PROFESSIONAL DOCTORATES

The ripple effect of sexual trauma: A qualitative exploration of direct effects on women survivors' partner relationships and indirect effects on clinical psychologists

Glinn, Laura

Award date:
2023

Awarding institution:
Bangor University

PROFESSIONAL DOCTORATES

The ripple effect of sexual trauma: A qualitative exploration of direct effects on women survivors' partner relationships and indirect effects on clinical psychologists

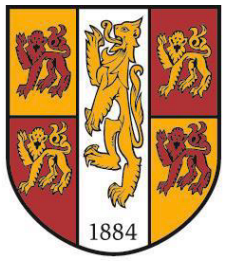
Glinn, Laura

Award date:
2023

The ripple effect of sexual trauma: A qualitative exploration of direct effects on women survivors' partner relationships and indirect effects on clinical psychologists

Laura Glinn

North Wales Clinical Psychology Programme



PRIFYSGOL
BANGOR
UNIVERSITY

Submitted in partial fulfilment for the degree of

Doctorate in Clinical Psychology

January 2023

Table of Contents

Declaration

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy.

22.01.2023

Original Word Count

Thesis section	Excluding tables, figures, references, and appendices	Inclusive
Thesis abstract	286	286
Systematic review	8,843	17,708
Empirical paper	8,701	16,337
Contributions and reflections	2,169	2,539
Title pages, content, declaration, word count, acknowledgments	-	1,591
Total	**19,999**	**38,461**

Acknowledgements

"We have such a long way to go" sighed the boy.
"Yes, but look how far we've come" said the horse.

Charlie Mackesy

To everyone who has believed in me, supported me, and been beside me on this journey, I sincerely thank you.

To all the participants who generously and courageously shared their experiences with me. To Emma, for your assistance and support with making this research possible. To Lee, for always fighting my corner. To Sam, for your warmth, encouragement, and for holding space for me to ramble. To Carolien, for your passion and ideas that helped to develop and shape the infancy of this research. To the research team, for your invaluable feedback on drafts of this thesis. To the dream team, Laura and Renee, for guiding me through this thesis with such wisdom, compassion, and enduring belief. We did it!

To my family, for always believing in me. To Beth, Carolyn, Georgia, Holly, Lucy, Sophie, and Veena, for a lifetime of friendship and for being my biggest cheerleaders. I hope you know how special you are to me and how deeply grateful I am for you. To Ellen, Jordan, and Miranda, for being such a source of strength, inspiration, and encouragement, and for generously offering to take on the mammoth task of proofreading a final draft of this thesis; thank you. How lucky are we that university brought us together. To Anna, my soul friend and fellow voicenoter/podcaster. Words cannot do justice to how grateful I am for you. For your wise and thoughtful comments and reflections on drafts of this thesis, and for all that you bring to my life.

To my cohort, for being such an important part of this journey. It has been a privilege to have trained alongside you. To Erin and Jess, my potatoes. For being an anchor through the storms, and for bringing strength, lightness, and laughter to my life. I hope you know how much love and gratitude I have for you.

To Luke, who taught me, and will continue to remind me, of what truly matters.

And last but not least, to Jonny, my rock. For your love, care, and unwavering belief in me. To say that I could not have got through this thesis and doctorate without you would be an understatement. Thank you for wiping my tears, helping me keep perspective, and for reminding me how far I have come. We finally did it! I am looking forward to the next chapter of our lives, thesis free.

Thesis Abstract

This thesis explores the wide-ranging and far-reaching effects of sexual trauma (ST). Chapter one is a systematic review of qualitative research that explored experiences of sexuality, sexual orientation, and partner relationships in 283 women survivors ('survivors') of childhood sexual abuse across 16 papers. Thematic synthesis identified four inter-related themes: 'The past is in the present', 'The push-pull dynamic', 'Concealing, revealing, and being seen', and 'Redefining and relating'. These themes illustrate that complex and diverse challenges, difficulties, and conflicts, were commonly experienced, yet partner relationships provided important contexts for relational and sexual recovery, and overall healing. Sensitively and appropriately incorporating sexuality and partner relationships into psychological interventions is encouraged.

Chapter two is empirical research that used interpretative phenomenological analysis to explore eight clinical psychologists' experiences and impacts of working therapeutically with adult survivors of ST in National Health Service (NHS) settings. Three inter-related super-ordinate themes were developed: 'Hidden versus seeing: an isolating experience', 'The sequelae of seeing: challenges, privilege, and transformations', and 'Surviving and getting through'. These themes capture complex and intense challenges, personal effects, and responses. The impact of socio-cultural-political contexts within society and the NHS were illuminated. Systemic and organisational changes are strongly recommended in line with trauma-informed care.

Chapter three integrates findings from the systematic review and empirical study to consider contributions to theory, directions for future research, and implications for clinical practice. A statement of the first author's positionality and a reflective commentary is included. This chapter discusses parallel processes experienced by ST survivors and clinical psychologists who support them. Key implications relate to making the hidden nature of ST seen. Mirrored experiences are understood by the 'ripple effect' phenomenon; this chapter illustrates how far the ripples of ST can reach.

Chapter one

Systematic review

The past is in the present: A systematic review and meta-synthesis of women survivors' experiences of partner relationships following sexual abuse in childhood

Laura Glinn[a*], Dr Renee Rickard[a], Dr Laura Spencer[a,b]

[a]North Wales Clinical Psychology Programme, School of Human and Behavioural Sciences, Bangor University, Bangor, United Kingdom

[b]Betsi Cadwaladr University Health Board, Bangor, United Kingdom

***Corresponding Author**: Laura Glinn, North Wales Clinical Psychology Programme, School of Human and Behavioural Sciences, Bangor University, Bangor, United Kingdom. Email: lrg19cjy@bangor.ac.uk, Telephone: +44(0) 1248 388365

This paper is intended to be submitted to Aggression and Violent Behavior

Submission guidelines can be found below:

https://www.elsevier.com/journals/aggression-and-violent-behavior/1359-1789/guide-for-authors

Abstract

The psychological impacts of childhood sexual abuse (CSA) have been well researched, yet person-centred research on relational and sexual lives following CSA remains relatively neglected. This systematic review synthesised qualitative literature exploring experiences of partner relationships for women CSA survivors ('survivors'). Searches conducted on PsycINFO, CINAHL and PubMed identified 16 eligible studies, comprising the experiences of 283 survivors. Thematic synthesis identified four inter-related themes: 'The past is in the present', 'The push-pull dynamic', 'Concealing, revealing, and being seen', and 'Redefining and relating'. These illustrate that CSA continued to adversely influence survivors' sexual and relational lives in complex and diverse ways, with survivors using various strategies to navigate challenges, difficulties, and tensions. Yet, partner relationships provided an important context for healing through experiencing safety, acceptance, and love, and supporting survivors to redefine themselves and reclaim sexuality. Key clinical implications include the need for clinician awareness of survivors' diverse relational and sexual experiences and challenges, as well as the potential for healing through partner relationships. Incorporating these arenas into interventions is important in facilitating healing and meeting survivors' holistic needs.

Keywords: Women; Childhood Sexual Abuse; Interpersonal Relationships; Intimacy; Sexuality; Qualitative

Registration

This meta-synthesis was registered with PROSPERO: February 2022. Number CRD42022306095.

Available from:

https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=306095

Introduction

Nearly one in four women are estimated to have experienced childhood sexual abuse (CSA) globally (Pan et al., 2021; 2022; Qu et al., 2022), though prevalence rates vary according to definitions of CSA (see Newsom & Myers-Bowman, 2017 for definitions). Despite differences in definitions, pervasive and long-term psychological impacts of CSA are well documented, which include vulnerability to experiencing mental health difficulties, substance misuse, and low self-esteem (Hailes et al., 2019; Neuman et al., 1996). Although an emerging focus (Davis & Petretic-Jackson, 2000), less attention has been paid to the relational and sexual impacts of CSA. This is surprising given CSA is an intimate interpersonal trauma that violates survivors' physical and psychological boundaries of autonomy, control, trust, safety, and intimacy (Herman, 2015). It might therefore be expected that CSA affects survivors' interpersonal relationships into adulthood, especially intimate relationships.

Finkelhor and Browne's (1985) Traumagenic Dynamic model postulates that CSA can distort survivors' perceptions of themselves and the world through four dynamics: betrayal, powerlessness, stigmatisation, and traumatic sexualisation. Survivors may therefore face barriers to developing healthy partner relationships due to a shattering of trust, safety and agency carried into adulthood and through internalising stigma and sexualisation. Indeed, survivors report difficulties trusting others, navigating safety and mutuality in relationships, feeling worthy of love, and sexual impacts ranging from avoidance of sexual activity to 'compulsive sexual behaviour' or 'oversexualised' relationships (Davis & Petretic-Jackson, 2000). However, less is known about broader relational impacts of CSA, including the

processes involved in achieving healthy and satisfying partner relationships in adulthood.

According to attachment theory (Bowlby, 1973; Johnson, 2004), beliefs and expectations about the self, others and relationships develop in childhood/adolescence and affect our adult relationships. Adult partner relationships are considered one of the most important attachment relationships because within these, the strongest emotions arise and have the most influence (Walker et al., 2009). For survivors, unresolved negative beliefs about the self, safety, and others' trustworthiness are likely activated in partner relationships, affecting survivors' perceptions of partners and survivors' emotional experiences within partner relationships (Walker et al., 2009). However, partner relationships can also provide a "corrective attachment experience" (Weetman et al., 2021, p.2), offering a context to experience safety, love, and acceptance, thus fostering healing by providing what was violated through CSA (Guyon et al., 2020).

The processes by which survivors adapt and heal from traumatic experiences has recently received increased research attention. Healing and recovery from CSA have been understood to involve dynamic processes over time that result in positive changes and growth (Arias & Johnson, 2013; Draucker et al., 2011). Internal characteristics (e.g., personal agency, self-efficacy, personal resolves, commitment to transcend CSA) and external factors (e.g., life events, supportive relationships, affirming messages, ongoing support) that include partner relationships have been identified as important in facilitating healing (Arias & Johnson, 2013; Draucker et al., 2011). Post-traumatic growth is conceptualised as transformative, positive changes

experienced following the struggle with highly challenging crises (Tedeschi & Calhoun, 2004). Relationships have been identified as one of five key dimensions of post-traumatic growth, with people experiencing relationships as closer, more intimate, and meaningful following trauma (Tedeschi & Calhoun, 2004). Research has found that supportive partners can help challenge and reframe negative self-beliefs and in turn, reduce feelings of shame and blame (Hartley et al., 2016).

Despite growing recognition of the wide-ranging impacts of CSA on survivors' relationships, there has not yet been a systematic review of person-centred research exploring women survivors' perceptions and experiences of partner relationships. To date, reviews have explored women survivors' relational and sexual experiences within broader contexts of interpersonal and family functioning (Rumstein-McKean & Hunsley, 2001) or resilience and healing (Draucker et al., 2009; Marriott et al., 2014), or focused on interpersonal distress within intimate relationships (Davis & Petretic-Jackson, 2000) or relational and sexual recovery processes (Guyon et al., 2020).

This systematic review of women survivors' perceptions and experiences of partner relationships aims to build on current literature. A similar systematic review (Weetman et al., 2021) explored men survivors' experiences in partner relationships. However, given differences between men and women survivors' reported experiences of CSA and resulting short- and long-term effects (Artz et al., 2016), it is important to conduct a systematic review focusing specifically on women survivors' experiences to identify shared as well as unique experiences. This systematic review is expected to inform clinical practice because interpersonal difficulties and distress

are common reasons that people seek help from psychotherapeutic services (Mailing et al., 1995).

Current review

The aim of this systematic review and meta-synthesis was to synthesise empirical qualitative literature to answer the following question: What experiences do women CSA survivors describe in their adult partner relationships? The review defines partner relationships as including experiences within and towards partner relationships and partners, as well as experiences relating to sexuality and sexual orientation.

Method

Rationale for a meta-synthesis

Meta-syntheses are a range of approaches that aggregate and interpret existing qualitative literature on a phenomenon, allowing researchers to develop novel conceptual insights whilst preserving original meaning and interpretations within studies (Booth et al., 2016; Walsh & Downe, 2005). Using a meta-synthesis approach enabled a broad and thorough exploration of women CSA survivors' experiences of partner relationships, capturing experiences across different settings and contexts.

There is no recognised 'gold standard' approach for conducting meta-syntheses (Sim & Mengshoel, 2022; Walsh & Downe, 2005), reflecting different epistemological positions in qualitative research. The approach chosen was thematic synthesis (Thomas & Harden, 2008) because it is recommended for synthesising qualitative studies that are heterogeneous in epistemological and theoretical backgrounds, data collection approaches, and data analysis methods (Booth et al., 2016; Harden et al., 2018; see Table 5).

Search strategy

A systematic search of the literature was performed in February 2022. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines (Page et al., 2021) were consulted. Relevant items of the 27-item checklist for a systematic review using thematic synthesis were followed to perform and report this meta-synthesis.

Three electronic databases (PsycINFO, CINAHL and PubMed) were searched to identify relevant articles from earliest records until the search date. Database alerts were set up to retrieve newly published relevant studies (until 2nd August 2022). Studies were also identified through manual searches of reference lists of included studies, and of reference lists of pertinent reviews identified through the search.

The search strategy followed the Sample, Phenomenon of Interest, Design, Evaluation and Research method (SPIDER; Cooke et al., 2012; see Table 1). Subject headings and free-text words were combined using Boolean operators. Search terms were selected based on identified key terms in relevant published literature. Databases were searched using a combination of the following search terms: women, females, survivors, victims, childhood sexual abuse, interpersonal functioning, partner relationships, intimacy, sexuality, impact, lived experiences, and qualitative methods (see Table 2 for full search terms). Search terms were adapted for each database.

Initial scoping searches produced limited results and indicated that relevant data was 'hidden' within broader literature on survivors' lived experiences, consistent with a previous similar meta-synthesis (Weetman et al., 2021). Through consultation with an experienced academic librarian and in line with Weetman and colleagues' (2021) approach and recommendations for reviewing qualitative evidence (Cherry et al., 2017), a broader search strategy was developed to identify studies where relevant data was contained within broader literature. The full search terms and strategy used for PsycINFO is provided in Table 2 as an example. Searches were limited to peer-reviewed published articles in English.

Table 1. Search strategy using the SPIDER method (Cooke et al., 2012)

Element	Approach
Sample	Adult (18+ years) women survivors of CSA
Phenomenon of Interest	Experiences of partner relationships, including: cognitive, psychological, emotional, behavioural and sexual experiences in partner relationships and towards partners; sexual orientation; and sexuality
Design	Any qualitative research design and method, including questionnaires, interviews, focus groups, participant observation, case studies, ethnography, phenomenology, thematic analysis, content analysis, narrative analysis, grounded theory
Evaluation	Participants' lived experiences
Research type	Qualitative or mixed methods; empirical research; primary studies; published and peer-reviewed; in English language

Table 2. The final search terms and strategy

Database	Search terms
PsycINFO (ProQuest) (Advanced search)	wom?n or female* or feminin* or "female surviv*" or "female victim*" (all fields) AND (child* or infan* or juvenile* or adolescen* or youth* or teen* or "young person*" or "young people") AND ("sex* trauma*" or "sex* abuse*" or "sex* violence" or "sex* assault*" or "sex* molest*" or "sex* offen?e" or rape or incest) OR CSA or 'subject heading: pedophilia (explode, major)' (abstract) AND (subject heading search: "marriage and partner measures" (explode, major concept) or partner* or spouse or "significant other*" or couple* or relationship* or "romantic relationship*" or "partner relationship*" or "intimate relationship*" or "sex* partner*" or "couple relationship*" or "couple function*" or "partner function*" or "romantic function*" or "interpersonal function*" or "interpersonal relationship*" or intimacy or marriage or "marital function*" or "marital satisfaction" or "relationship quality" or "relationship satisfaction") OR ('subject heading: experiences (events) (major)' or "lived experience*" or effect* or impact*) (abstract) AND 'subject heading: qualitative methods (major)' or qualitative* or interview* or audiorecording* or "audio recording*" or narrativ* or thematic* or phenomenolog* or "focus group*" or "grounded theory" or discursiv* or discourse* or interpretat* or ethnograph* (all fields)

	Limits: Peer-reviewed, journal article, English only, female population, Qualitative study

** Searches using these search terms and this search strategy were also conducted in CINAHL plus with full-text (EBSCOhost) and PubMed. Search terms were adapted for each database. Specific search terms were omitted from a database search if this term yielded no additional results in this database search*

Screening and eligibility

Full inclusion and exclusion criteria are outlined in Table 3. Screening and selection occurred in three stages (see Table 4). During stages one and two, articles were screened by the first author (LG) by titles and abstracts, respectively, using criteria provided in Table 4. Stage three comprised the first author screening retained articles by full text according to additional criteria specified in Table 4.

Considerable effort was made to assess inclusion in studies which appeared relevant but used a mixed sample. When it was unclear if experiences of adult partner relationships related specifically to women CSA survivors (Chouliara & Narang, 2017; MacIntosh et al., 2016; Tummala-Narra et al., 2012), the first author contacted the paper's lead author to request clarification. Two responses were received; one contained the necessary clarifying information and because it met full inclusion criteria, was included (Tummala-Narra et al., 2012).

At each stage, a random 10% subset of records were independently screened by the second author, producing a 91-98% consistency rate. Discrepancies were resolved through discussion, and consensus with all authors was reached on final inclusion eligibility. The full screening process is illustrated in Figure 1.

Table 3. Eligibility criteria

Element	Included	Excluded
Sample	Adult (18+ years old)	Children and young people (17years and younger) only; unable to distinguish adult from children and young people's experiences
	Identifying as a woman	Identifying as men only; unable to distinguish women's from men's experiences
	Survivor of CSA (sexual trauma of any type occurring between ages of birth-18years, or as defined by the study as any type of sexual trauma occurring in infancy, childhood and/or adolescence)	Non-CSA survivors only (sexual trauma experienced only in adulthood and/or other types of abuse only); unable to distinguish CSA survivor experiences from non-CSA survivor experiences
Phenomenon of Interest	Studies where primary focus is on an aspect of partner relationships (see Table 1 for definition of partner relationships)	Studies where primary focus was not an aspect of partner relationships
	Sufficient data defined as an aspect of partner relationships found as a theme or sub-theme which includes how participants experienced, made sense and/or felt impacted (cognitively, emotionally, psychologically, behaviourally)	Insufficient data defined as an aspect of partner relationships not found as a theme or sub-theme, or the theme or sub-theme does not include how participants experienced, made sense and/or felt impacted (cognitively, emotionally, psychologically, behaviourally)
	Corroborated by participant quotes	Not corroborated by participant quotes
Design and method	Qualitative studies, or studies that used mixed-methods and provided the qualitative data	Quantitative studies, or studies that used mixed methods and did not provide the qualitative data
	Data collection methods include questionnaires, interviews, focus groups, participant observation, case studies, ethnography	No exclusions
	Any qualitative analytic approach including phenomenological, thematic, content, narrative, grounded theory	No exclusions

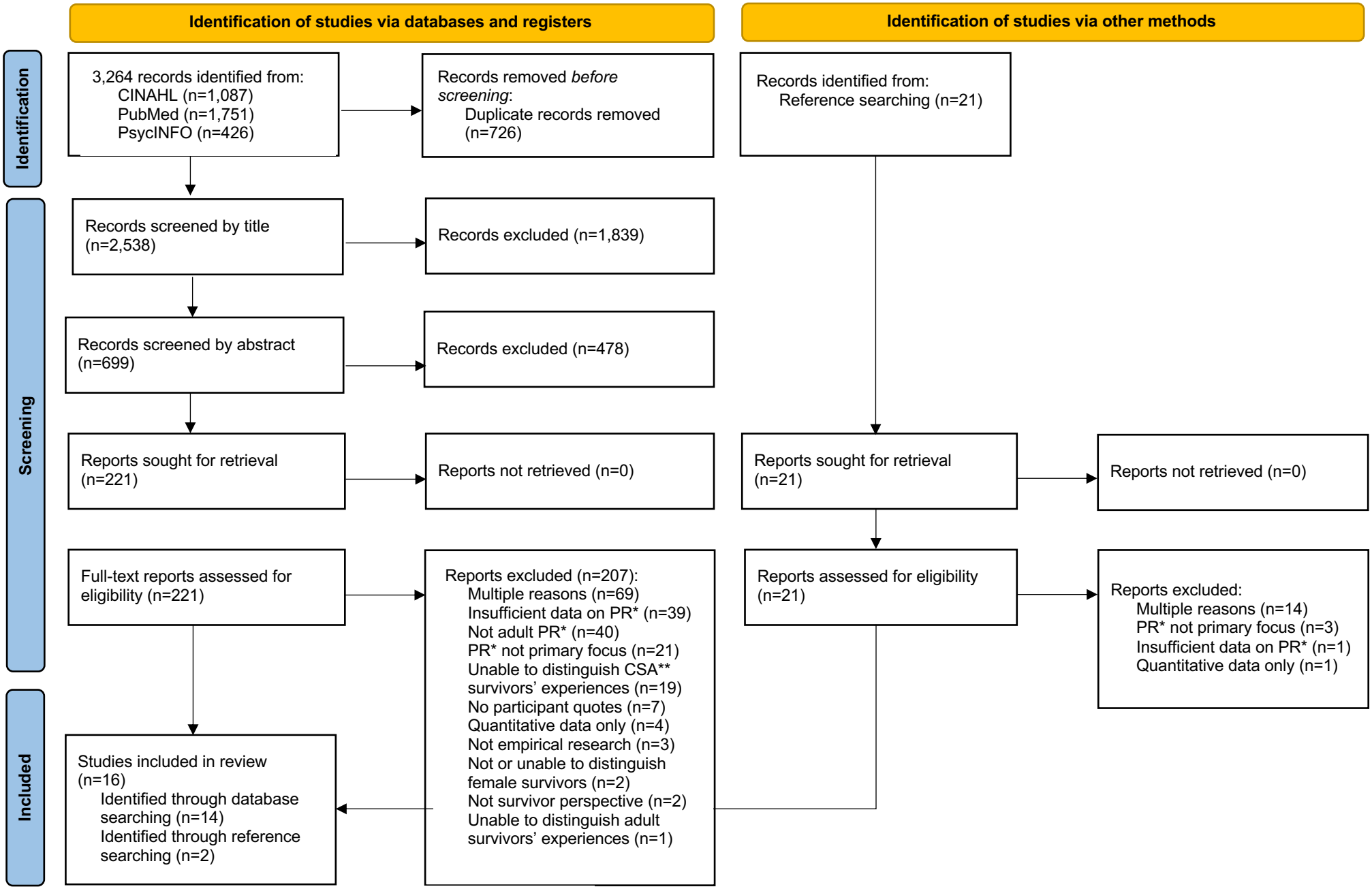
Evaluation	The survivors' perspective including first-person accounts	Non-survivor perspective, such as professional, partner, friend and/or family perspective
Research type	Empirical research	Not empirical research: reviews; case examples; book chapters and reviews; commentaries and editorials; conference proceedings; policy reports
	Primary studies	Secondary data studies
	Peer-reviewed published journal articles	Unpublished (grey) literature including unpublished dissertations and theses; non-peer reviewed published articles
	Studies available in English	Studies not available in English

Table 4. Stages of screening

Stage	Criteria
One and two	Articles were screened according to the following criteria: (i) Empirical primary qualitative study (ii) Sample which included adult (18 years+) self-identified women survivors of CSA (iii) Reported on an aspect of survivors' partner relationships or general relational experiences, or the impact of CSA, or survivors' lived experiences Articles that appeared relevant or where this was indeterminable were retained
Three	Articles were screened according to stage one and two criteria, with the additional criteria: (i) A primary focus on an aspect of partner relationships defined as experiences within and towards partner relationships and partners, participants' sexuality and/or their sexual orientation (ii) Sufficient experiential data on an aspect of partner relationships defined as being at the level of a theme or sub-theme and containing data on how participants experienced, made sense of and/or felt impacted (emotionally, psychologically, cognitively and/or behaviourally) by these experiences (iii) Corroborated by survivor quotes The inclusion criterion of studies with a primary focus on an aspect of partner relationships was adopted to ensure relevance and richness of data. The first author did, however, scan studies with a broader focus (e.g., exploring the impact of CSA or the lived experiences of adult female CSA survivors) that met the criteria of

	having sufficient experiential data on an aspect of partner relationships (n=21); no additional unique key codes or themes were identified suggesting conceptual saturation was reached.

Figure 1. Search strategy and outcome illustrated according to PRISMA 2020 guidelines (Page et al., 2021)



Note. PR* = partner relationships, CSA** = childhood sexual abuse

Data extraction

Key study characteristics and data were extracted (see Table 5) using a researcher-developed data extraction form (Appendix B). First-order data (participants' verbatim quotes) and second-order data (author(s)' interpretations) relating to women CSA survivors' experiences of partner relationships in adulthood were extracted from results and discussion sections. For studies with a mixed sample, only data that clearly related to women CSA survivors' experiences were extracted and included.

Quality appraisal

The Critical Appraisal Skills Programme (CASP, 2018) checklist for qualitative research was used to assess credibility, relevance, and methodological rigour of included studies. Quality ratings were computed based on Butler et al. (2016). Studies were appraised by the first author, and a random 25% sample were independently appraised by the third author, producing an 83% agreement rate. Final CASP scores were agreed through discussion. In line with recommendations for qualitative reviews (Siddaway et al., 2019), studies were not excluded based on quality scores because this can lead to excluding important findings.

Analytic procedure

Studies were repeatedly read by the first author prior to analysis to enable deep and active engagement. Thematic synthesis (Thomas & Harden, 2008) involved the first author following a three-stage procedure: (1) line-by-line coding of first- and second-order data according to content and meaning, (2) generation of descriptive themes through collating and refining codes, facilitated by cross-tabulating codes to develop common themes that translated across studies, (3) generation of analytical themes

through a cyclical and iterative process. The first author met regularly with the second and third authors who contributed to stages one and three. The second and third authors reviewed the full analytic process and these discussions helped shape the results.

Researcher reflexivity and rigour

Meta-syntheses require the interpretation of data which is inevitably influenced by researchers' subjectivities. To facilitate transparency, authors' positions are stated. As a trainee clinical psychologist, the first author has an interest in the relational experiences of survivors of inter-personal trauma and seven years of experience working with CSA survivors in NHS mental health and sexual trauma-specific services. The second and third authors are clinical psychologists with 30 and eight years of NHS experience working with CSA survivors, respectively. The research team have knowledge and professional experience in bearing witness to the sequelae of CSA and supporting survivors in their recovery. All authors are women, holding the position that CSA can have profound and long-lasting impacts, but that healing is possible through dynamic processes of coping and adaptation whereby survivors move towards self-defined recovery or survivorship, with some achieving post-traumatic growth (Tedeschi & Calhoun, 2004). It is recognised that these lenses may have influenced findings.

To increase analytic validity, researcher triangulation was used, and potential biases were identified and critically examined through supervision and reflexivity, aided by the first author's reflective journal.

Results

Database searches identified 3,264 articles. Following the removal of duplicates, 2,538 articles remained. Stage one screening by titles yielded 699 articles, stage two by abstracts provided 221 articles, and stage three by full text retained 14 articles. Hand-searching reference lists of relevant reviews (Draucker et al., 2009; Marriott et al., 2014) identified through database searches identified two additional eligible studies. Sixteen studies were therefore included in the final meta-synthesis (see Figure 1).

Summary of study and participant characteristics

Studies were given a 'study number' (see Table 5) and are referred to accordingly for the rest of the paper. Key participant, CSA and study characteristics are provided more fully for each study in Table 5, and across studies in Table 6.

Of the 16 included studies, six (1, 2, 6, 9, 11, 12) focused more broadly on survivors' partner relationships, sexuality and/or sexual orientation, with three specifically exploring experiences of survivors who identify as bisexual and/or lesbian (1, 6, 11). Three studies explored specific experiences or processes within partner relationships, including betrayal (5), CSA disclosure (3), and both partners' awareness of CSA effects and relational impacts (15). One study explored how survivors engage with CSA literature, particularly around sex (16). Two studies specifically explored rage: impact of CSA on rage and sexuality (10), and the intersects between trauma, rage, and violence towards partners (4). Two studies explored experiences of survivors engaged in psychological interventions: experiences in important relationships (14), and Emotionally Focused Therapy with

survivors and their partners (8). Two studies explored domestic violence survivors' (7) and substance misusers' (13) lived experiences, with CSA emerging as a common and important experience impacting partner relationships.

All studies used interviews to collect data except one which used case studies (8) and another which used an online questionnaire (11). Analysis approach and method varied, and included constant comparative (1, 10, 12, 14), grounded theory (15), phenomenological (3, 9), thematic analysis (8, 16), content analysis (2, 5, 11) and thematic content analysis (6). Three papers did not explicitly report analysis methods, but descriptions are suggestive of content analysis (13) and thematic analysis (4, 7). Study publication spanned 26 years (1995-2021), with most studies conducted in the United States (2, 3, 4, 9, 10, 11, 12, 14, 15) followed by Canada (1, 5, 8) and the United Kingdom (6, 13, 16), with one carried out in the Caribbean (7). Recruitment was mostly from community settings (1, 2, 5, 8, 11, 12, 16) followed by clinical settings (3, 10, 13, 14) or both (6, 9), with one study recruiting from a prison setting (4), one from an academic institution (15) and one where it was not clear (7).

The cumulative experiences of 283[1] survivors aged 18-64 years were included in this review. Participants' ethnicity was reported in ten studies (1, 2, 3, 4, 9, 10, 11, 12, 14, 15); although survivors' ethnicity could not be distinguished from the wider sample in one, which included participants who self-identified as White, African-American and Hispanic (4), and ethnicity was incompletely documented in another (2), which stated that most participants were of Black ethnicity. Of the remaining

[1] It is not possible to state the exact number of adult women CSA survivors included in this review because this number was not provided or discernible in one of the included studies (13; Singer,1995). The total number stated is derived from the total number of adult women CSA survivors across the remaining 15 papers

eight, survivors self- or were identified as White/Caucasian (n=110), African-American (n=25), “Person of Colour”, or Multi-racial (n=21), Canadian (n=14), European-American (n=12), Caribbean (n=4), North African (n=3), Hispanic (n=2), Eastern-European (n=2), European (n=1), First Nations (n=1), Israeli and Jewish (n=1), and Sephardic Jewish and Francophone (n=1). Participants’ sexual orientation was documented in nine papers (1, 3, 4, 5, 6, 9, 10, 13, 15); however, survivors’ sexual orientation could not be differentiated from the wider sample in two, which included participants who identified as heterosexual, homosexual/lesbian, bisexual, and having other sexual orientation(s) (4, 13). Of the other seven, 44 survivors identified as heterosexual, 18 as homosexual/lesbian, and one as “unsure, lesbian or bisexual”. Participants’ relationship status was detailed in eight studies (5, 7, 8, 9, 12, 13, 10, 15); although survivors’ were not distinguishable from the wider sample in two, which included participants who reported being single, partnered, married, having one regular sexual partner, and being separated/divorced (12, 13). Survivors’ relationship statuses included being in a relationship (n=33), single (n=11), married (n=8), divorced (n=5), and dating (n=1).

CSA details were reported in six studies (2, 3, 4, 5, 6, 7), and included sexual touch and/or digital/oral/vaginal/anal penetration. Age of onset was identified in six studies (1, 2, 4, 6, 7, 15), beginning as young as four years old. Duration was documented in three studies (1, 6, 9), spanning from one incident to 19 years. Three studies fully reported perpetrator(s)’ gender, with most being male (n=32, female: n=5; 1, 6, 10); one study provided incomplete details regarding perpetrator(s) gender, stating that two survivors had been abused by females (3). Four papers provided complete details on perpetrator(s) identities (1, 5, 6, 15), with most being a biological, adoptive

or step relative (n=33), followed by a friend or acquaintance (n=10), stranger (n=8), family friend (n=4), neighbour (n=3), person of authority (n=3), godfather (n=1), and housemother (n=1). Another three provided some details on perpetrator(s) identities, with two stating that most were relatives, family friends, people known in the community or a “nice guy” on the street (7, 13), and one stating that most perpetrator(s) in childhood were connected to the family, and in middle and late adolescence were outside of the family. At least 27 survivors reported multiple perpetrators (1, 2, 3, 6).

