This thesis is submitted in partial fulfilment of the requirements
for the degree of Doctorate in Clinical Psychology

Qualitative Explorations of Talking Therapies with CSA Survivors and Therapeutic Relationships Discussed by People Experiencing Dissociation

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Thesis Abstract

Initially, this thesis presents an idiographic systematic review that explored how adult survivors of childhood sexual abuse experience talking therapies. The key findings suggest that although the process of healing is challenging and often viewed as an ongoing process, talking therapies can facilitate healing through developing trust, safety, relational equality and establishing interpersonal connections. Additionally, the experiential learning of choice, control, respect and being believed was essential for long-term healing, which could facilitate intrapersonal reconnection. Secondly, the findings of an empirical study are presented, which qualitatively explored how people who dissociate experience therapeutic relationships with ward based staff through interpretative phenomenological analysis. The three superordinate themes suggest that the participants faced a number of challenges. For instance, managing their dissociative experiences alongside the inconsistent relationships on the wards, the difficulties of having differing interpersonal needs at varying times and the importance of working with alters, not around them. The findings reaffirmed the importance of therapeutic relationships for the purposes of feeling safe, being able to connect to others and then the self, feeling recognised as a whole person and accepted rather than judged. The results discuss how staff can facilitate this process and the implications for ward based treatment are considered in relation to the existing literature. Thirdly, the systematic review and empirical study are reflected upon through a critical appraisal, primarily focussing on the empirical paper, which concludes the thesis. Further findings from the empirical study are presented that discuss how participants reported experiencing dissociation on wards and the impact of their experiences for therapeutic relationships. The experience of completing the study is also considered, in accordance with changing perspectives in light of the meaning making processes of the participants.

Declaration

The research that is presented in this thesis has been designed and completed for the purpose of meeting the requirements for the thesis of the Doctorate in Clinical Psychology at Lancaster University between July 2012 and June 2015. It has not been previously submitted in any other form for another purpose elsewhere.

Signed:

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Date: 7th July 2015

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RUNNING HEAD: CSA Survivor Experiences of Talking Therapies

Section One: Literature Review

How do Adult Survivors of Childhood Sexual Abuse Experience Formally Delivered Talking Therapy? A Systematic Review

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[1] Please refer to Appendix 1-A for Author Guidelines

Abstract

This review explored how adult survivors of childhood sexual abuse experienced non-specific and trauma-focussed talking therapies. Following extensive systematic searches of academic databases, 23 qualitative empirical studies were chosen for review. Using a line-by-line thematic synthesis, four analytical themes developed. These themes were: *The Therapeutic Process as a Means for Forming Connections*, which discusses the connections developed with others; *Developing a Sense of Self Through Therapeutic Processes*, discussing the stages of developmental recovery; *Therapeutic Lights and Black Holes in the Shadows of CSA*, which reflects upon how a history of CSA influenced experiences of therapy; and *Healing or Harrowing: connecting with others and first time experiences*, which identified what was helpful, hindering and new throughout the therapeutic journey for participants. Findings related to participants developing new options for interpersonal relationships through the experience of authentic trust and the experiential learning of developing control and choice. Recommendations are discussed in relation to existing literature, developing clinical practice and future research.

Key words: adult survivors of childhood sexual abuse; psychological therapy

How do Adult Survivors of Childhood Sexual Abuse Experience Formally Delivered Talking Therapy? A Systematic Review

Adult survivors of any form of recurring childhood abuse are at greater risk of experiencing increased psychological distress, compared to the general population (Bromfield & Higgins, 2005; Johnson-Reid, Kohl, & Drake, 2012). Abuse can often take multiple forms (Higgins & McCabe, 2001; Richmond, Elliot, Pierce, Aspelmeier, & Alexander, 2009), for example, an abuser may be neglectful and emotionally, physically and sexually abusive concurrently, which can be termed *multi-type maltreatment* (Finkelhor, Ormrod, & Turner, 2007). Moreover, in cases where child abuse (CA) involves multiple types of abuse, particularly complex trauma responses can develop (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Ehring et al., 2014).

However, it has been noted that childhood sexual abuse (CSA) can have specific and persistent consequences for adult survivors due to the interpersonal violence they have experienced (Price-Robertson, Rush, Wall, & Higgins, 2013). For example, “childhood trauma, particularly sexual abuse, may set in motion chain reactions of trauma across the life cycle…” (Banyard, Williams, & Siegal, 2001, p.698). Further, Maniglio (2009) demonstrated, through a seminal review of reviews covering 587 studies, how adult psychological functioning was profoundly influenced by CSA, for example, in the development of eating disorders, self-injury and victimisation in adulthood. Additionally, CSA survivors have been suggested to be at an elevated risk of developing difficulties relating to their sexual functioning, anxiety, depression, interpersonal challenges including parenting difficulties and substance misuse (see Price, Hilsenroth, Petretic-Jackson, & Bonge, 2001). For the purposes of this review, CSA is considered as involving a child in any unlawful sexual act, with the intention of the act being to gratify the abuser (World Health Organisation, 1999). Additionally, it is recognised that CSA often occurs within the context of multi-type maltreatment (Finkelhor, Ormrod, & Turner, 2007) and so a survivor's experiences of CSA are likely to be influenced by other factors related to multiple forms of abuse.

Due to the personal nature and often prolonged experience of CSA, in addition to the complex sequelae of both physical and psychological repercussions, CSA survivors can develop complex posttraumatic stress disorder (PTSD) throughout childhood and adulthood (Cohen, Deblinger, Mannarino, & Steer, 2004; Herman, 1992; Saywitz, Mannarino, Berliner, & Cohen, 2000). Although the prevalence rates of complex PTSD are uncertain, it has been suggested that female CSA survivors are between three (Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999) and five (Coid et al., 2003) times more likely to develop PTSD than non-abused women. Complex PTSD symptoms can, in some cases, include dissociative experiences, which are thought to form as a coping mechanism to facilitate some distance and numbing from the pain of CSA (Nijenhuis, Van Engen, Kusters, & Van der Hart, 2001). In summary, coping mechanisms, such as dissociation and not engaging in relationships, can be protective short-term strategies. However, such shielding strategies can affect healing as time goes on (O'Brien, Henderson, & Bateman, 2007; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997; Spermon, Darlington, & Gibney, 2013), possibly due to the consequent difficulties people experience connecting to parts of themselves and to others in relationships.

Children with sexual abuse and interpersonal violence experiences often lose a sense of trust and safety with others (Briere, 1992), directly affecting interpersonal predictability in relationships, which can influence how the child perceives other people. A number of empirical studies exploring relationships for people with CSA experiences have also found participants have identified difficulties in forging and maintaining relationships (e.g. Kia-Keating, Sorsoli, & Grossman, 2010; McGregor, Thomas, & Read, 2006). Moreover, due to the importance of the therapeutic alliance in psychological therapy (Orlinsky, Grawe, &

Parks, 1994), interpersonal difficulties are thought to influence how CSA survivors experience talking therapies (Olio & Cornell, 1993). Additionally, a person's sense of self is irrevocably changed through CSA (as discussed extensively in Saha, Chung, & Thorne, 2011), leading to low self-esteem and often a sense of unworthiness (Courtois, 1988; Finkelhor, Hotaling, Lewis, & Smith, 1990), which may also impact upon seeking and engaging with psychological therapy. Specifically in relation to the therapeutic relationship and CSA, Olio suggested that: "in the treatment of adult survivors of sexual abuse it is probably the single most important factor" (1989, p.98). Consequently, as a result of the particular relational difficulties CSA survivors can experience, it seems imperative to understand how survivors experience talking therapies.

Due to the complex needs of CSA and multi-type trauma survivors, the process of finding help can be increasingly challenging (Gavey, 2003). Accordingly, a number of meta-analyses have been conducted to explore the role of healthcare services for CSA survivors. Most recently, Chouliara et al. (2012) focused on the qualitative experiences of CSA survivors across a range of healthcare services. The authors suggest there is a need to review the therapeutic relationship for CSA survivors further and explore survivors' perceptions of different therapeutic approaches.

In terms of therapeutic modality, CSA survivors have, in some studies, reported that the type of therapy they have received has not influenced whether therapy itself was beneficial (Chouliara et al., 2012; Nelson & Phillips, 2001). Moreover, a recent meta-synthesis (Draucker et al., 2009) exploring healing for sexual violence survivors concluded that it was understanding experiences, rather than developing positive or adaptive coping strategies, which survivors found helpful. Therefore, it may be that a person's understanding of their experiences through therapy may be more important to the process of healing than trauma resolution or symptom management. However, other empirical studies have suggested that working with a therapist who specialises in trauma is important (e.g. McGregor, Thomas, & Reid, 2006).

Ehlers et al. recommend: “further research into the active mechanisms of therapeutic change, including treatment elements commonly considered to be non-specific” is undertaken (2010, p.269). Although the quantitative literature suggests trauma-focussed therapies are significantly more effective than non-trauma oriented therapies for PTSD (as reviewed by Bisson & Andrew, 2007; Ehring et al., 2014), the qualitative evidence for CSA survivors’ experiences of talking therapies is not as clear. In summary, there are conflicting findings from empirical studies regarding the unique contribution to an improved outcome made by specific therapeutic modalities. Consequently, many specifically trained trauma therapists employ the guidelines for treatment set out by survivors’ groups and agencies such as Adults Surviving Child Abuse (ASCA, 2013) and the International Society for the Study of Trauma and Dissociation (ISSTD, 2011).

With regards to findings surrounding individual or group therapy, Ehring et al. (2014) reported from their quantitative findings that individual treatments were more effective than group treatments. Similarly, Price, Hilsenroth, Petretic-Jackson, and Bonge (2001) found that individual psychotherapy for CSA survivors enhanced interpersonal functioning and general health, as well as reducing trauma symptoms. However, there have been a number of studies suggesting that group interventions are therapeutically valuable (e.g. Harper, Stalker, Palmer, & Gadbois, 2008; Palmer, Stalker, Harper, & Gadbois, 2007; Saha, Chung, & Thorne, 2011). Among others, Martsolf and Draucker (2005) and Stige, Rosenvinge, and Træen (2013) found that their participants reported benefiting from concurrent individual and group therapy. Therefore, there seems evidence that individual, group or combined individual and group therapy can be helpful.

In summary, missing from the present body of research in the area of psychological therapies for CSA survivors is information regarding how the process of therapy, therapeutic modality and therapeutic relationship is perceived by survivors who have experienced a range of talking therapies. Understanding what makes therapy helpful and effective for survivors of CSA is particularly important due to the specific challenges survivors may experience in their adult relationships, such as with a therapist (Gill, 2010; Kendall-Tackett, Williams, & Finkelhor, 2001). It is acknowledged within the empirical literature that CSA survivors can experience difficulties regulating their emotions, affecting the management of anger and feeling overwhelmed by emotions (Gartner, 1999; Kia-Keating, Sorsoli, & Grossman, 2010), which may also impact upon the therapeutic alliance (Lev-Wiesel, 2008; McAlpine & Shanks, 2010) and thus the therapeutic experience.

Consequently, the current systematic review considers qualitative studies on the experiences of adult survivors of CSA in relation to formally delivered talking therapies. As Palmer, Stalker, Harper, and Gadbois suggest in relation to qualitative research: “when quantitative methods have shown overall benefits; it is a logical next step to understand better the process through which participants are helped.” (2007, p.63). However, no systematic review thus far has explored the therapeutic processes or mechanisms of change that survivors perceive as occurring through a range of talking therapies. Therefore, a review of CSA survivor experiences of psychological therapeutic interventions is both needed and timely due to the recognised need for survivors’ perspective and the recent development of survivor informed qualitative studies. The main aim of this review is to explore how a range of non-specific psychotherapies and trauma-focussed therapies are experienced by CSA survivors.

Method

Search Strategy

A comprehensive list of possible review papers was accumulated from online research databases between June and November, 2014. The databases were: PsycINFO, OneSearch, Academic Search Complete and PubMed. These databases were used for the searches due to their relevance to the topic area and their interconnection, which increased the likelihood that all appropriate studies would be found. Google Scholar and the Cochrane Library were also searched to cross-check the other searches undertaken. In order to ensure the search terms used captured all possible studies, the thesaurus facility of the search engines that featured this functionality was employed. The databases varied in how many relevant papers they generated. Finally, reference sections were considered for additional studies, although none were found. In order to refine the included studies for the review, 30 studies were condensed to 24 and then to 23, depending upon how directly they addressed the research question (Figure 1).

The final collection of studies for review involved 382 participants, with a mean age of 40.43 years[2]. Almost 90% of the overall sample reported experiencing CSA[3], often in the context of multi-type maltreatment. The studies took place in the United Kingdom (UK), Norway, United States of America, New Zealand, Australia, Israel and Canada. The studies employed a range of qualitative methodologies such as interpretative phenomenological analyses (IPA), grounded theory and thematic analyses (Table 1). Across the studies, a relatively small proportion of the overall participants were from ethnic minority groups.

<Insert Table 1: Characteristics of included studies >

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[2] In relation to two papers, where the mean of age was not obtainable from the methodologies or the corresponding authors, the mode was calculated from the age range available and then added to the equation for the overall mean. The overall mean age is therefore approximate.

[3] It was discussed with the assistant editor of the Journal of Child Sexual Abuse as to whether 89% was a high enough proportion of the sample for their journal; it was confirmed it would be sufficient for submission.

Quality Appraisal

The Critical Appraisal Skills Programme (CASP, 2013) was used to critique the characteristics of the selected studies. The CASP was chosen due to its development within the public health sector and the tailored checklist available for qualitative research. The appraisal process aimed to raise awareness of the methodological strengths and limitations within the overall review, rather than exclude studies. Additionally, it was recommended by Maniglio (2009) that future reviews in this field observe the quality of the studies reviewed, in order to enable the critical appraisal of the findings. Consequently, no studies were eliminated as a result of the CASP, rather each study was awarded a mark of 0-2 for each of the ten items (0 if the guidance for that item was not met, 1 if partially met, and 2 if fully met). Eventually, when the scores for each study were combined, each study was scored between 14 and 20 (Table 2).

<Insert Table 2: CASP appraisal of included studies >

Analytic Approach

Within the current synthesis, enormous variety was evident between the reviewed studies in terms of their approach to data and the level of interpretation from the findings. Therefore, the varying presentation of data needed to be taken into account, which presented some challenges (Sandelowski, Barroso, & Voils, 2007). Consequently, the entire results and findings sections of the reviewed papers, not solely quotes, were analysed line-by-line. The exceptions to this rule were the quotes from professional practitioners, which were not included in this synthesis, in order to maintain a homogenous approach. Consequently, the analysis was that of thematic synthesis (Harden & Thomas, 2008), rather than an ethnographic approach, to dilute the range of interpretation and difference across the studies.

Accordingly, a three level method to the interpretation of the findings was employed. Firstly, familiarisation with the interview quotes from the 23 studies gave individuality to the first person accounts. Secondly, considering the original researchers' meaning making and interpretations of those quotes provided the first layer of interpretation. Finally, I provided my own interpretation of the results and findings sections, based on my inductive analysis, and synthesised my findings (Gomersall, Madill, & Summers, 2011; Rice, 2008).

Although great care was taken to inductively generate my codes, the themes generated were subject to my epistemological perspective of critical realism. The process of line-by-line coding facilitated the translation aspect of the synthesis as individual codes were gradually consolidated to start to form groups of new findings (Harden & Thomas, 2008, Table 3). Each study was transposed into NVivo10, a computerised qualitative analysis software package. Following this, the line-by-line inductive thematic synthesis was undertaken. This approach facilitated the interpretation of each element of data into a unifying system of 1,967 codes, which created 295 descriptive themes. These descriptive themes were then grouped through a constant comparative method to form 18 preliminary analytical themes and, finally, the four analytical themes of the meta-synthesis. Lastly, once all the studies had been coded, the initial study to be analysed, Kallivayalil, Levitan, Brown, and Harvey (2013), was reviewed again to check its consistency with how it was originally coded.

<Insert Table 3: Summary of codes and themes >

Thematic Synthesis Findings

Theme 1: The Therapeutic Process as a Means for Forming Connections – "that's why I related to her . . . because she had that reaction." (McGregor, Thomas & Reid, 2006, p.49)

Interpersonal interactions appeared a crucial first step in the therapeutic process, which was challenging for the majority of participants across the studies, largely due to interpersonal difficulties that many attributed to experiencing abuse.

Theme 1.1: Developing trust in relationships and with oneself

A number of studies discussed participants' difficulties in developing relationships with others: "I see people as vicious." (Tummala-narra, Kallivayalil, Singer, & Andreini, 2012, p.644). However, once some relational connections had been made, other healing processes could begin. One participant explained how trusting his therapist had helped him connect with other people: "Trust is a miracle. I've never trusted anybody" (Kia-Keating, Sorsoli, & Grossman, 2010, p.677-8).

One way in which the therapists were able to develop trust in the relationship was through helping the client feel equal (O'Brien, Henderson, & Bateman, 2007; Palmer, Stalker, Gadbois, & Harper, 2004), as one client described: "I am a person, and you're a person, and we're doing this work together" (Koehn, 2007, p.51). Additionally, empowerment was an important feature, which was discussed in various forms across the studies (e.g. Chouliara et al., 2011; McGregor, Thomas, & Reid, 2006; Phelps, Friedlander, & Enns, 1997). In relation to feeling empowered or, conversely, re-victimised, having a sense of control, choice and direction appeared vital. For example, there were a number of statements recalling how choice could be offered and how that made the participant feel: ‘‘she makes sure that I'm in control of everything’’ (Harper, Stalker, Palmer, & Gadbois, 2008, p.369). Participants were also able to see how other people made choices, which helped develop their interpretation of events and trust themselves: "I am free to choose my way" (Stige, Rosenvinge, & Træen, 2013, p.425). Some also mentioned that it could be helpful to have suggestions, once trust had been established (Harper, Stalker, Palmer, & Gadbois, 2008; Phelps, Friedlander, & Enns, 1997): "if they [clients] knew the solutions they might have found them already" (McGregor, Thomas, & Reid, 2006, p.52). The choice to undertake therapy was also mentioned: "It was really difficult, but at the same time I wanted to do it" (Stige, Rosenvinge, & Træen, 2013, p.424).

Developing choice, control and empowerment is particularly important for CSA survivors as choice and control were so often missing from their childhoods and appeared to directly impact their experience of therapy as adults: "It's my soul. And I don't have to talk about it if I don't want to" (Koehn, 2007, p.49). When choice was not clearly provided for participants, it could be more difficult for the participants to exercise control. For example, one participant reported that not being able to prevent his therapist from self-disclosure was similar to not being able to "stop the abuse": "again you've gone through basically having something forced on you." (Harper, 2006, p.106).

1.2: Developing self-trust through therapeutic connections

Arias and Johnson found that participants were able to develop relational connections when they had the opportunity to share their abuse histories safely, with therapists who displayed "honesty," "competency," "trustworthiness," and "willingness to confront them on their inconsistencies", which seemed to reduce their sense of isolation (2013, p.832). Within the participant accounts was a sense that being believed and not judged was crucial in whether a therapist was trustworthy and worthy enough of hearing their stories (Anderson & Hiersteiner, 2008; Chouliara et al., 2011; McGregor, Thomas, & Reid, 2006). Accordingly, one participant described: "didn't judge and wasn't shocked. She didn't question whether this was 'the truth.'' (O'Brien, Henderson, & Bateman, 2007, p.4). Trust also seemed to be an intrapersonal experience for some, as one participant explained: "She wasn't scared of me being mad. . . . I learned a lot of self-trust in that" (Koehn, 2007, p.50).

Further, developing connections appeared most commonly through the studies exploring group therapy or individual and group combined therapy “we became really good friends.” (Palmer, Stalker, Gadbois, & Harper, 2004, p.116). In summary, the process of telling stories and having “somebody who listens and believes” (Phelps, Friedlander, & Enns, 1997, p.325) facilitated bonding intrapersonally and interpersonally. For instance, as one participant described: “having somebody who wants to sit and listen to me for an hour and values my time (tearful) … very healing” (Edmond, Sloan, & McCarty, 2004, p.265). Within the accounts was a sense that participants learnt trust through safely connecting with trustworthy others and then were able to internalise trust, which appeared to soften their perspective on the world around them: “it’s [the world] too beautiful to give up and be scared.” (Tummala-narra, Kallivayalil, Singer, & Andreini, 2012, p.644).

1.3: Tools for developing safety

In addition to establishing a sense of equality, trust and safety, participants described some of the explicit tasks their therapists undertook that they found helpful. For example, there were several mentions of therapists normalising the reaction their client was having in response to their traumatic pasts (Edmond, Sloan, & McCarty, 2004; Palmer, Stalker, Gadbois, & Harper, 2004). For instance, “I had thought, since I was nine, that I was crazy.” (McGregor, Thomas & Reid, 2006, p.48). Another participant discussed how her therapist facilitated therapeutic space: “she defused that [potential conflict] by giving me more room… room to express myself.” (Koehn, 2007, p.50). For other participants, their therapist explicitly demonstrated they were listening: “I feel so heard when she says back to me what I'm saying to her.” (Phelps, Friedlander, & Enns, 1997, p.325).

