SR. When a disagreement arose in rating for the current review an agreement was reached through discussion and a final agreed rating was given.

The CASP does not have a scoring matrix, or a cut-off point to establish the overall quality rating. Moreover, there are no accepted, or empirically tested methods for excluding qualitative studies from syntheses on the basis of their quality (Carroll & Booth, 2015; Daly *et al*., 2007; Dixon-Woods *et al*., 2006; Popay, 2005). Some suggested that scoring is a useful means of comparing and contrasting the studies' quality (Chenail, 2011). Therefore the 10-items on the checklist were rated with either a score of 'zero' (no reported adherence), 'one' (indicator partially fulfilled) or 'two' (criteria met). Thus, studies were allocated an overall score between zero and 20.

Some suggest that checklists for qualitative research should be used in a reflective manner rather than prescriptive (Miller & Dingwall, 1997). Barbour (2001) discusses such concerns,

and suggests 'technical fixes' to confer rigour on qualitative analysis appropriately (see Table Six). As others recommend that SR syntheses should include a discussion regarding the studies' impact on the data synthesis based on the results of the CASP (Thomas & Harden, 2008) this table was referred to throughout the SR. However, it was likely that studies that came up short on the quality ratings were those studies with fewer details regarding the methodology adopted and shorter description of the results. Therefore, the methodological shortcomings of a study were likely to emerge during synthesis that follows.

Technical fix	Concerns addressed	Realistic potential
Purposive sampling	Bias	Enhancing sample coverage and providing a framework for analysis
Grounded theory	Original Theorising	Developing existing theory, or occasionally new theories. Refining interpretations or coding frameworks
Multiple coding	Inter-rater reliability	Refining interpretations or coding frameworks
Triangulation	Confirmation or refutation of internal validity	Corroborating or, more often, refining findings
Respondent validation		

Table Six. 'Technical fixes' detailing how rigor should be explored within the epistemological stance of qualitative research approaches (Barbour, 2001).

Quality review

The quality review for all studies is presented in Table Seven. In summary, the quality of each study varied. No study achieved the maximum score of 20. One study received a quality score of 18 (Chouliara *et al*., 2014); two studies scored 17 (Arias & Johnson, 2013; Banyard & Williams, 2007), two studies scored 15 (Draucker, 1992; Draucker *et al*., 2011), one study scored 13 (Anderson & Hiersteine, 2008), one study scored 11 (Glaister & Abel, 2001), and the remaining study scored 10 (Godbey & Hutchinson, 1996). The following provides a narrative of Table Seven. A summary highlighting the gaps in the literature identified through conducting the quality review is then provided.

Study	1) Aims *Was there a clear statement of the research aims?*	2) Methodology *Is a qualitative methodology appropriate?* If 1 & 2 were satisfied then the study quality was reviewed.	Design *Was research design appropriate to address research aims?*	Recruitment *Was recruitment strategy appropriate to address the research aims?*	Data Collection *Was the data collected in a way that addressed the research issue?*	Reflexivity *Has the relationship between research and participants been considered?*	Ethics *Have ethical issues been taken into consideration?*	Data Analysis *Was the data analysis sufficiently rigorous?*	Findings *Is there a clear statement of findings?*	Value of research *Does the research discuss the contributions of research?*
Draucker (1992) **15/20**	Clear aim, importance and relevance noted in relation to existing literature	**Yes:** Aim to generate a descriptive theoretical framework of the healing process of female adult survivors of incest based on the perceptions of those who had experienced some degree of healing.	Design based on techniques from grounded theory methodology, some explanation given. No rationale for methodology given.	Recruitment method transparent, no reasons for sampling method identified. No exclusion criteria stated.	Interview method described and justified. Interviews audio taped and transcribed	Relationship between researcher and participant, including role bias not discussed.	The use of informed consent was mentioned. Ethical considerations were not discussed further. Ethical approval was not reported.	Clear and transparent description of analysis process. Quotes used to illustrate findings	Findings are explicit and discussed in relation to research question. Credibility discussed via triangulation.	Implications for practice identified. Areas for future research considered.
	(2)	**(2)**	**(1)**	**(1)**	**(2)**	**(0)**	**(1)**	**(2)**	**(2)**	**(2)**
Draucker *et al.* (2011) **15/20**	Clear aim, importance and relevance noted in relation to existing literature.	**Yes:** Aim to generate a theoretical framework of the healing process from five frameworks previously created from a wider qualitative research project	A design based on constructivist grounded theory methods was used in for the study. Description of this was provided. A rationale for this approach was also provided, i.e. its systematic approach.	Recruitment methods were transparent. Reasons for sampling method were identified. No exclusion criteria stated.	Interview method described and justified. Interviews audio taped and transcribed.	Relationship between researcher and participant, including role bias not discussed. The occupations of the researchers' were identified.	Ethical considerations were not discussed. Ethical approval was reported.	Clear and transparent description of some analysis process. Limited quotes used to illustrate findings; described as exemplars.	Findings are explicit and discussed in relation to research question. Some credibility was discussed in relation to multiple researchers.	Implications for practice identified. Areas for future research considered.
	(2)	**(2)**	**(2)**	**(1)**	**(2)**	**(1)**	**(1)**	**(1)**	**(1)**	**(2)**

Chouliara et al. (2014) 18/20	Some confusion regarding the aim of the study; two have been noted although no discussion of which one is primary. The importance and relevance of both are noted in relation to existing literature. **(1)**	**Yes:** The aim was explore the lived experiences of survivors of CSA. **(2)**	Design based on techniques from Interpretative Phenomenological Analysis (IPA) methodology, some explanation given. Rationale for methodology given. **(2)**	Recruitment method transparent and rationale provided, inclusion and exclusion criteria provided. **(2)**	A clear description and rationale of how the data was collected was provided. The use of field notes was discussed. A clear rationale was given to why the critical incident technique was used although bias in accordance to an IPA epistemology was not discussed. **(1)**	Relationship between researcher and participant, was described as taking place during the development of field notes. The field notes were described as being used during analysis. **(2)**	Ethical considerations were discussed and principles of sensitive interviewing in health settings were followed. Ethical approval was reported. **(2)**	Clear and transparent description of analysis process was provided. Quotes used to illustrate findings throughout. **(2)**	Findings are explicit and largely discussed in relation to one of the research questions. Credibility was discussed. **(2)**	Implications for practice and research were identified. Areas for future research considered. **(2)**
Arias & Johnson (2013) 17/20	There is no aim(s) clearly stated within the methodology. Aim is mentioned in the abstract. The importance and relevance of exploring healing from CSA was noted in relation to existing literature. **(1)**	**Yes:** As the aim was to compliment a previous qualitative study that aimed to develop a theoretical model of recovery/healing from CSA. **(2)**	A design was based on grounded theory approaches. The design was clearly described and justified. **(2)**	Recruitment method transparent and rationale provided, inclusion and exclusion criteria provided and rationales given. No definition was given to CSA and participants defined this themselves. **(1)**	A clear description and rationale of how the data was collected, and the form of the data were provided. The researcher discussed saturation and the use of follow-up interview. **(2)**	Relationship between researcher and participant, was described through a bracketing statement for both researchers. The use of this was also discussed. **(2)**	Ethical considerations were made in terms of describing informed consent and research procedures. Ethical approval was granted from the university. **(2)**	Clear and transparent description of analysis process was provided. However, whether this analysis was appropriate is questionable. Quotes used to illustrate findings throughout. **(1)**	A clear statement of the findings were presented. The relationship between themes were described. Credibility checks were considered in detail. **(2)**	Implications for practice and research were identified. Areas for future research considered. **(2)**

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Godbey & Hutchinson (1996) 10/20	There is no aim(s) clearly stated within the methodology. Aim is mentioned in the abstract. Only explained that the present study attempted to contribute to knowledge in the area of healing from incest. **(1)**	**Yes:** As the researchers sought to explore the subjective experience of healing from incest from survivors perspectives. **(2)**	The design was grounded theory although there was no discussion regarding the justification for this choice. **(1)**	The recruitment strategy was not transparent. Inclusion and exclusion criteria were provided but no rationale for why. No discussion was provided regarding why participants were selected. **(1)**	A brief description of how the data was collected, and the form of the data were provided. The researcher did not discuss saturation. There was no justification for the methods used. **(1)**	Relationship between researcher and participant was not described in any detail. **(0)**	Ethical considerations made in terms of describing the support available to participants. Information regarding informed consent and research procedures were not included. Ethical approval was granted from the university. **(1)**	A brief outline of the analysis was provided. Quotes were used in most instances to illustrate findings. No consideration for the researchers bias. **(1)**	A statement of the findings were presented. The researchers did not explain how the findings represented a model despite stating they formed a model. The relationship between themes was described. Credibility checks were considered. **(1)**	Brief discussion regarding the application of the findings. Future research stated. **(1)**
Glaister & Abel (2001) 11/20	The aim was outlined as a study that describes the healing process of CSA from the perspectives of women who feel they have achieved some measure of success in healing from CSA. **(2)**	**Yes:** The researchers aimed to give voice to the women who experienced CSA and to allow them to describe their experience. **(2)**	The design was based on Denzin's qualitative method of interpretive interactionism. Justification for this approach was given. **(2)**	The recruitment strategy was not transparent or clear. Where the final sample had been recruited was unclear. Inclusion and exclusion criteria were not provided. No definition of CSA was stated. No definition for a 'measure of healing' was explained. No exclusion criteria were described. **(1)**	No details were provided regarding how the data was collected. **(0)**	Relationship between researcher and participant was not described in any detail. **(0)**	No details were provided regarding ethical considerations or gaining ethical approval. **(0)**	Strategies to maintain scientific rigor were discussed. No discussion regarding the analysis process. Data was presented to support the findings. **(1)**	A clear statement of the findings was provided. Creditability was discussed. **(2)**	Implications of the findings were described. No application to future research was made or to current policy. How applicable the results are to other populations was unclear. **(1)**

	Research aims	Rationale	Justification	Recruitment	Data collection	Relationship	Ethical considerations	Data analysis	Statement of findings	Implications
Banyard & Williams (2007) 17/20	A clear statement of all the research aims were provided. There was a clear separation between the quantitative and qualitative research aims. **(2)**	**Yes:** A clear rationale to why a mixed-methods approach was adopted was provided. **(2)**	Justification to why a qualitative methodology was used was explicit and supported by relevant evidence. **(2)**	The recruitment strategy to the sub-sample who completed the qualitative section was explained in context to the wider quantitative sample. Reference was given to where to find additional information regarding the wider sample. There was mentioned of why the sub-set was selected. **(2)**	Clear description of the data collection and rationale given. **(2)**	Relationship between researcher and participant was mentioned in terms of using the wider research team to assess the data interpretation trustworthiness. Those who analysed the data were mentioned. There is no explicit critical examination of the researchers role. **(1)**	There is no mention of ethical considerations within the paper. Whether ethical approval was sought was not detailed. **(0)**	An in-depth description of the data analysis was provided. The influence of contradictory cases was stated. There was discussion surrounding steps taken to maintain trustworthiness of the analysis. **(2)**	There was a clear statement of the findings that was separated from the quantitative findings. Creditability was discussed (i.e. trustworthiness). **(2)**	Implications of the findings were described. The application of the findings to future research was made. Limitations were discussed in terms of the sample. **(2)**
Anderson & Hiersteine (2008) 13/20	Clear statements of all the research aims were provided. **(2)**	**Yes:** A clear rationale to why a qualitative approach was adopted. **(2)**	Justification to why a qualitative methodology was used was explicit and supported by relevant evidence. **(2)**	Recruitment strategy and rationale were described. No definition of CSA was stated. No exclusion criteria stated. **(1)**	Clear description of the data collection and rationale given. **(2)**	Relationship between researcher and participant was not described in any detail. **(0)**	Ethical considerations were discussed. Whether ethical approval was sought was not detailed. **(1)**	Data analysis was presented with an in-depth description. Use of evidence to support findings. No discussion of the researchers role and bias. **(1)**	Clear statement of findings. No discussion surrounding credibility. **(1)**	Discussion of the implications in terms of clinical application within therapy. No discussion on future research. **(1)**

Table Seven. Results from the CASP analysis of the studies selected for the current SR.

Research aims, methodology and design

A majority of the studies provided a clear statement of their research aims, whilst some vaguely described their aim as 'extending current knowledge' within the field of recovery from CSA (Arias & Johnson, 2013; Godbey & Hutchinson; 1996). One study presented two aims with no discussion regarding which one took precedence. However, the importance and relevance of both were noted in relation to existing literature (Chouliara *et al*., 2014). All studies justified their aims in terms of relevance to literature and practice. Qualitative methodologies were appropriate in meeting the study's aims and intentions of gathering survivor's narratives. However, the rationale for choosing specific qualitative methodologies were not reported or discussed for two of the studies (Draucker, 1992; Godbey & Hutchinson, 1996). Although, Banyard and Williams (2007) used mixed methods to capture the process of recovery, the need to adopt this methodological approach was described.

Recruitment and data collection

Purposeful sampling is used in qualitative research, but the methods adopted should be clearly described. Only two studies explicitly reported the sampling method. One was Godbey and Hutchinson (1996) who used a snowballing technique, and the other was Anderson and Hiersteine (2008) who adopted a convenience sampling approach. The vagueness of the sampling approaches may reflect the difficulty surrounding recruitment in sensitive research areas (Veenema *et al*., 2015). Limitations also arise from a sampling bias, which occurs as a consequence of clinicians working within the research site, but outside of the research project, managing the recruitment process. Whilst it is recognised that it would be unethical for researchers to make the initial approach to potential participants, clinicians may have selected participants whose experiences were particularly positive *or* negative, thus such perspectives may be biased towards either extreme. Additionally, clinician's availability and motivation to aid recruitment may have added to this bias.

The depth of information other studies provided regarding participant recruitment varied. For instance, Arias and Johnson (2013) describe sampling from a university campus to ensure a sample that achieved some degree of healing (measured through working at a higher education level). Chouliara *et al*. (2014) explained their need to recruit from community samples and through mental health professionals to capture a range of experiences, however they excluded those who 'recently' experienced mental health difficulties, which possibly limited their range. On the other hand, Drauker (1992) gave a rationale to why only women were recruited, but did not explain why she sampled from community and mental health settings. Godbey and Hutchinson (1996) failed to provide any details regarding where their

sample was from, but made reference to all their participants having access to a professional counsellor or support group. Similarly, Glaister and Abel (2001) detailed the geographical location of where the sample were recruited, but did not identify the setting they were recruited. This seems an important missing detail for this study as they wished to represent women who believed they achieved some degree of healing making it difficult to establish what this entails. Two studies recruited participants from a sample of participants from larger studies (Banyard & Williams, 2007; Drauker *et al*., 2011). Rationales for selecting these participants were provided. Banyard and Williams (2007) also identify how many people within their study answered specific questions that resulted in a narrative that formed a theme. Therefore, their overall reported sample size may not be a true representative of the sample that were asked a particular question.

Generally, descriptions of the samples within the studies were poorly defined. Inclusion and/or exclusion criteria were only reported in four studies (Arias & Johnson, 2013; Banyard & Williams, 2007; Chouliara *et al*., 2014; Godbey & Hutchinson; 1996). Only two studies failed to report demographic information regarding gender, age, and ethnicity (Chouliara *et al*., 2014; Godbey & Hutchinson; 1996). Other criteria documented were: marital status, religious affiliation, occupation/employment status, characteristics of abuse (including perpetrator characteristics), number of children, education level, poly-abuse/poly-victimisation, mental health difficulties, physical health conditions, incarceration history. There was little agreement to what demographic data should be collected to situate the sample; information collected appears to be led by what is gathered within quantitative research regarding CSA.

None of the studies mention reaching theoretical saturation regarding their sample sizes, and small sample sizes were described as a limitation in all of the studies. Given that the stated intentions of the research were to give a voice to people who have experienced abuse, or gain a detailed understanding of the recovery process than to present generalizable conclusions, sample sizes across all studies were deemed appropriate.

All but one of the studies utilised face-to-face interviews as the method of data collection. Glaister and Abel (2001) describe adopting a naturalistic approach to data collection although it was unclear what this specifically entailed. Another study, although conducted face-to-face interview did so in a group setting (Anderson & Hiersteine, 2008). The presence of others whilst discussing the recovery process may have biased narratives. A common challenge in groups is to ensure that both reticent and gregarious participants have an opportunity to be heard. The facilitator of the focus group must be skilled in group process and interviewing

techniques, but the interviewers background was not discussed. However, this approach provides another context in which the data was collected, and this environment is common for people who have experienced abuse and who have accessed support. Four studies obtained data through conducting semi-structured interviews (Arias & Johnson, 2013; Banyard & Williams, 2007; Drauker *et al.*, 2011; Godbey & Hutchinson, 1996). Draucker *et al.* (1992) was the only researcher to conduct an unstructured interview. Chouliara *et al.* (2014) conducted their interviews through the use of a critical incident interview framework. Rationale for this approach was discussed, however this seemed to conflict the data analysis epistemology (Interpretative Phenomenological Analysis [IPA]) they used due to its inductive stance unlike semi-structured interviews.

Reflexivity

Researcher reflexivity was an aspect of quality lacking in a majority of the studies reviewed. Four of the studies failed to report on reflexivity entirely (Anderson & Hiersteine, 2008; Drauker, 1992; Glaister & Abel, 2001; Godbey & Hutchinson, 1996). Only one study provided a bracketing statement regarding the researcher's subjective values and/or biases (Arias & Johnson, 2013). Other studies reviewed either provided details regarding the occupation of the researchers (Drauker *et al.,* 2011), discussed how field notes documenting the researcher's thoughts throughout the interviews were used during the data analysis (Chouliara *et al.*, 2014), or provided details surrounding the process of improving the study's trustworthiness through consulting colleagues on their analysis (Banyard & Williams, 2007). Therefore, the credibility of findings from all studies aside from one can be brought into question.

Ethical considerations

Studies that noted they had sought ethical approval had done so through university ethics committees (Arias & Johnson, 2013; Chouliara *et al.*, 2014; Drauker *et al.*, 2011; Godbey & Hutchinson, 1996). This could reflect the samples recruited for the research, and could reflect the lack of participants who received support from statutory services.

Despite the absence of reported ethical approval, considerations concerning informed consent were reported by some (Anderson & Hiersteine, 2008; Drauker, 1992). Banyard and Williams (2007), and Glaister and Abel (2001) also failed to report any considerations of ethical standards. Only Chouliara *et al.* (2014), and Godbey and Hutchinson (1996) took into account the sensitive nature of the interviews and discussed steps taken to overcome such

issues, for example, discussing the support available for participants and using methods of sensitive interviewing.

Data analysis

Descriptions of data analysis were clear and detailed in six of the studies (Anderson & Hiersteine, 2008; Arias & Johnson, 2013; Banyard & Williams, 2007; Chouliara *et al*., 2014; Draucker, 1992; Draucker *et al*., 2011). Glaister and Abel (2001) failed to acknowledge the analysis process they adopted, and Godbey and Hutchinson (1996) only provided a brief outline of their strategy. A majority of studies analysed their findings through Grounded Theory methodology. Other methodologies used were: IPA (Chouliara *et al*., 2014), and Denzin's qualitative method of interpretative interactionism (Glaister & Abel, 2001). The level of interpretation within the analysis varied considerably, for example, Banyard and Williams (2007) chose a highly descriptive account of their qualitative findings. This may have been due to the study also drawing on quantitative findings and this level of interpretation may have been more appropriate.

Quotes from participants were used to support findings in all studies; however the quantity used to illustrate themes varied. A majority of the studies did not state whom the quote belonged to; quotes were used to support interpretations but little inference could be made regarding how representative these interpretations were to the study population. Therefore, it was unclear whether all participants' voices were 'heard'. Failing to report 'who said what' does not allow the reader to explore the similarities and/or difference between the sample's narratives (Elliott *et al.,* 1999). Only one study identified who said a particular quote that supported an interpretation, however the quotes used were not rich, although did provide details regarding contradictions within the narratives (Glaister & Abel, 2001). Some used quotes within 'exemplars' that were essentially case studies that situated a person's experience to illustrate a particular stage within a model. Again, the narratives were not rich and more focus was on the author's description of the person (Draucker *et al*., 2011). Overall, there was a lack of 'thick' description of participant's narratives, which was in contrast to the ethos of promoting CSA survivor's voices.

Triangulation and/or credibility checks were discussed in all but one of the studies (Anderson & Hiersteine, 2008). Quality assurance was largely dominated by having more than one research analyse the data or peer debriefing (Arias & Johnson, 2013; Banyard & Williams, 2007; Chouliara *et al*., 2014; Draucker, 1992; Draucker *et al*., 2011; Glaister & Abel, 2001; Godbey & Hutchinson, 1996); and conducting some variation of responded checks (Arias &

Johnson, 2013; Draucker, 1992; Glaister & Abel, 2001; Godbey & Hutchinson, 1996). Other methods discussed were conducting disconfirmatory case searches; obtaining rich data sets; comparing results with other quantitative and qualitative outcomes (Banyard & Williams, 2007); and triangulation of multiple data sources (e.g. reflective notes) (Banyard & Williams, 2007; Chouliara *et al.*, 2014). All were used in accordance to Barbour's (2001) conceptualisation of understanding rigour.

Findings and outcomes

Despite reporting the use of Grounded Theory methodology two studies did not report on a theory or model produced by their findings (Arias & Johnson, 2013; Banyard & Williams, 2007). Instead they produced more of a descriptive account of what was found. Furthermore, the analysis does not seem appropriate; especially for Arias & Johnson (2013) who describe capturing people's 'lived experiences', in which case IPA would have been a more suitable analysis (Smith & Osborn, 2008). This is a methodology adopted by Chouliara *et al.* (2014) although whether this was an appropriate approach to devise a theoretical model is questioned by the current researcher. Furthermore, their data collection and analysis approaches epistemological stance do not match. Some researchers adopting Grounded Theory approaches invite us to trust that the theory somehow emerges from the data without being offered a step-by-step explanation of how theoretical insights have been built up. For example, within Draucker *et al.*'s (2011) model it was particularly unclear where the rationales for the five domains of functioning within each stage of recovery were drawn from. Although some studies failed to report the analysis process undertaken, poor methodological reporting does not equate with poorly conducted research (Atkins *et al.,* 2008). This highlights one of the reasons why all studies were included in the synthesis regardless of their overall 'quality rating'.

All papers were judged to have contributed unique and valuable findings to the limited literature base. All of the studies reported their findings in relation to the original aims of the research and related outcomes to relevant literature. Some of the studies also drew upon policy and service provision to discuss clinical relevance, and some outlined future research directions that should be considered. A synthesis of the findings can be found below.

Quality review summary and critical reflection

The studies selected for the current SR all met the screening criteria to be reviewed in full using the CASP. Although each of the study's aims varied in clarity all provided rationales and justifications for conducting the research. Generally, authors explained that there was a lack of research within the area of CSA and recovery, especially research promoting survivors' voices. In line with qualitative approaches (see Table Six suggested by Barbour, 2001), sampling methods used seemed purposeful, which may also relate to recruitment difficulties. However, this was only speculation drawn from other literature rather than rationales provided within the studies reviewed.

All studies aimed to recruit women who had experienced some degree of recovery. Healing was largely measured through either clinician judgement, as they were prominent 'gatekeepers' within the recruitment process, or the participants status i.e. students of higher education. As all ethical approval committees documented were associated to universities, this may represent a different population sample than those recruited from statutory services. It is unclear from the sample descriptions what mental health services people had received in the past. Although some studies recruited from larger samples initially recruited for broader topic areas, such as sexual violence, Chouliara *et al*. (2012) discuss within their SR the difficulties of this approach within the CSA literature. Future studies would benefit from situating samples in more depth, and recruiting from a variety of population, such as statutory services. As a whole the recruitment processes adopted were poorly defined and lacked specific inclusion and/or exclusion criteria. Although a variety of demographic information was collected, the rationales for why certain information was prioritised was un-clear; there is no agreement of what information is needed to suitably situate the sample.

Few studies detailed their efforts to position those conducting the interviews or analysing the data collected. Furthermore, the credibility checks used varied. Both, may be related to the editorial constraints of the journals in which the studies were published and in particular word limits, which are generally set according to the needs of quantitative studies (Sibeoni *et al*., 2017). Or it may be due to the lack of clarity surrounding what should be favoured within qualitative research approaches. Effort should be made to provide such details to improve methodological robustness.

Within the reviewed literature there seemed a lack of research undertaken in statutory services. This may reflect the difficulty gaining approval for this research within such environments, or the value placed on conducting such research. Despite some of the studies

outlining sensitive nature of the research, and the vulnerability of the sample, there was a lack of discussion surrounding support strategies taken to facilitate this research. This lack of insight may impact decisions to conduct similar research, further hindering the development of the literature within the field, and therefore is an ethical issue.

A majority of the studies adopted an objective idealism epistemological stance within their data analysis. Grounded Theory techniques dominated the choice of analytical approach chosen to either create, synthesise or to extend theory to aid understanding of the recovery process and to implement this knowledge to practice. 'Practice' was largely in relation to nursing, although there was some application to a variety of practices across professions. The fact that CSA does not fall into one particular discipline has been discussed previously (Finkelhor & Araji, 1986) and has caused problems in communication between the disciplines.

Overall, at times it was felt that appraising the studies became an exercise in judging the quality of the written report rather than the research procedure itself (Atkins *et al*., 2008; Sandelowski & Barroso, 2002). Studies published in qualitative-oriented journals were easier to evaluate because the length of the articles allowed authors to elaborate on the research process (Campbell *et al*., 2003; Jones, 2004). Research suggests that quality reviews of qualitative studies often produce variable results and there is disagreement to whether 'lower quality' studies should be included in the synthesis (Dixon-Woods *et al*., 2007). Thus, despite some studies seeming to lack scientific rigor in comparison to others this should be understood within the context of the nature of publication restrictions for qualitative papers. Finally, the data included in the SR was derived from peer-reviewed research only. No reference was made to grey literature; therefore there is the risk of publication bias. Although further synthesis of such data would be a challenging task it may have added a valuable critical step.

- Section c. –

Synthesis of study findings

The following section outlines the meta-ethnography stages three to six suggested by Noblit & Hare (1988) (see Table Four) to provide insight into how adult female survivors of CSA describe their experience of recovery from CSA. This process began by repeatedly reading and noting the key concepts (interpretive metaphors) discussed within the findings and discussions of each paper identified above. The key concepts were treated as 'raw data', and considered one possible translation. In order to increase the transparency of this process the researcher created a table identifying the concepts (refer to Appendix five). Once the key concepts were identified they were systematically examined in relation to each other using a constant comparison methodology (Charmaz, 2006). This process began using Choulaira *et al*.'s (2014) study as an index paper due to its overall relatively high quality rating (see Pope *et al*., 2007; Campbell *et al*., 2011). Studies with a greater quality rating were positioned earlier in the analysis and their findings were weighted more heavily within the synthesis. To aid this process a table was created to enable the researcher to easily see any possible connections (Appendix five) (Campbell *et al*., 2003). This allowed the researcher to develop an understanding of how the data between studies were similar or different from one another.

Once the researcher developed greater understanding of the relationship between the studies' findings categories of shared meanings were developed. Whilst attempting to preserve and maintain the integrity and context of the original research the synthesis began with an attempt to make sense of the list created. Three processes have been specified to facilitate this: 1) line of argument; 2) reciprocal translation; and 3) refutational translation (Noblit & Hare, 1988; Schutz, 1962). Due to the nature of the studies' findings the idiomatic process of reciprocal translation (themes across studies were compared and matched) was used, which led to the development of new interpretations of existing, original interpretations. Although Campbell *et al.* (2011) stated that if one study is omitted it is unlikely to have an impact on the overall outcome the researcher continuously held in mind whether the conclusions made were supported by sufficient evidence.

Within meta-ethnography Schutz (1962) presents the terms first, second and third order constructs. First-order constructs are key concepts true to context with quotes from original participants. Second-order constructs are interpretive themes developed by the original researchers. Finally, third-order constructs are those derived from the synthesis of the findings

between studies; they are new constructs developed from the researcher conducting the meta-ethnography. Third-order constructs move the original findings to a higher level of understanding. Within the current synthesis third-order constructs are described as superordinate, and subordinate constructs. The researcher decided to focus on second-order constructs to devise superordinate and subordinate constructs for the current synthesis in accordance to seminal published examples (Britten *et al*., 2002; Campbell *et al*., 2003; Toye *et al*., 2014). In regards to labelling the concepts, the researcher aimed to use terminology that encompassed the most relevant and prevalent themes to attempt to answer the SR question.

Expressing the synthesis

The following section outlines step seven of the meta-ethnographic approach 'expressing the synthesis' suggested by Noblit & Hare (1988).

The synthesis of the findings from the studies selected for the SR fell into the following superordinate constructs:

- The recovery process
- Factors hindering recovery
- Factors enhancing recovery
- How the current self is understood

A number of subordinate constructs were identified within these superordinate constructs that will be described below. Table Eight describes the overall, third-order/superordinate and subordinate concepts development. Figure Two provides a diagrammatic representation of the concepts. There are no consistent methods to report the meta-ethnographic synthesis findings. Reference has been made to Parry and Simpson's (2016) recent qualitative SR regarding how adult survivors of CSA experience formally delivered talking therapy when deciding how to present the narrative of the synthesis. The current study chose to use quotes from the studies synthesised to evidence the concepts. Due to variability of the use of quotes between the papers (see 'Quality review' above) some studies were not quoted as often as others.

	Superordinate concepts			
	The recovery process	*Factors hindering the recovery process*	*Factors enhancing the recovery process*	*How the current self is understood*
Subordinate concepts	***On-going challenge*** ***Oscillating*** (Back and forth process)	***Other's responses to disclosure***: lack of empowerment, secrecy, reductionist, dehumanising, not believed ***Beliefs and coping developed during CSA***; shame, avoidance, protecting others	***Turning points***; realisation/recognition of inner resources Supportive, unconditional, secure ***connections with others***; family, friends, religion spirituality, other survivors > influencing motivation and determination ***Understanding the abuse*** as an adult in a safe environment; role of blame, guilt ***Forgiveness*** of self and perpetrator ***Disclosure***	***Acceptance*** of self and experience ***Compassion and empathy*** for self and other Empowered to develop **inner resources** and develop purpose ***Reduced shame and guilt***

Table Eight. Overall, third-order superordinate and subordinate concepts derived from the meta-ethnography synthesis. Text in bold and italics represents subordinate themes.

The recovery process

On-going challenge

Oscillating

Factors hindering recovery

Others responses to disclosure

Beliefs and coping developed during CSA

Factors enhancing recovery

Turning points | *Connections with others* | *Understanding the abuse* | *Forgiveness* | *Disclosure*

How the current self is understood

Acceptance | *Compassion and empathy* | *Inner resources* | *Reduced shame & guilt*

Figure Two: Diagrammatic representation of the superordinate and subordinate concepts from the SR synthesis.

The recovery process

The motion of the recovery process was reported by a majority of studies. From the findings it was clear that recovery was described as a long-term, on-going process requiring continuous work with no guarantee of a 'storybook' ending. Some authors suggested that this process occurred in stages that people can move between. Due to the continuous nature of recovery a majority of participants within the studies challenged the notion of ever removing the impacts of their experience, and therefore challenged the notion of recovery when it referred to being a 'cure'.

"It's backwards, forwards, backwards until you finally get it. . .. To get over it and fix the patterns and behaviors."
Glaister & Abel (2001) p. 190

"It really hurt me to be violated like that. . . . All this, all this. . . . Even though I am 62 years old, all this is still in my mind. It [the power of the CSA to ruin her life] never goes away"
(grappling).
Draucker *et al*. (2011) p. 450

"I wanted it fixed yesterday. I've realised that it's going to take years of work because there's years of damage."
Chouliara *et al*. (2014) p. 74

"I don't think anyone is actually FULLY recovered . . . I think it's a lifelong process in which you just, you might find other ways of being able to deal with it."
Banyard & Williams (2007) p. 285

To emphasise that the nature of the process of recovery from CSA was different from other trauma experiences some drew comparisons with recovery from physical illnesses.

"I don't think you can ever be healed. If you were in an accident and your right arm was cut off, you're never going to get that arm back, but you will learn to go on and manage. It doesn't mean that you can't have a good life. It's just that it's always going to be there."
Anderson & Hiersteiner (2008) p. 418

The process of recovery was detailed as a particularly challenging, arduous, taxing and painful experience. Being faced with the difficulties they had hidden for many years placed them in a place of vulnerability.

"Extremely painful. . .times when you won't feel like living."
Glaister & Abel (2001) p. 190

"I had built up around that and kept in place over the years, it's scary to let all of that go and be more vulnerable."
Godbey & Hutchinson (1996) p. 308

The process was largely perceived as active, rather than passive. Although some suggested that at times the best thing to do was to adopt a passive role due to the difficulty of the struggle.

"When I first came into treatment, I thought okay I am going to work really hard on this and in a year's time it's going to be wrapped up in a package with a bow on top. And I can go on with life. And when it didn't, I fell into the pits of despair."
Anderson & Hiersteiner (2008) p. 418

"Difficult to live through flashbacks, only thing I can do is to ride them out."
Godbey & Hutchinson (1996) p. 308

Factors hindering recovery

The second concept described aspects of an individual's life that hindered their experience of recovery. Within this concept the impact of relational influences were prominent. Relationships between family members were emphasised. Hindering factors within these relationships entailed: 1) fostering a lack of empowerment, 2) reductionist and dehumanising understanding of difficulties, and 3) not being believed. All were unhelpful responses to disclosure largely experienced in childhood.

"Place in the family was to be the good little girl who didn't cause any waves. To fade into the woodwork as much as I possibly could or in other words be invisible."
Glaister & Abel (2001) p. 191

". . . They didn't want to believe that he done this, you know, so that was hard . . . I didn't get support from my family at all, the way I thought I would have got support, you know; they weren't there for me . . ."
Choulaira *et al*. (2014) p. 74

"[I] do things that are going to benefit me., like this thing with my mom now. I am making another attempt at it, but if it becomes hurtful and destructive, I'm not going to be in the relationship anymore."
Draucker (1992) p. 6

"It was like my parents were saying, 'Well, you really don't have a broken leg,' when the bone was sticking right out through the skin."
Anderson & Hiersteiner (2008) p. 420

Relationships that harvested the shame and secrecy surrounding the abuse were damaging, and maintained feelings of isolation. These beliefs and feelings were often carried into adulthood. Such experiences were considered to influence the participant's willingness to

disclose their experiences in adulthood. In part, there was a sense of comfort in obeying beliefs surrounding not being able to disclose as it not only protected the survivors but also their families.

"But it's like now you feel a sense that nobody talks about it and they still don't, I don't know why, but nobody ever says anything regarding it, you know, how are you coping, how do you cope, are you managing fine, nothing is spoken about, it's a secret, it's just not spoken about. . . . and how do you find that? I find it quite hard to deal with . . . actually I find it quite hurtful . . . but it's almost as if you're the bad person . . ."
Choulaira *et al*. (2014) p. 73

"I never did tell about my [step] father because no one cared. I'll put it that way, so I never did tell nobody."
Draucker *et al*. (2011) p. 450

"I feel like I would have never said anything because I felt like I would have gotten in trouble. I was extremely afraid to talk about anything to my mom."
Glaister & Abel, 2001, p. 191

Some studies made reference to this experience with professionals, such as therapists, however this was not the focus. Unhelpful responses to disclosure from therapists were similar to unhelpful responses made by family members, such as responding with curiosity and inquisitiveness rather than concern, pressure to heal quickly, belittling counselling approaches, pressure to forgive the offender, advice, anger and blaming the survivor for causing pain by bringing it up and not acknowledging the significance of the abuse (Anderson & Hiersteiner, 2008). Glaister and Abel (2001) add to this list suggesting that advocating medication and hospitalisation were not viewed positively. Overall, relational influences that mirror elements of an abusive relationship, for example, being told they are "stupid" and "crazy" (Glaister & Abel, 2001, p. 191), were detrimental to motivating further support opportunities.

Beliefs regarding self worth and coping strategies developed during their experience of CSA, such as shame and avoidance of past abuse memories (e.g. substance misuse, self-harming, over-functioning) were pertinent within the participant's current life. These beliefs and strategies largely hindered recovery, increased distress and resulted in them continuing to find themselves in abusive relationships, or life patterns, that mirrored their past.

"The only person who held me back was myself…The thing that got in the way of healing is the internalization of the lack of value in me."
Glaister & Abel (2001) p. 192

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"I became a workaholic, so to avoid even thinking about the issues or anything else I threw myself into work night and day."
Choulaira *et al*. (2014) p. 73

<u>Factors enhancing recovery</u>

The third concept surrounded factors that enhanced recovery in those who had experienced CSA. Generally these were factors that moved someone forward in times of difficulty and distress, and moved individuals away from abusive dynamics. Integral to enhancing recovery were connections with others. These connections provided individuals with secure, safe, unconditional relationships that were perceived as supportive and non-judgmental especially in times of need. Such connections increased people's motivation to want to change. Essentially, such support was a key vehicle within recovery as the process of recovery was challenging. Both informal and formal connections with others were discussed, such as family, friends, community, professionals, religion, spirituality, and other survivors.

"A lot of stories out there like mine" and wished all people who had been abused had someone to talk to so they "would feel normal and better."
Draucker *et al*. (2011) p. 456

"Through prayer and attending church, I got over what happened to me."
Draucker *et al*. (2011) p. 459

"I could just tell him whatever I wanted to, and I knew because He was a loving God, He wasn't going to judge me for it. He was just going to love me for it."
Arias & Johnson (2013) p. 832

"The support groups were such a huge step for me. The whole thing of finding other women that had a voice . . . there is a level of sharing, whether or not you tell each other your whole story, but being with other women who have been through similar things either a lot worse or whatever, that there is an acceptance here, there is a warmth and compassion that I never knew could possibly exist."
Anderson & Hiersteiner (2008) p. 421

"Well, what helped was that for one I got tired of bein' out there, doin' the drugs. Y'know an' I wanted my old self back, I wanted that person who was independent an' strive to reach higher goals and that was number 1. Second one was believin' in God, that he will help me through this. The third was the support of my family 'cause when I told them I was ready they was like, right there by my side."
Banyard & Williams (2007) p. 286

Some participants commented on the specific value of connections with others who have shared a similar experience to them. Value was placed on being shown that life can become more enjoyable, and relationships that validated childhood experiences, confirmed self worth,

provided them with a voice, created a feeling of empowerment and helped reduced feelings of shame and secrecy.

"I really would love to see an adult survivor come to our group who feels like she's made it all the way through to the other side [healed]. . . I would like to meet a survivor who has a happy marriage, who is like living life. I haven't found those yet, and really need to."
Anderson & Hiersteiner (2008) p. 421

It was also suggested that connections with others who had a shared experience were highly valued due to understanding the pain they experienced and created a sense of universality.

"There's a place, I think, in everyone that has been abused, where we go that no one else can go, and I think you need to understand that."
Draucker (1992) p. 7

Connections with others, i.e. those with a shared experience, God or therapists, also appeared to provide space and opportunities for people to develop an understanding of their abuse and current position in life.

"Cause I had to ask God. I needed to ask for direction, why has my life been like this? And he showed me why. . . . And I'm healing since 40 years old."
Draucker *et al.* (2011) p. 456

Spirituality was largely favoured due to the absence of judgment within these relationships.

Gaining an understanding and closing information gaps often resulted in the re-attribution of blame of their experiences and helped people connect their current experiences with their past abuse, i.e. giving meaning to their current experience. It also helped people come to some understanding of the perpetrator's motivations. This new perspective seemed highly important within a majority of the studies and was a freeing experience.

". . . I think it's also about restoring, like, the balance of power a little bit by reporting it to the police. I've kind of said, look, I'm in control of it, and you won't get away with it, and then having the courage to do that really showed that I do. . . . I think a lot of it is to do with feeling powerless, and it's what probably makes you feel bad about it. So I think, yeah, it is about getting the control or power back, like control back over your life, really. Don't think I'm to blame for it. . . ."
Chouliara *et al.* (2014) p. 74

People commonly describe points in time where they can identify a change in perspective of their situation. These events could be positive or negative events that were considered crossroads in life that result in significant changes. These are pivotal within people's narratives. The exact event was personally meaningful; some suggest motherhood, disclosing

and finding place for spirituality as specific points. These points varied considerably, but seemed to provide people with a sense of persisting hope as a result of an alternative outlook on life.

> *"Well, when I realized that, of all that had happened to me, I love myself and that's what made me actually get myself into a program. To get myself back in life, y'know, on the right track. And there's still so much in life that's worth living, living for . . . these things that have happened to me, they were horrible things, but, that I was not the cause of it, but I can do something about it, as far as how it's going to affect me."*
> Banyard & Williams (2007) p. 286

Such experiences can ignite motivation and conjure energy in people to face their past experience and to step 'into', or begin the recovery process.