Table 5. Summaries of Key Participant and Study Characteristics by Study

ID	Authors, Date	Setting	Sample Characteristics and CSA Data	Research Aim	Design and Method	Summary of Key Findings Relating to Partner Relationships
1	Baker (2009)	Canada; community: LGB community organisations	- 10 Women CSA survivors - Aged 19-64 (mean=36.6 years) - Self-identified: White (n=1), Israeli and Jewish (n=1), First nations (n=1), Sephardic Jewish and Francophone (n=1), European-born, now Canadian (n=1), Canadian-born, Irish background (n=1), none (n=4) - Homosexual (n=9), "unsure, lesbian or bisexual" (n=1) - Perpetrator gender (male: n=17; female: n=3) - Perpetrator(s): Biological, adoptive or step relative (n=13), family friend (n=3), doctor (n=2), housemother (n=1), stranger (n=1) - Multiple perpetrators (n=6) - Age of CSA: before 13 years (n=10) - Duration of CSA: 1 incident – 19 years (mean=7.3 years)	To explore the interaction between being, or coming out as, a lesbian and healing from CSA	- Open-ended interview - Grounded phenomenological approach - Constant comparative method	For most, being or coming out as a lesbian further complicated healing from CSA. CSA interfered with survivors knowing, understanding, and accepting their sexual orientation. Most struggled with integrating CSA and lesbian identities. For about half, being in a lesbian partner relationship or "coming out" was healing, though a few had negative or abusive experiences in lesbian partner relationships
2	Clum et al. (2009)	United States; community: research network sites for HIV positive or at-risk adolescents	- 30 Women CSA survivors, from a sample that also included CPA survivors (n=10) - Aged 18-24 - Majority identified as Black - Perpetrator(s) in childhood mostly biological, adoptive or step relatives. Perpetrator(s) in middle and late adolescence mostly non-relatives, including boyfriends, friends, and acquaintances - Multiple perpetrators (n=11) - Age of CSA: before 12 years (n=19) - CSA: forced fondling, oral/vaginal/anal penetration	To explore the emotional, cognitive, and behavioural reactions to CSA and/or CPA, coping strategies and HIV risk behaviour, and how these factors intersect with partner relationships	- In-depth life story interview method - Content analysis	All reported difficulties in partner relationships and their sexuality, including distrust of men and their partners, impacted engagement in sexual activities, impacted sexual desire and pleasure, and sexual activities triggering CSA memories. Difficulties with sexuality and intimacy led to conflict in partner relationships

3	Del Castillo & O'Dougherty Wright (2009)	United States; clinical settings for CSA survivors and snowballing	- 7 Women CSA survivors - Aged 18-50 - Self-identified: Caucasian (n=5), Hispanic (n=2) - Heterosexual (n=7) - Perpetrator gender (female: n=2) - Multiple perpetrators (n=4) - CSA: fondling (n=2), digital penetration (n=2), "more severe" e.g., incest, intercourse (n=3)	To explore women CSA survivors' experiences of disclosing CSA to a romantic partner	- Semi-structured interview - Interpretative phenomenological analysis	The influence of CSA on identity, CSA intrusions in the partner relationship, and fear of disclosing CSA to a partner affected whether, what, when and how survivors disclosed CSA to a partner. All experienced at least one adverse response by a partner, and a negative impact on the relationship. However, the majority also experienced at least one positive response from a partner which was important in healing
4	Flemke (2009)	United States; urban medium secure prison treatment unit	- 13 Women CSA survivors, from a sample that also included survivors of other childhood trauma (n=24) - Aged 19-47 - Whole sample: self-identified: African-American (n=20), White (n=16), Hispanic (n=9) - Whole sample: heterosexual (n=27), bisexual (n=12), lesbian (n=2) - Age of CSA: began 7-13 years (n=6), not identified (n=7) - CSA: included touching of genitals, oral/vaginal/anal penetration	To explore how unresolved childhood trauma intersects with women's experiences of rage and violence towards intimate partners	- Two in-depth interviews - Feminist framework - Qualitative analysis, not specified but description suggestive of thematic analysis	Most women CSA survivors who expressed rage and violence towards a partner reported being triggered by unresolved emotions related to CSA and/or by memories or reminders of CSA
5	Guyon et al. (2021)	Canada; community: mailing list of a prevention programme for youths at risk of abusive relationships, flyers and word-of-mouth	- 19 Women CSA survivors - Aged 18-25 (mean=20.3 years) - Self-identified: Canadian (n=12), Caribbean (n=4), North African (n=3), Eastern European (n=2). Majority identified as Caucasian. - Heterosexual (n=19) - In a relationship (n=10), single (n=9) - Perpetrator(s): Friend or acquaintance (n=10), stranger (n=7), biological, adoptive or step relative (n=5), person of authority (n=1) - CSA: defined as unwanted sexual touch or	To explore issues related to betrayal by a partner for young women survivors of CSA	- Semi-structured interview - Content analysis	All reported impacted trust of men and their partner, and betrayal by a partner in adult partner relationships which echoed feelings of betrayal caused by CSA. Differences in how women coped with the effects of CSA and the effects of betrayal by a partner including hyperactivation, deactivation and ambivalence in relationships. These strategies affect emotional, relational, sexual, and

			penetration before 18 years - CSA: sexual touch (n=16), oral/vaginal/anal penetration (n=6)			physical intimacy towards a partner and in partner relationships
6	Hall (1999)	United Kingdom; clinical/ community: professional contacts, advertising in LGB press	- 8 Women CSA survivors - Aged 27-45 (mean=33.9 years) - Lesbian (n=8) - Perpetrator gender (male = 8) - Perpetrator(s): Relative (n=10), neighbour (n=3), godfather (n=1), family friend (n=1) - Multiple perpetrators (n=6) - Age of CSA: began 8-10 years - Duration of CSA: 1-7 years (mean=5.1 years) - CSA: contact (n=8), oral/vaginal/anal penetration (n=5)	To explore the sexual relationships of lesbian survivors of male-perpetrated CSA	- Interview - Phenomenological approach - Thematic content analysis	Majority experienced difficulties in sexual relationships including difficulty acknowledging and expressing sexual needs, difficulty differentiating sex and love, and CSA memories triggered by sexual experiences. Women whose partner was also a CSA survivor described the CSA always being present as well as a fear of initiating sex and replicating abuse. A few had experienced re-victimisation by a woman partner. Some experienced greater sexual freedom and satisfaction with a woman partner
7	Jeremiah et al. (2017)	Caribbean; unclear: women associated with a domestic violence programme	- 5 Women CSA survivors, from a sample that also included survivors of domestic violence in adulthood and/or ACEs (n=4) - Aged 27-34 (mean=28 years) - Married (n=1), in a relationship (n=2), single (n=1), not identified (n=1) - Perpetrator(s): mostly relatives or someone known in community - Age of CSA: began 10-13 years - Duration of CSA: most reported multiple episodes spanning childhood and adolescence - CSA: sexual touch (n=1), oral/vaginal/anal penetration (n=5)	To explore the lived experiences and presence of ACEs including CSA of women associated with a domestic violence programme	- Semi-structured life-history interview - Critical ethnographic approach - Qualitative analysis, not specified but description suggestive of thematic analysis	More than half of women in domestically violent partner relationships in adulthood had experienced CSA. Cultural and structural factors as well as longstanding effects of CSA identified as making sense of this link. Women CSA survivors described wanting love and protection that was absent in childhood and a lack of understanding as to healthy relationships that made them vulnerable to abusive partner relationships in adulthood
8	MacIntosh & Johnson (2008)	Canada; community: women CSA survivors and their partners	- 10 Women CSA survivors, from a sample that also included their partners (n=10) - Age: mean=40.5 years - In a relationship (n=10) - CSA: defined as sexual touch before 18	To explore the use of Emotionally Focused Therapy for couples with	- Case-Study Replication - Thematic analysis	Most experienced difficulties with feeling, expressing, regulating, and coping with emotions triggered by their partner's needs or the relationship, and with low self-worth

		accessing couple therapy recruited through local media and community agencies	years by someone ≥ 2 years older. Most experienced chronic, severe, and early intrafamilial CSA	CSA survivors and their partners		which affected the relationship. The majority struggled with hypervigilance and difficulties with trust towards their partner. CSA also impacted women's' sexuality, with sex believed to be wrong and triggering CSA memories, which impacted the relationship. Women reported needing to be in control in sex and for emotional intimacy first. Therapy helped women CSA survivors and their partners to make positive changes
9	Newsom & Myers-Bowman (2017)	United States; clinical/ community: recruited through therapists/ counsellors, religious organisations, and snowballing	- 6 Women CSA survivors - Aged 22-53 (mean=40 years) - Self-identified: White American (n=6) - Heterosexual (n=6) - In an intimate sexual relationship with a partner (n=6): married (n=5), dating (n=1) - Duration of CSA: 1-16 years (mean=6.8 years) - CSA: defined as inappropriate sexual activities, molestation or rape as a child, occurring 5 or more times over at least 1 year	To explore how women survivors of CSA understand and experience resilience, intimate relationships, and sexuality	- Open-ended interview - Phenomenological approach and analysis	All emphasised the role of partner relationships in moving towards resilience and this being a journey. This involved recognising and challenging dysfunctional understandings and expectations of partner relationships as a result of CSA, such as abuse and aggression, and developing healthy partner relationships through developing trust, respect, and emotional intimacy before a sexual relationship. Forgiveness and reframing sex were important in developing a healthy sexual self-concept
10	Painter & Howell (1999)	United States; clinical: recruited through private therapists	- 7 Women CSA survivors - Aged 18-46 - Euro-American (n=6), African American (n=1) - Heterosexual (n=7) - Married (n=1), divorced (n=5), single (n=1) - Perpetrator gender (male: n=7, female: n=2) - CSA: defined as including fondling,	To explore the impact of rage on sexuality in women CSA survivors	- Guided interview - Phenomenological approach - Constant comparative method	Most women reported a negative sense of self and internalising the emotional effects of CSA, specifically anger and rage which often led to compliancy or shutting down in partner relationships, but that their partner would trigger rage often around issues of control. Majority identified that patterns of abuse were recreated in their adult partner

			exhibitionism, rape, and/or exploitation through prostitution or pornography			relationships. They also described difficulties in trust towards men and partners and an impacted sexuality. Therapy helped women CSA survivors identify and manage the effects of CSA, including identifying and changing patterns in choice of partner and in partner relationships
11	Robohm et al. (2003)	United States; community: recruited online through national LGB college organisations and snowballing	- 86 Women CSA survivors - Aged 18-23 (mean=20.4 years) - Self-identified: White (n=67), "person of colour or mixed-race" (n=19) - CSA defined as encouraged/forced sexual contact <18 years by someone 5 years older and perceived as being more powerful	To explore lesbian and bisexual young women CSA survivors' wellbeing and their experiences of sexuality and "coming out" in relation to CSA	- Online questionnaire, containing quantitative and qualitative items - Content analysis of qualitative items	Almost half indicated CSA had affected their feelings about their sexuality, sexual orientation and/or "coming out". Women identified that CSA impacted the developmental awareness and their experiences of their sexual orientation, "coming out" and/or sexuality, including understanding and accepting these. They also reported that CSA had negatively affected their relationships with men and male sexuality, including experiencing fear and difficulties with trust. For some, being in a partner relationship with a woman felt safer
12	Roller et al. (2009)	United States; community: adaptive sampling involving community canvassing and posting flyers, and meeting with community leaders and members	- 48 Women CSA survivors, from a sample that also included men CSA survivors (n=47) - Whole sample: aged 18-62 - Self-identified: African American (n=24), Caucasian (n=19), multi-racial (n=2), not reported (n=3) - Whole sample: Single (n=53), married (n=17), partnered (n=1), separated/divorced (n=16), not reported (n=7)	To explore the processes by which CSA influences survivors' sexuality throughout their lives	- Open ended interview - Constant comparative method - Grounded theory	Most women CSA survivors felt CSA had impacted their sexuality, including being 'hyper-sexual' or avoiding sexual behaviours or partner relationships due to being fearful or mistrustful of men. Many felt CSA affected their sexual sense of self, including feeling shame, confusion and low self-esteem regarding their sexuality, and a few reported confusion around their sexual orientation. Making sense of the impact of CSA in relation to sexuality was a journey requiring

						effort, time, and emotional consequences, but for some facilitated positive changes in reclaiming sexuality and in partner relationships
13	Singer (1995)	United Kingdom; clinical: recruited through patients accessing hospital drug-related services	- Number of women CSA survivors not reported. Whole sample for analysis comprised 46 women (men: n=77), all of whom were drug users and most had a history of childhood trauma, which included CSA. - Whole sample: Mean age = 32 years - Women: Heterosexual (n=38), bisexual (n=13), other/not reported (n=6) - Women: One regular sexual partner (n=40), other/not reported (n=17) - Perpetrator(s): mostly relative, family friend and/or “nice guy” met on the street	To explore the role of drug users’ past and current life experiences in their HIV risk related sexual behaviours	- Structured interview comprising closed and open questions - Qualitative analysis, not specified but description suggestive of content analysis	Most women drug users reported a history of CSA, and most felt this had affected their sexuality and partner relationships, including low self-esteem, mistrusting and/or fearing men, an impacted enjoyment of sex, difficulties asserting needs and wishes in partner relationships, and vulnerability to re-victimisation. For some, sexual or partner relationships with women felt nicer and safer.
14	Tummala-Narra et al. (2012)	United States; clinical: recruited CT survivors engaged in trauma-informed individual/ group therapy from a hospital setting	- 12 Women CSA survivors, from a sample that also included men CSA survivors as well as women and men non-CSA trauma survivors (n=9) - Aged 25-58 (mean=41.6 years) - Self-identified: White (n=12)	To explore how survivors of CT who are engaged in treatment experience relationships with significant people in their lives	- In-depth interview - Narrative approach - Constant comparative method - Grounded theory	Most reported continuing to experience significant relational consequences of CSA whilst also experiencing positive changes/healing in partner relationships. Reported difficulties included difficulties with vulnerability and control, trust, and feeling safe. Positive changes included identifying and working through unhelpful relationship patterns, improved communication, mutuality, and boundaries, reconciling trust, and reclaiming power over their bodies.
15	Wiersma (2003)	United States; academic: recruited through university counselling	- 6 Women CSA survivors, from a sample that also included their partner (n=6) - Whole sample: Aged 19-27 (mean=23.5 years) - Survivors: European American (n=6) - Heterosexual (n=5), lesbian (n=1)	To explore both CSA survivors’ and their partner’s awareness of the effects of CSA and how it	- Semi-structured interview - Grounded theory	A number of factors emerged as either facilitating or impeding the CSA survivor’s and her partner’s awareness of the effects of CSA and its impact on the partner relationship. This included survivors’ own

		service therapists, through a university course announcement, and snowballing	- Married (n=1), cohabiting (n=2), non-cohabiting relationship (n=3) - Perpetrator(s): Parent (n=2), other relative (n=3), non-relative (n=1) - Age of CSA: began 4-9 years (mean=5.3 years) - Duration of CSA: ongoing (n=5)	impacts on the partner relationship		understanding of the effects and impact, and/or survivors' perceived ability and/or desire to communicate this to their partner, influenced by anticipated or actual unhelpful responses by partners. Disclosures varied according to mode, intention, amount, and accuracy. Some survivors reported engaging in unwanted sexual acts due to a sense of obligation. A lack of couple awareness related to the effects and impact of CSA was related to relationship conflict.
16	Woodiwiss (2008)	United Kingdom; community: recruited through articles in CSA society/ self-help group newsletters	- 16 Women CSA survivors, from a sample that included women who believed they had false memories of CSA regarding perpetrator identity (n=5)	To explore how women with "continuous, recovered or false" CSA memories engage with the CSA recovery literature particularly about sex	- Questionnaire and in-depth semi-structured interview or written account - Thematic analysis	Women reported sexual difficulties, including a lack of interest in sex, difficulty with sexual touch, avoidance of sex, difficulties with intimacy, confusing sex and love resulting in lots of sex without emotional intimacy, and having sex to please a partner. All used the literature to help make sense of their sexuality, and some used the literature to develop their sexual sense of self.

Note. ACEs = Adverse childhood experiences; CPA = Childhood physical abuse; CSA = Childhood sexual abuse; CT = Complex trauma; HIV = Human immunodeficiency viruses; LGB = Lesbian, gay and bisexual

Table 6. Summaries of Key Participant and Study Characteristics Across Studies

Characteristics		Summary (study number)
Study characteristics	Research focus	- 3 x focused on an aspect of partner relationships or partner relationships more generally in women CSA survivors: 1 x on sexuality (12), 1 x on resilience, sexuality, and partner relationships (9), x 1 on the intersects between CSA, HIV risk behaviour and partner relationships (2) - 1 x looked at how women with "continuous, recovered or false" CSA memories engaged with the CSA literature, particularly around sex (16) - 3 x specifically explored experiences of CSA survivors who identified as bisexual and/or lesbian regarding: their sexual relationships (6), sexuality and "coming out" (11), and sexual orientation, "coming out" and healing (1) - 2 x specifically explored rage, with 1 x looking at the impact of CSA on rage and sexuality (10), and 1 x at the intersects between trauma, rage, and violence towards intimate partners (4) - 3 x looked at specific experiences or processes within partner relationships for women CSA survivors, including betrayal by a partner (5), disclosing CSA to a partner (3), and the survivors and their partners' awareness of the effects of CSA and how these impact on their relationship (15) - 2 x explored the experiences of CSA survivors engaged in psychological interventions, with 1 x looking at survivors' experiences in important relationships (14), and 1 x the use of Emotionally Focused Therapy for women CSA survivors and their partners (8) - 2 x studies did not aim to explore the impact of CSA but rather lived experiences, with CSA emerging as a common and important experience from the data. 1 x explored the role of life experiences on drug users' sexual behaviours related to HIV risk (13), and the other looked at life experiences and adverse childhood experiences in women who were associated with a domestic violence programme (7) - 3 x papers used data that were collected as part of a larger study (5, 12, 13)
	Design	- 15 x Qualitative (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 15, 16) - 1 x Mixed-method (11)
	Data collection method	- 14 x Interviews (1, 2, 3, 4, 5, 6, 7, 9, 10, 12, 13, 14, 15, 16) - 1 x Case studies (8) - 1 x Online questionnaire (11)
	Data analysis method	- 4 x Constant comparative (1, 10, 12, 14), 1 x Grounded theory (15) - 3 x Content analysis (2, 5, 11) - 1 x Phenomenological (9), 1 x Interpretative phenomenological analysis (3) - 2 x Thematic analysis (8, 16), 1 x Thematic content analysis (6) - 3 x papers did not explicitly report analysis method, but descriptions are suggestive of Content analysis (13) and Thematic analysis (4, 7)

	Country	- 9 x United States (2, 3, 4, 9, 10, 11, 12, 14, 15) - 3 x Canada (1, 5, 8) - 3 x United Kingdom (6, 13, 16) - 1 x Caribbean (7)
	Recruitment setting	- 7 x Community (1, 2, 5, 8, 11, 12, 16) - 4 x Clinical (3, 10, 13, 14) - 2 x Community and clinical (6, 9) - 1 x Prison (4) - 1 x Academic institution (15) - 1 x Unclear (7)
	Publication year	1995-2021
Participant characteristics	Number	283*
	Age	18-64 years
	Racial and Ethnic identity	- Women CSA survivors' racial and ethnic identity was fully reported in eight papers. Self- or were identified as: 110 x White/Caucasian, 25 x African American, 21 x "Person of Colour", or multi-racial, 14 x Canadian, 12 x European-American, 4 x Caribbean, 3 x North African, 2 x Hispanic, 2 x Eastern-European, 1 x European, 1 x First Nations, 1 x Israeli and Jewish, 1 x Sephardic Jewish and Francophone (1, 3, 9, 10, 11, 12, 14, 15) - Women CSA survivors' racial and ethnic identity could not be distinguished from the wider sample in one study which included participants who self-identified as White, African American, and Hispanic (4) - Racial and ethnic identity was incompletely documented in one paper which stated that most participants were of Black ethnicity (2)
	Sexual orientation	- Women CSA survivors' sexual orientation was fully reported in seven papers. Self-identified as: 44 x heterosexual, 18 x homosexual/lesbian, 1 x "unsure, lesbian or bisexual" (1, 3, 5, 6, 9 ,10, 15) - Women CSA survivors' sexual orientation could not be differentiated from the wider sample in two studies which included participants who identified as heterosexual, homosexual/lesbian, bisexual, as well as having other sexual orientation(s) (4, 13)
	Relationship status	- Women CSA survivors' relationship status was fully reported in six papers: 33 x being in a relationship, 11 x single, 8 x married, 5 x divorced, 1 x dating (5, 7, 8, 9, 10, 15) - Women CSA survivors' relationship status could not be distinguished from the wider sample in two studies which included participants who reported being single, partnered, married, having one regular sexual partner, and being separated/divorced (12, 13)
CSA characteristics	Definition	- An operational definition of CSA was provided in five studies (5, 6, 8, 9, 10, 11)
	Nature	- Details of the nature of CSA experiences were reported in six studies (2, 3, 4, 5, 6, 7) which included sexual touch and/or digital/oral/vaginal/anal penetration

	Age of onset	- Age of CSA onset was identified in six studies (1, 2, 4, 6, 7, 15), with this beginning as young as four years old, and for 54 women survivors, starting aged 13 years or younger
	Duration	- CSA duration was documented in three studies (1, 6, 9) and spanned from one incident-19 years (means: 5.1-7.3 years)
	Perpetrator(s) gender	- Perpetrator gender was fully reported in three studies. Most were male (n=32; female: n=5) (1, 6, 10) - Perpetrator gender was incompletely reported in one study, stating that two survivors were abused by female perpetrators (3)
	Perpetrator(s) identity	- Perpetrator identity was provided in four studies. Most were a biological, adoptive or step relative (n=33), followed by a friend or acquaintance (n=10), stranger (n=8), family friend (n=4), neighbour (n=3), person of authority (n=3), godfather (n=1), and housemother (n=1) (1, 5, 6, 15) - Two studies stated that most perpetrators were relatives, a family friend, someone known in the community or a “nice guy” on the street (7, 13) - One study stated that most perpetrators in childhood were connected to the family and most in middle and late adolescence were outside of the family (2)
	Number of perpetrators	- At least 27 x reported multiple perpetrators (1, 2, 3, 6)

Note: CSA = Childhood sexual abuse; HIV = Human immunodeficiency viruses

*It is not possible to state the exact number of adult women CSA survivors included in this review because this number was not provided or discernible in one of the included studies (13; Singer, 1995). The total number stated is derived from the total number of adult women CSA survivors across the remaining 15 included papers

Quality appraisal

Results of the quality appraisal for all 16 included studies are reported in Table 7. Most papers were considered of adequate quality, with six rated high and five moderate. Five studies were rated low. Strengths of the studies were that most authors provided a clear and appropriate rationale for the chosen methodology and design, consistent with the study aims, and most studies reported clear findings that contribute valuably to the literature. All studies provided at least partially sufficient details of data collection method and all except three (10, 13,16) of the data analysis process to enable rigour to be assessed. The most common methodological weakness was that most studies did not explicitly demonstrate that researchers had critically considered their own position. This is important as researcher reflexivity is essential in ensuring high quality research (Dodgson, 2019). Additional common weaknesses included brief or partial reporting of researchers' considerations of ethical issues and recruitment strategies, including omitting details of ethical approvals and details regarding rates and reasons for non-participation. These issues are especially important given the sensitivity of the research area.

Of the five studies rated low quality, common additional weaknesses included research conducted by single author and analyst with it not being clear how validity and credibility of findings were ensured. Robohm and colleagues (2003; 11) utilised a mixed-methods approach incorporating one questionnaire item to elicit qualitative data, precluding in-depth analysis. Painter and Howell's (1999; 10) paper had insufficient detail in many areas to allow appraisal of research quality, which may reflect changing reporting standards. Acknowledging these weaknesses is especially important because Painter and Howell's (1999; 10) study contributed a relatively

large amount of data to the review. Yet, importantly, none of the five low quality studies provided anomalous findings, with findings supported by other included studies. Other studies which contributed the most data to the review were rated as high (3) and moderate (5, 15) quality.

Table 7. Qualitative Appraisal of Included Studies Using the Critical Appraisal Skills Programme Checklist (CASP, 2018)

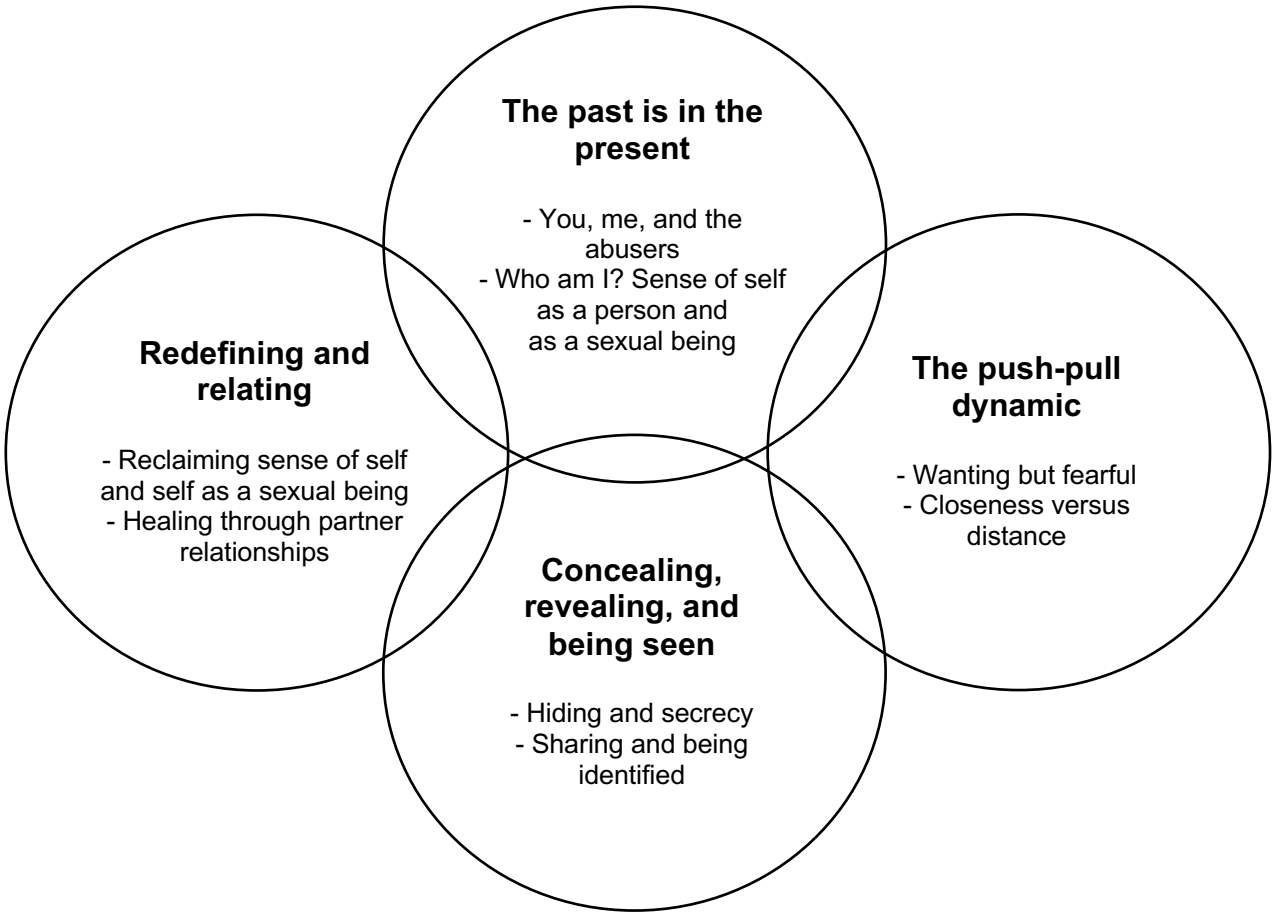
ID	Study	Aims	Method	Design	Recruitment	Data Collection	Bias Considered	Ethics Considered	Data Analysis	Findings	Value	Quality
1	Baker (2009)	Yes	Yes	Yes	Yes	Yes	No	Somewhat	Somewhat	Somewhat	Somewhat	Low
2	Clum et al. (2009)	Yes	Yes	Yes	Yes	Yes	Somewhat	Yes	Yes	Yes	Yes	High
3	Del Castillo & O'Dougherty Wright (2009)	Yes	Yes	Yes	Yes	Yes	Somewhat	Yes	Yes	Yes	Yes	High
4	Flemke (2009)	Yes	Yes	Yes	Somewhat	Yes	Somewhat	Yes	Somewhat	Can't tell	Yes	Moderate
5	Guyon et al. (2021)	Yes	Yes	Yes	Somewhat	Yes	No	Yes	Yes	Yes	Yes	Moderate
6	Hall (1999)	Yes	Yes	Yes	Yes	Somewhat	Somewhat	Yes	Can't tell	Somewhat	Somewhat	Moderate
7	Jeremiah et al. (2017)	Yes	Yes	Yes	Can't tell	Yes	Yes	Can't tell	Yes	Yes	Yes	High
8	MacIntosh & Johnson (2008)	Yes	Yes	Yes	Somewhat	Yes	Yes	Can't tell	Yes	Yes	Yes	High
9	Newsom & Myers-Bowman (2017)	Yes	Yes	Yes	Somewhat	Yes	No	Yes	Somewhat	Yes	Yes	Moderate
10	Painter & Howell (1999)	Yes	Yes	Can't tell	Somewhat	Somewhat	No	Yes	No	Somewhat	Yes	Low
11	Robohm et al. (2003)	Yes	Somewhat	Can't tell	Yes	Yes	Can't tell	Somewhat	Somewhat	Somewhat	Yes	Low
12	Roller et al. (2009)	Yes	Yes	Yes	Somewhat	Yes	Can't tell	Yes	Yes	Yes	Yes	High
13	Singer (1995)	Yes	Yes	Can't tell	Can't tell	Somewhat	No	Somewhat	No	Somewhat	Yes	Low
14	Tummala-Narra et al. (2012)	Yes	Yes	Yes	Yes	Yes	Somewhat	Yes	Yes	Yes	Yes	High
15	Wiersma (2003)	Yes	Yes	Can't tell	Yes	Somewhat	Somewhat	Can't tell	Yes	Yes	Yes	Moderate
16	Woodiwiss (2008)	Yes	Yes	Yes	Somewhat	Somewhat	No	Can't tell	No	Somewhat	Somewhat	Low

Note. CASP (2018) questions in full: (1) Aims: Was there a clear statement of the aims of the research? (2) Method: Was a qualitative methodology appropriate? (3) Design: Was the research design appropriate to address the aims of the research? (4) Recruitment: Was the recruitment strategy appropriate to the aims of the research? (5) Data collection: Was the data collected in a way that addressed the research question? (6) Bias considered: Has the relationship between researcher and participants been adequately considered? (7) Ethics considered: Have ethical issues been taken into consideration? (8) Data analysis: Was the data analysis sufficiently rigorous? (9) Findings: Is there a clear statement of findings? (10) Value: How valuable is the research? Scoring system: “Yes” = 1 point; “somewhat”; “can’t Tell” = 0.5 points; “no’ = 0 points; total scores: 9–10 = high quality; 7.5–8.5 = moderate quality; 7 and under = low quality

Thematic synthesis findings

The meta-synthesis produced four inter-related themes (Figure 2) capturing the complexity and diversity of survivors' sexual and relational lives. The relative endorsement of themes and sub-themes across studies is shown in Table 8.