Theme 2: Developing a Sense of Self Through Therapeutic Processes - “it was as if I got hit by my own life! Everything caught up with me!” (Stige, Rosenvinge, & Træen, 2013, p.1301).

The second theme of this synthesis regards how the participants experienced themselves through therapy, which appeared to be a multi-staged and fluid process. Together, the reviewed studies span a range of the developmental stages and offer an array of insights, encompassing stages of self-awareness and self-healing.

2.1: An ambiguous sense of self

Initially, the participants' early stories about engaging with therapy discussed an ambiguous self: "I didn't have myself, a sense of myself as being a child even or a little girl" (Kallivayalil, Levitan, Brown, & Harvey, 2013, p.272). Consequently, participants also struggled with self-esteem (O'Brien, Henderson & Bateman, 2007). However, over time in therapy, participants' narratives became more complete and they were able to develop and describe a framework for the trauma (Kallivayalil et al., 2013). Although, the process of engaging with the trauma was, in itself, distressing: "I can remember finding an identity, finding myself waking up, finding myself heaving in pain" (Phillips & Daniluk, 2004, p. 180). Therefore, engaging with therapy was not without its difficulties for the participants.

However, an important code that appeared in most of the studies reviewed was that of *not being alone*: "it [talking therapy] makes me feel that I am not alone, that there is help there when I need it." (Chouliara et al., 2011, p.137). Sometimes, participants described a sense of finding out more about themselves and a path towards healing through others (Kia-Keating, Sorsoli, & Grossman, 2010). Similarly, empathising with other survivors and developing an external perspective on abuse provided a new context for participants' experiences: ''if they didn't deserve to be abused… maybe I didn't deserve it either'' (Lev-Wiesel, 2000, p.9). It was suggested that group therapy facilitated participants' healing through the stories of others (Arias & Johnson, 2013), implying connections with others helped participants develop their meaning making processes around their pasts, developing their sense of self.

2.2: Bigger than one self: stages of healing

The first stage of healing from the papers reviewed appeared to be a process of recognising the impact of CSA upon their sense of self, as one participant recalled: “that was so detrimental to self-esteem… self-worth that… feeling of self” (Saha, Chung, & Thorne, 2011, p.107). Equally, becoming more comfortable with oneself seemed to be important in learning about the self: “before, I couldn’t look myself in the eyes” (Chouliara et al., 2011, p.138).

A second stage that arose from a recurrent code in the studies was that there was a sense for many participants of the self being *bigger than one self* before it seemed possible to become a “complete and whole human being” (Tummala-narra, Kallivayalil, Singer, & Andreini, 2012, p.646). For example, some participants described a dissociated sense of self, which appeared disconnected from feeling and living: “Am I really inside myself?” (Brown, Kallivayalil, Mendelsohn, & Harvey, 2012, p.107). This stage may represent how participants encompassed their extreme past experiences through dissociative coping strategies that could gradually be reduced as they processed their experiences.

Additionally, the sense of there being at least one inside and another outside self seemed to be an important coping mechanism for some participants. As participants started to become more aware of their inside and outside selves, a cohesion seemed to form from within. For example, “Just started feeling more like myself as a being in the world instead of living this double identity” (Tummala-narra, Kallivayalil, Singer, & Andreini, 2012, p.645). This third stage of healing appeared to give participants a way to connect with themselves and others.

Crucially, the connections made in therapy appeared to translate to connections outside of therapy too. For instance, one participant described how she felt she could connect her inner self with others following group therapy: “I never told anyone my true feelings [before]” (Tummala-narra, Kallivayalil, Singer, & Andreini, 2012, p.645). However, this coping mechanism of an inner and outer-self had clearly served an important purpose for many and the following quote indicates how important the aforementioned sense of trust and safety could be when looking at different selves in therapy: “It really infuriates me when people try to get into my life” (Brown, Kallivayalil, Mendelsohn, & Harvey, 2012, p.107). Therefore, these findings suggest that the development of trust, safety and a therapeutic relationship need to develop alongside the client, appreciative of the coping strategies they have used thus far.

2.3: Developing self-esteem and self-kindness

The development of self-esteem seemed intrinsically linked to self-kindness: “not feel guilty about it [self-kindness]… I am a worthwhile person” (Saha, Chung, & Thorne, 2011, p.108). Consequently, talking therapy appeared to give survivors a sense of permission to meet their needs as others had not done (Grossman, Sorsoli, & Kia-Keating, 2006, p.438). Once a more cohesive sense of self had developed, it appeared easier for participants to like themselves: “I tell myself okay, you are doing a good job.” (Parker, Fourt, Langmuir, Dalton, & Classed, 2007, p.67).

Furthermore, many of the studies identified examples of how therapy helped this process, for example: “helped me enhance my self-esteem” (Phelps, Friedlander, & Enns, 1997, p.326). Kindness and understanding towards others was also sometimes mentioned. One participant who had trained to become a psychologist said of his father who sexually abused him: “He was gang raped when he was about 6 years old, and when he would abuse me, it was a replication of what had happened to him.” (Grossman, Sorsoli, & Kia-Keating, 2006, p.438). The sense of a survivor identity also appeared to hold different amounts of value at varying stages of the participants’ healing. For example, one participant described how her survivor identity had evolved: “I think of myself as a woman, an artist.” (Phillips & Daniluk, 2004, p.180). This shift towards having a sense of self not reliant on being a survivor of CSA appeared an important step to finding an independent adult identity and required the process of recognising one’s strengths through self-kindness and self-esteem.

Theme 3: Therapeutic Lights and Black Holes in the Shadows of CSA - “He's allowed me to grieve” (Phelps, Friedlander, & Enns, 1997, p.326)

This third theme discusses specifically how the intra- and interpersonal shadows cast through experiencing CSA affected the participants in therapy and how helpful therapy could facilitate healing: “never made any connection that (the effects were) connected (to the CSA)–Therapy set me free from that… therapy has saved my life.” (McGregor, Thomas & Reid, 2006, p.49).

3.1: Specific relational needs

Participants who could connect positively to themselves, often through developing a positive therapeutic alliance with their therapist or group members (Stige, Træen, & Rosenvinge, 2013), could develop their self-perspective: “Before I was invisible, even though I wasn’t, I felt so invisible. And now I know I’m not invisible. I am a person who has an impact on people” (Phillips & Daniluk, 2004, p.179). Additionally, when therapists were alert to the specific relational needs of their clients, participants reported this facilitating them to safely engage in therapy: “people who suffer from any sort of abuse, they need to be told that they have the permission, to… interrupt, the permission to speak out, the permission to say “No” and permission to do what they think is right” (McGregor, Thomas & Reid, 2006, p.44). Similarly, normalising distress as a response to trauma, rather than as mental illness (Harper, Stalker, Palmer, & Gadbois, 2008; O’Brien, Henderson & Bateman, 2007), was also found to be very helpful: “it put everything in a framework that helped me.” (Palmer, Stalker, Gadbois, & Harper, 2004, p.116).

However, with self-awareness and self-cohesion, the healing of the self for many still seemed incomplete, as one participant described: “there is like fear and revulsion but not the immobilizing kind” (Edmond, Sloan, & McCarty, 2004, p.266). Nevertheless, hope appeared in numerous forms throughout some of the studies, hope for oneself and hope through others (Brown, Kallivayalil, Mendelsohn, & Harvey, 2012). One participant described hoping to meet someone who had healed, “made it all the way through to the other side [healed]”, to give her hope (Anderson & Hiersteiner, 2008, p.419).

In addition to participants struggling at times to relate to their therapist or group members, many described relating to themselves as hard too: “The most difficult part was to be confronted with yourself… the things that happened during the treatment within yourself.” (Stige, Rosenvinge, & Træen, 2013, p.424). Some participants described a multiplicity of the self in that their inner and outer selves could be very different. This difference affected how they related to therapists, which led one participant to ask therapists to “look deeper” (McGregor, Thomas, & Reid, 2006, p.46). Another participant described how: “inside, not that people would see this, I was very, very anxious and very insecure and distressed but outside I was outgoing, sociable” (Saha, Chung, & Thorne, 2011, p.104). This missing and misunderstanding appeared to enhance participants’ anxiety around therapy (O'Brien, Henderson, & Bateman, 2007, p.5).

3.2 Stumbling in the dark and repeating abusive dynamics

When non-specialised therapists were unable to meet the needs of their clients, they were sometimes likened to “stumbling in the dark” (McGregor, Thomas, & Reid, 2006, p.48). Depending upon how the ‘stumbling’ was managed, some data suggested that if therapists sought additional help when they felt under-resourced, participants could view this as helpful, perhaps also modelling seeking support: “he was just so open to making another connection and bringing someone else in, and working with someone else, like as a team.” (Harper, Stalker, Palmer, & Gadbois, 2008, p.369).

Replaying the dynamics of past abusive relationships was also a factor that participants had to face. For example, as one participant described: “I felt overpowered… Like, I’ve got to do what this parental person says, and he’s the professional… I felt like my power was taken away almost forcefully” (Koehn, 2007, p.47). The use of touch in the relationship was also a very delicate therapeutic process and both positive and negative experiences were found; both in terms of touch being “really significant and important” (Phelps, Friedlander, & Enns, 1997, p.327) or “not feel safe to pursue” (p.328). These findings again highlight the need for choice and control to be with the client at all times when working with someone who has experienced CSA. As one participant described choice: “she [therapist] had a wonderful holistic approach and we integrated all of that stuff.” (McGregor, Thomas, & Reid, 2006, p.47).

Other aspects of therapy that participants reported finding very challenging related to not following the client’s wishes around how to undertake the therapy (Koehn, 2007) and not including the multiplicity that so many people discussed, be it having an outer self or dissociative identity disorder (DID, Palmer, Stalker, Harper, & Gadbois, 2007). However, when participants felt safe within the relationship and therefore able to talk about the abuse, they reported finding this disclosure and being heard very healing: “We bonded in a way on a personal level so it made it easier for me to disclose a lot of really horrible things about the abuse.” (Edmond, Sloan, & McCarty, 2004, p.265). This may be reminiscent of the interpersonal unpredictability that CSA survivors can experience, which makes knowing the therapist an important part of the process to reduce the perception of threat for the client.

3.3: Endings, loss and grief

When therapy ended, particularly the group therapy programmes, new difficulties arose for the participants as they missed having the support (Anderson & Hiersteiner, 2008; O'Brien, Henderson & Bateman, 2007; Parker, Fourt, Langmuir, Dalton, & Classed, 2007). One participant described the ending of her therapy group as “like jumping off a train” as she felt unsupported (Harper, Stalker, Palmer, & Gadbois, 2008, p.366). Such findings further suggest some of the shadows of loss: loss of support as well as loss of connections and safety.

Other shadows of loss included grief for lost time and experiences, which emerged from therapy (O'Brien, Henderson, & Bateman, 2007; Phelps, Friedlander, & Enns, 1997). For example, “I never really thought of [her abusive childhood] as a loss, but it was” (Palmer, Stalker, Gadbois, & Harper, 2004, p.116). Other participants took a transgenerational perspective upon loss and looked to the next generation for healing: “The damage is probably too extensive… certainly within this generation, and that’s very sad.” (Phillips & Daniluk, 2004, p.181). However, some participants had managed to heal their wounds enough to find what they wanted: “I decided to succeed in both my marriage and my work, and I did. I am quite satisfied with my life.’’ (Lev-Wiesel, 2000, p.8-9).

Theme 4: Healing or Harrowing: connecting and first time experiences - “I might never have known how unlimited the human spirit is around finding its way through impossible odds.” (Phillips & Daniluk, 2004, p.182).

Within the studies reviewed were prominent codes around connecting with others and feeling a sense of togetherness through therapy (Parker, Fourt, Langmuir, Dalton, & Classed, 2007; Stige, Rosenvinge, & Træen, 2013; Tummala-narra, Kallivayalil, Singer, & Andreini, 2012). As one participant explained: “encouragement thread from one to another” (Saha, Chung, & Thorne, 2011, p.108).

4.1: Experiencing connecting and sharing

Finding strength through hearing other survivors was mentioned in several studies (Arias & Johnson, 2013; Chouliara et al., 2013; O'Brien, Henderson, & Bateman, 2007; Palmer, Stalker, Gadbois, & Harper, 2004), for instance: “finding other women that had a voice… there is an acceptance here, there is a warmth and compassion that I never knew could possibly exist.” (Anderson & Hiersteiner, 2008, p.421). Additionally, experiencing warmth and understanding within relationships was important for healing (Arias & Johnson, 2013; Phillips & Daniluk, 2004). Further, developing perspective through connecting with others’ experiences appeared to give the trauma a context as well as the survivor a platform for their healing.

Conversely, there were examples within the data in which the hearing of other’s stories would be detrimental to healing, although a degree of understanding and perspective was still apparent (Parker, Fourt, Langmuir, Dalton, & Classed, 2007). Hearing others’ stories could be challenging: “it has been hard at times to find sympathy for those I listen to, because I have experienced so much” (Stige, Rosenvinge, & Træen, 2013, p.1300). Additionally, there were numerous accounts across the studies that indicated there could be negative aspects to the groups if they were not managed or structured appropriately (O'Brien, Henderson, & Bateman, 2007; Palmer, Stalker, Harper, & Gadbois, 2007).

Alternatively, some participants described how they felt ready to engage with services, although they were told that they were “considered too complex” for talking therapy (Chouliara et al., 2011, p.143) or “not ready yet” if a particular approach to therapy was not successful, which was reported as “invalidating, like you are not worthy of recovery.” (O'Brien, Henderson & Bateman, 2007, p.6).

4.2 Experiential learning and change

The development of a safe space appeared to be highly reliant on the creation of appropriate and sensitive boundaries (Chouliara et al., 2011; Harper, 2006; O'Brien, Henderson, & Bateman, 2007; Parker, Fourt, Langmuir, Dalton, & Classed, 2007). Participants explained how when they felt highly distressed, they were unable to use the tools helpfully (Palmer, Stalker, Gadbois, & Harper, 2004; Parker, Fourt, Langmuir, Dalton, & Classed, 2007). As one participant explained: “I think the single most helpful thing with [my therapist] was defining a relationship that had boundaries and then experientially learning that there are people capable of maintaining those boundaries.” (Kia-Keating, Sorsoli, & Grossman, 2010, p.676). Boundaries appeared to be important for two main reasons: firstly, to establish the therapeutic relationship as safe; and secondly, to help the participants facilitate their healing outside of therapy (Tummala-narra, Kallivayalil, Singer, & Andreini, 2012). Perhaps due to the violation of the participants’ boundaries in the past, boundaries and safety appeared synonymous in the relationship.

In further relation to learning and using tools, some participants were able to recognise the strengths and skills they had developed: “I’ve survived it and because of that… I have learnt a lot of skills” (Phillips & Daniluk, 2004, p.181). However, when new coping strategies started failing, some participants found they started struggling quickly: “I lost my parachute… I was free falling.” (Stige, Træen, & Rosenvinge, 2013, p.1301). The process of helping participants find other parachutes when their own failed, seemed again to lie in the therapeutic alliance. When the participants recognised their own strengths in accordance with, but not reliant on their therapist’s abilities, they were able to identify their own skills: “I wouldn't crumble without him [therapist]” (Phelps, Friedlander, & Enns, 1997, p.326). One participant defined this process as: “The role of counselling [is] to enable survivors to find the strength within themselves to heal” (O'Brien, Henderson, & Bateman, 2007, p.5).

Participants were also able to reflect upon change: “without you noticing, you have changed many little things that make a huge difference!” (Stige, Rosenvinge, & Træen, 2013).

Finally, findings suggested that talking about choice and control may not be enough and that the survivor needs to experience having control before they can truly understand that they did not have control or choice as a child: “as a child didn’t have the power to stop anything or change anything, so it wasn’t my fault” (Parker, Fourt, Langmuir, Dalton, & Classed, 2007, p.66). It may have been that this contrast in experiencing what it felt like to have choice and control facilitated this change in perspective and thus the process of healing (Grossman, Sorsoli, & Kia-Keating, 2006; Harper, 2006; Harper, Stalker, Palmer, & Gadbois, 2008).

4.3 The language in talking therapy

Within the data from the studies reviewed was a large collection of codes relating specifically to how the participants experienced using language within talking therapy to talk about abuse, themselves and recovery. The participants’ quotes from the studies suggested that participants could still find it difficult to articulate certain feelings: “I wanna say, I want to say, my anger wants to say they were bastards, they were evil bastards. But my more balanced side says that they were sick” (Kallivayalil, Levitan, Brown, & Harvey, 2013, p.276). As another participant suggested: “aren’t words useless sometimes!!” (Chouliara et al., 2011, p.139). For some participants, it seemed as though they had never developed the language for their experiences: “I couldn’t tell my story… with the sexual abuse… you don’t have words for it…” (Palmer, Stalker, Gadbois, & Harper, 2004, p.116).

One of the reasons talking seemed to be so difficult for the participants, was that so many of them had been kept silent for so long (Chouliara et al., 2011; Saha, Chung, & Thorne, 2011; Stige, Rosenvinge, & Træen, 2013). However, despite the difficulties surrounding finding words, disclosing the abuse appeared to be an important first step in starting to understand their experiences (Arias & Johnson, 2013). One participant explained “breaking the silence… about what you feel and think, or have experienced… can sometimes feel overwhelming” (Palmer, Stalker, Gadbois, & Harper, 2004, p.115). For others, talking about what happened reduced some of the power of the abuser: “it helped me, after that I stopped hearing my abuser’s voice” (Saha, Chung, & Thorne, 2011, p.108).

<Insert Figure 2: The process of change as perceived by CSA survivors throughout talking therapy >

Discussion

The current synthesis provides a number of findings from the perspectives of CSA survivors who have experienced talking therapies. Firstly, the experience of healing was discussed as a largely ongoing process, which could be facilitated through developing trust, safety, equality and finding connections with others and discovering hope for the future. This synthesis highlighted how crucial the therapeutic relationship was, not only for survivors to find the words to tell their story but also to experience in adulthood what had been missing from their childhoods: choice, control, respect and being believed. Additionally, there were essential processes that survivors needed to experience before they could engage in therapy or end the silencing of their past, which many survivors reported lived with them. Although relational aspects of the therapeutic alliance are recognised as important with many client groups in terms of the therapeutic process and outcome (Mikulincer, Shaver, & Berant, 2013), survivors of CSA appeared to need the specific relational experiences described in this review to move towards recovery.

Herman suggests: “it should be possible to recognize a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection” (1992, p.155). The current synthesis helps to explain how the nuanced mechanisms of positive therapeutic processes facilitated healing (Figure 2). Mechanisms included having the safety and freedom to find words for trauma; to safely say those words aloud and for them to be witnessed through belief; to have therapeutic space for the parts of the self to move and express themselves at different rates, so as to develop a narrative that incorporated past abuse with a present ability to experience real choice and control.

Additionally, it was essential for participants to develop enough trust with the inner and outer self and with others, so that intra- and interpersonal connections could be made. Finally, changing perspectives of the self and others could facilitate healing towards a cohesive whole adult self, independent from the trauma of the past. Although it is recognised that the initial stages of therapeutic work with survivors should not focus on past traumas so as not to re-traumatise the client (e.g. Chouliara et al., 2011; Dillon, Johnstone, & Longden, 2012), the current synthesis suggested that from the survivor’s perspective, the process of getting to know the therapist was crucial for finding safety and reducing the anticipated threat of further abuse. Although this is a recognised process for people experiencing DID (ISSTD, 2011), these findings suggest that a phased approach is also required for people with trauma reactions to CSA. In summary, the interpersonal approach of the therapist appeared more important to the process of healing than the therapeutic modality.

Additionally, a novel finding emerging from the synthesis was that there appeared to be five distinctive stages of therapeutic change in relation to the developing self that, if managed well by the therapist, could facilitate healing and ongoing change (Figure 2). For example, the stages appeared to link past experiences of CSA with current distress, accepting the impact of CSA and becoming more comfortable in recognising that the self may have had to become bigger than one to encompass the abused past self and comparably well-functioning present self. Following this process, forming intrapersonal connections and integrating trauma histories through the ways discussed throughout theme two appeared to help participants connect to themselves and others, which further facilitated their own self-cohesion and healing. This seemed to be when a survivor identity appeared most helpful. Once a stronger sense of self had developed, self-kindness was increasingly possible, which could facilitate the development of self-esteem. Finally, the development of a self-governing sense of self, independent from CSA, appeared to be the final step away from a survivor identity towards a ”whole” adult self. Consequently, the mechanisms of change that Ehler et al. (2010) suggested we need to understand better appeared largely intrapersonal in nature.