> *"Talking about my story is like taking back my own power each time. It gives me more and more strength."*
> Anderson & Hiersteiner (2008) p. 419

Disclosure of their experience was described as a fragile moment in time due to threats in childhood and subsequent beliefs carried into adulthood. There was emphasis on the need to disclose in nurturing, supportive and secure relationships (described above). Subsequently, disclosures were discussed as positive experiences that acted in opposition of the oppression faced through silencing dynamics. Disclosure was described as the start of recovery.

> *"She [her therapist] is not afraid of my feelings and she will let me share about the flashbacks and the nightmares and none of the other therapists that I have had could figure out what to do and they would say, "Oh this must have been awful, but lets move on to a happy subject now!" But she will let me share what is real; instead of trying to fix and pretend that nothing happened."*
> Anderson & Hiersteiner (2008) p. 421

One study also described enhancing factors that were more centred on the abuser, such as confronting the abuser, and the importance of forgiving the abuser (Glaister & Abel, 2001).

How the current self is understood

The final concept drawn from the synthesis was how participants described their current self on reflection of their self prior to what they would describe as recovery. The ability to reflect on the before and after self also symbolised the overall internal change they had experienced. It was felt that these changes were what portrayed recovery for these individuals.

"With recovery there is change. So you have to change a whole lotta things in your life . . . You have to change old behavior, attitudes . . . and you gotta set in your mind that this is what you wanna do . . . y'know, you cut yourself, you doctor it up an' it heals. Y'know sooner or later it's recovered. We're like open wounds . . . y'know, you just have to keep working on yourself to get better. And then, y'know, you can recover."
Banyard & Williams (2007) p. 285

The ability to accept themselves for who they are and their experiences was a change commonly discussed. Acceptance was related to the integration of their experience to their life narrative. There was a reluctance to foresee a future where CSA was not part of their narratives and identity.

"I would call it an evolution. A finally coming to who you are suppose to be. Because I really think sexual abuse interferes with who you are meant to be.. . . Feeling at peace with myself. Accepting who I am. Accepting what life has handed me.. . .Experiencing the joy in the here and now."
Glaister & Abel (2000) p. 190.

"I wrote that abuse issues will become part of my life story but no longer my life. That's my goal."
Anderson & Hiersteiner (2008) p. 417

Acceptance provides space for individuals to develop compassion and empathy for themselves and others, which was essential to their new self-perspective. Participants described developing new relationships with themselves that resulted in them being more connected with their emotions.

"I was quite negative to myself, I think I was quite self abusive in the way that I would talk to myself or I often made jokes at my own expense. I didn't have very high expectations of myself. I didn't have very high expectations of how others should treat me. And I think that in changing the way that I related to me that helped me be able to respond to the distressed part of me in a much kinder and more productive way."
Chouliara *et al.* (2014) p. 74

"To me at this point in my life (I'm 47), it means I'm one hell of a warrior. It means I'm one incredible, powerful, magnificent being. I wouldn't relive a day of it. [Yet] I honour it at the soul level ... and I honour what I've done with that. I honour every tear, every grief, every feeling.., it has made me a tremendous therapist, a tremendous minister. It has led me on my path even when I was amnesic. It's leading me on my path, and I walk a magnificent path."
Godbey & Hutchinson (1996) p. 309

Both empathy and compassion towards themselves and others were enhanced through group therapy. Witnessing other's stories helped participants put their histories into perspective. It also provided them with opportunities to show empathy and compassion to others. Self-compassion allowed people to accept their vulnerabilities as part of them rather than something that had to be removed and fought against.

"I perceive myself as recovering. I don't know that I would say that I am recovered. I think that there would always be a slightly vulnerable part of me. A part of me that might be more easily wounded in a situation than maybe someone else. A part of me that would still get scared when . . . that does still get scared . . . I suppose I don't ever think well that's me done then. I suppose I say to me, look I do have a vulnerable part of me and it's important that I constantly be aware of that."
Chouliara *et al*. (2014) p. 75

Developing self-compassion and empathy, and knowledge regarding abuse (enhancing factor) seemed to influence a change in key self-beliefs developed during CSA, such as shame and guilt. The relationship between these processes was inseparable. There was sense of making peace with oneself.

"I no longer feel like I'm to blame for the abuse, really, I don't feel ashamed any more, I'm quite . . . I'm kind of quite happy to talk about it to people because I'm not ashamed of it."
Chouliara *et al*. (2014) p. 74

"I would like to truly believe that I have recovered from that because when I talk about it I don't cry as much as I used to cry . . . my shame or my guilt or blaming is not as much as it used to be."
Banyard & Williams (2007) p. 285

"When I fully realized that I wasn't responsible for the abuse, I began to like myself so much better."
Godbey & Hutchinson (1996) p. 308

Holding this new self-perspective appeared to empower people to recognise their inner resources that helped them work through the hardship of recovery. Survivors of CSA developed a more active stance in their recovery. Inner resources discussed were personal agency, self-esteem and autonomy, which together play a role in providing new meaning to the participant's lives. One key example was becoming dedicated to helping others who had lived similar experiences.

Synthesis summary

In summary, the data from the eight studies included in the SR were subject to a meta-ethnography synthesis approach to gain insight into how adult female survivors of CSA describe their experience of recovery from CSA. After a quality review, four superordinate qualitative concepts were identified from the synthesis. The concepts provide an understanding of the key elements of recovery from CSA and factors that have a role in this process. These concepts were: 'The recovery process'; 'Factors hindering recovery'; 'Factors

enhancing recovery' and; 'How the current self is understood'. Within each of these concepts were a number of subordinate concepts. Although no new interpretations were developed through conducting the synthesis Noblit and Hare (1988) discuss how not all meta-ethnography synthesis result in new outcomes.

The synthesis suggested that the recovery process was an on-going challenging process that people felt they were going back and forth throughout. There was a desire to describe the recovery process as a staged model, although there is a lack of consensus regarding the nature of these stages. Factors hindering recovery were largely related to other's responses to disclosures that promoted a lack of empowerment, enhanced beliefs surrounding secrecy, and communicated a reductionist, dehumanising understanding of their experience that often resulted in not feeling believed. In addition, beliefs and coping strategies (avoidance) developed during childhood abuse played a detrimental role in the experience of recovery in adulthood. On the other hand, factors that enhanced recovery, or moved people on from distress, were developing supportive, unconditional, secure connections with others, being able to disclose the abuse experience, experiencing turning points (i.e. events that result in the realisation and/or recognition of an alternative approach to life), developing an understanding of the abuse as an adult in a safe environment, and finally, some discuss the need for forgiveness of self and the perpetrator of the abuse. The hindering and enhancing influence of relationships with others largely surrounded relationships with family members, others who had experienced similar life events, and God or 'higher powers'. Despite recognition for the role of formal and informal relationships there was scarce description of the role, or influence, of formal relationships and professionals in general. This could be a consequence of the nature of the SR research question and the studies subsequently drawn on, or because professionals do not play a significant role in survivor's narratives surrounding recovery.

Overall, studies described how recovery involves a change in how the current self is viewed. For instance, through acknowledging and accepting past experiences there was space to develop compassion and empathy, for their self and others. These are key emotions that enable opportunities that reduce feelings of shame and guilt surrounding their experience. The current self was also described as someone who was able to recognise personal inner resources.

All but one study reviewed were conducted in the USA. A majority of Americans identify themselves as Christian, and only a quarter identify as no religious affiliation (Wormald, 2015). Ganje-Fling and McCarthy (1996) proposed that adult survivors of CSA may need special help to identify their spiritual beliefs and develop spiritual practices to assist in their

healing process. The one study not conducted in the USA did not make reference to connections with religion or spirituality. Therefore, this may be a cultural factor unique to the USA. Draucker *et al.* (2011) made reference to this stating that as most espoused Judeo-Christian beliefs within their research it was unlikely to be representative of cultures that adopt agnostic or atheist perspectives. Furthermore, as most studies were conducted in the USA the results are likely to be representative of Western populations that primarily receive healthcare services that are paid for at the point of care; thus, findings may not be transferable to other cultures or systems of healthcare provision. There is emerging evidence on the importance of taking cultural differences into account when working with adult survivors of CSA. Although these are small-scale qualitative studies, they provide useful insight into how important cultural perspectives can be for individuals (Sneddon *et al.*, 2016). Studies conducted across different cultures would further current understanding.

Despite reference being made to the lack of agreement regarding reviewing the quality of qualitative studies, the following synthesis incorporated the quality ratings of the studies reviewed by indexing the highest ranking study, and placing more weight on the studies with higher overall quality ratings. This was a similar approach to others (e.g. Campbell *et al.*, 2011). Toye *et al.*, (2014) discuss the limitations of indexing based on one paper due to the influence of priory concepts. Not adopting this approach to the synthesis may have resulted in different outcomes, as meta-ethnography is a higher interpretive approach. Furthermore, Toye *et al.* (2014) emphasise the importance of conducting SRs such as this with large research teams due to the extensive nature of task. The current SR was conducted by one primary researcher under the supervision of one Academic Supervisor with prior experience of conducting SRs, and the quality review was conducted in collaboration with a peer researcher. The lack of a research team surrounding this SR may have resulted in concerns regarding the robustness of the findings and conclusions. Future SRs would benefit from adopting a larger research team.

Finally, the current synthesis adopted the assumption that all the studies reviewed were commensurable, and that themes were transferable across settings. These assumptions are unlikely to be endorsed by all qualitative researchers. Some will argue that attempting to synthesise ignores the rich detail that characterises rigorous qualitative research and the resulting generalisations fail to do justice to the original studies. Although the researcher acknowledged this, she was also aware that the full contribution of qualitative research will not be realised if individual studies merely accumulate and some kind of synthesis is not carried out. Britten *et al.* (2002) suggest consultation with original authors to test the validity of the third-order concepts and the extent to which they are supported by the primary data that

can help overcome some of these issues. The researcher of the current SR did not adopt this approach in accordance with recommendations from Bloor (1997), again this may be an approach for future research to adopt.

PART THREE

Introduction to the current study

The SR in Part two revealed methodological limitations and information gaps within the available peer-reviewed literature regarding how women who have experienced CSA perceive their recovery process. The quality review in Part two exposed that samples were ill defined and likely to represent those who had not accessed services or only accessed non-statutory services. Many of the studies reviewed also failed to describe how the unique position of researchers might have impacted data analysis and theme identification. Furthermore, a majority of the available research was conducted in the USA using Grounded Theory methodologies to discover models of recovery. Overall, there is a general lack of high-quality research promoting survivors voices in the UK.

The synthesis within the SR in Part two revealed the key role of relationships within recovery. Relationships appear to have both enhancing and inhibiting roles. However, the type of relationship focused on was between survivors of CSA and their family, others who have shared experiences, and God, or some higher being. There was less focus on mental health services and/or other helping professionals. Therefore, what role do these relationships play in the women's experience of recovery? This seems to be a highly relevant area to explore as research increasingly highlights the importance of relationships in recovery on the one hand, and on the other it suggests that the physical and psychological nature of CSA places survivors at risk of experiencing distress in healthcare settings (Cadman *et al.*, 2012; Leeners *et al.*, 2007; Robohm & Buttenheim, 1996) and difficulties forming and maintaining relationships with others (Gill, 2010; Kendall-Tackett, Williams, & Finkelhor, 2001).

Survivors perspectives of mental health services: Review of previous systematic reviews

Conducting a narrative review[7] using PsycINFO to find relevant literature that conducted reviews into CSA survivor's perspectives of services revealed two SRs of relevance that are discussed below and form part of the basis of the current study's aims. The following section provides an overview of two SRs (e.g. Chouliara *et al.*, 2012 and Parry & Simpson, 2016) exploring survivors of CSA's perception of mental health services.

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[7] Search terms used were those outlined in Part two, search process, in addition to: 'psychotherapy'; 'talking therapy'; 'therapy'; 'counsel*'; 'support'; 'service*'; 'mental health service*'; ' experiences'; 'views'; 'review'; 'systematic review'.

The nine studies reviewed by Chouliara *et al*.'s (2012) focused largely on positive experiences of talking therapies conducted outside of the UK. The positive experiences promoted developing trusting therapeutic relationships and the need for therapists to hold awareness towards individual needs. Studies shining light on the negative aspects of therapy were from non-peer reviewed papers conducted in Scotland, which encourages questions surrounding methodological robustness. Regardless, Nelson and Phillips (2001) and Nelson (2009) identified key areas of need and concern in regards to CSA service provision: a tension between medical and social models of mental health (prescription of heavy antipsychotic medications); the issue of opening the 'can of worms' after disclosure; issues of control and power and; a distrust between voluntary and statutory sectors; failure to diagnose psychological trauma in a timely manner; and disinformation. Overall, across all studies in Chouliara *et al*.'s (2012) SR the importance of a trusting therapeutic relationship was emphasised.

Parry and Simpson (2016) later conducted a SR on CSA survivor's perceptions of what makes the process of therapy, the therapeutic modality, and therapeutic relationships helpful in relation to a range of talking therapies, including both nonspecific and trauma-focused. The SR focus was not on whole service provision. Narratives portrayed the therapeutic process as a means of forming connections, which provided an opportunity to develop trust both intra and interpersonally. Talking therapies also seemed to play a role in developing a sense of self as there was an opportunity for people to explore who they were that enabled them to form a more complete narrative. This ability to form an understanding of themselves as a 'whole' was discussed as happening in stages.

The stages of therapeutic change in relation to the developing self were a novel finding from the synthesis, but shared similarities with a staged model of recovery. The first stages described someone's willingness to link past abuse with current distress. The final step was becoming a whole adult self-moving away from the survivor identity, almost like being able to integrate their experience to their current being. Therapy also enhanced self-kindness, which positively influenced self-esteem. This shared similarity to the development of empathy and compassion towards the self and others found in the SR developed in Part two. Therapists were more beneficial when they attuned to participant's specific relational needs as it allowed them to safely engage with therapy. Those who failed to do this were described as 'stumbling in the dark' and replaying the dynamics often seen in abusive relationships. There was a struggle with coming to the end of therapy, especially group therapy, due to the perceived lack of support. The final theme described connecting with others and first time experiences. Participants found strength from hearing other's stories, however, learning and

change were highly reliant on creating appropriate and safe boundaries, and experiencing choice and control within these boundaries. Disclosure was the first step to understanding their experience of abuse but using language to describe their experience was difficult.

Both Parry and Simpson (2016), and Chouliara *et al*. (2012) clearly identify the lack of cultural diversity across the studies. For example, Parry and Simpson (2016) were only able to draw on two studies conducted in the UK, and Chouliara *et al*. (2012) drew on two studies conducted in the UK but these were not published in peer-reviewed journals. Furthermore, the papers drawn on from the UK across both SRs enquire specifically on the influence of a specific type of psychotherapy experience rather than their experience of mental health services a whole.

UK specific literature

The following section introduces and critically discusses the available UK literature regarding survivors of CSA perspectives of mental health services. One document published the UK by University Campus Suffolk, and Survivors in Transition, of relevance is the 'Hear me. Believe me. Respect me.' paper (Smith *et al.,* 2015). Although the report was not peer-reviewed it outlines an online survey of nearly 400 survivors of CSA exploring their use of support services. The research was undertaken in the context of a severe lack of evidence about the support needs of adult survivors of CSA, and CSA survivors in the UK as a whole. The survey outlined the potential importance of services in CSA survivor's recovery process and that survivors use a range of support services, not just talking services. Generally, service use spanned over a ten-year period and involved movement between four and five provisions. Unlike studies conducted in the USA, only 6.6% of the UK sample accessed faith groups, which indicates the possibility that within the UK faith and spirituality are generally less influential factors in recovery and calls to question the applicability of generalising previous research findings that promote their prominence.

Overall, the impact of poor service experience was greater than the absence of effective support. Poor services were considered to have a long-term impact and hindered survivors' motivation to seek further support. Good service provision resulted in survivors of CSA reaching the point of recovery. Although what this 'point' looked like was not described. Participants' perceptions of service satisfaction were based on whether they felt listened to, believed and respected, which were measured using three likhert rating scales ranging from zero to four. These three factors were pre-determined by a service user group. Smith *et al*. (2015) reported that in regards to statutory mental health services in general 25.5% of the

sample rated their experience as 'Very Poor' and 'Good'. Only 8.5% rated their experience as 'Very Good'. On the other hand statutory psychotherapy more specifically was rated as 'Very Good' by 29.3% of the population, and 'Very Poor' by 14.6% of the sample. Furthermore, in comparison to voluntary services, within statutory settings, satisfaction and feeling as though they had been listened to, believed and respected was low. Overall, it appears there is a need to look at service user's experience of statutory mental health services as a whole rather than specific aspects of it, for example talking therapies. More understanding surrounding the impact of 'poor' service provision is required.

Although the results from Smith *et al.*, (2015) survey provide a starting point to understanding how mental health services play a role in recovery from CSA, it does not provide details surrounding what it means to survivors of CSA to feel listened to, believed or respected. There was little scope for participants to voice what else they felt was important due to questionnaire constraints. It is important to note that free text in surveys represent qualitative data, but do not constitute as qualitative research (Hammarberg *et al*., 2016). Furthermore, previous research discusses the bias of relying on satisfaction scales and encourages a move away from this approach (Hekman, *et al*., 2010; Sofaer & Firminger, 2005; Vogus & McClelland, 2016). Previous SRs, and the SR in Part two also highlight the importance of informal support, such as family and friends, which are likely to play a vital role but this element was not captured within their survey. Smith *et al*., (2015) go on to comment on the need for future research to take a dynamic perspective in examining how CSA survivors negotiate the services they receive in their recovery journey. Although the research was the first of its kind within the UK only 3.1% (n=12) of the sample were from Wales. As previously mentioned the support services within Wales are different from the rest of the UK (Mental Health [Wales] Measure, 2010).

Current study aims

Missing from the present body of research is rich qualitative information regarding how female survivors of CSA, who have accessed support from statutory UK mental health services, perceive their recovery experience as a whole. This includes talking therapies, other support services within statutory mental health and areas of people's lives outside of mental heath provisions. Therefore, the present study aimed at furthering current understanding by conducting a robust and credible qualitative study that aimed to:

- Elicit the views and lived experiences of recovery from CSA from female adult survivors in South Wales.

- Explore how mental health services have played a role in their recovery process as perceived by women survivors of CSA.

This will be achieved through attempting to answer the following research questions:

1. What is the lived experience of recovery after CSA from the perspectives of women survivors of CSA?

1.1 How do they perceive mental health services to have played a role in this experience?

Through qualitative enquiry the current study aims to gain knowledge to aid statutory service development within a Welsh context. This is a timely study as evidence shows gaps in service provision for adult survivors of CSA in England and Wales (Coy *et al*., 2011; Jones & Cook, 2008; McCarry *et al*., 2017; NAPAC, 2017). As the scale of CSA is much larger than previously believed in the UK (Smith *et al.,* 2015) the consequences of this lack of understanding could be detrimental for services with limited resources. NHS mental health services require a broad understanding of what works for a majority of people accessing services. A scientific approach that allows psychotherapeutic outcomes to be operationalized, quantified and compared is of great value (Berry *et al*., 2014; NICE, 2013). Nonetheless, individuals may also have strong beliefs about what has worked for them and to dismiss this as anecdotal risks not only invalidating peoples' experiences but ignores a source of data (Stuart, 2016). Gaining further understanding of recovery from CSA through qualitative data could also contribute to more effective training and supervision of professionals working with survivors, as well as developing public education and awareness (Smith *et al.,* 2015). It would be one element of an amounting evidence-base.

METHODOLOGY

Chapter two overview

This chapter details how the current study was developed and conducted. An outline of the study design is presented, along with a rationale for the use of the chosen qualitative methodology, Interpretative Phenomenological Analysis (IPA). The process of recruitment, a description of individuals who participated in the study, the ethical considerations and a detailed description of data collection and analysis procedures are also presented. Consideration is also given to the analysis and presentation of the study's findings.

Study aims

The current study aimed to:

- Elicit the views and lived experiences of recovery from childhood sexual abuse (CSA) from female adult survivors in South Wales

- Explore how mental health services have played a role in their recovery process as perceived by women survivors of CSA.

This was achieved through answering the following research questions:

1. What is the lived experience of recovery after CSA from the perspectives of women survivors of CSA?

    1.1 How do they perceive mental health services to have played a role in this experience?

Design

The current study focused on understanding individuals' experiences, for this reason a qualitative methodological design was selected. Data were collected via face-to-face, individual, semi-structured interviews with adult women who had experienced CSA and had accessed support from mental health services.

Rationale for using qualitative methodology

Slade *et al*. (2012) proposed that to understand recovery in any context, an understanding of the lived experience is essential. From a research perspective, qualitative methodology allows for exactly this: the exploration of individual experience in context (Barker *et al*., 2002; Harper & Warner, 1993), which may be particularly useful when the focus is on process rather than outcome (Poortman & Schildkamp, 2012). McClain and Amar (2013) describe the positive personal and societal benefits of women who have experienced CSA after participating in research surrounding abuse. This was discussed in Chapter One 'Giving a voice to 'the silenced population' through research'. Individuals who participate in research such as this are often more concerned with providing a meaningful narrative related to their traumatic experiences than they are in avoiding emotional distress (McClain & Amar, 2013). With this in mind, and in keeping with feminist values and philosophy (see Introduction section 'Historical context of CSA and its influence on research') a research design embedded in the belief that each participant's voice provides a unique and useful source of knowledge was deemed most appropriate. This is particularly relevant to the population of women recruited in the current study as they are often described as a silenced population (Herman, 1992).

Only over the last decade and a half has it become accepted by many within the health disciplines that research aiming to collect the lived experiences is most appropriately explored using qualitative methodologies (Biggerstaff & Thompson, 2008; Henwood, & Pidgeon, 1992; Loder *et al*., 2016; Smith, 1996a,b; The Psychologist, 1995; Turpin *et al*., 1997). One approach to collect qualitative data is through semi-structured interviews. Semi-structured interviews offer researchers opportunities to probe interesting areas that arise during the interview and follow the participant's interests and concerns; interviews are guided by the interview schedule rather than dictated by it (Smith *et al.,* 2009). Such interviews also allow for the interviewer to build rapport and express empathy. Overall, this approach tends to produce rich data (Smith *et al*., 2009).

Interpretative Phenomenological Analysis (IPA)

Data collected through semi-structured interviews can be analysed using IPA. IPA specifically seeks to capture the meaning of particular experiences through identifying key themes (Smith *et al*., 2009). It is an attempt to get an 'insider's perspective' of an event,

which is then interpreted by the researcher (Larkin *et al*., 2006). IPA relies on ideography, meaning that researchers focus on the particular personal experiences and an individual's personal perception of events rather the universal (Biggerstaff & Thompson, 2008; Smith, *et al*., 1995). The researcher can make specific statements about study participants because the analysis is based upon a detailed case exploration. The aim is to identify the essential components of experiences that make them unique (Smith *et al*., 1995).

The approach is phenomenological in that the meanings an individual ascribes to events are in part accessible through an interpretative process (Smith *et al*., 2009). It assumes an epistemological stance whereby, through careful and explicit interpretative methodology, it becomes possible to access an individual's cognitive inner world (Smith *et al*., 2009). Therefore this approach emphasises that the research task is a dynamic process with an active role of the researcher. It is a process of sense making by both the participant and researcher (Smith *et al*., 2009). Phenomenological studies thus focus on how people perceive and talk about objects and events, rather than describing phenomena according to a predetermined categorical system, conceptual and scientific criteria. This involves 'bracketing' one's preconceptions and allowing phenomena to speak for themselves and to overcome issues associated with the double hermeneutic (Smith *et al*., 2009).

Rationale for using IPA

The current research aims were not intended to define the process of recovery after CSA, or the role of mental health services, but to examine how women made sense of these experiences with the intention of gaining a greater understanding of their world. IPA was chosen over other qualitative methodologies due to its dual focus on the unique characteristics of individual participants' lived experience, and on patterning of meaning across participants' narratives (Smith *et al*., 2009). IPA shares the view that humans are sense-making creatures and therefore the accounts which participants provide will reflect their attempts to make sense of their experience. It is a methodology that is clearly set out and is both rigorous and yet sufficiently flexible for a variety of studies (Biggerstaff & Thompson, 2008; Brocki & Wearden, 2006; Smith & Osborn, 2008; Willig, 2008). The methodological approach and epistemological stance helps the researcher stay close to the data whilst allowing the researcher's own interpretations. The outcome of a successful IPA study is likely to include an element of 'giving voice' and 'making sense' of an individual's personal experience (Larkin & Thompson, 2012). This is closely aligned with the current NHS agenda that promotes service user involvement (Husband *et al.,* 2010; Reid *et al.,* 2005), and is in opposition to the historical context CSA belongs (Herman, 1992).

Other approaches such as Grounded Theory (another commonly used qualitative approach) primarily attempts to develop a theory through developing understanding of the relationship between categories and concepts rather than focusing on the meaning making experience (Pidgeon & Henwood, 1997). The emphasis is on developing models to denote their understanding of the data collected. Grounded Theory is often used when focusing on social processes or influencing factors, which was not the intention of the current research (Pidgeon & Henwood, 1997).

Quality Control

Yardley (2008) and Rolfe (2006) both emphasise the importance of the following principles when conducting high quality qualitative work. Rodham *et al*. (2015) emphasise the importance of transparency within IPA research. Since IPA has been described as "a creative process" and "not a matter of following a rule book" (Smith *et al*., 2009, p. 184), there is greater need to demonstrate the trustworthiness of this flexible method. In addition, the expectation that future IPA work will "push the boundaries further" (Smith *et al*., 2009, p. 185) it is important to do so whilst demonstrating the trustworthiness of the analysis. To ensure quality is maintained throughout the current study extensively cited criteria for ensuring rigor in qualitative research was followed.

Steps taken to ensure quality

To ensure quality of the current study the research has adapted published qualitative research checklists to create a comprehensive checklist shown in Table Nine. From reviewing the literature the: Critical Appraisal Skills Programme (CSAP; 2010), the consolidated criteria for reporting qualitative research (COREQ; Tong *et al*., 2007), and from Mays and Pope's (2000) checklist were amalgamated. A more detailed description of bracketing, the researchers position statement and the role of transcription are also provided.

Quality check area	How to maintain quality	Reported in section
Study design	The aim of the study is clearly stated and the appropriateness of a qualitative methodology is provided. The theoretical framework and methods used at every stage of the research are explicitly accounted for.	Study aims, design, Rational for using qualitative methodology.
Research team	Details regarding the role of researcher throughout the research are described. Reference is made to the participant's knowledge of the researcher's role. The relationship between research and participants is adequately considered through reflexive journals and the use of continuous supervision. The occupation of the researcher at the time of the study is stated. The role of other members of the research team e.g. Academic, and Clinical Supervisor is stated.	Researchers positioning statement, Procedure, Reflexive journals (Appendix five-six), Semi-structured interview schedule, Recruitment, Analysis
Study context	Information about the context in which the study was conducted is outlined. This includes: Where the data was collected The presence of non-participants.	Participants
Sample and sampling	Information is provided about the: Sampling and recruitment method Final study sample (situating the sample) Sample size and rationale.	Participants
Data collection	Information is provided regarding the procedure of data collection. Information is provided on: Interview schedules The field notes taken Form of data Duration of interviews and whether repeated interviews were conducted Transcription. Procedures relate to the original research aims and theoretical underpinnings of the research methodology.	Participants, Semi-structured interview schedule, Analysis, Procedure, Transcription

Data analysis transparency	An in-depth description of the analysis process is provided. How themes and concepts are identified from the data is described in detail and follows the principles of IPA. Overall themes were discussed with Academic, and Clinical Supervisors and colleagues independent from the study. The researcher maintained a clear audit trail of the coding and analysis that was monitored through supervision. More than one researcher (peer, supervisors) repeated parts of the analysis, which allowed for more informed discussions around interpretations of the data during supervision throughout the analysis stages, rather than a form of inter-rater reliability. Sufficient data is provided to support the themes. This was monitored throughout on-going supervision. Details regarding the extent contradictory data was taken into account. Acknowledgement was given to the researchers own role and influence in the analysis and selection of data through competing a bracketing and producing a researcher's positioning statement. Respondent verification checks were conducted- allowing for data triangulation Consistency between data presented and the findings were monitored. Each participant is represented in a verbatim quotation within the results write-up.	Analysis, Appendix (i.e. example coding and them development, reflexive diary entries), Results
Clarity regarding the value of the research	Evidence is presented systematically in the written account to satisfy the sceptical reader of the relation between the interpretation and the evidence. Guidelines on how to present the results discussed by Smith *et al*. (2009) were followed. A discussion is provided on the researches contribution to existing knowledge. Thought was given to identifying new areas where research is necessary. Discussions surrounding how the findings can be transferred to another population and discussion how the research findings were used.	Results, Discussion
Ethical considerati on	Detail is provided surrounding relevant ethical issues e.g. how the research was explained to participants, how informed consent was attained and how confidentiality was communicated and maintained, and how the effects of the research on the participants were managed	Ethical considerations

Table Nine: Adapted version of quality assurance for qualitative research.

Bracketing the researchers position

Bracketing is a means of demonstrating the validity of the qualitative research process; it is a major part of quality control used to enhance the rigor and ethics of a qualitative study (Bradbury-Jones, 2007; Gemignani, 2011; Pillow, 2003).

Bracketing requires the researcher to 'bracket' their own assumptions and understandings to let the phenomena collected from the research participants 'speak' (Crotty, 1996). This means suspending preconceptions or transcendences of everyday experiences and requires the researcher to adopt reflexive stance. Reflexivity is a crucial strategy in the process of generating knowledge by means of qualitative research (Dunya *et al*., 2011; D'Cruz *et al*., 2007; Gerstl-Pepin & Patrizion, 2009; Horsburgh, 2003; Koch & Harrington, 1998). The researcher needs to acknowledge that they are part of the world that they are trying to research (Frank, 1997).

Reflexivity should be present throughout the entire research process (Bradbury-Jones, 2007; Guillemin & Gillam, 2004). The concept of bracketing is somewhat controversial in IPA as any event gives way to a more interpretative process as analysis proceeds. This is one of the reasons why the IPA researcher usually keeps a reflexive diary (See extracts in Appendix six) that records details of the nature and origin of any emergent interpretations. Some argue that keeping a diary limits reflexivity, as it is a private event and the unconscious elements that may be influencing you are kept unconscious (Rolls & Relf, 2006). Supervision is thought to overcome such issues. Rolls and Relf (2006) discuss facilitating a bracketing interview to encourage the reflexivity of the researcher.

Berger (2015) discusses the use of a log, repeated review, and seeking peer consultation for maintaining the necessary balance between researcher's own experience and that of the participants in IPA analysis. The researcher for the current study sought peer consultation to complete a bracketing interview during the initial stages of the research process. Clinical supervision that followed this interview often involved reflecting on the researcher's bracketing interview and its fluidity.

Researcher's positioning statement

The following statement is based on previous literature indicating which factors are important to bracket (Bradbury-Jones, 2007; Finlay, 2008; Horsburgh, 2003; Kosygina, 2005; Padgett, 2008; Primeau, 2003).

The researcher writes from the position of a twenty-seven-year-old, white British middle-class female Trainee Clinical Psychologist. The researcher is heterosexual and has a partner of one and half years who she does not live with. The researcher is undertaking this research as part of her qualification to become a Clinical Psychologist. The researcher did not know any of the participants prior to conducting the study. Participants were made aware of the researcher's trainee status and understood that the research was a partial requirement of their Doctoral studies. The participants were told that the researcher had a keen interest in trauma.

During the researcher's first year of Clinical Psychology training she met her Clinical Supervisor for the current study. She met her through a psychology team meeting and later observed supervision groups for staff who were taking part in a group for women who had been sexual abused as children (the Survivors of Abuse: Freedom and Empowerment [SAFE] group). The researcher also worked closely with the supervisor to complete a small-scale service evaluation for the group. During this period the researcher did not meet any of the women who attended this group, and only handled pre and post questionnaires completed by the women who attended the group. The researcher also had a role in conducting a qualitative interview for staff involved in the group to capture their perceptions of the effectiveness of the group for the attendees.

Prior to training the researcher undertook a BSc degree in Applied Psychology at Cardiff University, and an MSc degree in Clinical Forensic Psychology, at King's College London. Whilst studying at these universities the researcher took preference to quantitative research methodologies and prioritised the importance of neuroscience evidence in relation to mental health difficulties and offending behaviour. Her work experience had largely consisted of forensic settings with adolescents and adults who had committed sexual offences and/or been sexually abused as a child. The majority of the work she was involved in surrounded risk assessment and working with individuals to reduce the likelihood of recidivism. Through reading numerous reports to inform her psychological formulations, and add to the risk assessments, the researcher became aware of the prevalence of developmental trauma within a forensic population. The researcher began questioning the treatment approaches this population received whilst in mental health services and how such approaches and

environments can be damaging. She felt that more could be done for such a disadvantaged population.

During the first two years of Clinical Psychology training the researcher became more exposed to a non-forensic population of people with mental health difficulties. Working in a trauma informed service and being exposed to the critical view of psychiatric diagnosis the researcher became more interested in the impact of trauma and the resilience of the clients she was seeing. During her third year of training she worked within a psychology team that focused on promoting attachment informed ways of working to professionals in contact with young people who have input from health care professionals or education authorities.

The researcher began finding comfort from reading literature surrounding social constructionist thinking, narrative approaches to understanding someone's personal experience and the empowerment of marginalised populations. The researcher has felt connected with the feminist values[8] and principles that underpin the historical context of CSA for women. In brief, this approach aims to counter the oppression experience by survivors of CSA that is historically documented (Blume, 1990; García-Moreno *et al*., 2015). Feminist approaches are on the emancipatory type of inquiry, which documents aspects of reality and adopts a personal, political and engaging stance to viewing the world (Terry, 2014). This stance facilitates the erosion of hierarchies developed between the researched and the researcher by actively involving the research community and encouraging their involvement (Nielsen, 1990; Taylor 1998). These approaches seemed to fit well with the researcher's values, both personally and professionally and it became the main lens she adopted to view the world. The researcher developed frustration towards the larger system that mental health services belong to and felt a sense of responsibility to play a role in changing current mental health practices.

The researcher used supervision with both Academic and Clinical Supervisors to acknowledge her position during the process of the research. The researcher was aware throughout the entire process of conducting the research that there were different sources 'pressures' and 'standards' likely to be influencing her work. At times these pressures seemed to conflict, which required the researcher to take a reflexive stance in making decisions and refer to the literature to help build her confidence in the decisions made. The overarching 'pressure' experienced surrounded thoughts of failing the research viva voce and not qualifying as a Clinical Psychologist. A reflective essay has been written with regards to these

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[8] A socialist feminist stance emphasising egalitarianism and the collective good is the main focus (Kennedy, 2008).

pressures in Appendix seven. Writing this essay allowed the researcher to accept these concerns and continue to conduct the current research project.

Respondent validation

There is debate as to whether qualitative researchers should have their analyses verified or validated by a third party to add rigor and reduce bias to findings (Harf *et al*., 2015). One way of doing this is through conducting respondent validations (or member checks) (Baxter & Babbie, 2004; Harf *et al*., 2015; Rodham *et al*., 2015; Stiles, 1993). This is the process of returning to the research participants and asking them to validate analyses. Respondents can be asked to read through their interview transcripts and/or the data analysis (Harf *et al*., 2015). This process provides researchers with a method of checking for inconsistencies, challenges the researchers' assumptions, and provides them with an opportunity to re-analyse their data, and assess the degree to which the themes resonated with their experience (Anderson, 2010). However, when adopting this strategy, it is important to be mindful of the possible impact of the double-hermeneutic (Smith *et al*., 2009). After reviewing the literature it was apparent that there was no guidance regarding the best practices to undertaking respondent validation. Therefore guidelines for service user involvement in research were reviewed (National Institute for Health Research, 2009). The current study used respondent validation by asking participants for their views regarding the development of themes. Their feedback formed additional data that was used in the later stages of analysis. Further details regarding this procedure can be found in the 'Analysis' section.

Transcription

The researcher transcribed all transcripts verbatim. The importance of this process in qualitative research is emphasised by Bird (2005). Previous research suggests that the act of transcription is interpretive in that it is the process of formulating and producing a meaning to a narrative that is unique to the context (Lapadat & Lindsay, 1999). Thus, the researcher acknowledged the transcription phase as a form of data emersion. For this analysis to meet the demands for rigor in qualitative research, it was suggested that reflectivity is maintained regarding the transcription process. Therefore the researcher asked herself: "What is a useful transcription for my research purposes?" throughout (Kvale as cited in Lapadat & Lindsay, 1999, Contextualised section, p. 7).

Clinical Governance

Gaining ethical approval

The current study gained full ethical approval from REC NHS ethics and the research site's Health Board's Research and Development (R&D) prior to commencing recruitment and data collection. A copy of the approval letter can be found in Appendix eight. A Minor Amendment had to be made during the research process for two reasons: 1) to allow for one interview to be conducted over the telephone and, 2) to allow for participants to have a role in the analysis of the data (respondent validation). A copy of the approval letter for the Minor Amendment can be found in Appendix nine.

Informed consent

In line with the Health and Care Professions Council (HCPC) Guidance (HCPC, 2012) and the British Psychological Society ([BPS]; BPS, 2009) the researcher sought and obtained consent from all women who participated in the research. To help potential participants make an informed decision as to whether or not to participate in the study an information sheet (see Materials) outlining the details and rationale for the study was posted to each of the potential participants by their usual, or previous member of their care team at the research site. The researcher did not have access to any contact details of potential participants until they had indicated their interest in participating in the study by returning the 'Consent to be contacted form', which was attached to the information sheet (see Materials). The researcher also showed the information sheet to participants when they attended the semi-structured interview. During this time participants asked whether they had any further questions about the study. Participants signed a consent form (see Materials) to acknowledge their agreement to engage in the current study. The consent form confirmed that participants had read and understood the information sheet, that participation was entirely voluntary and that withdrawal from the study would not impact on their mental health treatment.

Confidentiality and anonymity

While the limits of confidentiality were acknowledged, every effort was made to ensure that confidentiality was maintained in accordance with BPS (2009) and HCPC (2012) Code of Ethics and Professional Standards. This was explicitly stated in the information sheet, on the consent form, and verbally discussed prior to commencing the interview. If concern was

raised by a participant regarding risk of harm to either themselves or another, the research site's procedures for disclosures of risk were followed.

The researcher assigned a pseudonym to each participant, which was used throughout the research process. Only the researcher knew participants' real names and the corresponding pseudonym. Contact information and other identifiable information, such as the completed consent form, were stored separately from the data in a secure cabinet that only the researcher had access to.

Participant wellbeing

Participants recruited had experience of talking about their experience of abuse prior to their participation. Despite the interviews not focusing on the participant's actual experience of CSA it was anticipated that asking questions surrounding their experience of recovery from CSA would bring up distressing memories. However, there is evidence to suggest that research participation of this population does not result in long-term negative impact (McClain & Amar, 2013), discussed in detail previously. However, as an additional safeguard the following procedures were implemented to protect participant wellbeing:

1) Participants were reminded that they could take a break during the interview and it was their decision whether they wanted to continue. Withdrawal from the research had no consequences for them.
2) All participants were asked a set of debrief questions (10 minutes at the end of the interview)
3) All participants were provided with a debrief form
4) All participants were given a leaflet highlighting the support options available to them (see Appendix ten and details below)
5) Care Coordinators of those participants still receiving support from the research site were informed of their involvement to ensure they were informed of the nature of the research should the participants seek support from them
6) As the researcher had developed competence in managing others' distress it would have been possible to implement this knowledge.

Support leaflets

The nature of the participant's current and past involvement with the research site determined what support leaflet they could access. Participants were identified as either:

A) Currently seeking mental health support and having completed the Survivors of Abuse: Freedom and Empowerment SAFE group (SAFE group) *(Provided with Support Leaflet v1 (a)).*

B) Currently seeking mental health support and having received/are receiving individual therapy *(Provided with Support Leaflet v1 (c)).*

C) Not currently seeking mental health support and having previously accessed support from the SAFE group *(Provided with Support Leaflet v1 (d)).*

D) Not currently seeking mental health support and having previously accessed support from individual therapy *(Provided with Support Leaflet v1 (b).*

All support leaflets provide information on:
- Local and national helplines and websites relevant for survivors of CSA
- Details of the Book Prescription Scheme and relevant books
- Information on mobile phone apps designed for people who have experienced trauma.

Support Leaflet v1 (a & d) provided additional details regarding the SAFE Graduate Group that meets fortnightly, which offers support for women who have finished the SAFE group. Support Leaflet v1 (c) highlighted that support could be accessed from their mental health care co-ordinators. Support Leaflet v1 (b) highlighted that support could be accessed from their GP. Some of the information used was obtained from a 'Stabilisation' manual/booklet that was co-produced by service users and used at the research site as standard practice. The support options outlined were discussed alongside a service user representative group who provided their feedback, and the relevant amendments were made.