Figure 2. Themes and sub-themes



1. The past is in the present

This theme captures the extent to which CSA continued to influence the present. For some, CSA would "*resurface*"[2] (15, p.159), for others, it had a constant influence on

[2] Italicised quotes represent first-order data (i.e., original study participants verbatim quotes) Non-italicised quotes represent second-order data (i.e., original study author(s) interpretations)

them, "*It's always on my mind*" (13, p.242) and their partner relationships, *"...it's lingering around us […] in between us […] always going to be a part of me and therefore us…"* (3, p.393). CSA impacted survivors' partner relationships through CSA memories and effects entering relational/sexual spheres, re-enactments and replications of CSA dynamics and patterns, and through affecting survivors' identities.

1a. You, me, and the abusers

CSA directly entered many participants' partner relationships through flashbacks and other intrusions (1, 3-4, 6) with various triggers identified, particularly smell (3-4), "…*smell of alcohol on my partner's breath […] I re-live the rape moment…*" (4, p.134). Sexual or intimate acts were often a time "the past comes flooding back"[2] (6, p.66; 2-3). CSA permeating partner relationships was especially prominent when both partners were survivors, mostly reported in same-sex partner relationships. For these survivors it felt like "the abuse never went away" (6, p.67).

CSA-related emotions and feelings were commonly carried into adulthood and included: helplessness (7-8), shame (7-8), disgust (2), anxiety (2, 13), fear/terror (2, 4, 10), and rage (3-4, 10). Despite attempts at disavowing these, CSA-related emotions often impacted survivors' partner relationships (4, 7-8, 10) and sexual lives, particularly disgust (2), anxiety (2), fear (2), and rage (4, 10), "*rage was just so tied into my sexuality*…" (10, p.9). For some, CSA-related rage was misdirected towards partners (4, 10), often through being reminded of abuser(s), *"…when I'm with my partner, I see my father's [abuser] face, but the rage is directed toward my partner..."*

(4, p.133). For a few, this led to violence towards partners (4). In these instances, survivors occupied positions of both victim and abuser.

CSA memories and emotions were also triggered through re-enactments of CSA dynamics within partner relationships (1, 10). Feeling objectified led some to experience rage towards partners, "…*when it feels like I'm only about sex, that's when I get angry. There's another part of me that I want people to know or love…"* (10, p.11). For some, CSA memories and emotions were activated by power and control (1, 10), "*… male in their way of being sexual […] sent me into like flashback hell…*" (1, p.41), however this relationship was sometimes complex and confusing. For example, through being dominated sexually by a partner, one survivor "felt her rage could be triggered and then expressed within safe boundaries" (10, p.12) but this was also "wounding" (10, p.12) as it reminded her of CSA, "…*kind of slip[s] back and forth from history to the present*" (10, p.12).

Partners' responses to CSA disclosure sometimes mirrored abuse dynamics and re-activated and reinforced CSA-associated feelings, such as self-blame, shame, and objectification (3, 8, 15). This included "*sexualising*" (3, p.398) the abuse, showing "*intrigue*" (3, p.398) about survivors' sexual orientation, a perceived pressuring to have sex as encouragement to "desensitize" (3, p.397) from CSA effects, and perceived attribution of blame or complicity, for example, "well you remained in that [abuse], you must have liked it" (3, p. 397). Other responses were more subtle or less intentional, such as a lack of response which reinforced survivors' minimisation of CSA (3), or through reinforcing a victim identity (3).

CSA significantly impacted survivors' schemas (i.e., cognitive frameworks) about their relational selves, "…*I'm too much. I'm too messed up and can't have a normal relationship*…" (8, p.307) and partner relationship, "*...I expected anger […] I expected physical violence, I expected emotional violence…"* (9, p.936). Such schemas affected survivors' choice of partner, making them vulnerable to further abuse (4, 5, 7, 9-10, 13-14). These patterns reflected what was "*normal*" (9, p.936) or familiar (13), or were attempts to resolve or "overcome" (10, p.13) CSA effects. Other survivors felt "powerless" (13, p.243) in changing relational patterns. For others, abusive partner relationships represented attempts to attain feelings absent during childhood, feeling loved, cared for and/or protected (7, 9) with abuse being confused with these feelings, "…*I felt more comfortable and appreciated when he [partner] was being abusive because his abuse made me feel like he really cared and wanted me in ways that I wish someone would have helped me as a kid"* (7, p.57). Needing to feel loved and protected led some to minimise or excuse a partner's abusive behaviour, "…*I know at times he does not mean it when he slaps me around, but he promised to protect me in ways that no one ever has promised me…*" (7, p.57; 13).

1b. Who am I? Sense of self as a person and as a sexual being

Understanding the impact of CSA on the sense of self was commonly experienced as complex, confusing, and effortful (1, 3, 6, 8-9, 11, 12-13, 16). For some, CSA had a profound negative impact on their global self-concept, defining themselves as "*damaged goods*" (8, p.307), "*screwed up*" (3, p.395), "*messed up*" (8, p.307) or "unlovable" (8, p.307). These self-definitions contributed to negative and unhelpful beliefs and expectations about their capacity for healthy and successful partner

relationships (8). A fragmented sense of self was common, with many placing CSA and its effects at the centre of their identity and hiding or burying other parts of themselves. For some, being a CSA victim or survivor was "*everything*" (1, p. 37; 3, p.393) about who they were, whereas for others, sex was perceived as their worth or value (9, 12-13), *"…I always think people don't like me if I don't have sex with them…"* (13, p.242). Some managed negative or fragmented sense of selves through becoming who they perceived their partner wanted them to be, creating an unstable and/or enmeshed identity.

Impacted sexuality was frequently reported across studies. For some, their sexual selves felt 'taken away' by CSA (10, 12, 16) and for others, their sexual desire or pleasure had been negatively affected (2, 6, 13, 15-16). Pain (2, 9), flashbacks (2-3, 6), emotional numbing (2) or dissociating (1, 6, 10) during sex, were commonly reported and had "negative repercussions on sexual arousal and satisfaction" (6, p.66) and restricted survivors' motivation for sexual intimacy (6). Some avoided specific sexual acts, and others, sex, "…*we rarely had sex, rarely, rarely. […] Because then my past will come up*" (2, p.1762).

Other survivors experienced sexual feelings or desire, but "denied" (6, p.65), or perceived this as "unimportant" (1, p.36) or wrong, "*I had sexual feelings but I felt that sex was dirty […] Instead of feeling the abuse was wrong, I felt sex was wrong. Even having sexual feelings was wrong […] I felt that having sexual feelings meant that I'd wanted the abuse to happen*" (6, p.65). For these survivors, CSA-related feelings of shame, guilt, blame, and disgust were carried into adulthood and were barriers to accepting their sexuality. Contrastingly, some survivors connected with

their sexuality, experiencing sexual pleasure through themselves (16) or within partner relationships, *"…[CSA and sexuality] do not live in the same place inside of me. They do not interact. I have...very clear, very grounded, very sexual experiences with my partner…"* (1, p.42).

Experiencing CSA "created considerable interference in [survivors'] attempts to know and accept their sexual orientation" (1, p.36; 6, 11-13), eliciting confusion and uncertainty, "…*I'm not only just a lesbian, now. And I'm not only just a survivor now. But I don't really think I've quite coalesced how the identities interact, fuse, or what that whole business is*" (1, p.37) and for some, created emotional turmoil, "*…whether or not I really am attracted to women […] I wish I could know how I would feel if I weren't abused as a child–as I was meant to feel, without having been messed with"* (11, p.42). Some achieved a form of negotiation between their sexual orientation and CSA identities, feeling that CSA had contributed to their sexual feelings and/or orientation (1, 11, 13) or that their sexual orientation was separate to their experiences of CSA (11). Survivors' knowing, understanding and acceptance of their sexual orientation was complicated by "internalised homophobia" (1, p.43; 6, 11) and the social stereotype that "women are lesbians because they fear, hate, or simply have not met the right man or men" (1, p.36; 11), leading some to 'deny', "*dismiss"* (11, p.41) and/or "*justify*" (11, p.42) non-heterosexual feelings or orientations, reflecting heteronormativity.

2. The push-pull dynamic

This theme highlights ambivalence and tensions that survivors experienced in navigating intimacy within partner relationships. Human needs of connection,

proximity and care were evident, with many needing to regain trust and security taken by CSA through a "redeeming relationship" (5, NP11522) with a partner. Yet these needs often coexisted with emotional, physical, and/or sexual intimacy confusion, fears and difficulties related to CSA. Survivors used a range of strategies to navigate these relational challenges.

2a. Wanting but fearful

Wanting to be loved, and to feel valued and close with a partner was common but for many this remained difficult to achieve or trust fully (1, 2, 5-10, 11, 13-14). Receiving love and allowing themselves to be loved was unfamiliar for some and difficult to navigate, "…*the hardest thing for me to deal with was, like, being loved…I will love you to pieces, but just don't love me back too hard, 'cause I don't* know *what to do with it!"* (1, p.38). Believing that a partner will hurt them, let them down or betray them was expressed by many and seemed to represent attempts to protect from future disappointment or humiliation. This often led to hypervigilance towards partners (5, 8) as survivors "wait[ed] for something to go wrong*"* (8, p.307). Ambivalence between wanting emotional intimacy and safety but believing this was not possible was common, "…*I know he can't be there for me. I want to but I can't…"* (8, p.308).

Believing that a partner will hurt them was often borne from difficulties with trust (2, 5, 7-9, 11-13). Mistrust was reported towards people (13), men (2, 11-12), "no man can be trusted" (2, p.1760), and partners specifically (2, 5, 8-9), "I will never trust him/her" (8, p.308). Survivors' terror that their partner might betray their trust continued "in the face of ongoing fidelity, support, reassurance, and in some cases

heroic efforts to prove their trustworthiness" (8, p.308). Yet, for many, mistrust and fear coexisted with wanting to be seen and valued romantically, *"I don't trust men. I'm always wondering when they are going to want the sex. Come over…have sex…leave…That's what happened to me when I was a kid […] I need for someone to know me in other ways than just sex…"* (10, p.14).

2b. Closeness versus distance

Survivors tried to navigate or resolve these tensions through strategies that reduced or increased emotional and/or physical distance with partners and within partner relationships (1-2, 5-6, 8-10, 12-16). For some, attempts to regain trust, security and love taken by CSA led to "over-invest[ing]" (5, NP11519) in partner relationships, often marked by reducing emotional and/or physical distance through increased dependency and enmeshment in partner relationships and not remaining single for long (5). Needing a partner and trying to achieve closeness were often attempts to mitigate fears of abandonment, *"…I'm a bit afraid of abandonment in life so I need someone to reassure me […] to take care of me*" (5, NP11519). Perceived or actual loss of a partner was highly threatening, leading some to minimise unhealthy behaviours such as violence or betrayal (5, 7, 13) and focus on positives to preserve relationships (5).

Confusion between emotional and sexual intimacy was a common struggle leading some to "perceive sexuality as a strategy to obtain the attention or affection of a romantic partner" (5, NP11523; 2, 6, 12, 15). This presented as sexual behaviour at an early age, with many partners and/or early into relationships. For others, sex served to regulate emotions (2), achieve a felt sense of value (2, 5), obtain material

rewards (2, 13) or "regain [power and] control over their sexual life, which was violated during the CSA" (5, NP11523). For some, sexualising relationships facilitated the attainment of attention and proximity while remaining emotionally detached or avoiding the vulnerability inherent in emotional intimacy, "…*fell obsessively in love over and over again, a kind of love and sex addiction with no real intimacy*" (16, p.353). However, over-investing in sexuality had costs. Many felt or were labelled "*promiscuous*" (16, p.353; 12, p.52), which conflicted with their "*worldview"* (9, p.938) and/or sense of themselves (2), and some felt "objectified" (5, NP11521) resulting in feelings of shame (9). Sexualising relationships also exacerbated unmet needs of feeling seen, cared for, and loved, "…*a longing for love and attention got mixed up with sex and led me into repetitive short-term affairs that never developed into the relationship I craved"* (16, p.353).

Conversely, some navigated relational ambivalence and conflicts by increasing emotional and/or physical distance, through being "guard[ed]" (5, NP11516), distan[t] (5, NP11516), independent and under-investing in partner relationships (5). For some, realising they had over-invested in previous relationships and had "*lost*" (5, NP11518) themselves led to withdrawing and disinvesting in current and future partner relationships (5) or changing relational boundaries, "*I went from having no boundaries to having every boundary there was, and I wasn't letting anyone else in…"* (10, p.13). This served to protect from terror of further hurt, *"It's too dangerous for me to let my wall down. It's going to get slammed"* (8, p.308).

For some, distancing strategies were in response to physical affection, believing this would inevitably lead to unwanted sex, *"…hugging is not allowed, no way – if I let her*

get too close and be affectionate it would mean sex eventually. I don't want sex, so I push her away…" (6, p.66; 5). Others "no longer felt like they could handle the relationship" (10, p.14) once it became sexual and so ended it. Some avoided partner relationships altogether because they wanted to "*avoid all sexual contact"* (10, p.14) or wanted to protect from further hurt, *"…I've been through so much I'd just rather like be by myself, stay by myself…"* (2, p.1762).

3. Concealing, revealing, and being seen

This theme captures the decisional processes survivors faced regarding revealing their CSA identity, and their own wishes, choices and needs within partner relationships. These processes were influenced by fears, anticipation, and expectations, and were associated with risks, costs, and benefits.

3a. Hiding and secrecy

The pain of CSA was universally carried into adulthood, yet most made significant attempts to deny or hide CSA and its effects from partners (1-8, 10, 15-16). The hidden nature of CSA often continued, with many "struggling in private" (3, p.392). Fear that their partner could/would not accept their CSA history, or expecting other unfavourable responses, reduced motivation to disclose (3, 15) and reflected survivors' internalised stigmatisation, projected onto their partner (3, 15). This included fear of "abandonment" (3, p.394), "*rejection*" (3, p.394), "judgment" (15, p.156), or concerns that their partner would not "*understand*" (3, p.395) or would be "disinterested" (15, p.157; 3). When survivors experienced an adverse response from a partner, further conversations about CSA were avoided and there was "increased fearfulness about disclosing in subsequent relationships" (3, p.395).

Hiding needs within partner relationships was also reported (5, 8), especially sexual needs (6, 10, 15-16). Difficulty in expressing and asserting sexual choices and limits, and a tendency to appease partners led some to initiate or participate in unwanted sex (6, 10, 15-16). Some had learnt "…*if a man asked me for something I was supposed to give it no matter what it did to me…*" (10, p.13) and for some, reflected a safety strategy, "…"*no" never worked*" (16, p.356). Others felt a "sense of duty" (6, p.65) or "obligation" (15, p.158) to their partner, reported in both same-sex and heterosexual partner relationships, even when their partner "never or rarely pressured them into having sex" (6, p.65). Difficulties with expressing and asserting sexual choices, anxieties and/or fears led some survivors to give "*mixed signals*" (16, p.357), and for some contributed to relationship conflict (2, 15). For others, difficulty expressing sexual needs and choices presented as "difficulty in telling sexual partners how best to give them sexual pleasure" (6, p.65). Sexual needs were often suppressed when both partners were CSA survivors out of fear of replicating the abuse and being seen as an "'abuser'": *"…I feel like I'm being abusive too…if I make the moves. I don't want her seeing me as an abuser […] sometimes easier just not to bother, but then I end up getting frustrated"* (6, p.66). Sexual discordance and dissatisfaction were commonly cited sources of relationship conflict for survivors and their partner (2, 8).

3b. Sharing and being identified

The processes by which survivors' CSA history and/or its sequelae were shared with partners were complex and varied by motivation, content, mode, perceived control, and intentionality (3, 15). Some felt like they had little choice in disclosing because of

the centrality of CSA, *"It was everything about who I was at that point…I was either in pain or I was enraged […] he had to know what that was about"* (3, p.393), as well as CSA directly entering partner relationships, such as through flashbacks during sexual intimacy (3, 15). Some felt "they gave off signs of having been abused" (3, p.400) and that their partner was somehow *"just very aware*" (15, p.156) and "*would see…or sense, or know somehow…*" (3, p.396; 15). For some, this provided strong affective motivations that marked the beginning of disclosure, feeling a need to verbally disclose, "…*put it into context*, *"well, this is why I am the way I am"…"* (3, p.396). Others felt that they had already shared CSA non-verbally through facial expressions or "*body language*" (15, p.158), suggesting a perceived lack of choice and control in sharing. Others disclosed by providing a "rough outline", "practic[ing] the speech*"* (3, p.396) or saying it "…*like it was something factual, like it was something I had seen on TV*" (3, p.396). Disclosing in more planned, selective ways afforded survivors a greater sense of control.

Survivors' experiences of sharing varied within and across partner relationships. Most reported at least one adverse response from a partner, reinforcing CSA-related feelings. Others expressed discomfort unrelated to their partner's response, feeling vulnerable and exposed, *"… I shouldn't have told him […] I think it's just because it's made me feel really insecure […] I don't think that he would ever do anything with it…"* (15, p.156). However, despite adverse experiences, most experienced at least one positive response to disclosure by a partner (3, 8-9, 15), which helped "contain aspects of the abuse experience that they [survivors] felt unable to endure alone" (3, p.398). 'Letting go' of the CSA secret along with supportive responses by a partner provided a context for healing.

4. Redefining and relating

This theme captures the processes experienced in healing from CSA. Developing a positive self-image and accepting and reclaiming a sexual self were highly important. Partner relationships helped survivors "achieve a new perspective on themselves" (14, p.647), providing important contexts for healing through "understanding [survivors'] experience of sexuality" (9, p.937). Healing was possible for many, characterised by deliberate and continued efforts including successes and failures, and negotiation of ongoing struggles alongside positive relational shifts and feelings of increased stability (6, 12, 14).

4a. Reclaiming sense of self and self as a sexual being

Becoming aware of and understanding the effects of CSA (9-10, 12, 14) and re-allocating blame to abuser(s) (9, 12) were central in developing self-compassion. This included making sense of previous sexual behaviours, *"…the promiscuity was one of the symptoms [of CSA] that…I realized"* (12, p.56; 9), and making sense of relationship patterns, for example, realising that CSA had led them "to look for love in all the wrong places" (12, p.56; 10, 14). This understanding helped survivors start to challenge unhelpful beliefs and expectations about themselves and partner relationships created through CSA (9-10) facilitating improved self-acceptance and self-worth, and in turn, progressing towards establishing healthier partner relationships (10, 14). Developing healthier boundaries (14) and acknowledging and asserting rights and choices outside and within partner relationships helped survivors reclaim their sense of self and develop healthier partner relationships, *"I would stay [in relationships] because I wanted to please them. Now I don't worry so much about*

pleasing them, I'm worried about how I feel…I worry about if it is good for me" (12, p.57). Needing to "*learn"* about themselves and *"know"* who they were (9, p.936) and experience themselves as "*complete and whole human being[s]*" (14, p.646) before entering partner relationships was emphasised by some. Changes in how survivors viewed themselves inevitably affected relationship choices, *"I've come to value myself and hopefully like myself more and want to be with someone who likes me and wants to be with me…"* (14, p.645).

Forgiving themselves for the effects of CSA was integral in reclaiming a sexual self, *"…I have forgiven myself…An honest look at the impact […] placing blame and responsibility where it belongs, physiological response does not indicate consent"* (9, p.938). Letting go of shame and guilt created by CSA and developing an identity beyond CSA victim or survivor was important for reclaiming sexuality, *"Seeing [my]self as more than an object and/or sexual victim. Acceptance of [my]self as a sexual being, not just a sliced off part of me that was taken…*" (9, p.938). For some, redefining themselves also involved reclaiming a feminine identity lost through CSA (1, 12).

As survivors forgave and redefined themselves, they began to differentiate between sex and abuse, and reconstructed sex: *"sex is desirable in romantic relationships. It is healthy for the most part* (9, p.938). Accepting and giving "*value*" (9, p.939) to sex resulted in giving themselves "*permission to be sexual…"* (9, p.940). Accepting their sexual selves also involved coming to know, accept and connect with their sexual orientation which, for some, was a "vital source of fun, joy, soothing, and distraction […] from the pain and labour of healing" (1, p. 42): *"it was ointment on my wounds.*

Because it was so sweet to my soul to feel alive, to feel sexual…" (1, p.42). For these survivors, reclaiming a sexual self involved a more active sexuality. However, for others, it involved "choosing temporary celibacy as a way to claim their right to determine when and with whom they would have sex" (12, p. 57).

4b. Healing through partner relationships

Several partner qualities were identified as important for healthy partner relationships and in survivors' healing. Being honest, trustworthy, and authentic were important for survivors to feel emotionally safe (9, 14). A partner who "*sees*" (1, p.38) and "*accepts*" (9, p.939) them for who they are, including their background of CSA, and being consistent and patient (9, 14) promoted healing. A partner having their own experience of trauma aided a deeper sense of understanding and acceptance for some survivors through having a "context of mutuality" (3, p.399).

Within partner relationships, many needed emotional intimacy before physical or sexual intimacy (8-9). Being "friends first" (9, p.937) helped develop trust, honesty, and open communication. Openly communicating their sexual wants, needs, fears and limits, including "*developing a no"* (9, p.944) and this being heard and respected by a partner helped survivors feel safe and "*empowered*" (9, p.937). Having control over sex (8, 10, 14) and sex being distinguishable from abuse was important in feeling safe, "*The way [partner] approaches my body is much different than the abuse; he is more gentle…"* (9, p.940), which helped survivors connect with their sexuality (6, 9, 11, 13). Achieving emotional safety was identified within heterosexual (9) and same-sex (1, 6, 11, 13) partner relationships, although most frequently reported within same-sex partner relationships. Being in a partner relationship with

another woman was often described as “intrinsically healing” (1, p.38), perhaps reflecting women’s socialisation to more readily express qualities identified as important in healing (Costa et al., 2001).

Table 8. Study endorsement of meta-synthesis themes and sub-themes

Study number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. The past is in the present a) You, me, and the abusers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓		
1. The past is in the present b) Who am I? Sense of self as a person and as a sexual being	✓	✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
2. The push-pull dynamic a) Wanting but fearful	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
2. The push-pull dynamic b) Closeness versus distance	✓	✓			✓	✓		✓	✓	✓		✓	✓		✓	✓
3. Concealing, revealing, and being seen a) Hiding and secrecy	✓	✓	✓	✓	✓	✓		✓		✓					✓	✓
3. Concealing, revealing, and being seen b) Sharing and being identified	✓		✓					✓	✓						✓	
4. Redefining and relating a) Reclaiming sense of self and self as a sexual being	✓					✓			✓	✓		✓		✓		✓
4. Redefining and relating b) Healing through partner relationships	✓		✓			✓			✓		✓	✓		✓		

Discussion

This meta-synthesis illuminates the complex, diverse and multifaceted nature of women's relational and sexual lives following CSA. Challenges, difficulties, and tensions were reported, as well as the potential for healing through partner relationships. Our findings identify important points of convergence with past qualitative reviews (Davis & Petretic-Jackson, 2000; Guyon et al., 2020; Weetman et al., 2021), thus this systematic review builds on the extant literature.

Captured in the theme '*The past is in the present',* CSA continued to influence survivors' relational and sexual lives in various ways. CSA directly entered these spheres in the form of flashbacks and other intrusions, consistent with previous research (Denov, 2004; Mackey et al., 1991; Liang et al., 2006) and the literature on post-traumatic stress (Herman, 2015; Siegel & Soloman, 2003). Sexual and physical intimacy were common triggers for reliving CSA, which has been documented in the literature (Davis & Petretic-Jackson, 2000) and can be explained by theories of complex trauma which state that trauma is stored in somatic memory within the body (Rothschild, 2000; van der Kolk, 1994). Sexual or physical intimacy can, therefore, powerfully activate memories of violation and invasion experienced during CSA (Talmon & Ginzburg, 2018; Weetman et al., 2021). CSA-related memories, emotions and somatic responses led many to experience difficulties with sexual motivation, desire, arousal and/or pleasure, often leading to avoidance. This is consistent with existing research (Leonard & Follette, 2002), yet our findings illuminate the complexity of women survivors' experiences of sexuality. Some women reported difficulties in *acknowledging, accepting, and/or expressing* sexual desire and

arousal, rather than an absence of these feelings, due to sex being associated with CSA, leading to feelings of shame, guilt, and disgust.

CSA also continued to influence through CSA dynamics being enacted or mirrored within partner relationships and through the repetition of patterns of betrayal and abuse. Vulnerability to revictimisation has consistently been identified in the literature (Classen et al., 2005) and this review suggests that this can be understood through several processes. Within partner relationships, a partner's behaviour, including their response to the disclosure of CSA, can echo aspects or dynamics of abuse either intentionally or unintentionally, activating and reinforcing feelings of self-blame, shame, and objectification. Re-enactments of CSA-associated dynamics can be conceptualised as survivors' attempts to "overcome" or seek resolution through regaining power and control violated during CSA (Herman, 2015). Findings suggested a strong need for a "redeeming relationship" (Finkelhor & Browne, 1985, p.535), seeking feelings of care, love, trust, security, and protection that was taken by CSA. Yet because of the negative impact of CSA on many survivors' global self-concepts and relationship schemas, as well as impaired agency and power over their lives, many were vulnerable to choosing partners and staying in partner relationships that replicated patterns of abuse, mapping onto Finkelhor and Browne's (1985) traumagenic dynamics of betrayal, stigmatisation, and powerlessness.

CSA interfered with survivors knowing and accepting their sexual orientation, with some experiencing confusion and distress and some denying or questioning the legitimacy of their feelings. Internalised homophobia further complicated these processes, consistent with existing literature (Weetman et al., 2021). However, our

review identified that women survivors also faced the social stereotype that “women are lesbians because they fear, hate, or simply have not met the right man or men” (Baker, 2009, p.36), which seems to represent an additional challenge for women survivors.

Despite these difficulties, many wanted proximity, intimacy, and security within partner relationships, as illustrated in the theme ‘*The push-pull dynamic*’. This can be explained by attachment theory (Bowlby, 1973) and evolutionary psychology (Buss, 2015) which propose that humans have an evolved innate need for social and relational connection (Gilbert, 2014; Young, 2008). However, for many this had been profoundly affected by CSA, creating ‘fearfulness’ of physical and sexual intimacy and of being hurt in partner relationships, resulting in ‘push-pulls’. Most displayed pervasive mistrust of potential and actual partners, consistent with research that has shown that survivors are more prone to developing an insecure attachment style and have difficulty trusting that a partner will want to and be able to meet their needs (Frias et al., 2014; Meyer et al., 2017). Survivors responded to these fears by seeking or avoiding attachment through partner relationships, supporting Mikulincer and Shaver’s (2007) model of attachment. Attempts to seek attachment through increasing emotional and physical proximity (‘closeness’) resembles Mikulincer and Shaver’s (2007) ‘hyperactivation’ strategies, mostly used by people with insecure-anxious attachments. Responses of ‘closeness’ are also consistent with Finkelhor and Browne’s (1985) betrayal dynamic which postulates that some survivors have a strong need to obtain feelings of love, trust and security taken by CSA and to reassure from fears of abandonment.

Others avoided attachment through increasing emotional and physical ‘distance’, such as through avoiding partner relationships altogether or ending them once they became sexual. This is consistent with Mikulincer and Shaver’s (2007) ‘deactivation’ strategies, most often used by people with insecure-avoidant attachment. It also supports another aspect of Finkelhor and Browne’s (1985) betrayal dynamic as survivors may avoid partner relationships or altogether or avoid intimacy within partner relationships because of suspiciousness and fear.

We found that some survivors struggled to differentiate between emotional and sexual intimacy and/or with holding both within partner relationships, leading some to use sexuality to obtain proximity. This can be understood through the traumatic sexualisation dynamic (Finkelhor & Browne, 1985) and is a strategy documented elsewhere (Weetman et al., 2021). Yet our findings identified that women survivors reported feeling objectified following using this strategy, which has not been documented within men survivors’ experiences (Weetman et al., 2021). This may reflect internalisation of societal discourses relating to different standards of sexual permissiveness and behaviour for women and men (Crawford & Popp, 2003).

As survivors moved towards connection within partner relationships, they faced ongoing dilemmas and decisions regarding how much of their CSA history and needs to share or ‘reveal’ with their partner, and how much to keep hidden or ‘conceal’, reflecting a dialectic tension of trauma recovery (Herman, 2015). Hiding the CSA ‘secret’ from others, including partners, has been documented in women (Smith et al., 2000) and men (Weetman et al., 2021). Our review found that hiding was mostly motivated by beliefs that a partner could or would not accept their CSA

history. Some believed they gave off signals or that their partner could somehow ‘sense’ their CSA identity, leading them to feel ‘identified’, affecting decisions regarding disclosure. These beliefs suggest the internalisation of shame and can be understood through Finkelhor and Browne’s (1985) stigmatisation dynamic. Having control over the content, timing and mode of CSA disclosure was associated with less distress, consistent with restoration of power and control in trauma recovery (Herman, 2015). There was also evidence of hiding needs and difficulty asserting choices and limits within partner relationships, consistent with previous research (Davis & Petretic-Jackson, 2000; Weetman et al., 2021). This led to unwanted sexual activity for some, and for others resulted in difficulty expressing sexual needs and wishes, particularly if both partners were survivors out of fear of replicating abuse and being perceived as an abuser. We are not aware of this finding having been identified in previous reviews.

As highlighted in the theme ‘*Redefining and relating’*, ‘letting go’ of the CSA ‘secret’ and being seen and accepted by a supportive partner was transformative in many survivors’ relational and sexual recovery as well as overall healing, consistent with previous research (Guyon et al., 2020; Weetman et al., 2021). Thus, whilst CSA often led to fearing connection with actual or potential partners, this connection facilitated recovery and healing, supporting models of CSA healing (Arias & Johnson, 2013; Draucker et al., 2011, Herman, 2015). Partners had a key role in helping survivors develop new perspectives and redefine themselves and, importantly, reclaim sexuality by reframing, accepting and valuing sex, and through asserting sexual needs, choices, and limits.

Reclaiming sexuality seems particularly important in women survivors' healing (Guyon et al., 2020) and appeared to hold great symbolism by epitomising restoration of power and control that was taken by CSA. Achieving emotional intimacy before sexual intimacy and having control over sex was emphasised, representing a particularly important need in women survivors' sexual and relational recovery. The dynamic nature of CSA recovery (Guyon et al., 2020) was supported; survivors negotiated recovery through deliberate and continued efforts over time. This included successes and failures, and positive relational shifts coexisting with challenges, difficulties, and struggles caused by CSA, consistent with trauma research (Zięba et al., 2019). Thus, whilst healing was achieved by many, the past continued to be present in women survivors' relational and sexual lives.

Strengths and limitations

Studies utilised different methodologies and had different sexual/relational foci, with survivors of diverse sexual orientations across a relatively large age range, from community and clinical settings. This review therefore captured broad experiences from survivors accessing support services as well as those not, and thus offers a thorough synthesis of extant research on women survivors' sexual and relational lives. However, because of this heterogeneity, it is recognised that contextual influences might not have been sufficiently attended to. It is also acknowledged that studies which contributed larger amounts of data, or which explored more similar phenomena might have had more influence on the development of themes. All studies except one were conducted in western countries, and only half (n=8) fully reported survivors' racial and ethnic identities, with the majority identified as 'White/Caucasian'. Differences in societal, cultural, spiritual, and religious discourses

and practices, and political and legal frameworks, are likely to influence women survivors' experiences and navigation of CSA histories as well as their sexual and relational lives. Caution must therefore be exercised when extending these findings to women survivors of different cultural, racial, and ethnic backgrounds. Most survivors also experienced other forms of childhood trauma or adversity and had experienced interpersonal trauma in adulthood. It is therefore not possible to ascertain that our findings are because of the effects of CSA alone. Furthermore, whilst most studies were considered to be of adequate quality, many did not explicitly state that researcher bias had been considered and mitigated which could have influenced original findings. To reduce potential impact of researcher bias, we analysed and synthesised participants' own words as well as author interpretations. However, we recognise that researcher bias might have influenced selection of participant quotes as well as interpretations of findings in original studies. We acknowledge that our lenses of survivorship might have influenced the meta-synthesis findings. Potential biases were mitigated through critical examination, reflexivity, and researcher triangulation.