Although the processes identified in this synthesis are unique as they formed as a result of an in-depth synthesis of the available survivor accounts of talking therapy, this phased approach towards integrating “fragmented experience into a meaningful autobiographical narrative”, within the context of a secure and trusting therapeutic relationship, is concurrent with other theoretical (Dillon, Johnstone, & Longden, 2012, p.151) and empirical recommendations for supporting survivors through therapy (Arias & Johnson, 2013; Bicknell-Hentges & Lynch, 2009; Brown, Kallivayalil, Mendelsohn, & Harvey, 2012; Chouliara et al., 2011; Koehn, 2007; McGregor, Thomas, & Read, 2006; Phillips & Daniluk 2004). As Palmer, Stalker, Harper, and Gadbois suggest, recognising that survivors are likely to be at different stages of healing, a “one-size-fits-all” therapeutic approach is rarely likely to benefit all (2007, p.75). This synthesis would add to this, suggesting that not having a specific modality or expectations in mind and constantly facilitating the client to choose the direction of therapy can help the client guide therapy and experience having choice and control, which was found to be pivotal for healing.

A number of studies have considered the many adverse effects of CSA for survivors (e.g. Bagley & Ramsey, 1986; Banyard, Williams, & Siegel, 2001), and it has been noted that considerably less attention has been paid to the resources survivors use to reconcile with their traumatic experiences (Cicchetti & Toth, 2005; Maniglio, 2009). This synthesis suggested participants could discover their strengths through new experiences of having choice and control in the therapeutic relationship, explicit equality, implicit trust and being encouraged to feel empowered.

Similarly to the meta-analysis undertaken by Hetzel-Riggina, Brauschb, and Montgomery (2007) on therapeutic modality outcomes for young people who had experienced CSA, it was found in this study that different therapeutic approaches were helpful for different developmental areas of social and emotional healing. For example, the process of grieving could only occur once the trauma and relating losses had been recognised. Correspondingly, the process of relinquishing guilt for the abuse could only happen once the survivor had experienced having control and choice in a relationship, so as to know they did not have control over the abuse. These processes of experiential learning appeared to take time and could only occur once trust and safety had been firmly established. These findings support the phased model of recovery and treatment (ASCA, 2013; Cloitre, Petkova, & Wang, 2012; ISSTD, 2011), although for people with a range of trauma responses within a context of secure-base relational support.

Lastly, despite the efforts to incorporate all relevant empirical studies and analyse them idiographically, rather than ethnographically to account for their interpretative and epistemological differences, this systematic review encompasses a number of limitations. Clarification from the corresponding authors was generally required to ascertain how many participants had experienced CSA and the type of talking therapy they had encountered. Future research could make such information more explicit for the interpretation of findings. Additionally, this synthesis considered CSA in a fairly broad sense, which is likely to have influenced the interpretation of the data at the original and synthesis levels. However, it was considered that it was important to include as many participant voices as possible in the review, to explore the processes CSA survivors' experience with talking therapies comprehensively. Additionally, CSA commonly occurs in the context of multi-type maltreatment and, consequently, the findings should be contextually relevant for many CSA survivors. Furthermore, the idiographic, rather than ethnographic, nature of the review meant that selected quotes could be carefully considered to represent CSA survivors' experiences in particular, leading to an enhanced CSA focussed analysis (Appendix 2-A). Finally, due to the relatively limited cultural diversity across the studies, future research should aim to explore the role of different cultures upon relational experiences in therapy and how culture may influence meaning making processes through healing. Specifically, as the construct of the self varies across cultures (Castillo, 1997), it would be interesting to know more about how different perceptions of the self influence some of the intrapersonal processes discussed throughout this review.

Conclusion

The current synthesis combines the findings from empirical studies that span a range of survivor experiences of talking-therapy, from initial impressions to completing their journey through therapy. Within the accounts emerged some significant new indications as to what survivors require from talking therapies, such as the experiential learning of choice and control, finding a framework for the trauma and recognising their strengths.

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Table 1

Characteristics of included studies

Authors & Date	Manuscript Title	Participants	Data Collection	Analysis	Epistemology	Country
Anderson & Hiersteiner (2008)	Recovering From Childhood Sexual Abuse: Is a “Storybook Ending” Possible?	2M, 25F, *M*age = 43.6	Convenience sampling and group interviews	Grounded theory - categorical-content approach	Not declared, appears constructionist	USA
Arias & Johnson (2013)	Voices of Healing and Recovery from Childhood Sexual Abuse	2M, 25F, *M*age = 43.63	Semi-structured individual interviews	Grounded theory	Constructivist	USA
Brown, Kallivayalil, Mendelsohn, & Harvey	Working the Double Edge: Unbraiding Pathology and Resiliency in the Narratives of	2M, 18F, *M*age = 32	Semi-structured interview (The Multidimensional Trauma Recovery and	Grounded theory	Constructivist	Canada

(2012)	Early-Recovery Trauma Survivors.		Resiliency Interview) and The Multidimensional Trauma Recovery and Resiliency Scale			
[4]Chouliara et al. (2011)	Talking Therapy Services for Adult Survivors of Childhood Sexual Abuse (CSA) in Scotland: Perspectives of Service Users and Professionals.	0M, 13F, *M*age = 40	Semi-structured interviews.	IPA	Not explicitly declared, although reference is made to the "realist ontology of the social cognitive paradigm" within IPA	Scotland

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[4] Only survivor quotes were used in the review.

Edmond, Sloan, & McCarty (2004)	Sexual Abuse Survivors' Perceptions of the Effectiveness of EMDR and Eclectic Therapy.	0M, 38F, *M*age = 35	Individual interviews (with quant measures also)	Thematic analysis	Not declared - appears constructionist	USA
Grossman, Sorsoli, & Kia-Keating (2006)	A Gale Force Wind: Meaning Making by Male Survivors of Childhood Sexual Abuse	16M, 0F, *M*age = 42.5	Individual semi structured interview (around 5 hours each)	Thematic content analysis	Ambiguous, appears largely realist	USA
*Harper (2006)	Negotiating Therapeutic Boundaries with Childhood Sexual Abuse Survivors: Choices in Decision-Making	3M, 8F, *M*age = 40	Individual interviews with follow-up questionnaires	Grounded theory	Not declared – appears constructionist	Canada
Harper,	Adults traumatized by	5M, 25F,	Individual interviews	Constant	Not declared -	Canada

Stalker, Palmer, & Gadbois (2008)	child abuse: What survivors need from community-based mental health professionals	*M*age = 40.8		comparative method for codes followed by ethnography between researchers	appears constructionist in most parts	
Kallivayalil, Levitan, Brown, & Harvey (2013)	Preliminary Findings from a Qualitative Study of Trauma Survivors in Treatment: Changes in Personal Narratives	1M, 13F, *M*age = 42	Semi-structured interviews	Grounded theory approach to the analysis of narrative accounts of the process of trauma recovery.	Not declared - appears constructivist	USA
Kia-Keating, Sorsoli, &	Challenges and Recovery Processes in Male	16M, 0F, *M*age =	Semi-structured interviews	Grounded theory approach	Not declared - appears positivist	USA

Grossman (2010)	Survivors of Childhood Sexual Abuse.	41.5				
Koehn (2007)	Women's Perceptions of Power and Control in Sexual Abuse Counselling	0M, 50F, *M*age = 37	Individual interviews	Critical incident method	Not declared - appears critical realist	USA
Lev-Wiesel (2000)	Quality of Life in Adult Survivors of Childhood Sexual Abuse Who Have Undergone Therapy	2M, 25F, *M*age = 38	Individual quasi-open ended interviews and quantitative quality of life questionnaire	Narrative (based on Rosenthal (1993) narrative biographical interviews)	Not declared, discusses constructs and reconstructs	Israel
McGregor, Thomas, & Reid (2006)	Therapy for Child Sexual Abuse: Women Talk About Helpful and	2M, 25F, *M*age = 38	Semi-structured interviews	Grounded theory approach	Not declared - appears critical realist	New Zealand

	Unhelpful Therapy Experiences					
O'Brien, Henderson, & Bateman (2007)	Finding a place for healing: Women survivors of childhood sexual abuse and their experience of accessing services	0M, 14F, *M*age = unknown	Focus groups and individual interviews	Thematic analysis	Not declared, realist aspects, although largely unclear	
Palmer, Stalker, Gadbois, & Harper (2004)	What Works for Survivors of Childhood Abuse: Learning From Participants in an Inpatient Treatment Program	5M, 25F, *M*age = 40.8	Individual interviews after completing an inpatient post-trauma (CSA) programme.	Grounded theory informed constant comparative method	Not declared - appears critical realist	Australia

Palmer, Stalker, Harper, & Gadbois (2007)	Balancing Positive Outcomes with Vicarious Traumatization: Participants' Experiences with Group Treatment for Long-Term Effects of Childhood Abuse.	5M, 25F, *M*age = 40.8	Individual interviews	Grounded theory informed constant comparative method	Not declared - appears critical realist	Australia
Parker, Fourt, Langmuir, Dalton, & Classed (2007)	The Experience of Trauma Recovery: A Qualitative Study of Participants in the Women Recovering from Abuse Program (WRAP)	0M, 7F, *M*age = 38	Completed WRAP at least six months prior to semi-structured interviews.	IPA	Not declared - appears critical realist	Canada
Phelps,	Psychotherapy Process	0M, 11F,	Individual semi-	Pattern coding	Not declared -	USA

Friedlander, & Enns (1997)	Variables Associated With the Retrieval of Memories of Childhood Sexual Abuse: A Qualitative Study	*M*age = 41.7	structured interviews	leading to thematic analysis	appears largely constructionist	
Phillips & Daniluk (2004)	Beyond “Survivor”: How Childhood Sexual Abuse Informs the Identity of Adult Women at the End of the Therapeutic Process.	0M, 7F, *M*age = 43.5	Individual interviews with a focus on self-identity and healing.	IPA	Not declared - appears constructionist	Canada
Saha, Chung, & Thorne (2011)	A narrative exploration of the sense of self of women recovering from	0M, 4F, *M*age = 47.5	Narrative interviews. 1) life-story interview; 2) recovery-story interview;	Narrative analysis	Not declared - appears constructivist	South-west England

	childhood sexual abuse.		3) semi-structured interview which aimed to explore participants' understanding of how their selves evolved after their therapy experiences.			
Stige, Rosenvinge, & Træn (2013)	A meaningful struggle: Trauma clients' experiences with an inclusive stabilization group approach.	0M, 13F, *M*age = 39	Interviews were interviewed within three months of completing the therapy group. Age range 18-60 (mean=39 years).	Hermeneutical-phenomenological approach – focus personal accounts whilst recognising researcher bias.	Not declared - appears critical realist	Norway
Stige, Træen, &	The Process Leading to Help Seeking Following	0M, 13F, *M*age = 39	Participants were interviewed within three	Hermeneutical-phenomenological	Not declared - appears critical	Norway

Rosenvinge (2013)	Childhood Trauma.		months of completing the therapy group.	approach – focus on lived experiences while attempting to account for researcher bias.	realist	
Tummala-Narra, Kallivayalil, Singer, & Andreini (2012)	Experiences of Complex Trauma Survivors in Treatment: Preliminary Findings From a Naturalistic Study.	3M, 18F, *M*age = 43.2	Individual interviews	Grounded Theory	Not declared - appears critical realist	USA

Table 2
CASP appraisal of included studies

CASP Criteria / Journal	Anderson & Hiersteiner (2008)	Arias & Johnson (2013)	Brown, Kallivayalil, Mendelsohn,, & Harvey (2012)	*Chouliara et al., (2011)	Edmond, Sloan, & McCarty, (2004)	Grossman, Sorsoli, & Kia-Keating (2006)	Harper (2006)	Harper, Stalker, Palmer. & Gadbois, (2008)	Kallivayalil, Levitan, Brown, & Harvey (2013)	Kia-Keating, Sorsoli, & Grossman, (2010)	Koehn (2007)	Lev-Wiesel (2000)
1.Clear statement of aims	2	2	2	2	1	2	2	1	2	2	1	1
2.Qualitative methodology appropriate	2	2	2	2	2	1	2	2	2	2	2	2
3.Appropriate research design	2	2	2	2	2	2	2	2	2	2	2	2
4.Appropriate recruitment strategy	2	2	2	2	2	2	2	2	1	2	2	2

5.Consideration of data collection	2	2	1	2	2	1	2	2	2	2	2	1
6.Consideration of research relationships	1	1	1	2	2	1	1	1	1	1	1	1
7.Ethical issues considered	1	2	1	1	1	1	1	1	0	2	2	1
8.Rigourous data analysis	1	2	2	2	1	2	2	2	2	2	2	1
9. Findings clearly stated	2	2	2	2	2	2	2	2	2	2	2	2
10.Value of the research	2	2	2	2	2	2	2	1	2	2	2	2
Total Score	17	19	17	19	17	16	18	16	16	19	18	15

CASP Criteria / Journal	McGregor, Thomas, & Reid (2006)	O'Brien, Henderson, & Bateman (2007)	Palmer, Stalker, Gadbois, & Harper (2004)	Palmer, Stalker, Harper, & Gadbois (2007)	Parker, Fourt, Langmuir, Dalton, & Classed (2007)	Phelps, Friedlander, & Enns (1997)	Phillips & Daniluk, (2004)	Saha, Chung, & Thorne (2011)	Stige, Rosenvinge, & Træen (2013)	Stige, Træen, & Rosenvinge (2013)	Tummala-Narra, Kallivayalil, Singer, & Andreini (2012)
1.Clear statement of aims	2	1	2	2	2	2	2	2	2	2	2
2.Qualitative methodology appropriate	2	1	2	2	2	1	2	2	2	2	2
3.Appropriate research design	2	1	2	2	2	2	2	2	2	2	2
4.Appropriate recruitment strategy	2	2	2	2	2	2	2	2	2	2	2

5.Consideration of data collection	2	1	1	2	2	2	2	1	2	2	2
6.Consideration of research relationships	1	1	1	1	2	2	2	1	2	2	1
7.Ethical Issues considered	2	2	1	1	2	2	1	2	2	2	2
8.Rigourous data analysis	2	1	2	2	2	2	2	2	2	2	2
9. Findings clearly stated	2	2	2	2	2	2	2	2	2	2	2
10.Value of the research	2	2	2	2	2	2	2	2	2	1	2
Total	19	14	17	18	20	19	19	18	20	19	19

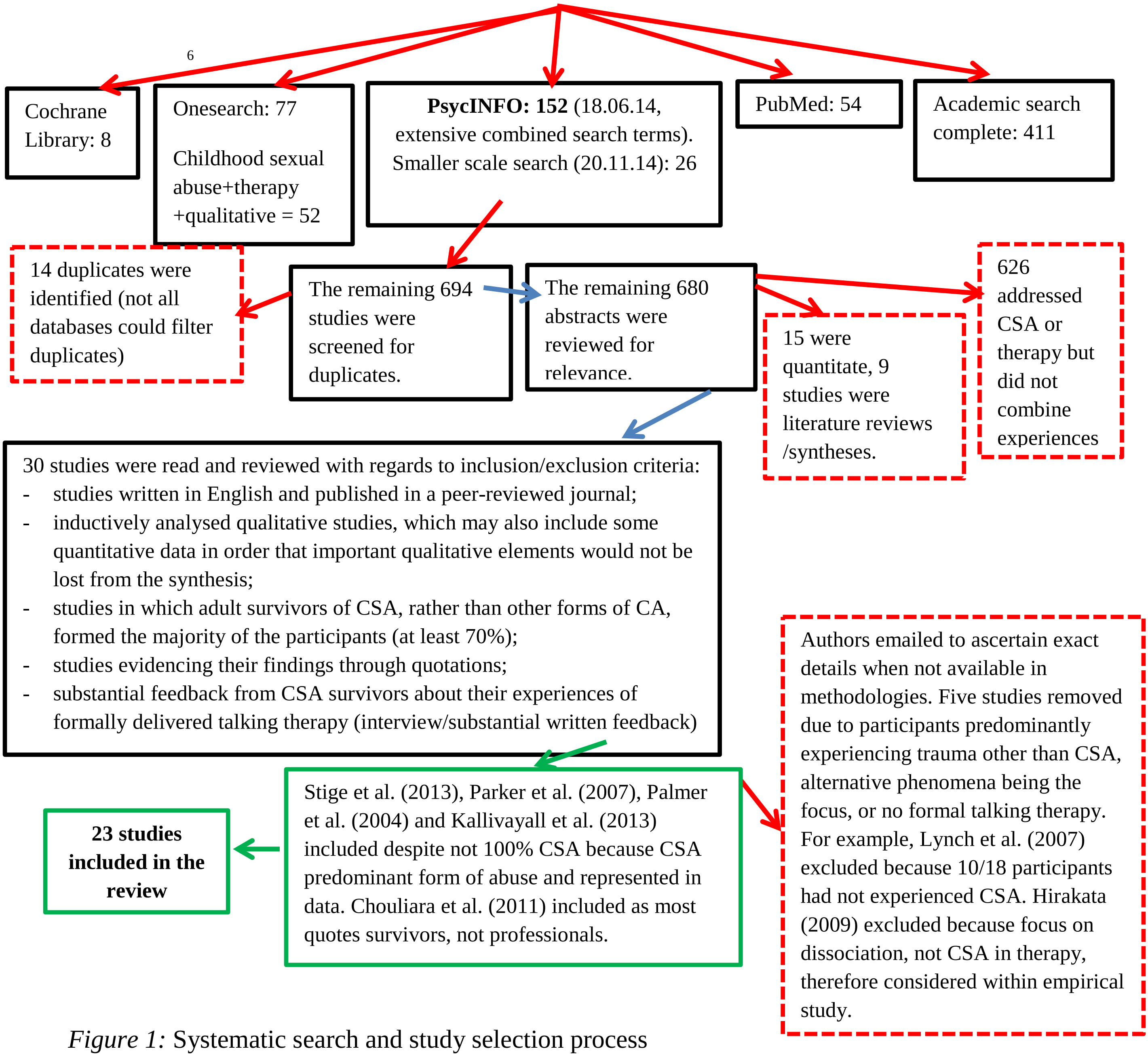
Table 3

Summary of codes and themes

Free code examples	Descriptive theme examples	Preliminary analytical themes	Analytical themes
“in control” “Well I have found myself” “I love when she does it” “trust is a miracle”	Finding control Relationships that strengthen self Meaningful moments in relationship Helpful and unhelpful Being believed	Choice and Control Interactions in therapy Meanings in the therapeutic relationships	1. The therapeutic process as a means for forming connections
“I couldn’t look myself in the eyes” “you’re not alone in your struggle” “didn’t have myself” “double identity”	Bigger than one self Whole self Before and after self Double identities	Self and Developing self Covering, not coping Healing/Recovery	2. Developing a sense of self through therapeutic processes

“he’s allowed me to grieve” “That’s not mental health” “the pain that was opened up” “what this parental person says” “I kind of felt I was lost” “the permission”	They need to look deeper, “stumbling in the dark” Loosing time and options Inflexibility, not understanding CSA/PTSD No fix, expectations Understanding interpersonal processes	Unhelpful Systems Support between sessions and endings Therapy in the shadows of CSA What’s not helpful in therapy Loss and grief	3. Therapeutic lights and black holes in the shadows of CSA
“taking it out of my head” To talk for the first time To see it for the first time To be heard “I was learning boundaries” Replaying dynamics from past	Re-experiencing abuse Being listened to and in control Flexibility and accessibility Hearing/saying: Gaining understanding and perspective on abuse Talking about what happened Navigating the past and present Experiencing empathy	Change/difference Strengths Barriers and Boundaries Therapy tools Connecting with others Readiness and Willingness Talking with language	4. Healing or harrowing: connecting and first time experiences

Search terms (20.11.14): therap*[5] AND child abuse AND emotional trauma / therap* AND child sexual abuse AND qualitative / therap* AND trauma focussed AND child sexual abuse AND child sexual assault / therap* AND psychotherapy AND child sexual abuse (Limiters: English, 18yrs and older, qualitative, peer-reviewed)



Cochrane Library: 8

Onesearch[6]: 77

Childhood sexual abuse+therapy +qualitative = 52

PsycINFO: 152 (18.06.14, extensive combined search terms). Smaller scale search (20.11.14): 26

PubMed: 54

Academic search complete: 411

14 duplicates were identified (not all databases could filter duplicates)

The remaining 694 studies were screened for duplicates.

The remaining 680 abstracts were reviewed for relevance.

15 were quantitate, 9 studies were literature reviews /syntheses.

626 addressed CSA or therapy but did not combine experiences

30 studies were read and reviewed with regards to inclusion/exclusion criteria:

- studies written in English and published in a peer-reviewed journal;
- inductively analysed qualitative studies, which may also include some quantitative data in order that important qualitative elements would not be lost from the synthesis;
- studies in which adult survivors of CSA, rather than other forms of CA, formed the majority of the participants (at least 70%);
- studies evidencing their findings through quotations;
- substantial feedback from CSA survivors about their experiences of formally delivered talking therapy (interview/substantial written feedback)

Authors emailed to ascertain exact details when not available in methodologies. Five studies removed due to participants predominantly experiencing trauma other than CSA, alternative phenomena being the focus, or no formal talking therapy. For example, Lynch et al. (2007) excluded because 10/18 participants had not experienced CSA. Hirakata (2009) excluded because focus on dissociation, not CSA in therapy, therefore considered within empirical study.

Stige et al. (2013), Parker et al. (2007), Palmer et al. (2004) and Kallivayall et al. (2013) included despite not 100% CSA because CSA predominant form of abuse and represented in data. Chouliara et al. (2011) included as most quotes survivors, not professionals.