Disclosure of risk by participants

The researcher, Clinical, and Academic Supervisor followed the research site's procedures and the BPS Code of Conduct at all times. The limits of confidentiality were outlined to the participants in the consent to participate form, and the limits of confidentiality regarding harm to self and others was emphasised. Participants were informed at the start of the semi-structured interview that disclosures of risk of harm to self and others would be followed up in accordance to the research sites procedures.

Participants were also informed that the Multi-Agency Safeguarding Hub (MASGH) would be notified if concerns regarding a child's safety were highlighted during the study. Referral to MASGH would follow the research sites procedures.

All participants had received therapy and had contact with mental health services and had experience talking about their experiences of past abuse. It is likely that subsequent to therapy the participants would have developed their own coping strategies to manage any potential distress related to talking about their past. If there were concerns regarding a participant's safety, the researcher contacted the Clinical Supervisor regarding additional support.

Materials

All materials for the current research were developed in consultation with a service user advisory group (five service users attended along with the service user advisory group co-ordinator) in the local area where the research sample were recruited. The researcher met on two occasions with the advisory group (totalling four and a half hours). All materials were also in line with REC NHS ethics committee and the researcher site's Health Board's R&D committee. Involving service users during the planning and design of the research materials ensured the language used and overall approach was clear and respectful, and that the topic area appeared relevant to the CSA community who accessed services.

Participant information sheet

A participant information sheet (Appendix twelve) was designed to provide potential participants with the necessary information required for them to make an informed decision as to whether they wanted to participant in the study.

All participants saw the information sheet at least twice before taking part in the semi-structured interview. For example, they would have been sent a sheet as part of the recruitment process, had the opportunity to discuss the information with a Clinical Psychologist or their Care Co-ordinator during recruitment. Participants also had time to discuss anything with the researcher when arranging the semi-structured interview, or just before the semi-structured interview was conducted.

Consent form

The consent form (see Appendix thirteen) enabled the researcher to gain written informed consent from participants.

The consent form included confirmation that the participant:
- had read and understood the information sheet

- understood that their participation was voluntary and they were free to withdraw without any consequences to themselves

- understood that any disclosure of risk would be followed up in line with the UBH's relevant policies

- was aware that academic and clinical staff involved in the study may look at the data collected. Staff from the from the Health Board's R & D Department may also look at the data. This was to ensure the study was being conducted in the right manner

- understood that the interview would be voice recorded

- understood that the information they provide would be confidential and anonymous, and used as part of a Doctorate in Clinical Psychology

- and finally, to acknowledge consent to take part in a semi-structured interview.

Semi-structured interview schedule

The interview schedule (see Appendix fourteen) aimed to explore adult women's experience of recovery after CSA, and their experience of mental health during this process. The interview schedule was developed using guidance from the literature (Smith & Osborn, 2008; Smith *et al.,* 2009), which suggests that the researcher should think broadly of the range of issues to be covered during the interview and then place them into an appropriate structure. Willig (2013) suggests that the interview schedule should include a relatively small number of open-ended questions. Furthermore, Smith *et al*. (2009) suggest that questions should avoid jargon or technical language and be neutral rather than leading. To ensure the suitability of the interview questions, and to maintain quality, a number of strategies were adopted, for instance service users were consulted during the development of the schedule to ensure it adhered to a sensitive approach and adopted appropriate language, and as suggested by Biggerstaff and Thompson (2008) a pilot interview was conducted with a peer to confirm that the questions were clear and answerable. Close supervision was sought throughout this entire process.

Interviews were designed to last on average approximately one and a half hours. The topics covered were:

- Experience of recovery.
- Factors that helped and/or hindered recovery.
- Their experience of mental health services during recovery.
- Messages to pass on to others.

The schedule had prompts that were used throughout the interview to obtain further information.

Participants

Sample size

According to Turpin *et al*. (1997) the Clinical Psychology Doctoral Programmes in Britain recommend that having six to eight participants is appropriate for an IPA study. More recently Smith *et al*. (2009) suggest that between four to 10 participants is adequate for analysis of data at doctoral level. The lack of clarity surrounding absolute sample sizes required in qualitative research has been reviewed by leading researchers (Baker *et al*., 2012). Baker *et al*.'s (2012) review identified a number of factors that should be considered when predicting adequate sample sizes. Factors identified of particular importance to the current research are that the desired sample may be hard to reach, and the time-pressures to collect the data. Hefferon and Gil-rodrigues (2011) describe how students consistently appear to experience pressure to include too many participants, seemingly in order to satisfy research boards and supervisors in line with the quantitative monopoly within academic research. This necessarily de-emphasises IPA's commitment to ideography as IPA aims to describe in detail the perceptions and understanding of a particular group under investigation, rather than making more general claims (Smith & Osborn, 2008). Samples in IPA studies are usually small, which enables a detailed and very time consuming case-by-case analysis. It is inappropriate to use a large sample size just because that is more common in psychological studies (Pietkiewicz & Smith, 2012). Reid *et al*. (2005) explain that with IPA less is more to allow for greater depth of analysis, which is always preferable to a broader, shallow and simply descriptive analysis of many individuals, as commonly seen in thematic analysis, grounded theory or poor IPA (Hefferon & Gil-rodrigues, 2011; Larkin & Thompson, 2012).

Malterud *et al*. (2016) discusses the concept of 'information power' to guide adequate sample size for qualitative studies. Information power indicates that the more information the sample holds relevant for the actual study, the lower amount of participants needed. They suggest that the size of a sample with sufficient information power depends on (a) the aim of the study, (b) sample specificity, (c) use of established theory, (d) quality of dialogue, and (e) analysis strategy. All the factors discussed above were considered during the recruitment phase of the research.

Sample

Typically, IPA researchers aim for a fairly homogeneous sample that is purposively selected allowing one to find a defined group for whom the research problem has relevance and personal significance (Pietkiewicz & Smith, 2012; Smith *et al*., 2009). All participants in the current research were adult women who had received care from NHS community mental health services in South Wales that at the time of recruitment aimed to deliver care in accordance to trauma informed principles (see Rosenberg, 2011, for more details regarding these principles). All participants had disclosed that they had experienced CSA. All women would have attended the SAFE group (see Appendix eleven for details on the group format) or would have received individual psychological therapy (approaches would have varied).

The sample was selected based on the following inclusion and exclusion criteria at the time of recruitment and interview.

Inclusion criteria

- +18 years of age.
- Female.
- A history of CSA, where sexual abuse was defined as any unwanted sexual contact or repeated exposure to sexual material (e.g. pornographic images), and childhood was defined as prior to the age of 18 years (as defined in Chapter two, Part one).
- Is known to the research site services either from engaging in individual therapy or attending the SAFE group.
- Willingness to participate and could provide informed consent.
- Able to communicate in the medium of English.

Exclusion criteria

- Is assessed by the multidisciplinary team (MDT) at the research site as being high risk, e.g. having suicidal intent, intent to harm others or inpatient status.
- Under the influence of illicit substances.

Description of overall sample

Seven women were identified as meeting the inclusion criteria for the research. All were selected through purposive sampling. All women selected to participate responded to the invites and took part in the study. The final sample is described below (Table Ten).

Age	Nationality	Experience of services for mental health
40	British	GP, Secondary Care (Outpatient Support)
35	British	GP, Primary and Secondary Care (Outpatient and Inpatient Support), Perinatal Services
44	British	GP, Third sector for sexual abuse, Secondary Care (Outpatient and Inpatient Support)
54	Not EU	GP, Secondary Care (Outpatient Support)
49	British	GP, Primary Care, Secondary Care (Outpatient and Inpatient Support), Tertiary Services (Eating Disorder Service, Drug and Alcohol Service, Medium Secure; Outpatient and Inpatient Support), Third sector for sexual abuse
45	British	GP, Primary Care, Secondary Care (Outpatient Support), Christian Counselling
34	British	GP, Secondary Care (Outpatient Support)

Table Ten. Description of sample recruited in the current research.

The researcher ensured anonymity through minimising the possibility of identification by only reporting a limited amount of demographic data. The data collected was in accordance to similar research projects to allow for consistency within the literature. All participants were aged between 34-54 (mean age of 43 years). At the time of the interview all participants had completed the SAFE group ($n = 5$) or were not currently engaged in individual psychological therapy but had done in the past ($n = 2$). All participants had originally sought mental health care through their GP. All participants had involvement with secondary care mental health services. Three participants had received inpatient mental health care on more than one occasion; all others had received outpatient mental health care. Other forms of mental health care included: Christian counselling, tertiary services (eating disorder services, drug and alcohol services, medium secure; outpatient and inpatient support), third sector support for sexual abuse, and perinatal support. All participants were white British with the exception of one who lived the majority of her life outside of the EU. One participant attended the interview with their support worker.

Procedures

Recruitment procedure

Following ethical approval the researcher's Clinical Supervisor introduced the study during the research site's MDT. The MDT was provided with a copy of the study information sheet. A member of the potential participants usual/previous (depending on whether they have been discharged from the service) care team made initial contact with the participants through written communication (initial participant information sheet, with the cover letter for participation attached, see Appendix fifteen). If potential participants agreed to be contacted by the researcher (by either phone, letter or email) they were contacted to discuss the research study and their participation (see Appendix fifteen). The researcher had no contact with the

potential participants until they returned the consent to be contacted form to their member of the care team who sent them the information about the study. After the initial contact the potential participants were then given two weeks to decide whether they wanted to participate. Following this, a convenient date, time and location for the participants to attend an interview were arranged with the researcher.

Interview procedure

All participants took part in a one-off semi-structured interview. All but one interview took place in meeting/therapy room within the research site (NHS mental health setting). One interview took place via telephone communication due to unforeseen circumstances. All participants followed the same interview procedure. At the outset, participants were reminded of the study aims and shown the participant information sheet. The researcher reminded participants of the limits of confidentiality and that participation was entirely voluntary. The researcher discussed the consent form with the participant and each item was carefully covered to ensure that informed consent was gained. Participants were reminded that the interview would not enquire about their experience of CSA, and an outline of the topics that would be discussed were given. Participants were reminded that they could take a break at any point during the interview and it would be their decision whether they wanted to continue. None of the participants chose to take a break during the interview. The start of the interview also afforded the researcher time to build rapport with the participant and to help put them at ease (Smith *et al.,* 2009). The interview was conducted in a flexible manner, using the interview schedule and appropriate prompts to encourage participants to elaborate on topics discussed (Smith & Eatough, 2007).

On completion of the interview the researcher thanked participants and gave them the opportunity to comment on the research process and ask any further questions. All participants were given a debrief sheet (see Appendix sixteen) and informed about the support options available. They were also asked if they would like to be involved in the analysis and dissemination of the research findings. All women wanted to be involved in this process.

Each interview was recorded using an encrypted digital recorder to enable later transcription and analysis. Following each interview, data from the digital recorder was transferred to a password-protected computer file in order for transcription to take place. Recordings were deleted following transcription. Interviews were transcribed by the researcher and the transcript document file was saved under the participant's pseudonym and password protected.

The researcher collected field notes on factors that were not captured on the voice recordings of the semi-structured interviews. Factors include contextual information, information regarding participant's body language, and spontaneous emotional reactions (Smith *et al*., 2009). These notes were also transcribed as they enriched the data collection and analysis further through triangulation.

Data Analysis

Data were analysed according to IPA methodology, using a structured framework proposed by Smith and Osborn (2008) and Smith *et al*. (2009). It is recommended that this framework is used flexibly. It was decided that the framework would be used in a non-directive way as a starting point for analysis. Harper (2013) cautions that many Clinical Psychology Trainees approach the phenomenological method in a formulaic manner, and that they sometimes allow external models or discourse to shape their research. It should be noted that the researcher analysed the data prior to conducting the SR detailed in Chapter One. Although this is commonly a Grounded Theory approach it was felt that this would act as a method to reduce bias and preconceptions (Charmaz, 2012).

During collection, transcription and analysis of the data the researcher kept a record of the process and reflections on any changing ideas and assumptions made (see Appendix six for extracts of this process). Research participants that identified themselves as willing to have a role in the analysis were consulted once a draft version of the overall themes was achieved.

Outline of analysis

Stage one: Reading, re-reading and noting

Transcripts were individually read repeatedly and coded to identify themes within each transcript that best captured the essential qualities of that interview. Findings from the first case were set aside (as far as is possible), through dynamic bracketing, which required the researcher to adopt a reflexive stance and note any reflections[9]. This was done to maintain sensitivity to each person's unique story (Smith *et al*., 2009) and was referred to during the later stages of the analysis (developing the overall narrative). Comments made on the transcripts were initial interpretations or attempts to summarise or paraphrase, or highlight associations or connections. Willig (2001) suggests that it is usually here that psychological

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[9] Stages one-four were conducted on one transcript before moving to the next.

concepts and terms may be used in an IPA analysis, therefore psychological theories were considered. As the researcher moved through the transcript comments began to highlight similarities and difference, amplifications and contradictions (see Appendix seventeen for an example of this).

Stage two: Developing emerging themes

At this stage, the researcher aimed to transform the codes into emergent themes through working more closely with the notes, rather than with the transcript. The emergent themes then began to reflect the more detailed and comprehensive notes produced in the earlier stage of analysis. Emergent themes aimed to capture the essential quality of what was found in the narratives, and began to move to a higher level of abstraction.

Stage three: Searching for connections across emergent themes (within a case)

This stage provided an overall structure to the analysis by relating the identified themes into 'clusters' or concepts. The aim was to arrive at a group of themes and to identify super-ordinate categories that suggest a hierarchical relationship between them. Themes were compiled for the whole transcript before looking for connections and clusters. Each theme was written on a Post-It note and arranged in accordance to the clusters that produced a narrative that represented the participants'. Some of the themes were dropped at this stage if they did not fit the emerging structure well, because they had a weak 'evidence base', or were not specific to the research question. Supervision was sort throughout this process and aided the development of the overall structure of each case. Peer discussions and reviews were also sought to confirm the theme development (Biggerstaff & Thompson, 2008).

Stage four: Summarising theme in a table

The fourth stage aimed to develop a 'master' list, or table of themes. Clusters of themes were ordered to identify the main features and concerns produced within the narrative. Tables in a word processing document were used to organise this information. The tables had evidence from the interview using a quotation that the researcher felt best captured the essence of the participant's thoughts and emotions about the experience of the phenomenon being explored. This was an attempt to remain faithful to the individual through illustrating the particular life-world of participant whilst also illustrating more general themes (Smith & Eatough, 2006; Smith & Osborn, 2008). This facility for highlighting unique perspectives as well as shared experiences is one of the cornerstones of IPA (Smith & Osborn, 2008).

Stage five: Moving to the next case

All of the four stages detailed above were repeated for the other six transcripts. Smith *et al.* (2009) highlight two ways in which the researcher can move to the next case. Firstly, the researcher can use the emergent themes generated by the first case analysis to guide the overall structure of the analysis for the following cases. Secondly, the researcher brackets their ideas from the previous case(s) analysis using the reflective journal, whilst working on the next so that new ideas can be noted on subsequent analyses. The researcher of the current study attempted to bracket their assumptions and ideas generated from each case but was aware of the difficulty of this process.

Stage six: Identifying patterns across cases

This ideographic approach then moved towards searching for recurrent themes across transcripts. Themes reflected a shared understanding by participants but also highlighted differences. Naturally, as in any qualitative analysis, the researcher encountered material that did not fit the emerging picture (Smith *et al.*, 1995). Such dissonance prompted the researcher to revisit earlier transcripts, and reflexive notes in case something vital was missed or misunderstood. As this was not the case the researcher was able to comment on the dis-confirmatory or contrasting narrative within the themes it emerged. Finally, an overall list of recurrent subordinate themes was generated. These themes were then clustered into superordinate themes that best described the narratives of the participants.

The final analysed account offered a layered analysis of the phenomenon; firstly a descriptive, phenomenological level which conveyed an empathic understanding of the experience, and secondly a probing, more critical analysis based on the deeper interpretative work of the researcher (Eatough & Smith, 2008; Larkin *et al.*, 2006; Smith *et al.*, 2009).

Stage seven: Assessing the trustworthiness of the themes

Data were compared and analysed until the researcher, Clinical, and Academic Supervisor were satisfied that emerging themes adequately described the text and that final themes closely reflected the data. Any differences in thoughts regarding the analysis were discussed until a resolution was sought. Additionally, all participants were re-contacted a month after participation to go through a draft version of the themes that were found across the interviews (respondent validation). Five participants were able to provide feedback, two gave feedback via email and three met the researcher face-to-face. Participants were given the opportunity to

make any comments regarding the overall structure of the themes. These comments were taken into consideration in the final stages of the analysis and were used as a form of data triangulation. All participants who took part in this process stated that overall the analysis reflected their experience well. Once a final draft of the analysis was derived the Clinical Supervisor provided feedback reading the overall theme coherence.

Presenting themes

How people engage with the data is an essential element to consider regarding dissemination. Medical professionals are becoming more open to the idea of using creative approaches to present complex scientific material to introduce a new medium of learning (McCullough, 2012). However, scientific data presentation in this manner, and data presentation in general is often overlooked in qualitative research (Furman *et al*., 2006). The research endeavour should not be viewed merely as an activity aimed at finding facts but should be geared toward creating knowledge that might affect its audience intellectually and emotionally. Displaying data visually helps organise, summarise and simplify data to help the audience make inferences and conclusions (Furman *et al*., 2006; Verdinelli & Scagnoli, 2013). Qualitative data produces large volumes of words that do not lend themselves to the space limitations of academic journals, or the data is too impersonal or dense to be easily consumed and often leaves readers overwhelmed or unmoved (Chandler *et al*., 2015; Francis, 2002). Unfortunately condensed visual elements such as summary charts, tables, or graphs often used in quantitative research findings are not commonly transferred to qualitative research (Slone, 2009). Within current society more value is being placed on presenting qualitative research succinctly and clearly. Therefore, new approaches and modalities beyond text, which emphasise the importance of voice, are required.

There are a growing number of examples of innovative and creative ways to present dense qualitative data. For example, Richardson (1992) crafted her interview data from traditional qualitative methods into lyrical poems to present lived experiences. To create the poems she relied on her sense of the data and knowledge of literary tools to stay as true to the meaning of the original text as possible. During the writing of the drafts of her poems, she used a journal as a reflexive tool to explore her potential biases about her research. More recently, Chandler *et al*. (2015) proposed a hypermodal space where sound is integrated with innovative data visualisation elements. Others have used a similar approach, for example Wiles *et al*. (2011) and Barnes and Murphy (2009) both discuss the use of visual information throughout their research however this was in the context of a Grounded Theory methodology (e.g. Barnes & Murphy, 2009). Furthermore, Mathews and Collin-Vézina (2016) suggest that

images are useful for raising awareness and empathy when attempting to promote new public health responses.

In an attempt to make potentially complicated and inaccessible information more accessible to the majority, the researcher of the current study developed a table to organise all the themes and created images to express each superordinate theme. Images were created in close consultation with one of the study participants' whom was passionate about art and stated that they would like to have a role in the analysis and dissemination of the research findings. Communication was largely via email and meeting face-to-face. One reason for this close consultation was to overcome the issue of double hermeneutics (e.g. avoiding the illustrator attempting to make sense of the researcher's interpretation of the participant's narratives). The goal of presenting data in this manner was to inspire an empathic, emotional reaction, to the data so the audience can develop a deep, personal understanding of people's lived experiences, which can also aid recovery experiences (Glass, 2008). The overall aim was not to reduce people's experiences but to illuminate and expand on them to show the richness and fullness of the phenomenon being explored (Glass, 2008). The researcher sought advice from Dr Nina Borrows regarding creating images for a population of individuals who have experienced CSA as she has published self-help books that have been created from survivors' narratives.

ANALYSIS

Chapter three overview

This chapter presents the themes that emerged following the implementation of an Interpretative Phenomenological Analysis (IPA) of the data collected via semi-structured interviews with seven women survivors of childhood sexual abuse (CSA). The analysis was conducted in an attempt to answer the following research questions:

1. What is the lived experience of recovery after CSA from the perspectives of women survivors of CSA?

      1.1 How do they perceive mental health services to have played a role in this experience?

From the data collected several interrelated themes became prominent within the women's narratives. The analysis revealed two levels of themes: superordinate; and subordinate, and incorporated both research questions, as it was felt that the women's narratives did not entirely separate the role of mental health services from their lived experience of recovery. This was likely due to the context in which the sample was recruited. A dialogue surrounding how the role of mental health services was incorporated within the analysis is presented within Appendix eighteen. However, it was felt that the narratives that created superordinate themes two and four best reflect the women's understanding of the role mental health services played in their experience of recovery.

Superordinate themes were developed through clustering the subordinate themes drawn from the women's narratives (see Chapter Two, Outline of analysis). Each superordinate theme will be explained and a detailed description of the subordinate themes within them will be provided. One of the participants created images to illustrate the superordinate themes in consultation with the researcher during the analysis of the data (see Chapter Two, Presenting themes). Appendix nineteen provides an example of the reflective notes of the participant who developed the images during this process. To highlight and support the subordinate themes further, verbatim extracts of the interview transcripts written in *italics* are included, along with the participant's pseudonym and transcript line numbers to reference (Elliott *et al.*, 1999). This was in accordance with Elliott *et al.*'s (1999) recommendation that quotations should be provided to allow the reader to scrutinise the analysis. Within the verbatim extracts square brackets '[ ]' were used where the researcher has added information (e.g. to explain what the participant was referring to), and at times, three full stops '…' have been used to

indicate when text has been edited to shorten extracts. Descriptions of non-verbal communication from participants are provided in paired parentheses '( )'. Furthermore, all identifying information has been removed or changed to maintain anonymity. Rich and detailed narratives will be presented to provide a platform for women who have experienced CSA a voice. Although this may result in a lengthy analysis presentation it was hoped that providing this level of detail moved away from the silencing culture these women experienced in the past (a theme discussed in detail within this research). Furthermore, the subordinate themes have been labelled in accordance to the women's narratives to emphasise their voice throughout.

The themes identified were one possible account of the experience of recovery after CSA and the role mental health services have had within this. It should be acknowledged that this is a subjective interpretation and others may have focussed on different aspects of the women's narrative. Therefore, the themes will not cover all features of the women's experiences. Themes that are discussed were considered most relevant to the research aims. While many of the themes were common to the seven participants, there were areas of divergence and difference. Furthermore, although the researcher has attempted to order the themes it should be acknowledged that there was no true way to order them. Each theme was present within each other, therefore no theme can be considered to stand alone.

Theme outline

For clarity Table Ten provides an overview of the superordinate and subordinate themes that emerged from the analysis. Each theme will be discussed in detail below.

SUPERORDINATE THEME	SUBORDINATE THEMES
1) The on-going, unfinished journey of recovery	**"Just continuing the journey"**
	"Constantly, constantly fighting everything"
	"A shocking moment, a landslide"
2) The power of being silenced by others	"Putting on my mask"
	"I was going to ruin everyone's lives"
3) Acknowledging the past and uniting it with my life	**"I just hated it…how the hell is this going to help?"**
	"Hatred of this little girl I used to be"
	"Trying to protect them"
4) I can't do this alone: Ingredients for connections with others	"Started on the same path and then we branched out"
	"Not pity. We don't like pity!"
	"It's got to be their choice, or you are just making it worse"

Table Ten. An outline of the superordinate and subordinate themes identified within the analysis. Superordinate themes were created by the researcher, whilst the subordinate themes are verbatim extracts from the women's narratives.

THE ON-GOING, UNFINISHED JOURNEY OF RECOVERY

SUPERORDINATE THEME	SUBORDINATE THEMES
1) The on-going, unfinished journey of recovery	"Just continuing the journey" "Constantly, constantly fighting everything" "A shocking moment, a landslide"

Women in the current study make sense of their lived experience of recovery after CSA as a journey from the time of the first incident of sexual abuse to present day and the future. A majority of the women wanted to highlight that their experience of recovery was different from recovery in the sense of one-off traumas, such as a car accident, or a physical illness. The subordinate themes attempt to unveil some understanding of this experience. For example, the first theme the women communicate, "Just continuing the journey" represents a continuous journey that cannot be separated from the daily routine of life. This journey is a constant fight or battle ("Constantly, constantly fighting everything") (theme two) and includes many obstacles to overcome, peaks and troughs to scramble over, and pits of despair to crawl out of. Some of these experiences form "A shocking moment, a landslide" (theme three), which is an event that precedes a significant change in their lives. These three themes appear to be the constant core factors of the recovery journey process; the women comprehend them as permanent elements of life. Figure three contains the images created to represent this superordinate theme.
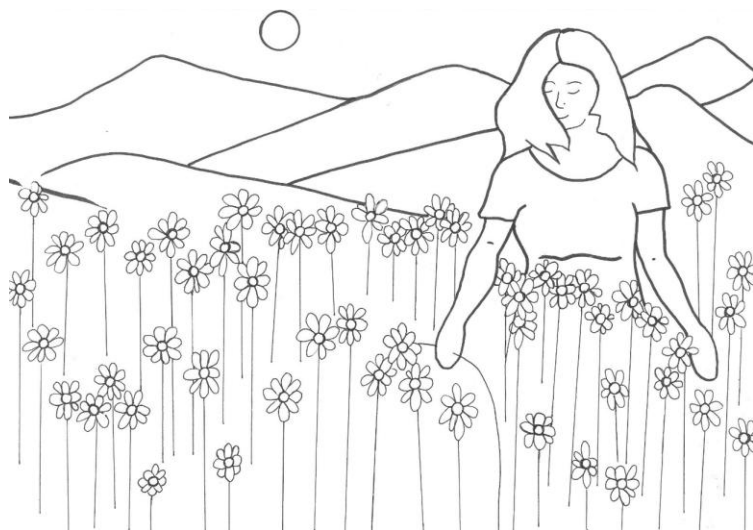
Figure three: Images created to represent superordinate theme one.

"Just continuing the journey"

Women in the current study shared that their lived experience of recovery was an on-going, continuous process with no end-point or goal to 'check-off' a list. Their experience of recovery is their life, and therefore follows the same course.

When asked about her experience of recovery Ann clearly illustrates her experience as on-going, rather than a standalone event.

"Maybe adding on-going in front of it. On-going recovery." (Ann; 999-1000)

Sarah and Fran detail their frustrations towards the wider societal view of recovery as an isolated, overcomeable event. They go on to challenge others' views by identifying that there is no 'one fix,' the journey/process is more complex than this. It is constantly present in their lives.

"I think the biggest hurdle is when people don't understand what recovery is from childhood sexual abuse. People think that you can see a counsellor or that it's a one fix and it's done (10)… I think one of the things I found frustrating was that other people's understanding was a one fix" (Sarah; 18-20)

"I think a lot of people think 'oh if you have therapy it will go away' I think a lot of people think like that…I think a lot of people think with people who are abused, 'oh it happened years ago, just get over it' I have had people say that. Not to me directly, but you know these ones on the TV with Jimmy Savile and things, and people say 'it's been 40 years now, why bother' but it's not 40 years ago for that person, because I know it's now every day. I think a lot of society is like that." (Fran; 151-167)

Charlie goes on to share how her on-going experience of recovery varies. She was unsure of the catalyst of this variability. Her narrative outlined her reality of her experience, which did not fit the 'one fix' understanding she felt others perceived. It also highlights a passage of time and how this passage had no end-point; it reflects a moment-by-moment process that was not separated from the course of life.

"It's been on and off. I have good spells, bad spells. But at the moment the bad spells of depression are closer together. But I don't think it's related to my past. I think it's depression on its own." (Charlie; 694-697)

Taking a similar view and narrative as Charlie, Sue shares the turbulent nature of her experience of on-going recovery.

"I think I'm a bit up and down. So I will do well for a period and then I will slip back again. So that's sort of how I have been for the whole time really (6-9)… But it's sort of the ups and downs sort of all the time really." (Sue; 17-18)

None of the women talk about an end-point to this journey when they are alive, as it was viewed as *"just continuing the journey and recovery" (Mandy; 224-225)*. Sarah details the end-point of the recovery process as her death; again this reflects the natural process of life.

"I will be dead. When I die, project over. So if that's next week or if that's 30 years from now, well that's the way it ends." (Sarah; 978-980)

Sarah also touches upon the uncertainty of this recovery process by making inference to the uncertainty surrounding inevitable death that everyone faces. She makes inference to the uncertainty she faces within the following metaphor. Although she portrays herself as 'free', her experience of CSA has shaped who she is, and therefore the shadow of her past is always present and has formed a cage that is inescapable.

"I remember at school we studied about slaves being freed after the civil war in the 1860s. All these millions of black people who were enslaved, and most of these slaves were born into slavery and they had no idea what it was like to be free, they didn't know what that meant, 'they were slaves' and I thought it was extraordinary when we studied this at school. And when we were told that when the slaves were freed most of them stayed where they were. They didn't suddenly just up sticks and go somewhere else. Well, why not? But where would they go? They don't know any other life than what they know. And a lot of them just stayed where they were. And carried on doing what they did. The only difference was if they wanted to go they could. But where? And how? And I felt like that you know. OK I'm free now, what do I do? So it's a strange experience, I don't know quite how to describe it." (Sarah; 1115-1138)

Participants seem to be aware and accept the on-going, uncertain nature of recovery, or life after CSA. For instance, Sue explains that at any time she may experience a trigger that will derail her from her ability to fully engage with life. She has come to some acceptance of this, and shares how it is an uncontrollable experience that does not get 'easier'.

"You can recover as in, like I say I have ups and downs…like somebody might be recovered for like years and one thing might trigger them and it bring it all back again. So you can be recovered as in, if you spoke to me eight weeks ago, then yeah, I was fully recovered, I'm fine now." (Sue; 1043-1051)

"And I'm still working on it. I mean it's on-going project. And things come up and I have to deal with them, and I do now… I dread to think what is going to be next." (Sarah; 967-973)

"I'm feeling loads better again now. So I am on the recovery up again now. It's as if I hit crisis point and it all crashes down and then I'm loads better again…" (Sue; 922-927)

"…You're just having to live with it on a daily basis….Now I have learnt to accept it I guess." (Fran; 33-40)

Participants spoke about the realisation that with a down comes an up, and this seemed to reduce the intolerability of uncertainty. This awareness gives some comfort when in the past it has left people feeling as though they were 'losing their minds'.

Sue and Sarah paint a picture of this on-going process by describing themselves as being 'haunted' by the abuser. They are being followed by a persistent shadow that is impossible to remove. Making reference to being haunted and something in their 'head' may also reflect the difficulty they may face when trying to 'convince' others this experience is real.

"…She remembers me saying to her 'he's just always in my fucking head, just always in my head' … is just constantly there and sometimes it's more and sometimes it's less." (Sue; 980-984)

"This business from my childhood always haunted me, always comes back." (Sarah; 897-898)

"Constantly, constantly fighting everything"

Although women convey that recovery is on-going and part of life, this theme does not necessarily represent the difficulty of this experience. The ability to move through life following CSA is not comfortable for these women. To be in the position they are today the women have arisen from lonely prisons. They have done more than survive.

"I read the bible as a child so I can't help referring to it… King David says he is in a pit of despair and he wants to be lifted out of the pit and he is asking God to lift him out of this pit, he is saying 'lift me out of this pit it stinks down here, it's hot and I have nothing to eat and I'm lonely and I'm sad and I can't stand it anymore, please take me out of this pit' (1482-1490)… I was in the pit and I wanted to be lifted out (1497)… I was trying to claw my way out of a stone cavern by my fingernails and kept slipping down and that went on throughout the seizure and that was the pit. I thought I had died and so I emerged from this pit of despair... That's how I see it rather than recovery and survival. Survival means I'm still alive." (Sarah; 1500-1509)

This journey takes a lot of fight and strength, which some liken to being a warrior in an on-going battle. This notion of being a warrior was reflected in participants' concern regarding

the term 'survivor'. For instance, during the feedback interview Sam said that since the initial interview the word 'survivor' had been playing on her mind. She began reading the following note she had prepared prior to the interview to communicate why 'survivor' did not fit well with her. Sam expressed considerable emotion whilst reading this extract highlighting its value to her. Her note seemed to reflect that discussed by others in the above narratives regarding the term recovery.

"Would I call myself a survivor? Well yes. Nine years ago I had a car accident. The decision whether I lived or died that day was not in my hands. I lived. I survived. Am I a survivor of sexual abuse? Well, the decision to be a victim of abuse was not mine. Every day I have the decision to make whether I live or die. Some days it's not battle at all. I feel great; I look into the eyes of my children and wonder how I could ever leave them. Other days I can't look at them, I have to fight an oh so familiar battle with myself. To survive is to experience a one-time trauma and to live afterwards. To suffer sexual abuse and choose to live, not kill myself afterwards, and face that battle everyday of your life needs bigger recognition, a bigger word. A 'survivor' does not do justice to what I have gone through just to be here today and the on-going battle I am yet to face." (Sam; 8-33)

Concern revolves around the concept of survivor not reflecting the strength and determination required to live after experiencing CSA.

"I don't know if I would use survivor… survivor makes you feel like your boat has sunk and you have swam to shore…and in another way it does make you sound like a bit of a warrior. I don't know if that's the right word to use, yes you survive it but, it just seems like a general term and you've got to go through so much and you've got to go through so much recovery to survive I think it needs a better word but I don't know what (1123-1134)… It needs like a stronger word because you have got to be a strong person to get through it, you have got to be a survivor, it's not just surviving it and that's it… Something to say that it isn't just a general thing…something to say that yes, you have survived it, and look what you have had to go through to get it, and to make it sound like you're a stronger person."
(Sam; 1139-1151)

"I do see myself as a survivor and sometimes a warrior. I said that to the group, I'm a warrior but on a clapped out old donkey." (Sue; 1350-1358)

Essentially, the word 'survivor' is inadequate to give justice to the battles they faced throughout their lives. Questioning the language used by others encapsulates the women's desire for them to recognise their strength rather than feel that others view them as passive recipients of mental health services and a drain on society.

Participants outline the battles they face throughout the journey process. Charlie shared her experience of having the strength to put herself through seeking help and touched upon the fragility of this emerging strength. This highlights her thoughts regarding the strength

required to be more engaged in life rather than just 'coping' or 'surviving'. As described above, there was a need for others to acknowledge the difficulty of the battle they faced, especially services that tried to help them through the process.

> *"I think if someone has taken that step to do something about it [seeking support] I think it needs to be acted on as quickly as possible. Because it takes such a lot of guts to do something about it. There is every chance that person won't come again." (Charlie; 898-993)*

Charlie went on to explain how she did not want to forget this battle and the strength it required. The battle the women had experienced was something to be proud of. It was something to be celebrated and worn as a badge of honour. The strength to battle was positively viewed if recognised.

> *"When I did this SAFE [Survivors of Abuse: Freedom and Empowerment [SAFE] group] course at the end of it, I got this tattoo. It represents courage. So I wanted it to hurt. I was a bit disappointed it didn't hurt as much as I wanted it to, so when I look in the mirror I can see it and it stands for courage and it's significant for what that course meant to me and so yeah, it took courage to do it and I survived." (Charlie; 1028-1034)*

Sue uses a metaphor to depict her experience of court, which as she spoke, felt that she applied to a number of instances in her life. It reflected her personal battle. Within Sue's story she encapsulated her isolation throughout her lived experience of recovery and the physical and emotional strength required to stand against the odds. Considerable strength was required from these women, and although it may be perceived as fragile at times it will continue, which represents the tireless, continuous battle of recovery from CSA.

> *"…The court case, going on for the eight months, I describe it as having to climb Everest and there are a few friends trying to help you up and a few friends trying to pull you back and it's the hardest thing you have ever done, but you make it, and when you get to the top someone says, 'no that's too easy' and kicks you all the way down to the bottom and then you have got to do it again but with two broken arms, two broken legs and a broken sprit and a broken heart and you know you have got to get back up there again." (Sue; 1142-1152)*

This battle is a relentless personal experience, and one that may not be 'won'. False and unrealistic expectations make this battle harder. Regardless, it is a battle the women continue to pursue. As Mandy shares, recognition that there is no end-point allowed her to become more compassionate towards her efforts to continue.

"I might not win the battle, but I will fight and do my best, and if I don't win the fight I don't win the fight, but at least if I can improve the fight it's better." (Mandy; 698-701)

Participants are clear to state that if you do not battle through there are few options left. There was strength in their determination to face the battle.

"I will never recover from what happened to me, ever, no way will I ever accept that what happened to me was right or forget what happened to me. I will never recover from it. I have no choice, I will either go under, or I can get on with life and battle on. They are the only two choices I have." (Fran; 434-438)

"It was either I would fizzle out and die or I was going to have to do something to change my life." (Sarah; 99-101)

"It's like having a baby, it's going to hurt and it's going to be really painful and traumatic and you don't know how long it's going to take but that baby has got to come out. You know? And you have just got to sit it through until it's done, and push, but at the end of the day it's something that had to happen. Even between the two court cases the text messages from my two cousins got more frequent asking me not to do it and everything is stopping you but you are battling to get up there." (Sue; 1168-1192)

Unlike the other participants, Ann did not carry as much determination in her narrative surrounding the constant battle she faced with her experience of recovery. Although her narrative does unveil her willingness to be present within the battle there was less energy or hope to fight.

"I live everyday as, as if I can't breathe, I get up every morning and think 'oh god not another day to get through', I can't wait for the night to come so I can go to bed. Every day. Every hour. Every second. I think it just takes all of my energy and I still get to the point where it's so difficult... It's just the way it's always been." (Ann; 768-777)

"A shocking moment, a landslide"

The women conveyed their narratives through a number of pivotal points that began to map their recovery route. These points were detailed as events where their usual/normal pattern of how they have lived their life changed. These points seem to be followed by a significant change in their perspective regarding recovery from CSA.

Participants with children all identified motherhood as a particular turning point. This point resulted in a change in their purpose in life, from 'just surviving' and going with the motions of life, to a position of being a protector and having to take responsibility and to provide.

"...Totally changed my life in some ways. I wish I hadn't been pregnant. I wish I had stayed there because I had family in another country. I wish I could have stayed there, and I wish I could have had this new life but, in a way she's given me life, and she has given me something to live for. She is an amazing girl, my eldest is. She really is. And you know she has totally changed everything, she has changed my perspective of life and she has sort of made everything slot into place and given me reason to live really, keep strong." (Sam; 487-498)

"And I suppose that when my journey started, having my first child and then realising that if anyone laid a finger on them that I would kill them. I think as a parent you do see things differently. Whereas when you haven't had kids, it is different the way you, you know, your instincts and everything is different." (Mandy; 288-294)

Becoming a mother was a powerful moment for the women and was the start of a new and welcomed perspective, but only once they have lived it. There was a change in their beliefs about themselves and their role in life. The women acknowledge their value through feeling depended on.

There was a difference from the time before and after these points in life. The lived experiences the women shared were rich in description, which suggests the importance of these points and the value they had in the women's lives. Sarah identified this experience and felt it was reflected in a lot of people she had met. Sarah highlights its importance within her experience and the shock related to it. It was almost like presenting an alternative, preferred reality to what she knew her entire life.

"When the change comes there is a shocking moment, a landslide. I think that would apply to all the women there is this sudden moment that you just reject the idea that you have been abused because you are bad…the change that occurs in so called 'recovery', there is a big change that happens. An epiphany if you use an old word." (Sarah; 1300-1314)

The alternative reality offered purpose, and encouraged the women to embrace elements of control over their lives. Women often shared two distinct time periods within their narratives, one where they did not feel they had control in the direction of their lives and the other when they first felt able to gain this control. This was interpreted as a decorated and almost sacred moment. They became important stories within the women's lives. Everyone has created a coherent narrative around them.

"...Then I had the carrot moment not long after. I hate carrots. I was bought up you have got to eat what's on your plate…so I would always have my carrots on my Sunday dinner…and I would eat them first to get them out the way so I could enjoy the rest of my dinner… so I was dishing up a Sunday dinner in the kitchen of my own house … I'm giving them all [her family]

the options of what they do and don't like and I'm putting carrots on my own plate even though I don't like them. And somewhere, something inside me went, 'I'm a grown woman...I don't have to put carrots on my plate.' It was like 'no, I don't have to do it'. So I scraped the carrots into the bin and it was like, 'oh', it just felt good. And there was something in my carrot moment that led to a sort of chain reaction of decisions." (Charlie; 543-614)

"I came to a point one day when I thought 'I don't feel nothing'. I think my favourite pet died and I felt nothing. I didn't shed a tear. And I thought 'this is abnormal, something is wrong with me' and I started to think, 'why am I still alive? There is no reason for me to be alive? I don't feel anything. What's the point?' ...that's when I realised that I was thinking in the wrong direction so I withdrew myself from antidepressants and I went to the GP and said I want to stop these drugs. Well the GP wasn't very pleased about that and wanted me to carry on because then I would be asking for some other service wouldn't I? And he was quite right, but I didn't think so at the time." (Sarah; 608-630)

The rich narratives drew on everyday events but were deeply personally significant to these women. Again this reflected the journey process being another element of life to these women.