Clinical implications

Clinicians should sensitively include survivors' sexual and relational experiences in interventions to support meaningful person-centred recovery (Chouliara et al., 2014; Weetman et al., 2021). This could include sensitively exploring survivors' experiences of developing and maintaining partner relationships; their beliefs, expectations, fears, ambivalence, and conflicts regarding partner relationships; their relationship patterns, responses, and strategies; and their wants, needs and hopes relating to partner relationships.

Clinicians must be aware of women survivors' increased vulnerability to revictimisation and mirroring or re-enactments of abuse dynamics within partner relationships. Understanding the processes involved, and factors which might contribute to abuse being kept hidden is vital in ensuring and supporting survivors' safety and recovery. Clinicians must be mindful of internalised stigmatisation, powerlessness, betrayal and traumatic sexualisation dynamics (Finkelhor & Browne, 1985), and of homophobia and sexual orientation social stereotypes, as well as their own assumptions and biases through supervision and reflexive practice, to avoid reinforcing unhelpful beliefs, feelings, and responses in survivors, and to work competently with survivors of diverse sexual orientations. Clinicians can take a more active role in supporting sexual and relational recovery through tailoring interventions towards managing intrusions, increasing self-efficacy and agency, reclaiming a sense of self beyond CSA that includes acceptance and valuing of sexuality, and helping survivors navigate relational challenges.

Partners were significant in many survivors' sexual and relational recovery, and overall healing. However, partners are often not included in formal support. This review supports a more systemic and holistic approach to CSA recovery that includes partners, such as couples therapy (e.g., MacIntosh & Johnson, 2008) and/or groups for partners (e.g., Sims & Garrison, 2014). Increasing partners' understanding of the relational and sexual impacts of CSA and supporting safe relational contexts where intimacy is negotiated is important for survivors to feel respected, seen, and in control, and for partners to feel understood, validated, and supported in having their relational needs met. Such interventions are not only

important for women survivors' sexual and relational recovery but are likely to foster healthier partner relationships and improve both partners' relationship satisfaction (MacIntosh & Johnson, 2008; Sims & Garrison, 2014).

Directions for future research

Future research is needed with women survivors with diverse cultural, racial, and ethnic identities to develop understanding of how these intersect with survivors' experiences of partner relationships and sexuality following CSA. Ensuring that the research and evidence base represents survivors of diverse identities is important in developing and delivering culturally sensitive and effective support services.

CSA inevitably affects partners who may become "secondary victims" (Remer & Elliott, 1988, p.389; Wiersma, 2003), however partners' experiences and needs have been overlooked and represent an important area for future research. This is particularly important where both partners are survivors. Our findings offer preliminary evidence suggesting that these couples may face additional challenges and difficulties yet might experience a context of mutuality that can foster healing. Further research is needed to develop greater understanding of experiences and support needs of these couples.

Conclusion

This meta-synthesis builds on extant literature and illustrates the complexity and diversity of women's experiences in their sexual and relational lives following CSA. Whilst CSA continued to impact women survivors' lives, there was variation in how survivors negotiated challenges and tensions relating to their self-concepts and

sexual selves, and towards intimacy and connectedness with partners. Most survivors wanted romantic connection, and partners played a key role in survivors' sexual and relational recovery and overall healing. Partner relationships provided a context for experiencing safety, acceptance, and love, and helped survivors redefine themselves and reclaim sexuality. Clinicians must be aware of the diverse sexual and relational experiences and challenges that women CSA survivors encounter, as well as the transformative potential for healing and growth through partner relationships. Clinicians are encouraged to provide interventions that meet survivors' sexual and relational needs in line with person-centred recovery approaches.

Declaration of interest

The authors declare that there are no conflicts of interest.

Funding

None. This review was undertaken as part of a research project for the doctorate in Clinical Psychology award.

Acknowledgements

The authors would like to thank Yasmin Noorani, Bangor University, for her assistance with the development of the search strategy.

References

Studies included in the meta-synthesis are marked with an asterisk (*)

Arias, B. J., & Johnson, C. V. (2013). Voices of healing and recovery from childhood sexual abuse. *Journal of Child Sexual Abuse, 22(7),* 822-841.

Artz, L., Burton, P., Ward, C. L., Leoschut, L., Phyfer, J., Lloyd, S., Kassanjee, R. & Le Mottee, C. (2016). *Sexual victimisation of children in South Africa. Final report of the optimus foundation study: South Africa. Cape Town*. UBS Optimus Foundation.

*Baker, S. (2009). Lesbian survivors of childhood sexual abuse: Community, identity, and resilience. *Canadian Journal of Community Mental Health*, *22(2),* 31-45.

Booth, A., Noyes, J., Flemming, K., Gerhardus, A., Wahlster, P., Van Der Wilt, G. J., ... & Rehfuess, E. (2016). Guidance on choosing qualitative evidence synthesis methods for use in health technology assessments of complex interventions. *Bremen (DE): Integrate-HTA*.

Bowlby, J. (1973). *Attachment and loss: II. Separation anxiety and anger*. New York: Basic Books

Buss, D. M. (Ed.). (2015). *The handbook of evolutionary psychology, volume 1: foundation* (Vol. 1). John Wiley & Sons.

Butler, A., Hall, H., & Copnell, B. (2016). A guide to writing a qualitative systematic review protocol to enhance evidence-based practice in nursing and health care. *Worldviews on Evidence-Based Nursing, 13(3),* 241–249.

Cherry, G., Smith, H., Perkins, E., & Boland, A. (2017). Reviewing qualitative evidence. In A. Boland, G. Cherry, & R. Dickson (Eds.), *Doing a systematic review* (pp. 193–222). Sage.

Chouliara, Z., Karatzias, T., & Gullone, A. (2014). Recovering from childhood sexual abuse: A theoretical framework for practice and research. *Journal of Psychiatric and Mental Health Nursing, 21(1),* 69–78.

Chouliara, Z., & Narang, J. (2017). "Recovery from child sexual abuse (CSA) in India: A relational framework for practice." *Children and Youth Services Review, 79,* 527-538.

Classen, C. C., Palesh, O. G., & Aggarwal, R. (2005). Sexual revictimization: A review of the empirical literature. *Trauma, Violence, & Abuse*, *6(2),* 103-129.

*Clum, G. A., Andrinopoulos, K., Muessig, K., Ellen, J. M., & Adolescent Medicine Trials Network for HIV/AIDS Interventions. (2009). Child abuse in young, HIV-positive women: linkages to risk. *Qualitative Health Research*, *19(12),* 1755-1768.

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: the SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research, 22(10),* 1435-1443.

Costa Jr, P. T., Terracciano, A., & McCrae, R. R. (2001). Gender differences in personality traits across cultures: Robust and surprising findings. *Journal of Personality and Social Psychology*, *81(2),* 322.

Crawford, M., & Popp, D. (2003). Sexual double standards: A review and methodological critique of two decades of research. *Journal of Sex Research*, *40(1),* 13-26.

Critical Appraisal Skills Programme. (2018). CASP qualitative checklist. https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Davis, J. L., & Petretic-Jackson, P. A. (2000). The impact of child sexual abuse on adult interpersonal functioning: A review and synthesis of the empirical literature. *Aggression and Violent Behavior*, *5(3),* 291-328.

*Del Castillo, D., & O'Dougherty Wright, M. (2009). The perils and possibilities in disclosing childhood sexual abuse to a romantic partner. *Journal of Child Sexual Abuse*, *18(4),* 386-404.

Denov, M. S. (2004). The long-term effects of child sexual abuse by female perpetrators: A qualitative study of male and female victims. *Journal of Interpersonal Violence, 19(10),* 1137–1156.

Dixon-Woods, M., Bonas, S., Booth, A., Jones, D. R., Miller, T., Sutton, A. J., ... & Young, B. (2006). How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research, 6(1),* 27-44.

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation*, *35(2),* 220-222.

Draucker, C. B., Martsolf, D. S., Roller, C., Knapik, G., Ross, R., & Stidham, A. W. (2011). Healing from childhood sexual abuse: A theoretical model. *Journal of Child Sexual Abuse, 20(4),* 435-466.

Draucker, C. B., Martsolf, D. S., Ross, R., Cook, C. B., Stidham, A. W., & Mweemba, P. (2009). The essence of healing from sexual violence: A qualitative metasynthesis. *Research in Nursing & Health*, *32(4),* 366-378.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, *55(4),* 530-541.

* Flemke, K. (2009). Triggering rage: Unresolved trauma in women's lives. *Contemporary Family Therapy*, *31(2),* 123-139.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British*

Journal of Clinical Psychology, *53(1),* 6-41.

Guyon, R., Fernet, M., & Godbout, N. (2020). ‘‘A journey back to my wholeness’’: A qualitative metasynthesis on the relational and sexual recovery process of child sexual abuse survivors. *International Journal of Child and Adolescent Resilience*, *7(1),* 72-86.

* Guyon, R., Fernet, M., & Hébert, M. (2021). Relational and sexual experiences of betrayal from the point of view of sexually victimized young women. *Journal of Interpersonal Violence*, *36(21-22),* NP11506-NP11530.

Hailes, H. P., Yu, R., Danese, A., & Fazel, S. (2019). Long-term outcomes of childhood sexual abuse: An umbrella review. *The Lancet Psychiatry*, *6(10),* 830-839

* Hall, J. (1999). An exploration of the sexual and relationship experiences of lesbian survivors of childhood sexual abuse. *Sexual and Marital Therapy*, *14(1),* 61-70.

Harden, A., Thomas, J., Cargo, M., Harris, J., Pantoja, T., Flemming, K., ... & Noyes, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series—paper 5: Methods for integrating qualitative and implementation evidence within intervention effectiveness reviews. *Journal of Clinical Epidemiology*, *97*, 70-78.

Hartley, S., Johnco, C., Hofmeyr, M., & Berry, A. (2016). The nature of posttraumatic growth in adult survivors of child sexual abuse. *Journal of Child Sexual Abuse*, *25(2),* 201-220.

Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. Hachette, UK.

*Jeremiah, R. D., Quinn, C. R., & Alexis, J. M. (2017). Exposing the culture of silence: Inhibiting factors in the prevention, treatment, and mitigation of sexual abuse in the Eastern Caribbean. *Child Abuse & Neglect*, *66*, 53-63.

Johnson, S. M. (2004). *The practice of emotionally focused couple therapy*. New York: Brunner-Routledge.

Leonard, L. M., & Follette, V. M. (2002). Sexual functioning in women reporting a history of child sexual abuse: Review of the empirical literature and clinical implications. *Annual Review of Sex Research, 13,* 346–388.

Liang, B., Williams, L. M., & Siegel, J. A. (2006). Relational outcomes of childhood sexual trauma in female survivors: A longitudinal study. *Journal of Interpersonal Violence*, *21(1),* 42-57.

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the

Critical Appraisal Skills Programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences, 1(1),* 31–42.

MacIntosh, H., Fletcher, K., & Collin-Vézina, D. (2016). "I was like damaged, used goods": Thematic analysis of disclosures of childhood sexual abuse to romantic partners. *Marriage & Family Review*, *52(6),* 598-611.

*MacIntosh, H. B., & Johnson, S. (2008). Emotionally focused therapy for couples and childhood sexual abuse survivors. *Journal of Marital and Family Therapy*, *34(3),* 298-315.

Mackey, T. F., Hacker, S. S., Weissfeild, L. A., Ambrose, N. C., Fisher, M. G., & Zobel, D. L. (1991). Comparative effects of sexual assault on sexual functioning of child sexual abuse survivors and others. *Issues in Mental Health Nursing, 12*, 89–112.

Maling, M., Gurtman, M., & Howard, K. (1995). The response of interpersonal problems to varying doses of psychotherapy. *Psychotherapy Research*, *5(1),* 63-75.

Marriott, C., Hamilton-Giachritsis, C., & Harrop, C. (2014). Factors promoting resilience following childhood sexual abuse: A structured, narrative review of the literature. *Child Abuse Review*, *23(1),* 17-34.

Meyer, D., Cohn, A., Robinson, B., Muse, F., & Hughes, R. (2017). Persistent complications of child sexual abuse: Sexually compulsive behaviors, attachment, and emotions. *Journal of Child Sexual Abuse, 26(2),* 140–157.

Mikulincer M, Shaver PR. *Attachment in adulthood: structure, dynamics, and change.* New York: Guilford; 2007.

Neumann, D. A., Houskamp, B. M., Pollock, V. E., & Briere, J. (1996). The long-term sequelae of childhood sexual abuse in women: A meta-analytic review. *Child Maltreatment, 1*, 6–16.

*Newsom, K., & Myers-Bowman, K. (2017). "I am not a victim. I am a survivor": Resilience as a journey for female survivors of child sexual abuse. *Journal of Child Sexual Abuse*, *26(8),* 927-947.

Noyes, J. & Lewin, S. (2011). Chapter 5: Extracting qualitative evidence. In: Noyes J, Booth A, Hannes K, Harden A, Harris J, Lewin S, Lockwood C (editors), *Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions.* Version 1 (updated August 2011). Cochrane Collaboration Qualitative Methods Group.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., ... & Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *British Medical Journal, 372.*

*Painter, S. G., & Howell, C. C. (1999). Rage and women's sexuality after childhood sexual abuse: A phenomenological study. *Perspectives in Psychiatric Care*, *35(1)*, 5-17.

Pan, Y., Lin, X., Liu, J., Zhang, S., Zeng, X., Chen, F., & Wu, J. (2021). Prevalence of childhood sexual abuse among women using the Childhood Trauma Questionnaire: A worldwide meta-analysis. *Trauma, Violence, & Abuse*, *22(5),* 1181-1191.

Qu, X., Shen, X., Xia, R., Wu, J., Lao, Y., Chen, M., ... & Jiang, C. (2022). The prevalence of sexual violence against female children: A systematic review and meta-analysis. *Child Abuse & Neglect*, *131*, 105764.

Remer, R., & Elliott, J. E. (1988). Management of secondary victims of sexual assault. *International Journal of Family Psychiatry*.

*Robohm, J. S., Litzenberger, B. W., & Pearlman, L. A. (2003). Sexual abuse in lesbian and bisexual young women: Associations with emotional/behavioral difficulties, feelings about sexuality, and the “coming out” process. *Journal of Lesbian Studies*, *7(4),* 31-47.

*Roller, C., Martsolf, D. S., Draucker, C. B., & Ross, R. (2009). The sexuality of childhood sexual abuse survivors. *International Journal of Sexual Health*, *21(1),* 49-60.

Rothschild, B. (2000). *Body remembers: The psychophysiology of trauma and trauma treatment* (Vol. 1). WW Norton & Company.

Rumstein-McKean, O., & Hunsley, J. (2001). Interpersonal and family functioning of female survivors of childhood sexual abuse. *Clinical Psychology Review*, *21(3),* 471-490.

Siddaway, A. P., Wood, A. M., & Hedges, L. V. (2019). How to do a systematic review: A best practice guide for conducting and reporting narrative reviews, meta-analyses, and meta-syntheses. *Annual Review of Psychology, 70,* 747–770.

Siegel, D. J., & Solomon, M. F. (Eds.). (2003). *Healing trauma: Attachment, mind, body and brain (Norton Series on Interpersonal Neurobiology)*. WW Norton & Company.

Sim, J., & Mengshoel, A. M. (2022). Metasynthesis: Issues of empirical and theoretical context. *Quality & Quantity*, *1-23.*

Sims, P. L., & Garrison, S. (2014). Childhood sexual abuse and intimate relationships: A support group for male partners. *Contemporary Family Therapy*, *36(1),* 17-24

*Singer, N. (1995). Understanding sexual risk behavior from drug users' accounts of their life experiences. *Qualitative Health Research*, *5(2),* 237-249.

Smith, D. W., Letourneau, E. J., Saunders, B. E., Kilpatrick, D. G., Resnick, H. S., & Best, C. L. (2000). Delay in disclosure of childhood rape: Results from a national survey. *Child Abuse & Neglect*, *24(2),* 273-287.

Talmon, A., & Ginzburg, K. (2018). "Body self" in the shadow of childhood sexual abuse: The long-term implications of sexual abuse for male and female adult survivors. *Child Abuse & Neglect, 76*, 416–425.

Tedeschi, R.G. & Calhoun, L.G. (2004). Post-traumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15(1),* 1–18.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8(1),* 1-10.

*Tummala-Narra, P., Kallivayalil, D., Singer, R., & Andreini, R. (2012). Relational experiences of complex trauma survivors in treatment: Preliminary findings from a naturalistic study. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4(6),* 640.

Van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry*, *1(5),* 253-265.

Walker, E. C., Holman, T. B., & Busby, D. M. (2009). Childhood sexual abuse, other childhood factors, and pathways to survivors' adult relationship quality. *Journal of Family Violence, 24(6),* 397–406.

Walsh, D., & Downe, S. (2005). Meta-synthesis method for qualitative research: A literature review. *Journal of Advanced Nursing*, *50(2)*, 204-211.

Weetman, C., Kiemle, G., Lowe, M., & Balfour, R. (2021). The experience of partner relationships for male survivors of childhood sexual abuse: A qualitative synthesis. *Trauma, Violence, & Abuse*, *0(0),* 1-16.

*Wiersma, N. S. (2003). Partner awareness regarding the adult sequelae of childhood sexual abuse for primary and secondary survivors. *Journal of Marital and Family Therapy*, *29(2),* 151-164.

*Woodiwiss, J. (2008). 'Compulsory sexuality': A guide to healing? *Culture, Health & Sexuality*, *10(4),* 345-359.

Young, S. N. (2008). The neurobiology of human social behaviour: An important but neglected topic. *Journal of Psychiatry and Neuroscience*, *33(5),* 391-392.

Zięba, M., Wiecheć, K., Biegańska-Banaś, J., & Mieleszczenko-Kowszewicz, W. (2019). Coexistence of post-traumatic growth and post-traumatic depreciation in the aftermath of trauma: Qualitative and quantitative narrative analysis. *Frontiers in Psychology*, *10,* 687.

Appendix A – Screening and selection tool

Review question: What experiences do adult female survivors of childhood sexual abuse describe in their partner relationships?

Inclusion criteria:
Sample (S) = Female adult (18+yrs) survivors of childhood sexual abuse
Phenomenon of interest (P of I) = Experiences of and in partner relationships
Design (D) = Any qualitative design
Evaluation (E) = Lived experience
Research type (R) = Qualitative, mixed-methods

Note: At screening titles and abstracts phases, exclude articles where titles/abstracts clearly indicate meet exclusion criteria. Retain articles where titles/abstracts, subject headings and/or keywords indicate might be relevant (e.g., includes an aspect of partner relationships and/or interpersonal relationships, or the lived experience more generally, such as the effects, impact, negative effects, growth, recovery, healing etc) or where this is indeterminable.

Reviewer name:		Date:
Author name/study ID:		Year:
Title:		Journal:
Sample (S)	**INCLUDE** ☐ - Adult (18+yrs) ☐ - Identifying as female ☐ - CSA survivors *(ST of any type, occurring birth-18yrs or as defined by study as occurring in infancy, childhood and/or adolescence)*	**EXCLUDE** ☐ - C&YP (<=17yrs) only sample ☐ - Unable to distinguish adult from C&YP survivor experiences ☐ - Male only sample ☐ - Unable to distinguish female from male survivor experiences ☐ - Non-CSA sample *(ST only in adulthood and/or other types of abuse only)* ☐ - Unable to distinguish CSA from non-CSA (*ST only in adulthood and/or other types of abuse only)*
Phenomenon of Interest (P of I)	**INCLUDE** ☐ **-** At least one aspect of partner relationship and how survivors experienced, made sense of and/or felt impacted by this (i.e., emotionally, psychologically, cognitively and/or behaviourally) ☐ - Corroborated by survivor quotes	**EXCLUDE** ☐ - Insufficient data on at least one aspect of partner relationship and how survivors experienced, made sense of and/or felt impacted by this (i.e., emotionally, psychologically, cognitively and/or behaviourally) ☐ - Not corroborated by survivor quotes
Design (D)	**INCLUDE** ☐ - Qualitative or mixed-methods ☐ - Sufficient qualitative experiential data on *P of I*	**EXCLUDE** ☐ - Quantitative data only ☐ - Insufficient qualitative experiential data on *P of I*
Evaluation (E)	**INCLUDE** ☐ - Survivor perspective	**EXCLUDE** ☐ - Non-survivor perspective *(e.g., professional, family, friend and/or partner perspectives)*
Research type (R)	**INCLUDE** ☐ - Empirical research ☐ - Peer-reviewed published journal articles ☐ - Full-text available in English	**EXCLUDE** ☐ - Not Empirical research ☐ - Not peer-reviewed published journal articles ☐ - Full-text unavailable ☐ - Not available in English

Overall decision	☐ **INCLUDED**	☐ **EXCLUDED**
Notes		

Appendix B – Data extraction form

Data extraction field	Information to be extracted
Context and participants	Authors and publication year, study country and setting, participants and characteristics, research questions and aims
Research design and method	Research design, methodological approach, data collection, analysis method(s), theoretical models used to interpret findings
Findings	Key findings, concepts and themes. First-order data (participant verbatim quotes) and second-order data (authors' interpretations) relating to adult female survivors' experiences of partner relationships, as reported in the results and discussion sections
Quality	Assessed using CASP (2018) checklist

Adapted from Noyes and Lewin (2011)

Appendix C – Example of extracting data from papers with mixed samples

was. . . . They say that the person that does do damage to the victim, that they're sick." Some figured out that the sexual abuse had been going on in their families or communities for generations. One 50-year-old man, who was molested by a male friend of his family, stated, "Everybody else in the family . . . had all been molested by an uncle. My uncle was molesting two of my cousins and the family knew about it. Yea, the whole family knew about it . . . this is multigenerational."

Many of the participants also figured out how the CSA had affected their sexuality. Some decided that their propensity to have casual sex or sex with older partners was related to the CSA. A 47-year-old woman, who experienced multiple episodes of CSA between the ages of 5 and 18 by her stepfather, stated, "I would just kind of sleep around . . . the promiscuity was one of the symptoms [of the CSA] that . . . I realized." Several female participants realized abuse caused them to "look for love in all the wrong places." Some participants connected their uninterest in sex or an aversion to a particular sexual activity with their abuse. A few believed that their sexual orientation was related to the abuse. A 42-year-old man, who experienced CSA by his brothers, stated, "I'm gay . . . so that's probably why. . . . Cause what happened when I was younger [the sexual abuse]." Other participants were convinced there was no relationship between their sexual orientation and their CSA. Some participants figured out that their experiences with abuse had caused them to become perpetrators. A 36-year-old man, who was sexually abused by his older brother, stated, "I went on to do the same thing to my little brother."

Transition to the next phase was facilitated by resources available to the participants, especially enduring relationships that were supportive and personal resilience. Participants moved from understanding the impact of CSA to making life changes because they had connections to others who supported the participants' progress. The connections were with friends, family members, professionals (often a therapist), or a Higher Being. In addition, participants indicated that this transition was facilitated by their own personal characteristics; they spoke of needing to be resilient, courageous, or tenacious to take this next step.

Tackling . . .

The process of *Determining My Sexual Being* continued for some participants with the phase of *tackling*. The term *tackle* ("make determined efforts to deal with a problem or difficult task": *New Oxford American Dictionary*, 2005. p. 1717) was selected to capture the participants' descriptions of how they took what they had figured out about the abuse, accepted it with conviction, and worked hard to use these insights to change their lives.

Once the participants had figured out that they had been abused and were not at fault, they sought to gain more insight about the abuse and its effects. They sought opportunities to gain better understanding of the phenomenon of CSA, the disturbances of perpetrators, the family dynamics that provide the context of the abuse, and the community factors that enabled it. Many sought therapy, but others "processed" the abuse with a close friend, family member, or clergy. Although tackling "issues" related to the abuse was hard and often painful work, the participants ultimately experienced a sense of relief or catharsis. A 54-year-old Hispanic male, who had been sexually abused by foster brothers, his mother, and older boys, had realized that the abuse was a "mess, . . . a cycle that becomes overwhelming" but revealed that he had tackled his abuse issues by doing "intense analysis." He explained, "I read every book, I worked on myself." A 37-year-old man, who was abused by an older cousin, used the research interview to begin the tackling process. He said the interview "was a stepping stone to a deeper realization—a deeper introspection."

Fortified with new knowledge, participants struggled to improve their lives by changing their sexual behaviors, improving their intimate relationships, and refocusing their energies on healing. They took steps to become healthier physically and emotionally and to ameliorate sexual problems that they believed to be tied to the abuse. One 47-year-old woman, who had experienced CSA by her stepfather, stated, "Giving myself the space when I need the

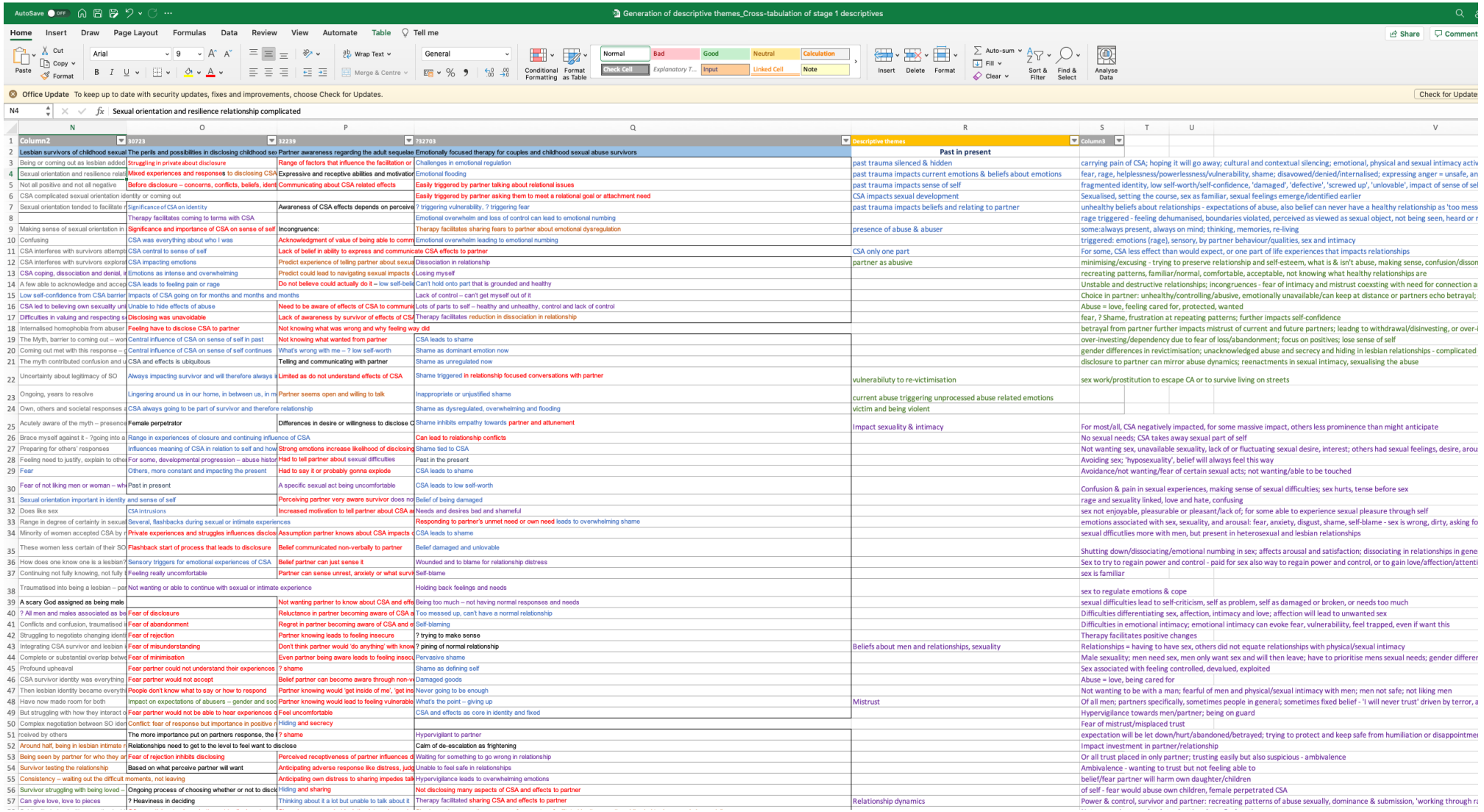
Note. Highlighted text represents extracted data from Roller et al. (2009; 12)

Appendix D – Example of stage one analysis

First Order Data	Second Order Data	Third Order (Reviewer)
I wanted to, I had sexual feelings but I felt that sex was dirty, was wrong that it made me feel very uncomfortable, because it always triggered off all these memories. So, I connected them completely with sex. Instead of feeling the abuse was wrong, I felt sex was wrong. Even having sexual feelings was wrong. I think that I felt that having sexual feelings meant that I'd wanted the abuse to happen. I thought it was disgusting to feel like that, sex was something very dirty and I was dirty wanting it. I don't think I ever had an orgasm at all, I don't think I knew what one was, it [sex] was about satisfying them because that was the way it had always been with my dad.	<u>Inability to acknowledge and express sexual needs</u> This was an issue almost unanimously expressed. Linked to this was the women's denial of their own sexual nature – this being seen as wrong, shameful and dirty. This problem also meant that these women felt it wrong to tell their sexual partners how best to give them sexual pleasure. Therefore, there was a tendency towards lack of arousal and anorgasmia. These difficulties were mainly experienced with male partners. One would not necessarily classify these women as lacking in sexual desire or motivation to some extent (as reported in previous studies). Rather, they were fearful of expressing their desires and needs. Two women, however, stated that they only had sex with their current female partner under duress out of a 'sense of duty'. Interestingly, according to these women, their lesbian partners never or rarely pressured them into having sex. This may in part be explained by the fact that the partners of these women were also survivors of CSA.	All: inability to acknowledge and express sexual needs but have sexual feelings, desire and motivation Denial of self as a sexual being Sexuality is wrong, shameful and dirty Wrong to ask for sexual pleasure from partner Leads to lack of sexual arousal and orgasms Difficulties mostly experienced with male partners Do have sexual feelings and wanting sexual experiences Belief that sex is dirty and wrong and feeling uncomfortable Sexual experiences triggers abuse memories Sex connected with abuse Abuse is wrong, so sex is wrong Even having sexual feelings is wrong Having sexual feelings means having wanted the abuse Self-blame for abuse due to own sexuality Sex is dirty and wanting sex is dirty, leads to disgust CSA leads to belief that sex is about pleasing other Fearful of expressing sexual desires and needs A minority have sex when don't want to Having sex with a female partner under duress out of 'sense of duty' Sex is for other, not self Placating partner in sex Lesbian partner rarely pressures into having sex Lesbian partner also CSA survivor Own perceived obligation or sense of duty Relationships = need to have sex

Note. Analysis on data from Hall (1999; 6)