23 studies included in the review

Figure 1: Systematic search and study selection process

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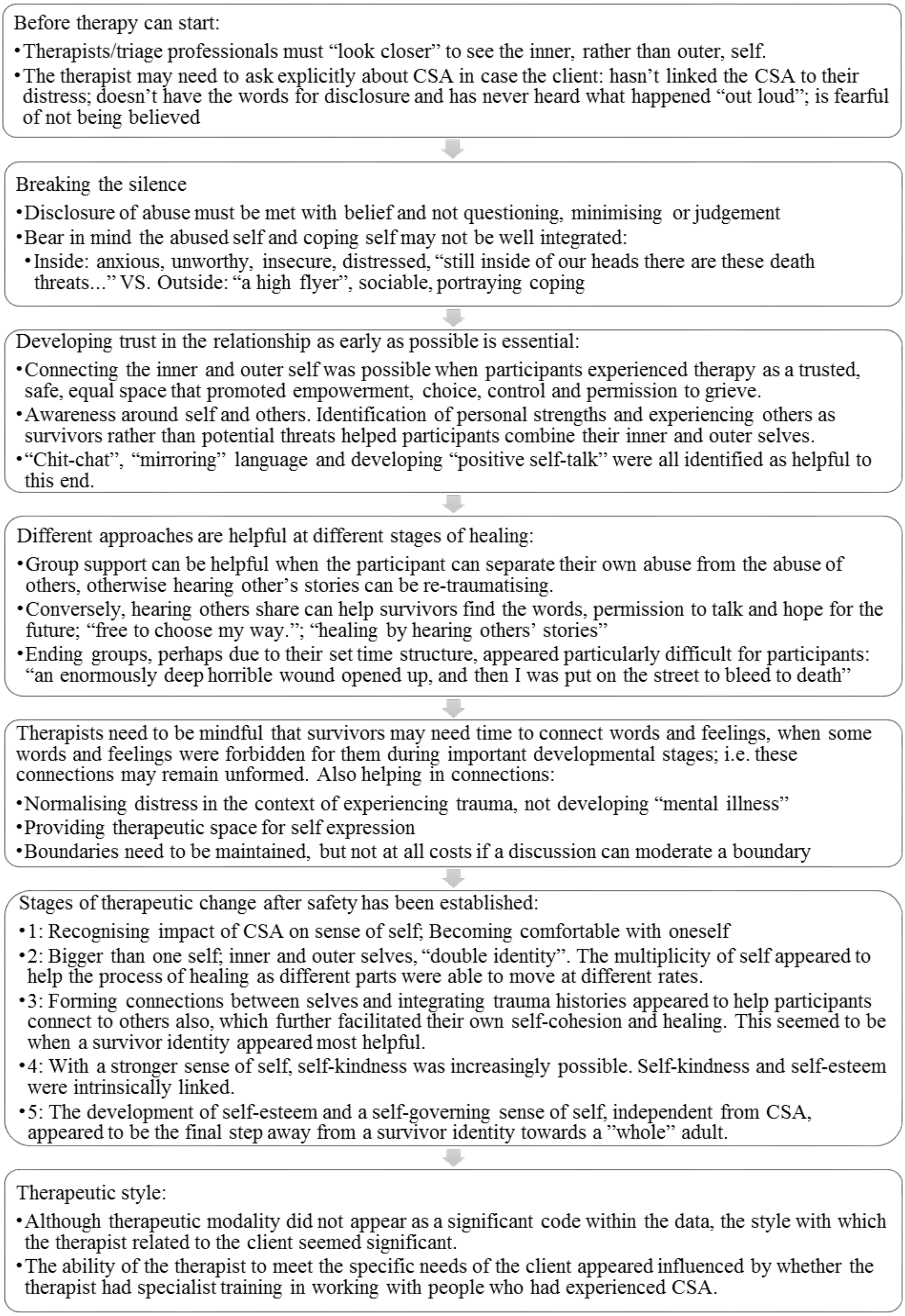
[5] therap* was recommended for use by the Subject Librarian in order to encompass a number of possible therapy options, which were explored further through PsycINFO: Treatment; interpersonal psychotherapy; Acceptance and Commitment Therapy; Rational Emotive Behavior Therapy; Relationship Therapy; Emotion Focused Therapy; Cognitive Therapy; Dialectical Behavior Therapy; cognitive behavioural therapy; Brief relational therapy; Mind body therapy; Insight Therapy; Gestalt Therapy; Feminist Therapy; Motivational Interviewing; Guided Imagery; Crisis Intervention; Therapeutic Community; client education; treatment outcomes; Psychodynamic Psychotherapy; Empty Chair Technique; Interpersonal Interaction; Listening (Interpersonal); Interpersonal Relationships; Interpersonal Control; Interpersonal Communication; client centred therapy; Systematic Desensitization Therapy; personal therapy; solution focussed therapy; narrative therapy; exposure therapy; behaviour therapy; Analytical Psychotherapy; group psychotherapy; Psychoanalysis; Individual Psychotherapy; Individual Psychology; Emotion Recognition; Therapeutic Camps; Therapeutic Camps; Supportive Psychotherapy; life coaching; Attachment Behavior; Allied Health Personnel; Allied Health Personnel; Therapists; Therapist Selection; Therapist Characteristics; Stress Management; Self Monitoring; Self Management; self Expression; schema; resilience (psychological); mindfulness; counselling)

[6] Onesearch, Expand beyond library collections



Before therapy can start:

- Therapists/triage professionals must “look closer” to see the inner, rather than outer, self.
- The therapist may need to ask explicitly about CSA in case the client: hasn’t linked the CSA to their distress; doesn’t have the words for disclosure and has never heard what happened “out loud”; is fearful of not being believed

Breaking the silence

- Disclosure of abuse must be met with belief and not questioning, minimising or judgement
- Bear in mind the abused self and coping self may not be well integrated:
  - Inside: anxious, unworthy, insecure, distressed, “still inside of our heads there are these death threats...” VS. Outside: “a high flyer”, sociable, portraying coping

Developing trust in the relationship as early as possible is essential:

- Connecting the inner and outer self was possible when participants experienced therapy as a trusted, safe, equal space that promoted empowerment, choice, control and permission to grieve.
- Awareness around self and others. Identification of personal strengths and experiencing others as survivors rather than potential threats helped participants combine their inner and outer selves.
- “Chit-chat”, “mirroring” language and developing “positive self-talk” were all identified as helpful to this end.

Different approaches are helpful at different stages of healing:

- Group support can be helpful when the participant can separate their own abuse from the abuse of others, otherwise hearing other’s stories can be re-traumatising.
- Conversely, hearing others share can help survivors find the words, permission to talk and hope for the future; “free to choose my way.”; “healing by hearing others’ stories”
- Ending groups, perhaps due to their set time structure, appeared particularly difficult for participants: “an enormously deep horrible wound opened up, and then I was put on the street to bleed to death”

Therapists need to be mindful that survivors may need time to connect words and feelings, when some words and feelings were forbidden for them during important developmental stages; i.e. these connections may remain unformed. Also helping in connections:

- Normalising distress in the context of experiencing trauma, not developing “mental illness”
- Providing therapeutic space for self expression
- Boundaries need to be maintained, but not at all costs if a discussion can moderate a boundary

Stages of therapeutic change after safety has been established:

- 1: Recognising impact of CSA on sense of self; Becoming comfortable with oneself
- 2: Bigger than one self; inner and outer selves, “double identity”. The multiplicity of self appeared to help the process of healing as different parts were able to move at different rates.
- 3: Forming connections between selves and integrating trauma histories appeared to help participants connect to others also, which further facilitated their own self-cohesion and healing. This seemed to be when a survivor identity appeared most helpful.
- 4: With a stronger sense of self, self-kindness was increasingly possible. Self-kindness and self-esteem were intrinsically linked.
- 5: The development of self-esteem and a self-governing sense of self, independent from CSA, appeared to be the final step away from a survivor identity towards a ”whole” adult.

Therapeutic style:

- Although therapeutic modality did not appear as a significant code within the data, the style with which the therapist related to the client seemed significant.
- The ability of the therapist to meet the specific needs of the client appeared influenced by whether the therapist had specialist training in working with people who had experienced CSA.

Figure 2: The stages of therapeutic processes and changes as perceived by CSA survivors

Appendix 1-A for Author Guidelines

Aims and Scope: The Journal of Child Sexual Abuse is interdisciplinary and provides an essential interface for researchers, academicians, attorneys, clinicians, and practitioners. The journal advocates for increased networking in the sexual abuse field, greater dissemination of information and research, a higher priority for this international epidemic, and development of effective assessment, intervention, and prevention programs. Divided into sections to provide clear information, the journal covers research issues, clinical issues, legal issues, prevention programs, case studies, and brief reports, focusing on three subject groups—child and adolescent victims of sexual abuse or incest, adult survivors of childhood sexual abuse or incest, and sexual abuse or incest offenders. The articles emphasize applying research, treatment, and interventions to practical situations so the importance of the results will be clear.

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The Journal of Aggression, Maltreatment, and Trauma, the Journal of Child Sexual Abuse, and the Journal of Child Custodyare all edited by Dr. Robert Geffner. If you are interested in submitting an article but are uncertain about which journal your article may be best suited for, please contact the editor at journals@alliant.edu.

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Manuscript Format: All manuscripts submitted to the Journal of Child Sexual Abusemust be written in English, APA format, and should not exceed 30 double-spaced pages, including abstract, references, tables, and figures. All parts of the manuscript should be typewritten in Times New Roman font, size 12pt, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Headings must follow APA format with bold, italics, and indentation as appropriate. Each article should be summarized in an abstract of 150 words (recommended) to 250 words (maximum) and should include eight keywords or phrases for abstracting. Avoid abbreviations, diagrams, and reference to the text in the abstract. Please consult our guidelines on keywords here. The title page for each manuscript should be uploaded in ScholarOne as a separate document. The title page should include the full title of the manuscript along with an author note identifying each authors name, affiliations, address and other contact information for correspondence. Please consult our guidelines on author notes here.

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Journal: Anderson, A.K. (2005). Affective influences on the attentional dynamics supporting awareness. *Journal of Experimental Psychology General*, *154*, 258-281. doi: 10.1037/0096-3445.134.2.258

Book: Weschsler, D. (1997). *Technical manual for the Wechsler Adult Intelligence and Memory Scale - III*. New York, NY: Psychological Corporation.

Chapter in a Book: Chow, T.W., & Cummings, J.L. (2000). The amygdale and Alzheimer's disease. In J.P. Aggleton (Ed.), *The amygdale: A functional analysis* (pp. 656-680). Oxford, England: Oxford University Press.

Illustrations. Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

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Tables and Figures. Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

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Appendix 2-A Details of original quotes to further illustrate the construction of Theme Two

2.1: An ambiguous sense of self

“I didn’t have myself, a sense of myself as being a child even or a little girl. I had a sense of myself as being somehow monstrous I think.” (Kallivayalil, Levitan, Brown, & Harvey, 2013, p.272).

“I somehow woke up. Before that I was just sort of functioning . . . very painful to wake up. I can remember finding an identity, finding myself waking up, finding myself heaving in pain.” (Phillips & Daniluk, 2004, p. 180)

“it [talking therapy] makes me feel that I am not alone, that there is help there when I need it.” (Chouliara, et al., 2011, p.137)

‘‘Sometimes when I feel so bad, I try to remind myself of my friends who participated in group therapy with me. And I think to myself that if they didn’t deserve to be abused by their parents, maybe I didn’t deserve it either.’’ (Lev-Wiesel, 2000, p.9)

“You know it’s like I have this sense of belonging, connectedness, whereas before I wasn’t ready to involve myself, I was terrified of this world.” (Parker, Fourt, Langmuir, Dalton, & Classed, 2007, p. 69).

“Repeatedly, the women described having no sense of ‘self’: ‘There was nothing there.’

(O'Brien, Henderson & Bateman, 2007, p.4)

“I wish they could incorporate the multiplicity piece (DID) there . . . because I always . . . felt different from everybody. And then I wasn’t allowed to talk about that . . .” (Palmer, Stalker, Harper & Gadbois, 2007, p.70)

“Participants noted the failure of therapists to ‘understand’ as being unhelpful; but more specifically they noted ‘failure by therapists to understand the façade of coping that belies the turmoil beneath,’ as frightening.” (O'Brien, Henderson & Bateman, 2007, p.5) “I was so ashamed of and couldn’t share a thought . . . I didn’t tell anybody.” (Saha, Chung & Thorne, 2011, p.105)

"I suppose I always imagined . . . . dirty things hanging from me and people could see what had happened and they thought . . . ugh." (Saha, Chung & Thorne, 2011, p.105)

2.2: Bigger than one self: stages of healing

"realising that there were lots of irrational beliefs . . . that were built into the abuse . . . that was so detrimental to self-esteem . . . self-worth . . . that . . . feeling of self . . . . . . you can when you understand something when you know where it is coming from you see" (Saha, Chung & Thorne, 2011, p.107)

"I can look in the mirror, I couldn't look in the mirror before, I couldn't look myself in the eyes" (Chouliara, et al., 2011, p.138).

"I've decided that my higher-power wants me to experience myself as a single person, as a complete and whole human being without worrying about you know, do I need a partner, do I have to have a partner." (Tummala-narra, Kallivayalil, Singer, Andreini, 2012, p.646)

""There've been a lot of times when I've wondered if I'm really here and that I didn't really die a long time ago and I'm just feeling the experience of what my life would be like had I lived. I mean I know I'm alive, but sometimes I do really wonder – Am I really inside myself?" (Brown, Kallivayalil, Mendelsohn, & Harvey, 2012, p.107).

"Just started feeling more like myself as a being in the world instead of living this double identity, you know where I'm just constantly acting to everybody, something incredible, what's going on inside me." However, feeling and acknowledging their inside selves could also lead participants to feel vulnerable when they showed their inner selves to the outside world: ""I feel victimized and powerless. "And I feel being a woman, and feel good about being a woman. I feel scared a lot." (Tummala-narra, Kallivayalil, Singer, Andreini, 2012, p.645)

"I can be truthful with friends of mine now. I feel that group (psychotherapy) helped a lot with being able to risk. That is a big thing because I never told anyone my true feelings, I just never did." (Tummala-narra, Kallivayalil, Singer, Andreini, 2012, p.644-5)

"I've always worked very hard keeping parts of my life secret . . . It really infuriates me when people try to get into my life" (Brown, Kallivayalil, Mendelsohn, & Harvey, 2012, p.107).

"I feel like I'm a person that does stand out and that is so different than how I saw myself before. . . . Before I was invisible, even though I wasn't, I felt so invisible. And now I know I'm not invisible. I am a person who has an impact on people." (Phillips & Daniluk, 2004, p. 179) "Just started feeling more like myself as a being in the world instead of living this double identity, you know where I'm just constantly acting to everybody, something incredible, what's going on inside me." (Tummala-narra, Kallivayalil, Singer, Andreini, 2012, p.645).

"My survivor identity used to be everything. There was a time that I thought that if I don't think of myself as an abuse survivor who would I be? It was like it felt like a hundred percent of my identity. It just felt like that was everything and I had to hang onto it. It was like a little life raft in a way, that I made it and if I hung on to that identity I'd be okay." (Phillips & Daniluk, 2004, p. 180)

"I have now realised that one of my strengths is my determination and my sense of hope for the future and my compassion towards other people . . .um. . . and my weaknesses . . . I now realise are my impulsiveness . . . um. . . and my stress levels because I can't, I am getting stronger all the time but I still don't think I will ever be able to have as much stress as the average person because I think that it will be too much for me . . . that was something I was not aware before" (Saha, Chung & Thorne, 2011, p.107)

"I am the person I am because of all my experiences and there are plenty of things that I wouldn't give up and so there's no sense in thinking these things shouldn't have happened." (Phillips & Daniluk, 2004, p. 181)

"In a way, I understood that it was bad back then, but I had not come far enough to look at myself in that way. Not at all. (Stige, Rosenvinge and Træen, 2013, p.1299) "it gave me the opportunity to speak about things for the very first time and actually to hear things out loud it . . . it really gave me permission to actually say that it was the most terrible and horrific experience that I have been through really" (Saha, Chung & Thorne, 2011, p.108)

"Well I have found myself . . . that is the biggest gain from psychotherapy and while nothing erases the abuse or the grief over it . . . if you can imagine if you have a scar and you get an infection in it and the pain and all the puss that comes out of it, there is now the scar has healed over, it is still there but it is not painful and its not its not going to flare up or very seldom, occasionally it might; so that's the biggest gain" (Chouliara, et al., 2011, p.139)

2.3: Developing self-esteem and self-kindness

"to be kind to yourself, even to just sit down and read a book or just sit and have a coffee you know and not feel guilty about it so and it's a yeah I am a worthwhile person" (Saha, Chung & Thorne, 2011, p.108)

"And that way, leaving the secret away and don't having them, I helped to like myself, and I tell myself okay, you are doing a good job." (Parker, Fourt, Langmuir, Dalton, & Classed, 2007, p. 67).

"So in . . . reinforcing that with me, I know she was probably one of the . . . therapists that really helped me enhance my self-esteem that, you know, you . . . are a good person, you know." (Phelps, Enns, & Friedlander, 1997, p.326)

"Yes, that makes sense . . . Yes, that usually happens. I remember this incredible feeling . . . almost like tears of joy! I just felt inside that there's people who really understand me and just that in itself is amazingly liberating." (Palmer, Stalker, Gadbois, & Harper, 2004, p.115)

"It is comforting to know that particularly within the groups being able to listen to other women's stories and to know in some form in a sense a little bit normal that you are not alone and you are not isolated and that is a huge benefit (Chouliara, et al., 2011, p.138)

“Web, a psychologist, said of his father who sexually abused him: “He was gang raped when he was about 6 years old, and when he would abuse me, it was a replication of what had happened to him.” (Grossman, Sorsoli, & Kia-Keating, 2006, p.438)

“[F]or quite awhile when I was in therapy I used to think of myself as a survivor and I don’t anymore. I think of myself as a woman, an artist.” (Phillips & Daniluk, 2004, p. 180)

“The more space between it and me and the more healthy experiences I have in between, the more I can draw from its richness. So it seems to me, time is a very big piece here, in the sense that it’s long ago and far away, those tragedies. The more I’m fed by all the wonderful things that the world has to offer, the more I can reflect on what did happen as just an experience I had and not who I am.” (Phillips & Daniluk, 2004, p. 180)“I’ve become a lot more calmer and more rational in the sense that I can actually go “no stop wait, think about this first.” (Parker, Fourt, Langmuir, Dalton, & Classed, 2007, p. 66).

“I ground myself, stop, take a deep breath, and just acknowledge that you know I’m gonna be ok, I’m gonna get through this.” (Parker, Fourt, Langmuir, Dalton, & Classed, 2007, p. 70).

“It (the abuse) has totally changed. I can accept myself for who I am and I can accept what happened and I don’t judge myself any more. (Edmond, Sloan, & McCarty, 2004, p.268).

“I didn’t care what I looked like but now I am beginning to think I well I do need to look after myself, I do need to look nice just for me not for anybody else.” (Chouliara, et al., 2011, p.138)

“I never did used to reflect on things about myself before; I never gave myself any time to think” (Saha, Chung & Thorne, 2011, p.105) “I am able to do things now that I have never done… I feel freedom” (Chouliara, et al., 2011, p.138)

RUNNING HEAD: Dissociative Experiences and Therapeutic Relationships on Wards

Section Two: Research Paper

What are the experiences of therapeutic relationships on hospital wards of people who experience dissociation?

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Prepared for the Journal of Trauma and Dissociation[7]

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[7] Please refer to Appendix 1-B for Author Guidelines

Abstract

This qualitative study sought to explore how people who reported moderate to high levels of dissociation experienced relationships with multidisciplinary ward staff. An interpretative phenomenological analysis suggested three superordinate themes relating to participants' experiences. Firstly, the theme *Multiple Me and Multiple Them* explores the unpredictability experienced by the participants in terms of managing their dissociative experiences alongside the inconsistent relationships on the wards. Secondly, *Recognising, Meeting or Neglecting Interpersonal and Care Needs*, reflects upon the needs within therapeutic relationships and the psychological impact of positive and negative experiences. Thirdly, *Between the Needs of the Internal System: navigating between "better on my own" and "someone to talk to"*, discusses the confusion and understanding around dissociation and the importance of working with parts, not around them. The findings reaffirmed the importance of therapeutic relationships for the purposes of feeling safe, being able to connect to others and then the self, feeling recognised as a whole person and accepted rather than judged. Additionally, the findings suggested that the current culture and environment of some hospital wards directly influenced participants' distress, which could lead to further dissociative experiences as a means of coping with relational challenges and perceived threats. Reflections upon relational complexities and how ward based treatment can be developed are discussed.

What are the experiences of therapeutic relationships on hospital wards of people who experience dissociation?