This alternative reality was a watershed moment that introduced a new or alternative way to live that they felt represented part of recovery. Such moments were empowering to the women. They did not appear to occur when they are enforced by an external agency, external agencies were likely to play a role through providing opportunities for these experiences (see 'I can't do this alone: Ingredients for connections'). Women seemed unconsciously in control of when, and how much they saw of this alternative reality, which was protective, as being exposed to this all at once may be too radical to entertain or may be too damaging, as suggested by Charlie's following metaphor.

"My experience is that it's more like an onion. So it's like layer-by-layer which, at the time can be frustrating. But in hindsight looking back on it because there is no way I could have got to the middle part all in one go without doing layer-by-layers. I think mentally I could not have done it. Especially with all the things, like I had children of my own and I just don't think you could deal with it all in one go anyway."(Charlie; 10-18)

THE POWER OF BEING SILENCED BY OTHERS

SUPERORDINATE THEME	SUBORDINATE THEMES
2) The power of being silenced by others	"Putting on my mask" "I was going to ruin everyone's lives"

Women in the current study conveyed the power of being silenced by others throughout their lived experience of recovery. This superordinate theme was underpinned by two subordinate themes that depict the influence of not feeling listened to or being silenced. These themes occurred across many systems for instance at home, school and when seeking support from mental health services. As a whole it was a barrier to recovery as it maintained core beliefs developed during abuse. It can be likened to a re-traumatising experience due to its association with past events.

The two subordinate themes are: Theme one, "Putting on my mask" that surrounds the influence of being a silenced member of society who feels they have to hide behind a mask to hide the truth (their inner thoughts, experiences and feelings). Silencing, from both professionals and personal relationships, resulted in a lonely experience, and a feeling of being unable to share the difficulties that haunt their memories and lives. The ability to overcome being/feeling silenced was not a choice but something that had to take place and often resulted in the feeling that "I was going to ruin everyone's lives" (superordinate theme two). This theme details how breaking the silence barrier was a form of self-sacrifice for some women as they lost aspects of their lives that were highly valued, i.e. supportive relationships. Figure four contains the images created to represent this superordinate theme.

Figure four: Images created to represent superordinate theme two.

"Putting on my mask"

Women shared points in their lived experience of recovery where they had hidden their inner feelings, thoughts, and memories behind a mask as the consequence of the silencing culture they perceived around them. Their experience of suffering in silence as a child, as often revealed, spread into adulthood. At times hiding was the 'easier' option for them and others. Women detail that throughout their lived experience of recovery they are, in part, living an alternative life in the eyes of others, which was largely a form of protection.

"...I would get up out of bed every day. I would make myself have a shower every day. And I would take the kids to school. And nobody knew any different. In school I would go there and say 'Hiya!' to everyone, and put a smile on my face." (Sam; 643-648)

"...People always thought I was alright. Because I never show the real me. Only to myself. I was able to put up a front. I had to lie for eight years about what was going on. I can easily put up a front when I am easily not ok. On the inside it's different." (Fran; 616-620)

"I was quite a jolly person. I'm quite outgoing on the outside but it's always this front that I put up." (Sue; 975-977)

"I was putting on my mask because I didn't want anybody to say to me 'oh, you know, you look like you're struggling, you look like you're tired' and I was putting on that mask." (Sam; 1047-1054)

Women talked about how mental health services played a pivotal role in this silencing process and helped develop the narrative behind making sure the mask was tightly fixed until the 'right moment' comes when it was OK to take it off; this right moment was determined by services rather than the women.

"The first two psychologists I saw. One decided, and obviously didn't listen to what I said and ended up phoning social services and the second one I think didn't know how to deal with it and by saying 'put it back in the closet and keep it there' was, because they didn't know how to deal with it." (Mandy; 881-886)

"It wasn't until I came to my CPN that I realised that I was able to talk and then as soon as I started talking my daughter was safeguarded and I just thought 'oh, am I just not allowed to talk about my problems?' Why do I feel like every time I try to talk about it something bad happens?" (Sam; 823-836)

Living life behind a mask was isolating as shown by Fran's narrative.

"...Very alone, I think I felt that most of my life. Like a guilty secret that I had, that no one else knew about." (Fran; 224-225)

The lonely experience of living behind the mask fits the narrative the women have grown up with. Fran draws reference to the silencing nature of society mirroring the silencing she experienced from her abuser. Dynamics of the abusive relationship are echoed by society, which makes it more difficult to escape the impact of abuse.

"I find you're told all the time not to say anything, and now I don't tell anyone anything. Unless they ask me I don't tell, sort of thing. And it's not in a way that I am trying to be deceitful. It was just drummed into me for eight years 'don't tell anyone, don't talk to anyone' I think it's something I still do now." (Fran; 268-274)

Sarah makes reference to the mask hiding her difficulties. The passage below highlights the ease at which the psychological 'injuries' resulting from CSA can be hidden behind 'war paint', but more obvious injuries, such as broken bones, are harder to ignore because you can physically see them. Here the mask, or war paint, represents her body. It was a mask you cannot remove rather than a mask in the literal sense. There was a sense of being powerless within her body; there was no obvious escape from the paint or mask.

"He had nine children and he beat the daylights out of them daily and that was normal where I grew up. Being beaten all the time, it was just perfectly normal. You're talking Bible belt...1960s and 70s and children were beaten savagely, and it was not OK to kill them or break their bones, but anything up to that was permissible, you could do it in public, and it was permissible...That was normal, and I hated it." (Sarah; 323-337)

Sue's narrative surrounding being silenced as an experience of her recovery also alludes to the strain of showing others her true 'self', i.e. the person behind the mask, as the harm was not physical, and therefore could be a figment of her imagination. Disappointingly, society is shaped to disbelieve the women who have been abused. It has let these women down.

"...The judge said that the maximum sentence was five years, he gave four years and he said he should serve a minimum of two... because there was no evidence of psychological impact, because I hadn't been seen by my secondary mental health yet (474-480)... they had all those reports. But I wasn't officially diagnosed with PTSD or complex trauma or anything. That was a bit of a blow." (Sue; 489-491)

"I was going to ruin everyone's lives"

Throughout women's lived experience of recovery there came a point, or multiple points, where there was a need to break and overcome the silence, which was not the same as a landslide moment. This moment was not a choice, but something that had to be done; as the women came to recognise that action should be taken to overcome the injustice they faced.

"...I regret losing my family but I don't regret taking him to court. I had no choice. I don't wish I had not done that because I had to." (Ann; 567-573)

This theme represents the difficulties the women associated with breaking the silence. It was a self-sacrificing act. Some women shared that they had lost everything, and were likely to blame themselves for causing this. They talked about losing everything they had spent their existence trying to maintain and/or develop. For instance, there was a fear that they would destroy important relationships by ruining other's/and their own lives through exposing them to the knowledge that they were abused. Weighing up the cost and benefits of breaking the silence was unbearable and impossible.

"At some points I was thinking should I go to the police or should I just withdraw it? Shall I just say 'look I was drunk I made it up' just to get rid of it because I had nothing, I told my mother what had happened, I mean it was my own father it was her husband and she was still going down to see him going for walks with him every day." (Sam; 204-216)

Participants often shared the feeling of losing, or the fear of losing, relationships with their family, which resulted in them being alone. This was often a threat given by the abuser to stop victims disclosing when they were children. However, now in adulthood their worst nightmare was unravelling in front of them because they exposed the truth. The childhood threat became very real for some women; they were being punished for their honesty.

"So I was like 'what's the point?' So now all my family have disowned us." (Sue; 494-504)

"I had to do it, it wasn't like a choice it was something I had to do, so it wasn't a case of, which I think my family think it was, of me being vindictive or anything like that, it was just something I had to do, you know after all that time before he died it was the right thing to do." (Sue; 193-214)

"We would sit down together with my son and daughter and have a family meeting and that was probably the hardest thing I ever had to do (120-122)... I felt it was the only way, for me

to have a chance to move on at all (127-128)… the hardest thing I ever had to do because I thought I was going to lose him [her son]." (Ann; 153-154)

"I felt I was cutting off my nose to spite my face by telling people my troubles and I clammed up and I didn't tell, because, and also my father had told me very clearly that if I told lies about him that he would have me put in a children's home, and in that time and place he could have done that and I would never see my mother again, it was a very credible threat. My father was very socially prominent." (Sarah; 296-305)

"I was absolutely devastated because she was on the child protection register because she was at risk. But I had already gone through my trauma in June, and mental health got involved in the September after I was starting to recover from my trauma. And as I was on my way to recovery and to heal myself they got involved and so did social services. So even though I had help on one hand it was causing me a whole lot of grief on the other hand…I felt like I was losing my mind again then because through everything that had happened to me, the one thing I felt I was good at was being a mother and now I felt like that was being taken off me, being stripped away from me, so I couldn't even be a mother anymore (701-725)… I'm being stripped of being a mother for talking about my problems and again then it took me back to issues I had." (Sam; 786-791)

Sam's use of the word 'stripped' powerfully created a feeling of vulnerability, a lack of control and humiliation. She was made to feel worthless, which was likely to reflect her childhood beliefs about herself.

Through disclosing and breaking the silence some women shared experiencing a break in trust between them and the person they disclosed to. This could be considered an act of betrayal that had the power to destroy any possibility of establishing a secure connection again. Understandably, such betrayal was difficult to process and come to an understanding of; it was physically painful and left a scar.

"But even when I told my mother…she asked for the details of what happened and I told her the details and she still liked to see him [her abuser, her father] every day to walk the dog, they would hold hands they would kiss each other and that to me was like a major stab in the back. It totally ripped me and my mother apart to a point where I didn't want to be with my family I wanted to move away." (Sam; 162-170)

Sarah was able to reflect on an advantage of 'losing' her family within the context of her recovery. She recognises that this was useful for her but may not be for others, which reflects the uniqueness of these experiences.

"I have lost all the family that I had, which makes me sad, but then seeing the way people are struggling with it [their family] I think 'well that's the upside of it.' It also means I will get old and die alone but I might do that even if I did have a family. So in its own way being

rejected by my family is an advantage but I wouldn't recommend it to people…I have a freedom that some other people don't have." (Sarah; 1020-1030)

Sarah's and Sam's narrative regarding losing relationships were in sharp contrast to each other; Sarah had a sense of freedom. She shared her feelings of liberation but also drew a lonely picture of this celebration, which she warned others about. There was recognition that this may not be for everyone highlighting the difficulty of this experience for her.

Breaking the silence had a significant influence on others, which the women struggled with. This was likely due to their experience of wanting to protect others rather than harm them (see "Trying to protect them" within superordinate theme three). The women talked about being trapped in a situation that had no answer.

"Whereas my mum said that 'if you take this any further it will kill me' (86-87)… I think what my mum was worried about, and what she actually said was, 'what will people think of her?" (Ann; 91-93)

"My cousins were texting me and begging me not to do it 'I was going to ruin everyone's lives' and that they knew they had no right to ask me not to do it because they knew he had done it." (Sue; 180-186)

Ann, Sarah and Fran shared similar theories to why others were highly impacted by their disclosures. This seemed to help them come to terms with the harm that their families caused them due to their disclosure response, or justify why they had not broken the silence to others at that point in time.

"I think it takes them time to come to terms with it as well. Well because I suppose I have lived with it all my life, it's just a massive shock to most of them, so it's a new thing for them, whereas it's not for us." (Ann; 120-123)

"…I haven't shared that with my husband. Like I said because he has so much to deal with in his life and I don't know how he would process it, I don't know." (Sarah; 1181-1191)

"No I don't think I want to tell other people because it is not a very nice thing to hear. I have had friends tell me that have no idea about me. It's not nice to hear you know (490-492)… They [her family] know I have been abused but I have never discussed it with my family what happened. Or how long it took place for. I would never tell my mother it would kill her. She had all the guilt that most mothers would you know 'it's my fault', I would never ever disclose to her what happened in those eight years, it would kill her. As far as she is aware I was raped and that's all she knows." (Fran; 454-461)

The sacrifices these women made to break the silence fits the identity of a warrior; someone who is acting in a way for the greater good, which did not seem to be immediately recognised

by others, again creating a sense of frustration towards society. There was a sense of determination to change the way they are treated.

> *"The thing Steven Fry said; 'it's not because we want it to stop that's why we keep talking about, it's because we won't be shoved under the carpet or buried in the sand, we won't be because it will carry on'. That's why we are warriors." (Sue; 1476-1481*)

However, this theme was, in part, contrasted with a feeling of letting go of a burden after breaking the silence. All the women's narratives suggested some sort of physical and mental relief having overcome the silence. This relief surrounded sharing responsibility and breaking out of the lie they felt suffocated by.

> *"I guess it makes you feel that you're not alone that you haven't got that secret you have shared it with other people. It doesn't feel quite so much of a burden. You are finally able to share it with someone else, say things out loud, finally able to talk about it." (Fran; 264-268)*

> *"I did feel relief at my mother knowing. It was like putting down a load of shopping, you can breathe a bit more and a weight was lifted off your shoulders." (Charlie; 450-453)*

This contrast between sacrifice and relief was echoed in Charlie's narrative, which detailed how she perceived breaking the silence of her abuse as a constant battle between what the right thing to do was.

> *"It was both liberating and terrifying at the same time (613-614)... I think it's because it's great to have all that freedom and that sense of being liberated, but again what do you do with all that? Even when those chains are on, as horrible as it is there is that sense of security in it." (Charlie; 618-627)*

This was a very similar narrative to Sarah's regarding how it must feel to be a freed as a slave detailed in subordinate theme "Just continuing the journey". A sense of comfort was expressed regarding the familiarity and certainty of environments consistent with their CSA experiences, reflecting its constant presence and the difficulty of breaking away from it.

ACKNOWLEDGING THE PAST AND UNITING IT WITH MY LIFE

SUPERORDINATE THEME	SUBORDINATE THEMES
3) Acknowledging the past and uniting it with my life	"I just hated it…how the hell is this going to help?" "Hatred of this little girl I used to be" "Trying to protect them"

When the women shared their lived experience of recovery from CSA and the role mental health services played, they conveyed processes of becoming aware and in-touch with their past CSA experiences. They began to view their experiences in light of someone who was no longer a child being sexually abused. This awareness, or acknowledgement, provided the women with space to find a place, even if temporarily, for these experiences within their current life. This overarching theme is underpinned by three subordinate themes that represent these processes. The first theme "I just hated it…how the hell is this going to help?" portrays a process whereby the women became more willing to embrace the vulnerability associated with facing or looking at their past rather than attempting to escape it and its impact. Theme two, "Hatred of this little girl I used to be" represents how the women's perspectives surrounding core beliefs, or self-attributions, developed during CSA (i.e. shame, blame and guilt) and strengthened throughout other abuse experiences, were recognised and evolved alongside their non-abusive experiences. Finally, the theme "Trying to protect them" illustrates a process whereby the women recognise and embrace the qualities they have developed as a result of being a person who has been through CSA. Figure five contains the images created to represent this superordinate theme.

Figure five: Images created to represent superordinate theme three.

"I just hated it…how the hell is this going to help?"

This theme represents the difficult, unexpected transformation the women experience in regards to changing their willingness to confront the past CSA. When women initially talked about their lived experience of recovery, they often gave a narrative surrounding their early lives attempting to escape anything associated with CSA. Escape took different guises for each woman, some more elaborate than others. For some, the more elaborate the escape scenario the more hope this strategy provided. However, it did not seem appropriate to judge whether these were good or bad strategies to adopt at this point in someone's life, instead they are considered possible options in a world with minimal choice. Sarah's suggestion that her escape options were her weapon creates a sense of control and strength that are in sharp contrast to her abuse experiences.

"I remembered having this notion that I was a prisoner of war and I would escape some day and when I was in school I was 16/17 I said I had this idea, 'I'm going to escape', it was getting closer to the time that I knew the cage would be blown to bits and I would make a run for it. And I did, eventually… it had to be an outrageous fantasy. But that was my weapon."
(Sarah; 415-433)

"As I grew up I guess I just pretended things didn't happen. I guess I just blocked it out. I think it was my minds way of coping. I think your mind does it for you. I don't even think it is a choice. I think that's your brain's way of coping and making sure you survive." (Fran; 136-143)

"…I think I started drinking when I was 13. I can only be sexual if I have had a drink, any other time I would have to dissociate." (Ann; 777-790)

"I stopped counselling about a year ago. I think I always felt to myself 'ah it's not the right time; it's not the right time to deal with it now.' And I would push it. But I don't think there is ever going to be a right time. There is never ever going to be right time to tell someone the most intimate, most horrific things that have happened to you." (Fran; 568-574)

In the context of their experience of recovery the women began to discuss how they made the decision to stop using their weapons of escape, or wait for the right moment to face the past. There was a point when the women considered changing tactics and instead spent more time allowing themselves to sit with their vulnerability and pain. This was related to an experience of 'facing their past' and freeing up more resources to process the past. Importantly, this vulnerability seemed to sit alongside feeling safe.

"…When I emigrated I probably had the ridiculous idea that if I went far away enough my past wouldn't follow me, but of course it did you know. The problem was where ever I went…I thought 'well I'm not going to run away this time, I'm not going to run away, I'm here, I'm getting too old for this. I'm too ill.' so I just had to turn around and face it."
(Sarah; 936-948)

"I had to face it because it was the only way if, how can I describe it. I have never been terrified to leave the house but I know there are people who won't go out the house, they are too afraid to go out even in the front garden, and imagine being that afraid but doing it anyway because it's the only way you can get out. There is no other way. You have just got to face it no matter how horrible it is. And once you get out you have got to face the fact that you were there voluntarily, not always, but eventually it became your own doing. So I did. I had to face that. That was tough." (Sarah; 200-230)

Women shared their lived experience of being willing to put themselves in vulnerable situations, such as group therapy. These narratives depict individuals who were originally fearful of placing themselves in new situations that they dreaded could expose them as their inner beliefs developed during abuse. This willingness was in contrast to the attempts made to escape. As interpreted from Sarah's narrative (above) there was recognition that this avoidance was, in part, their decision and there are difficult emotions surrounding this notion. However, there was a sense of inner strength that helped them face the past, which could be related to support developed from the people they face these situations with (see "I can't do this alone: Ingredients for connections").

"I just hated it [SAFE group]. Thinking 'how the hell is this going to help? What's it going to bloody do?' But I gained strength from it. I was able to put some things to bed. Some of the activities I had to join in on were really difficult because I felt really stupid." (Mandy; 739-747)

"I started the SAFE course. I did the first week, and when you first go you think 'what have I let myself in for? Can I do this?' I have got to be honest; I am a person who can take on anything and I did the first week and thought 'Oh, I'm not entirely sure." (Charlie; 718-725)

"There were times when I thought 'ah this is too hard' but I would force myself to go [to the SAFE group]. I wouldn't quit or anything I am not like that I am quite determined, if I want to do something I will do it." (Ann; 392-395)

Sue discusses her experience of allowing herself to become vulnerable in the context of acknowledging her past and the difficulty surrounding this experience. The narratives illustrate the struggle surrounding articulating this experience.

"Yes, but really weird because it takes you back, and that's what it's supposed to do and it's so vivid, and I have tried to explain to my people what it is (885-857)… she brings that memory out it is like I am there as me now, watching and actually there watching what happened." (Sue; 861-863)

Charlie's and Sarah's narratives conveyed their willingness to allow themselves to be vulnerable but paint a gruesome picture of how this experience felt. These painful pictures highlight the struggles they went through but that this was something they needed to

experience. It was as though they had seen an alternative path or way of living and their curiosity or desperation motivated them to endure this painful route. There was also the possibility that they would feel to blame if they did not go through this process.

"…When I talk about the SAFE course to others, I really do feel like I have ripped out that core doing that course. By the end of it, it felt ripped out (784-789)… you know you pull at weeds, but they always come back unless you get to the bottom of them. And that is what the SAFE course was for me. It was literally ripping it out. And it's gone." (Charlie; 803-810)

"…In fact I felt worse for a while. But I thought 'No, I'm on to something here.' I'm spewing all this poison, getting rid of all this toxic waste and eventually I came out the other side still alive and I started to feel, think and behave differently (128-134)… It was physically really hard on me." (Sarah; 136-143)

The pain associated with embracing vulnerability was shared between the women and those who cared for them. This may add to thoughts surrounding "How the hell is this going to help?" This could in some way act as a deterrent for them to allow themselves to face the past and act as a form of silencing.

"I know my husband was incredibly worried about me doing it because he said to me at the start 'I will support you in it, but I'm not entirely sure it's the right thing'. I think he was obviously worried about pulling it all out and it making me ill again." (Charlie; 1119-1124)

"Hatred of this little girl I used to be"

Within the women's narratives they often discussed their relationship with their beliefs, or self-attributes, central to their abuse experience. The core abuse beliefs discussed surrounded feelings of shame, blame and guilt. Most women shared and reflected on these beliefs, although their relationship with them differed. These beliefs had a role in moulding who they perceived their current selves to be. Through their lived experience of recovery, the women recognised these beliefs and attempted to find a place for them and unite them with their current lives, which was a difficult as these beliefs continuously shift. There was no suggestion that a 'perfect' relationship with these beliefs would ever mature.

'It's OK to accept a bit of help, and that I am not as bad as I think I am. You know and that it's not all my fault." (Mandy; 1099-1101)

"This is very new, yes. Because I felt so desperate and such a failure for so long. And I felt like that because of what had been done to me. And I didn't realise that it was done to me. I was always told it was my response to what was done to me that was my failure. And in a way that is true, if I had never decided to see it off essentially, to turn around and face it and banish it well, I don't like this idea of blame for everything, you know I have gone past that." (Sarah; 1058-1067)

"It made me feel like I should be ashamed, which is what I always felt…I guess to a certain degree I always still feel shame and guilt and a load of other emotions. Those two, guilt and shame, I find really difficult to get rid of." (Ann; 97-104)

"…A common theme that I felt from it was that we all felt that it was our fault." (Charlie; 763-771)

"And another thing is that I was taught not to blame. When I hear other people's stories of people blaming themselves I think 'ah how could you blame yourself, it wasn't your fault' and then that sort of eventually starts to click in, and you think ' well hang on a minute, yeah maybe it wasn't my fault' you hear other women blaming themselves for what other people have done and you think 'ah you're crazy how could you blame yourself?' I guess it does kind of kick off in your head 'perhaps I should sort of stop blaming myself?' (322-331)… Yeah a massive change, my life before was that I hated myself, I blamed myself, I self harmed, you know everything was aimed at me."(Fran; 340-343)

At times, some women were uncomfortable with the position they had given these beliefs, as if they were new, unfamiliar relationships they were yet to establish boundaries with. Earlier in her narrative Sue narrated how she *"…had always hated this girl that let him [her abuser] do that, that I was dirty and I was ashamed and 'why me?' (Sue; 201-204)*. Questioning 'why me' and 'what if' is something she often refers to. This was an example with how her new relationships with her beliefs were fragile and unfamiliar and would take time to sit comfortably. Sarah talked about these feelings in a similar manner, her language emphasised their sinister nature.

"I thought, if only I hadn't been so cute, if only I had managed to worm my way into living with my aunt and uncle's house…I thought of all kinds of reasons why it was my fault, it was horrible, I was just sure it was, and still it haunts me sometimes I think 'maybe it was my fault, oh no it's not my fault', but it creeps in and I think of the wasted years, and my life has not been wasted" (Sarah; 980-984)

Another example was in Sam's narrative. Although she previously suggested not blaming herself for the way she behaved around men, she later placed blame on herself by questioning whether something was wrong with her.

"…But she says things like 'when are you going to get married mammy?' and such a simple question makes me think 'is there something wrong with like me, why can't I change my perception of men really?' And most of the time I do think 'well not every man is like that', but that hasn't really changed at all, my view of men." (Sam; 103-110)

Some participants talked about the blame they placed on others rather than, or in addition to, themselves. Most women mentioned the role of blame, shame and/or guilt in relation to others who played a significant role in their childhood. The difficultly the women discuss finding a

place for these feelings within themselves was reflected in placing these feelings towards others. There was a feeling of betrayal felt towards these significant others that was detrimental to their relationships.

"I used to leave her signs because I wanted her to find out, because I would leave things like soiled nighties…I just can't see how she didn't notice…I just don't believe her and there is nothing I can do about it. She said that she didn't know. I don't know I just don't believe her. I found it harder to forgive her to be honest or to find some sort of place with her." (Charlie; 400-428)

"…And that's why it also made me so angry towards my aunt because I realised she did know what was going on and she did think I was dirty and horrible." (Sue; 900-903)

Sarah spoke in depth about her hatred for the blaming culture and shared how she made peace with some of her abuse beliefs and beliefs surrounding how others should have acted. This was in contrast to others who had associated such beliefs with people they felt should have protected them. Her perspective was highly influenced by the culture she grew up in and tried so hard to escape.

"So how could I blame her? I mean on the one hand I could say 'you were the grown up you had the responsibility of three children why didn't you protect us?' But then on the other hand she didn't know that she could. So, so instead of trying to blame I think I have just let that rest." (Sarah; 1067-1102)

Her narrative also expressed some doubt regarding the position she ascribed blame towards others. She left open the possibility of 'waking-up' these beliefs and re-organising them, which reflected the fluidity of the women's relationships with these beliefs.

"Trying to protect them"

Women in the current study shared how throughout their lived experience of recovery they began to recognise current personal qualities that may be related to their past abuse. Among these qualities their role in protecting others shone brightly. This shared similarity to the self-sacrificing nature of breaking the silence surrounding their abuse, such as facing the consequences of disclosing in court in order to protect others. Through acknowledging their past experiences the women recognised that the abuse they endured may be a possible origin of this quality. Rather than rejecting this possibility they began to embody it, which allowed them to engage with life as a person with meaning and purpose.

The women's narratives reflected individuals who had always adopted roles as protectors. Unfortunately, during their childhood this was shown through acts of sacrificing their own body for the benefit of others. This form of protector could be likened to the 'detached protector mode'. This was not a role the women were willing to openly express pride towards. Sarah and Charlie had two different narratives around this.

"I'm the eldest of six, five younger than me and I was the only one who was sexually abused. There was three sisters and two brothers…I took my sister's place as well with my grandfather (254-261)… I spent my growing up years looking out for them and trying to protect them because they knew nothing of it at all."(Charlie; 270-274)

"That was my role you see. I was supposed to be the one who goes up in flames, the one who's used so that other people aren't…I just didn't have a choice, it was imposed on me…I was the thing that was used up and thrown away, that was me. That was my role." (Sarah; 410-413)

Mandy, Sam and Ann shared their current roles as protectors towards their children. This new experience influenced how they perceived the world, and was a role they held in high regard. Still maintaining the protector role but with the addition of being valued by someone seemed to have opened up an alternative perspective towards their meaning in life.

"…Having my first child and then realising that if anyone leaned a finger on them that I would kill them. I think as a parent you do see things differently." (Mandy; 288-294)

"…Especially having two children, two girls as well. Everything has changed really. I'm far more aware of things, in life really. And it does change you a lot. It makes you think of things that other people don't really think of." (Sam; 51-55)

"I had him to protect [son]. And that's how I lived my life. Just trying to protect my son and trying to bring him and my daughter up." (Ann; 546-549)

Adopting and embracing a more socially accepted protector role outside of their abuse experience could now be viewed positively in aiding their recovery. Previously this role was associated with being worthless and vulnerable. This role allowed them to protect others in a way of giving back to those they shared a connection with.

"I was the strong one for her then and I felt like I have to be, because I know what it's like to feel so down and not having anyone to talk to. So I thought 'right, I really need to be strong for this woman now, and I need to get her out of this.'" (Sam; 888-901)

"There are two people that I have come across at children's parties in school and I have thought 'the way he is, is not right' and I have warned other people (142-145)… The people I have told have been really understanding and they have sort of looked at this other person in

a different light and thought 'oh God yeah, he's really weird' so they have thanked me for that." (Sue; 149-158)

"I just want to help other women, make them feel able to come forward. And men, I think the stigma that is attached to abuse needs to go… If I could just help one other woman feel as good as I feel now then I think all that happened to me would you know, wouldn't be all bad I guess." (Fran; 597-606)

However, Ann reflected on the negative aspect of this quality during her experience of recovery that others did not draw on. Although there was a hope within her narrative that this would change.

"It has made me really cautious. About my own children, protecting them, I was always terrified that something bad would happen to my daughter and I am still terrified that something bad will happen to my granddaughter. And that has affected me being able to look after her…I just work myself up into such a state if I know I am going to have her and just so anxious and terrified, I mean terrified to the extreme that something bad is going to happen to her. So I don't have her that often because it makes me that anxious and I would like that to change." (Ann; 209-223)

Qualities surrounding being a protector were fully embodied by a majority of the women interviewed. They had found a place for their past experience within their current existence. But, there was some hesitance within their narratives to welcome this view because of the horrific nature of the experience they lived and the stigma surrounding it.

"You can, you get through it and I suppose in a way you become a better person from it, and stronger person, but I don't know what the word is? (Laughter)" (Sam; 1152-1155)

"I try not to think it was wasted because of the appalling circumstances that shaped it. But then on the other hand if I hadn't gone through all that I wouldn't be me. So. I have what I consider to be a very interesting life. And I don't think all that being spurred on to travel the world and do all the things I have done. I don't think I would have done if I didn't feel driven out of my hometown because of what happened so. So in a weird way it served me." (Sarah; 1045-1054)

"In a warped way it's made me the person I am as well. It either makes you bitter or it moulds you, one or the other. I think I have an empathy and an understanding that I think others don't have I know that as far as my job is concerned I work completely different to the rest on my team, it's not a tick box, it's about building a relationship and trust and I get more done because of that. Yeah, I think I get it more than others." (Charlie; 1168-1176)

"So I think it's part of who I am, which has probably made me who I am today. It's made me more stronger really, I think in a lot of ways. Although, I didn't feel it at the time. I must be pretty strong to get through, and gone through what I have been through and to still be here." (Fran; 64-68)

Charlie had a creative narrative around acknowledging and embracing her qualities related to the past by describing herself as an object that is valued due to its imperfections. Charlie's narrative conveys someone who had made considerable effort to blossom from the experience of trauma and its enduring impact.

"Japanese pottery called Kintsugi. It's where quite pretty Japanese pottery is smashed and they put in back, it takes ages, but they painstakingly put it back together with gold. So they use liquid gold and when they put is back together, well it's a smashed pot but it's intricate, and it looks beautiful. It's kind of how I see what the end result was or that's what I want to see." *(Charlie; 1059-1066)*

I CAN'T DO THIS ALONE: INGREDIENTS FOR CONNECTIONS

SUPERORDINATE THEME	SUBORDINATE THEMES
4) I can't do this alone: Ingredients for connections with others	"Started on the same path and then we branched out"
	"Not pity. We don't like pity!"
	"It's got to be their choice, or you are just making it worse"

The following superordinate theme represents the importance of: 1) personal connections; 2) services and professional connections; and 3) connections developed with others who have shared similar abuse experiences to the women. There was a need for others to be united with the women in their experience of recovery. All these connections shared similarities in terms of their 'core ingredients'. The core ingredients are represented by three subordinate themes. The first theme is represented by one women's quote: "Started on the same path and then we branched out", which refers to forming a relationship with another or service that acted as a secure and safe 'guide' that was highly valued. Theme two, "Not pity. We don't like pity" represents the value women place on making connections with others that enabled them to 'feel' empathy and compassion, rather than emotional expressions such as pity. The final theme, "It's got to be their choice, or you are just making it worse" conveys the need for connections with others to contain elements of choice. Choice provides the women with a sense of control, which was vital in relationships with others. Essentially, the quantity of each ingredient was related with how supported the women felt throughout their lived experience of recovery. Figure six contains the images created to represent this superordinate theme.

Figure six: Image created to represent superordinate theme four.

"Started on the same path and then we branched out"

When sharing their lived experience of recovery and the role mental health services play, women illustrated the need to make connections with others who/that acted as a 'guide' when they were unsure of the directions they could take. The guidance provided was not uniform across the women. For example, Ann discussed the need for guides to initially provide constant physical support and reassurance.

"I still feel, I know I'm doing it I hold my breath almost constantly. Until, I can be with, say my support worker, and she will say to me 'breathe'. And it's like (breathed out) like someone had given me that permission to breathe. And, it's really weird with food as well, and sometimes my CPN will come to me and say prescribe me chocolate bar and I feel it's OK, because someone else has said it's OK for me to have that." (Ann; 803-811)

"I feel I need people to reinforce that I have done the right thing. People keep telling you 'you have absolutely done the right thing'. It does help me feel a little bit better about what I have done." (Ann; 165-168)

From the narratives, guides did not necessarily tell the women what to do, but provided safe, supportive connections that nurtured and encouraged independence in their recovery. In essence, guides embodied secure attachment figures. This was likely something that was missing from these women's past, and potentially current experiences. Sarah reflected on the process of developing a relationship with such a guide and the difficulty developing independence from this relationship. The difficulty expressed could reflect her concerns surrounding separation and abandonment she experienced as a child. Her narrative shared some resemblance to a child developing the ability to internalise a feeling of constant support. She drew on strategies that were used to help her through this process.

"...In February this year the SAFE group ended. And I have been going to the support group all this time, sometimes once a fortnight, sometimes once a month, it depends. And that eased me out of it, my dependency. And I acknowledged my dependency of this therapy, well I know I have become depend on it and I would have to wean myself off with help from others. And the SAFE group, well the support group will go on for as long as we want it to. So the unhelpful thing was that heavy burden of knowing that no matter how great my need is it's only going to be met up until this point and I knew it wasn't going to be enough, I knew it, so arrangements were made." (Sarah; 1451-1467)

This notion of internalisation was also expressed within Mandy's narrative below that depicts a metaphor for gaining independence. She emphasised that this experience was enhanced because it occurred with others who had a shared experience. The process of internalising was 'easier' with those who have a shared experience.

"I think it was about doing it as a group of women together. And you could take the strength from other people and they would have your back. It's almost like they were holding your hands you know, they were there with you on that journey, taking their path you know, we all started on the same path and then we branched out, it's like a tree isn't it. And yeah, it grew from that." (Mandy; 766-773)

 Although mental health services provided the environment for Mandy's experience it was the solidarity and connections felt by others who shared a similar experience to her that seemed vital. Her narrative created a sense of strength gained from the guidance of others. Guides with shared experience help illuminate possible pathways to take in her experience of recovery but allowed her to decide which one she chose. There was a deeper sense of connection from these 'types' of guides. Using the metaphor of a tree emphasised the importance of feeling constantly connected through belonging to the same seed, which is a process reflected in a secure attachment relationship. The feeling of on-going guidance was needed. This was something missing from some of the women's experiences with mental health professionals.

"And I think you haven't got that constant, you don't feel like, you don't feel like you're being cared for properly, you don't feel like you have got that on-going support." (Sam; 1073-1082)

Sam highlighted a feeling of being supported, rather than actual, physical support or guidance. Mental health services, at some point, played a role in adding to the women's feelings of being lost and abandoned as a result of not providing continued guidance to the women. A majority of the women's narratives emphasised the value of this need, and comment on how its absence reminded them of the cruelty of their past abuse.

"They [counselling therapist] used to phone every week and talk to you about different stuff and then that was it. It was all right, but then it stops, and that's it you're just left to get on with it. Which when you have been abused or whatever it often takes you back to being that lil (sic) kid. And that lil (sic) kid needs an adult or somebody to help look after them. And then you end up feeling like this lil (sic) scared kid again, all alone in the world." (Mandy; 944-952)

"After the trauma there wasn't really any support. There was nothing really until I actually had a break down. It's only then people got involved. After an incident there isn't really anyone to step in and sort of say 'we will help you get through this, we will help you deal with that.' I was basically on my own." (Sam; 19-26)

"The length of time you have to wait for stuff sometimes. When things were really bad, and it was months before you could see someone, you feel abandoned. It was a horrible feeling. Waiting for counselling, even waiting to see a primary mental health nurse, the length of time was horrible (962-968)… it made you feel even worse. I mean, you feel crap, you feel used,

you feel dirty, you feel all these things. And then you feel non-important to anybody that you have got to be stuck on an end of a list and I know everybody else has to as well, but it's not nice at all." (Charlie; 972-977)

"But this idea of telling a person you know 'no matter how bad it is you have got X number of sessions and you're finished'. I can see why therapists would say, 'OK we have got six sessions we will see what we need after that, we will see', maybe that's enough and maybe not. But to say there is a 'definite limit' and whatever you have got to say you have to say it in that time, well I almost didn't do it for that reason."(Sarah; 1390-1403)

Importantly, as most of the women experienced continuous chaos within their personal relationships, mental health services also seemed to be an obvious 'new' person and/or environment that could fill the role of a secure and safe guide. This was something the women convey as 'should' be provided. The use of the word 'should' indicated that this was something they did not receive.

"Mental health services should provide a support network. Make it a safe environment to come and get the help. Because people who have been abused don't know what help they need. If you have been abused you do need help, you can't necessarily deal with it by yourself. And that there is help out there if you want it. Just letting people know there is help there if you want it." (Mandy; 1065-1072)

"Not pity. We don't like pity!"

The expression of empathy and compassion were vital in developing connections that promoted recovery. Mandy and Sarah were clear to explain that with hindsight the expression of compassion and empathy were important in mental health services. However, the lack of tangibility and experience of these expressions were likely to have influenced the women's ability to verbally communicate these ingredients.

"I think back on all the time I spent with her and I can't remember anything specific she [therapist] did. She was so good at what she did you know. I can't remember that she did anything, but she did a lot. I mean what a facilitator! She was extremely skilled, very highly skilled empathic person. And I didn't know what these things meant at the time. I know it was empathy I was getting but I didn't know what that was really. Well I did, but I couldn't define it, I couldn't talk about it and say what it was. She allowed me to disclose things to her that I have never told any other person." (Sarah; 116-128)

"Always show your compassion and not to judge no matter what people tell you it takes a lot for them to tell you something (1464-1466)… You know but after having therapy and feeling that my psychologist understood you know it wasn't judging that helped me get through that aspect of recovery. But not pity, we don't like pity, and I think that's part of the survivor warrior thing. You know we are not victims we are survivor warriors." (Mandy; 1469-1474)

Interestingly, the women did not mention the importance of specific, evidence-based psychological approaches. The ability to communicate and truly understand their position was valued above all. Pity seemed confused with expressions of compassion and empathy, and was highlighted as damaging to part of their identity they valued. Pity potentially placed them in a position of vulnerability, which did not seem welcomed as it reflected the position they were in as children.

"My teacher, aside from the fact, I thought I saw what I hoped was compassion in her face, after that, it was probably more like pity, then after that I didn't feel supported by either of them really." (Sarah; 316-320)

Some women talked about experiencing empathy and compassion from others who shared similar backgrounds and were in a similar position to them. This was a different, more powerful experience than that provided by professionals within a mental health service. There was an added layer of empathy that could not be experienced in any other context that was highly valued. There was something more genuine about this expression that made it easier to believe.

"I don't feel anybody really understands unless they have been through it themselves like even my husband." (Charlie; 777-790)

"I think with counselling is not about sympathy is it, it's about empathy and those women genuinely empathised with you. I mean someone who hasn't been abused, I mean of course you would empathise if you were hearing something awful. Any compassionate person would empathise with that person. But it's like you know those women really do." (Fran; 281-287)

"In the SAFE group there was a very dramatic moment for me. Something bad had happened. I had had an argument with my husband before I went to one of the meetings. And he had said things to me that I thought were really, just about to cross the line into being abusive…And I came to the group and was just in a state when I got there. And we had this check in when we all got there that we all went through and I went 'argh I can't stand it.' And they all said 'what's happened?' So I told them what had happened (1251-1228) … I told the girls all about it and they all sat there and listened and when I finished one of them said 'how awful!' And they all thought 'that's terrible that that happened to you, you must feel really bad', and I thought 'wow, I'm not being told off, they aren't all telling me to divorce him, or passing judgement, they just listened.' I was heard. And no one said, 'ah you're exaggerating, it couldn't be that bad' nothing like that happened (1235-1234)…. It was the first time in my life when I told a group of people about something that had happened and not only did they listen but they reflected empathy back, and I could tell they were all thinking about it and thinking what must that of felt like. And nobody made any judgemental remarks of any kind. And it was extraordinary; I had never had that experience (1246-1254)… It was very powerful. Extremely powerful, it's a shame I had to wait so long in life to have it. If that and if that type of empathy had been shown to me in the past I didn't recognise it. I can't think of a single incident." (Sarah; 1344-1348)

Sarah's narrative painted a surreal picture of her experience of feeling empathy that was almost unexpected. Within her narrative she suggested that in the past others may have attempted to express empathy but she may not have 'received' it. For her, the ability to truly feel empathy was the result of a process of developing secure and safe connections first. She did not feel judged, the women sat alongside her in her distress. For both Sarah and Fran there was a difficulty in trying to explain what exactly was so valuable about experiencing empathy from others who had lived through CSA. It was as if there was an unseen force that strengthened the connection between these people. It may have been that the women's ability to mentalize with others who shared a similar experience to them came more naturally.

The power of feeling empathy in this manner influenced the women to want to pass it on to others. However, being able to express empathy and compassion was only possible once they had experienced it, believed it, and not felt judged themselves. In some respect being able to express these feelings towards others was likely to fit their identity of trying to protect others, which reflected the subordinate theme: "Trying to protect them" above.