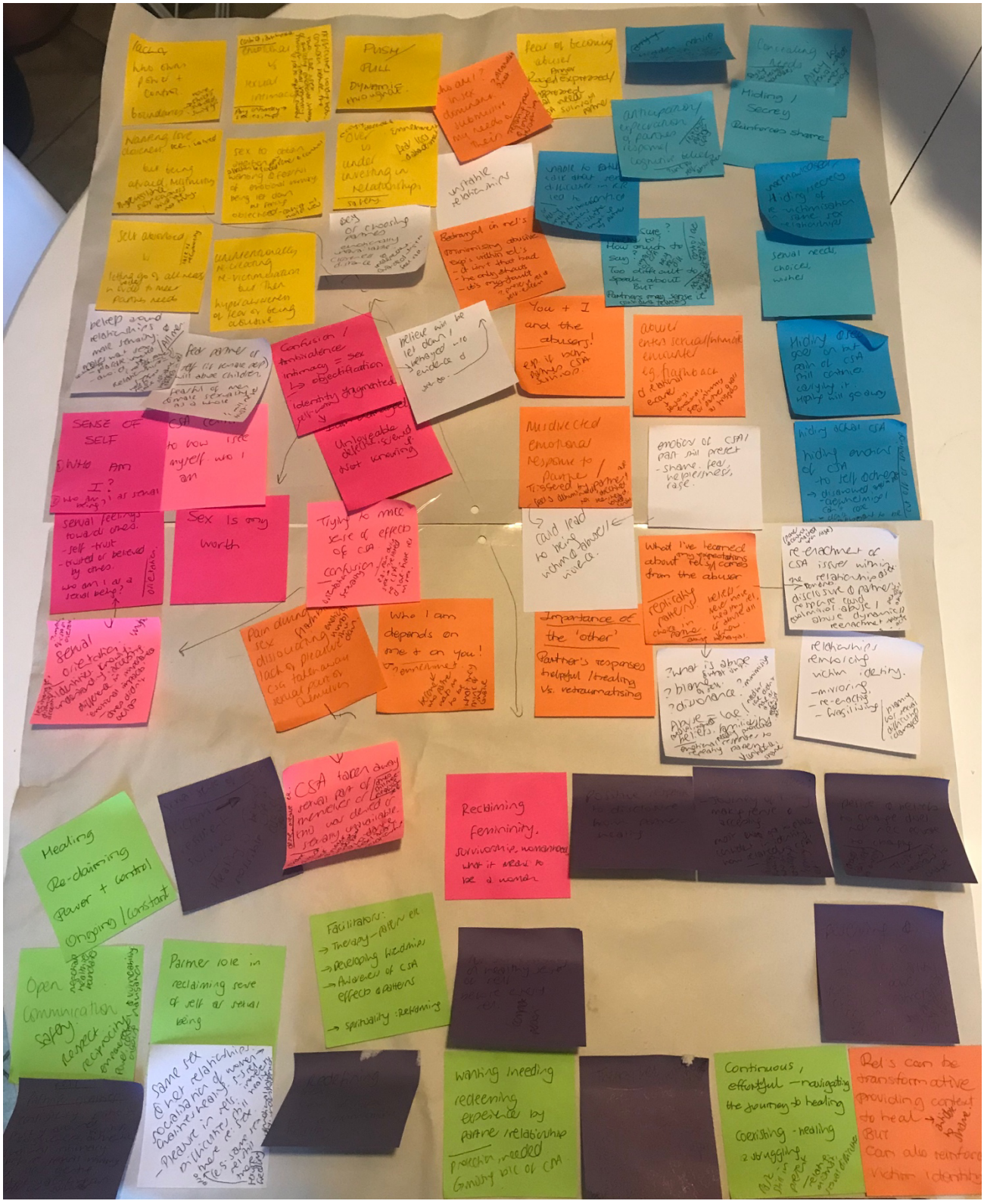
Appendix E – Example of stage two analytic process



Generation of descriptive themes_Cross-tabulation of stage 1 descriptives

	N	O	P	Q	R	S	V
1	Column2	30723	32239	732703	Descriptive themes	Column3	
2	Lesbian survivors of childhood sexual	The perils and possibilities in disclosing childhood se	Partner awareness regarding the adult sequelae	Emotionally focused therapy for couples and childhood sexual abuse survivors	Past in present		
3	Being or coming out as lesbian added	Struggling in private about disclosure	Range of factors that influence the facilitation or	Challenges in emotional regulation	past trauma silenced & hidden	carrying pain of CSA; hoping it will go away; cultural and contextual silencing; emotional, physical and sexual intimacy activ	
4	Sexual orientation and resilience relati	Mixed experiences and responses to disclosing CSA	Expressive and receptive abilities and motivation	Emotional flooding	past trauma impacts current emotions & beliefs about emotions	fear, rage, helplessness/powerlessness/vulnerability, shame; disavowed/denied/internalised; expressing anger = unsafe, an	
5	Not all positive and not all negative	Before disclosure – concerns, conflicts, beliefs, ident	Communicating about CSA related effects	Easily triggered by partner talking about relational issues	past trauma impacts sense of self	fragmented identity, low self-worth/self-confidence, 'damaged', 'defective', 'screwed up', 'unlovable', impact of sense of sel	
6	CSA complicated sexual orientation id	entity or coming out		Easily triggered by partner asking them to meet a relational goal or attachment need	CSA impacts sexual development	Sexualised, setting the course, sex as familiar, sexual feelings emerge/identified earlier	
7	Sexual orientation tended to facilitate r	Significance of CSA on identity	Awareness of CSA effects depends on perceive	? triggering vulnerability, ? triggering fear	past trauma impacts beliefs and relating to partner	unhealthy beliefs about relationships - expectations of abuse, also belief can never have a healthy relationship as 'too mess	
8		Therapy facilitates coming to terms with CSA		Emotional overwhelm and loss of control can lead to emotional numbing		rage triggered - feeling dehumanised, boundaries violated, perceived as viewed as sexual object, not being seen, heard or r	
9	Making sense of sexual orientation in	Significance and importance of CSA on sense of self	Incongruence:	Therapy facilitates sharing fears to partner about emotional dysregulation	presence of abuse & abuser	some:always present, always on mind; thinking, memories, re-living	
10	Confusing	CSA was everything about who I was	Acknowledgment of value of being able to comm	Emotional overwhelm leading to emotional numbing		triggered: emotions (rage), sensory, by partner behaviour/qualities, sex and intimacy	
11	CSA interferes with survivors attempt	CSA central to sense of self	Lack of belief in ability to express and communicate	CSA effects to partner	CSA only one part	For some, CSA less effect than would expect, or one part of life experiences that impacts relationships	
12	CSA interferes with survivors explorat	CSA impacting emotions	Predict experience of telling partner about sexua	Dissociation in relationship	partner as abusive	minimising/excusing - trying to preserve relationship and self-esteem, what is & isn't abuse, making sense, confusion/disson	
13	CSA coping, dissociation and denial, i	Emotions as intense and overwhelming	Predict could lead to navigating sexual impacts	Losing myself		recreating patterns, familiar/normal, comfortable, acceptable, not knowing what healthy relationships are	
14	A few able to acknowledge and accep	CSA leads to feeling pain or rage	Do not believe could actually do it – low self-belie	Can't hold onto part that is grounded and healthy		Unstable and destructive relationships; incongruences - fear of intimacy and mistrust coexsting with need for connection a	
15	Low self-confidence from CSA barrier	Impacts of CSA going on for months and months and	months	Lack of control – can't get myself out of it		Choice in partner: unhealthy/controlling/abusive, emotionally unavailable/can keep at distance or partners echo betrayal;	
16	CSA led to believing own sexuality un	Unable to hide effects of abuse	Need to be aware of effects of CSA to communi	Lots of parts to self – healthy and unhealthy, control and lack of control		Abuse = love, feeling cared for, protected, wanted	
17	Difficulties in valuing and respecting s	Disclosing was unavoidable	Lack of awareness by survivor of effects of CSA	Therapy facilitates reduction in dissociation in relationship		fear, ? Shame, frustration at repeating patterns; further impacts self-confidence	
18	Internalised homophobia from abuser	Feeling have to disclose CSA to partner	Not knowing what was wrong and why feeling way did			betrayal from partner further impacts mistrust of current and future partners; leadng to withdrawal/disinvesting, or over-i	
19	The Myth, barrier to coming out – wor	Central influence of CSA on sense of self in past	Not knowing what wanted from partner	CSA leads to shame		over-investing/dependency due to fear of loss/abandonment; focus on positives; lose sense of self	
20	Coming out met with this response – (	Central influence of CSA on sense of self continues	What's wrong with me – ? low self-worth	Shame as dominant emotion now		gender differences in revictimisation; unacknowledged abuse and secrecy and hiding in lesbian relationships - complicated	
21	The myth contributed confusion and u	CSA and effects is ubiquitous	Telling and communicating with partner	Shame as unregulated now		disclosure to partner can mirror abuse dynamics; reenactments in sexual intimacy, sexualising the abuse	
22	Uncertainty about legitimacy of SO	Always impacting survivor and will therefore always i	Limited as do not understand effects of CSA	Shame triggered in relationship focused conversations with partner	vulnerabiluty to re-victimisation	sex work/prostitution to escape CA or to survive living on streets	
23	Ongoing, years to resolve	Lingering around us in our home, in between us, in m	Partner seems open and willing to talk	Inappropriate or unjustified shame	current abuse triggering unprocessed abuse related emotions		
24	Own, others and societal responses a	CSA always going to be part of survivor and therefore	relationship	Shame as dysregulated, overwhelming and flooding	victim and being violent		
25	Acutely aware of the myth – presence	Female perpetrator	Differences in desire or willingness to disclose C	Shame inhibits empathy towards partner and attunement	Impact sexuality & intimacy	For most/all, CSA negatively impacted, for some massive impact, others less prominence than might anticipate	
26	Brace myself against it - ?going into a	Range in experiences of closure and continuing influence of CSA		Can lead to relationship conflicts		No sexual needs; CSA takes away sexual part of self	
27	Preparing for others' responses	Influences meaning of CSA in relation to self and how	Strong emotions increase likelihood of disclosing	Shame tied to CSA		Not wanting sex, unavailable sexuality, lack of or fluctuating sexual desire, interest; others had sexual feelings, desire, arou	
28	Feeling need to justify, explain to othe	For some, developmental progression – abuse histor	Had to tell partner about sexual difficulties	Past in the present		Avoiding sex; 'hyposexuality', belief will always feel this way	
29	Fear	Others, more constant and impacting the present	Had to say it or probably gonna explode	CSA leads to shame		Avoidance/not wanting/fear of certain sexual acts; not wanting/able to be touched	
30	Fear of not liking men or woman – wh	Past in present	A specific sexual act being uncomfortable	CSA leads to low self-worth		Confusion & pain in sexual experiences, making sense of sexual difficulties; sex hurts, tense before sex	
31	Sexual orientation important in identity	and sense of self	Perceiving partner very aware survivor does no	Belief of being damaged		rage and sexuality linked, love and hate, confusing	
32	Does like sex	CSA intrusions	Increased motivation to tell partner about CSA a	Needs and desires bad and shameful		sex not enjoyable, pleasurable or pleasant/lack of; for some able to experience sexual pleasure through self	
33	Range in degree of certainty in sexual	Several, flashbacks during sexual or intimate experiences		Responding to partner's unmet need or own need leads to overwhelming shame		emotions associated with sex, sexuality, and arousal: fear, anxiety, disgust, shame, self-blame - sex is wrong, dirty, asking fo	
34	Minority of women accepted CSA by t	Private experiences and struggles influences disclos	Assumption partner knows about CSA impacts	CSA leads to shame		sexual difficulties more with men, but present in heterosexual and lesbian relationships	
35	These women less certain of their SO	Flashback start of process that leads to disclosure	Belief communicated non-verbally to partner	Belief damaged and unlovable		Shutting down/dissociating/emotional numbing in sex; affects arousal and satisfaction; dissociating in relationships in gene	
36	How does one know one is a lesbian?	Sensory triggers for emotional experiences of CSA	Belief partner can just sense it	Wounded and to blame for relationship distress		Sex to try to regain power and control - paid for sex also way to regain power and control, or to gain love/affection/attenti	
37	Continuing not fully knowing, not fully t	Feeling really uncomfortable	Partner can sense unrest, anxiety or what survi	Self-blame		sex is familiar	
38	Traumatised into being a lesbian – pa	Not wanting or able to continue with sexual or intimate	experience	Holding back feelings and needs		sex to regulate emotions & cope	
39	A scary God assigned as being male		Not wanting partner to know about CSA and effe	Being too much – not having normal responses and needs		sexual difficulties lead to self-criticism, self as problem, self as damaged or broken, or needs too much	
40	? All men and males associated as be	Fear of disclosure	Reluctance in partner becoming aware of CSA a	Too messed up, can't have a normal relationship		Difficulties differentiating sex, affection, intimacy and love; affection will lead to unwanted sex	
41	Conflicts and confusion, traumatised i	Fear of abandonment	Regret in partner becoming aware of CSA and e	Self-blaming		Difficulties in emotional intimacy; emotional intimacy can evoke fear, vulnerability, feel trapped, even if want this	
42	Struggling to negotiate changing identi	Fear of rejection	Partner knowing leads to feeling insecure	? trying to make sense		Therapy facilitates positive changes	
43	Integrating CSA survivor and lesbian i	Fear of misunderstanding	Don't think partner would 'do anything' with know	? pining of normal relationship	Beliefs about men and relationships, sexuality	Relationships = having to have sex, others did not equate relationships with physical/sexual intimacy	
44	Complete or substantial overlap betwe	Fear of minimisation	Even partner being aware leads to feeling insecu	Pervasive shame		Male sexuality; men need sex, men only want sex and will then leave; have to prioritise mens sexual needs; gender differer	
45	Profound upheaval	Fear partner could not understand their experiences	? shame	Shame as defining self		Sex associated with feeling controlled, devalued, exploited	
46	CSA survivor identity was everything	Fear partner would not accept	Belief partner can become aware through non-v	Damaged goods		Abuse = love, being cared for	
47	Then lesbian identity became everyth	People don't know what to say or how to respond	Partner knowing would 'get inside of me', 'get ins	Never going to be enough		Not wanting to be with a man; fearful of men and physical/sexual intimacy with men; men not safe; not liking men	
48	Have now made room for both	Impact on expectations of abusers – gender and soc	Partner knowing would lead to feeling vulnerable	What's the point – giving up	Mistrust	Of all men; partners specifically, sometimes people in general; sometimes fixed belief - 'I will never trust' driven by terror, a	
49	But struggling with how they interact c	Fear partner would not be able to hear experiences c	Feel uncomfortable	CSA and effects as core in identity and fixed		Hypervigilance towards men/partner; being on guard	
50	Complex negotiation between SO iden	Conflict: fear of response but importance in positive r	Hiding and secrecy			Fear of mistrust/misplaced trust	
51	rceived by others	The more importance put on partners response, the f	? shame	Hypervigilant to partner		expectation will be let down/hurt/abandoned/betrayed; trying to protect and keep safe from humiliation or disappointme	
52	Around half, being in lesbian intimate r	Relationships need to get to the level to feel want to disclose		Calm of de-escalation as frightening		Impact investment in partner/relationship	
53	Being seen by partner for who they ar	Fear of rejection inhibits disclosing	Perceived receptiveness of partner influences d	Waiting for something to go wrong in relationship		Or all trust placed in only partner; trusting easily but also suspicious - ambivalence	
54	Survivor testing the relationship	Based on what perceive partner will want	Anticipating adverse response like distress, judg	Unable to feel safe in relationships		Ambivalence - wanting to trust but not feeling able to	
55	Consistency – waiting out the difficult	moments, not leaving	Anticipating own distress to sharing impedes talk	Hypervigilance leads to overwhelming emotions		belief/fear partner will harm own daughter/children	
56	Survivor struggling with being loved –	Ongoing process of choosing whether or not to disck	Hiding and sharing	Not disclosing many aspects of CSA and effects to partner		of self - fear would abuse own children, female perpetrated CSA	
57	Can give love, love to pieces	? Heaviness in deciding	Thinking about it a lot but unable to talk about it	Therapy facilitated sharing CSA and effects to partner	Relationship dynamics	Power & control, survivor and partner: recreating patterns of abuse sexually, dominance & submission, 'working through ra	

Appendix F – Example of stage three analytic process



Chapter two

Empirical paper

Challenges, privilege, and transformations: An interpretative phenomenological analysis of clinical psychologists' experiences of working with adult survivors of sexual trauma in the NHS

Laura Glinn[a*], Dr Laura Spencer[a,b], Dr Renee Rickard[a]

[a]North Wales Clinical Psychology Programme, School of Human and Behavioural Sciences, Bangor University, Bangor, United Kingdom

[b]Betsi Cadwaladr University Health Board, Bangor, United Kingdom

***Corresponding Author**: Laura Glinn, North Wales Clinical Psychology Programme, School of Human and Behavioural Sciences, Bangor University, Bangor, United Kingdom. Email: lrg19cjy@bangor.ac.uk, Telephone: +44(0) 1248 388365

This paper is intended to be submitted to Journal of Clinical Psychology

Submission guidelines can be found below:

https://onlinelibrary.wiley.com/page/journal/10974679/homepage/forauthors.html

Abstract

The experiences and impact of sexual trauma work on clinical psychologists working in the National Health Service (NHS) remains understudied and unknown. Using interpretative phenomenological analysis, the experiences of eight clinical psychologists working with adult survivors of sexual trauma in NHS services were explored. Three inter-related super-ordinate themes were identified: 'Hidden versus seeing: an isolating experience', 'The sequelae of seeing: challenges, privilege, and transformations', and 'Surviving and getting through'. These capture complex and intense challenges, negative and positive responses, and mostly unwelcomed transformations to participants' selves. Ways of coping inside and outside work were identified. Key clinical implications include the need for more resources, appropriate training, robust support, and better balance in workloads/caseloads, as well as systemic and organisational changes in line with trauma-informed care. Prioritising and embedding such changes are important for supporting the wellbeing of clinical psychologists and in turn, the quality and sustainability of sexual trauma services.

Keywords: Sexual trauma; NHS; Impact; Coping; Burnout; Vicarious trauma; Vicarious post-traumatic growth; Qualitative

Introduction

In England and Wales, around 22.9% of women and 4.7% of men have experienced sexual trauma in adulthood (Office for National Statistics, ONS, 2021) and 7.5% of adults within childhood (ONS, 2020), though actual figures are likely higher due to under-reporting. Sexual trauma has been shown to have wide-ranging and pervasive psychological and emotional impacts, playing a causal role in the development of various mental health problems (Chen et al., 2010). Individuals who have survived sexual trauma ('survivors') have been found to seek more help from mental health and medical services (Golding et al., 1988; Lewis et al., 2005).

In recent years there has been growing interest in the impact on therapists of supporting survivors. Existing research has largely focused on examining burnout, compassion fatigue, vicarious trauma, and secondary traumatic stress as negative risks (Baird & Jenkins, 2003) and more recently, compassion satisfaction and vicarious post-traumatic growth as positive effects (Cohen & Collens, 2013). Whilst these terms are often used interchangeably and definitions vary (Rothschild, 2006), burnout is considered the emotional and/or physical exhaustion, cynicism, detachment, sense of ineffectiveness and/or lack of accomplishment resulting from the chronic impact or overload of work (Maslach, 2003), compassion fatigue is emotional and/or physical exhaustion from sustained empathic exposure to others' suffering (Figley, 2002). Vicarious trauma is the cumulative transformative effects on identity, worldview and beliefs resulting from chronic exposure to trauma and its sequelae (McCann & Pearlman, 1990), and secondary traumatic stress the development and experiencing of trauma symptoms (avoidance, intrusion, arousal) through vicarious exposure (Figley, 1995a). Compassion satisfaction refers to

positive effects through helping others and seeing change (Figley, 1995b), and vicarious post-traumatic growth, transformative positive psychological changes in perceptions of self and others through vicarious exposure to trauma (Arnold et al., 2005).

Therapists supporting survivors have been shown to be particularly vulnerable to burnout, compassion fatigue, vicarious trauma, and secondary traumatic stress. Research has identified significant disruptions in psychological functioning and/or wellbeing in therapists, including altered perceptions of safety, changed beliefs about themselves, others and the world, and strong emotional (e.g., sadness, anger, fear, helplessness), arousal (e.g., irritability, disturbed sleep) and somatic (e.g., nausea, numbness, headaches/migraines, tension, exhaustion) responses (Baird & Jenkins, 2003; Cohen & Collens, 2013; Sui & Padmanabhanunni, 2016; VanDeusen & Way, 2006).

However, research has also identified signs of compassion satisfaction and vicarious post-traumatic growth in therapists supporting survivors, including improved awareness of personal strengths and increased feelings of interpersonal connectedness, fulfilment, hope, and meaning in life (Cohen & Collens, 2013; Coleman et al., 2021; Sui & Padmanabhanunni, 2016). Interestingly, these studies identified that positive and negative effects co-existed. Research has also indicated that compassion satisfaction and vicarious post-traumatic growth can moderate against secondary traumatic stress (Samios et al., 2013).

Several factors influence therapists' experiences, including workload/proportion of caseload, amount of experience, sexual trauma-specific training, personal coping strategies and organisational support. However, how these factors influence experiences appears complex and findings are inconsistent. For example, while Schauben and Frazer (1995) found a positive relationship between proportion of sexual trauma in caseload and secondary traumatic stress and vicarious trauma, Baird and Jenkins (2003) found the opposite. A negative relationship between length/amount of sexual trauma work experience and vicarious trauma has been found by some researchers (Cunningham, 2003) whereas others have found the opposite (Baird & Jenkins, 2003). These findings suggest that therapists' experiences of working therapeutically with survivors is complex, diverse, and multifaceted.

Thus, although current literature provides some understanding, this area remains poorly understood, and existing research is limited. Most research is quantitative, and the small amount of qualitative research has largely focused on the construct of vicarious trauma and more recently, vicarious post-traumatic growth. Yet studies differ in how they define these constructs, and experiences falling outside these bounds have not been captured. Current research suggests likely complexities and nuances in therapists' experiences. A broader qualitative approach may facilitate richer understanding of the full range of experiences and impact of this work.

Most research has been conducted in the USA and might not translate to the UK. Between these countries, there are differences in professional requirements regarding training and supervision. Furthermore, most therapists in the USA work

privately, and a high proportion in the UK work in the National Health Service (NHS). It is recognised that NHS services are experiencing increasing pressure to provide care to growing numbers of people with limited resources (Sizmur & Raleigh, 2018). This may contribute to differences in therapists' experiences because of increased waiting times (Sizmur & Raleigh, 2018) and criteria for access to NHS services determining the presentations of survivors that NHS therapists support. Pressures of lengthy waiting lists, limited resources, and other NHS service demands may also indirectly contribute to differences in therapists' experiences.

Coleman and colleagues (2021) recently explored 21 therapists' experiences of working with complex psychological trauma survivors within NHS settings in Scotland. Using interpretative phenomenological analysis, they identified challenges, benefits, and positive changes, in line with vicarious post-traumatic growth. Whilst their study included therapists' experiences of working with sexual trauma survivors, it did not specifically focus on this client group. Furthermore, participants included therapists from different professional backgrounds, including psychologists, psychotherapists/counsellors, and occupational therapists.

To our knowledge, there is no qualitative research exploring experiences of clinical psychologists working with adult survivors of sexual trauma within NHS services. Clinical psychologists represent a homogenous group of clinicians, having received similar training and experiencing similar expectations regarding therapeutic work and wider remits of their jobs. Understanding how NHS clinical psychologists working with adult survivors experience this work can inform how to best equip and support them. Ensuring clinical psychologists' wellbeing is beneficial to services and

organisations as therapist wellbeing has been associated with staff retention, patient safety, engagement, and satisfaction (Chouliara et al., 2012; Summers et al., 2021).

Current study

The aim of the present study was to explore clinical psychologists' experiences of sexual trauma work in NHS services.

Method

Design and methodology

This study utilised interpretative phenomenological analysis (IPA; Smith et al., 2009) chosen because of its inductive and idiographic approach that seeks to explore and interpret participants' lived experiences and meaning making of phenomena whilst preserving their own words. IPA is useful for analysing under-researched dynamic, contextual, and subjective phenomena (Smith, 2004). Within IPA a 'double hermeneutic' is employed, whereby understanding is sought through researchers' attempts to make sense of participants making sense of their lived experiences. IPA is therefore consistent with the critical realist epistemology underpinning this study.

Recruitment

Participants were recruited from two geographically diverse health boards in Wales. After obtaining university ethical approval and site-specific NHS research and development approval, administrative and psychology leads across specialisms providing psychotherapy to adult survivors were contacted and asked to disseminate an invitation email and study poster. Interested participants were invited to contact the first author to receive further information, a participant information sheet and consent form. These outlined that participation was voluntary and identified potential risks, including that difficult emotions may be elicited. Eligibility criteria included being (i) a clinical psychologist qualified at least one year, and (ii) having NHS experience of working therapeutically with adult survivors of sexual trauma (any type, perpetrated at any age) to help survivors come to terms with, and recover from, its effects.

Fourteen clinical psychologists expressed interest; however, one was not eligible and two did not respond after receiving or returning study documents. Due to a disproportionately higher response rate from females (91%), a second recruitment phase was undertaken specifically targeting males to better reflect the population (females: 80%; Johnson et al., 2020). Eight clinical psychologists with a wide range of experience of this work across different specialisms were recruited, consistent with recommended IPA sample sizes for professional doctorates (4-10 interviews; Smith et al., 2009).

Participants

Participants represented an acceptably homogeneous sample (Smith et al., 2009) comprising eight clinical psychologists aged 31-46 years. Six identified as female, two as male. Although it is recognised that this may have affected sample homogeneity, this broadly reflects the gender distribution of clinical psychologists in the UK (80% female; Johnson et al., 2020). All described their racial and ethnic identity as White British/Welsh. Seven identified their sexual orientation as heterosexual, one as homosexual/gay. Five reported their relationship status as married, one in a relationship, one cohabiting, and one single.

At the time of participation all were working with adult survivors in NHS settings and had experience within secondary mental health (5), learning disability (3), and physical health (3) services. Length of time working with adult survivors as a clinical psychologist ranged from 1.5-18 years. Overall number of adult survivors worked with in this capacity ranged from 2-“hundreds”. Current proportion of caseload ranged from 2.5-100%. Current number of survivors on caseload ranged from 1-5

per week, equating to <1-10 hours of direct clinical sexual trauma work per week across participants. Most survivors were complex trauma/childhood sexual abuse survivors.

Data collection

Participants completed a consent form and basic demographic and clinical information sheet prior to interview. In-person, videocall or telephone interviews were offered. Six videocall (Microsoft Teams) and two in-person (private room in participants' work setting) interviews were conducted (by the first author). At the outset, participants were reminded of confidentiality and limits, that participation was voluntary, and that they could withdraw at any point without consequences. Consent was verbally confirmed. Interviews were audio-recorded.

Interviews were semi-structured guided by an interview schedule (Appendix H) developed collaboratively by the research team (LG, LS, RR) and tested and revised through piloting with two trainee psychologists with experience in this area. The interview schedule comprised ten broad open questions covering experiences within and beyond the therapy room, personal impact over time, and support and coping. Interviews were participant-led, and participants were probed on topics which appeared more personally salient. Interviews lasted 70-101 minutes.

After interviews participants were fully debriefed. Participants were reimbursed with a £15 Amazon voucher. Field notes were made after interviews to document observations and initial impressions.

Analytic procedure

Interviews were transcribed verbatim by the first author and anonymised. Participants were assigned pseudonyms. Transcripts were analysed by the first author following IPA's six-stage process (Smith et al., 2009). Analysis began with repeated reading of the first transcript to facilitate immersion in the data. Line-by-line analysis was undertaken noting descriptive, linguistic, and conceptual features, which were translated into emergent themes. Connections among emergent themes were identified and themes were refined, which resulted in a table of super-ordinate themes for the first case. This was repeated for each case.

In line with the principles of IPA and with guidance which states that IPA analysis can either be approached by analysing each case by putting aside analyses of previous cases, or by using themes from previous cases to help orient and inform analysis of the subsequent case (Smith & Osborn, 2008), it was first decided through research team (LG, LS, RR) consensus to approach each analysis 'blind'. That is, themes from analyses of previous cases were put aside to analyse the next case from scratch. This approach was used for the first five cases. The order of analysis was chosen according to richness of transcripts, consistent with a suggested approach in IPA guidance (Smith et al., 2009). Richness was intuited by the first author based on depth and powerfulness of experiences shared during interviews and on divergences in experiences within and across participants. By the analysis of the fifth case, patterns or themes that were capturing participants' shared experiences and, importantly, areas of divergence, nuances, and idiosyncrasies, were becoming clearer. It was therefore decided through research team consensus to analyse the subsequent three cases oriented by preliminary themes from

preceding analyses, consistent with the other recommended way of approaching IPA analysis. Through remaining aware of what had come before, it was possible to identify new and different experiences in the subsequent three cases whilst identifying experiences that mapped onto and further developed the preliminary extant themes (Smith & Osborn, 2008). Importantly, throughout analysis careful attention was paid to ensuring detailed examination of all eight cases, identifying areas of convergence and divergence, as well as nuances and idiosyncrasies, consistent with IPA's phenomenological and idiographic focus.

Preliminary themes were shared and discussed with the research team, and patterns across cases were established and mapped to develop provisional super-ordinate and subordinate group themes. This helped ensure themes were grounded and well represented in transcripts, important for rigour and validity. Analysis was iterative and continued throughout write-up.

Final themes were developed according to richness and recurrence, defined as appearing in at least half the transcripts (Table 1; Smith et al.,2009). This facilitated detailed examination of the essence of phenomena across participants whilst promoting idiographic perspectives. Transcript excerpts and participant quotes were selected from all eight participants and were chosen because they capture the essence of themes or provide the richest or most powerful expression of themes.

Researcher reflexivity and rigour

The key influence of researchers' subjectivities is explicitly recognised and stated in IPA, facilitating transparency. As a trainee clinical psychologist ('trainee'), the first

author has seven years pre-qualified NHS lived experience, and the second and third authors collectively have 38 years qualified NHS lived experience, of this work. They hold a broad position that this work can powerfully personally affect clinical psychologists in adverse and positive ways, sometimes facilitating growth. It is recognised that these lenses may have influenced findings. A potential influence of the first author being a trainee approaching qualification with an obvious interest in this work is acknowledged and attended to further within the Discussion.

To increase analytic validity, researcher triangulation was used, and potential biases identified and critically examined during supervision and through a reflective diary kept by the first author.

Results

Three inter-related super-ordinate themes were identified (Table 1) capturing the intensity and complexity of these clinical psychologists' experiences of sexual trauma work in NHS settings.

Table 1. Participant endorsement of super-ordinate and subordinate themes

	Christine	Ffion	George	Hannah	Lloyd	Lori	Madeline	Siân
1. Hidden versus seeing: an isolating experience a) Hidden: unaware, distancing, avoidance	✓	✓	✓	✓	✓	✓	✓	
1. Hidden versus seeing: an isolating experience b) Seeing: looking and approaching	✓	✓	✓	✓	✓	✓	✓	✓
2. The sequelae of seeing: challenges, privilege, and transformations a) Intensity and intimacy: a mixed experience	✓	✓	✓	✓	✓	✓	✓	✓
2. The sequelae of seeing: challenges, privilege, and transformations b) Transformation of self		✓			✓	✓	✓	✓
3. Surviving and getting through a) Surviving as a clinician	✓	✓	✓	✓	✓	✓	✓	✓
3. Surviving and getting through b) Surviving as a person	✓	✓	✓	✓	✓	✓	✓	✓

1. Hidden versus seeing: an isolating experience

Participants described challenges, conflicts, and personal costs in navigating perceived unacknowledged sexual trauma within society and systems.