Dissociation can be understood as a disconnection or psychological absence from an experience or the self (British Psychological Society [BPS], 2014a). It is thought that dissociation as a coping mechanism develops due to unbearable experiences, usually with an attachment figure in childhood, that are too overwhelming to be managed through one self (Dalenberg et al., 2012; Schimmenti & Caretti, 2014). Dissociative conditions can be considered on a continuum (BPS, 2014a; Braun, 1988), which suggests dissociative experiences range from non-clinical forms of dissociation such as day-dreaming and momentary disconnectedness through to moderate to high levels of dissociation including derealisation, depersonalisation and dissociative identity disorder (DID).

Specifically, DID can be understood through the theory of structural dissociation, which proposes a division in one’s personality (Van der Hart, Nijenhuis, & Steele, 2005; Nijenhuis, & Van der Hart, 2011). Divided parts of the person can be familiar or unknown to the central personality and are usually referred to as parts, alters, self-states or personas. A possible cause of structural dissociation, which is similar to the concept of compartmentalisation dissociation (see Brown, 2006; Holmes et al., 2005), is thought to be interpersonal trauma from which there is no escape (Herman, 1992; Nijenhuis & Van der Hart, 1999). For instance, there have been robust connections drawn between experiencing childhood sexual abuse (CSA) and dissociation (e.g. Bird, Seehuus, Clifton, & Rellini, 2014; Courtois, 1988; Herman, 1992), although other types of interpersonal trauma can also lead to significant dissociative experiences (Cloitre et al., 2012).

A recent review considered the construct of DID and concludes the diagnosis: “meets accepted standards for content, criterion and construct validity” (Dorahy et al., 2014, pp.

407). DID is thought to affect 0.5% to 5% of the general population, although there is variation across cultures (Castillo, 1997; Slogar, 2011) and the varying methods of assessment are likely to influence these statistics (see Dorahy et al., 2014). Also, women are nine times more likely to receive the diagnosis than men (Lewis-Hall, Williams, Panetta, & Herrera, 2002). However, recent evidence suggests men are just as likely as women to experience dissociation, although due to socio-cultural factors (Spitzer & Freyberger, 2008), they are less likely to receive a diagnosis recognising the impact of childhood trauma (Shevlin, Murphy, & Read, 2015). Additionally, the functional roles of dissociation have become increasingly understood as a learned automatic response to cope with trauma related stress (Kisiel & Lyons, 2001). Consequently, dissociation has been argued to be protective in its function, as it supports “escape and avoidance from stressful triggers” (McAllister et al., 2001, pp. 20-21).

Despite the increased understanding surrounding dissociative mechanisms in relation to extreme stress and trauma, there remains uncertainty among many multidisciplinary healthcare professionals regarding how best to support people in services who experience dissociation (McAllister, 2000; Slogar, 2011). Guidelines for therapists working with clients with DID have been produced by the International Society for the Study of Trauma and Dissociation (ISSTD, 2011). However, the evidence base for these guidelines in practice is in need of further clinical examples, in order to develop interventions for people experiencing a range of dissociative conditions (Hirakata, 2009). Furthermore, the majority of multidisciplinary ward staff in the United Kingdom (UK) receive little training around supporting people who experience dissociation, unless through specially arranged training with organisations such as the ISSTD (Aquarone & Hughes, 2005). In the UK, no guidelines are available from the National Institute for Health and Care Excellence for supporting people on wards who experience dissociation.

Due to the links between early trauma and dissociation (e.g. Braehler et al., 2013; Brown, Schrag, & Trimble, 2005), the interpersonal needs of people experiencing dissociation have been understood within attachment (see Dillon, Johnstone, & Longden, 2012; Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006) and developmental frameworks (see Schimmenti & Caretti, 2014). Thus highlighting the relational needs within therapeutic alliances throughout interventions. The importance of a positive and mutually trusting relationship is identified as particularly important in the ISSTD guidelines (2011). The therapeutic relationship has various definitions, however this study adopts the re-phrased definition of McCormack and McCance (2010), which states a therapeutic relationship is "built on mutual trust, understanding and a collective knowledge" (Strachan, 2011, pp. 2). Specifically, through her empirical research with people experiencing higher levels of dissociation, Hirakata (2009) suggested that positive therapeutic relationships could facilitate the reconnection and integration processes with parts of the divided self. Therefore, the importance of the therapeutic relationship and its possible role in healing and the integration of parts of the self seem highly relevant for this client group (Gill, 2010; McAllister et al., 2001).

Previously, McAllister (2000) reviewed empirical studies on DID within a number of paradigms. Different treatment models and methodologies were discussed, such as reassociation, forming social connections and self-awareness. It was also considered how nurses could sensitively support people in hospital who dissociate through facilitating a sense of belonging and containing traumatic memories. McAllister et al.'s later empirical work highlights the importance of positive interpersonal relationships in the "recovery from past trauma, social connections, resilience and safety" (2001, pp. 31). Additionally, McAllister et al.'s second theme in their qualitative analysis, "making connections" (pp. 22), highlighted some of the difficulties of the therapeutic relationship within acute trauma care. The main areas of difficulty identified related to boundaries, trust and victim-based schemas. In summary, case studies (e.g., Gill, 2010) and empirical papers (e.g. Hirakata, 2009) have identified an important link between the healing of the self and the role of interpersonal relationships: interpersonal relationships with health professionals often being a first step.

Furthermore, some evidence suggests that the implicit communications between a therapist and client can help the client regulate their emotions, which in turn lessens the need to use dissociative coping strategies (Schore, 2001; 2003). Similarly, it has been suggested that "new patterns of neural organisation may be formed through the psychotherapeutic relationship" (Gill, 2010, pp. 261), assisting emotional regulation, which is a key component of the DID guidelines for therapists (ISSTD, 2011). Although these neuropsychological connections are tentative at present, they present a strong indication that this is an area in need of further exploration, in a range of settings where therapeutic relationships can be established, rather than only psychotherapy. Consequently, interpersonal connections have been cited as a crucial component of healing (Gill, 2010; Hirakata, 2009; McAllister et al., 2001) and the therapeutic relationship can play an essential role in facilitating inter- and intrapersonal reconnection and wider attachment changes (Mikulincer, Shaver, & Berant, 2013).

In light of the disconnection that people who dissociate can experience from others (Hirakata, 2009), their experiences of therapeutic relationships may be particularly complex. Therefore, hearing the perspectives of people who experience dissociation regarding therapeutic relationships could provide the most accurate insights into the complexity of those relationships and enhance the delivery of care in this field. These relational experiences may be particularly multifaceted as it is thought that the divided parts of the self are likely to hold different perspectives on the self and other people (Nijenhuis, 2008). Moreover, seeking the stories of clients who dissociate is contextually appropriate as it is the “perception that guides how dissociative symptoms are treated” (Hirakata, 2009, pp. 299). Personal accounts can provide an insight into another’s perceptions (Kalitzkus & Matthiessen, 2009) and thus provide the most authentic perspective on this phenomenon. Although it may be difficult to explore therapeutic relationships from the perspective of all of a person’s alters, first person accounts are likely to be the most appropriate approach to accessing an overall perspective. Finally, McAllister et al. highlighted that greater understanding of the subjective experiences of people who experience dissociation in hospital is required in order to help professionals “respond with greater sensitivity and efficiency” (2001, pp. 32).

No empirical qualitative study thus far has attended specifically to the perceptions of people experiencing dissociation with regards to their perspectives on the therapeutic relationships they develop with staff on hospital wards. Therefore, an interpretative phenomenological analysis (IPA) sought to explore how hospital patients reporting moderate to high levels of dissociation experienced therapeutic relationships with multidisciplinary ward staff. Wider aims of the study included exploring what factors could improve participants’ experiences on wards in light of the interpersonal difficulties that people experiencing dissociation can encounter.

Method

Design

In order to explore the experiences of people who dissociate and the therapeutic relationships they encountered during ward-based care, semi-structured interviews were employed. The interview schedule was used as a guide, although the participants were encouraged to lead the conversation (Pietkiewicz & Smith, 2014), so as to preserve their perspective (Hefferon & Gil-Rodriguez, 2011), prior to my interpretations of the data. It was considered that IPA would be the most relevant analytical framework for this study, as IPA is often used as a tool through which a researcher can explore the “unique individual experiences” of the participant (Kellett, Greenhalgh, Beail, & Ridgway, 2010, pp. 144). IPA also accepts the process by which the researcher interprets the concepts reported by the participant, following the participants’ meaning making of their experiences (Shinebourne & Smith, 2009; Smith, Flowers, & Larkin 2009). Finally, due to the idiographic tradition of IPA (Smith et al., 2009; Osborn & Smith, 2008), the individuality within the sample was maintained throughout the analysis, which was important for this exploratory study.

Procedure

In accordance with ethical approval, adverts for the study were placed with appropriate newsletters and sent by email to therapists registered with the European Society of Trauma and Dissociation in the UK (ESTD-UK). All participants were asked to complete the brief self-report questionnaire, the Dissociative Experiences Scale ([DES-II], Carlson & Putnam, 1993). The DES-II is a 28-item self-report measure employing a 0-100 point Likert scale that can usually be completed in about ten minutes. It was designed as a psychological self-assessment questionnaire to explore the extent to which people experience a range of dissociative indicators, with higher scores indicating higher levels of dissociative experiences. Once the DES-II was completed and scored (group M = 64.13, SD = 17.16), the participant and chief investigator discussed when to conduct the interview.

During the planning stages of the study, it was agreed that participants would only be able to take part in the study if they scored 30 or above on the DES-II, so as to ascertain the likelihood of the participants experiencing moderate to severe levels of dissociation (Mosowitzt, 2004). Carlson and Putnam (1993) have previously validated the threshold score of 30 as showing clinically significant dissociative symptoms . Evidence also exists to support its internal consistency and test-retest reliability (Schimmenti, Caretti, Giannone, & Lucarelli, 2011[8]).

Participants

Seven women took part in the study (*M*age = 40.57 years, *SD* = 10.34) and two potential participants withdrew due to illness around the time of data collection. However, this number is in accordance with the recommendations of Hefferon and Gil-Rodriguez (2011) for IPA doctoral research, to conduct in-depth explorations of idiographic experiences. Interviews lasted between 38 and 103 minutes. The length of time participants had spent on hospital wards over the two-year period required for inclusion to the study varied between two weeks and four years. However, six of the participants had experienced recurrent admissions in numerous locations, on both physical health and mental health wards (Table 1). The inclusion criteria for those who took part was: (1) to have been on a National Health Service (NHS) ward for at least two weeks within the last two years (Frank & Gunderson, 1990), (2) engaged in a therapeutic relationship with a ward-based health professional; and (3) score at least 30 on the DES-II (Carlson & Putnam, 1993). Finally, all participants chose a pseudonym.

Research has suggested that people with a trauma history are likely to score higher on the DES-II than people who have not experienced trauma (Raudsepp, 2006; Shin, Jeong, & Chung, 2009; Van den Hout, Merckelbach, & Pool, 1996). However, the experience of trauma itself does not necessarily lead to higher DES-II scores (Van Ijzendoorn & Schuengel, 1996). Consequently, the study did not exclude based on the aetiology of dissociation, as past experiences were not assumed to influence how participants dissociated, only that participants had developed the ability to dissociate due to some cause.

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[8] Based on the Italian translation of the DES-II

Lastly, the homogeneity of the sample derives from the experience of dissociation and the purposive sampling of people who had experienced treatment on NHS hospital wards. Homogeneity was important within the sample because of the rationale of IPA, which suggests a participant sample should be well-defined, rather than arbitrary, so that the research question is increasingly meaningful, even on an individual basis (Smith & Osborn, 2003).

<Insert Table 1. Participant Information>

Ethical Considerations

This study was approved by a committee who specialise in qualitative research through the NHS Integrated Research Application System (IRAS) and appropriate research and development (R&D) offices. Further, approval was sought from the research committee of the ESTD-UK, which includes survivors, academics and clinicians. The committee also shared some thoughts and advice during the development stages of the study. In accordance with the committee's recommendations, participants were invited to be accompanied by a companion. Ashleigh, Hermione and Amelia did not want anyone else present throughout their interview, although Sam, Ellie, Mel and Claire had a member of their team available.

Prior to the start of each interview, I explained the interview procedure and invited each participant to take a lead in terms of the information discussed. Following this, I confirmed whether the participant would still like to take part. Furthermore, I discussed what the participants would like me to do if they dissociated during the interview. Issues relating to seeking consent when working with people experiencing DID were discussed with the field supervisor and other colleagues (e.g. Wilson, 2015). All participants asked that I continued recording but request for their central identity to return to complete the interview, rather than trying to engage an alter in the interview. However, none of the five participants who reported DID dissociated to an alter during our interviews.

Throughout the interviews, several safeguarding issues emerged regarding how five participants had been treated in hospital. All but Mel had already submitted formal complaints following the safeguarding incidents. . Consequently, I met with Mel as soon as possible following supervisory discussions to explore whether she needed support to pursue a formal complaint regarding the treatment she had experienced (advice available in BPS guidance , 2014b).

Data Analysis

IPA aims to explore the “participant’s cognitive and affective reaction” to their experiences and acknowledges there is a “chain of connection between embodied experience… and a participant’s making sense of, and emotional reaction to, that experience” (Smith, 2011, pp. 10). Therefore, IPA was an appropriate analytical method as it was most fitting for the sample population who were assumed to potentially have some difficulties in integrating emotional and cognitive experiences (Figure 1).

<Insert Figure 1: Process of analysis according to IPA>

IPA is also based upon a double hermeneutic, as the researcher interprets the interpreted accounts of the participant (Smith, Flowers, & Larkin, 2009). Therefore, a degree of experiential distance was recognised in terms of emotional representation and the selection of experiences recollected throughout the interviews. However, this is not considered a weakness as the participant, not the researcher, creates the initial interpretation and dictates the selection of accounts to explore their perception of experiences (Brocki & Wearden, 2006).

Finally, an epistemological stance of critical realism was taken, which discerns the "essence of things from their appearance" (Losch, 2009, pp. 86), thus facilitating finding the nuances in the data to illustrate experiential subtleties. Epistemological and empirical discussions highlight that autobiographical accounts are based upon perception rather than fact (Bedard-Gilligan & Zoellner, 2012), which is highly relevant to this sample due to the recognised difficulties people experiencing detachment dissociation can have in terms of autobiographical memory (Holmes et al., 2005).

Findings and Discussion

Three superordinate themes were found in relation to how participants experienced therapeutic relationships with staff on physical health and mental health wards. The findings suggest that there were both negative and nurturing factors that affected the development of interpersonal therapeutic relationships between participants and ward staff, which were influenced by intrapersonal factors (Figure 2).

<Insert Figure 2: Diagrammatic representation of phenomena that affected the development of therapeutic relationships>

Theme 1: Multiple Me and Multiple Them - "we [central persona and alters] have problems with change." (Sam)

A predominant phenomenon within the data was that of participants trying to cope with the inconsistencies of the ward environment and multiple staff members, while managing their dissociation and adjusting to new experiences. All participants found the stability they required, in order to help them find some internal unity, was lacking.

1.1: Adjusting as one self or parts – "you just get used to one place and they move you and… you have to get used to the staff again…" (Claire)

Within all the participants' accounts were statements surrounding adjusting, adapting and trying to cope with change. For the five participants with alters (Sam, Ellie, Mel, Amelia, and Hermione), this process seemed particularly complex; as Sam described "It's hard when you have different people [alters] talking to you… they [staff] think your being rude". Furthermore, Ellie experienced that her parts were responding differently to ward staff, saying that: "part of me was bemused… and another part of me was angry". It has been suggested that early disorganised attachments relating to attachment figure related traumas, leading to disorganised internal working models, can develop a perspective and experience of the self and others as unintegrated and with multiple representations (Dutra, Bureau, Holmes, Lyubchik, & Lyons-Ruth, 2009; Liotti, 2013; Stovall-McClough & Cloitre, 2006). This theoretical process seems relevant to the participants' accounts in that multiple-self experiences were reported, which appeared to influence participants' perception of how others may have perceived them. For instance, Hermione described how she had adapted to the ward environment through dissociation: "switching into perfect Hermione mode". Participants' alters could appear very separate from the main persona or more connected. Importantly, participants discussed alters as additional or separated selves, rather than metaphors for differing emotional states as was suggested by Merckelbacha, Devillyc, and Rassin (2002).

In relation to moving between wards, most participants described moving as difficult for a range of reasons. Most apparently, establishing new relationships, managing change and adjusting to new people appeared particularly challenging. Although not explicitly stated, some of the accounts around change and new staff seemed reminiscent of mistrust and anxiety in relationships. Such relational responses have been cited elsewhere as very difficult for this client group due to previous violations of trust in childhood (McAllister et al., 2001). Ellie described how she felt unsettled when she had not been given any warning she would move wards: “It made me worse I think… more switchy because I think the more stressed I got... the more dissociative… so I’d lose more time”. Similar accounts suggested that although dissociative experiences were recognised conditions by the participants and most ward staff, the approach of some staff seemed to exacerbate the extent to which participants would dissociate. Participants reported perceiving most acute psychiatric and physical health wards as potentially dangerous places, as is also discussed by some of the contributors to a recent report exploring psychosis (BPS, 2014a).

However, Mel, Claire, Ellie, and Ashleigh reported that some staff on the mental health wards became familiar with their personalised grounding techniques, such as controlled breathing or having familiar objects. The importance of grounding techniques, particularly for people with DID, has recently been reviewed and endorsed by Brand, Loewenstein, and Spiegel (2014). Grounding strategies are also included in the first stage of the phasic model of therapeutic treatment recommended for people with DID (Dorahy et al., 2014; ISSTD, 2011). In this study, Claire and Ashleigh who did not report having a DID diagnosis, also recommended individualised grounding techniques. Therefore, the findings suggest that people with a range of dissociative conditions may benefit from similar guidelines that promote the importance of safety, stabilisation and a person-centred approach to care, as suggested in Brand, Loewenstein, and Spiegel (2014).

In summary, within the data was a phenomenon of a ricochet effect for participants, in that when one alter was unsettled, the whole person felt the anxiety and discomfort in different ways, which could lead to further dissociative experiences as a familiar means of coping. Elsewhere in the literature relating to in-hospital treatment (Laird, McCance, McCormack, & Gribben, 2015), it has been suggested that person-centred care is particularly important due to the vulnerability people feel on hospital wards. The current study highlights how vulnerability without person-centred care can lead to further dissociation.

1.2: Staff understanding of the internal system and the importance of parts' own names - "I wasn't addressed by my own [alter's] name at all." (Sam)

Positive relationships could develop if staff could recognise alters and support the whole person through dissociative experiences. For instance, Hermione explained how perceived understanding opened channels of communication: "you felt you could talk to someone that was somewhat… trained". However, participants with younger parts often found that staff did not recognise how to support them. For example, following Amelia's stroke, she explained how: "She [seven year old] had no concept of that [stroke repercussions]… staff just didn't get that". Furthermore, because Amelia had lost much control over her alters, she struggled with instructions: "Stop asking all of me to walk." The phenomenon of "all of me" was common within the data and an apparent challenge for staff. Although adult parts seemed to feel anger in the face of judgements, younger parts seemed to feel increasingly "vulnerable" (Ellie) and "distressed" (Sam), which may have added to participants' overall distress and use of dissociative coping strategies. In addition to existing therapeutic guidance (Cloitre et al., 2012), these findings indicate that the processes of establishing an alliance and developing stabilization in order to promote affect regulation and intra- and interpersonal connections would be highly relevant on wards.

To add further complications to existing interpersonal difficulties, some participants found that staff could miss when they dissociated, as Hermione stated: "people don't know you're switching!" Within several accounts appeared a connection between being *seen*, *recognised* and *known*, which seemed to facilitate a sense of perceived understanding. Conversely, when participants interpreted staff as being unaware, uninformed and as making judgements, participants seemed to feel unaccepted. Importantly, when dissociative experiences were met with understanding and calm by staff, participants reported feeling calmer themselves and needing dissociative coping mechanisms less. Additionally, Ashleigh discussed how: "having some control… it calmed me down, it was about having a choice." Therefore, the findings suggest that although emotional regulation directly influenced the need for dissociation as found in other empirical studies (e.g. Powers, Cross, Fani, & Bradley, 2015), it was the relational dynamics and the emotional regulation of staff around the participants that enabled them to manage their emotions and dissociation.

1.3: Recognising who I am and when I am in time - "Something bad is going to happen to you if you show any emotions" (Hermione)

Some participants shared they had experienced abusive pasts that affected their perceptions of environments as adults, which increased their perception of threat and danger on the wards. For instance, Hermione explained how childhood learning experiences influenced how she related to ward staff in adulthood: "he [abuser] trained you to take pain… if you show any sign of emotion you're in trouble". Therefore, despite often feeling very distressed on the wards, Hermione found it difficult to communicate this to staff for fear of inciting further "trouble". Similarly, Mel explained how the way in which staff had responded to her four year old alter's request for a cigarette had made her feel disbelieved and judged: "They thought I just wanted a cigarette and not dissociating. But I was and I did smoke at four." Therefore, participants suggested some staff members were unable to recognise that participants were not necessarily reacting to experiences and relationships in the present, but rather in their pasts. Interpretatively, apart from Hermione and Amelia who discussed their experiences of their younger alters' anxiety and confusion, the participants did not seem to recognise the direct impact of their childhood learning and their present day fear perception. This was perhaps due to the separation between younger and older alters that participants evidenced though codes relating to *not knowing* what other parts of the self did know; for example “someone says hello but we don’t know we said hello yesterday” (Sam).