"My psychologist helped me learn to trust again (583-584)…Someone not judging me and someone who doesn't have to listen to me you know like your family or your friends, she was there because she wanted to help. I think that is another reason why I want to do the job. I want to help people. And I think it's rewarding." (Fran; 588-592)

But sharing the experience of empathy could be damaging for some in terms of reminding the women of how unfairly they had been treated and how unfairly other women were still being treated. There was a sense of injustice, which was difficult to overcome when they heard other's stories.

"Something that has helped and doesn't is that I'm on a couple of Facebook groups (1215)… and knowing that they all go through the same thing as me, and when we help and support each other you know there are a lot in American, Canada, Britain. And that helps but sometimes it gets me down as well sometimes. I have to give it a break for a bit because it makes me angry that there are all these people out there that, who have lost family through it who have turned their back on it for disclosing and you know so that doesn't help." (Sue; 1226)

Furthermore, some women explained that they might not be at the same stage to be able to 'hear' or feel the empathy as highlighted by Sarah. This could in part add to the feeling of shame, as this was not how they currently felt.

"I mean you get so much reassurance from each other. However when someone says in the support group says 'oh I think you're really brave I couldn't do that' I don't know, I don't

know how that makes me feel. You would think that would empower me but it, I don't know, I know what I am trying to say." (Ann; 324-329)

Within this theme mental health services played a role in recovery by providing opportunities to experience vital ingredients to forming connections that promote recovery. However, others who had experienced CSA embody the 'true power' of these ingredients. There was the possibility that services provided compassionate environments, whilst empathy was best experienced with others who had shared similar experiences.

It was felt necessary to highlight that within this theme it became evident that mental health services at times, for some of the women, failed to show empathy and compassion.

"Because what happened was when social services came in it was at top level…they are forceful to begin with and they are nasty to be honest, it was horrific. I wasn't shown any of sympathy whatsoever. It was basically 'you are not fit to look after your child, we've got to safeguard her' then you are passed down to a social worker." (Sam; 730-738)

These experiences generally resulted in the women feeling traumatised and let down by a figure who was 'supposed' to provide support. This may mirror the betrayal they experienced when no one was able to protect them when they were abused as a child. For some, the lack of perceived compassion tainted their view of professionals.

"It's got to be their choice, or you are just making it worse"

Finally, women illustrated that throughout their experience useful connections with others offered opportunities for choice. Without this ingredient it was felt that the relationship could be damaging.

"It's hard but you can get there… it's not easy by any means, but it can be done and it can't be forced by anybody. It's got to be their choice, or you are just making it worse." (Charlie; 1157-1163)

Sam's narrative emphasised the need for connections with others to always provide choice, rather than to dictate what was going to happen. True choice seemed to harbour fairness and equality within a relationship. Sam's narrative highlighted that this was not something that was readily experienced by her and only on reflection could she identify this need.

"I think there needs to be a service that gives you free advice and they can say to you 'do you want us to contact social services, do you want us to'…. Instead of just saying 'this is going to

happen' and just to ask them to talk to you, because even now I haven't got anyone to talk to." (Sam; 1196-1201)

This theme was largely born out of the women's narratives surrounding examples of when connections with others had been damaging in their lived experience of recovery from CSA. Generally, these experiences shared a common undertone of lacking choice. Again, these experiences seem harrowing and resonated with their CSA experience.

"After five years of working with my psychologist I went to the medium secure [mental health hospital] and someone else took over. My psychologist was my care co-ordinator and her boss decided that everything that I had been done for me here could have been done and more had to be done, so he took over as my care co-ordinator…and a decision was made that for my own safety I had to go to a secure hospital. So I was assessed for three places, two locally, and the other far away in England. The one far away was my last choice. I was accepted for all places but they decided to send me to the one far away (835-867)…it was totally made without me…So I ended up there. Four hours away. I lost all my dignity." (Ann; 876-884)

"The other frustrating part that I found was other people trying to, I knew I needed counselling, and I knew that, but some well meaning people would try and make appointments, well did try and make appointments and physically turned up to take me. And I wouldn't go. And I mean, it wasn't until years later I understood why I would refuse to go, point blank. They were well meaning … they were just trying to force me to do something I just didn't want to do and it was exactly the same as the perpetrators in the first place." (Charlie; 52-64)

Ann's narrative surrounding the lack of choice she experienced carried a lot of emotion. She created an image of someone who was completely powerless, someone who was worthless being shipped around like an object that no one wanted. This was a particularly difficult experience for her to recall. This could reflect how raw this experience was to her and how influential it was during her lived experience of recovery whilst under the care of mental health services. This experience represents the trauma that can be experienced when connections with others do not provide choice. As Charlie clearly stated it repeated their childhood experiences of abuse, which was something she actively avoided.

Limiting choice within a relationship also limits the women's perception of control within the connection. Mandy explained how in her experience control was often an unexpected new experience but one that was highly valued.

"That's it, control, I was in control. I was, for the first time, I was actually in control. Me. Which yeah, that was probably what it was, I got some control." (Mandy; 807-810)

Overall, it can be suggested that forming connections with others that provide opportunities for choice, and that allow the women to perceive that they have control surrounding what happens within the connection, was driven by their personal needs. This was a vital ingredient within the women's experience, especially since each woman's experience was unique as depicted by Sarah's narrative.

"Yeah it should be based on a client's needs, and if the client has had enough then he or she will know by the time the limit is reached. Will the person benefit from more input or not. The client will know." (Sarah; 1423-1427)

DISCUSSION

Chapter four overview

The following chapter provides a summary of the current study's findings and an overview of how they can be interpreted in light of existing literature and theoretical perspectives. Service, clinical and research implications evolved from the findings will also be considered. Following this a discussion of the methodological strengths and limitations of this study will be drawn out, and attention will be given to how the study's findings are furthered and disseminated.

Summary of the findings

This study explored the lived experiences of recovery of women who were subject to childhood sexual abuse (CSA) and their understanding of the role mental health services had in this throughout. Interpretative Phenomenological Analysis (IPA) methodology was used for data collection and analysis. Semi-structured interviews were conducted with seven women recruited from a South Wales Health Board mental health service. To the author's knowledge this was the first qualitative study to explore recovery from CSA and the role of statutory mental health services within a UK context. This was a timely study as evidence shows gaps in service provision for adult survivors of CSA in England and Wales (Coy *et al*., 2011; Jones & Cook, 2008; McCarry *et al*., 2017; NAPAC, 2017).

Four interlinked superordinate themes were drawn from the analysis: 'The on-going, unfinished journey of recovery'; 'The power of being silenced by others'; 'Acknowledging the past and uniting it with my life'; and 'I can't do this alone: Ingredients for connections with others'. Subordinate themes were also identified within each of these four superordinate themes. Overall the research pointed towards the on-going and never-ending process of recovery following CSA. Recovery is a non-linear journey that was portrayed as a constant fight and accelerated by pivotal moments in the women's lives. Recovery was often hindered by the silencing nature of abuse and breaking free from this was significant to the women's healing, although often done to protect others and sometimes met with dire consequences. Women described recovery as a process whereby they acknowledged their past experiences and associated beliefs, and attempted to find a comfortable place for these within their current self. This was a challenging process that required the women to allow themselves to become vulnerable only in the context of supportive relationships. Connections with others require specific ingredients in order to avoid replicating past abuse interpersonal dynamics. Women

who had experienced CSA benefit from others acting as supportive guides who express compassion and empathy, and promote choice.

Both the superordinate and subordinate themes outlined will be discussed in turn and related to existing literature and relevant psychological theories in the following section. Although the current study focused on CSA and the interpretation of the findings largely drew on the CSA literature, the findings bear similarities with generic evidence on recovery from mental health difficulties (e.g. Brown & Kandirikirira, 2008).

Interpretation of the findings

Superordinate theme one: The on-going, unfinished journey of recovery

Superordinate theme one, symbolised the women's attempts to make sense of the process of recovery. The women often challenged the notion of recovery by stating that the experience of recovery from repeated episodes of CSA is different to recovering from a physical illness, or a one off trauma. The main difference was the notion that recovery has no end-point; life could never return to how it 'used to be', often CSA is all they knew. Anderson and Hiersteiner (2008) are also clear to emphasise this point, although this is in contrast to suggestions from other literature that implies functioning and wellbeing does return to a pre-trauma state (e.g. Sneddon *et al*., 2016). Returning to their previous functioning was not an expectation the women in the current study envisaged. Instead, how they made sense of the process of recovery was an on-going, unfinished journey. Although the concept of recovery has been criticised as ambiguous and vague (Beresford, 2015; Smith-Merry *et al*., 2011; Stuart *et al*., 2016), the three subordinate themes were clustered together as it was felt they described this journey: "Just continuing the journey"; "Constantly, constantly fighting everything"; and "A shocking moment, a landslide". As the women in the current study were clear to express the difference between their experience of CSA in comparison to other experiences that could be traumatic, reference will be largely made to literature surrounding CSA throughout.

"Just continuing the journey"

The women's notion of "Just continuing the journey" highlighted the on-going nature of recovery after CSA. This adds to previous literature that describes recovery as never 'fully' possible[10]; rather it is a lifelong process involving personal change with no quick fixes

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[10] Fully refers to recovery whereby an individual no longer experiences any of the effects of an event that happened.

(Anderson & Hiersteiner, 2008; Banyard & Williams, 2007; Chouliara *et al*., 2014; Draucker *et al*., 2011; Phillips & Daniluk, 2004). With this journey comes high and low points, which may fit patterns of behaviours thought to represent mental health difficulties commonly diagnosed in women with CSA experience, such as borderline personality disorder (McFetridge & Coakes, 2010). Although there is consensus that recovery is on-going there is emphasis to categorise this process into a model that people work through to reach an end-point. Devising a model of this nature may create the implicit assumption that reaching the 'end' or final stage represents completing the recovery process. The current study does not support this suggestion as the women clearly experienced a back and forth motion rather than a process of continuous linear progression to reach a stage of self-actualisation. Although Chouliara *et al*. (2014) introduce a more circular/systemic model of recovery, it is unclear how useful this is in overcoming assumptions of aspiring to be in a particular fixed state of 'recovery' and describing someone's personal experience. An alternative is to place more prominence on supporting and providing hope for people through their unique experience of recovery or life after CSA. It is evident that the concept of recovery needs to be clearly defined according to someone's personal experience. Different stakeholders have different conceptualisations of the term, which is a source of frustration.

"Constantly, constantly fighting everything"

The second subordinate theme represented the women's understanding of their role within the process of recovery, and the role of mental health services. The women paint an image of a warrior battling against the odds to endure the continuous process of life after CSA. This image is in concert with the past literature, which discusses how survivors' life stories contain on-going themes of challenges, defeat, and struggle (e.g. Anderson & Hiersteiner, 2008; Banyard & Williams 2007; Glaister & Able, 2001; Stuart *et al*., 2016). This stresses the amount of effort required to continue with their lives, which is incongruous with the use of the word 'survivor' to describe these women. Within the rich descriptions of the difficult battles the women face throughout recovery there was a sense that the women in the current study chose to adopt a fighting stance. This seems related to the women's reluctance to adopt the use of the word 'survivor' within their narrative as it devalued their active position. Although the term 'survivor' is commonly used in the clinical and theoretical literature, previous research also draws attention to its inappropriate use (Chouliara *et al*., 2014). In line with this finding effort has been made to move away from this language from hereon. However, Stuart *et al*. (2016) caution against only discussing recovery in light of people's strengths and progression. By not acknowledging the difficulties associated with recovery can create a view that people who 'cannot' recover are not trying hard enough. In turn this may result in adding further shame and blame to this population.

"A shocking moment, a landslide"

The third subordinate theme characterised significant points portrayed within the women's narratives. Although recovery was well conceptualised as a process with no end, this process was framed by a number of highly valued, influential events. These positive events are turning points that unveil an alternative perspective in life; almost like an alternative reality that acts as powerful catalysts for change within the women's lives (e.g. Chouliara *et al.* 2014; Draucker *et al.*, 2011; Godby & Hutchinson, 1996; Glaister & Able, 2001; Ochocka *et al.*, 2005; Saha *et al.*, 2011; Thomas & Hall, 2008). Banyard and William (2007) and Harvey *et al.* (2000) describe these as events that lead to gradual realisations of different possibilities, and Stein *et al.* (2000) labels them as 'second chances'. Draucker *et al.* (2011) explain how these events spur individuals to make drastic changes and a commitment to transcend the CSA rather than just recover. Women become determined to ensure that something good came from the CSA, either for themselves or for others (Draucker *et al.*, 2011). However, unlike previous literature these events were all viewed positively as opposed to negatively (Wethington, 2003).

The general trauma literature emphasises that these points are highly personal and unique experiences (Rutter, 1996). For example, for those women who were mothers in the current study, motherhood was often depicted as a turning point. Others have identified turning points occurring after naming the abuse, getting married and entering therapy (Thomas & Hall, 2008). Within the current findings the turning points detailed by the women related to them recognising their inner strengths and ability to follow a different life course that was influential in helping them break away from abuse cycles. These points were not enforced by an external agent, but were controlled and come from within the women, thus they were not perceived as overwhelming. Some suggest that experiencing a turning point was related to posttraumatic growth (PTG), though others have contested this and suggested that more research was needed to reach this conclusion (Easton, 2013). The role of PTG within recovery is discussed with the third superordinate theme.

Superordinate theme two: The power of being silenced by others

The second superordinate theme illustrated the powerful influence of being silenced by others that the women understood as intertwined with their lived experience of recovery. Mental health services, as well as others within the women's personal social spheres, played a role in this. Overall, the influence of feeling silenced was a hindering factor in the women's experience of recovery. Although previous research discusses the influence of feeling judged

and the social stigma that promotes a silencing culture in the context of recovery (Chouliara *et al*., 2014; Glaister & Able, 2001), reference is made towards the role of family rather than mental health professionals. Previous research also highlights the importance of disclosure in the initial stages of recovery (Anderson & Hiersteiner 2008; Chouliara *et al*., 2014). However, the current study would suggest that mental health services do not always create appropriate environments to encourage these, and overcoming silencing cultures is an enormously difficult decision that should not be taken lightly. The influence of feeling silenced and the experience of overcoming this are captured in the subordinate themes.

"Putting on my mask"

The first subordinate theme represented the influence of a silencing culture. This culture is reported in a number of studies (e.g. Collin-Vézina *et al*., 2015; Cromer & Goldsmith, 2010; Fontes & Plummer, 2010; Mathews & Collin-Vézina, 2016). The women's descriptions of perceiving themselves in a silencing culture resulted in them actively attempting to hide their inner difficulties behind a false exterior. This adds to Glaister and Able's (2001) study where a participant describes feeling as though she had to always be the good girl with no difficulties. A number of past studies highlight people having to live in a similar manner (e.g. McGregor *et al*., 2006; Saha *et al*., 2011; Tummala-Narra *et al.,* 2012). Women in the current study conveyed the difficulty of showing their true self due to the lack of physical evidence of their abuse experience, which is likely to leave them with a feeling of always having to prove themselves highlighting the difficult battle they face with society. For some, this mask formed a type of protection and provided security by maintaining certainty within their lives, however this was also related to feeling lonely. Chouliara *et al*. (2014) also felt that participants took some comfort keeping the abuse a secret. It has been suggested that over time the masked and non-masked self can come together (Parry & Simpson, 2016; Tummala-Narra *et al*., 2012), which is reflected in the next superordinate theme.

Moreover, the current findings suggest that mental health services play a pivotal role in encouraging the women to hide behind masks because of some responses made when disclosing their CSA. For example, telling the women this is not the time to discuss their experience, or reacting in a manner that was perceived as punishing. Evidence supports the notion that mental health services play a role in silencing, especially since there is a lack of enquiry about abuse experiences made by health and mental health professionals (Sampson & Read, 2016). Furthermore, evidence suggests that responses to disclosure may be the most predictive factor of later negative outcomes (Sneddon *et al*., 2016).

"I was going to ruin everyone's lives"

The second subordinate theme interpreted was the fear and apprehension women experienced regarding attempting to break silencing cultures. Ultimately the fear surrounded thoughts concerning how others would be influenced or react. Evidentially, this theme began to highlight the role of others in the experience of recovery, which is drawn on more heavily throughout the coming superordinate themes. Unlike previous literature discussed in Chapter one, Part two, the current study focuses on the actual consequences of disclosure in adulthood rather than the influence of fears developed in childhood. Although these studies discuss that women feel overwhelmed by the fear of the consequences of disclosure and the sense of losing control through letting go of the secrecy (Chouliara *et al.* 2014), the women's narratives surrounding what actually happens is not evident. The current study suggests that disclosing abuse can be likened to a self-sacrificing act as women lose core relationships with others, which was associated with incredible pain and discomfort. It was as if the women had lost everything, and gained nothing. At times, this pain was unbearable and women reflected on their thoughts of wanting to take back their disclosure as a result. This interpretation is in contrast to Anderson and Hiersteiner (2008) and Saha *et al.* (2011) who both emphasise the positive experiences of disclosure in adulthood in terms of beginning the recovery process. Nevertheless, this may have been in relation to disclosure within safe relationships, whilst the narratives in the current study did not differentiate disclosure within different relationships.

Superordinate theme three: Acknowledging the past and uniting it with my life

The third superordinate theme represented the women's lived experiences relating to coming to some acceptance, or acknowledgement of the past and beginning to integrate, or find a place for this, within their current life. The three subordinate themes underpinning this superordinate theme detail different aspects of this process. This superordinate theme is reflected by Parry and Simpson's (2016) systematic review (SR), which made attempts to develop stages of change after CSA through therapy. The first stage surrounded the ability to link the past with the current self, and the final stage surrounded being able to move away from the survivor identity and integrating their experience with their current self.

"I just hated it…how the hell is this going to help?"

The first subordinate theme portrayed the women's attempts to stop adopting strategies to escape memories of their CSA. The use of such strategies, or experiential avoidance coping, has been documented as a means of distraction from abusive memories (Chouliara *et al.*, 2014; Cole & Putnam, 1992). Godbey and Hutchinson (1996) refer to this process as the

burial process that occurs in adulthood, as an attempt to stow away unprocessed emotions and memories. In part, this had a functional element allowing the women to go on with their everyday lives (Saha *et al*., 2011). This shares some resemblance to the function of hiding behind the mask. Yet, the women in the current study acknowledged that they could no longer continue their lives avoiding the past; rather they made the choice to face it.

The need to come to an understanding of the past through facing it is a key theme in the CSA recovery literature (Banyard & Williams, 2007; Glaister & Able, 2001). Initially women in the current study did not feel certain whether facing the past was the right choice to make to aid their recovery. The uncertainty felt by the women stemmed from their unwillingness to place themselves in positions of vulnerability, as these were situations they had spent a majority of their lives avoiding. The initial recognition of needing to face the past, usually through choosing to engage with mental health services or therapy, or seeking support from others in general, is a challenging decision. Thus it cannot be forced. This decision is recommended in therapeutic models of trauma recovery. For example, Judith Herman (1992) proposes a three stage therapeutic model of trauma recovery that can be applied to CSA. The first stage is 'education and stabilisation' that shares similarities to the current theme in terms of gaining an understanding of the trauma experience, and is a stage that encourages coping strategies other than harmful avoidance approaches. Stage two is 'remembering and mourning', which again resembles the current theme as it represents the willingness to face past experiences. Finally, stage three is 'meaning and reconnection', which involves giving back to others and the community. It was felt that this stage shared similarities with the "Trying to protect them" subordinate theme discussed below. Chouliara *et al*. (2014) and Arias and Johnson (2013) discuss the uncertainty and difficulty of facing the past but also emphasise the importance of being able to embrace this vulnerability to gain an understanding of past experiences. Together these findings stress that engaging with a traumatic past is not an easy decision but something that is important to CSA recovery.

The willingness to face the past also shares some similarity with mindfulness principles. For example, mindfulness "refers to attentiveness to present experiences coupled with an accepting attitude toward experience, including emotionally painful and traumatic experience" (Allen, 2013, p. 27). Therefore, the women's ability to be mindful towards their thoughts and memories surrounding their CSA experience may be an ability developed through the process of recovery. Research has begun to show that mindfulness is more likely in those who have developed secure attachments (Shaver *et al.,* 2007). The importance of this attachment relationship will be introduced in superordinate theme four.

"Hatred of this little girl I used to be"

The second subordinate theme represented the women's narratives surrounding their past and present relationship with core beliefs developed during their experience of CSA. Having lived through CSA the women developed core beliefs, or negative attribution patterns related to guilt, shame and blame. Guilt is a negative evaluation of behaviour, and shame is a negative evaluation of the global self (Brown, 2006; Tangney *et al.,* 1996; Tangney *et al*., 2007). Blame on the other hand is conceptualised as a cognitive appraisal of an event rather than an emotion (Janoff-Bulman, 1979). Such attributions are unique to CSA due to the relational aspect of the abuse (Fergusson *et al*., 2008; Lewis *et al*., 2016). These were core beliefs that the women found difficult to unite, or find a comfortable place for within their current selves. The position given to these core beliefs played a vital role in the women's experience of recovery in the current study and previous literature. Such beliefs are believed to be highly influential in prompting the onset of trauma symptoms (Finkelhor & Browne, 1985).

Herman (1992; 1997), and Meiselman (1980) explain that both shame and guilt are reinforced constantly throughout the life of adults who experienced CSA. The findings of the current study suggest that these beliefs are constantly challenging but there were times when the women found a place for these once detrimental beliefs. Hartley *et al*. (2016) describe a similar theme within their research and referred to this process as 'relating to the self in a new way'. Literature often explains how people have managed to overcome struggles with guilt, shame and blame by gaining an understanding of their experience of abuse (e.g. Saha *et al*., 2011), which is also applicable to the current findings. However, the current findings suggest that this process does not end. Each person had a different personal battle, and their association and strength within the women's narratives seemed to be constantly changing. This finding would suggest that interventions that encourage cognitive restructuring of distressing or inaccurate appraisals may be 'ineffective' if the outcome is to eliminate them. It is felt that the struggle with such appraisals are reflected in Draucker *et al*. (2011) first stage of recovery 'grappling with meaning'. Although Draucker *et al*. (2011) describe this process as the very early stages of recovery, within the women's narratives of the current study this was an on-going challenge that is highly influenced by external factors. Therefore, this cognitive process does not seem to be exclusive to those who could only identify within the earlier 'stages' of recovery. Overall, the suggested variability of these beliefs does not sit well with the rigidity of Draucker *et al*. (2011) model, which adds to the mounting evidence that current models of recovery from CSA may be providing a limited perspective of individual's experiences.

"Trying to protect them"

The final subordinate theme was associated with reaching the process whereby the women in the current study acknowledged and accepted aspects of their current personal strengths that were likely related to their experience of CSA. In essence the women begin to integrate their past experience with their current self. The central strength voiced by the women in the current study related to the desire to protect others. 'Others' were family members, and those who they have a shared experience with. The desire to protect others shares resemblance to the third stage of recovery suggested by Herman (1992). This stage represents the willingness to reconnect and give back, which is thought to be essential in recovering from CSA (Herman, 1992). The women's strength developed over time and became recognised in adulthood as something they are proud of. In part, it formed a segment of the women's warrior identity, but there was some hesitance to fully embrace this strength due to its perceived origin. Women were unsure whether it was acceptable to admit its origin. The sense of an evolving 'survivor identity' is consistent with previous research (Phillips & Daniluk, 2004). For instance, Parry and Simpson (2016) highlight the shift toward having a sense of self not reliant on being a survivor of CSA appeared an important step to finding an independent adult identity and required the process of recognising one's strengths through self-kindness.

Within the current study the role of being a protector was not a view held by all. This is consistent within the literature, for instance Chouliara *et al*.'s (2014) participants described feeling guilty and inadequate when their hypervigilance and overprotection interfered with their parenting style. Furthermore, many survivors claimed that their urge to protect others from distress and stigma took energy away from their recovery and often hindered or delayed disclosure. Therefore, it is likely that the 'positive' aspects of their identity considered related to their past experiences are unique.

The women's ability to integrate personal qualities developed as a consequence of their past experience of CSA into their current identity shares similarities with the PTG literature (Tedeschi & Calhoun, 1995, 1996, 2004; Tedeschi *et al*., 2016). Indeed PTG has been documented in people who have experienced CSA (Shakespeare-Finch & de Dassel, 2009; Wright *et al*., 2007). PTG refers to the experience of actively coping with traumatic events and the progress from a negative trajectory towards positive psychological change, which generally results in a better level of functioning. Tedeschi and colleagues (1995, 1996) dominant theory of PTG suggests that growth occurs when core beliefs about the self, the world and the future are challenged (Cann *et al*., 2010), which shares similarities to a turning

point. Recovery could therefore be viewed as a process of challenging previously established negative beliefs resulting in some cognitive restructuring to acknowledge the fact that traumatic events do occur. Therefore, this superordinate theme, along with others drawn from the current study may reflect the growth women have experienced as a process of their personal journeys of recovery.

Within the literature there seems little difference between the definition of recovery used in the current study and growth. Though, PTG theories and models may be of limited applicability due to the nature of CSA, i.e. in some cases sexual abuse was a typical feature of someone's entire childhood; there are no memories before their trauma experience. Therefore, whether someone's assumptive world has been fully developed in order for a 'shattering' to occur is unclear. Hartley *et al*. (2016) suggests that when trauma is likely to play a role in someone's belief development "rather than incorporating trauma information into their assumptive world, growth appears to occur when the trauma-laden belief systems are challenged through new non-traumatic experiences, such as developing stable, non-abusive relationships; engaging in therapy, music, and writing; taking career-based risks; and starting a family of their own" (Hartley *et al*., 2016, p. 218). Such an interpretation fits well with the current findings. However, in some respect referring to any positive/adaptive personality trait as growth or PTG may imply that a survivor's qualities are all a result of the past abuse rather than influences later in life or a result of natural developmental processes. This may be disempowering and add to the stigma already associated with CSA and its impact.

Superordinate theme four: I can't do this alone: Ingredients for connections with others

The final superordinate theme conveyed the women's narratives surrounding the need for others throughout their lived experience of recovery. The need for others to be present supports available literature detailing that recovery can be enhanced or hindered by interpersonal connections (e.g. Arias & Johnson, 2013; Banyward & Williams, 2007; Chouliara *et al*., 2009, 2014; Draucker *et al*., 2009; Easton *et al*., 2015; Godbey & Hutchinson, 1996; Hartley *et al*., 2016; Thomas & Hall, 2008; Valentine & Feinauer, 1993). Within the current theme 'others' were people within the women's personal lives, professionals involved in their support and care and those who have shared similar CSA experiences.

Unlike previous findings (e.g. Banyard & Williams, 2007; Draucker *et al*., 2011), the importance of connections through religion or spirituality was not deemed significant. There is the possibility that the participants from the current study did not portray the importance of

connections with religion and spirituality as they had developed similar connections with others that participants in previous studies did not. This interpretation suggests that it is not the person who is important in the connection but the quality of the connection itself that is vital. The need for connections with others is contrasted with the empirical evidence reporting that people with CSA experiences have difficulties in forging and maintaining relationships (e.g., Kia-Keating *et al*., 2010; McGregor *et al*., 2006). Therefore, it is likely that this need does not come without its challenges.

The subordinate themes constituting this superordinate theme depict the core ingredients for connections with others. Overall, this superordinate theme best highlights the role of mental health services, in addition to the role of other important figures within the women's lives. The important core elements of the connections with others are in keeping and add to previous literature. Arias and Johnson (2013) report that sources of support include the other being forgiving, accepting, trustworthy, dependable, moral, and nurturing. Whilst, Glaister and Able (2001) describe supportive persons as those who are able to listen without judgment, provide information, understanding, and guidance, and share themselves. Overall, these attributes share a number of similarities with the attributes required to form a secure attachment relationship (Mallinckrodt, 2010).

"Started on the same path and then we branched out"

The first subordinate theme, or core ingredient, was the need for the 'other' in a supportive relationship to act as a guide. The women entered relationships with guides with high dependence. McGregor *et al*. (2006) makes reference to the high level of relational need of people who have experienced CSA, and for therapists in particular to be well attuned to this. The women in the current study often experienced guides as being either a mental health professional or someone who has also experienced CSA. Over time dependence on a guide reduces through the guide providing opportunities to empower the women to become more independent in their experience of recovery, or in life in general. Importantly the women within the current study emphasise that a guide needs to encourage a feeling of continuous support even when they are not present, which is consistent with previous literature (Anderson & Hiersteiner, 2008; Harper *et al*., 2008; O'Brien *et al*., 2007; McCarry *et al*., 2017; Parker *et al*., 2007).

The role of a guide can be understood through the application of attachment theory principles originally developed through studying parent-infant interactions (Bowlby, 1969; 1973). In brief, according to the attachment theory in the initial stages of good, or secure relationship

development a primary caregiver is required to be highly responsive and attuned to the infant; the infant requires a high level of dependency and emotional responsiveness (Bowlby, 1969; 1973). Eventually through these positive interactions the infant develops a mental representation (internal working model [IWM]) of the self, other, self in relation to others and the world (Bowlby, 1969; 1973). IWMs serve as templates for perceiving the world and building future relationships (Waters *et al.,* 1979). Overtime IWMs developed from secure attachment relationships allow individuals to respond independently and adaptively; they provide a framework for the belief that when you are in distress, the person to whom you are attached will be available and emotionally responsive to your needs, there is an sense of consistent support regardless of the caregivers physical presence. The overall function of developing secure relationships is to move to a more independent position and develop the ability to regulate emotional turmoil (Ainsworth *et al*., 1974; Feeney & Thrush, 2010). This process is strongly reflected within the women's narratives regarding other's roles who promote recovery. Women in the current study felt a guide could be likened to what the attachment theory calls the 'primary caregiver'. This is a highly relevant perspective because women who have experienced multiple exposures to CSA may have disrupted attachments (Rumstein-McKean & Hunsley, 2001), thus further harmful interpersonal interactions might hinder the most basic IWMs (Herman, 1992; Herman & van der Kolk, 1987), which in theory could add another challenge to the recovery process the women experience.

"Not pity. We don't like pity!"

The second subordinate theme to emerge in the current study was the need for others to express compassion and empathy in relationships. Empathy has been given different meanings across disciplines. The current study refers to empathy as both the correct cognitive understanding of another person's situation, feelings and needs, and an affectively motivated action that is appropriate to that person's situation (Batson *et al*., 1987; Baron-Cohen *et al*., 2005; Baron-Cohen, 2011; Lamm *et al*., 2007). The key qualities of compassion are the motivations to be caring, sensitive, be moved by distress, and tolerate distress and understand it (Gilbert, 2005, 2010a,b); it is commonly understood as a communicated sense of empathy. Both compassion and empathy are reported as necessary when working with people who have experienced CSA (Sneddon *et al*., 2016), and is often described as more influential than a specific therapeutic approach (Draucker *et al*., 2009). Indeed, increasing neurological evidence outlines relationships between kindness, compassion, and a variety of recovery and healing processes (Fehr *et al*., 2009; Hamilton, 2010), although this is mainly in relation to mental health symptom reduction.

The women within this study promoted the added value of experiencing empathy from others who had lived through similar experiences to them; there was an added value of having a literal shared understanding. Draucker's (1992) early research comments on the value of shared understanding. Both Arias and Johnson (2013) and Lev-Wiesel (2000) specify how participants in their studies gained compassion and empathy for others in anguish by hearing others' accounts of suffering. As empathy requires a capacity and willingness to imagine the abused child's perceptions, needs, and trauma, while avoiding the profound distress, this may be something more genuinely experienced by others who have also suffered CSA, rather than health professionals who may have not. Therefore they are showing a 'purer' form of empathy. Brown's shame resilience theory (Brown, 2006) can also be applied to understand this phenomenon. Brown's theory suggests that an enhanced sense of connection between people with shared experiences harbours mutual empathy and this context reduces feelings of shame. Therefore, it may be the mutual empathy reducing feelings of shame that creates a connection highly valued by the women in the current study.

Furthermore, some claim that expressing empathy to trauma experiences decreases helping behaviour for self-preservation (Bloom, 2016; Klimecki *et al*., 2014). Therefore health professionals may be less able to empathise as a result of wanting to help their clients. On the other hand, Anderson and Hiersteiner (2008) suggested that those who experienced CSA benefited from being with others who have a shared experience as it validated their experience of being victimised, confirmed their self-worth, and empowered them to have a voice. Although a number of theories have been discussed it is unclear which is most applicable. Although the available evidence regarding the effectiveness of individual versus group therapy (Martsolf & Draucker, 2005; Sturkie, 2013) is fraught with methodological limitations the current findings support the notion of group therapy with others who have a shared experience.

"It's got to be their choice, or you are just making it worse"

Finally, the third subordinate theme in the current study symbolised the need for others to provide choice within relationships. This theme was largely borne out of poor formal and informal relationship experiences. A number of studies exploring aspects of the therapeutic relationships between people who have experienced CSA and professionals emphasise the importance of choice (Chouliara *et al*., 2009; Harper *et al*., 2008; McGregor *et al*., 2006; Parry & Simpson, 2016; Phelps *et al*., 1997; Stige *et al*., 2013). Choice was highly important, as it was an aspect of the women's lives that was not often experienced during childhood (Parry & Simpson, 2016).

Within the current study, a lack of choice experienced from mental health services appeared to harbour a lack of control. There is a need for people who have experienced CSA to develop relationships that do not enforce abusive power dynamics and encourage decisive action (Koehn, 2007; Orbke & Smith, 2013) as it replicates aspects of their abuse (Harper, 2006; Sneddon *et al*., 2016) or harmful coping behaviours (Heney & Kristiansen, 1998). Prescott (2000) published a powerful first-hand account of her experience of support services in relation to her difficulties surrounding her experience of CSA. Within her article she talked about the trauma surrounding her experience of care and in particular her experience of being secluded. She referred to her experiences as re-traumatising, and an act of punishment, in part due to the lack of control and choice. Since this publication others recognise that many women located in mental health settings report feeling unsafe (Kennedy & Fortune, 2014).

The women in the current study explained that choice was vital in their connections with others as it promoted support that was driven by their needs. Relationships, especially with mental health services, should not be based on what others think is right, as this may result in a clumsy attempt to provide help (Parry & Simpson, 2016; Smith *et al*., 2015). This again, was considered a re-enactment of past abusive relationships.

Interpretation summary

Overall, there was not one theoretical model that encompassed all the findings. Rather several positions were required, which reflects the complex nature of the lived experience of CSA as shared by the women in the current study. For instance, superordinate theme one provided evidence to contradict thinking surrounding attempting to categorise the stages of recovery. It would also support the use of theories to understand complex relational trauma or complex post-traumatic stress disorder rather than one-off non-relational traumas. Superordinate theme two did not draw on any particular theory but shared resemblance to previous literature describing the role of societal influences and how mental health services could play an influential role, therefore promotes systemic thinking regarding people's behaviour.

Superordinate theme three shared similarities with the PTG literature although there was some concern regarding the nature of growth in terms of the onset of the trauma experience. However, Hartley *et al*. (2016) offers an alternative perspective of PTG that fits well with a majority of the current findings. The findings and interpretations also add evidence to Herman's (1992) therapeutic model of trauma recovery commonly used to support individuals who have experienced CSA. Finally, superordinate theme four could be

understood in light of attachment theory principles and theories of resilience suggested by Brown (2006) to help comprehend why connections with others with a shared experience were highly valued. The fourth superordinate theme highlighted the relational needs of women who experienced CSA throughout their lives. This may add to PTG theories by suggesting that growth was promoted when in unison with another who embodies the core relationship ingredients outlined in superordinate theme four. Both superordinate themes three and four bear similarities with the resilience and protective factors associated to CSA (see Chapter One, Part one).

Clinical and service implications

Given the relative dearth of research in the UK exploring the experiences of recovery from CSA and the perceived role mental health services play, this study provides valuable insight into how local mental health services can best support women who have experienced CSA. Unlike previous research the focus was not on the role of an individual therapeutic relationship but the relationship with mental health services as a whole. The current research suggests that mental health services are failing to provide the core elements required to develop relationships, or connections with others that promote recovery, re-enacting abuse dynamics and silencing culture associated with CSA. In part, the current findings advocate that at times service provision in South Wales is not meeting the needs of service users' who have experienced CSA (Coy *et al*., 2011; Jones & Cook, 2008; McCarry *et al*., 2017; NAPAC, 2017; Smith *et al*., 2015). This may hinder recovery and unintentionally perpetuate the abuse cycle. Service users accessing general mental health settings often refer to themselves as 'survivors' not only of their mental health difficulties and associated traumatic life events, but more importantly, of services themselves (e.g. organisations such as, 'Survivors Speak Out' and the 'Survivors History Group'). Moreover, Smith *et al.* (2015) commented that poor service provision could be more detrimental than the absence of service provision. This conclusion is not in accordance to the Welsh Government's agendas for healthcare, such as the four core principles of Prudent Health Care[11].

It is probable that a significant proportion of clients accessing mental health services have a history of CSA (Chu & Dill, 1990; Glaister & Abel, 2001; Read *et al.,* 2004), therefore, accounting for the current study's limitations (see below), the study's implications may have

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11 Four principles of prudent healthcare: Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production; Care for those with the greatest health need first, making the most effective use of all skills and resources; Do only what is needed, no more, no less, and do no harm; Reduce inappropriate variation using evidence based practices consistently and transparently (Aylward et al., 2013).

far reaching recommendations for mental health services as a whole. The findings do not necessarily encourage the development of services specifically for individuals who have experienced CSA, rather a reassessment of services designed to meet the needs of the population. Below is an outline of the implications suggested from the current research. Consideration is also given to a possible framework to encompass these implications and the role of a Clinical Psychologist in promoting and delivering them.

Raising awareness

Based on the current findings gaining an understanding of someone's past CSA experience may be challenging due to the influence of silencing cultures and subsequent reluctance to disclose. People who have experienced CSA may weigh up the cost of disclosing their abuse as outweighing the benefit. Professionals likely to be in contact with people who have experienced CSA (all healthcare professionals) would benefit from developing an awareness of theirs and the wider society's influence on disclosure. Professionals need to be aware that their responses or non-responses can be re-traumatising. Continuing professional development events should value this. Through holding awareness action can be taken to avoid reinforcing silencing cultures within healthcare settings. For instance, when disclosures do arise staff should feel confident and supported to manage these situations rather than to actively avoid or discourage them (Sampson & Read, 2016). This is highly important as previous research suggests disclosure marks the onset of recovery and seeking support (Chouliara *et al*., 2014). Resources, such as the British Psychological Society's guidance of the management of disclosures of non-historic CSA (Rouf *et al*., 2016[12]), may provide a further forum to overcome silencing cultures within healthcare settings.

Furthermore, a general awareness of CSA should be promoted across all healthcare settings. In line with the current study's findings professionals should be trained to understand the nature of life after CSA (e.g. on-going, back and forth experience framed by turning points that may be useful targets for intervention) in addition to the impact of complex trauma. Gaining further understanding surrounding the difficult, on-going daily battle these women experience may encourage the use of psychological formulation and the development of other's compassion. There has been interest in promoting compassion within healthcare relationships, for instance, initiatives by organisations such as the Kings Fund (2009) (Maben *et al*., 2009; NHS Confederation, 2008; Smith, 2008).

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[12] This resource has been well received by health care professionals and successfully disseminated across the UK (Personal correspondence with Dr Benna Waites (co-author).

Recovery has a number of connotations within health settings. Therefore the concept of recovery in relation to CSA should be debated. For example, should the term recovery be used at all, and would 'growth' be more applicable (see Tedeschi & Calhoun, 2008)? One participant in the current study suggested the term 'evolution'. All stakeholders should develop a common understanding of what recovery refers to in terms of CSA, for all women in the current study it did not refer to mental health symptom reduction[13]. A coherent understanding of recovery may trigger larger acknowledgment that currently mental health services are not meeting the needs of people who have been sexually abused. To highlight this need it would be highly relevant to educate, and raise awareness, of the nature of recovery from CSA to those in societal spheres wider than frontline healthcare professionals (Stuart *et al*., 2016). For example, those who determine overall funding of mental health, commission services developed to support individuals who have experienced CSA, or work in the criminal justice system (Crenshaw *et al*., 2016). Raising such awareness may also bring to attention that a cure, in the sense of removing the impact of CSA, is not possible. This would advocate the need for funding to also be invested into CSA prevention. Such messages are strongly communicated in strategies such as Stop It Now! Wales (Morgan & Findlater, 2012).