1a. Hidden: unaware, distancing, avoiding

A broad unawareness or reluctance to acknowledge and engage with the reality of sexual trauma within society was perceived. Participants reflected that most people "…*wouldn't know the extent…"* (Hannah) and are "…*unaware apart from […] the odd*

thing that comes up in the news" (George). Participants perceived that the 'hidden' nature of sexual trauma permeated society. A few reflected that they had not "*connected*" (Lloyd), "*heard*" (Christine) or "…*had any experience…*" (Madeline) with sexual trauma before being exposed through this career. Christine and Madeline attributed this to having "*positive*" (Christine) "*traditional nice"* (Madeline) upbringings:

> "I never had any experience of that [sexual trauma] in my personal life, um I had a very kind of traditional nice upbringing. Um, it was really shocking…" (Madeline)

For Madeline, this "*really shocking*" emotional experience led to initially distancing from this work, "…*it actually put me off this work […] I was almost over-exposed to it… I couldn't process it".* Thus, for Madeline, distancing served to protect from this new awareness.

Some participants perceived that society similarly chooses to distance, "*…it's just not a nice topic that people want to talk about […] people don't really want to hear about it […] people just don't quite know how to respond…"* (Ffion). Ffion suggests that in addition to aversion, helplessness underlies societal avoidance, "*don't quite know how to respond"*. Most participants identified personal costs to this, feeling "*a bit different*" (Christine), "*isolate[ed*]" (Lori, Ffion) or "*lonely*" (George).

A few participants felt that distancing extended to colleagues:

> "…these people that I am working with are survivors of sexual trauma, that's the way I see it, but the way my colleagues might see it is that […] they are PDs [personality disorder], that term gets used a lot in my team…" (Lori)

> "…colleagues talk about 'I don't want to go down that road, I don't want to open it up?' well what, what, where has that come from? Why do people think that's a thing? that there's something to open up? […] I think where [specialism] still fits is in that shaming box, 'let's not talk about this' […] 'you talk about that to the psychologist', 'we don't deal with that', so the person [survivor] holds onto the shame …" (Madeline)

Lori and Madeline's narratives speak to their experiences and perceptions of colleagues distancing from sexual trauma, with consequences for survivors: "*shaming".* It is interesting that Madeline questions these motivations given her reflection that she was at first "*put off this work"*. Whilst Siân and Madeline alluded to perceptions of complexity and feeling 'stuck', Madeline also interpreted this as a defence against confronting vulnerability:

> "I think that's what scares people […] when we recognise this could happen to any one of us or anyone in our family, we, we put it over there and we don't want to think about it, so we distance ourselves, and we do it as professionals" (Madeline)

Madeline's switch from talking *about* colleagues to her use of plural pronouns, "*we do it as professionals*"[3], perhaps suggests that clinical psychologists and non-psychology colleagues distance from sexual trauma to self-protect.

George and Lloyd identified fear in approaching this work, although this was motivated by concern regarding the impact on survivors rather than self-protection. They described the work as a "*double bind*" (George) or "*bind"* (Lloyd). For George, this reflected internal conflict between wanting to provide therapy but experiencing practice and ethical dilemmas regarding ongoing legal investigations:

> "…real fear I think around oh my god, what if I say or do something that actually means they don't get justice […] I want to help this person and I want them to have justice um and what I'm ending up doing is holding back and not offering support that feels like it would be helpful, and that doesn't feel like I'm helpful or doing what's just" (George)

Here, George's strong want to help survivors therapeutically and judicially is apparent, emphasised by repetition of "*I want".* Yet this is experienced in conflict, resulting in "*fear"* and a tension between going "*straight in*" versus "*holding back*".

For Lloyd, fear was all-encompassing, his experiences nested within strong and emotive language evoking war imagery, "*constant battle", "fraught with danger", "minefield".* The impact of Lloyd's gender (male) in relation to survivors' (female) and

[3] Underlining used for analytic emphasis here and throughout

perpetrators' (male), as well as his perceived lack of knowledge and skill in this area, were central to fear, which often led to distancing through referring to a sexual trauma third sector organisation:

> "…I'm a bit torn then, I'm like ok I could work with this but also there's [*third sector organisation*] so, I, I'm in a bit of a bind then, it's like, well there's a specialist service that are geared towards working with this who are probably far more competent than I. Or, you know, do I work with you because you've, you've made this disclosure to me, and you felt safe enough to do it?" (Lloyd)

Within this extract and throughout Lloyd's account his effort in wanting to "*do what's best*" and not wanting to "*get it wrong"* was apparent, leading to confusion and inner conflict: "*torn".* This was often resolved through distancing, referring to "*specialists*". Interestingly, this seems to mirror non-psychology colleagues referring to clinical psychologists: *'the specialists'*, as described by some participants. It is worth noting that Lloyd and George had the least experience and highest expressed self-doubt in effectively navigating this area.

1b. Seeing: looking and approaching

Through being clinical psychologists, participants chose to 'look' and 'approach' sexual trauma, though the extent varied according to chosen specialism. For Lori and Madeline, this motivated choice in their area of work:

> "Well, it [sexual trauma work] was what I kind of went into this kind of area for" (Lori)

> "…what I came to realise was that actually it was peoples' stories that interested me, and understanding um what had happened to them in their lives, and I ended up going full circle and going back into [specialism]…" (Madeline)

Lori and Madeline's accounts highlight participants' choice in 'approaching' sexual trauma, although the degree to which this is considered a choice is illuminated by Madeline: "…*if you choose this career or it chooses you…".* Most participants described strong 'pulls' to this career as it aligned with their identity and/or values. However, being female, Madeline also described what might be considered a 'push' rather than choice, "…*some would ask to see a female, so I think by definition [my] caseload became very skewed with female survivors".* Indeed, the co-existence of 'choice' and 'needing' to engage with sexual trauma is captured below:

> "…it's part of the work when you work in [specialism], as a psychologist, you can't get away from it [sexual trauma], it's everywhere […] it just kind of comes with the territory" (Siân)

And later:

> "…I mean the work is hard […] but it's not something I would shy away from. Definitely, you, you just can't in our line of work…." (Siân)

Here, Siân alludes to a desire to distance from sexual trauma, yet she illustrates that this is not possible as well as her choice and commitment to 'approach' and engage.

Participants wanted others to 'see' and/or 'approach', "…*everybody should be aware*…" (Lori), "…*it's everybody's business…*" (Madeline), not "…*something that should be hidden"* (Christine). However, for some this introduced a dilemma:

> "…sometimes you want to show people how bad it is, tell them, um or you want them to listen and then you think 'well that's a bit unfair really because they've not chosen this career'…" (Madeline)

Choice was again identified as important. Interestingly, some participants expressed an appeal towards 'not seeing', feeling "*envious"* (Madeline, Hannah) or that it would be "*nicer"* (Christine) to not know. Yet this fantasy was recognised, "…*you can't not see it…"* (Madeline) "…*you can't unknow…"* (Christine), reflecting the lasting changes from 'looking'.

Some participants experienced relational costs caused by differences in awareness, though the magnitude varied. For Hannah, this "…*probably […] play[ed] a part"* but did not have a *"significant impact*" on her romantic relationship, whereas for Lori and Madeline it resulted in relationship breakdowns, "…*I think a part of that was about, I can't speak to you about…there's a huge part of my life that you will never know anything about and be completely disconnected from…"* (Madeline).

2. The sequelae of seeing: challenges, privilege, and transformations

As participants 'approached' and 'saw' sexual trauma they experienced intense challenges and rewards and for many, transformations.

2a. Intensity and intimacy: a mixed experience

The intensity and intimacy of sexual trauma work was evident across all narratives. Many described it as "*emotionally demanding*" (Hannah, Ffion) or "*heavy*" (Christine, Hannah, Ffion, Lori), though the extent varied and was influenced by survivors' stories and/or demographics. The intense difficulty in bearing witness to sexual trauma was apparent for some participants, "…*probably the worst to hear"* (Lloyd), "…*traumatic to hear about and traumatic to think about"* (George) and less so for others, "*I don't think I particularly find it drastically different from working with anyone else with any other difficulty*" (Christine).

Participants experienced a myriad of emotions within the therapy room, interpreting this as "*reflect[ing*]" (Lori) or "*matching*" (Hannah) survivors' emotional experiences. Although difficult, many identified these as "*expected*" (Lori) or "*making sense"* (Lori, Hannah), being "*quite healthy*" (Lori, Madeline) and "*help[ful]"* (Lloyd, George). Participants described horror, terror/fear, anxiety, shock/disbelief, anger/rage, sadness, disgust, hopelessness, powerlessness/helplessness, and overwhelm; with severity emphasised through "*really*", "*very*", "*a lot of"*. The intensity of participants' emotional experiences was most powerfully expressed by Lori:

> "A lot of the time I feel um 's***, oh my god, um f****** hell, this is b***** awful', what they have been through this is horrendous, I feel

> like I am going to vomit. Sometimes I feel sick, and I think that is, yeah, some absorption of their [survivors'] trauma, um, you know sometimes I can feel my physiological arousal levels really getting quite high […] I think that's probably you know countertransference" (Lori)

And later…

> "…often you just feel this disgust and you know, horror about what goes on […] you are hearing like the nitty gritty of it, and you, you can't help but have this, this image a lot of the time of this client as a tiny little child being abused in these horrific ways and, it is just like a horror film…" (Lori)

Here, the frequency of raw and intense emotional responses is stark, emphasised through changing language to using profanities and being compared to a "*horror film*". Through survivors' emotions being transferred to her and "*hearing the nitty gritty",* Lori indirectly yet powerfully experiences the trauma. The emotional impact is profound, reflected by responses being elicited during the interview:

> "…it makes me feel a bit sick even just sort of thinking about it…" (Lori)

Echoed by Lloyd:

> "…I'm getting emotional even talking about it now…" (Lloyd)

These quotes illustrate the pervasiveness of the emotional impact of this work, being experienced through "*just"* or *"even"* "*thinking*" or "*talking*" about it.

Some participants expressed fear of "*retraumatising*" (Lloyd), "*making them [survivors] worse"* (Lori) or "*doing damage*":

> "[at beginning] I remember it [sexual trauma work] feeling pretty terrifying. And I remember thinking about um you know, fear of doing damage" (Ffion)

Ffion suggests a perceived responsibility and power to potentially harm survivors permanently.

Participants described "*carrying"* (Lori), "*taking"* (Lloyd) or "*bringing"* (Hannah) this work into their personal lives through 'thinking about it' (Lori, Ffion, Christine, Madeline, George) and 'images' (Hannah), especially with highly distressed survivors, where there was risk, or the sexual trauma was "*particularly heinous*" (Siân). "*Carrying*" evokes heaviness which reflects Lori's and other participants' (Christine, Hannah, Ffion) descriptions, and speaks to the experiences and impact for some:

> "…not really satisfied with how things are in those other areas of my life at that point, like my relationship or friendships because […] it's

> so hard to switch off from [this work] […] I'm not really present or giving my all to those other areas" (George)

> "…if I'm you know changing my child's nappy or something, when I'm giving them a bath you know, it [sexual trauma] pops in your head…" (Lloyd)

George and Lloyd's accounts illustrate relational costs to this work on friendships, romantic relationships, and parenting. Intrusions during parenting was also reported by Madeline yet both Lloyd and Madeline indicated that, whilst being difficult, intrusions during intimate parenting tasks did not prevent them from doing such tasks. Many participants similarly reported that intrusions did not significantly distress them or adversely affect their lives, and made sense through still "*processing"* (Ffion, Hannah) sessions:

> "I don't think I get particularly distressed by them [images] […] I think it's almost our mind […] trying to still process […]. So, it feels ok, it doesn't feel like it intrudes on my life" (Hannah)

Whilst all participants continued to experience emotional responses to this work, especially with "*more extreme*" (Christine, Ffion) abuse or when abuse happened younger, most reported the impact had significantly lessened over time. Becoming "*less or de-sensitised*" (Hannah, Christine, Ffion), and more confident in the therapy process and their ability (aided by trauma-specific training post-qualification) were believed to contribute importantly to this.

Indeed, many felt insufficiently skilled to begin with which impacted self-confidence and emotional experiences, "…*high caseload without much training in trauma-specific models apart from what the kind of course equipped me with […] fed into the hopelessness because it felt like I wasn't particularly skilled or equipped to support those individuals"* (Ffion). This was echoed and extended by some who felt unprepared for the "*real[ity]*" (Madeline, George), particularly the "*emotional impact*" (George, Lloyd). Timely access to trauma-specific training was expressed as necessary and important.

Changes within participants' personal lives commonly affected experiences and impact of this work. Becoming a parent was universally identified (by those who were) through it "*connecting"* (Lloyd, Christine) differently and changing participants' "*understanding*" (Christine) and "*reality"* (Madeline). The profound effect that having children can have in this work is powerfully captured below:

> "…a greater understanding of what a child *that* young would *actually* be like […] like an emotional understanding rather than an academic kind of knowing […] as to how that person experienced that, thinking of my own young child…" (Christine)

> "'[after having children] It felt too big […] like there was too much in the world, there was too much abuse, too much horribleness…" (Madeline)

Systemic challenges were commonly reported and included differences in professional perspectives within teams, feeling silenced/ignored, undervalued/unsupported, team expectations and pressures towards clinical psychologists, competing demands, and service pressures such as high caseloads, waiting lists and lack of resources. For some, this impact was immense:

> "Some of the battles are more with the systems and the politics rather than the client work" (Madeline)

> "…for me the most challenging thing is the systemic problems" (Lori)

Madeline's narrative elicits war imagery, "*battles".* The gravity of impact for Lori is best understood when considered within context. That is, whilst therapy experiences can be "*like a horror film*", systemic problems are harder for her. Wanting a fairer trauma-informed system, more staff and resources, and fewer waiting lists were reported.

However, despite these challenges, participants felt "*passionate*" (Madeline) about this work, and all described intense positives, experiencing it as interesting, enjoyable, and rewarding. For many, being entrusted with information not shared with others was a "*privilege*" (Lori, Ffion, Hannah, Siân) and "*humbling*":

> "…it's a deep privilege to hear it [sexual trauma] when people do [tell you], when maybe they've never told anyone else […] that

> people would have the confidence and courage to be able to share with me […] it's a deeply humbling experience…" (Siân)

Siân illustrates the magnitude of felt privilege: "*deep[ly]".*

Feeling inspired, encouraged, hopeful and in awe of survivors' strength and courage within therapy and in their resilience was common. All experienced positive emotions through contributing towards survivors' recovery, described as "*amazing*" (Ffion, Lloyd), "*fantastic*" (Lori, Lloyd), "*great*" (Siân, Lloyd), and making this work "*really worthwhile"* (Christine). This was most powerfully expressed by Lloyd:

> "…dare I say it you know corrective emotional experience where they've [survivors] been fearful of men since and to have a man […] sit alongside and be with and be compassionate and emotive, I sometimes found that it's, it's brought a new person to life again…" (Lloyd)

The stark contrast in Lloyd's experiences is palpable. On one hand, he feels immense fear doing this work (with his male gender pivotal) and experiences it as "*probably the worst to hear".* Yet his profound influence in survivors' recovery leads to his *"biggest highs".*

2b. Transformation of self

Participants' experiences reflected the idea of transforming themselves into a powerful other. They spoke of the importance of demonstrating competency within the therapy room:

> "…really important about in-the-moment showing the person that you can, that you can hear it and you're not going to go 'oh my god, this is too much'. Um, that you can bear it…" (George)

> "Sometimes I feel this sort of like, I rise up […] and I feel quite big and sort of like yeah, you know, I've got the skills and we can do this…" (Lori)

For Lori, competence is communicated through becoming physically bigger. As survivors are likely feeling overwhelmed and powerless, it seems that clinical psychologists may feel the need to step into the 'powerful' position to contain overwhelming emotions and communicate their ability to "*bear*" and help.

Participants referenced all-powerful 'other-worldly' phenomena, "*magic*-" (Christine, George, Madeline, Siân), "*miracles"* (Siân), "*messiah*" (Madeline). Some believed this came from others, "*sometimes it just feels like people just expect miracles, that you're going to be able to 'fix' everybody*" (Siân) and from themselves, particularly when feeling 'stuck', "…*maybe if I just train in that other therapy over there, I will have that magic answer*" (Madeline). Yet participants recognised this as a fantasy, that they were "*not special*" (Madeline) and that there was no magic answer:

> "I don't have any magical powers […] there is no magic therapy…" (Madeline)

It appears that clinical psychologists may feel 'put' or 'step' into all-powerful positions in response to feelings of powerlessness within survivors, themselves and/or systems.

This powerful 'self' position was also seen in trying to "*advocate*" (Ffion) for survivors or being like 'allies', which extended outside therapy. Evoking war connotations, a few reported "*flying that flag*" (Lori), challenging "*quite ferociously"* (Madeline) and "*crusading*" (Madeline), trying to get people to acknowledge and understand sexual trauma and how it relates to wider structures of power and control.

Transformations *to* the self were also evident. Some participants described having a "*different lens"* (Madeline) they viewed the world through, with a few initially feeling like sexual abuse was "*everywhere*" (Madeline, Lori). Many felt that this had affected areas of their lives, particularly parenting:

> "I watched them [children] 24/7 […] [sexual trauma] work impacted on decisions I made about my children, about their nurseries had to have CCTV […] I probably would have been less hawk-like if I didn't have the knowledge I had from my job" (Madeline)

Madeline's account elicits strong images of monitoring and protection, yet she perceived her knowledge of sexual trauma to be "*helpful*", using it to "*foresee anything happening",* reflecting her perception of threat and danger. For Madeline, the impact of coming to 'know' was pervasive:

> "…almost like a shattering of your reality […] when you have that knowledge you can't help but look back [at own history] and think what I held to be true probably wasn't…" (Madeline)

Knowledge of sexual trauma changed the entirety of Madeline's reality, changing her past, present, and future. This profound impact was recognised by Madeline and seemed to have led to welcomed transformations, "…*doing this work has made me the person I am, and that's something I'm grateful for…".*

Whereas for most, transformative effects were adverse and corresponded to volume of this work. For some, their view of others and the world had been affected, "…*losing faith in humanity"* (Lori, Siân):

> "…when you get a lot of these clients, you can just start to think that like the world is a dark place […] you can lose a bit of the colour of life really because all you hear is trauma stories. Um, and that everywhere is just full of bad people…" (Siân)

For a few, the impact of repeated engagement with sexual trauma on the self was insidious, and is powerfully captured below:

> "…we have this joke that if you work in those kind of services [high caseloads of this work] too long you get 'trauma face', where you are very kind of really low looking [..] you're obviously more aware of trauma in the media […] it kind of gets into your bones…" (Ffion)

> "I feel like I am being robbed of my own energy and my own self" (Lori)

The invasion of this work and its effects on participants' whole selves is palpable. For Lori, not only does it rob her of her "*own energy",* but it also robs her of her "*own self",* which raises the question: what is left of Lori?

3. Surviving and getting through

Various "*survival strategies"* (Siân) were identified for "*getting through*" (Lloyd) and 'surviving' within and outside work. This reference to 'survival' (Lori, Siân) not only speaks to the profound impact on participants, but also echoes language adopted for people who have directly experienced sexual trauma, 'survivors', alluding to strong parallels between direct (i.e., survivors) and indirect (i.e., clinical psychologists) 'survivors'.

3a. Surviving as a clinician

Some identified changing therapeutic approach, focusing on survivors' "*readiness for change"* (Lori) and offering more "*change-focused work*" (Siân). Whilst this seemed partly motivated by service pressures, "…*huge amount of people that we could be*

seeing and should, you know are expected to be seeing…" (Lori), it also appears self-protective:

> "…I've spent a lot of time as a psychologist sitting with people [survivors] without any change […] I'm not doing that anymore because it's just not, it's not helpful to them I don't think, and it's definitely not helpful to me in terms of 'am I any good at my job?'" (Siân)

This strategy did, however, have costs, leading to unresolved inner conflicts:

> "I often try and reflect and think 'is that ok?' […] How does that fit with my morals, my values? How much are people able to really make the changes that I am saying that they need to make and how much am I just being unfair? [...] it kind of feels like the antithesis of what you go into this work to do" (Lori)

For Lori, the costs of this 'survival strategy' were ongoing and completely conflicted with her "*morals*" and *"values".*

Most participants similarly identified the importance of recognising and accepting their limits, protecting from burnout:

> "…if you get overwhelmed early on in your career you will just burn out […]. If you work twenty-four hours a day, seven days a week,

> there would still be people needing your service. You can only do what you can do" (Madeline)

Practicing self-compassion, "*…compassionate with myself as a psychologist and think I'm doing the best I can…"* (Siân), "*being good enough*" (Lloyd), and taking encouragement from "*small changes"* (Siân), "*little moments"* (George) and "*little comments"* (Ffion) helped participants manage.

For some, obtaining distance or balance by reducing to part-time hours or choosing/moving to specialisms or positions (leadership/managerial) which have less direct clinical sexual trauma work was necessary to remain doing this work:

> "…I have to do less of it, I want to carry on doing it, but I need to do less of it, and I need to balance it out more…" (Lori)

Balancing sexual trauma work with other types of work within caseloads and working days were commonly experienced as "*helpful"* (Hannah) and protective against burnout.

Having time and space, particularly after 'difficult' or 'intense' sessions allowed participants to "*process*" (George, Madeline, Hannah, Christine) and 'look after themselves' (e.g., going for a walk, having a tea/coffee, not writing notes straight away). However, a few identified difficulties "*protecting*" (George) this time because of competing demands:

> "…[after sessions] I've not had time to really look after myself and that was really hard and felt really stressful but also a bit of resignation […] this is what you've got to do, keep on you know, slog away onto the next thing. Um, and a bit of a sense of, this is just the NHS isn't it" (George)

For George, systemic demands and pressures resulted in a sense of helplessness with personal costs, *"not had time to really look after myself".*

Available and accessible support from colleagues, particularly after 'difficult' or 'intense' sessions was helpful:

> "…all I need to probably be able to kind of leave my office and it not to affect the rest of my day is to have told somebody…" (Christine)

> "…sharing if it's been tough or full on or if I just feel really sad. I just, it helps to acknowledge it…" (Hannah)

Christine and Hannah's accounts illustrate the importance of sexual trauma and its sequelae being 'seen' by others and shared.

However, barriers to this support were experienced by a few:

> "…there's informal support in the team, but when you're a psychologist […] they [colleagues] don't expect you to want to

> offload onto them […] it's not usual that people say, 'and how are you coping with that? how are you?" (Siân)

Formal support through regular and robust clinical supervision was identified as imperative, especially at the beginning of this work. Access to specialist supervision was 'really helpful' to those receiving it and wanted/needed by those not. Within individual supervision, many described needing time and space to reflect on the impact of this work and supervisors prompting this, but this was often absent because of supervision being hurried, supervisors being "*stretched*" (George), and other things taking priority. The helpfulness of reflecting on the impact of this work through participating in this research was powerfully expressed by some:

> "…some of this stuff I hadn't particularly thought about before in much detail […] I don't think until today realised the impact of this specific work…" (Hannah)

3b. Surviving as a person

Outside work, some participants needed to temporarily distance from people generally, "*… not talking to anybody, you know so sometimes I think 'I don't want to listen to anybody, I don't want to listen to any more problems'"* (Siân), or more permanently from certain relationships:

> "…I am more distant from my family […] I am just very mindful of like where I put my energy, um, because I feel I have less of it" (Lori)

> "…at times feeling a little bit kind of burnt out in terms of empathy […] so I've almost kind of withdrawn from some people […]. It makes me think of that spoons analogy, you've only got so many spoons so if you're giving so much to work, you've got to kind of figure out other ways of managing outside of work" (Ffion)

For these participants, distancing from personal relationships protected their remaining energy, the rest being 'given' or 'taken' by this work.

Separating work from the personal self was important for "surviving":

> "…key to surviving in this work as a therapist is not having it as your entire who you are […] it is part of my identity but it's not like my whole self" (Lori)

Given Lori's intense emotional responses and the profound impact of this work, "*robbed of own self*", as well as her effort and enthusiasm that extended beyond the work, "*flying that flag"*, this separation may reflect her 'survival' response to self-preserve, "*…it has taken a lot from me actually and I want some of it back"* (Lori).

Many participants recognised the importance of boundaries and separation between work and their personal lives, including sticking to contracted working hours and avoiding trauma-related or 'heavy' things outside work, visually illustrated by Siân:

> "…as I'm leaving [work] building I imagine taking off my coat and leaving it behind and it's like everything is on that coat" (Siân)

Personally meaningful self-care activities were universally recognised as necessary in managing this work and included breaks/holidays, spending time with important others, exercising, and being in nature. Such activities helped "*get rid of*" (Ffion) or *"get that [work] out"* (Lori), again eliciting notions of sexual trauma being absorbed. This was most powerfully expressed by Lloyd:

> "My old supervisor said, 'we work with people's s*** so it's important to clean yourself off' […] it's relevant you know; you've got to do it" (Lloyd)

Lloyd's narrative of needing to "*clean*" the "*s****" off powerfully mirrors experiences of some survivors in feeling soiled or dirtied by sexual trauma, reflecting parallels between impacts of sexual trauma on 'direct' (i.e., survivors) and 'indirect' (i.e., clinical psychologists) 'survivors'.

Discussion

The clinical psychologists in this study illustrate the complexity and intensity of experiences, impacts, and responses to sexual trauma work with adult survivors in NHS services. Their experiences map onto challenges, personal costs, a sense of privilege, and transformations of self, entwined with dilemmas and conflicts.

Participants' experiences relate closely to the literature on burnout (Maslach, 2003), compassion fatigue (Figley, 2002), vicarious trauma (McCann & Pearlman, 1990), secondary traumatic stress (Figley, 1995a), compassion satisfaction (Figley, 1995b), vicarious post-traumatic growth (Arnold et al., 2005) and coping (Sanderson, 20130), and corroborate existing research (Crivatu et al., 2023). As captured in the superordinate theme '*The sequelae of seeing: challenges, privilege, and transformations*', bearing witness to sexual trauma resulted in intense adverse emotional, arousal and somatic responses which, for some, extended beyond the therapy room. Whilst most believed these were "expected", reflecting survivors' responses and/or being an "absorption" of survivors' trauma, participants felt unprepared, and their responses had personal and/or relational costs for some. The "heaviness" of this work entered participants' personal lives, particularly with highly distressed survivors, more "extreme" abuse or when abuse happened younger, or where there was risk. Intrusions of traumatic material were experienced, such as during intimate parenting tasks. Becoming a parent significantly affected experiences and for some led to more protective parenting. Some experienced profound transformations, experiencing changes in their reality; "losing faith in humanity", seeing the world as "dark", and in their sense of themselves. Participants with higher and/or less variation in workload/caseload appeared to experience more intense and

pervasive negative effects, consistent with previous research (Crivatu et al., 2023; Schauben and Frazer,1995).

At the same time, participants found this work enjoyable, rewarding, and a “deep privilege”, supporting research identifying the co-existence of negative and positive impacts (Crivatu et al., 2023; Samios et al., 2013). Contributing to survivors’ recovery and feeling inspired by survivors’ strength and courage led to positive emotional experiences and for a few, personal growth. Identified by the superordinate theme ‘*Surviving and getting through’,* personally meaningful self-care activities and self-compassion helped participants manage the effects of this work, consistent with previous research (Crivatu et al., 2023). This included accepting limits, achieving balance, separation/boundaries, taking encouragement from small changes, and informal (i.e., colleagues) and formal (e.g., supervision) support.

Yet participants’ experiences seemed beyond what has just been outlined. They described raw and powerful personal experiences, conflicts, responses, and impacts and, importantly, illuminated the socio-cultural-political contexts within which these occurred. Our analysis therefore presents a nuanced extension of current understanding in this area.

Illustrated by the superordinate theme ‘*Hidden versus seeing: an isolating experience’,* many participants expressed feeling alone; they perceived society to be unaware of sexual trauma through having no context for knowing, or that society chooses to distance, partly motivated by overwhelm, helplessness, and/or fear of vulnerability. Societal denial and disavowal of atrocities (e.g., sexual trauma) has

been documented (Herman, 2005) and has been understood as feeling too horrific to talk or think about. Participants were left feeling disconnected and isolated, and for some, relationships broke down. Some experienced conflicts, wanting to advocate for survivors and combat stigmatisation and shame through 'telling' or 'showing' others, but also recognising and wanting to respect people's choices not to 'see'.

Perhaps surprisingly, participants perceived colleagues (who work within services supporting survivors) to also distance from sexual trauma in the form of diagnostic labelling, not wanting to "open it up" (i.e., not talk about it), and referring to clinical psychology ("you talk about that to the psychologist"), as 'the specialists'. It might be that diagnostic labelling creates emotional and psychological distance and positioning this work within psychology creates actual distance (see Cooke et al., 2019). Similar motivations to society were alluded to, including fear, and feeling helpless/powerless and insufficiently trained or skilled ('stuck'). Yet, this had costs for participants, feeling unintegrated within teams and overloaded.

Clinical psychologists also seemed prone to distancing, with a few participants "holding back" or referring to sexual trauma third sector organisations, perceived as 'the specialists'. This was mostly identified in less experienced and less confident participants, and for one, was heavily influenced by gender (male). Distancing was motivated by fear (e.g., adversely impacting legal investigations, retraumatising) and was associated with confusion and emotional turmoil regarding 'approaching' versus 'distancing'. Supporting clinicians to feel more adequately knowledgeable, trained, and skilled, and in managing emotional responses, is important as clinicians could

inadvertently reignite abuse dynamics through distancing (e.g., silencing, shaming), which could potentially be retraumatising (SAMHSA, 2014).

Highlighted in the subordinate theme '*Transformation of* self', being 'the specialists' sometimes meant that participants felt it was necessary or expected of them to transform and transcend themselves to become all-powerful, 'other-worldly' (e.g., magician, messiah, miracle-maker) in response to powerlessness within survivors, themselves and/or systems. This could be understood through reciprocal roles (Ryle & Kerr, 2020), with clinical psychologists being invited or stepping into the 'powerful' position and survivors, colleagues and/or systems occupying the 'powerless' position. Yet this 'all-powerful' position was recognised as fantastical, and could risk survivors, colleagues and/or systems staying in the 'powerless' position and hence more passive contributors in change. It may also inflate felt responsibility in clinical psychologists, increasing vulnerability to self-doubt through striving towards unattainable standards.

For many, this work transformed them. Repeated engagement with sexual trauma (i.e., high volume, caseloads/workloads) led to changes in some participants' entire selves, with it "getting into [their] bones" and "robbing [their] own self". The magnitude of impact is not sufficiently captured by existing constructs (e.g., 'change in identity' related to schema change in vicarious trauma; McCann & Pearlman, 1990); for some, it changed their entire *being* or took their *own self*. To reclaim some of themselves and "survive", participants engaged in various strategies, captured in the superordinate theme '*Surviving and getting through'.* Some of these strategies could be considered forms of distancing, including more change-focused work,

balancing workload (by reducing to part-time, changing specialisms, moving to leadership/managerial positions) and caseload, protecting time after sessions, and separating work from the 'personal' self.

Most participants reported systemic difficulties that disrupted coping, including lack of staff and resources, and competing demands. Other systemic challenges were commonly identified including differences in professional perspectives within teams, distancing/avoidance of sexual trauma by colleagues, feeling silenced/ignored, unintegrated/undervalued, lack of informal support by colleagues, team expectations/pressures, and service pressures (high caseloads, lengthy waiting lists). The gravity of systemic challenges is palpable, being expressed by all participants, and for some was the most challenging aspect of this work despite experiencing profound adverse responses within therapy (e.g., being "like a horror film", feeling sick, intrusions). This speaks to the urgent need for systemic changes.

Limitations and future research

Due to the cross-sectional nature of this study, participants' accounts were retrospective and may have been skewed by memory, experience over time, and current beliefs/emotions. Given the reported change in impact over time, it would be useful to conduct a longitudinal study following clinical psychologists from pre-qualification (i.e., during clinical training), to recently qualified and to years into practice. Due to the interviewer's (LG) status as a female trainee approaching qualification with a clear interest in this area, with professional links to some participants, participants may have self-censored their narratives. However, participants spoke at length and shared rich, raw and adverse/challenging as well as

positive experiences. We are therefore confident that a full range of experiences have been shared and explored. We had difficulty in recruiting male clinical psychologists, and for one male participant his gender was central to fear and distancing from this work. It is possible that fear contributed to a reticence toward participating for other male clinical psychologists. It is also recognised that parallels in gender dynamics (i.e., female research team) might have further impacted recruitment. A study purposely selecting by gender (i.e., male) from the same geographical and occupational contexts, with consideration given to gender dynamics within the research, would be helpful in exploring and furthering understanding into the experiences and needs of clinical psychologists working with sexual trauma.