Accordingly, participants discussed the phenomenon of specific time perception difficulties, as discussed in Van der Hart and Steele (1997), due to their learned coping mechanisms, which transcended to how they related to ward staff. Specifically regarding autobiographical memory, Huntjens, Wessel, Hermans, and Van Minnen (2014) found that people with DID struggle to access specific memories from their past, which can influence present day solution finding and emotional regulation. It may be that the difficulties around communicating, managing and tolerating distress in combination with autobiographical memory difficulties may have affected how participants perceived and responded to situations on the ward.

Finally, some experiences seemed specifically upsetting for younger parts, such as when younger parts were overlooked or ignored. For example, Amelia described how: “My upset was about non-acceptance of who I was.” Additionally, Amelia also explained how difficult it was for her younger seven year old part who “didn’t realise I had a stroke”. These experiences highlighted the impact of time perception difficulties for the participants and their parts in relationships with staff. Similarly, Sam described how she wanted staff to recognise her whole self: “say good morning to Alter four, or Alter two! Or hi everybody!” As it was often the younger parts who had experienced abuse, it may have been that the perception of being unrecognised by adults in roles of authority and care may have been particularly distressing and reminiscent of previous neglect. Additionally, the participants reporting a DID diagnosis described dissociating most frequently when witnessing staff members displaying distress, misunderstanding participants’ needs or when they felt trapped:

"I just didn't want to be there so I just kind of went away and left it to other parts of me" (Ellie). Barlow and Chu suggest that dissociation is a means "to keep relationship-threatening information out of conscious awareness and memory." (2014, pp. 5). Consequently, the participants' learnt adaptive mechanisms to preserve relationships through switching or detaching from experiences may have occured with staff also, using their prior learnt coping strategies to reduce conflict and compartmentalise relational distress. As comprehensively discussed in the review of Brand, Loewenstein, and Spiegel (2014), therapy that does not address alters will lead to negative outcomes as the process of integration is not initiated. The findings of this study indicate hospitalisation should be developed as part of a consistent and integrated treatment plan.

Theme 2: Recognising, Meeting or Neglecting Interpersonal and Care Needs – "I discharged myself because my DID was becoming so unmanageable" (Amelia)

All participants found their condition was unrecognised by some ward staff, which seemed to underlie some of the anxiety and wariness participants described: "that's the scary bit for me, I know there are probably more people stuck on a ward today who probably have DID who no one has probably picked up" (Ellie).

2.1: Staff's preconceptions and assumptions around normality– "they just label you. They don't ask, they just presume" (Mel)

The extraordinary lives and experiences of participants seemed to be unrecognised on occasion. For instance, Hermione discussed her construction of normality and reflected that: "most people don't experience themselves like I do". Similarly, Ashleigh also reflected on how: "The illness was a protective factor in itself", which appeared strongly connected to her meaning making process around her experiences and her healing.

Additionally, all participants reported that when their condition was not recognised appropriately, they felt increasingly judged, misunderstood and consequently more vulnerable. Ellie explained how having a support worker with her on a physical health ward influenced how other patients responded to her too: “Some of them [patients] would never speak to me because they must have wondered what on earth was going on”. It has been suggested in the empirical literature that peer support from fellow patients can be experienced as very healing (Bradstreet, 2006). However, because Ellie had been admitted and supervised on the health ward, she felt unable to connect with the other ward patients, which appeared to add to her sense of being too different.

2.2: Understanding the needs of the participants’ internal system - “I just think they didn’t know what to do” (Ellie)

Due to the dissociation participants experienced, they recognised that they had specific interpersonal needs. In some cases, participants reported that staff noticed and tried to meet these needs. For example, Ellie reported a good relationship with the occupational therapist (OT), explaining: “she made me feel like a normal… a normal person.” Similarly, Ashleigh suggested that positive relational experiences were more likely with the day staff: “being nicer, lighter and jokey”, in addition to finding common ground. This phenomenon of dual normality within the patient-staff relationship seemed highly important to how participants thought they were perceived and how they could connect with staff. In this sense, sharing common ground and reducing feelings of difference seemed to foster hope, connection and trust. Trust has been cited as particularly important for people experiencing high levels of dissociation in that they can develop the ability to “experience a depth of trust and safety in themselves, others, and the world” (Hirakata, 2009, pp. 311). Through the aforementioned accounts, the current study suggests some of the means through which trust was established.

However, all participants reported experiences of relational courtesies being overlooked. For example, Ellie found she “didn’t get the communication with the medical staff that I would have got [on a mental health ward]… if I didn’t have DID, I’d have been in and out within a week”, as she suggested there was confusion around the support she would require at home. Similarly, Hermione discussed how: “there’s no one available to say ‘I really feel like crap, can we talk?’”. Throughout all of the accounts were suggestions that participants saw talking to someone about how they felt as an alternative container for their distress, which if not managed, seemed to lead to further dissociative experiences because of the emotional regulation difficulties that the participants reported. Similarly, in relation to containing distress, Sam seemed to suggest that her alters shared distressing truths within, rather than between the parts, thus containing distress in manageable compartments. In this way, the participants’ internal systems, with their respective alters, worked to contain aspects of emotional distress. For instance: “if we were Sam only we would not survive… to be safe we have to be all of us, if we switch we can’t remember what we know is true.”

2.3: Meeting and neglecting the relational needs of the internal system - “I wanted them to make decisions with me, rather than for me.” (Ellie)

All participants reported some positive relational experiences with staff, through which staff tried to meet their needs. Claire explained how: “you can talk through your problems or things that are worrying you… I didn’t know my key nurse [on another ward]”. Claire also explained how the staff in her last hospital “Just acted normally… they spoke to you on a normal level”. Correspondingly, Sam reflected talking with a psychiatrist: “First time asked what’s going on for me! He said he got all the time.” Accordingly, being heard seemed closely associated with being believed, recognised and accepted. This may have been particularly resonant for the participants who had experienced abuse as children, as disbelief and being unheard were likely dynamics that had previously caused much distress (Ullman, 2002). Finally, Ashleigh described a derealisation experience through which she felt understood, as she described: “her [nurse’s] face had morphed and frightened me. I explained about her face changing… she arranged to have someone else check me at night”. Ashleigh’s account highlights the sensitivity that some ward staff demonstrated, which may have also signalled compassion and therefore nurtured collaboration and understanding.

However, Ellie described how she found staff hard to relate to when they did not address her directly: “because they weren’t engaging with me”. Participants provided numerous examples of how their experiences of relationships were influenced by the environment. There could be rapid changes in how participants experienced staff and themselves, individually and as they perceived they were seen through the eyes of the staff. This multiple perspective on self-perception and perceiving others connects with the work of Liotti who discussed the development of multiple-perspectives developing through disorganised attachment, as a form of dissociation in itself (Liotti, 2008; 2013). Relational difficulties were influenced by dissociating to alters, staff shift changes and further distressing dissociative experiences at night with fewer staff available, highlighting the apparent need for a member of staff to be “on the floor” (Hermione) whenever possible. Similarly, Mel and Ellie suggested that being on a one-to-one could be helpful if participants were rapidly switching because they were not able to maintain a coherent narrative around events themselves (Foa, Cashman, Jaycox, & Perry, 1997). Therefore, having their experiences witnessed by another and recounted sensitively could be helpful in integrating current experiences, thus developing a complete narrative.

Finally, findings suggest all ward staff should employ a combination of their judgement and guidance from the patient when considering how much of lost time and events to share following a dissociative experience. Therefore, the participant can make sense of their missing experiences, while not experiencing excessive distress. For example, Mel recalled how she had disclosed abuse as a younger alter: “She [nurse] told me how I behaved and I couldn’t remember any of that… I’d rather not have known. I couldn’t understand how she [abuser] could do it to a baby.” This example highlights how the process of memory recovery can be detrimental to a person’s wellbeing, despite novice therapists sometimes considering it helpful (Loewenstein & Wait, 2008), as seems to have happened in Mel’s case. Experiences such as this highlight how important it is to promote the wellbeing of the central person. Similarly, Dillon, Johnstone, and Longden, recommend that “the therapist must work with ‘‘just enough of’’ the trauma at a time, so that each bit can be processed emotionally, physically and cognitively.” (2012, pp. 152).

Theme 3: Between the Needs of the Internal System: navigating between “better on my own” and “someone to talk to” - “We usually say it’s better to be lonely as you don’t expect anything” (Sam)

The final set of phenomenological themes centres on how the participants experienced being surrounded by people on the ward in one sense, although simultaneously experienced themselves as very isolated and alone.

3.1: Working with dissociated parts, not around them - “I just want to be treated the same as every other patient on the ward, same empathy” (Amelia)

When staff did not reportedly attend to the needs of the participants' younger parts, experiences on the ward seemed considerably more difficult. For instance, Amelia explained how she had found it difficult to elicit communication with staff: "just because the seven year old part of me is there just now… people talked about me in front of me." Equally, Ellie noticed a younger alter had drawn a child-like picture. The staff did not tell Ellie what had happened, although she was aware how their "attitudes and responses was different", which led her to "feeling uncomfortable and wanting to leave hospital". Interestingly, the participants discussed wanting staff to relate to their younger or detached parts and older parts in similar ways, with empathy and positive communication. However, they also recognised that their younger or detached parts needed more sensitive care at times. Therefore, there appeared a phenomenon of participants wanting relational care to be the same whilst different, which seemed connected to participants' difficulties in integrating their varying needs and preferences at times.

Similarly, Hermione explained how difficult it could be to experience certain dissociative phenomenon in the company of staff who did not recognise her dissociative experiences: "I was… frozen… for an hour and a half… they don't care… they're not informed… they don't know that that's a terrifying place to be… little parts crying… teenage parts angry". Experiences of these parasympathetic states, thought to be used in extremely threatening situations when active responses could elicit more harm (Baldwin, 2013), could signify how Hermione perceived the ward as "terrifying", thus relying on this type of dissociation.

Accounts from all participants suggested how the potential of help from staff could enhance feelings of helplessness and loneliness. For example, Sam explained how: "in hospital there are lots of people and you're always lonely. That's worse". Therefore, this may be further evidence of how past experiences of harmful attachment figures in authority may be a particularly powerful parallel process within a ward environment. This process may also be reminiscent of the trauma re-enactment processes discussed in Schimmenti and Caretti, (2014). This process of experiencing a frightening but needed attachment figure has been termed: “fright without solution,” as the attachment figure encapsulates both potential danger and comfort (Main & Hesse, 1990, pp. 163). Consequently, desires for closeness through connection and safety through being alone conflict, causing further distress (Liotti, 2013; Van der Hart, Nijenhuis, & Steele, 2006).

3.2: Trying to help others understand what the self doesn’t always fully understand - “[therapist] did a great job with the nurses, more understanding after” (Mel)

Although all of the participants understood their dissociative experiences, it appeared difficult to articulate that understanding to others at times of distress. Sam found the lack of understanding of her experiences contributed to the loneliness she felt: “They’re supposed to be helping you, expectations they can fix us…” Although these aspects of the data seemed connected to being heard and listened to, there was an additional frustration from participants around perceiving staff who had been trained in helping professions as unable to understand dissociative conditions. For example, Hermione explained how: “It’s not like you have PSTD with a touch of dissociation… how can I exist if they don’t think I [DID] exist…” Sam and Hermione seemed to suggest that if DID was not recognised, they were not recognised, which influenced upon their already fragile sense of a whole self.

Conversely, for Claire, after several ward admissions and a misdiagnosis of an autoimmune disease as a result of her paralysis, she found that the ward staff: “could explain it [the dissociation] to me so I could try to get my head around it, so I could understand what was happening to me.” However, although the staff were able to tell Claire what she had, they did not recognise she was struggling to understand because she was experiencing dissociation at the time and therefore not experiencing herself as a whole: “looking down on myself… so I didn’t feel anything, I just felt numb all the time”. This example highlights the complexities of a range of dissociative experiences, rather than only DID where much of the literature has focussed. Within Claire’s account, she described feeling detached from herself and therefore disconnected from understanding the nature of her difficulties. Equally, the staff were able to explain Claire’s condition but not how she may experience dissociation, which seems connected to other participant accounts of the condition but not experience being recognised.

3.3: Forgetting, remembering and reorganising information and experiences - “don’t remember getting stitched up, must have dissociated, I come round and was on the ward and they [ward staff] were a nightmare” (Mel)

Memory loss could cause distress in the form of anxiety, such as that explained by Ellie, “what have I done, have I done anything wrong, have I embarrassed myself?” However, memory losses could also result in physical harm or perpetuating abusive dynamics, as Mel described: “They say if you can do that to yourself [self-injury], you can be stitched without anaesthetic.” Similar experiences have been evidenced through empirical studies in the self-injury literature (e.g. Morris, Simpson, Sampson, & Beesley, 2015), through which compassion and validation have been encouraged. Hermione added that due to her unrecognised memory difficulties, she missed her medication on the ward, which included her diabetes medication: “’you have to be responsible for your own medication’… when you’re even more in a distressed state, when you’re in a bloody hospital, it’s ridiculous!”

Additionally, most of the participants reported having a named nurse and described confusion around recognising them because of difficulties recognising faces and names. These difficulties could be indicative of visual and auditory recognition complications, which may tentatively be connected to more generalised cognitive avoidance recognised in dissociative conditions (Stovall-McClough & Cloitre, 2006). In terms of participants' cognitive functioning on the wards, numerous examples emerged from the data of participants experiencing delayed memory difficulties (as found in Giesbrecht, Lilienfield, Lynn, & Merckelbach, 2008), perhaps unsurprisingly considering the cognitive interference of voices, time losses and alters reported. Consequently, there appeared to be a need for repetition, reminders and predictability.

Furthermore, Amelia described how she needed her dissociative coping strategies to manage her experiences on the ward: “I was happy to allow my 13 year old who swears continually to tell them where to go, it was so frustrating”. Additionally, Mel, Ellie and Sam shared similar experiences. These experiences of alters managing certain situations appeared connected to the drama triangle postulated by Liotti (2004), through which the self and others are viewed as a rescuer, persecutor and victim. It appears from the data as though alters could become rescuers when the main persona became the victim, with staff viewed as the perpetrator. This pattern seems similar to the victim-based schemas found in the empirical study of McAllister et al. (2001), which add complexity to the interpersonal relationships between patients and ward staff, until new roles can be developed through relationships.

Concluding Discussion

In summary, the findings of this study suggest that trying to provide generic services on wards could increase psychological distress and enhance the need for dissociative coping strategies. Additionally, as people experiencing dissociation are at a higher risk of self-injury, suicide attempts, mental health sections and unplanned hospital admissions (Foote, Smolin, Neft, & Lipschitz, 2008), it appears as though this is a client group in need of appropriately tailored ward based services.

Accordingly, a number of preliminary recommendations in the form of guideposts specific to the needs of people who experience dissociation has emerged from the findings (Appendix 1-C). These include providing a structured ward environment with staff who could understand the role of the internal systems of people experiencing dissociation. Additionally, compassionate support for people with younger parts was identified as essential for the wellbeing of the whole person. A trauma-informed person-centred approach seems particularly crucial for people who require personalised grounding techniques, familiarity, and nurturing relationships for self-regulation and affective-regulatory strategies (ISSTD, 2011; Laird, McCance, Mccormack, & Gribben, 2015). Finally, participants identified that in order to develop positive relationships, staff needed to be calm, humorous, comforting, nurturing, friendly, provide choices, and be approachable and available.

Mounting empirical evidence suggests that the ISSTD recommended treatments for people experiencing DID in therapy are beneficial (Brand, Loewenstein, & Spiegel, 2014; Lynn, Lilienfeld, Merckelbach, Giesbrecht, & Van der Kloet, 2012). The next stage would be for appropriate guidelines to be developed for ward-based treatment. Therefore, initial guideposts such as those recommended in this study require further research in collaboration with existing networks and support groups so that hospital treatment guidelines can be refined with a view to developing a cohesive and integrated treatment pathway for people experiencing dissociation. A consistent approach to care is particularly important for people experiencing dissociation due to the disconnections experienced through relationships and personal needs around consistency and integration.

Limitations and Future Research

While a number of findings emerged from this study, all of the participants were women and future research could seek to explore whether men have similar experiences. For instance, it has been found there are existing gender differences in diagnosis and treatment (Shevlin, Murphy, & Read, 2015; Spitzer & Freyberger, 2008). More generally on hospital wards, women report more negative experiences, specifically in terms of staff communication around medication and discharge (Elliott et al., 2012), as was demonstrated in the present study. Some of the particularly distressing experiences of the participants may have encouraged them to participate in this study, which is likely to have influenced the findings. However, the variety of positive and negative experiences reported in the accounts and the variety of wards the participants experienced may accommodate some of the personal motivations for participating in the research.

Additionally, the reflective nature of the participants' experiences will have influenced the findings. IPA is an explorative form of analysis and commonly used for exploring current phenomena (Smith, 2004). In this study, the IPA analysis explored past experiences. However, due to the time distortions that many people who experience dissociative conditions report (van der Hart & Steele, 1997) and the related complexities these subjective perceptual difficulties might pose for clinicians and researchers (Todd, Simpson, & Murray, 2010), it is unclear at this stage what the impact of dissociation is for IPA research. This appears an important area for further exploration so the experiences of people experiencing dissociation can reliably inform practice guidelines. Nevertheless, due to the idiographic nature of IPA and the rich accounts of perceived experiences that the participants shared and the meaning making processes that occurred through reflection and analysis, there is a degree of theoretical generalisability to the findings of this study (Smith, Flowers, & Larkin, 2009).

Finally, some of the experiences participants could not talk about in detail were experienced by alters, who may have reported the experience differently through their own perspective (Van der Hart & Nijenhuis, 2011). Such factors likely influenced the interpretations made. There appears a need for future research to explore some of the issues surrounding research with alters, in order to develop informed and consistent guidance, which could enhance the quality and scientific recognition of research into dissociative conditions.

Conclusion

This study explored how people experiencing moderate to high levels of dissociation experienced therapeutic relationships with ward staff. The interpreted data highlights some of the difficulties participants faced in developing relationships and how past dynamics and present complexities could make the formation of therapeutic relationships difficult. However, through developing an environment that feels safe, structured and nurturing, combined with ward staff providing empathy, warmth and acceptance around dissociative experiences; participants could feel less distressed, which reduced their need to rely on dissociative coping strategies. Although staff training is an essential first step, the complex intra- and interpersonal needs of people experiencing higher levels of dissociation indicate specialised trauma-informed care provision is undoubtedly required.

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Table 1

Participant Information

Pseudonym	Age Range	DES Score	Type(s) of inpatient stay
Amelia	40-49	65	Numerous health and psychiatric admissions over many years, health admission for stroke most discussed in interview
Ashleigh	20-29	35	One long-term admission to a secure mental health unit, then an acute ward and then to a general mental health ward
Claire	20-29	51	One long-term admission, initially on an acute psychiatric ward, then a neuro-rehabilitation ward and eventually to a preparatory supported living mental health unit
Ellie	40-49	61	Many admissions to physical and mental health wards over a 20 year period, admission to health ward most discussed in interview
Hermione	50-59	76	Multiple admissions to mental health wards over 30 year period, frequent admissions for physical health care at certain times due to self-injury
Mel	40-49	70	Multiple admissions to mental health wards over 15 year period, largely acute mental health wards with one long-term physical health ward
Sam	40-49	88	Multiple admissions to mental health wards over 25 year period, mostly acute mental health wards

Interviews were audio recorded, transcribed verbatim into a word processor and arranged to enable the start of coding.

- The validity of the analysis was checked according to Yardley's guidelines (2000, 2008).

In accordance with IPA procedures (Smith, Flowers & Larkin, 2009), each transcript was listened to and read thoroughly a number of times.

- The initial stage of coding involved making notations on the transcripts of key words, phrases and summaries.
- Following this, the transcripts and initial notes were read again and initial themes were extracted that interpreted the findings.
- From this stage, recurrent themes started to emerge, based on interpretation and summaries.
- Subsequently, the transcripts and their emerging themes were read together, to identify comparable themes, repeating patterns, new themes and similarities in the accounts (Smith & Osborn, 2003).
- Connections between the transcripts were sought, which facilitated the clustering of subthemes to form superordinate themes.

Superordinate themes and subthemes were then checked through re-reading the transcripts to ensure that they were recognisable within the transcripts.

Finally, quotations for each theme were collated before the theme was described.

- This final stage also led to any final interpretations of the data and the re-labelling of the subthemes within the superordinate themes.