Promoting 'recovery-enhancing' relationships with mental health services

The current study's findings emphasise the need for people who have experienced CSA to be provided with opportunities to acknowledge and understand past CSA experiences, and find a place for core beliefs related to the past. This supports the use of many trauma-focused interventions adopted and recommended (see United Kingdom Society for Post-Traumatic Stress, 2016, for a review). However, women suggest that these processes cannot be forced or done in isolation, as it is a highly exposing and vulnerable process. This introduces the core role of mental health services. Women from the current study felt their experience of recovery was promoted when they formed relationships with others that acted as guides who expressed empathy and compassion whilst also allowing them choice and control. The importance of some of the core ingredients to develop recovery-enhancing relationships are mentioned in Welsh national strategies for mental healthcare, for example the 'Together for Mental Health' 10-year strategy endorses the need for compassionate care (Welsh Government, 2012). Unfortunately though developing such relationships did not seem a priority, with focus is still on mental health symptom reduction.

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[13] Christmas and Sweeney (2016) discuss the difficulty of developing common language in relation to the term 'service users'.

The importance of establishing an effective therapeutic relationship has long been recognised as "probably the single most important factor" in the successful treatment of adults who have experienced CSA (Olio, 1989, p. 98). However, the difficulty in forging and maintaining secure relationships in adulthood has been hypothesised to contribute to the challenges faced by survivors of CSA (Olio & Cornell, 1993; Pearlman & Courtois, 2005). One-way to facilitate the development of recovery-enhancing relationships would be to apply attachment theory principles to elements of service delivery.

Attachment theory provides a universal evidence-based theory that can inform mental health policy to promote psychologically 'safe' services (Seager *et al*., 2007). Some believe that as trauma entails such extreme emotional pain increasing attachment security in emotionally close relationships should always be a crucial goal of trauma treatment (Allen, 2012). Attachment theory can provide an intervention structure for guides, which should be anyone or everyone within a mental health service and not solely a therapist (Mallinckrodt, 2010). The underlying assumption is that the relationship built within a service as a whole provides an opportunity to rework attachment difficulties, or revise IWMs (Pearlman & Courtois, 2005). In theory the development of new, secure relationships will encourage IWMs that result in people believing they are constantly supported by the service. This perception may encourage independence from the guide and may make the prospect of time-limited therapeutic interventions more acceptable. It may also lessen the impact of potentially losing vital personal relationships when disclosures of CSA are made. The Department of Health UK, and an empirical evidence-base, support the application of attachment theory (Bucci *et al*., 2015; Lahav & Elklit, 2016; Seager *et al*., 2007), however this is a relatively new area that needs further development (Berry & Danquah, 2016).

The need for more continuous guidance throughout recovery is also reflected in Smith *et al*.'s (2015) UK survey. Although attachment theory suggests that this can be developed through secure connections this is likely to require considerable time due to the nature of the trauma endured by these women. One alternative is to provide actual support through increasing access to psychological or counselling services. A country that has adopted this approach is New Zealand (NZ) who recognised the limited support within the public health system. Within NZ the Accident Compensation Corporation (ACC) offer 16-sessions of support immediately after a claim has been made for counselling/psychotherapy following any reported experience of sexual abuse (see ACC, 2013). Unfortunately, both considerations for increasing recovery-enhancing relationships will add further pressure to services with limited resources (e.g. as suggested by Cwm Taf University Health Board, 2014). Therefore emphasis on promoting such implications may be best placed at a commissioning and government level.

Valuing shared experiences

Compassion and empathy were two core ingredients in relationships that support the women in the current study through their experience of recovery. Yet, the expression of empathy was valued more when expressed by others with a shared experience to the women. Thus, it may be that mental health services offer compassionate environments, but those with a shared experience offer empathy in a group setting. Some suggest the context of a group environment may be more important than the content (United Kingdom Society for Post-Traumatic Stress, 2016). This suggestion sits alongside the evidence that group therapy is effective in reducing the isolation, stigma, shame, self-blame and re-victimisation associated with CSA (Brown *et al*., 2013; Callahan *et al*., 2004; Fouché & Walker-Williams, 2016; Hébert & Bergeron, 2007; Trepper & Chew, 2014). Furthermore, group environments offer a safe and powerful forum that validate and normalise experiences through the development of significant, non-judgemental empowering positive peer connections (Cruz & Essen, 1994; Walker-Williams & Fouché, 2017). This directly counteracts the lonely, stigmatising culture reported by the women in the current study. The current study builds upon this research as it emphasises the added value of shared experiences due to how empathy is perceived. The current findings would promote group therapy, such as the Trauma Recovery and Empowerment Model ([TREM], Harris, 1998), as it provides an opportunity to both express and feel empathy that is more influential than that experienced within a therapy room with a therapist.

Shared experience adopting a salutogenic perspective

The findings from the current research further recommend that rather than focusing on a pathogenic paradigm (deficit based approach) (Kessler *et al*., 2003; Taylor & Harvey, 2010) to group delivery services may benefit from a salutogenic paradigm (strengths based approach). The strength drawn from the current study is the role of protecting others and the ability to actively engage in recovery, which forms part of their warrior identity. These personal strengths could be applied as a resource to encourage change for themselves and others. For example, women may experience therapeutic benefits by co-facilitating groups for others who have experienced CSA. This is also highly valuable for professionals as the women are in positions of being 'experts by experience' (McLaughlin, 2009). Furthermore, this approach is inline with Herman's third stage of trauma recovery within therapeutic settings (Herman, 1992).

Transformative co-production

The current study would promote principles of co-production that endorse equal and reciprocal relationships between service users and professionals to design, create and deliver services (Cottam & Leadbetter, 2004). It is important to acknowledge that this implication is not driven from a consequence of limited resources to facilitate care. Instead, it is born out of the current research findings. Co-production can offer opportunities to overcome silencing cultures, build on strengths, such as roles as protectors and wanting to help others in similar situations, help develop safe and secure relationships with others, and advocate choice for this population. This approach is also in accordance to Stuart *et al*. (2016) who suggested the need to move away from the professional led understanding of recovery.

Co-production lies across a continuum. An intermediate level implies good quality consultations or shared decision-making to healthcare approaches. A transformative level promotes service users and professionals working as equal partners to commission, design, deliver and evaluate public services (Needham & Carr, 2009). A transformative level would be favoured in light of the research findings. Unfortunately this level of co-production is not specified in policies. For example, the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 that suggests "The experience of service users should regularly and systematically be used to inform the partnership on the effects of its work and to suggest improvements" (Welsh Government, 2015, p. 15). Here women are positioned as informants rather that creators of innovative solutions. One example of this method to service delivery in the UK is by Allnock and Wagner (2016) who developed a co-created service for adult survivors of CSA with people who had experienced CSA and professionals. Their evaluation drew a number of recommendations, such as: the need for clear expectations for all involved; communication between service users should promote security and safety and avoid potential abusive dynamics; the impact of this work may be distressing at times but this is outweighed by the positives; continuous support for professionals is necessary due to increased feelings of responsibility; relationships and networking are key; a whole systems approach is more sustainable; and creativity in the approach will prevail. Due to its relevance reference should be made to Allnock and Wagner (2016) evaluation in the development of a co-produced service.

How does this all fit together: Adopting a trauma-informed service delivery framework

As a whole, the current findings support the implementation of a trauma-informed service delivery framework (Bateman *et al*., 2013). Trauma-informed services are those that acknowledge the impact of interpersonal violence and victimisation on an individual's life and development (Elliot *et al*., 2005). This approach has shown success in a range of healthcare settings (e.g. Barton *et al*., 2009; Bateman *et al*., 2013; Chandler, 2012; Covington, 2008; Frisman *et al*., 2008; Harris & Fallot, 2008; Morrissey *et al*., 2005; Regan, 2010; Rosenberg, 2011). Bateman *et al*. (2013) suggest the following eight guiding principles to developing trauma-informed services: promoting safety, role-modelling interpersonal relationships that heal, understanding culture, advocating for consumer control, choice and autonomy, understanding trauma and its impact, sharing power, inspiring hope and supporting recovery, integrating care and sharing power and governance. The suggested implications fit well within these principles as shown in Table Eleven.

Principles of trauma-informed services	Current study implications
1) Promoting safety	Promoting 'recovery-enhancing' relationships within mental health services
2) Role modelling interpersonal relationships	
3) Advocating for consumer control	Transformative co-production
	Valuing shared experiences
4) Choice and autonomy	Transformative co-production
5) Understanding trauma and its impact	Raising awareness
6) Inspiring hope and supporting recovery	
*7) Integrating care	*The role of a Clinical Psychologist
8) Sharing power and governance	Transformative co-production

*Table Eleven. Outline of how the current study's implications fit with a trauma-informed service delivery framework (Bateman et al., 2013). *Discussed further in section below ('The role of a Clinical Psychologist').*

As shown from Table Eleven each of the eight principles of trauma-informed care are reflected in the implications outlined above. Therefore the current study's findings would promote trauma-informed services, or fit well within a service that adopts this stance. The principles of trauma-informed care are flexible enough to allow for the application of theories and approaches, such as attachment theory and co-production to be built into service delivery. Overall, adopting these implications would move away from the medical model that most mental health services originate.

The role of a Clinical Psychologist

A Clinical Psychologist can play a central role in the delivery of the suggested implications due to their relevant 'high level' transferable skills (British Psychological Society, 2010; Division of Clinical Psychology, 2010; Lavender & Hope, 2007). Clinical Psychologists often find themselves leading healthcare teams made up of a number of professions. This places them in leadership roles that provide platforms to raise awareness of the suggested implications and implement new ways of working.

Clinical Psychologists can aid the implementation of the suggested implications whilst also managing the possible challenges. For example, advocating the importance of developing secure safe relationships with service users, and the expression of empathy towards other's traumas through trauma-informed frameworks may place further demands on staff, which may result in burn out, compassion fatigue or secondary traumatising (Herman, 1997). As shown by Allnock and Wagner (2016), professionals involved in co-produced services experience increased feelings of responsibility to 'get it right'. Therefore, Clinical Psychologists can be prepared to offer space for supervision, consultation and reflection to help promote staff wellbeing and avoid blocked care (Pearlman & Courtois, 2005).

The suggested implications framework will only be effective if a whole-systems approach is adopted. Bloom (2010) describes possible failures in trauma-informed ways of working when there is incongruence between the approach management adopt in comparison frontline staff. This is termed as an issue of parallel processes, which is highly relevant as mental health systems are under chronic stress (Aylward *et al*., 2013; Bloom, 2010). As Clinical Psychologists have the unique position of working at all levels of the healthcare system (organisational to frontline working) they can advocate the need for a trauma-informed framework such as this to be endorsed at all levels of the system whilst also offering the support to help sustain this approach. Consideration also needs to be given to the support offered to Clinical Psychologists. One example of this would be through recognising the value of regular service wide psychology peer support or reflective groups.

Strengths and limitations of the current study

The current study's findings, interpretations and suggested implications should not be considered outside of the study's methodological strengths and limitations. To aid the assessment of the strengths and limitations reference will be made to the Critical Appraisal Skills Programme (CASP; 2010), the consolidated criteria for reporting qualitative research

(COREQ; Tong *et al*., 2007), and Mays and Pope's (2000) checklist (all outlined in Chapter two). In line with the quality assessments, focus will be given to the most prominent strengths and issues in relation to study design, recruitment and sample, data collection and analysis, and credibility.

Design

A primary strength of the current study is the use of service user involvement throughout (Mjøsund *et al*., 2017; Syrett, 2011). Service users were involved in the initial stages of the study design, the design of the study materials, the analysis (respondent verification) and dissemination (participant creating images and co-facilitate conferences). Reference was made to guidance regarding service user involvement in research (National Institute for Health Research, 2009) to ensure the credibility of their use. Consultation (Williamson, 2001) and collaboration (Hanley, 2004) were primary methods adopted to integrate service users' voices, thus there is further scope for more in-depth service user involvement.

The qualitative methodology adopted was considered another strength as the aim of the current research was to explore lived experiences. As discussed there is limited UK research conducted on this population, even less literature is available surrounding the concept of recovery and experiences of the statuary support services. What is available (i.e. Smith *et al*., 2015) is based on satisfaction survey data that may not capture the richness of the experience, and risks 'fitting' the individual's experience into a framework that is incongruent with their own understanding (Yardley, 2000). Although findings from individual qualitative studies such as this are not generalizable (Malterud, 2001) in part this can be overcome through the synthesis of a number of qualitative studies (Smith *et al*., 1995).

One limitation of the design was its retrospective nature. This is relevant to the current study as women conveyed that the on-going nature of recovery was synonymous to life. Therefore, asking participants to discuss their experience is likely to have been a large feat. With this in mind it is likely that the participants chose to discuss dominant narratives during their life that they felt symbolised recovery. This may be reflected in the theme 'A shocking moment, a landslide'. Therefore, it is unclear whether this theme was an artefact of the study design.

Recruitment and sample

Sample sizes are often debated within qualitative methodologies. The current study recruited seven participants. Although this was deemed appropriate (see Chapter Two, Sample size) it could be argued that relative to other similar studies the sample was not sufficient. Overall, there was difficulty recruiting an increased number of participants for the current study. This was largely due to clinicians not being able to identify anyone who met the inclusion criteria. This may be related to society's views regarding other's abilities to talk about past trauma, or reflect the lack of suitable participants within statutory mental health settings. Furthermore, participants choosing to take part may have held particular positions in relation to the topic of recovery, which may have increased the likelihood of selection bias within the current sample.

Pietkiewicz and Smith (2014) explain that homogeneity within IPA research largely depends on the availability of the sample population. The current study recruited a relatively homogenous sample. Yet, the homogeneity could have been improved by recruiting women who had all accessed similar support in relation to their experience of CSA. For example, a majority, but not all of the women in the current study attended the SAFE group (discussed in Chapter Two, Participants), which may have influenced the narratives the women provided.

Consideration should also be given to knowledge regarding the detrimental impact of developmental trauma and how this may have influenced the samples ability to provide data. In line with current evidence it is likely that a majority of individuals involved, or recently discharged from mental health services that had experienced severe developmental trauma, at times may have had difficulty articulating their experience as a result of the cognitive impact of trauma. For instance, Herman (1992) argued that the terror perceived from a traumatic event results in an overwhelming emotional response that results in a flight, fight and/or freeze response as a form of coping (Zaleski *et al*., 2016). Difficulty regulating the emotional impact of trauma often results in an increase in the hypothalamic-pituitary-adrenocortical axes response, resulting in the increase release of stress hormones, which can influence an individual's ability to cognitively process information and engage interpersonally. This is because the brain's response to high levels of stress is to operate from a bottom-up (amygdala-controlled, primitive brain) circuitry, rather than relying on higher processes involving the neocortex required for higher level cognitive processes, such as recalling events (Zaleski *et al*., 2016). Asking people to recall experiences related to trauma can trigger this system. Based on models of trauma recovery, such as Herman (1992), those who have not learnt to manage emotions effectively would not be suitable to participant in the current study. From the findings of the current research recovery is ever changing and on-going,

which highlights the difficulty in recruiting someone who is 'at the right' stage of their recovery in a certain moment to 'effectively' recall their past. Taking into consideration the above, the sample recruited in the current study and the rich data collected can be considered a strength.

Elliott *et al*. (1999) proposed the importance of situating a sample in qualitative research. Within the current study the sample could have been situated in further. For example, the CSA history of participants, in terms of typology, severity and frequency, was not adequately described. The current study also did not include an objective measurement of traumatic symptomatology and/or psychological functioning at the time of inclusion. Therefore, the information solely relied on self-reports, which also makes it difficult to disentangle the influence of polyvictimisation (see Chapter One, Part one, Potential outcomes). One strategy would have been to include a brief questionnaire regarding this information as done by van Dyk (2004) and Hartley *et al*. (2016). Less information was collected regarding situating the sample in the current study due to issues of anonymity. Maintaining anonymity was considered paramount especially since a small number of women were recruited.

Data collection and analysis

One-off semi structured interviews, averaging one and half hours were used to elicit rich, detailed, first person accounts of experiences in the current study. Others have commented on the appropriateness of this approach for the current study's population (e.g. Chouliara *et al*., 2012). Yardley (2000) explains that data analysis is only as good as the data collection. Subsequently there is heavy emphasis on the researcher's interviewing skills (Pietkiewicz & Smith, 2014). This was considered a strength of the current research project as the researcher was well versed in developing rapport and navigating potentially distressing conversations. However, due to the one-off nature of this approach whether adequate rapport was developed is unknown despite time set aside at the start of the interview for this process. This may have limited participant's narratives. Considering the study's findings regarding mental health services being perceived as silencing and not always enforcing connections that promote recovery this is a likely possibility due to the interviews being conducted within the mental health service they received support from. There was the possibility that participants would have been reminded of these experiences at the start of the interview as the safeguards were outlined in the participant information sheet and consent form.

Efforts were made to collect all data via face-to-face interviews, however due to unforeseen circumstances one interview was conducted via telephone conversation. It was felt that in

comparison to the other interviews the level of rapport developed was not as 'strong'. Therefore there is a likelihood that this influenced the richness of the data collected. Having to conduct interviews in a different medium highlights the difficulty related to recruiting participants for the current study.

The data collected was analysed using IPA, which allowed for the microanalysis of individual experience to infer how individuals made sense of their experiences (Smith *et al*., 2009). Importance is placed on the analyst being able to bracket his or her own stance in relation to the phenomena being explored. Although this process was highly privileged there were times when the experiences being discussed elicited a highly emotional response that was difficult to disentangle (see Appendix six and eighteen). On reflection this may have been a different experience for a researcher who was not working within an NHS context. Biggerstaff and Thompson (2008) discuss similar difficulties faced by researchers who are also clinicians. Thus, there is the possibility that others may have derived an alternative interpretation of the women's narratives due to their personal and professional stance.

One aim of adopting IPA was the methodology's ability to provide a voice for a historically silenced population (Blume, 1990; García-Moreno *et al*., 2015). The analytic process cannot ever achieve a genuinely first-person account, as it is both the participant and the researcher that construct the final narrative; taking 'the insider's perspective' is only part of the analytic process. There are a number of interpretations that shape the narratives provided. For example, it is the researcher who decides what to study, how to do it, what questions to ask, and what quotes are used as evidence. Even if the transcripts were published verbatim they would only be publishing what the participants felt comfortable talking about and what they are consciously aware of. Furthermore, awareness should be given to the interpretative authority of the researcher, and therefore, concern with representing the voices of others may be constrained by the researcher's own voice as an academic (Devault, 1994). It should be acknowledged that the final result of the analysis is as 'close' to the participant's view as possible (Larkin *et al*., 2006).

Ensuring credibility

The use of credibility checks was viewed as another strength of the current study. Firstly, the positioning statement, along with a reflexive diary, was drawn on throughout the research process during supervision with both Clinical and Academic Supervisors. Secondly, credibility was enhanced through the use of respondent verification. This is a hugely time consuming process that is conducted soon after data collection (Harf *et al*., 2015). Once a

draft analysis was developed all participants were immediately re-contacted via their preferred means and asked whether they would be willing to have a role in the analysis. Although Riessman (1993) advocates asking for participants' views on an interpretation offered by the analyst, she explicitly rejects the idea that the analyst's intellectual independence should be abandoned by taking participants' opinions as an authoritative judgement of the value of the interpretation. However, overall, the women felt the analysis largely reflected their experience; therefore this was not a concern.

Future research

Considering the study's limitations, recommendations for future research to expand on the present study's findings are outlined in the following section.

The current research was borne out of the understanding that there is limited research exploring recovery from the perspectives of people who have experienced CSA (see Chapter one, Part two). As IPA aims to describe in detail the perceptions and understanding of a particular group under investigation, rather than making more general claims (Smith & Osborn, 2008), future research would benefit from attempting to replicate the current study but recruit a larger sample. Recruiting a larger sample may provide the opportunity to explore the same research question across different demographics, or moderating factors, such as abuse related variables or gender differences. One of the strengths of the current research was the use of service users throughout the entire process. The current study largely adopted the use of consultation and collaboration approaches. With the continuation of this project in an attempt to recruit a larger sample there may be scope to encourage further 'service user controlled' aspects (Hanley, 2004). In favour of the above suggestion, a greater level of service user involvement is associated with increased ease of participant recruitment (Syrett, 2011). Overall, future research within this area should move away from the use of 'lip-service involvement' (Trivedi & Wykes, 2002). Commitment to service users should be demonstrated through validating their worth through means of payment and providing opportunities for development, such as training and education (Syrett, 2011). The aim of this approach would be to empower this population and more effectively communicate their voice. This may encourage more innovative approaches to research and dissemination that would inevitably result in improving the finding's impact.

Considering this time of austerity the current NHS finds itself (Aylward *et al*., 2013), it would be beneficial for future research to explore the added value of developing relationships with others who have a shared experience of CSA. The current study provides some insight to the

added functions of this relationship (i.e. improved perceived empathy) although research specially focusing on this may unveil further insight that can further inform service development. This would be in contrast to the perspective held that therapeutic groups are solely used as a money saving tool (Trachtenberg *et al*., 2013). Additionally, it would be useful to gain understanding of health professionals' experiences in accordance to an empathetic and compassionate approach towards people who have been abused as children. This would allow further understanding of the resources required to effectively undertake this work.

There is very little research of the current study's nature conducted with young people (Jones *et al*., 2013; McGregor, *et al*., 2006). A majority of the narratives provided in the current study relate to adulthood experiences, rather than experiences of recovery during childhood. Consequently, there is a distinct need to understand CSA recovery experiences through the eyes of children to enhance prevention and intervention efforts (Foster & Hagedorn, 2014). The paucity of published studies recruiting children is related to the obstacles that limit research with children who have experienced trauma (Walker *et al*., 2009). In part, it seems that these decisions are not informed by evidence, for example, Crane and Broome's (2017) review reported that children prefer to be involved in the decision-making of whether they will participate in research. This further highlights the need for the promotion of service user involvement within this research field.

The recommended future research areas would benefit from adopting a variety of research methods. For instance, a study design valuing a prospective approach that obtains both rich qualitative and quantitative data would be advantageous. Inherent in qualitative designs are small sample sizes therefore, this approach may provide 'real time' insight into the continuous nature of recovery and combine complimentary methodologies to expand and generalise understanding. Moreover, it may be appropriate to adopt a multidisciplinary, practice-based evidence approach to data collection to further overcome some issues regarding recruitment and ethical dilemmas previously discussed.

Dissemination approaches and public engagement

It has become widely recognised that roughly 80% of research funding is ineffectively spent due to the failure to disseminate the findings (Chalmers *et al*., 2013). It is estimated to take 17 years for 14% of original research that is disseminated to influence the clinical care someone receives (Green, 2009). This creates an ethical dilemma, and does not justify the amount of money spent on research. One reason for this may be that dissemination approaches are rarely

given the attention they truly require. This has been a historical issue for research within the CSA field (Finkelhor & Araji, 1986). Therefore considerable thought was given to this in the current research. For example, all participants were asked whether they would like to have a summary of the research findings and were also asked whether they would like a role in the presentation of the research if it were presented at a conference. All participants expressed interest. Chapter Two provides a discussion of how the current study aimed to overcome this issue by focusing on the presentation of the findings. In an additional attempt to overcome this issue an initial dissemination approach plan has been devised (Figure seven). Overall, the plan emphasises the importance of service user involvement and the need to recognise the target audience agendas. As CSA falls into many disciplines (Finkelhor & Araji, 1986), and not just psychology, effort should also be placed on effective communication between disciplines to develop a more substantial evidence-base (Finkelhor & Araji, 1986).

Local level
(Collaboration/consultation/controlled service user involvement)

Examiners of the DClinPsych thesis *How: Write-up of thesis*	University students and staff *How: Thesis published on ORCA, presenting research to students in a teaching session using Prezi, and group discussions*	Participants of the current research project *How: presenting participants with a written summary of the findings along with images, offering a face-to-face or telephone conversation to discuss findings*	Relevant service users at the research site *How: Attending service user groups to provide a verbal overview of the research aims and findings. Presenting the images of the themes to accompany overview.*	Relevant staff at the research site *How: Attending team meetings to provide a verbal overview of the research aims and findings. Presenting the images of the themes to accompany overview. Send abstract of research to R&D*

National level
(Collaboration/consultation/controlled service user involvement)

Attendees of identified conferences outside of NHS *How: See appendix for details regarding the BPS Community Psychology Section & UWE Bristol present: The 3rd Community Psychology Festival 'Falling apart; Pulling together: Collaboration in times of division'.* *Attending workshops on related topics such as that for the Resources, such as the British Psychological Societies guidance of the management of disclosures of non-historic CSA (Rouf et al., 2016)*	Attendees of identified conferences with in Welsh NHS University Health Boards, e.g. annual research conferences – Attended by health care staff, students, service users and commissioners *How: Poster presentation using mainly images of themes, presenting a talk with the aid of Prezi*	Development of resources *How: Leaflets created to communicate research findings (same leaflet for service user and staff) placed in healthcare settings, such as GP surgeries, substance misuse clinics, sexual health clinics*	Identification of other useful forums to present finings to service users in Wales; consideration of how to target Welsh Government *How: Further consultation with mental health services and service users. Possible collaboration with local charities such as Stop It Now! Wales (already established relationship with Welsh Government)*

International level
(Collaboration/consultation/controlled service user involvement)

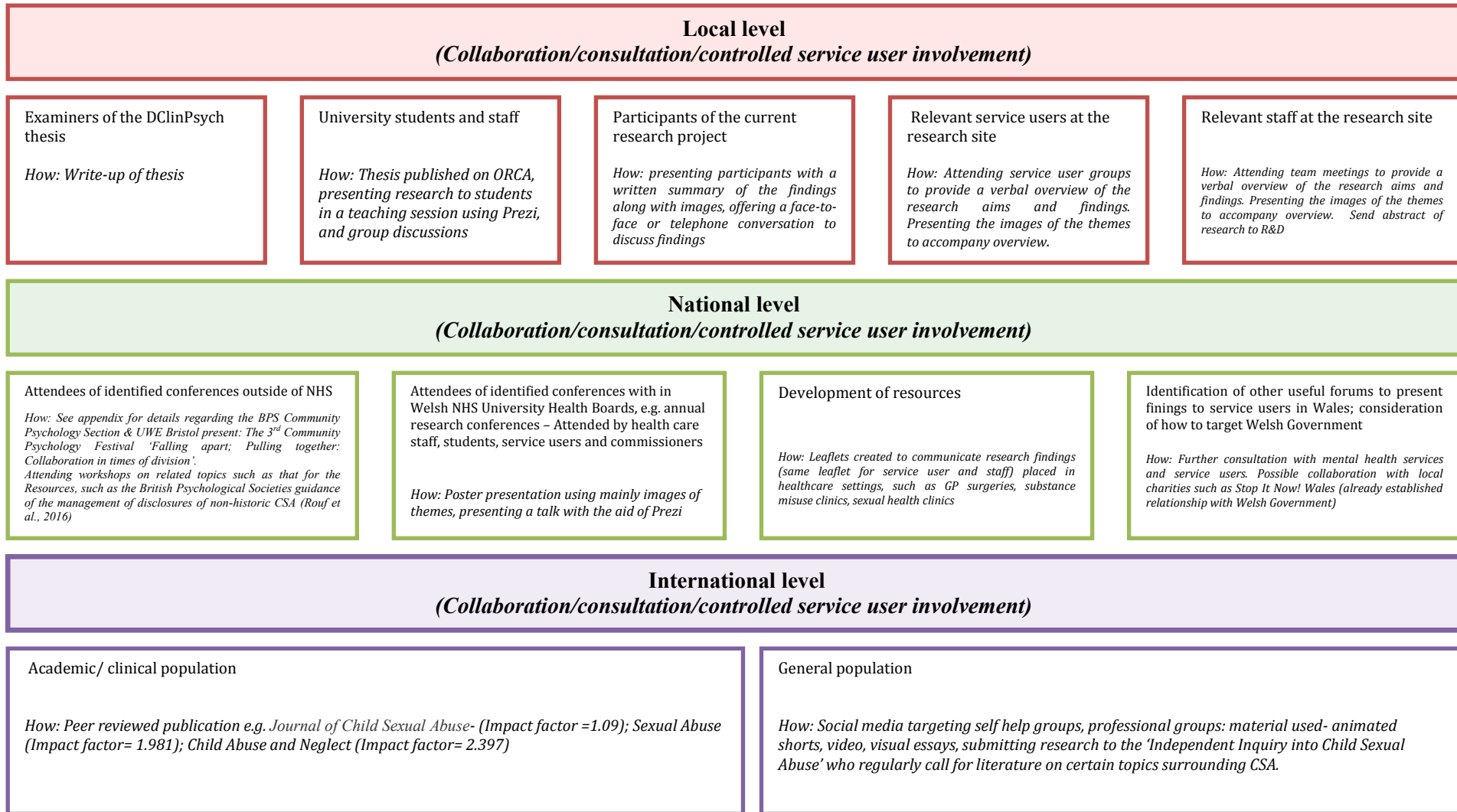|	
Academic/ clinical population *How: Peer reviewed publication e.g. Journal of Child Sexual Abuse- (Impact factor =1.09); Sexual Abuse (Impact factor= 1.981); Child Abuse and Neglect (Impact factor= 2.397)*	General population *How: Social media targeting self help groups, professional groups: material used- animated shorts, video, visual essays, submitting research to the 'Independent Inquiry into Child Sexual Abuse' who regularly call for literature on certain topics surrounding CSA.*

Figure Seven. Dissemination approach initial plan: will be amended as seems fit after service user involvement. The plan is not presented in any particular order.

Translating research findings does not begin and end through publishing research in peer reviewed journals. There are a number of approaches to dissemination and a number of stakeholders to consider, approaches need to be used judiciously (Bartlett, 2013). Communicating complex scientific information to the general public is increasingly recognised as a researcher's responsibility (James, 2013; Leshner, 2003; Reichenfeld, 2011). However, researchers receive little training in communicating scientific concepts to a layperson audience (Brownell *et al*., 2013). The UK is currently experiencing a phenomenon referred to as 'the institutionalisation of public engagement' (Maile & Griffith, 2014) in regards to translating research findings to laypeople, which constitutes a majority of the population. The researcher believes that more focus should be on accurately communicating to the layperson in line with current technological landscape in which the general population are situated. Advances in technology have provided laypeople with a wealth of information at their fingertips. Unfortunately, this does not come without its challenges. For instance, there is concern regarding the use of 'fake news' and the public being misinformed. Secondly, although peer-reviewed journals are mostly accessible online this comes at a cost. For example, without an institutional affiliation there is a heavy fee to pay to gain access to this material for a limited time. Therefore, it is the researcher's belief that more focus should be on alternative strategic approaches to dissemination that would result in a larger 'impact value' (Moylan *et al*., 2015).

Moylan *et al*. (2015) discuss a number of approaches to using technology to disseminate research findings. For instance the use of Prezi over PowerPoint as it gives presenters an added way of telling the story through the use of visual metaphors. However, the movement of the camera around the canvas can make audience feel motion sickness. Moylan *et al*. (2015) also discuss how to engage non-academic populations. They suggest the use of Twitter to publicise and share brief updates about research findings, blogs offer a venue for engaging in discussion and dialog about issues related to research (Hookway, 2008; Vannini, 2013), and the use of info-graphics, or visual and graphic depictions of research findings to offer engaging and accessible ways for others to quickly understand the gist of the results (Bartlett, 2013; Vaughn *et al.,* 2013).

There has been a growing trend in the use of dissemination of research in venues not traditionally used in an attempt to engage a wider audience (Bultitude, 2014). Although traditional venues such as universities, theatres or galleries are popular they do little to attract those not already interested in science or who feel intimated by science (Falk, 2006). This encouraged the birth of using 'generic venues', which are familiar locations, such as cafes, parks and shopping centres, where the public naturally congregate for leisure (Bultitude &

Sardo, 2012). Such venues provide an alternative platform to engage a wider audience. Successful examples of this are TEDX, and Einstein's Garden that is situated in the UK-based Green Man music festival (Dowell, 2014). Dowell (2014) explains that by situating a science platform within a primarily music venue has resulted in engaging audiences that were not originally motivated by science. One key advantage of presenting in these environments is the opportunity to provide a flexible and personal experience empowering visitors to identify their own path to engaging with the scientific material. The researcher of the current study aims to present the current research at the British Psychology Society (BPS) Community Psychology Section & UWE Bristol: The 3rd Community Psychology Festival 'Falling apart; Pulling together: Collaboration in times of division' (see Appendix twenty for outline of presentation plan). Bultitude (2014) stresses that key to success of presenting research in this forum is effective collaboration and support from well know organisations and local government engagement. However, as this is a relatively new approach to research dissemination more research is required to fully understand the success of this approach (Bultitude, 2014).

The array of possible dissemination approaches can become overwhelming and can bring many challenges in terms of what is the best platform to use. One choice may be to join together with relevant stakeholders to develop individual dissemination plans. For example, one of the participants from the current research explained that she regularly uses social media self-help groups and finds the material on there useful, such as the use of Memes (i.e. an image, story or joke that is passed between internet users using email, social networking, blogs and other websites) and short videos. Furthermore, it may be that the most useful strategy is to collaborate with the research sites public engagement department to develop the most effective medium to disseminate the research findings.

Conclusions

CSA is not a historical concept. In the UK the scale of CSA it is much larger than previously believed (Smith *et al.,* 2015). CSA is not something that can naturally be moved on from (Hudson & Barnett, 2015). However, evidence shows gaps in service provision for adult survivors of CSA in England and Wales (Coy *et al*., 2011; Jones & Cook, 2008; McCarry *et al*., 2017; NAPAC, 2017). There is also a lack of research into recovery from CSA (Smith *et al.*, 2015). The consequences of this could be detrimental for statutory services in a time of austerity (Aylward *et al*., 2013). The current study adds to the existing literature base on CSA and recovery in adulthood by exploring women who were subject to CSA lived experiences of recovery and their understanding of the role mental health services had throughout. The overall aim of this project was to further the evidence base to aid the development of local and national service provision for a population of women who are seldom heard.

Seven women who had experienced CSA shared their rich stories regarding recovery and the role of mental health services throughout. The findings moved beyond the therapeutic models of recovery that over emphasise the impact of psychotherapeutic factors and over look external factors to recovery (Chouliara *et al*., 2012). The women's narratives suggested that recovery is synonymous to life. It can be likened to an on-going journey with many challenges and obstacles to overcome and times of tranquillity and joy. There is no specific end-point, or finished goal in this journey. This brings into question whether the term recovery should be used in relation to CSA as it is often confused with recovery in the sense of the removal of the experience's impact. Furthermore, models that emphasise stages of recovery should be called into question; do staged models promote a sense of attempting to reach a final finished point that suggest that this is how you should be and this is how you do it?

Throughout their lives the women in the current study experienced pressures to keep quiet about the trauma they endured and its impact. This influence was initially developed in childhood from the abuser and family dynamics and spread into adulthood. Society as a whole including mental health services and families played a role in maintaining the silence. Consequently overcoming this culture was a self-sacrificing act. The women shared losing key relationships, which was not only re-traumatising but proved their perpetrator's threats true.

Recovery, as described by the women in the current study could be seen as the process of acknowledging the past and uniting with it. Finding a place comfortable enough for this union was challenging and one that would be continuously juggled. Recognising core strengths, such as protecting others, was fundamental to how the women understood their current selves. Women portrayed the need to undergo this process alongside others. Others were required to guide them through this difficult process, whilst offering compassion and empathy, and opportunities for choice and control. Overall, women who had experienced CSA were able to form more powerful relationships with women who had experienced CSA due to the way in which empathy was perceived. This was often a relationship far removed from the abuse dynamics they had previously encountered.

If services are to be effective in meeting the needs of women that have experienced CSA, their views must be included in service development (Hague & Mullender, 2006; Sneddon *et al.*, 2016). The research findings in unison with previous research provide the basis for a number of clinical approaches and interventions. Those drawn on in the current study were; the need for society and healthcare professionals to obtain a greater awareness regarding the notion of recovery for this population as well its impact; the promotion of recovery enhancing relationships within healthcare settings; recognition of the benefits of women with shared experiences coming together; emphasis on strengths based interventions; and the use of transformative co-production within services for this population. As a whole the implications fit well within a trauma-informed way of working within a South Wales mental health service. Emphasis needs to be placed on services unintentionally repeating abuse dynamics the women experienced during childhood, which can only be achieved if a whole service approach is adopted.

The women in the current study largely discussed CSA in the context of relationships within the family system. This constitutes 70% of CSA in the UK (Smith *et al.,* 2015). Evidence has shown differences in outcomes as a result of abuse characteristics such as this. However, the focus of the media is largely on the 'evil stranger' who commits these offences on young children from 'dysfunctional' backgrounds. Evidentially society has a way to go before the stigma surrounding CSA occurring in the family home is removed. Media reports state that lessons have been learnt and will continue to be learnt from the recent sex abuse scandals. This will only be accomplished through strategic dissemination of research such as this, which is the responsibility of the researcher. Overall, the importance of communicating the need for further funding to continue research in this area should be prioritised.

Although the findings offer hope for services working with people who have experienced CSA, one important message to take is that recovery in the sense of entirely removing the impact of the sexual abuse is not achievable for these women. Therefore, if this is truly what society strives towards more effort needs to be placed on preventing CSA from ever occurring.

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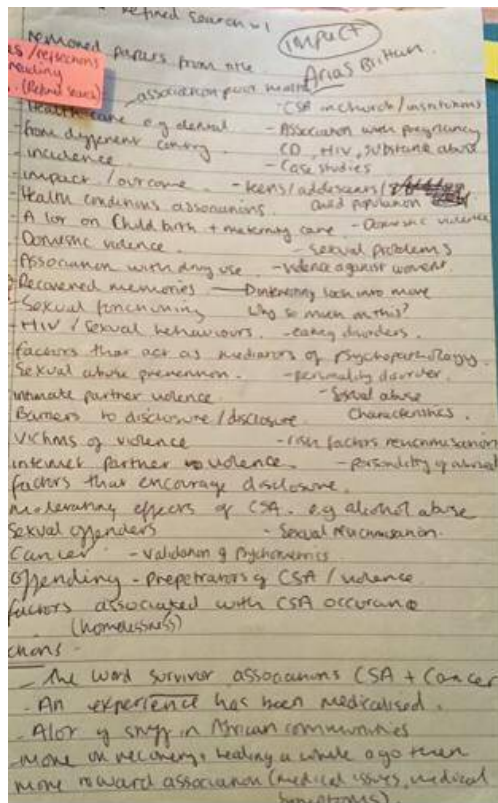
APPENDICES

Appendix One. Seven steps of conducting meta-ethnography from Toye *et al*. (2011).
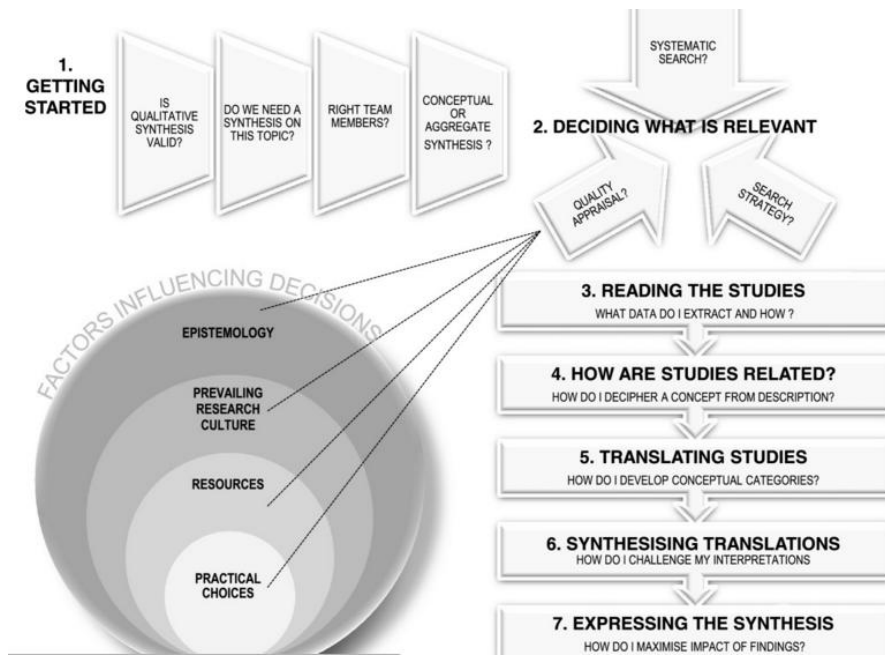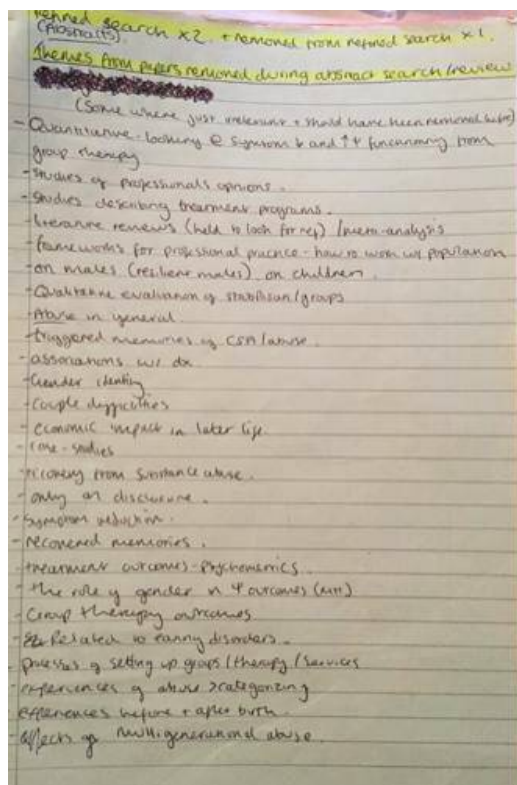
Appendix Two. Notes on why studies were excluded from SR search

Reasons for studies being excluded from reading titles:

Reasons for studies being excluded from reading abstracts:

Reasons for studies being excluded from reading full text:

Appendix Three: A detailed summary of SR studies

Author, date, country and journal	Aim	Method	Participants	Findings	Discussion
Draucker (1992) USA Journal of nursing scholarship	Aimed to generate a descriptive theoretical framework of the healing process of female adult survivors of incest based on the perceptions of those who had experience some degree of healing.	Qualitative methodology. Formal, unstructured in-depth interviews using open-ended questions. Questions included: the causes, circumstance and consequences of healing experiences. Interviews lasted thoroughly one and ½ hours. Data analysis was based on grounded theory.	Participants were recruited through asking professionals to identify incest survivors who had experienced some healing. Women who had identified themselves publically as experiencing some healing. N = 11 female survivors of incest, aged between 20-64 years. 10 participants were Caucasian, one declined to specify her race. All from the USA. All experienced sexual abuse from a family member or significant caretaker. There was no formal definition of CSA. All participants had sought professional or peer counselling as an adult for a variety of reasons, including relationship problems, substance abuse problems and depression. No exclusion criteria stated.	Recovery process was described using the metaphor of building a house (stages) The healing process involved **building a new place for themselves in the world**. The process was active, on-going, complex and time-consuming. Facing and confronting, and working to overcome to odds aided healing. **Deciding to build** was the preceded by the thought that something was "not right", or something was happening in their lives that they did not understand, i.e. physical illness. Once participants connected current distress with past abuse participants described making a commitment to recovery but needing a connection with another to do so. **Constructing the residence** represented the healing process, which included: building new relationships with the self to provide nurturing and security; regulating ones relationships with others; influencing the community in a meaningful way. ***Constructing a new relationship with the self*** requires the participants to be accepting and caring towards themselves, and attributing the responsibility of the abuse to the abuser. ***Regulating boundaries*** is the ability for the participants to provide structure separating the inhabitant from the environment while allowing them to control access to their private lives. Participants explained that those they felt closest to were those who had also experienced abuse as they understood their experiences the most. ***Influencing ones community*** is the participants ability to have a positive impact on the world e.g. reaching out to other survivors, sharing their experiences, treating others with compassion and understanding an providing guidance, becoming an advocate for abuse prevention.	Findings of the framework were consistent with the victimisation literature. However, whilst much of the literature focuses on internal cognitive processes the theoretical framework described here emphasises the activities that have impact on the environment or on the self. They perceived that actively building a new world for themselves was key to the healing process. This framework offers unique insights into the concerns and needs of others and thus can guide clinicians in planning interventions. This framework needs to be extended to a wider population.