Implications

Whilst it should not be assumed that these participants' experiences represent experiences of all clinical psychologists working therapeutically with sexual trauma survivors in NHS settings, the similarity and intensity in experiences across participants indicates the strength of impact of this work on these clinical psychologists and is suggestive of wider transferability and applicability. As such, this study clearly highlights the need for systemic changes to support the wellbeing of NHS clinical psychologists and in turn, support staff retention and the quality and sustainability of sexual trauma services.

We strongly recommend that the NHS implements and embeds trauma-informed care into practice (see SAMHSA, 2014), in line with recent national guidance developed by the Adverse Childhood Experiences Hub Wales and Traumatic Stress

Wales (2022), which is supported by Welsh Government: '*Trauma-Informed Wales: A Societal Approach to Understanding, Preventing and Supporting the Impacts of Trauma and Adversity'*. This guidance is underpinned by five practice principles: a universal approach that does no harm which is person-centred, relationship-focused, resilience and strengths-focused, and inclusive. It outlines four practice levels. The first level, *'trauma-aware'*, represents a universal all-society approach which recognises that everyone in Wales, including the public, communities, systems, and organisations (i.e., the NHS), are aware of and understands the impact of trauma, has a role in preventing and reducing trauma, and supports resilience through connection, inclusion, and compassion. The second level, '*trauma skilled'*, refers to the practice of everyone who provides care or support to people who may have experienced trauma, irrespective of whether the trauma is known. Thus, this level applies to the whole of the NHS workforce. Key elements include providing safety and promoting trust, mitigating the impacts of trauma, and preventing re-traumatisation. The third level, '*trauma-enhanced'*, applies to frontline workers who provide direct or intensive support to people who are known to have experienced trauma, and hence applies to NHS staff working within roles and settings which support survivors. Important aspects include acknowledging and understanding the link between trauma and current distress and coping, and sensitively and appropriately asking about a person's experiences, which involves feeling confident in how to ask about traumatic experiences, and compassionately and helpfully responding to information shared which may include disclosures of trauma. This is also consistent with the literature on routine enquiry of past trauma, such as within mental health services (e.g., Hepworth & Mcgowan, 2013). The fourth level, *'specialist interventions',* refers to practitioners and services which provide specific

support and interventions to help with the consequences and effects of trauma. This would, therefore, apply to clinical psychologists who provide sexual trauma work. There is growing evidence that trauma-informed services are effective and can offer significant benefits to staff and survivors (Sweeney et al., 2016).

Highlighted by this study and consistent with the NHS workforce being '*trauma-aware'* and '*trauma-enhanced'*, a greater awareness, recognition and understanding of sexual trauma across the NHS workforce is needed. This should include sexual trauma training for all staff, with further enhanced training and support to frontline staff who are providing direct or intensive support to survivors, such as on the impact of sexual trauma and on routine enquiry (see Hepworth & Mcgowan, 2013). This is important for mitigating risk of re-traumatisation, for example by inadvertently reigniting abuse dynamics (e.g., silencing, shaming) through distancing.

Illuminated by this study and in line with the NHS providing '*specialist interventions'* for survivors, more training during clinical psychologists' training and enhanced and timely training post-qualification for clinical psychologists working across specialisms is important. This should include sexual trauma-specific training, training on normalising, recognising, and managing emotional responses and impacts, and navigating wider remits of this work (e.g., implications for ongoing legal investigations). Support that meets the needs of clinical psychologists includes regular and robust specialist clinical supervision that enhances awareness and reflection on impacts of this work. This may be especially important for less experienced clinical psychologists (e.g., earlier in career, working within certain specialisms) and for clinical psychologists who become parents. Balancing sexual

trauma work within workloads and caseloads is important, especially for females, and for those working within certain specialisms. An ethos of prioritising and protecting time for self-care within and outside work should be instilled. Our findings also clearly highlight the need for increased staffing and resources. Such changes would not only help ensure NHS clinical psychologists' wellbeing but might also offer opportunities for professional and personal growth.

Conclusion

Clinical psychologists working with adult survivors of sexual trauma within NHS services may face intense and complex experiences, responses, challenges, and transformations in themselves, including positive/welcomed and adverse/unwelcomed. The socio-cultural-political contexts within which these experiences occur has been illuminated, with many participants experiencing NHS systemic challenges as more personally difficult than sexual trauma work. Systemic changes have been identified and recommended in line with trauma-informed care. This study suggests that the NHS should actively implement such changes to support the wellbeing of NHS clinical psychologists and in turn, support staff retention and the quality and sustainability of sexual trauma services.

Declaration of interest

Due to the method of sampling, five participants were known to the first author through professional links prior to their participation in the study.

Funding

None. This review was undertaken as part of a research project for the doctorate in Clinical Psychology award.

Acknowledgements

The authors would like to thank the participants for generously giving their time and sharing their experiences. They would also like to thank Dr Emma Lloyd, Aneurin Bevan University Health Board, for her assistance with this research, as well as Dr Carolien Lamers, North Wales Clinical Psychology Programme, and Dr Kelly Savery, Manchester Rape Crisis Centre, for preliminary conversations that contributed towards the decision to undertake research in this area.

References

Adverse Childhood Experiences Hub Wales & Traumatic Stress Wales (2022). *Trauma-Informed Wales: A Societal Approach to Understanding, Preventing and Supporting the Impacts of Trauma and Adversity*. Retrieved from https://traumaframeworkcymru.com/

Arnold, D., Calhoun, L.G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45,* 239–262.

Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims, 18(1),* 71-86.

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., Elamin, M. B., Seime, R. J., Shinozaki, G., Prokop, L. J., & Zirakzadeh, A (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings, 85,* 618–629.

Chouliara, Z., Karatzias, T., Scott-Brien, G., Macdonald, A., MacArthur, J., & Frazer, N. (2012). Adult survivors' of childhood sexual abuse perspectives of services: A systematic review. *Counselling and Psychotherapy Research*, *12*(2), 146-161.

Cohen, K., & Collens, P. (2013). The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy, 5(6),* 570-580.

Coleman, A. M., Chouliara, Z., & Currie, K. (2021). Working in the field of complex psychological trauma: A framework for personal and professional growth, training, and supervision. *Journal of Interpersonal Violence*, *36*(5-6), 2791-2815.

Crivatu, I. M., Horvath, M. A., & Massey, K. (2021). The impacts of working with victims of sexual violence: A rapid evidence assessment. *Trauma, Violence, & Abuse*, *24(1),* 56-71.

Figley, C. R. (1995a). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (pp. 1–20). New York: Brunner/Mazel Publishers.

Figley, C. R. (1995b). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel Publishers.

Figley, C. (2002). *Treating compassion fatigue*. New York: Brunner-Routledge.

Golding, J. M., Stein, J. A., Siegel, J. M., Burnam, M. A., & Sorenson, S. B. (1988). Sexual assault history and use of health and mental health services.

American Journal of Community Psychology, *16*(5), 625-644.

Hepworth, I., & Mcgowan, L. (2013). Do mental health professionals enquire about childhood sexual abuse during routine mental health assessment in acute mental health settings? A substantive literature review. *Journal of Psychiatric and Mental Health Nursing*, *20*(6), 473-483.

Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. Hachette, UK.

Johnson, J., Madill, A., Koutsopoulou, G. Z., Brown, C., & Harris, R. (2020). Tackling gender imbalance in psychology. *The Psychologist*, *33*, 5-6.

Lewis, S. F., Resnick, H. S., Ruggiero, K. J., Smith, D. W., Kilpatrick, D. G., Best, C. L., & Saunders, B. E. (2005). Assault, psychiatric diagnoses, and sociodemographic variables in relation to help-seeking behavior in a national sample of women. *Journal of Traumatic Stress*, *18*(2), 97-105.

Maslach, C. (2003). Burnout: The cost of caring. Malor Books.

McCann, L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3(1)*, 131-149.

Office for National Statistics (2020). Child sexual abuse in England and Wales: Year ending March 2019. Retrieved from Child sexual abuse in England and Wales – Office for National Statistics (ons.gov.uk)

Office for National Statistics (2021). Sexual offences in England and Wales: Year ending March 2020. Retrieved from Sexual offences in England and Wales – Office for National Statistics (ons.gov.uk)

Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York, NY: W. W. Norton.

Ryle, A., & Kerr, I. B. (2020). *Introducing cognitive analytic therapy: Principles and practice of a relational approach to mental health*. John Wiley & Sons.

Samios, C., Abel, L. M., & Rodzik, A. K. (2013). The protective role of compassion satisfaction for therapists who work with sexual violence survivors: An application of the broaden-and-build theory of positive emotions. *Anxiety, Stress & Coping*, *26*(6), 610-623.

Sanderson, C. (2013). *Counselling Skills for Working with Trauma: Healing from Child sexual abuse, sexual violence and domestic abuse.* London: Jessica Kingsley Publishers.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma the effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, *19*(1), 49-64.

Sizmur, S., & Raleigh, V. (2018). The risks to care quality and staff wellbeing of an NHS system under pressure. *The King's Fund: Oxford*, *24*.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Smith, J.A. and Osborn, M. (2008) Interpretative Phenomenological Analysis. In: Smith, J.A., Ed., *Qualitative Psychology: A Practical Guide to Research Methods*, 58-80, London: Sage.

Substance Abuse and Mental Health Services Administration (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach. HHS Publication No. (SMA) 14-4884.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

Summers, E. M., Morris, R. C., Bhutani, G. E., Rao, A. S., & Clarke, J. C. (2021). A survey of psychological practitioner workplace well-being. *Clinical Psychology & Psychotherapy*, *28*(2), 438-451.

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: What is it and how can we further its development?. *Mental Health Review Journal*, *21(3),* 174-192.

VanDeusen, K. M., & Way, I. (2006). Vicarious trauma: An exploratory study of the impact of providing sexual abuse treatment on clinicians' trust and intimacy. *Journal of Child Sexual Abuse, 15(1),* 58-69.

Appendix A – University ethical approval

Ethical approval granted for 2021-16968 Exploring Clinical Psychologists' (and Psychotherapists') experiences of working with survivors of sexual trauma

ethics@bangor.ac.uk ethics@bangor.ac.uk

Mon 18/10/2021 14:45
To:
Laura Glinn <lrg19cjy@bangor.ac.uk>

Dear Laura,

2021-16968 Exploring Clinical Psychologists' (and Psychotherapists') experiences of working with survivors of sexual trauma

Your research proposal number 2021-16968
has been reviewed by the [Pre-Aug 2021] School of Psychology Ethics and Research Committee and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

Appendix B – NHS research and development approval

BA BCU Research Applications (BCUHB - Research & Development) <BCU.ResearchApplications@wales.nhs.uk>
To: Laura Spencer (BCUHB - Clinical Psychology) <Laura.Spencer@wales.nhs.uk>
Cc: Renee Rickard; Laura Glinn; Laura Longshaw (BCUHB - Research & Development) <Laura.Longshaw@wales.nhs.uk>
Wed 09/03/2022 15:02

Outline_16_11_2021_Organis... 122 KB

Dear Dr Laura Spencer,

Re: 305837 - Confirmation of Capacity and Capability at BCUHB NHS Organisation.

Full study title: Exploring Clinical Psychologists' (and Psychotherapists') experiences of working with survivors of sexual trauma

This email confirms that Betsi Cadwaladr University Health Board (BCUHB) has the capacity and capability to deliver the above referenced study, documents reviewed are those as listed in the HRA/HCRW approved list.

The localised Organisational Information Document is attached.

We agree to start this study on the date you, as Sponsor, provide as the "Green light".

If you wish to discuss further, please do not hesitate to contact me.

N.B. Future submission of amendments, should be sent to our R&D generic inbox: BCU.ResearchApplications@wales.nhs.uk

Cofion cynnes - With kind regards
Alice Jones-Blunt
Hwylusydd Ymchwil · Research Facilitator

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Research & Development Office
Holywell Community Hospital
Halkyn Road
Holywell
CH8 7TZ

Ffôn · Tel: 03000 856753
e-bost · e-mail: alice.jones-blunt@wales.nhs.uk

AD Heidi Lawson (Aneurin Bevan UHB - Research And Development) <Heidi.Lawson@wales.nhs.uk> on behalf of ABB_Research and Development (Aneurin
To: Huw Roberts; Renee Rickard; Laura Spencer (BCUHB - Clinical Psychology) <Laura.Spencer@wales.nhs.uk> **+2 others**
Cc: ABB_Research and Development (Aneurin Bevan UHB - Research and Development) <ABB.RandD@wales.nhs.uk> **+4 others**
Thu 24/03/2022 12:19

Outline_21_02_2022_Organis... 396 KB

Dear Laura and Huw,
Full Study Title: Exploring Clinical Psychologists' (and Psychotherapists') Experiences of working with survivors of Sexual Trauma
This email confirms that **ABUHB** has the capacity and capability to deliver the above referenced study. Please find attached our agreed **Organisation Information Document** as confirmation.
We agree to start this study on a date to be agreed when **you, as sponsor, give the green light to begin**. ***Please copy us in to this email.***

Please copy R&D into all monitoring reports, for the duration of the study.
Please Note: we are unable to receive emails with large attachments. Please notify us in advance of sending any amendments or emails with many documents attached.
Cofion caredig /Kind regards
Heidi Lawson
Quality Manager (Capacity and Capability)

Centre for Clinical Research - Research and Development
Canolfan Ymchwil Gllinigol –Ymchwil ac Ddetblygiad
Ward B5W / Ward B5W
Bwrdd Iechyd Prifysgol Aneurin Bevan/Aneurin Bevan University Health Board
Ysbyty Brenhinol Gwent/ Royal Gwent Hospital
Ffordd Caerdydd/ Cardiff Road
Casnewydd/ Newport
De Cymru/ South Wales
NP20 2UB / NP20 2UB

E-bost/email: Heidi.Lawson@wales.nhs.uk
E-bost tîm generig/Generic team email: ABB.RandD@wales.nhs.uk.
Twitter/Twitter: @ABUHB_Research

Please note my working week is Monday-Thursday
http://www.healthandcareresearchwales.org/

Croesawn ohebiaeth yn Gymraeg ac yn Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi. We welcome correspondence in Welsh and English. Corresponding in Welsh will not lead to a delay.

Appendix C – Invitation email, first phase

Dear _____,

I hope that you are well and that this email finds you well.

I'm a third-year Trainee Clinical Psychologist on the North Wales Doctorate in Clinical Psychology Programme at Bangor University working in BCUHB. I am recruiting participants for my doctoral research study. I am seeking to recruit Clinical Psychologists who currently work (or who have worked) in BCUHB with adult survivors of sexual trauma (sexual trauma can be any type and perpetrated at any age) to help survivors come to terms with the sexual trauma and in their recovery from the effects of sexual trauma. The study aims to better understand the personal experiences of Clinical Psychologists who work therapeutically with adult survivors of sexual trauma in NHS settings.

Participation will involve completing a demographic and basic clinical information form and taking part in an interview that is expected to last between 60 and 90 minutes. Participants will be reimbursed with a £15 Amazon voucher for their participation in the study.

I am kindly asking you to circulate this recruitment email and the attached study poster to Clinical Psychologists working in _____. I am also asking if it would be possible for you to put up the attached poster in staff areas. If you would like me to send you printed posters, please do not hesitate to contact me. I would be enormously grateful for your assistance with this process.

If you have any questions or would like any more information, please do not hesitate to contact me: Laura Glinn, lrg19cjy@bangor.ac.uk / laura.glinn@wales.nhs.uk
Tel: 01248388365 and ask for me to call you back.

Thank you in advance.

With warm wishes,
Laura Glinn

Invitation email, second phase

Good morning _____,

I hope that you are well and that this email finds you well.

Please could I kindly ask you to forward on this email and the attached poster to Clinical Psychologists, in particular Clinical Psychologists who identify as male, who might be eligible to participate in this study. Thank you very much for your support with this study.

My name is Laura Glinn and I am a third-year Trainee Clinical Psychologist on the North Wales Doctorate in Clinical Psychology Programme at Bangor University working in BCUHB. I am recruiting participants for my doctoral research study. I am seeking to recruit Clinical Psychologists who currently work (or who have worked) in BCUHB or Aneurin Bevan UHB with adult survivors of sexual trauma (sexual trauma can be any type and perpetrated at any age) to help survivors come to terms with the sexual trauma and in their recovery from the effects of sexual trauma. The study aims to better understand the personal experiences of Clinical Psychologists who work therapeutically with adult survivors of sexual trauma in NHS settings.

A big thank you to everyone who has expressed interest and participated in this study to date. **We have had a much higher response rate from Clinical Psychologists who identify as female, and we are very keen to also hear about the experiences of Clinical Psychologists who identify as male. I am looking for one or two more participants, preferably Clinical Psychologists who identify as male.** We are therefore kindly asking eligible Clinical Psychologists who identify as male and who are interested in finding out more about the research study to get in touch.

Participation will involve completing a demographic and basic clinical information form and taking part in an interview that is expected to last between 60 and 90 minutes. Participants will be reimbursed with a £15 Amazon voucher for their participation in the study.

If you have any questions or would like any more information, please do not hesitate to contact me: Laura Glinn, lrg19cjy@bangor.ac.uk / laura.glinn@wales.nhs.uk Tel: 01248388365 and ask for me to call you back.

Thank you in advance.

With warm wishes,
Laura Glinn

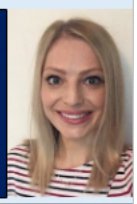
Appendix D – Study poster

NWCPP-RSCGC

RHAGLEN SEICOLEG CLINIGOL GOGLEDD CYMRU
NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME

PRIFYSGOL BANGOR UNIVERSITY

Would *YOU* like to take part in our research study?
Exploring Clinical Psychologists' experiences of working with survivors of sexual trauma



Principal Investigator: Laura Glinn, lrg19cjy@bangor.ac.uk, North Wales Clinical Psychology Programme, Bangor University, LL57 2DG
Chief Investigator: Dr Laura Spencer, laura.spencer@wales.nhs.uk, Conwy CMHT, Nant-y-Glyn Resource Centre, Colwyn Bay, LL29 7RB
Academic Supervisor: Dr Renee Rickard, r.rickard@bangor.ac.uk, North Wales Clinical Psychology Programme, Bangor University, LL57 2DG

What is our study about?

This study aims to better understand the personal experiences of Clinical Psychologists who work therapeutically with survivors of sexual trauma in NHS settings. Current research suggests that the personal impact of sexual trauma work is likely complex, with professionals experiencing this work in different ways. There is little research on the experiences of Clinical Psychologists in NHS settings. Understanding how Clinical Psychologists in the NHS experience sexual trauma work might inform what could be helpful to support the well-being of Clinical Psychologists who do this type of work.

Who are we looking for?

- Clinical Psychologists who have been qualified at least one year.
- Current or previous experience of working in the NHS therapeutically with adult survivors of sexual trauma (sexual trauma can be any type and perpetrated at any age) to help survivors come to terms with the sexual trauma and in their recovery from the effects of sexual trauma.

What will it involve?

- You will be asked to take part in an interview with Laura Glinn about your experiences of this type of work and how it has impacted you.
- You will also be asked to provide some basic demographic and clinical information.
- All information will be stored securely and confidentially in accordance with the Data Protection Act (2018), and Bangor University and BCUHB policies.
- Your participation is voluntary; you will be free to end your participation at any point
- *You will receive a £15 Amazon voucher as a thank you for your participation.*

Who should you contact for more information?

If you would like to know more information or if you have any questions, please contact: Laura Glinn, lrg19cjy@bangor.ac.uk, Tel: 01248388365 and ask for Laura Glinn to call you back.

Appendix E – Participant information sheet

Study Title

Exploring Clinical Psychologists' experiences of working with survivors of sexual trauma

Invitation to Participate in a Research Study

We would like to invite you to participate in a research study. Participating in this study is entirely up to you. Before you decide whether you would like to participate, it is important that you understand why the research is being done and what it will involve. Please read the following information carefully and take as much time as you need to consider it. The Principal Investigator (Laura Glinn) can go through this information sheet with you, to help you decide whether or not you would like to take part and to answer any questions you may have. Please feel free to talk to others about the study if you wish.

What is the purpose of the research?
The purpose of the study is to try to better understand the personal experiences of Clinical Psychologists who work therapeutically with survivors of sexual trauma in NHS settings. Current research suggests that working therapeutically with survivors of sexual trauma is complex, with professionals experiencing this work in different ways. The personal experiences and impact of this work for Clinical Psychologists working in NHS settings is currently not known. Understanding how Clinical Psychologists working in the NHS personally experience sexual trauma work might inform what could be helpful to support the well-being of Clinical Psychologists who do this type of work.

Who is able to take part in this research?
You can take part in this research if you are aged 18 years or over and are a Clinical Psychologist who has been qualified for at least one year. You must have experience of working in the NHS therapeutically with adult survivors of sexual trauma (sexual trauma can be any type and perpetrated at any age) to help survivors come to terms with the sexual trauma and in their recovery from the effects of sexual trauma. For interviews that will be conducted over videocall or telephone, you must have access to the required equipment and an appropriate space. You must be fluent in English.

What will the research involve?
You will be asked to sign a consent form and to complete a brief demographic questionnaire before taking part in an interview that is expected to last between 60 and 90 minutes. The interview will include questions about your work with survivors of sexual trauma, how you have personally experienced this work, and the personal impact this work may have had on you in areas including your well-being, your relationships and your hobbies and interests. The interview will take place with yourself and the Principal Investigator (Laura Glinn) and will be audio-recorded. You do not have to answer any questions that you do not want to.

How will you use information about me?
We will need to use information that you provide us with for this research study. This information will include your name and a contact email address (if you would like to receive the completed paper). You will also be asked to provide demographic information and information relating to the nature of your clinical work with survivors of sexual trauma. You do not have to answer any questions that you prefer not to answer. Only the research team will have access to this information. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code identifier instead and you will be allocated a pseudonym. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write and present the findings in a way that no-one can work out that you took part in the study.

Where will the research take place?
The research will follow current COVID-19 guidelines. We will try to offer you the choice of the interview taking place in-person in a room in Ysbyty Wrexham Maelor, Ysbyty Glan Clwyd or Ysbyty Gwynedd, or in a mutually convenient and appropriate location (e.g., your workplace), or the interview taking place over video-call or over the telephone. We will try to be flexible in meeting your preferences whilst abiding by current COVID-19 guidelines.

Do I have to take part in this research?
No, it is entirely up to you whether you take part in this study and participation is entirely voluntary. You do not have to answer any questions that you prefer not to answer. You are free to withdraw from this study at any point before, during and after the interview without giving a reason and without any detriment to yourself. However, it will not be possible to remove your data from the project once it has been anonymised because it will form part of the dataset and we will not be able to identify your specific data. This does not affect your data protection rights.

What are my choices about how my information is used?
You can stop being part of the study at any time, without giving a reason, but we will keep information that we have about you once the data has been anonymised. This is because it will be a part of the dataset and it will not be possible to identify your specific data.

Will I be reimbursed for taking part?
You will be reimbursed for your time with a £15 Amazon voucher. If you need to travel for the interview, travel expenses will be reimbursed as discussed with and agreed with the Principal Investigator (Laura Glinn) beforehand.

Who is organising and funding this research?
The study is being conducted as part of the Principal Investigator's (Laura Glinn's) Doctorate in Clinical Psychology degree at Bangor University. It is being supervised by Senior Clinical Psychologist, Dr Laura Spencer, Betsi Cadwaladr University Health Board and Clinical Director of the North Wales Clinical Psychology Programme (NWCPP), Dr Renee Rickard. The study is being organised and funded by the

NWCPP at Bangor University, in partnership with Betsi Cadwaladr University Health Board (BCUHB). The project has been ethically approved by Bangor University School of Psychology Ethics Committee.

What will the information that I provide be used for?
The findings of this research study will be written up in a thesis as part of the Principal Investigator's (Laura Glinn's) Doctorate in Clinical Psychology degree. It is also possible that the findings will be included in a research paper for publication and/or be presented at a conference in the future.

Will my taking part in this research be kept confidential?
All information you provide will be held in the strictest confidence. The data you provide will be anonymised in the write-up of the study through the use of a pseudonym and through the removal of other identifying information. All data will be stored securely in password protected documents on a password encrypted device, on the cloud of the Principal Investigator's university email and on the Principal Investigator's secure BCHUB NHS drive. Identifying information will be stored separately from the interview data in password protected folders on the Principal Investigator's BCUHB NHS secure drive. Any hard copies of the data will be stored securely at one of the research team's clinical bases or at Bangor University. Only the research team will have access to your data. Interviews will be transcribed by the Principal Investigator. Once the interviews have been transcribed, audio recordings of the interviews will be immediately destroyed. Anonymised transcripts and demographic information will be stored securely using password protection on the Chief Investigator's BCUHB NHS secure drive for up to ten years in accordance with Bangor University policy to allow for further analysis and post publication scrutiny, after which it will be destroyed.

You will be offered the opportunity to be emailed the completed paper that will be included in the Principal Investigator's (Laura Glinn's) thesis. You will be asked whether you would like to receive the completed paper prior to commencing the interview and if you decide that you would like to, you will be asked to provide a contact name and email address on your consent form. Your contact email address will not be linked with your interview data. Signed consent forms will be destroyed after the study has been completed and after participants who have chosen to receive the completed paper have been sent it by email.

What safeguards will be in place to protect confidentiality?
Your confidentiality will be protected through the allocation of a code identifier and the allocation of a pseudonym. Your identifiable information (name, and contact details if you choose to receive a copy of the write-up of the study) will be stored securely and separate to the rest of your data.

Your data will be anonymised in the write-up of the study and no potential identifying information relating to yourself or to the sexual trauma survivors that you have worked with will be included in the analysis or write-up of the study. Any possible identifying information will be removed during transcription or will be reported in more general terms (e.g., reporting age in age brackets rather than specific ages). Specific quotes

from your interview may be included in the write-up of the study but these will be anonymised, and any identifying information will be removed or will be reported more generally to ensure that you and the sexual trauma survivors that you have worked with cannot be identified through these quotes. This means that it will not be possible to identify you or the sexual trauma survivors that you have worked with in the write-up of the study, and no-one will be able to work out that you took part in the study. Each member of the research team will read through the analysis and write-up to ensure that no identifying information relating to yourself or to the sexual trauma survivors that you have worked with is included.

To protect the anonymity of the sexual trauma survivors that you have worked with, we kindly ask you to be mindful to not share any information (e.g., during the interviews or on the demographic form) that could identify them. This could include names, specific identifiable demographic information, specific geographical locations, or any specific details of survivors' experiences of sexual trauma that could identify them. We will remind you of this before the interview begins. If you accidentally disclose any identifying information in the interview, we will kindly remind you to try your best to not share any information that could identify the sexual trauma survivors that you have worked with. Any accidental sharing of potentially identifiable information relating to sexual trauma survivors will be removed during the transcription process or will be reported in more general terms. This means that it will not be possible to identify any sexual trauma survivors in the write-up of the study. Each member of the research team will read through the analysis and write-up to ensure that no identifying information relating to sexual trauma survivors is included. In addition, the member of the research team who will be conducting the interviews (Principal Investigator, Laura Glinn) is also an employee of BCUHB and therefore has a duty to adhere to the BCUHB data protection and confidentiality policy.

However, if any risks to yourself or to others is disclosed or identified, information may be shared with a third-party. Risks may include the disclosure or identification of self-harm, suicidal ideation, suicidal intent or the planning or knowledge of potential harm to other people. Under these circumstances, it might be necessary to inform your GP or to speak to your line manager or to the police, as appropriate. Wherever possible, this will be discussed with you in advance. You will be reminded of this during the process of obtaining consent and before the interview begins.

Are there any possible risks of taking part?

Working with survivors of sexual trauma can be a difficult experience and talking about your experiences and any possible impact on you may bring up difficult memories and/or unpleasant emotions. If you do experience any discomfort or distress as a result of taking part in this research, the researcher will discuss and provide you with contact information for support services where you can get further help and support. After the interview has concluded, a debrief with the researcher will also be offered. You can request to stop the interview at any time without giving a reason and without consequences.

Where can I find out more about how my information is used?
You can find out more about how we use your information by asking one of the research team, by contacting the Principal Investigator (Email: lrg19cjy@bangor.ac.uk Tel: 01248388365 and asking for Laura Glinn to call you back) or by visiting: www.hra.nhs.uk/information-about-patients/

Who should I contact if I have any questions or want to make a complaint?
If you have any questions, would like any further information and/or have any concerns about any aspect of the research process, please do not hesitate to contact me:
Principal Investigator: Laura Glinn, North Wales Clinical Psychology Programme, School of Human and Behavioural Sciences, Brigantia Building, Bangor University, Bangor, LL57 2DG. Email: lrg19cjy@bangor.ac.uk Tel: 01248388365 and ask for Laura Glinn to call you back.

Alternatively, you can contact one of the study supervisors if you have any questions or concerns about how the study has been conducted:
Chief Investigator: Dr Laura Spencer, Conwy Community Mental Health Team, Nant-y-Glyn Resource Centre, 10 Nant-y-Glyn Road, Colwyn Bay, LL29 7RB.
Email: laura.spencer@wales.nhs.uk Tel: 03000 850049
Academic Supervisor: Dr Renee Rickard, North Wales Clinical Psychology Programme, School of Human and Behavioural Sciences, Brigantia Building, Bangor University, Bangor, LL57 2DG. Email: r.rickard@bangor.ac.uk Tel 01248383778

If you are still not happy and would like to raise a formal complaint about any aspect of the study, you can contact Huw Roberts, who is the Bangor University contact for complaints regarding research:
Bangor University School of Human and Behavioural Sciences Manager: Huw Roberts, School of Human and Behavioural Sciences, Brigantia Building, Bangor University, Bangor, LL57 2DG.
Email: huw.roberts@bangor.ac.uk Tel: 01248 383136

Thank you in advance,
Yours sincerely,
Laura Glinn

Appendix F – Consent form

Study Title

Exploring Clinical Psychologists' experiences of working with survivors of sexual trauma

Consent to Participate in a Research Study

Please initial box

1. I have read the information sheet for this research study (*dated 01.02.2022 Version 2*) and have been given a copy. I have had the opportunity to consider the information, discuss the details and ask questions which have been answered satisfactorily. I understand what is being asked of me. ☐

2. I understand that my participation is voluntary and that I have the right to withdraw from the study without having to give a reason and without detriment to myself at any point before, during and after the interview. I understand that it will not be possible to remove my data from the project once my data has been anonymised. ☐

3. I understand that my involvement in this study involves taking part in an interview which will be audio-recorded. ☐

4. I understand that specific quotes from my interview may be included in the write-up of the study. These will be anonymised, and the researchers will ensure that I cannot be identified through these. ☐

5. I understand that the data that I provide will be kept confidential and only the research team involved in this study will have access to my data. Information about me and my data will be anonymised and stored securely in line with standards outlined under the Data Protection Act 2018. ☐

6. I understand that information may be shared with a third-party if any risks to myself or to others is disclosed or identified. Risks include the disclosure or identification of self-harm, suicidal ideation, suicidal intent or the planning or knowledge of potential harm to other people. Under these circumstances, it might be necessary to inform my GP or to speak to my line manager or to the police, as appropriate. Wherever possible, this will be discussed with me in advance. ☐

7. I understand that this study involves talking about my experiences of working with survivors of sexual trauma and any personal impact that this work might have had for me. I am aware that this could result in me experiencing discomfort and/or distress. I am aware that I will be offered ☐

8. a debrief after the interview has concluded and that I will be provided with contact information for support services where I can get further help and support. I understand that I have a right to request that the interview be paused or stopped at any point (should I experience distress). ☐

9. When the study has been completed, I would like to receive the completed paper. I agree for this to be sent to the name and email address that I provide below. I understand that once I have received the completed paper, these details will be destroyed. ☐

   Name: _____

   Email address:_____

10. I have read the above information and agree to take part in the study.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

One copy for participant, one for researcher

Appendix G – Demographic and basic clinical information form

Study Title

Exploring Clinical Psychologists' experiences of working with survivors of sexual trauma

This form contains questions about you and the nature of your clinical work with survivors of sexual trauma. Please complete this form and return it by email to the Principal Investigator (Laura Glinn) prior to the interview. Please hold in mind that all questions are optional; you can leave blank any questions that you do not wish to answer. If you have any questions, please do not hesitate to contact me: Laura Glinn, North Wales Clinical Psychology Programme, School of Human and Behavioural Sciences, Brigantia Building, Bangor University, Bangor, LL57 2DG. Email: lrg19cjy@bangor.ac.uk Tel: 01248388365 and ask for Laura Glinn to call you back.