Figure 1: Process of analysis according to IPA

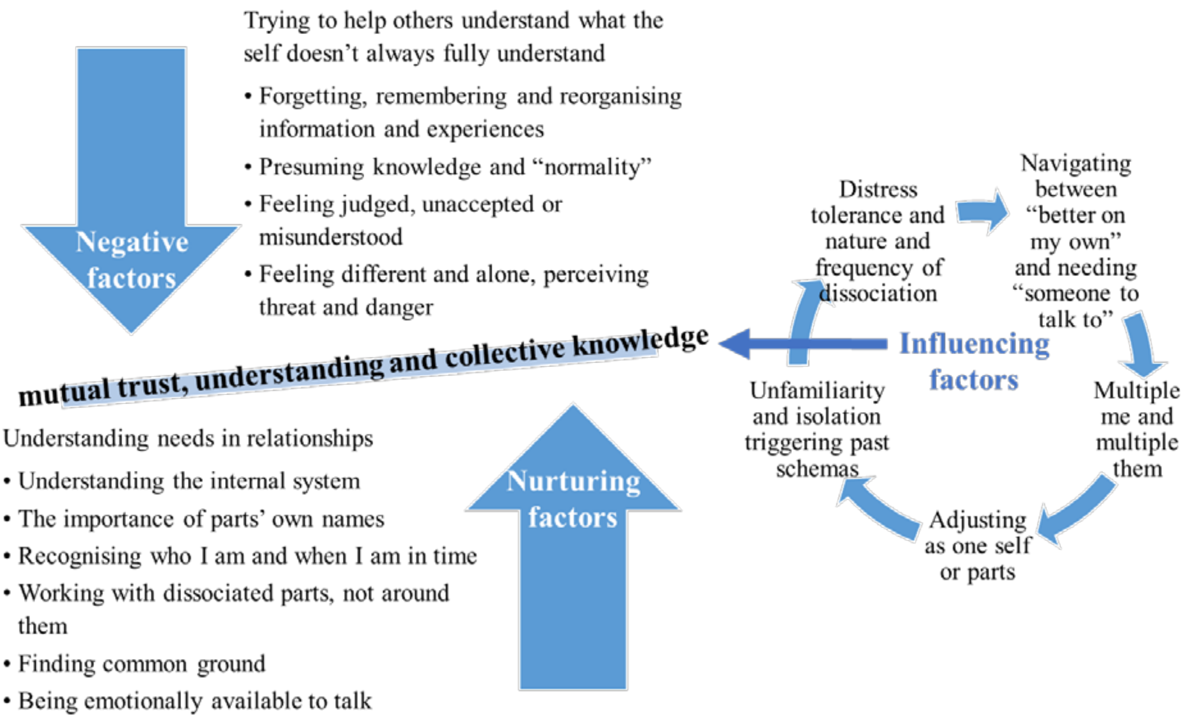

Figure 2: Diagrammatic representation of phenomena that affected the development of therapeutic relationships

Appendix 3-A: Guidelines for Authors from the Journal of Trauma and Dissociation

1. MISSION. The Journal of Trauma & Dissociation is the official journal of the International Society for the Study of Trauma and Dissociation. The Journal is dedicated to publishing peer-reviewed scientific literature on dissociation, the dissociative disorders, posttraumatic stress disorder, psychological trauma and its sequelae, and on aspects of memory associated with psychological trauma and dissociation. The Journal of Trauma & Dissociation seeks manuscripts on theory, basic science research, clinical treatment and research related to psychological trauma, dissociation and traumatic memory in children and adults. The Journal welcomes contributions from anthropological, cross-cultural, neurobiological, pharmacologic, physiologic, psychological, psychometric, psychotherapeutic, and social viewpoints. The journal is published quarterly.

2. TYPES OF ARTICLES. The Journal of Trauma & Dissociation accepts review articles, theoretical articles, original research articles, clinical contributions, case reports, and letters to the editors. Regular articles are limited to 5,500 words and brief reports to 3000 words. Authors should specify the type of article they are submitting. The editors may reclassify the type of submission as appropriate. The Journal does not review or publish first person case reports (accounts of authors' personal psychological experiences). Due to our value on authenticity and veracity of crucial case information, composite case studies are not published. The Journal does not publish unsolicited book reviews but welcomes recommendations of recent books for book reviews. Book authors and publishers should send copies of books for review to either of the Book Review Associate Editors and should notify the Editors by email of the name and author of the books sent to the Book Review Editors.

3. PRIOR PUBLICATION. Submission of a manuscript to the Journal of Trauma and Dissociation represents a certification on the part of the author(s) that it is original material,

and that neither the manuscript or a version of it has been published elsewhere, is not being considered for publication elsewhere, and has been approved by each author. Any form of publication other than an abstract of less than 400 words constitutes prior publication. This includes portions of symposia, proceedings, books/chapters, invited papers or any types of reports, and electronic databases. Authors wishing to submit manuscripts involving data or clinical observations previously used in published, in press, submitted (or to be submitted) papers should provide the Editor with this relevant information and an explanation regarding how those papers differ from the current submission.

4. AUTHORSHIP. Authorship credit should be limited to those who have made substantial contributions to the article in terms of design, data collection, data analysis and interpretation, and drafting and revising the manuscript. Acquisition of funding or provision of data alone is not sufficient to merit authorship. General supervision of the research group is not sufficient either. Individuals contributing less than a key role to the paper should be recognized in an Acknowledgement. Editors may require authors to justify the assignment of authorship. Each author must take public responsibility for the content of the article.

5. DISCLOSURE OF COMPETING INTERESTS. All forms of financial support must be stated in an Acknowledgment. Any commercial or financial involvements among the authors that might present the appearance of a conflict of interest in connection with the submitted article should be disclosed in the cover letter. Such involvements may include (but are not limited to) institutional or corporate affiliations not already specified, paid consultations, stock ownership or other equity involvement, patent ownership, travel funds, and royalties received from rating scales, inventions, or therapeutic methods. The Editor may share this information with the reviewers, but such involvements will not represent automatic grounds for rejection of the submission. A statement of such involvements will accompany

the article, if published. Authors will be asked to attest in writing concerning any competing interests at the time of submission.

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9. MANUSCRIPT FORMAT. Manuscripts must be prepared in a standard U.S. letter or A4 page format, double-spaced, with 1 inch or 3 centimeter margins on all sides. Text font should be proportional and with serif (e.g., Times New Roman 12 point font). Manuscripts should have the following order: Title page, abstract, text, references, tables and figures. Pages should be numbered beginning with the title page.

Title Page

Title page must include, title; authors and degrees; location of the institution and place where the work was done; corresponding author's name, address, telephone number, fax number, and e-mail address; word count; key words for index purposes; and acknowledgment of previous presentation, grant support, commercial support, or other credit. For mailing of a complimentary copy of the issue in which your article is published, please supply a postal mailing address for each author. Please place addresses of authors other than the Corresponding Author on a separate page immediately after the Title Page.

Abstract

A single paragraph abstract of 100-250 words must be provided.

Text

The text should contain an introduction that describes the objectives of the article and a review of the relevant scientific literature. Subsequent sections should describe the main subject matter (theoretical, clinical or research), a discussion of the subject matter, and conclusions. Research papers must include sections on methods and results, followed by discussion. Methods must contain an adequate description of instruments, research participants and statistical analyses, and results must be fully reported including the test values, degrees of freedom, whether tests were one- or two-tailed, probability and significance, and N values as appropriate. Research articles involving research with human participants must include a statement that informed consent was obtained or if not, why not.

Citations and References

For writing style and reference formats, the Journal uses the style of the Publication Manual of the American Psychological Association (6th Edition, 2010). We urge authors to consult this manual for formats not listed in the Information for Authors. The Publication Manual of the APA may be obtained from the APA Order Department, P.O. Box 92984, Washington, DC, 20090-2984, USA, www.apa.org/books/ordering.html.

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Use the author-date method within parentheses inserted into the text.1. Work by one author: (Putnam, 1989).

2. Work by two authors: (Cardeña & Spiegel, 1993). Cite both names every time the reference occurs in the text. Use no comma between authors.

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Bowman, 2000; Kluft 1985a, 1985b, 1986; Kluft & Fine, 1993; Michelson & Ray, 1996; Ross et al., 1992).

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Reference List

Consult the Publication Manual of the American Psychological Association for formats of types of references other than those listed below.

1. Journal article. Putnam, F.W., Guroff, J.J., Silberman, E.K., Barban, L., & Post, R.M. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *Journal of Clinical Psychiatry, 47,* 285-293.

Titles of and volume number journals should be italicized. Journal titles should have all important words capitalized.

2. Book. Putnam, F.W. (1997). *Dissociation in children and adolescents.* New York: Guilford Press.

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4. Book Chapter Goodwin, J. (1996). Childhood DID: The male population. In J.L. Silberg, (Ed.), *The dissociative child* (pp. 69-84). Lutherville, MD: Sidran Press. Page numbers must be included for book chapters.

5. Association Author: American Psychiatric Association. (2000). *Statement on therapies focused on memories of childhood physical and sexual abuse.* Washington, DC: Author.

6. Republished works: James, W. (1902/1961). *The varieties of religious experience.* London: MacMillan.

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8. Authors. Please include all authors for each reference. Use commas after all authors except the last (including two author references).

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Graphics, Tables, Figures, and Illustrations

All graphics must be “camera-ready.” Tables should be prepared using standard word processing software (MS Word preferred). Illustrations should be prepared using either graphics software or artistically rendered in black ink so that they can be used either as they are or reduced in size. Whenever possible, figures should be submitted with the manuscript in digital form. Fonts should be proportional and sans serif (e.g., Arial). Author name(s) and manuscript name should be lightly written on the reverse of graphics. Indicate in the text the approximate placement of all graphics. Graphics including photographs are considered part of accepted manuscripts and are retained by the Publisher. If submitted graphics are unacceptable for publication, the Publisher reserves the right to redo the graphics and to charge the author(s) a fee of $35 per hour for this service.

10. MANUSCRIPT STYLE. Authors who need a guide for English journal writing may wish to refer to the Style section of “Suggestions to Authors” in Neurology 1996; 46: 298-300. The editors are recommending only the writing style section.Use gender inclusive language. In referring to human beings, authors should use the phrases “in humans,” “in humankind,” or “in human beings,” rather than the phrase “in man” or the word “man.” Authors should avoid “he” in referring to generic persons as well as the awkward “he/she” construction by making the subject plural, e.g., “Therapists should inquire about amnesia whenever they suspect dissociation,” rather than “A therapist should inquire about amnesia whenever he/she suspects dissociation.” Alternatively, when referring to hypothetical persons, authors may alternate between male and female subjects. Numbers in the text. Authors should use Arabic numerals for numbers above nine, and for designators such as Case 4 or Patient 2. Authors should spell out numbers one through nine and numbers at the beginning sentences. Use the active voice whenever possible: We will ask authors that rely heavily on use of the passive voice to re-write manuscripts in the active voice. While the use of the phrase “the author(s)” is acceptable, we encourage authors to use first and third person pronouns, i.e., “I” and “we,” to avoid an awkward or stilted writing style.

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Appendix 4-A: Recommendations for multidisciplinary ward staff supporting people who can experience dissociation from the participants of this study

The ward culture

1. A ward culture of predictability, respect, acceptance, warmth and availability is needed, which is responsive to the abuse schemas that many people who experience dissociation report.
2. Provide everyone with a voice through facilitating patients to provide feedback and reflect upon their experiences on the ward.
3. Patients can be helped to feel empowered by acting quickly on the patients recommendations and feeding back to them how their advice has influenced your approach.
4. Staff need to be aware of abuse schemas and the impact of these schemas upon perceived punishment, degrees of risk, the risk of others towards the self, the perception of risk in relation to self-harm; and the concept of being trapped and unable to get out “like a prison”.
5. An available safe space to talk to someone informed about dissociation who will not be afraid of dissociative experiences and who can be accepting of dissociative parts.
6. Self-harm should be recognised as a consequence of the person’s overall life experiences, not viewed as an isolated and preventable incident.

The ward structure and environment

7. The ward should be friendly, calm, structured and facilitate relationships between patients and staff. Patients with dissociative disorders are likely to require additional support if there are incidents on the wards.
8. Morning therapeutic groups could be helpful, which explain the ward rules and culture and help new people settle into the ward environment.

9. The ward environment should be sensitively explicit. For example, information detailing the time, date, day, month, year and even weather outside may help participants ground themselves in the present rather than relying on past schemas for information.
10. Staff should also have their names and roles clearly visible.

Enabling freedom, choice and control

11. In order to sensitively challenge the perception of being trapped, patients should be facilitated to go outside and on short walks when possible and safe to do so, either to get a drink, reading material or just to be outside of the hospital.
12. Respect confidentiality and choice, i.e. if sensitive discussions need to be held, offer a private room rather than rely on a curtain.
13. Staff handovers in certain circumstances may require particular planning and sensitivity to the patient’s needs.
14. Effective handover between shifts is essential, which includes the patient so that they are aware of what information has been provided.

Specific support for people with younger parts

15. Younger parts should not be neglected, but rather acknowledged, nurtured and supported.
16. For people with alters, ask how “they” are, rather than maintaining a singular perspective on the self as a construct.
17. Younger parts may be specifically sensitive to being overlooked or disregarded. Therefore, choice and control may be particularly important to younger parts.
18. Within the care plan, participants should be asked for guidance regarding what staff should do when younger parts appear. For example, they may need certain materials for comfort, communication or drawing.
19. Similarly, some participants may wish their younger parts to have time to play, whereas other patients may wish staff to ask their main persona to return.

20. Younger parts may have particular difficulties expressing themselves verbally. Therefore, alternative methods of communication should be agreed with the main persona.
21. Try not to assume younger parts can read or remember who you are. Introduce yourself every time you are aware of a switch.
22. Professional judgement should be used or sought when new information arises through a younger alter. Tentatively explore with the patient whether they wish to know the information held by a younger alter.
23. Ensure you are aware of switches through discussion and familiarisation with the patient. For example, some people can have some warning signs before they switch, which means they may be able to signal a switch for you. Otherwise, become familiar with the signs yourself.

Nurturing authentic and consistent relationships

24. Demonstrate authentic interest in participants' wellbeing through asking questions and becoming educated around their condition.
25. The confusion that people who experience dissociation often report needs to be taken into account when providing key staff. The data from this study seems to suggest that participants often had difficulty recognising, remembering and locating their named nurse. Therefore, patients should be provided with an information sheet about their key nurses including a photograph, name and perhaps some appropriately brief information about hobbies or interests.
26. Common ground was seen as being very important in order to develop relationships.
27. Voluntary listening services, akin to the Samaritans, with volunteers present on the ward to talk to patients was recommended as being a helpful development.

Specialist training and availability of specific specialities

28. Access to psychology and occupational therapy was often highly valued, although rarely readily available.
29. All staff should have training in recognising dissociation, parts or alters and how to talk to patients about how to develop a relevant care plan on the ward, including what to do if the person dissociates
30. Awareness of personalised grounding techniques and how to support patients use them when distressed is essential.
31. A member of staff available to listen and talk compassionately to patients at all times, day and night.
32. Access to activity and expression groups such as art therapy groups or craft groups.
33. Links between the ward and community groups who come to the ward to undertake activity groups.
34. Readily available information about charitable and community groups to ease transition out of the ward.

Appendix 5-A: Example of coding with an IPA transcript excerpt

Notations	Excerpt from Sam's interview ('S' for Sam, 'I' for interviewer)	Emerging themes
	I: What was that like, going back onto the ward?	
Frightening to go back Me looking at my body The wrong person Not listening Different people Struggling to manage voices Brushing it off, not addressing difficulties	S: It was frightening… everyone calling me by my name, "I'm not Sam". I can see me looking at my body and they're addressing the wrong person in the first place and that was very distressing… just not listening to, what made you come in the first place, distressing thoughts, different people, thoughts in your head, brought you in this time. It wasn't… just put her there… just calm her down, not to be a danger to anyone else, not any more activities of ways of managing your voices, what you can do outside… It was like what you can do inside… calm her down, brushing it off, not dealing with it on the ward.	Not me, multiple me Struggle to manage dissociative experiences in ward environment
	I: At any time were you able to say, it's the wrong name? How you were feeling?	
Couldn't tell them, suicidal, obs Didn't take the time Staff perceived as not engaging and not knowing "You're lucky" – couldn't see that	S: No it wasn't possible. It was suicidal, I was suffering all the time and on level one observation. They are supposed to engage with you but because they didn't take the time… my behaviour was flipping, I was calm, then not, so the staff found me difficult to work with and they found it was easier to stay silent… 98% never took the time to ask what was going on for me, "you've got everything in life", how lucky I was… But I couldn't see that, a lot of them would say that, but I couldn't see. Because my parents used to come well dressed, I had no reason to be unwell, that's what they thought.	Needs not being met Unseen, unheard Misunderstood
Appearances	I: What was that like?	
Judging Someone to talk to Bring reality "you're in the right place" Made "us" angry	S: I thought it was wrong to judge me, not even asking how I am, doing it for attention. I just wanted someone to talk to me, bring me to reality. In the morning just "Hello, what would you like to do today", "we can help you", "you're in the right place"… just some encouragement. "You're throwing your life down the drain", that rubbish. It made us more angry and the only way to get attention… you act up. Not act up but just be really mad and if you want someone to listen to	Wrong to judge Cries for help misunderstood

“Mad” for attention Not my name, I won’t respond Evil	you… I would flood the bathroom. It was a cry for help, I kept flooding the bathroom, they ask “why’s she flooding the bathroom!” It was negative, the wrong way of getting attention… It’s like “you don’t want to be called Sam, what do you want to be called?” There was one lady, her name was [redacted] I want to be called [redacted], on the board it said who’s responsible. But me they called Sam, but I’m not, so I’m not going to respond. They said I was evil because of that. I wasn’t addressed by my own name at all.	The right name for the internal system
	I: Was it the same on wards or different?	
Transferred if no space Issues with change Moves difficult but could settle sometimes Kind – attention Surprised consultant had time to talk I’m different people Different approach Not so manic now	S: No it was different. There are four consultants and each had a floor. So if you came in there was no space, you got put on a different ward and then transfer. I have issues with changes… I got settled on a ward and I’d be moved and found that difficult. Some staff were kind and if you get more attention, you want to stay there. The best time was in a private hospital in [redacted] as there was no space. The consultant spoke to me, asked what I wanted, to feel better, no one ever asked me that before. I asked “are you for real?” First time asked what’s going on for me! He said he got all the time. “Tell me what’s going on for you?”, “I’m different people”, and he’d say something and it was exactly what I was feeling. He said I was on wrong medication and he changed it, I was manic manic manic. He put me on something else. I said “are you really a consultant?” He was so different talking and that. Then I had to go back to my own hospital, I said “you’ve changed medication, will they change it back?” He said “no”. Now I’m ok he’s written in my notes that I stay on that. I’m not so manic now.	Adjusting as a challenging process Taking time to talk – understand – make changes to care

RUNNING HEAD: Dissociative Experiences and Therapeutic Relationships on Wards

Section Three: Critical Appraisal

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Choosing a Topic and Methodological Approach

The topic of the thesis was originally considered following my work with a client on my adult placement, who experienced moderate levels of dissociation. Throughout my work with this client, I heard how she experienced a number of difficulties while she was on a hospital ward, following a section under the Mental Health Act (2007). During discussions with my then placement supervisor, who specialises in dissociative conditions, I heard about other people experiencing dissociation who required ward based support at times. Consequently, I started to research the existing empirical literature and guidance surrounding how hospital wards are advised to support people who experience dissociation.

Although there are guidelines available for therapists supporting people experiencing dissociative identity disorder (DID, International Society for the Study of Trauma and Dissociation [ISSTD] 2011; Hirakata, 2009), I found few recommendations that could transcend to help multidisciplinary ward based staff support people with a range of dissociative conditions, not only DID. Currently, there are no guidelines from the United Kingdom's National Institute for Health and Care Excellence (UK, NICE) regarding how staff can support people experiencing dissociation specifically. I therefore concluded there was an identified need for further information and guidance relating to how people who dissociate experience being on wards and, particularly, how they experience therapeutic relationships with multidisciplinary staff on those wards.

Within the limited literature relating to undertaking qualitative research with people who experience dissociation (e.g. Fox, Bell, Jacobson, & Hundley, 2013; Hirakata, 2009), there were a number of methodological issues. For example, challenges to the design of the project related to developing an epistemological position in relation to the construct of dissociation and whether the aetiology of dissociation may influence the findings from the study (Dorahy et al., 2014). Additionally, the construct of dissociation in terms of it being a condition on a continuum (BPS, 2014; Braun, 1988) or a condition of two forms (detachment and compartmentalization as discussed in Holmes et al., 2005) was also considered. Consequently, the construct of dissociation and how the defined construct could influence the concept of personality and relationships was explored through theoretical articles (Dorahy et al., 2014), discussion with researchers in the field and through analysing the participants' scores on the Dissociative Experiences Scale (DES-II, Carlson & Putnam, 1993).

For the purpose of this study, it was concluded that dissociation would be identified as a phenomenon developed as a coping mechanism and that participants would be screened for the possible severity of their dissociative experiences, rather than type of dissociation. Additionally, as suggested by Nijenhuis and Van der Hart (2011), the concept of personality for a sample of people experiencing moderate to high levels of dissociation was considered as constructed of parts of one structurally divided self. As detailed in the methodology section of the empirical paper, these issues were resolved sufficiently in order to design a study that could include a sample group homogenous enough in order to interpretatively explore their experiences of both mental health and physical health wards.