Draucker, *et al*. (2011) USA Journal of child sexual abuse	Aimed to develop a new theoretical model to describe how adults heal from CSA with the consideration for other forms of childhood abuse. This was part of a larger study: the Sexual Violence Study.	Qualitative methodology. Semi-structured, open-ended interviews. Participants were asked to describe their experiences with healing from CSA and other victimization throughout their lives. Constructivist grounded theory methods were used to develop constructs and hypotheses about healing drawn from the influence of frameworks developed as part of the Sexual Violence Study to describe the participants' life patterns, parenting experiences, disclosures about sexual violence, spirituality, and altruism. Several analytic techniques were used to synthesize the findings of these frameworks to develop an overarching theoretical model.	A subsample of 48 women and 47 men of the sexual Violence study were recruited. The larger sample was recruited from the community. Of the women, 50% (n = 24) were African American and 40% (n = 19) were Caucasian. The remaining participants were multiracial or did not report race. Of the men, 40% were Caucasian and 36% (n = 17) were African American. The few remaining participants were multiracial, of another race (e.g., Hispanic or Asian), or did not report race. All participants were from the USA. Participants ranged 18 to 62 years of age. Most had experienced on-going sexual abuse by a family member, a close acquaintance or a care provider. Most had experienced considerable adversity throughout the life span. Approximately 81% (n = 77) reported a religious affiliation that would be considered in the Judeo-Christian tradition. No mention of exclusion criteria.	The model includes four stages of healing; **1) Grappling With the Meaning of CSA;** *The drive to understand the abuse and integrate it in their life stories* **2) Figuring out the Meaning of CSA;** *rendering new understandings of the abuse cause and consequences. Coming to believe they were not to blame for the abuse.* **3) Tackling the Effects of CSA;** *the long arduous process of engaging in a variety of processes to mitigate its long term negative outcomes.* **4) Laying Claim to One's Life;** *feeling empowered to assert ones right to live their lives how they see fit and in some cases seeing justice. Feeling fulfilled.* Within each stage there are five *domains of functioning*: 1) Life pattern 2) Parenting 3) Disclosure of CSA 4) Spirituality 5) Altruism. and there are six *enabling factors* that facilitate movement from one stage to the next: 1) Affirming messages 2) Personal agency 3) On-going support 4) Personal resolve 5) Critical life event 6) Commitment to transcend the CSA.	Healing is a complex and dynamic trajectory. Overall healing is associated with living a satisfying life, stopping the cycle of abuse and disclosing the abuse to help others. For some, it include experiencing a spiritual transformation and engaging in altruism. The final model suggests stages that are progressive but movement between stages does not have to follow any rule. This staged model implies that most people experience the first stage and fewer experience each subsequent stage. The model is consistent with literature. The results highlight the potential negative consequences of disclosure as well as the positive in childhood. Future longitudinal research is required to validate the findings.

Chouliara, *et al.* (2014) UK Journal of psychiatric and mental health nursing	Aimed to elicit the views and lived experiences of male and female adult survivors of CSA about their recovery to develop a survivor-centered and clinically meaningful theoretical framework of how people recover from CSA in adulthood. It also states that an aim is to investigate the mechanisms of disclosure by identifying and describing the dynamic aspects of the process.	Qualitative methodology. Data was collected using a one-off qualitative interview. The critical incident interview technique was used to structure the interviews. Interview questions surrounded: how recovery feels like from the survivors' insider's perspective; how survivors recover from their experiences of abuse; the main challenges and barriers in their recovery; strategies survivors employ to cope with their distress during their recovery journey. Data were analyzed using IPA.	Sample consisted of 22 adult survivors of CSA. All were from Scotland, UK. The study was advertised through the web sites of voluntary organizations and other formal and informal networks (i.e. online survivor support groups). Professionals working with survivors were also asked to pass on the flyers to prospective participants in their case load. Exclusion criteria consisted of: recently experiencing mental health difficulties that impacted ability to cope, current substance dependency and current thoughts of harming self or others. CSA was defined as any unwanted sexual contact or repeated exposure to sexual material (e.g. pornographic images) with a perpetrator prior to the age of 18 years	Experiences of the recovery were organized around the following: **1) The Affected Self;** *how individuals were affected in adulthood by their childhood experiences.* Themes within this were: -Lack of boundary awareness and self-blame -Over self-reliance -Over-vigilance and guilt -Shame, aloneness and social stigma. **2) Factors Hindering Recovery;** *experiences that made it more difficult to move on from their childhood trauma.* Themes within this were: -Family avoidance and secrecy -Ambivalence about recovery and about disclosure -Perpetrator still in vicinity -Running away from abuse. **3) Factors Enhancing Recovery;** *helpful experiences in the recovery process.* Themes within this were: -New focus and meaningful activity -Formalizing a complaint -Building inner strength and resources -Disclosing and shifting shame. **4) The Hurdles of Recovery and the Recovering Self;** *milestones and challenges to overcome to move on with the healing process.* Themes within this were: -Ongoing long-term process -Unhelpful responses to disclosure -Protecting others. **5) The Recovering Self;** *the difference between the affected self, who suffered from the aftermath of the abuse, and the recovering self, who took charge of the healing process.* Themes within this were: -Increasing confidence and assertiveness -Self-acceptance and embracing vulnerability	The model of recovery from CSA shared some similarities with the model suggested by Draucker *et al.* (2011). Disclosure and critical life events were highlighted as a important in the recovery process. However this model highlights the struggles survivors face with some emotional factors such as shame, guilt and hopelessness. Recovery is dynamic, i.e. the suggested stages are experienced in circular process. The model suggests that safe and appropriate disclosure is of paramount importance in the recovery process- implications of this are explored. Psychological interventions promoting emotional well-being in the long term and a strong sense of self might also enhance personally meaningful recovery, as opposed to those focusing on symptom improvement
Arias & Johnson (2013) USA Journal of child sexual abuse	Aimed to complement Drauker *et al.* (2011) work with new data illuminating the external and contextual factors of healing and recovery. Overall the study aims to examine the perceptions of	Qualitative methodology. Qualitative semi-structured interviews (45-90 minutes) were conducted. One participant did not consent to being audiotaped therefore detailed notes were taken. Follow-up	Overall 10 women ranging from 44 to 56 years of age (mean age of 49) were recruited from a Midwestern community in the USA by placing flyers at various local organizations and a local public university (opportunistic sampling). Inclusion criteria consisted of: the minimum age was 25 years, having	The findings produce an extended theoretical model on the process of healing (i.e. Drauker et al., 2011). **Extensions:** Secure and healing relationships are integral in the recovery process. All participants believed in some type of *guiding force* and believed they were spiritual, which was associated with a higher power, such as with a benevolent	The healing trajectory was unique, therefore the model should be interpreted theoretically and warrants further testing. The model captures the significance of supportive relationships, internal characteristics, significant decision points, and sources of active healing.

	healing of CSA.	interviews (30 minutes) were conducted for 7 participants 6 months after the original interview. Examples of interview questions include the following: (a) "What have you done to cope, overcome, and heal from your abuse experience?" (b) "What strengths have you discovered within yourself?" and (c) "What resources have you discovered around you?" The analyses procedures followed grounded theory approaches.	experienced CSA, and considered themselves as doing relatively well in most spheres of life. Specifically they perceived themselves to have less symptomology associated with their CSA experience over time. Eight participants identified themselves as Caucasian and two as African American. CSA was self-reported and relied on the participants own definitions	God (extremely transformative to healing). Participant's most common resilient traits incorporated: -*Perseverance, Self-efficacy, Optimism, Sense of strength* Most stated they felt these characteristics by connecting with supportive relationships and/or a higher power. Participants indicated that as further hardships were encountered, old emotional, psychological, and/or behavioural patterns surfaced. Participants became more active in healing by: *getting therapy, volunteering, attending church/praying, journaling, learning/receiving education, and confronting the abuser.* One powerful cognitive process involved *attributing blame onto their abusers instead of on oneself.* A strong sense of *empathy and compassion* developed throughout the healing process. In addition to a greater *acceptance* of self, others, and their abuse. As a result of the process of healing, participants believed they had achieved an improved *self-concept and competence in relationships*. Their improved self-concept involved increased *self-esteem, empowerment, and autonomy*.	Critical sources of healing included therapy, informal and formal education, compassion, empathy, blame attribution to abusers, and confronting abusers. Consequent to active healing, participants were able to achieve acceptance, strengthened self-concept, and strengthen relationship competence. Findings suggest that strengths-based interventions focusing on survivors' active role of healing and recovery are integral to survivors' positive adjustment. Future empirical research is needed to explore the benefits of confronting the abuser and how the act of 'giving back' influences compassion and empathy.
Godbey & Hutchinson (1996) USA Archives of psychiatric nursing	Due to the lack of nursing research about the healing of incest survivors, the present study attempted to contribute to knowledge in this area.	Qualitative methodology. Data was collected through semi structured, in-depth interviews lasting 1-2 hours focusing on the healing process. Grounded theory methodology was used for the analysis.	A snowball word-of-mouth sampling strategy was used to invite 10 adult women who had experienced incest to participate. All participants were from the USA. No details regarding the samples race or ethnicity. Exclusion criteria: suicidal ideation within the last 6 months, being hospitalized for emotional difficulties during the last year. All women had access to a professional counsellor or support group.	The process of recovery from CSA (incest) was described through themes that contained spiritual cogitations: **1) Burying the integral self;** *the act of survivors literally burying, concealing, and laying away part of the self physically to survive.* **2) Resurrect the buried self;** the process of recovery involved the following stages; - <u>Reappearing</u> of memories associated with the past - <u>Revivifying</u> i.e. experiencing flashbacks - <u>Resuscitating</u> feeling the grief, the abandonment, the betrayal, and loss of control - <u>Renovating</u> is coming to an understanding that old, self-defeating patterns of thinking and behaving had to be changed - <u>Regenerating</u> beginning to live life differently - <u>Reanimating</u> is finding joy in life again - <u>Reincarnating</u> is accepting the experience of incest and all the associated life experiences and weaving these experiences into an integrated life.	Healing involves progress across all stages described. The results provide an explanatory model of the healing process of adult female incest survivors that can be used as a heuristic for nurse therapists. Understanding the constructs of burying the integral self, the phases of resurrecting the buried self can assist nurse therapists in identifying where clients are in their healing process and develop strategies to facilitate progress across phases. Future research can focus on expanding and diversifying the sample to include males and those incest survivors who have not had therapy. Research that aims to further

					populate the phases of healing in this study would add to our knowledge about the healing process, and its strategies, conditions, and consequences.
Glaister & Abel (2001) USA Archives of psychiatric nursing	Aimed describes the healing process from the perspective of women who believe they have achieved some measure of success in healing from their CSA	Naturalistic study adopting a qualitative methodology No details were given regarding how the data was collected. Denzin's qualitative method of interpretive interactionism was used to analysis the data.	Participants were recruited from a large southwestern metropolitan area in the USA by word-of-mouth and through contacting a variety of mental health providers. 14 women volunteered. 11 were Caucasian, one was African American, one Hispanic, and another Native American. Their ages ranged from 25 years to 60 (mean age of 46.4). All had participated in some form of organized religious activity during their lives. The women experienced a broad spectrum of abuse, ranging from suggestive remarks and exhibitionism to fondling and penetration. There was no formal description of CSA. No exclusion criteria were described.	**Characteristics of healing.** -Difficult and painful process but is manageable. -Healing brings about changes. -Healing creates a sense of wellbeing and acceptance that was evidenced by feeling joy and acknowledging positive and negative aspects of themselves. -Healing is influenced by the toxicity of an environment someone belongs. Factors that influence healing are: -Information -Relationships -Experiential activities -Inner strength and beliefs -Commitment, skills, and coming to term. The main factors interfering with healing were relational: -Therapists and other individuals -Themselves.	Findings from this study validate previous research and expand existing knowledge. Participants found support from other persons and God, church, angels, and nature. Healing is possible and there are factors that both facilitate and interfere with healing. It was essential that survivors find someone who can be present, understand, listen, and provide information on what to expect and on ways to grow. Survivors need control of their healing, and benefit from knowing someone who had already **completed** their own healing journey and who can model healthy behaviours. Interventions encouraging individualism, and acceptance of past helped them build skills. The importance of believing in the ability to heal and that they are not alone was emphasised.
Banyard & Williams (2007) USA Child abuse and neglect	Multiple methods are used to examine aspects of resilience and recovery in the lives of female survivors of CSA across 7 years of early adulthood.	Mixed methods: Quantitative approach explored the extent women stayed the same, increased, or decreased in functioning in a variety of spheres. Qualitative approach examined survivors' own narratives about recovery and healing to learn about key aspects of resilience in women's own words.	The participants in the study were women who were interviewed at three time points as part of a longitudinal study in the USA. A subset of 21 survivors were re-contacted and participated in the qualitative aspect of the study. Women invited to participate in this qualitative phase of the study included only those who recalled the documented CSA. Three women who evidenced very severe and long-standing psychological distress were excluded.	Recovery is never fully possible and is an on-going process. Recovery was described as including: 1) Acceptance of what happened 2) Making peace within oneself 3) Connections with others 4) Regrouping 5) Talking about one's experiences and feelings 6) Making links to substance abuse recovery. Recovery involves many challenges that have to be faced and this requires considerable effort to achieve positive outcomes. 16 women described "turning points" i.e. large shifts or changes in how	Resilience and recovery from trauma appeared to be a dynamic and unfolding process across the lifespan. Survivor's own narratives support notions of resilience and recovery as an on-going process that is not necessarily linear. This process includes experiences of 'turning points' or 'second chances'. Supports theoretical discussions and previous empirical findings about correlates of growth and adaptation post-trauma as in the qualitative interviews women often described relationships with others as sources of

		Focus on qualitative aspect of the research paper *(clear separation of the two methodologies)* In-depth qualitative interviews with open-ended questions were used to collect data. Questions explored their experiences with CSA, how they coped, and their views of recovery. Methods for approaching the qualitative data followed recommendations by many writers on qualitative analysis. Responses to open-ended questions were open coded by the authors using principles of grounded theory	The average age for this sub-sample was 31.52 CSA was defined as (a) was against the child's wishes, (b) involved force or coercion, or (c) involved a perpetrator who was at least 5 years. This was determined through official hospital records. The 21 women interviewed represented the full span of resilience and recovery demonstrated by the larger sample; assessed by their score on the resilience measure.	they were leading their lives, places where they were at some sort of crossroads and made significant changes. These played a large role in their recovery process.	motivation for creating change in their lives. This sample of survivors occupied an ecological niche that was less advantaged than other studies of abuse survivors. Many had exposure to multiple traumas across the lifespan along with complicating factors such as poverty. Limitations were discussed in terms of the sample. The study highlights the need to further examine factors that promote and hinder the positive growth across the full spectrum of adult development.
Anderson & Hiersteiner (2008) USA American journal of family therapy	Aimed to ascertain the recovery narratives of 27 adults involved in group treatment for the aftereffects of CSA. The research questions included: (1) What do adult survivors' narratives reveal about the process of recovery from childhood sexual abuse? (2) What common patterns or themes exist regarding how participants have "storied" their lives in regard to recovery from childhood sexual abuse	Qualitative study. A group narrative approach was used to collect. Eleven group interviews (1.5 hours) took place with at the research agency or at one of three outreach sites. Each interview began with asking participants to describe themselves as a person (i.e., demographics) and to discuss their childhood victimization. Next, participants were asked to "Please describe what has helped you in healing from childhood sexual abuse, with any lessons about recovery	A convenience sample (e.g., support groups) of 25 females and 2 males ranging in age from 25 to 68 years old (mean age of 43.63) who attended adult survivor support groups in the USA were used. This voluntary study took place at a sexual assault agency in a Midwestern metropolitan area of the USA. Participants were Caucasian (92.6%), one was African American, and one was biracial (i.e., Native American and Caucasian) There was no formal definition of CSA. No exclusion criteria described.	Recovery is possible i.e. achieving a 'normal' life where sexual abuse remains a part of who they are but no longer defines them. Healing was viewed as unobtainable as it was associated with being 'cured'; there is no 'storybook' ending. Participants were reluctant to claim a future where CSA would no longer be a part of their life stories or their identities. Factors aided recovery were; 1) Disclosure 2) Making Meaning 3) Supportive Relationships. Participants described pivotal moments when life as they knew it took a turn in redefining their recovery stories e.g. breaking the silence. Disclosure was difficult for adult survivors because they fear it will be minimized or ignored. Many participants talked about things not making sense and the need to fill in missing pieces and close information gaps. Many described the importance of a professional therapeutic relationship to help them tell and understand their trauma stories. Participants gave regular testimony about the importance of other people in their lives as they highlighted how recovery could not be done in	Similar to previous research participants selected out aspects of their lived experiences that highlighted their process of recovery. Healing was viewed as unlikely because participants could not imagine a future where their trauma and it effects would no longer impact their lives or identities. Implications were discussed in the use of a group format to allow survivors to describe their recovery experiences. The usefulness of others listening to survivors who feel they have 'healed' was discussed. Limitations and future research were not discussed.

abuse? (3) What can we learn from adult survivors' accounts of recovery that would be helpful to practitioners?	learned along the way." As their stories unfolded, additional questions were asked regarding recovery factors. The final two questions addressed recommendations for adult survivors and mental health service providers. Data was analysed using a categorical-content approach as part of the grounded theory method.		isolation e.g. being connected to a support group validated their childhood victimization, confirmed their self-worth, and empowered them to have a voice.	

Appendix Four. CASP criteria

Screening Questions

1. Was there a clear statement of the aims

☐ Yes   ☐ Can't tell   ☐ No

of the research?

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance

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2. Is a qualitative methodology appropriate?

☐ Yes   ☐ Can't tell   ☐ No

HINT: Consider

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal?

Is it worth continuing?

Detailed questions

3. Was the research design appropriate to address the aims of the research?

☐ Yes   ☐ Can't tell   ☐ No

HINT: Consider
- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

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4. Was the recruitment strategy appropriate to the aims of the research?

☐ Yes   ☐ Can't tell   ☐ No

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

5. Was the data collected in a way that addressed the research issue?

☐ Yes ☐ Can't tell ☐ No

- If the setting for data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
- If methods were modified during the study. If so, has the researcher explained how and why?
- If the form of data is clear (e.g. tape recordings, video material, notes etc)
- If the researcher has discussed saturation of data

6. Has the relationship between researcher and participants been adequately considered?

☐ Yes ☐ Can't tell ☐ No

- If the researcher critically examined their own role, potential bias and influence during
  (a) Formulation of the research questions
  (b) Data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

7. Have ethical issues been taken into consideration? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

5

9. Is there a clear statement of findings?

☐ Yes   ☐ Can't tell   ☐ No

HINT: Consider

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researchers arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Appendix Five. Table of themes drawn from each study

Study	Identified themes
Choulaira *et al.* (2014)	Lack of boundary awareness (abusive relationships) Self blame Over self-reliance Over vigilance Guilt, shame, alone, social stigma (Lasting impact into adulthood) On-going long-term process No quick fixes Requires time and determination Family avoidance and secrecy Self blame Not wanting to face recovery The abuser still living near-by Trying to escape e.g. avoidance coping Unhelpful responses to disclosure The need to protect others Taking legal action and being listened too Experiencing a turning point(s)that allows the recognition of inner strength and resources Disclosing abuse Reattributing blame Self-respect, self-compassion, self-protection, self-acceptance, assertiveness Embracing vulnerability Acknowledgement that vulnerability will not change- but their relationship with it can
Arias & Johnson (2013)	When old emotional, psychological, and/or behavioral patterns surfaced Constant supportive relationships (relationship security); Need people to be forgiving, accepting, dependable, moral, trustworthy A guiding force that was form a higher power e.g. God Seeking help Perseverance, self-efficacy, optimism, sense of strength all helped gain hope Attempting to actively alleviate pain associated with past Therapy- to help discover new meaning to experience Shared experiences Education helped them understand abuse due to improved problem solving Confronting abuser Attributing blame to abuser Having the choice to do something differently Having purpose in life Empathy and compassion for disadvantaged populations Less shame and guilt Acceptance of self and experience
Banyard & Williams (2007)	Recovery is never fully possible and is an on-going process. Recovery involves change Recovery involves many challenges that have to be faced and this requires considerable effort to achieve positive outcomes Turning points- events, which lead to large changes in perspective or the way they acted within their environment. – like realisation of changes Wanting to have better relationships with children, wanting better lives for children Spirituality Importance of positive relationships and people providing unconditional care in times of difficulty Acceptance of what happened Positive resilient functioning Change perspectives Making peace within oneself- reduced shame and guilt Connections with others Regrouping Talking about one's experiences and feelings Making links to substance abuse recovery
Draucker (1992)	Making the decision to accept the challenge to recover Difficult and hard process No end point Response to abuse that are not helpful: concerned, pressure to heal quickly, disparagement counselling, pressure to forgive the offender, advice, anger, blaming the survivor for causing pain by bringing it up an failing to acknowledge the significance of the abuse Feeling that something was 'not right' due to: distress, illness, a lack of understanding of difficulties Having a connection with another Connecting current difficulties with past experiences Reattributing blame to abuser Understanding the impact of abuse Feeling validated Disclosing abuse Shared experiences Compassion towards self- accepting and caring towards self Control in relationships, breaking abusive relationships Giving back to the community, sharing their experience, active role in helping others

Draucker *et al.* (2011)	Poor health (mental & physical)
	Stuck in abusive relationship cycles (inter-generational abuse)
	Attempt to integrate abuse experience into current life
	Challenging, hard, taxing and on-going process
	Secrecy within family
	Holding perspectives of self, others and world that were developed during abuse, e.g. self blame
	Gaining understanding of abuse
	Supportive relationships, family, God
	Finding a place for spirituality
	Shared experiences
	Affirming messages from others
	Drawing on inner strength and resilience
	Passing on stories of their experience to others- giving back
	Compassion for those maltreated/vulnerable
	Having purpose in life
	Control over life directions
	Empowered to live healthy life
Anderson & Hiersteiner (2008)	Recovery is possible, but healing was viewed as unobtainable as it was associated with being "cured"; there is no "storybook" ending
	Disclosure was difficult for adult survivors because they fear it will be minimized or ignored as it was in their families
	Parents ignoring when disclosed- silenced
	Disclosure
	Making Meaning
	Supportive relationships
	Pivotal moments and turning points when life as they knew it took a turn in redefining their recovery stories e.g. breaking the silence
	Many described the importance of a professional therapeutic relationship to help them tell and understand their trauma stories- NOT everyone talked about the professional relationship helping understand
	Recovery could not be done in isolation; group validated their childhood victimization, confirmed their self-worth, and empowered them to have a voice
	Importance of hearing others stories as reduced the secret, reduced feelings of shame and validated self worth
	Reluctant to claim a future where CSA would no longer be a part of their life stories or their identities- achieving a "normal" life where sexual abuse remains a part of who they are but no longer defines them.
	Reduced shame
Glaister & Abel (2001)	Difficult, complex and painful process but is manageable
	Painful and at times you wont feel like living
	Long and lonely process
	You are going back and fourth until you finally get it (it suggests there is an end point) fixing it. But then suggests there is an ending point
	Gets worse before it gets better
	Hope-light at the end of the tunnel
	Being in toxic, abusive environments
	The negative messages from others e.g. abusive parents telling them they are worthless, crazy or stupid
	Secrecy within the family- silencing leading to poor memory
	Fear of disclosing due to protecting others and not getting them into trouble
	Lack of listening, understanding and lack of empowerment or promoting growth. Therapists who advocated medication or hospitalization had a negative effect
	Self holding back- self-pity, minimizing their experience of abuse, being a abusive relationships, fear, substance misuse- these seem to be quite self-blaming
	Allow self to go through the process, determination to continue
	Understanding of abuse
	Shared experiences
	Supportive relationships, guidance from others- God can be this person
	Experiential activities- taking risks helped express and acknowledge vulnerability
	Connecting with feelings
	Inner strength- not giving up- commitment- taking control
	Accept what happened and understand them
	Forgiveness of self and some say perpetrator
	Brings about positive changes a sense of well-being and acceptance of themselves and their life events
	Not being the same, the before and after self.
	Being able to reflect on how you are different and how you have changed
	Well-being and acceptance by feeling of joy and acknowledgement of the positive and negative aspects of self.
	Having a new perspective
Godbey & Hutchinson (1996)	Attempting to block out abuse memories, escape
	Hurt from a secure bond being broken
	Mental health difficulties, flashbacks
	Feeling the grief, the abandonment, the betrayal, and loss of control
	A complex, long, arduous process but with long term rewards.
	Trusting therapist, having emotional support from family and friends, and most important having real commitment to heal.
	Stop trying to block and escape experience e.g. accepting the presence of flashbacks.
	Accepting the pain associated with abuse
	Coming to an understanding that old, self-defeating patterns of thinking and behaving has to change
	Reattributing blame for abuse
	Finding a place for guilt
	Being able to look back at old self e.g. trying to escape
	Developing a new reality, new life- seeing an alternative
	Acceptance of old self
	Experiencing joy

Extracts of reflections whilst conducting interviews:

The following are example extracts of the notes written up immediately after the interviews. These notes were also referred to throughout the analysis.

Interview 1:

Anxious, worried that the interview questions were not 'good enough'.

Worried throughout the interview that the voice recorder would not record.

A carer was present which added to my anxiety. This would have played a larger role if I did not have experience of family members being present in therapy, however I now feel comfortable with this from my child placement.

Participant highlighted that I seemed more worried than she was- but I was just going through the formalities of the ethical procedure- this was something the service user group highlighted- try to make this process 'more natural'- this is something I will take away for future interviews.

The participant seemed to have the story they wanted me to hear so at times felt that I had to bring the conversation back to focusing on recovery rather than on the impact. The participant discussed some really clear metaphors/pictures of her experience with recovery. Felt she was open and honest. At times she took time to breath and looked as if she was going to cry especially when asked to think about things impacted on her personally i.e. how it felt.

It was difficult to separate away from the clinician within myself. I wanted to ask more questions on topics that were not following my interview schedule- although I did this at times I was aware that I had to get back on task- I wondered how much this influenced my ability to listen to the participant. I felt like I had a lot of competing agendas.

The emotion was felt in the room. I felt exhausted afterwards.

Themes that I felt came up: individualised, gaining control, support/connections from others, being listened to, journey of recovery with the end goal of living a 'normal' life, gaining independence and lack of fear/uncertainty of the future.

Remember attachment theory coming into mind- unsure why at this point.

Interview 3:

I felt a real connection with the participant today. She had been involved in talks on her experience of trauma and her recovery before.

She spoke about her recovery being up and down and the downs seemed to be related to some very stressful times. I was amazed with how much this lady had been through and how much she was coping

From what she conveyed I felt that there were other types of recovery that I have not come across before e.g. there was recovery in terms of coming across to people that you are functioning fine but inside you're not, and recovery when you may seem like you are breaking down to others but inside you are in a better place. It was described as a swan/ugly duckling – the lady yesterday talked about something similar in terms of wearing a lot of make up when you are not OK, and not caring what she looked like at other times…. It's like wearing a mask for others to signal you are OK. I think this is an interesting concept to look at- what is recovery to different people?

Referred to self as warrior- this word seems more fitting than a survivor.

I felt a lot of anger when this lady was describing her experiences. I felt that she was alone in a lot of her experiences. Being with people who had experienced similar things she thought was helpful e.g. online groups.

I went away thinking about how strong this woman was. I could never imagine living through what she had been through.

A point of interest- the concept of recovery – some suggest that you go back to how you used to be but this can't be applied to childhood abuse because you don't know how 'you were' as you were a child. This lady said that she often thought about what her life would have been like if she hadn't been through the trauma. Recovery is about living a meaningful life- is there such thing as posttraumatic growth as this growth may have been there without the trauma occurring, as you don't know how someone is going to grow up when they're a child. Is recovery forgiving and moving on? Can you move on? Recovery and posttraumatic growth don't seem to fit. Society's constructs of normality seems to be what recovery is considered to be in the medical sense; but are society's constructs unrealistic?

After the interview again I felt very tired and found it difficult to do any work in the afternoon. I spent time just doing nothing when I got home. I am very pleased that I booked one interview a day, as I am finding them physically and emotionally draining.

I am finding it hard to not 'formulate' people's difficulties whilst they tell me their stories. I am wanting to interpret what they are saying and make connections with their current self to their past self.

I don't feel that I am dependant on the interview questions and am able to 'go with what the participant is saying'. However, it's hard not to be influenced by the literature. The participants largely seem to be leading the conversations.

The last participant said how it is useful talking to people about her experience as it's a way of letting off some steam as she doesn't feel that she can talk to family as she feels they would be thinking they have heard it all before.

Interview 5:

This was a very difficult interview. The lady was very tearful throughout. In accordance to the literature I feel that she was at a different 'stage of recovery' compared to others I have already interviewed. Generally she had been abused by the 'system'- however she was a very strong women.

During the interview she mentioned this was a difficult time of the year due to abuse history. Some minor risk issues came up that were passed on to her care co-ordinator, which the participant was aware of.

The participant talked about some of the abuse she experienced from an inpatient medium secure hospital I had worked at. I was able to really empathise with what she had been through- she had so much she could have gone into but there was not time- this seemed to be a theme for a lot of the people I interviewed. I cried with this woman as her story was so sad and she was still very tearful when talking about it. The emotion felt raw. I had a debrief with my supervisor over the phone after this interview- I left feeling very tired and slept for the afternoon. I'm still so surprised with how draining these interviews are- I reflected about this with my supervisor.

Transcription (General reflection):

First interview I was worried that the material collected was not answering my research question. Although I asked questions from my interview schedule the participant seemed to find it hard to answer and would seem to go 'off track'.

When listening back I found that the interviews were not as emotive/draining as when they were whilst conducting them. This is likely to highlight how I have begun to distance myself from the participants experience- therefore I referred back to my reflective notes for each interview to remind me of what I was thinking at the time. This feeling of 'distancing' may also have come from having to concentrate on what is being said as I wanted the transcripts to be accurate. This made me realise that when I am analysing and writing up the report I do not want to lose the emotion behind their voices and highlighted the importance of the reflective notes.

Extracts of reflections whilst analysing:

We [society] are always trying to remove the negative impact of trauma- but isn't that the best thing for someone who has been traumatised? But who dictates that all the 'symptoms' or impacts of trauma are negative; some may be adaptive, especially in the context of on going trauma. For example, some of the women have talked about having on-going 'depression' and feel that this will never 'go', but this 'depression' plays a role in blocking out painful memories/emotions to help them function in accordance to some of society's pressures. There does seem to be a useful role for depression. I can't help but think that if someone was to 'get rid' of depression this will unleash another 'symptom' and this pattern will continue. There is something about getting to the 'core' i.e. the origin of the 'dysfunction' to help someone manage it, not get rid of it. In some way I feel myself wanting to say that depression, or some other symptoms should not be looked at as a dysfunction, a germ, something that needs to be

eliminated, but it should be valued, its role should be recognised as, in part helping someone manage their every day struggle because what would life be like without the specific 'dysfunction' would it always be better?

I'm finding it hard to categorise these women's experiences as 'CSA'. Everyone's experience is different, unique. It's making me think that CSA is being categorised and/or medicalised. When you look at the literature you find many papers on 'the impact of CSA on X, Y and Z'. Would you find literature on the 'Impact of a car crash, or a major horse riding accident on X, Y and Z'? I am finding myself wanting to move away from categorising someone's experience as CSA. I think it does not add anything to our understanding on how to improve someone's life who has had a similar experience. But on the other hand I find myself stuck to think of an alternative that would fit society's fondness to reduce painful experiences because this clouds ideas of the 'perfect life'.

The nature of thinking about 'recovery' from CSA automatically makes me think that I am suggesting that the way people are feeling having experienced some type of CSA is wrong. The fact they need to think, feel and behave differently does not sit comfortably with me. A good example of this within the analysis is when I came across women talking about shame; it seems to be a common theme at the moment. The women appear to talk about shame as though they should not feel shame for what happened. Professionals, and people who have shared a common experience remind them that what happened was not their fault. This made me begin to think that if someone was told that its not their fault, and they struggled to believe this as it doesn't fit with their schema would this then lead to feeling more shame because have some inability to believe what even 'experts' and 'professionals' are telling them is the 'right' way to think about their experience? Is this an example of a never-ending shame cycle?

Following on from the above paragraph. Being faced with different/alterative perspectives of your reality e.g. 'its not your fault' over time, i.e. repetition of the phrase, would this then result in someone questioning their reality, i.e. is what I think about other aspects of my life 'wrong'. I can imagine this is a scary experience and would make you feel very vulnerable. It may take you back to feeling like a child and having to re-learn almost everything you know about the world? To do this a secure base would be vital- but does everyone have one of these? If not, this could be very un-stabilising and maybe lead to you 'losing your mind' which some of the women have talked about which seems to be related to not being able to control your extreme emotions and not understating where these emotions have come from. However, I do feel from reading the women's narratives that this stage in 'recovery' is necessary, you need to see the alternative pathway but with someone guiding you.

Appendix Seven: Reflective essay on the research area and question

The researcher has made the decision to include a reflective essay on the process of deciding the research topic and question. This essay was chosen as it was often an area of uncertainty that was, at times central to the research process. It is widely acknowledged that the reflective journals are seen as a form of quality control (Ortlipp, 2008).

The research topic for the current study, CSA, was chosen by the researcher after a year of attempting and failing to develop a research question independently with Clinical Supervisors external and internal to the Clinical Psychology Doctorate Course. After a year the researcher felt frustrated and disempowered at the process of selecting a 'suitable' research topic, i.e. one that would 'fit' within the restrictions of the course. After numerous meetings with the course staff and a building anxiety surrounding the thought of everyone else having a research topic, I remembered the work that psychologists from my first placement (adult mental health) were conducting.

During my initial placement I completed my small-scale research on a group for women who had been sexually abused as children. From this study I became familiar with the literature in the area, or lack of it. My supervisor had mentioned at the time that there was the potential for this work to be extended into a large-scale research study. During my time of frustration and anxiety I remembered this, and therefore contacted this supervisor to ask whether there was the possibility of working with her to create a research study for myself. Thankfully she was open to discussing this further.

As time went on I felt that a research study began to develop. Despite my efforts to move the study forward I was always faced with a challenge that I had to overcome. Looking back at this I can acknowledge that this is part of research and is expected. As a researcher I appreciate that being positioned in a place of 'uncertainty' enables you to develop as a researcher, and encourages you to become 'the expert' and over time your confidence in your ability grows. But this confidence does not grow when those seen to hold the 'power' do not nurture it and you do not feel contained. My Academic Supervisors constantly questioned my research question: 'The lived experience of recovery from CSA as described by women who have experienced CSA, and the role mental health services play in this'. I was often confronted with "this must have been done before?"; "are you sure you have checked the literature properly"; and "you have to be really clear about why your research is unique and what it is adding". Overtime these questions made me realise that I was the expert leading the research. The decisions made were my responsibility, therefore I was to 'blame' if later 'down the line' I came to realise that my research added 'nothing' to what was already known.

I found myself constantly searching online 'recovery from childhood sexual abuse'. I would find myself anxiously sifting through reference lists and related articles. Again and again I found and collected quotes stating that there was a lack of research in my chosen topic, especially in the UK. Despite this I did not feel confident. I feel my lack of confidence in myself is a reoccurring theme in my life and one that was not going to go away now. I could see that similar patterns of anxiety had arisen during my MSc thesis. Reflecting on this experience I was able to recognise that my lack of confidence in myself can be viewed as a strength. I have heard people say in the past that an awareness of the things you don't know is

a better position to be in rather than the blissful naivety of perceiving yourself to know 'everything'. Knowing what you don't know is a powerful position to hold and I recognise that when I am in these positions I grow. But I am only able to recognise this benefit when I perceive myself as being in a place of certainty and containment. Whether my lack of confidence is a strength or not seems to depend on my perceived certainty, or the amount I perceive others to have confidence in the area that seems uncertain.
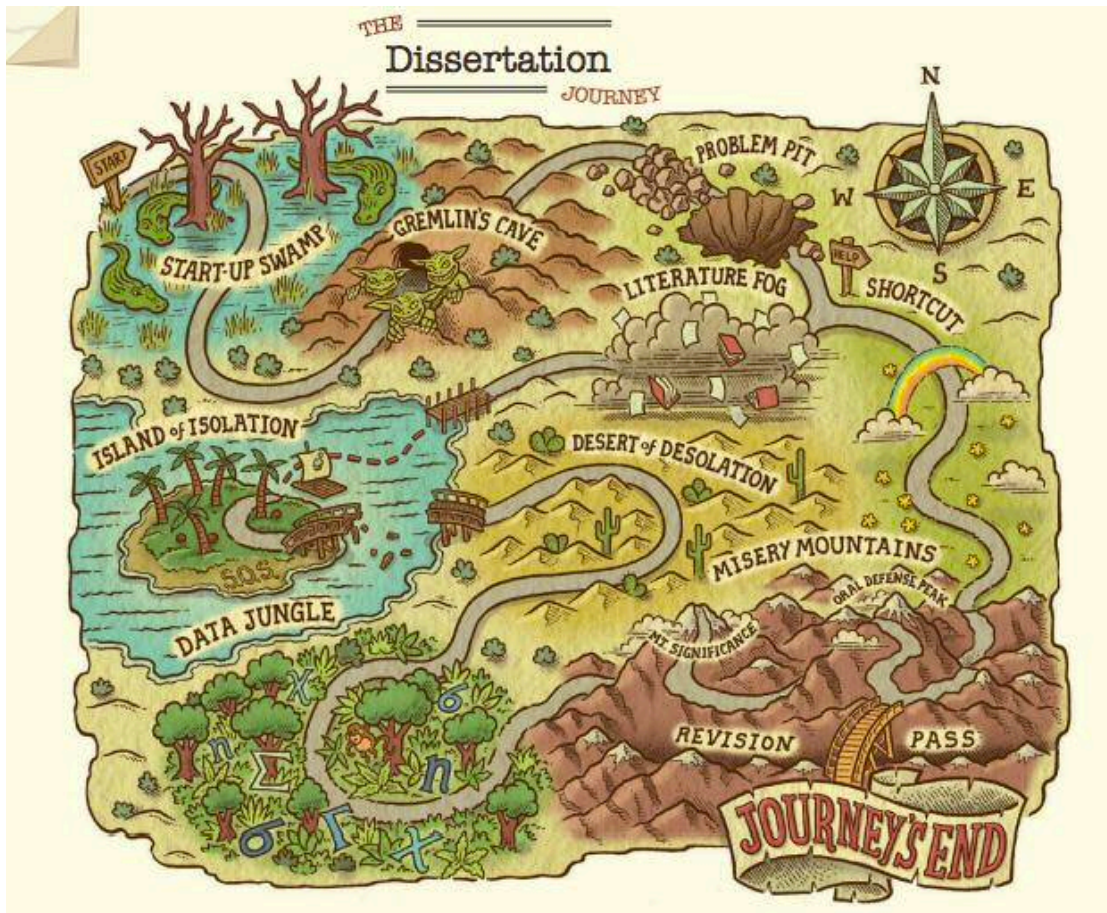
Relating this back to my research question. I did not feel that anyone, including myself was certain that this research topic/area had been explored and published before. This was also a concern of mine because half way through my study (once all my data was collected) my Academic and Clinical Research supervisors changed due to retirement and maternity leave. There was a lot of uncertainty, and that was not going to change. This required me to be confident in my skills as a researcher. I sought external advice from experts in the field and went to conferences, although they welcomed my research and expressed interest and even confirmed that there was a lack of research in the topic area my confidence was still fragile. The fragility of my confidence in myself would have likely been evident in how I communicated my research to others, which is also likely to influence their confidence in what I was communicating. I was in a cycle of uncertainty without confidence, and I was aware it was spiralling.