1. How old are you? _____
2. What is your gender identity? _____
3. What is your sexual orientation? _____
4. What is your racial and ethnic identity? _____
5. What is your relationship status? _____
6. How many years have you been qualified as a Clinical Psychologist? _____
7. Have you had any training since becoming a qualified Clinical Psychologist in working with trauma (including sexual trauma and/or complex trauma)? If yes, please specify below:

   _____

   _____

   _____

8. Have you had any other training since becoming a qualified Clinical Psychologist that you have found helpful in working with adult survivors of sexual trauma (of any type and perpetrated at any age)? If yes, please specify below:

   _____

   _____

   _____

9. Which intervention/s and/or therapy modality/ies have you commonly used when working therapeutically (in an NHS setting) with adult survivors of sexual trauma (of any type and perpetrated at any age) where your role has been to help survivors come to terms with the sexual trauma and in their recovery with the effects of sexual trauma? Please list below:

   _____

   _____

   _____

10. How many years have you been working in this capacity with this client group in an NHS setting/s?
    (*If you are no longer working in an NHS setting, please also indicate how long ago*)

    _____

11. Which NHS setting/s and/or service/s has this work taken place? (e.g., adult mental health, physical health, trauma-specific services). Please list below:

    _____

    _____

12. Overall, how many of these clients (approximately) have you worked with in this capacity (in an NHS setting)? _____

13. How many of these clients (on average) do you work with in this capacity per week (in an NHS setting)? _____

14. How many hours (on average) do you work with these clients per week in this capacity (in an NHS setting)? _____

15. What proportion of your caseload is this type of work? _____

16. Please specify the approximate proportion of this type of work by type of sexual trauma:
    i) Single event: _____
    ii) In adulthood: _____
    iii) In childhood: _____
    iv) Prolonged in a romantic relationship: _____
    v) Complex trauma: _____
    vi) Other (*please specify)*: _____

Thank you for completing this form. I look forward to speaking with you at the interview.

Laura Glinn

Appendix H – Interview schedule

Study Title

Exploring Clinical Psychologists' experiences of working with survivors of sexual trauma

Thank you very much for sharing your time to speak with me today and to agreeing to take part in this interview. I am very grateful. Before we remind ourselves what the interview will be asking you about, there are some formalities that are important for us to run through. So, to remind you, your participation is entirely voluntary, and you can stop the interview for a break, or you can stop the interview and withdraw your participation from the study at any time without consequences. You also do not have to answer any questions that you prefer not to answer.

This interview will be audio-recorded for transcription and analysis. Everything you say will be held in strict confidence unless you say anything that indicates any possible or actual risk to yourself or to others. If any possible risks to yourself or to others are identified or disclosed, it might be necessary to inform your GP or to speak to your line manager or to the police. Wherever possible I will discuss this with you beforehand. Please can I also remind you to do your best to not disclose any identifying information about the survivors you have worked with. If you accidentally disclose any identifying information, I will not include this during transcription and I will remind you in the interview to try your best to not disclose any more identifying information.

Do you have any questions about this or anything else that you would like to ask about?

The purpose of this study is to explore with you your experience of working therapeutically with adult survivors of sexual trauma. I am interested in what this type of work has been like for you. I am specifically interested in your experience of working in the NHS with adult survivors of sexual trauma of any type and perpetrated at any age, where your role has been to help survivors come to terms with the sexual trauma, to manage the impacts of it, and to support them in their recovery. I can see from your demographic form that you have [*summarise number of years of experience, setting, number of survivors worked with and type, common therapeutic approach used*]

Interview Schedule

1. What is it like to work with adult survivors of sexual trauma?

    a) What is it like to sit in the therapy room with someone who has been traumatised in this way?

    b) What is it like outside of these sessions and beyond the therapy room?

2. How has this work personally affected you?
   Possible prompts: emotionally, psychologically, physically, behaviourally, spiritually, hobbies, interests, relationships

3. Are there any aspects of this work that particularly resonate with you or when you find that the impact of this work is greater, and if so, what might those aspects be?

4. Are there any personal factors that influence your experience of this kind of work?

5. How, if at all, has the personal impact of this type of work changed over time?

6. Do you feel changed by this work and if so, in what ways?
   Possible probes: personally, professionally

7. How do you manage the personal impact of this work?
   Possible probes: personally, professionally

8. How supported do you feel in doing this type of work and the personal impact it has for you?
   Possible prompts: organisationally, professionally, personally

9. *If participant has described mostly/only difficult or challenging experiences and impact:*

   a) Have you experienced any positive or rewarding experiences in doing this type of work? If so, can you tell me more about this and how this has personally affected you?

   If participant has described mostly/only positive or rewarding experiences and impact:

   a) Have you experienced any difficult or challenging experiences in doing this type of work? If so, can you tell me more about this and how it has personally affected you?

10. Is there anything that you would like to say more about or that I haven't asked that you would like to discuss?

Thank you for taking part in this interview.

Appendix I – Debrief sheet

Study Title

Exploring Clinical Psychologists' experiences of working with survivors of sexual trauma

Thank you for participating in this research study. Your participation is greatly appreciated and will help in developing a better understanding in this under-researched area. If you indicated that you wanted to receive the completed paper for this study, this will be sent to you in due course via the email address that you provided.

The aim of this study was to explore the personal experiences of Clinical Psychologists who work therapeutically with survivors of sexual trauma in NHS settings. I was interested in:

- Your experiences of working therapeutically with survivors of sexual trauma
- What is has been like for you to work with survivors of sexual trauma at the time of this work (i.e., in the therapy room)
- What is has been like for you to work with survivors of sexual trauma outside of the time of this work (i.e., beyond the therapy room)
- Whether this type of work has had a personal impact on you (e.g., on your well-being, your relationships, your hobbies, and interests) and if so, how
- Whether the impact of this work has changed over time
- Whether there are any factors that have influenced how you have experienced this type of work
- Whether you feel adequately supported in working with survivors of sexual trauma
- What has helped you manage the impact of this type of work

There is a small but growing body of literature that suggests that mental health professionals who work therapeutically with survivors of sexual trauma are often affected by this type of work. This includes impacting professionals' identity, worldview, intimacy, trust, and emotional and physical well-being. A number of factors have been identified that seem to influence how therapists experience this type of work (e.g., caseload, length of time doing sexual trauma work, sexual trauma specific training, organisational support, and personal coping strategies). However, how these factors influence the impact of this type of work seems to be complex. The majority of existing research has either been quantitative through the use of standardised questionnaires or qualitative through exploring the construct of vicarious trauma. This study sought to explore a broader and richer range of experiences that might not be captured through the use of standardised questionnaires and/or that fall outside of how vicarious trauma is defined and measured.

Understanding how Clinical Psychologists working in the NHS personally experience sexual trauma work may provide important perspectives. It is intended that the findings of this study contribute to the current knowledge base to inform training and

organisational support. Ensuring that Clinical Psychologists are adequately prepared for, trained in, and supported with the experiences and personal impact of sexual trauma work is vital to ensuring the well-being of Clinical Psychologists who do this type of work.

Sources of help and support

We hope that you found participating in this study an interesting and positive experience. However, talking about your experiences of working therapeutically with survivors of sexual trauma and any personal impact may have brought up difficult memories and/or unpleasant feelings. If you are experiencing distress as a result of your participation in this study and/or you are in need of help to address any difficulties that may have arisen from this interview, there are sources of help and support which may already be familiar to you.

1. If you are an NHS employee, you can access sources of occupational help and support, such as through clinical supervision and/or your occupational health service.
2. You can talk to your GP who can signpost you and/or refer you to sources of help and support.
3. There are organisations who can offer you support, such as:
    - The Samaritans (Tel: 116 123; www.samaritans.org). The Samaritans helpline is available 24 hours a day, 365 days a year, for anyone in need.
    - Mind (Tel: 0300 123 3393; www.mind.org.uk). The Mind helpline is available 9am to 6pm Monday to Friday excluding bank holidays, for anyone in need.
4. You can contact me again to discuss any aspect of your participation in this research study, including to share concerns or to ask any questions: Laura Glinn, Email: lrg19cjy@bangor.ac.uk Tel: 01248388365 and ask for Laura Glinn to call you back.
5. If you have any further questions or concerns that you would like to share or raise with Bangor University, you can contact my academic supervisor: Dr Renee Rickard, Email: r.rickard@bangor.ac.uk Tel: 01248383778 Address: North Wales Clinical Psychology Programme, School of Human and Behavioural Sciences, Brigantia Building, Bangor University, Bangor, LL57 2DG or
   Bangor University contact for complaints regarding research: Huw Roberts, Email: huw.roberts@bangor.ac.uk Tel: 01248 383136 Address: Bangor University School of Human and Behavioural Sciences Manager, School of Human and Behavioural Sciences, Brigantia Building, Bangor University, Bangor, LL57 2DG.

Thank you again for your participation.

Yours sincerely,
Laura Glinn

Appendix J – Example of analysis process: Initial coding and emergent themes in extract from one participant's interview transcript

Emergent themes	**Interview *[date, means, pseudonym]***	**Exploratory comments**
ST and gender in referral form CP gender same as most perpetrators Worry and fear – apprehension Shared emotional experiences of client and CP – transference Responses and attempts to manage own emotional experiences Emotional experience of CP – uncomfortable Impact of CP on this work – personality traits, enthusiasm Effort of CP	P: Hmm, how I feel? Um, if in that referral form you know it says you know, um that the abuse has been by a man which statistically that is um, I found more likely. Um, I do, I do feel apprehension. Um, which I'm mindful is transference, and I'm mindful not to try and allow that countertransference to compromise the, the efficacy of, of the, of the work but [*slight inhale*] there is an apprehension and I'm very mindful of that and I try and acknowledge it's there and hold it. Um, and it sits um, it's uncomfortable I mean, I, I, as I said before, I know um I, I'm very enthusiastic generally, you know I, I, I like engaging with people and um and I found in my experience that when I work with survivors, and they are talking about this stuff they can be um quite um withdrawn and shy to start to disclose. So, I really have to do my best to you know, reign in my enthusiasm and to um be very you know careful and respectful and, and reign that back. And obviously not leaning forward but you know to be aware of my body language and um,	Information in referral form about gender of perpetrator, male– preparation in approach, or space to worry/anticipate? Unchosen and uncontrollable similarity between CP and perpetrator – male gender Apprehension – CPs emotional experience Making sense of emotional experience – transference Awareness of impact of own emotional experience on the work Response to emotional experience – awareness, acknowledge, holding it/allowing to be there Impact of emotional experience on CP – uncomfortable CP personality traits influencing approach to work – enthusiastic Survivors in disclosing – withdrawn and shy - emotional experience - fear? shame? Effort that CP makes – *'really have to do my best'* – speaks to importance of this, and wanting to do best and do it 'right', *really* A monitoring and changing of the self in this work – reigning in

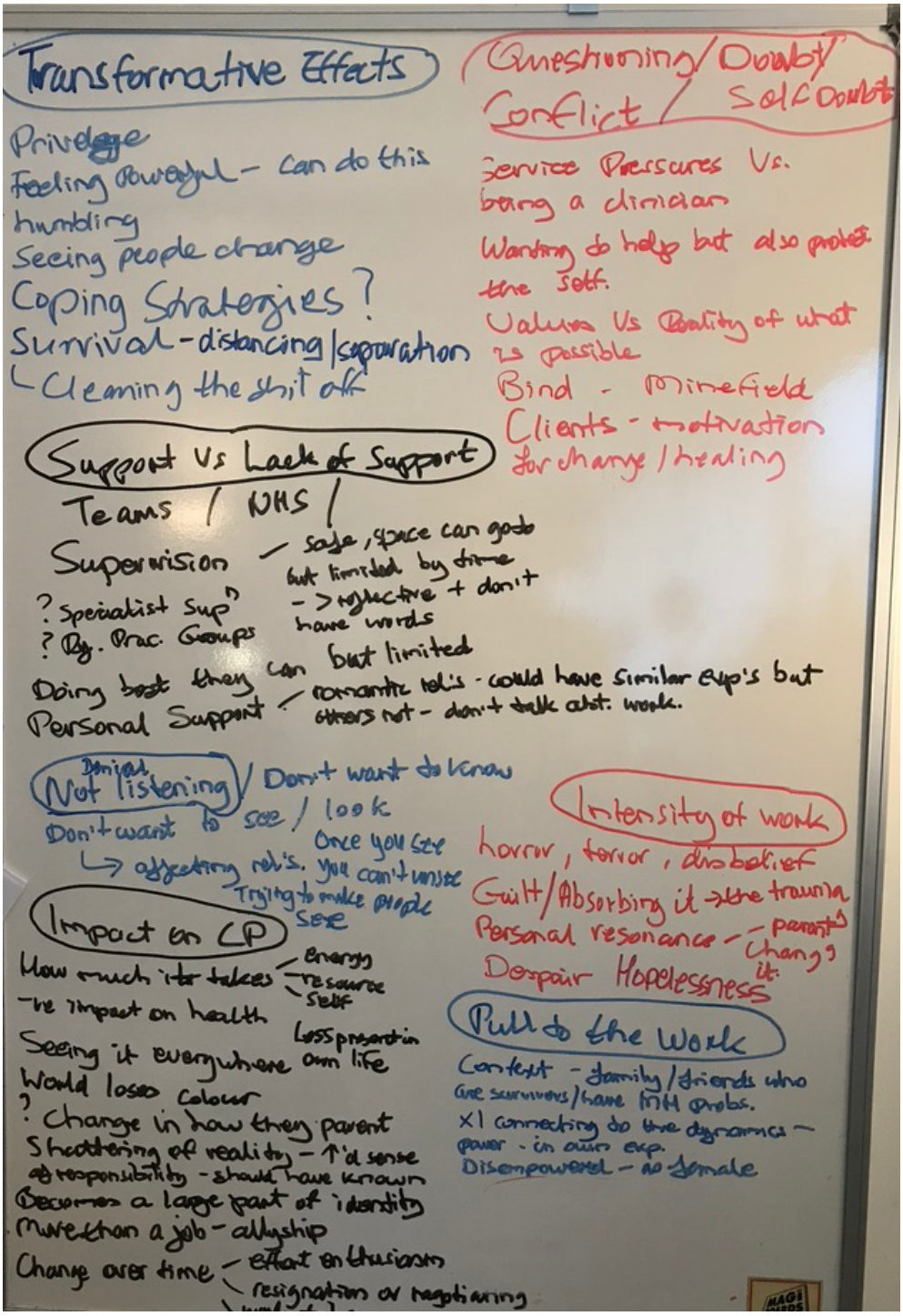
Monitoring and altering self – body language Can hear and manage the disclosure, the sexual abuse Worry and fear – apprehension Effort of CP Worry and fear – getting it wrong, retraumatising	I, I, I'm not at all embarrassed with the content of what is said, that, that doesn't have any, you can, people can disclose whatever they wanted to in that respect and I you know, it would be ok, I can manage that. But I'm just so apprehensive about doing my best to provide a space which is contained, safe and um like in terms of you know trauma-informed care, I wouldn't want to inadvertently you know um re-traumatise anyone I work with by in effect like getting it wrong. So, apprehension is the, is the key word for me I would say.	'careful' – again signifies potential danger or risk Awareness of body language CP wanting to affirm his position on how finds this work – can manage the content of disclosure, can manage hearing sexual trauma. would not be embarrassed – <u>does this imply that there is something to be embarrassed by? – who is embarrassed? survivor or client or both? Internalised stigma?</u> Repetition of 'apprehensive' and *'so'* emphasises importance and magnitude of emotional experience to CP Effort in wanting to create safety, trauma-informed Worry/fear of unintentionally getting it wrong and re-traumatising

Note. Exploratory comments: regular text = descriptive, italicised = linguistic, underlined = conceptual

Appendix K – Example of analysis process: Table of preliminary themes for one participant

'Culture of fear'	A questioning and conflicted self	Intensity of the work	Connecting to the work	Challenges	Managing effects of the work	'Other'
Impact of gender Fear of re-enacting abuse dynamics or retraumatising Fear of getting it wrong Legacy of feedback Monitoring and altering self Specialist area Risk and safeguarding Minefield/ danger	Constant battles or binds Specialist service vs him Female therapist vs him Evaluation of self/worry vs reality CP responsibility vs survivor wishes Managing content of ST Expressing empathy or emotional responses	Effort of CP CP vs perpetrator – 'battle' Intense highs and lows Healing, & 'corrective experience' - gender Strong emotional experiences – anger, helplessness, sadness, apprehension Shared emotional experiences Impact of empathy Carrying effects Changed by work - parenting Personal influencing work - parenting Journey – time, personal	Being a parent Contexts Personal values	Limitations of services Insufficiently prepared by training – emotional impact & being parent Lots of considerations Responsibility Not being able talk about work with personal relationships Limits in specialist support Lack of progress	In-moment awareness and managing emotions Normalising and validating own emotions After-session self-care 'Cleaning self' Importance of support Personal relationships Exercise Managing diary Being 'good enough'	Being parent impacts compassion to perpetrators Enthusiastic for further training for self More training and support with fear Reflected on Interview, helpful Only worked with female ST survivors

Appendix L – Analysis process: Mapping across participants to generate provisional group themes



Chapter three

Contributions to theory and clinical practice

Followed by a reflective commentary

This thesis sought to contribute towards furthering understanding of the wide-ranging impacts of sexual trauma (ST) by exploring areas relatively neglected in the literature. The systematic review focused on *direct* impacts, exploring the sexual and relational experiences of women childhood sexual abuse (CSA) survivors, the empirical research on *indirect* impacts*,* exploring experiences of National Health Service (NHS) clinical psychologists who support ST survivors. This chapter considers the contributions of these papers to theory and clinical practice, identifies areas for further research, and concludes with a statement of positionality and reflective commentary.

Contributions to theory and directions for future research

Both papers illuminate intense, complex, and wide-ranging experiences, entwined with dilemmas, conflicts and challenges, and reveal various parallel processes experienced by ST survivors ('direct survivors') and clinical psychologists who support them. Clinical psychologists in these contexts could therefore be considered 'indirect survivors', consistent with literature indicating that survivors' partners can be significantly impacted, and in effect, become "secondary victims" (Remer & Elliott, 1988, p.389). Mirrored experiences can be understood by the 'ripple effect' (Kounin, 1970), a term first used in educational settings following observations that an action can affect many things. This thesis illustrates the far-reaching ripples of ST.

The hidden nature of ST was reported by survivors and clinical psychologists, including within relationships, systems (e.g., NHS workforce, clinical supervision) and society. Aversion, helplessness, fear, and competing demands were believed to underpin and reinforce this, keeping ST unspeakable and unseen. This is important

because ST is maintained by secrecy which can perpetuate ST-related feelings of shame and isolation for survivors (Finkelhor, 1984; Schatzow & Herman, 1989) and create isolation for clinical psychologists. Survivors and clinical psychologists grappled with dilemmas and conflicts regarding how much of ST to share, and how much to keep hidden.

Survivors and clinical psychologists experienced intense ST-related emotions and feelings, including fear/terror, anxiety, disgust, anger/rage, and helplessness. Clinical psychologists' emotional responses can be understood as countertransference (Malan, 1979), reflecting survivors' experiences. Clinical psychologists described needing to demonstrate that they could "*bear*" ST. This could be understood by Bion's (1970) theory of containment, whereby clinical psychologists take survivors' distressing emotional experiences and 'contain' these, returning them in more tolerable forms. Clinical psychologists alluded to feeling like they had to transform and transcend themselves to become all-powerful, 'other-worldly'. This could be conceptualised as a countertransference response (Wastell, 2005), adopting an 'all-powerful' 'rescuer' (Karpman, 1968) position.

ST affected survivors' and clinical psychologists' intimate relationships, with ST effects being "*carried*" or intruding into survivors' partner relationships, and into clinical psychologists' partner relationships, friendships, and parenting. Whilst sexual intimacy was a powerful trigger for traumatic intrusions in survivors, this was not reported by clinical psychologists. In fact, only one participant mentioned sexual intimacy but stated that this was unaffected by ST work. This is surprising given that other symptoms of vicarious trauma were identified, hence it might be reasonable to

expect that ST could intrude into clinical psychologists' sexual lives given the nature of the trauma material. Because of the lack of qualitative research on clinical psychologists' experiences of ST work and in keeping with interpretative phenomenological analysis, participants were asked broader questions about their experiences and not directly asked about their sexual lives. Whilst it is possible that this arena remains unaffected, it is recognised that researcher and cultural influences might have inhibited discussion. For instance, the power dynamics of clinical psychologist-trainee clinical psychologist ('trainee') could have led to this sensitive area being avoided, possibly exacerbated by the trainee having professional links to some participants. There are also entrenched cultural taboos on talking about sex in the United Kingdom (Attwood & Smith, 2011). This is an interesting and important area for future research.

ST transformed some survivors' and clinical psychologists' selves, adversely affecting survivors' global self-concepts (e.g., "*damaged goods"*) and changing clinical psychologists' whole selves (e.g., *"getting into [my] bones"*). These bodily experiences in clinical psychologists can be explained by theories of complex trauma which state that trauma is kept in somatic memory (Rothschild, 2000; van der Kolk, 1994). For some, the centrality of ST was evident, with it being "*everything"* about who survivors were, and some clinical psychologists being allies, advocating within work and "*crusading"* within their personal lives. Moving beyond and developing a more diverse identity was integral for healing and 'surviving'. For survivors, this meant developing identities beyond ST survivors/victims and reclaiming themselves, commonly involving reclaiming sexuality. For clinical psychologists, this meant being more than a 'clinician', separating work from their personal selves.

Supportive relationships were emphasised by clinical psychologists and survivors. Spending time with significant others outside work and feeling connected and supported by colleagues and supervisors inside work helped mitigate the effects of ST work for clinical psychologists. Partner relationships were important contexts for healing for survivors through experiencing safety, acceptance, and love, and helping survivors redefine themselves and connect with their sexuality. This suggests that incorporating partner relationships and sexuality into interventions is important in supporting healing and recovery. However, research suggests that therapists feel unskilled and uncomfortable in raising sexual topics (Love & Farber, 2017) and most clinical psychologists do not or only infrequently ask clients about their sexual lives (Reising & Giulio, 2010). Clients accessing psychotherapy have been shown to experience significant difficulty in raising and talking about sex and sexuality (Love & Farber, 2017). It would be reasonable to expect that this could be more difficult for survivors. Exploring experiences, barriers, and enablers to successfully incorporating sexual and relational spheres into psychotherapy from survivors' and therapists' perspectives represent important avenues for future research.

Implications for clinical practice

The silent and hidden nature of ST and its sequelae is notable across both papers. Implications for clinical practice relate to making the hidden seen. This involves therapists sensitively incorporating partner relationships and sexuality into psychotherapy with survivors. Given that clients are unlikely to raise these issues (Love & Farber, 2017), therapists should take an active role in sensitively enquiring about, and appropriately including these areas into ST work. This is consistent with

our systematic review findings that partner relationships can promote survivors' healing and recovery.

Therapists need to be aware of CSA dynamics (Finkelhor & Browne, 1985) which might be adversely impacting survivors' sexual and relational lives. Supporting survivors in redefining themselves, building an identity beyond ST victim/survivor and reclaiming sexuality represent important processes in sexual and relational, and overall recovery. To effectively meet the needs of women survivors of diverse sexual orientations, therapists should be aware of how internalised homophobia and social stereotypes might intersect with ST and non-heterosexual orientations. Consideration of possible unique challenges as well as opportunities for healing within partner relationships where both partners are survivors is important. Offering more systemic and holistic approaches which involve partners might facilitate opportunities for healing whilst also fostering healthier partner relationships and relationship satisfaction.

Yet research suggests that therapists feel insufficiently skilled and experience discomfort in these areas (Love & Farber, 2017). Therapists must consider their own biases and barriers in supporting sexual and relational recovery, in line with professional ethical standards (Health and Care Professionals Council, 2016), and need to be supported to feel competent and comfortable in incorporating partner relationships and sexuality into interventions with survivors. Including specialist training on partner relationships and sexuality within therapists' training appears important. Clinical supervisors must also feel competent and confident in these areas. Actively prompting and holding space within clinical supervision for therapists

to reflect on their experiences of incorporating partner relationships and sexuality within psychotherapy with survivors might facilitate improved therapist confidence, comfort, and competence.

Clinical psychologists need to feel adequately trained, skilled and supported in ST work and in managing the emotional impacts of this work. ST-specific training and training on identifying and managing the emotional impacts should be included in clinical training, with timely enhanced training available post-qualification across specialisms. Clinical supervison tailored towards enhancing clinical psychologists' awareness and reflection on the impacts of this work, such as on intimate areas of their lives, is important and hence, supervisors should take an active role in sensitively and appropriately prompting and holding space for this. The value of reflecting on the impact of ST work through participating in this research was expressed by some, with a few having not realised the personal impact before. Increased support might be especially important for clinical psychologists who are less experienced in ST work (e.g., earlier in career, working within certain specialisms) and during life transitions, such as becoming parents. Greater awareness and recognition of ST across the NHS workforce in line with trauma-informed care (SAMHSA, 2014; Sweeney et al., 2016) is needed to ensure NHS professionals and the healthcare system do not inadvertently perpetuate the hidden nature of ST. This is important for reducing shame and stigma, reducing risk of possibly retraumatising survivors (SAMHSA, 2014), and for helping clinical psychologists feel less isolated. Balance in workload and caseload should be implemented for clinical psychologists across all specialisms. Instilling an ethos of self-care that includes supervisors and managers encouraging separation between

work and personal selves (e.g., keeping to contracted working hours) is important for promoting fuller identities (i.e., 'more than a clinical psychologist') and in turn, wellbeing.

Statement of positionality and reflective commentary

In qualitative research the key influence of researchers' subjectivities is acknowledged, with researchers' positions impacting the research, and the research likely impacting them (Berger, 2015). Analytic interpretations are inherently bound to researchers' experiences, assumptions, and beliefs. As such, transparency and reflexivity are essential to the rigour and trustworthiness, and thus the quality of qualitative research (Berger, 2015; Yardley, 2000). I have endeavored to make explicit my position and where this influenced the research, and the steps I took in mitigating biases.

I am a woman, a feminist, and I have close personal relationships with women survivors. I am an NHS employee with clinical experience of ST work. I chose this topic because I am passionate about understanding how survivors move towards seeking and experiencing romantic connection following inter-personal betrayal and terror, and in how survivors relate and come to experience pleasure through their bodies after these have been invaded and violated. I feel awe towards survivors' strength and courage in healing from ST. I believe that women's sexuality should be more openly recognised, talked about, and celebrated. Through my own vicarious exposure to ST, I am interested in how ST impacts those supporting survivors.

Throughout this research there have been potential risks of being overly drawn towards data and in developing themes that align with my interests. There have also been risks of over-identifying with participants' experiences, or projecting my own experiences, feelings, or beliefs onto them. Caution and care have been essential in ensuring that I adhered to my role as researcher, telling participants' stories and not my own. Potential biases, such as curiosity regarding how ST work affects clinical psychologists' sexual lives, were noticed, and critically examined through reflexivity (aided by a reflective journal) and supervision. Researcher triangulation was used to ensure analysis was grounded and well represented in the data.

I have also been impacted by this research. Like participants, systemic challenges and personal experiences have significantly affected my experience of conducting this research. Roadblocks and setbacks in the permissions process led to needing an extension to training. This happened in the context of healing from a traumatic bereavement. At times it felt difficult to stay committed to the research process, and even more difficult immersing myself in the content. I have often felt overwhelmed at the prospect of doing this research justice; my first qualitative piece.

I have also sometimes felt that there is too much abuse, too much horribleness. I have also wanted to distance. Despite this, I remain passionate about this research and committed to using this thesis as an opportunity to explore experiences and amplify voices that are often hidden and silenced. But this has had personal costs. At times I have also felt robbed of my energy. I have also had to distance from some relationships to self-preserve; I have been less present in others. I have often

wanted to get some of ‘myself’ back, to be more than a trainee, more than a researcher. To be me, Laura.

Yet I have also been given valuable lessons from participants, which I am grateful for. I have tried to acknowledge and accept my limits and recognise that I have done the best I can. I hope that I have done this research justice. It has been a deep privilege and humbling to have been entrusted with participants’ stories and personal experiences. I am inspired by their strength and resilience in continuing to work therapeutically with survivors despite some of the pervasive ways they are impacted. I have also come to recognise my own strength and resilience. I am deeply grateful to those who have supported me; these relationships feel closer and more meaningful than ever. In some ways, my experiences, and responses from being exposed to ST through this research parallel with those described by participants. I have therefore somewhat experienced, in an embodied sense, how far the ripples of ST can reach.

References

Attwood, F., & Smith, C. (2011). Investigating young people's sexual cultures: An introduction. *Sex Education*, *11(3),* 235-242.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15(2),* 219-234.

Bion, W. (1970). *Attention and interpretation.* London: Tavistock Publication.

Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. *New York*: Free Press.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, *55(4),* 530-541.

Health and Care Professions Council (2016). Standards of conduct, performance and ethics. https://www.hcpc uk.org/globalassets/resources/ standards/standards-of-conduct-performance-and ethics.pdf?v= 637171211260000000

Karpman, S. (1968). Fairy tales and script drama analysis. *Transactional Analysis Bulletin, 7,* 39-43.

Kounin, J, S. (1970). *Discipline and group management in classrooms.* New York: Holt, Rinehart, and Winston.

Love, M., & Farber, B. A. (2017). Let's not talk about sex. *Journal of Clinical Psychology*, *73(11),* 1489-1498.

Malan, D., & Parker, L. (1995). Individual psychotherapy and the science of psychodynamics. CRC Press.

Reissing, E. D., & Giulio, G. D. (2010). Practicing clinical psychologists' provision of sexual health care services. *Professional Psychology: Research and Practice, 41(1),* 57– 63.

Remer, R., & Elliott, J. E. (1988). Management of secondary victims of sexual assault. *International Journal of Family Psychiatry, 9,* 389-401.

Rothschild, B. (2000). *Body remembers: The psychophysiology of trauma and trauma treatment* (Vol. 1). WW Norton & Company.

Schatzow, E., & Herman, J. L. (1989). Breaking secrecy: Adult survivors disclose to their families. *Psychiatric Clinics of North America*, *12(2),* 337-349.

Substance Abuse and Mental Health Services Administration (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach. HHS Publication No. (SMA) 14-4884.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: What is it and how can we further its development? *Mental Health Review Journal*, *21(3),* 174-192.

Van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry*, *1*(5), 253-265.

Wastell, C. (2005). *Understanding trauma and emotion: Dealing with trauma using an emotion-focused approach.* Australia: Allen & Unwin.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*, 215-228.