Regarding the analysis, two analytic approaches were considered. Firstly, a constructionist grounded theory (Charmaz, 2006) approach, in order to build a theory from participants' voices and understandings of their experiences (Auerbach, Salick & Fine, 2006). As a consequence of the assumption that different parts of the divided self may hold different perceptions of events (Nijenhuis, 2008), it was particularly important for this study to elicit a broad a range of subjective perceptions from participants about their experiences. During the planning phase, it was also considered whether a stance accepting of a relativistic reality and the co-construction of meaning, through understanding participants' re-constructions of their experiences (Andrews, 2012), could be taken. This approach could have facilitated understanding around how participants had developed a collective meaning making from their experiences, possibly incorporating the varying perceptions of any alters. Grounded theory has been employed previously (Ågårda, Egerod, Tønnesenc, & Lomborg, 2012), in an attempt to capture participants' concepts of events and develop a practical and modifiable theory for clinical practice.

Nevertheless, despite these possible advantages of employing grounded theory for an analysis of a question similar to the final research question, in accordance with the exploratory and interpretative nature of the study, interpretative phenomenological analysis (IPA) was considered the most relevant analytical approach for two reasons. Firstly, I was aware that the number of people I would be able to recruit would potentially make purposeful sampling difficult. The undertaking of meaningful purposeful sampling may have also been highly complicated as it is generally recognised that many people with dissociative conditions are misdiagnosed or unrecognised (Boon & Draijer, 1993; Putnam, Guroff, Silberman, Barban & Post 1986; Spiegel et al., 2011). Therefore, potential participants might not have been identified by ward clinicians and so not included informed about the research. Secondly, the interpretative nature of IPA appeared more appropriate due to the likelihood of many participants developing their own interpretations of their experiences. Due to the recruitment process, it was assumed that many of the participants would have undertaken some psychological therapy and so may have begun to develop their meaning making processes of their experiences. The process of reflection and integration of experiences through therapy is often reported as helpful for clients due to the common difficulties people experiencing dissociation can have in maintaining a consistent narrative, while coping with different parts and lapses in memory or attention (Holmes et al., 2005; Staniloiu & Markowitsch, 2012).

Reflections and Discussions of the Thesis Experience

Considerations of the Findings

Following the discussions of the strengths and limitations presented in the two papers, this section discusses how the methodologies of the studies complemented the analyses and influenced the interpretations made. As a framework for this discussion, the analyses and findings are considered in relation to the critical realist epistemology employed for both papers. Critical realism refers to a practice and theory in relation to the study of knowledge, which proposes that we think and behave within a layered reality and that our own unique perceptions and interpretations derive from our personal meta-reality that we create through our social experiences and interactions with others (see Bhaskar, 1993). As illustrated in Figure 1, the use of critical realism within both papers varied according to my connection, or my co-presence, with the data.

Within the literature review, an approach appreciating a layered reality was consistent with the experience of re-interpreting the interpretations of the authors of the original studies, who heard the interpreted first person accounts of their participants. The intertwined concept of meta-realities accept the presence and importance of individual realities and perspectives. Consequently, my individual interpretations followed a process of meaning making that extended from the *actual* layer of realism, as I did not observe the participants' experiences, although I could observe their responses to their experiences through the quotes provided in the original studies that were reviewed. I considered the reported experiences of the *empirical* sphere and then used an idiographic analysis and consideration of existing literature to draw some conclusions about what may be happening for adult survivors of CSA in talking therapy throughout the *actual* and *real* spheres of thoughts and beliefs. However, due to the nature of any thematic synthesis, there were naturally limitations in terms of the selection of information originally chosen by the authors of the respective studies, in that the authors were evidencing their individual meaning making processes. Therefore, my interpretations, developed through my meta-reality, were also influenced by the meta-realities of the original authors.

<Insert Figure 1. Diagrammatic representation of the influence of critical realism in relation to the literature review and empirical paper>

Concerning the empirical paper, I found that the process in relation to the spheres of critical realism was both a top-down process in design and expectations but a bottom-up process when I conducted the interviews and analysis. Prior to conducting the interviews, I had expectations around how trauma experiences might influence dissociation and how experiencing reactions to trauma could influence a person’s sense of self. However, the individual nature of IPA meant that drawing upon information from the real and actual was not possible until the later interpretative stages of the analysis. My awareness of these processes was helpful in protecting the individual nature of the personal accounts of the participants, while using the IPA method to make interpretations about some of the possible mechanisms that might occur within the sphere of the real. In summary, the epistemological stance of the research facilitated personal awareness of my meta-reality, which further influenced and informed my interpretations of the data.

Additionally, the experiences of conducting the two analyses of the two papers highlighted some similarities between the findings in relation to what made therapeutic relationships helpful. For instance, the importance of choice and control were prevalent in both studies. In addition, participants of the empirical study and thematic synthesis discussed how divided or separated parts of themselves had different roles in situations. For example, within the thematic synthesis, many participants discussed an inner and outer self. However, within the empirical study, there were more extreme examples of self-separation, such as when Ellie described: “I just didn’t want to be there so I just kind of went away and left it to other parts of me to deal with … it seemed easier to just not be there sometimes”. Considering these similarities also helped me consider my perception of dissociation and how my perspective changed over the course of the research.

When I began developing ideas around the empirical study and started to consider my perception of dissociative conditions, I found the description of dissociation as a continuum helpful (BPS, 2014). This method of explaining dissociation appeared to be how many of the participants described their condition. However, as I undertook the interviews and listened to the audio recordings, I became increasingly aware and interested in the differences that the participants described in terms of their experiences of dissociation. There were some explicit differences in that five participants had a DID diagnosis, two participants had experienced conversion disorders, while all participants described experiences such as losing time and memory difficulties. In order to facilitate my learning and critical awareness, which would influence the nature of my interpretations throughout the analysis, I began to explore in detail some of the theories surrounding how dissociation can differ.

The DES-II has been considered for a range of functions (Carlson & Putnam, 1993). As a first step, the DES-Taxon was calculated (Waller & Ross, 1997), which attempts to differentiate non-clinical (e.g. daydreaming or loss of concentration) and clinical (e.g. derealisation, fugue states) dissociative experiences (Table 1). However, when the participants of the sample were considered on an individual basis, further evidence was found that the taxon did not identify those participants who experienced what would be considered to be pathological levels of dissociation, such as DID (similar to findings of Leavitt, 1999). As I reflected upon the participants’ accounts, , I too considered that the taxon approach did not capturethe severity of the participants’ experiences.

<Insert Table 1. Descriptive statistics for postulated types of dissociation>

Finally, I discussed the approach of qualitatively different forms of dissociation (Brown, 2006; Holmes et al., 2005) with two authors of the theory. After these discussions, as an exploratory exercise, I attempted to calculate approximate scores for the participants' DES-II items for detachment and compartmentalisation. Although it is accepted theoretically that the DES-II was not designed for this purpose, most items relating to each concept were generally clear. For example, "Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person" is an example of detachment; and "Some people have the experience of finding new things among their belongings that they do not remember buying" is an example of compartmentalisation. The findings from the sample of this thesis suggest that participants reporting DID indicated higher compartmentalisation scores, as would be predicted.

The ways in which participants discussed their experiences appeared on many occasions to connect to detachment or compartmentalisation. For example, Amelia explained how she felt as though "My head felt like a clock face, no one was in the right place", which would describe a compartmentalisation experience. There were also many descriptions of detachment type dissociation, for example: "I was in a wheelchair but I felt as though I was up here… um looking down on myself… so I didn't feel anything" (Claire). However, Claire and Ashleigh, who did not report a DID diagnosis, did not differ in their scores as might have been expected. For example, Ashleigh reported that her experiences of dissociation were largely detachment type experiences, although scored the lowest score within the sample on the detachment items. Further, considering the severity of Claire's conversion disorder, her compartmentalisation score was relatively low, although compartmentalisation items have been identified as lacking through the DES-II (Brown, 2006) and it is generally considered that the DES-II cannot reliably identify this phenomenon. Therefore, it would appear as though, from the sample of this study, new methods for analysing qualitatively different forms of dissociation need to be developed. Specifically, more research of this nature needs undertaking with people experiencing a range of dissociative conditions, not only DID.

Although aspects of the data appeared closely linked to compartmentalisation and detachment experiences, there also seemed to be reflections from participants that captured how forms of dissociation influenced the main persona at a metacognitive level. As I learnt more about the forms of dissociation as I undertook the study, I became increasingly aware that many theoretical perspectives on dissociation focus upon the more explicit forms of dissociation, such as detachment, disconnection, DID and other forms of compartmentalisation. A number of passages within the data that discussed the main persona’s experience of their dissociation, rather than dissociative phenomenon in isolation. Participants discussed the impact of forgetting information or actions, feeling separated from parts of themselves or alters and how dissociation affected their bodies and minds. For instance, as Sam reflected, “Sometimes you need help to handle the anger. I don’t know how to handle them, make them more peaceful.” Further, Hermione reflected, “most people don’t experience themselves like I do”. Crucially, the descriptions of dissociation that did not seem closely linked to detachment or compartmentalisation appeared connected to the experience of the central-self.

Therefore, it would be helpful for future research to explore the qualitative experiences of the main persona within the context of dissociation further, to develop a better understanding of the lived experiences of people with a range of dissociative conditions. An informed understanding of the experiences of people with dissociative conditions could facilitate the refining of the term dissociation, as it remains broad in focus, which likely adds to the ambiguity and confusion around people reporting dissociative conditions. As Claire described: “I saw no one really who’d heard of it. I was on a neurological rehab unit, they didn’t have a clue, they were oblivious and I came across a lot of bad things there…” Claire found that the lack of understanding and perceived willingness from staff to engage with her made her situation on one ward particularly difficult. However, Claire, Mel, Sam and Ellie spoke very positively about the members of staff who had asked them about their condition and how they could meet their needs, as is described in theme two of the empirical paper.

Reflections on Dissociation and Relationships on Wards

Towards the end of the interviews, participants were asked what they would recommend for staff supporting people experiencing dissociation. Most participants recalled incidents through which interpersonal dynamics had influenced their relationships with staff and how those dynamics influenced participants’ perceptions of the ward environment, their care and, at times, themselves. Additionally, Sam explained how the reaction of staff towards her influenced her perceived lack of control around switching, as she described: “to laugh at people when we [central-self] have to detach.” These were just two examples of how a lack of perceived therapeutic care could both increase the need for dissociative coping mechanisms and exacerbate control issues relating to dissociative difficulties. Liotti’s research (2008, 2011) would suggest that the perception of a lack of care would trigger dissociative coping strategies, as she suggested that the interrupted process of attachment and integration begins with an absence of security and stability. Therefore, it is not surprising that later attachment interruptions and perceived insecurity and instability would trigger further dissociative responses.

Reflections on Undertaking the Study

A somewhat unexpected finding from the paper was in relation to some participants experiencing the ward environment as a “prison” (Mel and Ashleigh) or as being trapped

(Ellie and Sam), which made me reflect upon the appropriateness of the title of this study. I became increasingly uncomfortable with the term “in-patient” as it seemed connected to being trapped and reminiscent of being kept in an environment without providing consent. Whilst I listened to the accounts of the participants, I also began to consider how disempowering the term can be and how conflicting being an in-patient is with the importance of choice and control. Consequently, I requested to change the name of the study through the Integrated Research Application System (IRAS) committee from ‘What are the experiences of therapeutic relationships on in-patient wards by people who dissociate?’ to ‘What are the experiences of therapeutic relationships on hospital wards of people who experience dissociation?’

Additionally, within the nuances of the findings was the sense that participants appeared to experience themselves as experiencing dissociation, rather than dissociation being something they did or a condition they had. Therefore, ‘people who dissociate’ was exchanged for ‘experience dissociation’. Furthermore, I ensured that the term “symptom” was not included anywhere in the analysis and discussion because the participants did not report *symptoms* of their condition. They did however explain and discuss how their dissociative experiences influenced almost every aspect of their life. Therefore, these dissociative experiences did not seem concordant with the construct of ‘symptoms’ as a description of something related to a condition or disease. Rather, dissociation was an experience in itself, although all participants, in their unique ways, linked dissociation to prior experiences for which they had needed to develop dissociation. In this way, dissociation was not a symptom or product of an illness; it was an experiential learning mechanism they had developed to help manage their distress.

As Amelia stated at the end of her interview: “It’s been nice to reflect [through research interview], but there’s still that injustice. I’m doing some research at the moment…

We have a long way to go until people lose their fear." Accordingly, I became increasingly aware how the language used by researchers, clinicians and survivors can reflect "injustice" and how important it is to highlight that dissociation is a developmental experience, to be discussed and reported in a non-pathologising and candid manner.

Reflections on the Researcher Experience of the Thesis

Due to the abusive childhood experiences some of the participants in the empirical study reported and the dissociative experiences that some participants in the systematic review discussed; there was a small degree of intersection between the two studies. For instance, although Hermione was interviewed in relation to her experiences on hospital wards, she also explained how difficult she finds it to talk to her therapist about her past as she is aware of the anxiety this provokes in her therapist: "I can't ever talk… to talk about anything if you feel distressed you might dissociate". This experience of clients of therapy feeling as though their therapists found their experiences too distressing to talk about was also present in some of the studies reviewed in the systematic review (e.g. Koehn, 2007; McGregor, Thomas, & Reid, 2006). Worryingly, she also indicated there is a long waiting list for her to receive additional support: "I'll be put down for short-term psychological therapy… umm in three years' time when the waiting list gets to my turn". Recently, difficulties for people experiencing a range of forms of psychosis around accessing psychological support have been highlighted elsewhere (BPS, 2014).

An aim of the thesis was to highlight the challenges people face when accessing appropriate services and how interventions can be tailored to accommodate dissociation. Perhaps due to the limited research into CSA and dissociative conditions in the UK (Chouliara et al., 2012), physical health and mental health services in many of the areas involved in this study appeared disconnected from the existing recommendations for care (Bicknell-Hentges & Lynch, 2009; BPS, 2014; Lypovski & Hanson, 2007). Historically, there have been numerous difficulties in obtaining the survivor experience and promoting that experience to inform change. This may have been due to the notions of ‘false memory’, lack of funding, some professions seeming reluctant to engage with the concept of past experiences attributing to adulthood psychological difficulties, the concept of DID, and so forth. However, a substantial amount of research now exists that could be shaping how services support survivors (Dorahy et al., 2014). Further research that obtains qualitative data regarding the lived experiences of people experiencing trauma reactions, which may include dissociative conditions, can start to address issues surrounding how theoretical research and specific guidelines can transcend to inform non-specific health services, such as hospital wards.

Although I hope that this thesis in its entirety can add to the research relating to the survivors’ lived experiences of services, I have become increasingly aware of an additional issue in undertaking such research. As Nelson suggests, it may be that certain reports regarding the prevalence or impact of CSA can be “too unpalatable to society” (2009, pp. 2). The concertinaed nature of research and acceptance around dissociation in relation to childhood traumas over the last century would perhaps support this theory. That is, Pierre Janet developed a theory of dissociation towards the end of the 19th century that is similar in some ways to present day theories. However, much of Janet’s work was eclipsed by the theories surrounding psychoanalysis and different perspectives on the personality during the 20th century (Van der Hart & Horst, 1989). While conducting this thesis, I also wondered if the emotional impact upon the researcher may influence the readiness of researchers to engage in such research. For example, researchers have suggested that there is a profound impact for therapists working with CSA survivors (e.g. Baird & Kracen, 2006; Hesse, 2002; Trippany, White Kress, & Wilcoxon, 2004). Therefore, it seems likely that researchers may also experience certain emotional challenges when working with people who have experienced interpersonal traumas.

Specifically in relation to the current study, during the first phase of familiarisation, the detail of some of the first person accounts and emotive nature of their stories became apparent. In order to ensure the inductivity of the analysis, through being consistently connected to the data, certain sections were analysed slowly in small stages, so as not to cause increased distress or overwhelming reactions to the data (Hubbard, Backett-Milburm & Kemmer, 2001), which might have triggered distancing, avoidance or mild dissociation. Additionally, the advice provided by the Sexual Violence Research Initiative (2006) was followed, in order to prevent vicarious trauma or desensitisation. Although this approach was structured and facilitated a degree of awareness around being boundaried in relation to the data, the detailed accounts of abuse and neglect from participants in both studies were distressing. It could be challenging to hear and stay engaged with the data, which was essential for the interpretative approach to the analyses.

Conclusion

Although both the empirical study and systematic review focussed on emotive issues, maintaining support, boundaries and structure facilitated the completion of the projects while preserving the interpretative nature of the findings. The findings from both the empirical paper and systematic review have led to a number of recommendations for clinical practice, which will hopefully lead to changes in perception, service provision and the lived experiences of the people who have contributed to these studies and others facing similar challenges.

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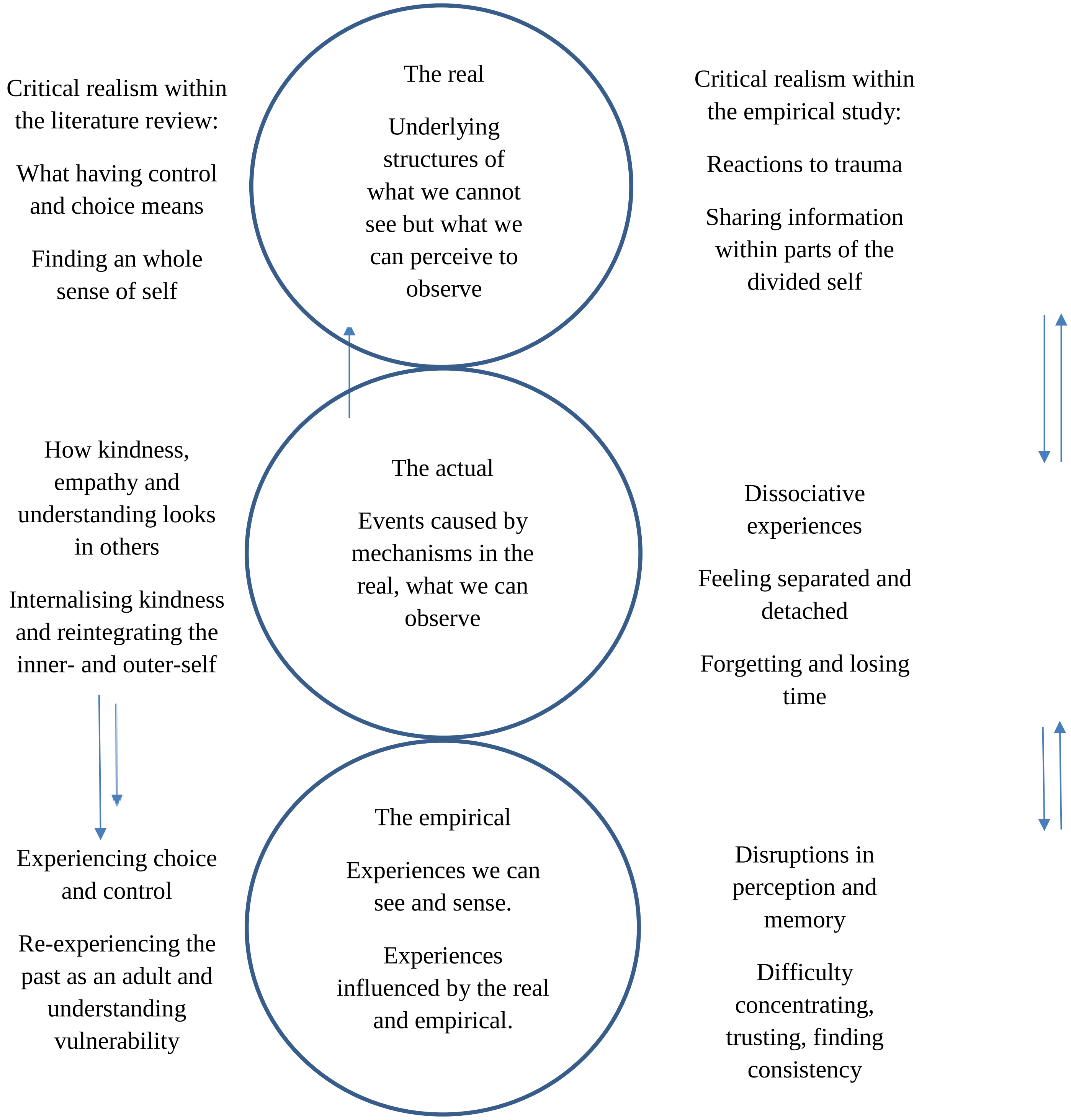
Table 1

Descriptive statistics for postulated types of dissociation

Aspect of dissociation Sample group scores	DES-II total score	DES-II Taxon	Detachment dissociation	Compartmentalisation dissociation
M	64.13	55.89	59.71	69.34
SD	17.16	16.94	18.60	16.22

Figure 1. Diagrammatic representation of the influence of critical realism in relation to the literature review and empirical paper[9]



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[9] Adapted from ideas presented in Bhaskar, R. (1991). *Philosophy and the Idea of Freedom.* Oxford: Blackwell and Mingers, J. & Willcocks, L. P. (2004). *Social Theory and Philosophy for Information Systems.* ISBN : 978-0-470-01121-8