One way I dealt with this fragile confidence was to talk to others that I felt comfortable and confident talking to. These 'others' where professionals that I did not perceive to be in a position of power in relation to me personally or professionally. During this time I started to read around the history of CSA and its research development. I started to make links between this literature and my current experience. Survivors of CSA are historically a silenced population, society and professionals fear working with this population, overall CSA has been, and still is a taboo. However, there is almost surprise when you highlight the lack of understanding from a research perspective. This made me begin to ask questions around whether other people were faced with similar challenges when trying to conduct research in this area? And does this result in them not conducting research in this area? Essentially, the question I began asking myself was: 'Are researchers being silenced as well as the survivors of CSA?'

Such a question led to be think, 'but how do I as a novice researcher overcome this?' During this time my Clinical Supervisor for my placement shared her research experience and what stuck with me was this: although not knowing can be useful the amount of anxiety that it sometimes causes can result in not knowing being unhelpful. Of course I knew this, but hearing her say this was almost the confirmation I needed to overcome this experience of 'not knowing what to do'. Therefore, I thought about strategies to reduce the anxiety and accept that uncertainty would likely always be present. This is the reason I choose to write this reflective essay. It would help me organise my thinking and be something tangible that I could refer to. I guess it would be similar to creating a certainty and in part make me feel more confident.

In keeping with the theme of presenting large amounts of information in a simplified appealing form, since writing this essay I came across the following image that I felt reflected my current research experience. The image, and a description of the 'stages' of the research

process can be found here: https://www.academiccoachingandwriting.org/dissertation-doctor/the-dissertation-journey

NHS
Health Research Authority

South West - Frenchay Research Ethics Committee

Level 3, Block B
Whitefriars
Lewins Mead,
Bristol BS1 2NT
Email: nrescommittee.southwest-frenchay@nhs.net
Telephone: 0207 1048 045

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for
09 August 2016

Miss Carly Jackson
South Wales Doctoral Programme in Clinical Psychology
Gc
School of Psychology, Cardiff University
Ap
Tower Building, Park Place, Cardiff
CF10 3AT
W
pa
Dear Miss Jackson
fro

Study title:	**The lived experience of adult female survivors of childhood sexual abuse: Change and recovery.**
REC reference:	**16/SW/0196**
IRAS project ID:	**198978**

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Sp
Thank you for your submission of 4ᵗʰ August 2016, responding to the Committee's request for
further information on the above research and submitting revised documentation.
or

Re
The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website,
All
together with your contact details. Publication will be no earlier than three months from the
on
date of this opinion letter.   Should you wish to provide a substitute contact point, require
m
further information, or wish to make a request to postpone publication, please contact the
tre
REC Manager, Miss Natasha Bridgeman, nrescommittee.southwest-frenchay@nhs.net.

Th
op
Confirmation of ethical opinion
the

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above
To
research on the basis described in the application form, protocol and supporting documentation
for
as revised, subject to the conditions specified below.

If ;
Conditions of the favourable opinion
(c;
The REC favourable opinion is subject to the following conditions being met prior to the start of
Gi
the study.

It i
Management permission must be obtained from each host organisation prior to the start of the
be
study at the site concerned.

A
Management permission should be sought from all NHS organisations involved in the study in
accordance with NHS research governance arrangements. Each NHS organisation must

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsorship Certificate]	v1	23 June 2016
Interview schedules or topic guides for participants [Interview Schedule]	Version 2	04 August 2016
IRAS Checklist XML [Checklist_24062016]		24 June 2016
IRAS Checklist XML [Checklist_27062016]		27 June 2016
IRAS Checklist XML [Checklist_01082016]		01 August 2016
IRAS Checklist XML [Checklist_04082016]		04 August 2016

Letters of invitation to participant [Initial Participant information sheet v1]	version 1	24 June 2016
Other [Consent to be contacted v1]	version 1	24 June 2016
Other [Participant debrief v1]	version 1	24 June 2016
Other [Support leaflet v1a]	version 1	24 June 2016
Other [Support leaflet v1c]	version 1	24 June 2016
Other [Support leaflet v1b]	version 1	24 June 2016
Other [Support leaflet v1d]	version 1	24 June 2016
Other [Cover Letter for Participation Letter]	version 1	24 June 2016
Other [Service User Participation Letter]	version 1	24 June 2016
Other [Clinical Supervisor's CV]	version 1	25 July 2016
Participant consent form [Consent to participate v1]	version 1	24 June 2016
Participant information sheet (PIS) [Participant information sheet v1]	version 1	24 June 2016
REC Application Form [REC_Form_24062016]		24 June 2016
REC Application Form [REC_Form_01082016]		01 August 2016
REC Application Form [REC_Form_04082016]		04 August 2016
Research protocol or project proposal [Research proposal v1]	version 1	24 June 2016
Summary CV for Chief Investigator (CI) [Research CV v1]	v1	09 May 2016
Summary CV for supervisor (student research) [Academic supervisor research CV]	version 1	24 June 2016

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

Your Ref/ eich cyf
Our ref/ ein cyf: JG/AJ
Date/ dyddiad: 24th August 2016
Tel/ ffôn: 01443 443421
Fax/ ffacs: 01443 443420
Email/ ebost: CTUHB_RD@wales.nhs.uk
Dept/ adran: Research & Development Dept

Miss Carly Jackson
Trainee Clinical Psychologist
South Wales Doctoral Programme in Clinical Psychology
School of Psychology
Cardiff University, Tower Building
Park Place
CARDIFF
CF10 3AT

Dear Miss Jackson

Re: CT/650/198978/16 Childhood sexual abuse: Change and recovery

Thank you for clarifying the points raised at the Risk Review Group (RRRG) meeting. I have pleasure in confirming that this project now has full approval to commence in the Cwm Taf University Health Board. However commencement of the project should be upon the receipt of ethical approval if required. If the project is a multi site study it is advised that you also obtain approval from all other Health Boards before commencing the project at individual sites.

The Group reserve the right to information on the progress of the project at any time and should receive a progress report six monthly and a written report on completion.

Random audits will be carried out to ensure that projects comply with the clinical guidelines of research. Any serious adverse incidents relating to the project should be reported to the R&D office and a Clinical Incident Form filled in.

If your project includes participants or resources from other Health Boards it is your responsibility to contact the relevant R&D Office(s) in order to gain R&D approval to commence. Without individual R&D approval from all Health Boards involved in the study Welsh Risk Pool indemnity will not be afforded to the researcher.

On completion of the project it is important that you inform the Health Board Research & Development office.

It is a requirement of approval that a synopsis of your project and its findings (if not commercially too sensitive) be submitted to the R&D department upon completion. This synopsis can then be placed on the R&D departments' web page to provide a useful R&D resource for other research active professionals across the Health Board.

Support leaflet

Project title:

The lived experience of adult female survivors of childhood sexual abuse: Change and recovery.

Chief Investigator:

Xxxx Jackson xxxxxx

(Trainee Clinical Psychologist)

Clinical Supervisor:

xxxxxx

(Clinical Psychologist in xxxxx)

Academic Supervisor:

xxxxxxx

(xxxxxxxx)

Where do I get further support after participating in the research project?

After participating this research project you may feel that you would benefit from some support surrounding any difficulties you experienced as a result of discussing your lived experience of recovery from childhood sexual abuse.

As you have previously attended the Survivors of Abuse: Freedom and Empowerment (SAFE group) group you are able to access a support from the 'xxxxxx' that meets xxxxx on a Friday at xxxxx in xxxxxx. Everyone who attends this group has been through the SAFE group. Here you will be able to discuss your experiences from participating in the research project.

If you are interested in attending the Graduates group please contact xxxxxx on (xxxxx) xxxxxx.

xxxxxx is available to discuss any problems that may have arisen after talking about your lived experience of childhood sexual abuse from 9-5 Monday – Friday.

If you're distressed out of hours then we would encourage you to ring the **crisis team on (xxxxx) xxxxx extension xxxxx**.

You may also want to seek support from your mental health care coordinator.

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Other support options

You may want to seek support outside of xxxxxx Health Board.

In **any emergency** don't delay, dial **999.**

Here are some support options that may be relevant to you:

Safer Wales can provide help and advice on safety, information on possible court options, advice on benefits and housing, and support services, such as counselling or refuge provision. They can be contacted by calling:

029 2022 2022
Monday to Friday between 9 and 5pm.

All Wales Domestic Abuse and Sexual Violence Helpline is a 24/7 helpline that can be contacted on:
0808 80 10 800

NAPAC (National Association for People Abused in Childhood) provide a national free phone support line for adults who have experienced any type of abuse in childhood. Telephone support is available on:

08000 853 330.
www.napac.org.uk

Survivors UK is a national helpline for adult male survivors of rape or sexual abuse. They can be contacted on:

0845 122 1201.
Helpline available Monday & Tuesday 19:00 – 21:30 or Thursday 12:00 – 14:30.
www.survivorsuk.org

The Samaritans is a national charity offering support to anyone. They can be contacted on:

Telephone:116 123
Helpline available 24-7
Email: jo@samaritans.org
Write: Freepost RSRB-KKBY-CYJK
PO BOX 9090,
Striling
FK825A

CALL (community advise and listening line)
Offers emotional support and information/literature on Mental Health and related matters to the people of Wales. They can be contacted on:

0800 132 737
or text 'help' to 81066
www.callhelpline.org.uk
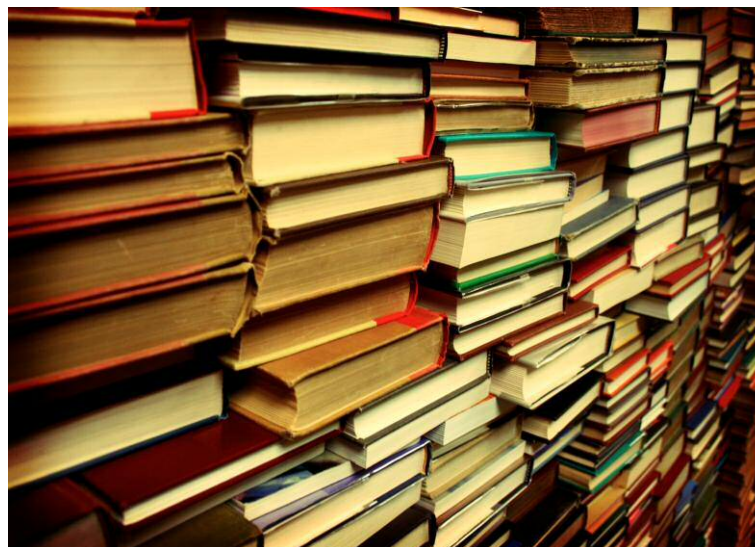
The Book Prescription scheme allows you to borrow copies of self-help books from any library.

Ask your care coordinator for details or your GP for details about the scheme.

We recommend:

Breaking Free: Help for survivors of child sexual abuse, by Carolyn Ainscough and Kay Toon, (2000), Sheldon Press.

Overcoming Traumatic Stress by Claudia Herbert and Ann Wetmore, (2002), Constable and Robinson.

A book that many have found helpful in thinking about trauma in society as a whole is **Trauma and Recovery**, Judith Herman, (1997).

Basic Books. **A straight talking introduction to psychiatric diagnosis** by Lucy Johnstone, (2014), PCCS Books. This will help you to think about the pros and cons of a psychiatric diagnosis.

Mobile phone apps that can be downloaded from the Google Play store and the iPhone App store that might be helpful too.

'Breaking Free – The Journey Begins' is an app for people who have experienced childhood sexual abuse, and consists of information and various coping strategies and is free to download.

'Breaking Free – Keeping Safe' is an app that provides strategies to help people stay safe while working through their difficulties, including managing harmful coping strategies, recognising triggers, coping with intense feelings and taking control of panic attacks.

'Breaking Free – Feeling Guilty' is an app that is designed for people with a history of abuse to help the user to overcome any thoughts or feelings of blame for being abused.

'Breaking Free – Safety Zone' is an app that contains over 15 techniques to help the user to gain more control over their emotions, thoughts and behaviour.

Appendix Eleven: SAFE group details

The SAFE group offers a structured, trauma focused, time limited (12 sessions with a six month follow-up) model of group psychotherapy. The group was primarily developed out of 1) recognition of the enormous strengths of women survivors of CSA 2) acknowledgement of both the impact of abuse and the resources that the women bring to the group work as fundamental to the processes of empowerment and healing 3) many mental health workers can use their personal experience during therapy 4) beliefs that the best services are provided by bringing women together in partnership 5) acknowledgment of the importance of safety for women within mental health services and 6) understanding that the process of enablement and empowerment is the basis of the group work offered.

The group is structured in the following way:

Session	Session theme
1	Safety and trust, building relationships, goals for session.
2	Introducing what is covered, brainstorming expectations
3	Setting the context of the abuse. Beginning to name abusers. Becoming witnesses for others.
4	Bringing the hurt child into the room, shifting responsibility off the innocent child
5	Coping skills
6-7-8	Disclosing own experience to group
9-10	Feelings. Loss, sadness, anger and ways of expressing this. Abuser cycle?
11	Preparing for ending, e.g. mothers, trust, coping strategies, healing, visualisation (variable session)
12	Celebrations, shedding, shredding, unfinished business. Group painting, Hopes and fears. Gifts. Date for review

The SAFE group adopts an empowerment model that draws from feminist theory and group work research (Herman & Schatzow, 1984; Herman, 1992, Brown, 2004; Walker & Rosen, 2004). Health professionals working inline with an empowerment model see themselves as facilitators, advisors, and authentic learners, in the process rather than as experts or ultimate authorities. They also view themselves as active group members.

Two female members of staff facilitate the group. Each woman who attended the group also met with an Individual Therapy Support Worker (ITSW) at least 15 times (at least once before the group commences and twice after completion). The ITSWs were also available for telephone contact via a work number. Their role was not to provide an individual therapy session but to primarily focus on empowering, enabling and supporting the women to address and work through the issues that were linked to a history of abuse. This can involve working through emotional or practical difficulties regarding the group. This support system is thought to add to the safety of the group and its effectiveness.

Staff involved in the group received support from an external supervisor. They could access this supervisor either via the phone or during three allocated group supervision sessions run alongside the group (weekly for one and half hours). The supervisor for these two mediums

was a different person, therefore if one supervisor was not present another was, or the emergency services can be contacted.

Appendix Twelve: Participant information sheet

Participant Information Sheet

Version 1, xxxxx

Title of Research Project:

The lived experience of adult female survivors of childhood sexual abuse: Change and recovery.

People involved:

Chief Investigator:

        xxxxx
        Trainee Clinical Psychologist at Cardiff University

Clinical Supervisor:

        xxxxx (Clinical Psychologist in xxxxx)
        Telephone: (xxxxx) xxxx

Academic Supervisor:

        xxxx (xxxxxxx)

WHAT IS THE PURPOSE OF THE RESEARCH PROJECT?
The aim of this research project is to explore women's lived experience of the impact of childhood sexual abuse and what helps and doesn't help them live with the consequences of childhood sexual abuse.

There are many theories about the impact of childhood sexual abuse but these tend to be based on the views of professionals rather than the individuals themselves. This research project is interested in the experiences of women living with childhood sexual abuse as described by the women themselves.

WHO IS ORGANISING AND FUNDING THE RESEARCH?
The research is being conducted by xxxxxx. The research is part of a doctorate in clinical psychology for the South Wales Doctoral Programme in Clinical Psychology at Cardiff University.

WHY HAVE I BEEN CHOSEN?
You have been chosen to take part in this research because:

You are female.
You are above 18 years of age.
You have experienced childhood sexual abuse.
You have accessed the mental health services in xxxxxx.

DO I HAVE TO TAKE PART?
It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time without giving a reason. Deciding not to take part or withdrawing at a later date will not have any impact on the treatment you are receiving from mental health services, or treatment you may receive in the future. If you decide to withdraw, any information you have provided will be safely destroyed and will not be used.

WHAT WILL HAPPEN TO ME IF I TAKE PART?
You will take part in a one-off interview with Xxxx Jackson in a private room in Ty Draw Community Mental Health Team offices, The Avenue, Pontypridd. The interview will be about your experience of living with the impact of childhood sexual abuse. You will not be asked about what happened to you when you were a child. Rather the interview will focus on how you are living with the experience of childhood abuse as a child, your experience with mental health services, and what has helped or not helped your recovery.

The whole interview process will take approximately one hour and 15 minutes. The interview will be recorded and will be typed-up by Xxxx. Once the entire interview has been typed the recordings will be deleted. The written accounts of the interviews will be destroyed after five years. All information you provide will be anonymised; this means that the information you provide will not be able to be traced back to you.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?
Your participation will contribute to our understanding of the impact of childhood sexual abuse. This will inform the development of services for other people who have experienced childhood sexual abuse.

WHAT ARE THE POSSIBLE RISKS AND DISADVANTAGES OF TAKING PART?
You will be giving one hour and 15 minutes of your time to complete the interview. The interview will be conducted thoughtfully and sensitively. If you find the interview difficult and experience any distress you will be supported and offered to break before continuing. You can also decide not to continue if the interview is too

difficult. You will be provided with information about support that you can access after the interview should you need it.

WHAT IF I DISCLOSE THAT I AM RISK TO OTHERS OR MYSELF, OR THAT I AM AWARE OF A CHILD AT RISK DURING MY PARTICIPATION?
If during the research project you disclose that you are at risk of harming your self or other people this will be followed up with the relevant professionals. The purpose of this is to provide you with appropriate support. Every effort will be made to involve you throughout this process.

If you raise concerns regarding the wellbeing and safety of a child the multi-Agency Safeguarding Hub (MASGH) will be notified. Again, every effort will be made to involve you throughout this process.

WHAT IF THERE IS A PROBLEM?
If you have any questions during the research project you could speak to Xxxx Jackson or the Clinical Supervisor (xxxxx) who will do their best to answer your questions.

If you remain unhappy and wish to complain formally, you can do this through the NHS Redress Scheme. Details can be obtained from Xxxx University Health Board's Concerns team (Telephone Number: xxxx) and Xxxx University Health Board's website (http://www.xxxxx)

You should know that the Chief Investigator has an obligation to act upon and report any poor practice and/or unprofessional behaviour disclosed in the interview. In the case that poor practice and/or unprofessional behaviour is disclosed during the interview this will be discussed.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?
All the information from the research will be treated as strictly confidential and the information you provide will be anonymous so it will not be possible to identify you. All data will be stored on a password-protected computer with no personal identifiable information. Some interviews will be looked at by the Clinical Supervisor and the Academic Supervisor, but only after they have been anonymised. Representatives from Xxxx University Health Board's Research & Development Department may also look at this information to ensure the research is being carried out in a proper manner.

If you are currently receiving support from Xxxx mental health service your care coordinator will be told about your participation in the research project. Their awareness of your involvement will allow you to discuss with them any issues that may arise during your participation in the research project.

WHAT WILL HAPPEN TO THE RESULTS OF THE STUDY?
The information you provide is for a doctorate in clinical psychology thesis for the South Wales Doctoral Programme in Clinical Psychology at Cardiff University. The

information will be written up as part of a large report and submitted to Cardiff University as part of a degree. This report will be published by Cardiff University library. There is also an intention of writing this report for publication in research journals. It is also hoped that the results can be shared with others through talks and poster presentations at conferences. This means that the results will be available to the public.

WHO HAS REVIEWED THE STUDY?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by xxxxx The project has also been given approval to commence by Xxxx University Health Board's Research Risk Review Group.

WILL I HAVE FEEDBACK ON THE RESULTS OF THE RESEARCH PROJECT?
If you would like feedback on results of the research project you can leave your details with the Chief Investigator. You will be given this opportunity during the debrief after the interview.

WILL I RECEIVE ANY PAYMENT?
You will not receive payment, however we are able to reimburse travel expenses up to £10 if you participate. To receive this payment we will require you to provide full VAT receipts of your travel.

Thank you for taking the time to read this information

Appendix Thirteen: Participant consent from

CONSENT TO PARTICIPATE FORM

Version 1, 24.06.2016

Title of Research Project:

The lived experience of adult female survivors of childhood sexual abuse: Change and recovery.

Name of Chief Investigator:
xxx (Trainee Clinical Psychologist)
Name of Clinical Supervisor:
xxx (Clinical Psychologist in xxxx)
Name of Academic Supervisor:
xxxxx (xxxxxxx)

Please initial all boxes

1. I confirm that I have read and understand the Information Sheet dated **xxxxxx** for the above research project. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and this will not affect my mental health treatment. ☐

3. I understand that if I disclose that I pose a risk to myself or others during my participation in this research project this will be followed up with relevant professionals in accordance with xxxx University Health Board's procedures. ☐

4. I understand that if I disclose that I am aware of a child who is at risk during my participation in this research project this will be followed up with relevant professionals in accordance to the xxx University Health Board's procedures. ☐

5. I understand that the Chief Investigator has an obligation to report any poor or unprofessional practice by Healthcare professionals which may be disclosed as part of the interview. ☐

6. I understand that the information collected during the research project, may be looked at by academic staff from the South Wales Doctoral Programme in Clinical Psychology at Cardiff University, by xxxx, Clinical Psychologist xxx University Health Board, and staff from xxx University Health Board's Research & Development Department to ensure the study is being conducted in the correct manner. I give permission for these individuals to have access to my data. ☐

7. I agree to take part in an interview and understand that the interview will be voice-recorded. I understand that the tape will be erased once it is written up. ☐

8. I understand that the information I give will be used for a doctorate in clinical psychology. The information may also be used in reports, which may include direct quotes.

9. I understand that the information I provide will be confidential and that the results of the study would be made anonymous.

10. I agree to take part in this research project.

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Name of Person (taking consent)   Date   Signature

Appendix Fourteen: Initial interview schedule

Initial Interview Seclude

Version 1, XXXXX

Title of Research Project:
> The lived experience of adult female survivors of childhood sexual abuse: Change and recovery.

Name of Chief Investigator:
> xxxxx (Trainee Clinical Psychologist)

Name of Clinical Supervisor:
> xxxxxxx (Clinical Psychologist in xxxxxx)

Name of Academic Supervisor:
> xxxxxx (xxxxxxx)

Introduction to the interview:

We are going to spend the next hour together going through these interview questions.

Within this hour will be a 10-minute catch-up at the end to see how you feel and talk about

what support you can access. There will also be an opportunity towards the end of the interview for you to add any comments you feel may have been missed. Just to remind you that at no point will I be asking you about your own experience of abuse when you were a child but you may feel that it is important to refer to this during the interview and this is OK, the choice is with you. Firstly I will ask you about your experience of recovery and/or change after sexual abuse as a child. After that I will ask you about what helped and did not help your experience, and the role mental health services have played. The questions asked are around your experience of a meaningful and valued life after your experience of sexual abuse as a child and what message you want to share with others. There are no right or wrong answers; it is your personal experience that I am interested in.

I am aware that having these discussions can be distressing and can bring back memories. If at any point you want to take a break or end the interview please do. We can take as much time as you need. Your decision to whether you want to continue with the interview will be fully respected. Before we start, thank you very much for agreeing to take part in this study your voice and experience is very important.

Before we start, I would like to talk through the consent form with you to ensure that you understand what taking part in this study will involve and that you are happy to continue with our interview today (each item on the consent form will be discussed with the participant).

During our interview it is important that I listen to you very carefully so I am planning on recording the interview (point to the digital recorder). Are you happy with the recorder being here and recording our conversation? Only I will hear the tapes.

As I said the interview will focus on change and recovery from your experience. If we go off track what would be the best way for me to bring you back to the question asked?

Do you have any questions?

<div align="center">**RECOVERY AND CHANGE QUESTIONS**</div>

TOPIC GUIDES/THEMES AND PROMPTS

Start of interview:
I am interested in how your experience of sexual abuse as a child has affected your life with a focus on change and recovery.

1) <u>Recovery and change: narratives about living a positive/fulfilled life</u>

- What does the word recovery mean to you?
- How would you describe your experience of recovery or change after CSA?
- Would you use the word recovery? *(Would you use the word change?; What words would you use to describe your experience of recovery and change after CSA?)*
- Has your experience changed over time?
- If so, what was related to this change?
- If not, why don't you think it has changed?
- How has society's views on CSA and its impact influenced your experience of recovery/change? *(e.g. the media, your community, the wider community)*

** Use the participants narrative to explain their experience of 'recovery and/or change from this point on**

2) <u>What has/has not helped?</u>

- What have been the most useful experiences for your change and recovery? (*Prompts- services or other aspects of your life?)*
- What have been the most un-helpful experiences for your change and recovery? (*Prompts- services or other aspects of your life?)*
- What has encouraged your experience recovery/change? *(What has allowed you to recover/change)*
- What has prevented your experience recovery/change? *(what has stopped you from recovering/changing)*

3) <u>Mental health services</u>

- How have mental health services helped your experience recovery/change? *(Mental health services include services that are provided by your mental health team, e.g. your psychologist, psychiatrist, CPN, social worker)*
- If they have helped, how?
- If they haven't helped, how have mental health services not helped your experience recovery/change?
- What do you feel you need now from mental health services?
- What do you think mental health services should be providing to people who have experienced CSA? *(what would the perfect service look like for people who have experienced sexual abuse as a child?).*

4) <u>Living with and sharing</u>

- What have you learnt about yourself having had this experience?
- How do you describe yourself, either to yourself or others, having had this experience? *(When I am writing this research how would you like to be described as a population of people who share a similar experience, e.g. a survivor, victim?)*
- What would you want to pass on to others who have had a similar experience to yourself? (e.g. advice, thoughts)
- We talked about some really difficult things today, what is the message you hope I heard?

Additional probing question examples:
Can you tell me more about that?
Can you give me an example?
What did you think about that?
How did you feel about that?
What did that mean for you?

5) **Closing and debrief:**

- That's all I wanted to ask, thank you for your time in helping me.

- Do you feel your experience was captured by the questions asked? Are there any final things you would like to say?

- What was the experience like for you throughout the interview? Do you think any of your views have changed since the start of this interview?

- What do you plan on doing if you feel distressed following this interview?
  Give debrief letter and leaflet
- After reading this information do you feel fully informed of the support that you can access?

DEMOGRAPHICS AND ADDITIONAL INFORMATION:

1) How old are you?

2) How would you describe your nationality?

3) Can you give me a brief description of the mental health services they have received in the past?

Initial Participant Information Sheet

Version 1, xxxxx

Title of Research Project:

The lived experience of adult female survivors of childhood sexual abuse:
Change and recovery.

People involved:

Chief Investigator:

> xxxxx
> Trainee Clinical Psychologist at Cardiff University

Clinical Supervisor:

> xxxxx (Clinical Psychologist in xxxxx)
> *Telephone:* (xxxxx) xxxx

Academic Supervisor:

> xxxx (xxxxxxx)

xxxxxx is studying to become a Clinical Psychologist on the South Wales Doctoral Programme at Cardiff University. As part of her studies she is required to complete a research project. xxxxx decided to complete this research project. I will supervise xxxxx during this research project along with xxxxx (please see her role above).

Please take time to read the following information carefully and discuss it with others if you wish.

If there is anything that is not clear or if you would like more information you can contact me between 9-5 Monday – Friday on (xxxxxx) xxxxx.

If you are willing to be contacted by Carly to discuss your participation in the research project please complete the 'Consent to be Contacted' form enclosed and provide me with information about the best way for Carly contact you. Enclosed is a pre addressed and stamped envelope for you to return the forms.

Thank you for taking time to read this.

Yours sincerely,

xxxxxxx
Clinical Supervisor
Clinical Psychologist

-Information sheet (as shown in Appendix Twelve) was then inserted-

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CONSENT TO BE CONTACTED FORM

Version 1, xxxx

Title of Research Project:

The lived experience of adult female survivors of childhood sexual abuse:
Change and recovery.

Name of Chief Investigator:

xxxxx (Trainee Clinical Psychologist)

Name of Clinical Supervisor:

xxxxx (Clinical Psychologist in xxxx UHB)

Name of Academic Supervisor:

xxxx (xxxxxxxxx)

Please initial all boxes

11. I confirm that I have read and understand the Participant Information Sheet dated xxx for the above research project.

12. I confirm that I am willing for the Chief Investigator to contact me to discuss my participation in the research project further (please provide your contact details below).

13. I understand that my decision to whether I want to be contacted by the Chief Investigator will not affect my mental health treatment.

14. I understand that by signing this form I am not consenting to participant in the research project, but I am consenting to be contacted by the Chief Investigator to discuss my possible involvement in the research project.

Name of Participant	Date	Signature

Name of Person (taking consent)	Date	Signature

If you have any further questions at this point please contact the Clinical Supervisor, xxxxx between **9-5 Monday – Friday on (xxxx) xxxxx.**

CONTACT INFORMATION
Please provide details of the best way to contact you.

Telephone:
Home (………………………)…………………………….
Mobile …07…………………………………………………….
When is the best time to contact you, please tick below:

	Monday	Tuesday	Wednesday	Thursday	Friday
AM					
PM					

Email:
Address: …………………………………………….

Letter:
What is the best address to send you letter to?

First line of address: …………………………….
Second line of address: …………………………….
Town/city: …………………………….
Post code: …………………………….

Thank you for taking time to complete this.

Please return this information with the above Initial Consent Form

Appendix Sixteen: Participant debrief sheet

PARTICIPANT DEBRIEF

Version 1, xxxxx

Title of Research Project:

The lived experience of adult female survivors of childhood sexual abuse:
Change and recovery.

Name of Chief Investigator:

          xxxx (xxxx)

Name of Clinical Supervisor:

          xxxx (Clinical Psychologist in   xxxx)

Name of Academic Supervisor:

          xxxx (xxxxx)

Dear Participant,

I would like to thank you for taking part in this research project. Your help and contribution is very much appreciated.

This research project was not intended to cause any emotional distress. If you feel you need support and or information about any of the issues raised during the interview please contact xxxx between 9-5 Monday –

Friday on (xxx) xxxx who will discuss these with you. You can also find further support from the Support Leaflet provided.

If you would like to know the results of this research project, please leave your email address with me and I will send you a summary of the results.

If you would like to help me feedback the results of the research project in the future please let me know before you leave today. xxxx is a local voluntary charity that aims to improve mental health services who are willing to support you if you choose to help feedback the research project results. Please take a leaflet before you leave.

Again, I would like to thank you for your time. Your participation is greatly appreciated. I wish you all the best for the future.
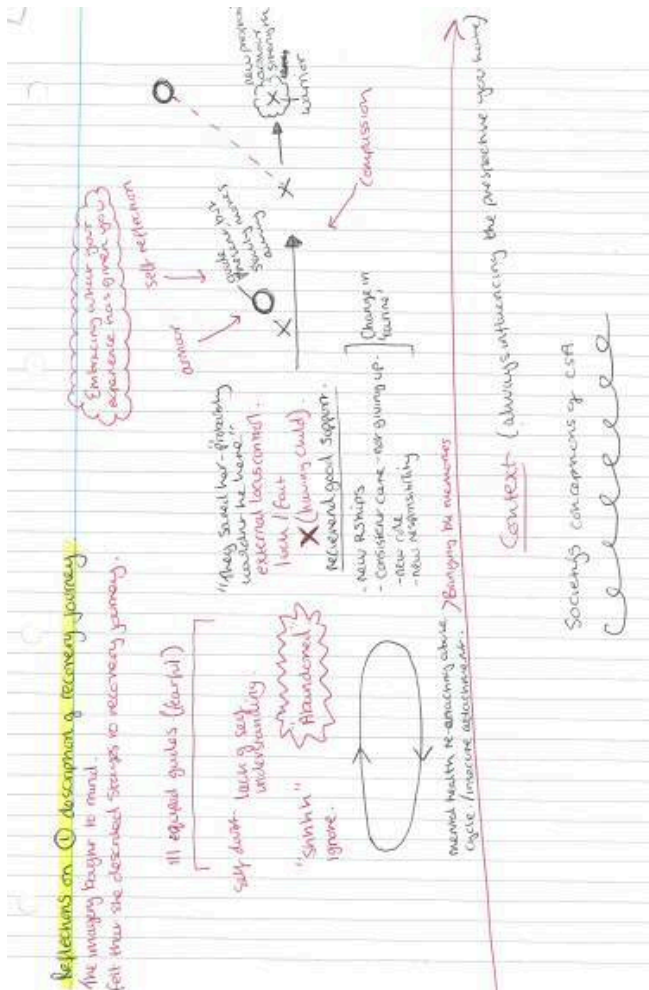
Yours sincerely

xxxxx

Chief investigator

Trainee Clinical Psychologist

Appendix Seventeen: Example of stage one of IPA.

105 and people need help to deal with it. Because it

106 does impact on peoples lives a lot.

107

108 I think that's quite reflective being able to look

109 back and think "why did that professional say that

110 to me", but at the time what was that like?

111

112 It made me angry because I had worked myself up

113 thinking "yer we are going to deal with it;" and I

114 still remember the place and everything that it was,

115 the way the room was laid out I just sat there and

116 was like "oh right ok". You know it had taken a lot

117 to get where I was. I had had my first child which

118 was a nightmare. Because of how it made me feel

119 being pregnant, obviously due to what had

120 happened. And it did make me really angry, so I did

121 locked it away for a long time. And a coupe of

122 years later I was referred again to see a

123 psychologist and, she obviously didn't listen to me

124 properly because we ended up with social services

125 at our door because she thought the abuser lived

Appendix Eighteen: Reflexive diary: how the role of mental health services was incorporated within the analysis

Analysis and interpretation, summary of reflections

Each time I look at my analysis something changes. This causes me a sense of frustration and I am wondering if this will continue. Speaking to colleagues they had similar experiences with their qualitative analysis. I read about this process further online and decided that I should accept that I will have to come to a point where I stop makes changes once I feel I have a coherent narrative that makes sense to me. I found this very difficult. This was reflected in the initial stages of the analysis when I was reluctant to drop any themes from my

analysis; I was married to them. I was convinced that the themes I identified where vital in communicating my message. As I had distanced myself from the literature surrounding CSA and recovery I was unaware of the themes that 'fitted' or did not 'fit' previous literature, which I felt played a roll in my reluctance to drop any themes.

Some of the feedback I had from my supervisors in the initial stages of my analysis write up suggested that within some of my themes I was talking about the 'bad aspects' of mental health services and a suggestion was put forward to whether these should be a theme in their own right. I thought about this for a period and after reading relevant literature of CSA and recovery I came to the decision that I would not create this theme as it would reflect the interview questions I asked. I felt this would not reflect the deep level of interpretation required in IPA. I also considered this decision later in supervision. I discussed with my Clinical Supervisor why I had not created a 'bad aspects' of mental health theme and we had a discussion surrounding how this reflected the intention of the current research. For example, within the research the role mental health services have in peoples recovery from CSA, within a population of people who may not initially be considered resilient due to their mental health difficulties, was largely separated from their experience, a holistic approach equally valuing the role of personal and support services was difficult to find. Therefore, I did not want my analysis to reflect this. I felt this would require a deeper level of analysis to help identify what exactly is it that is 'bad' about someone's experience of mental health services, as this knowledge may be transferred to what is 'bad' about other areas of their life. Overall, effort was made to move away from self-evident themes within the analysis.

Appendix Nineteen: Example of the reflective notes from the participant who developed images for the superordinate themes

Thoughts on creating the image: a drawing with plain, uncomplicated lines with few details makes it easier to apply the drawing to any woman.

Clear of clutter = room for a new way of living and being.

Mending the vase: it will never be the same, but that is a GOOD thing.

Visible lines of brokenness: think of the Japanese vases mended with gold—stronger than before being broken, and now with beauty in the mended brokenness.

Being able to make this drawing, knowing what it represents, means to me that I am moving beyond what brought about the brokenness. I like it that way. ☺ Evolution, here I come.

Appendix Twenty: An example of a dissemination approach

The researcher aims to present the findings of the current research project at the following Community Psychology Festival (see below). This medium has been chosen as it appears to fit with the epistemological stance and ethos of the current research project.

How the research is presented will be developed in consultation with the women who participated in the research and in collaboration with service users who have experience CSA and who show an interest in taking a role in this process.

Initial ideas developed by the researcher surround attempting to present the findings using preforming art and the images created from the analysis. The researcher hopes to use a darken room, a spotlight and screen to present the research. How the research is presented will symbolise the research process. For example, the presentation would begin on a screen outlining the elements of the research, i.e. introduction, previous literature, the research aims and objectives and methodology. This would be presented in brief using Prezi to encourage a more interactive stance and can be developed to represent the 'journey' of the research process. The researcher would provide a narrative alongside this presentation. The room would be darkened with a spotlight on the researcher whilst she talks to emphasise her voice and her influence. Following this the results from the analysis would be presented on the screen. The images developed by the research participant would be used to represent the superordinate themes. The researcher would describe each theme whilst the image of the theme is on the screen. Actors, or service users, would then provide prominent narratives the women used to represent the theme. When the narratives are spoken the spotlight would shine on the person speaking. The spotlight would follow whoever is talking. This would be done for each superordinate theme. The implications of the findings would then be spoken by the researcher and presented on the screen at the end.

The BPS Community Psychology Section & UWE Bristol present:
The 3rd Community Psychology Festival
'Falling apart; Pulling together: Collaboration in times of division'
15th -16th September 2017
The Arnolfini, Bristol (UK)

http://www.arnolfini.org.uk

Community Psychology is a recently reinvigorated branch of applied psychology that highlights the detrimental effects of structural inequality and competitive individualism on mental health and wellbeing. Community psychologists are typically clinical, counselling, health, organisational, and educational psychologists, who work in diverse settings such as the NHS, third sector, social enterprises, local councils, academia, and policymaking. Community psychology believes that healthy individuals are the product of healthy societies, as it seeks to create ways of living and working that adhere to social justice, and to advocate for those that have been marginalised, excluded, and/or oppressed.

The **Festival** is a friendly and accessible educational alternative to an academic conference with public participation at its heart. It is a celebration of the work of psychologists as well as community organisations, and showcases initiatives that fit with our ethos and themes. Feedback from past Festivals has extolled the atmosphere of solidarity and 'coming together', which we value above any single individual contribution. Past contributions have included talks by prominent European scholars; 'walk and talk' sessions; dancing workshops; research papers; an 'Ideas Wall'; activist groups; Theatre of the Oppressed; prospective reflection through 'letters from the future'; and photography workshops. The Festival has an international outlook and has hosted participants from Europe, Israel, the Americas, India and New Zealand. It can be attended by anybody with an interest in psychology or community work. We welcome contributions from related disciplines and opportunities to collaborate with people from a wide variety of backgrounds.

Call for Contributions

Proposals are invited in relation to four thematic strands:

(1) Housing, mental health, and wellbeing

(2) Supporting those who work in communities

(3) What's art got to do with it?

(4) What does it mean to be critical?

We are aiming to host imaginative and interactive programmed activities for Festival participants. Proposed activities could include any of the following:

- **Workshops and masterclasses** (e.g. sharing how to use a research & development technique or how to use a community participation method)
- **Debate** or discussion forum
- **Films** (to be screened in a projector-enabled dark studio)
- **Research**: papers, symposia, Pecha Kucha (format and content must be engaging for a general audience)
- **Performances**: song, poetry, dance, audio-visual art installations or other media
- Overview of **community projects**
- Examples of **collaborative work**