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An exploration of the changing relationship with shame and guilt for survivors of complex trauma whilst accessing therapy: A research portfolio

Deirdre Maria Buckley

Doctorate in Clinical Psychology
University of Edinburgh
August 2013
DClinPsychol. Declaration of own work

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- Received ethical approval from an approved external body (e.g. NHS Research Ethics Committee) and registered this application and confirmation of approval with the University of Edinburgh’s School of Health’s ethical committee

Signature ............................ Date ..........................
ACKNOWLEDGEMENTS

First and foremost I would like to thank all the wonderful women who gave their time to take part in this study and share their stories with me.

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Lastly, to my darling James, for your emotional and practical support, thank you.
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Thesis Overview

This thesis follows the research portfolio format and is carried out in part fulfilment of the academic component of the Doctorate in Clinical Psychology at the University of Edinburgh. An abstract provides an overview of the entire portfolio thesis.

Chapter Two contains a systematic review of published research investigating the impact of psychological interventions on the experience of depression for survivors of Childhood Sexual Abuse. This review focuses specifically on methodological issues highlighted in previous reviews. It was prepared for submission to the Journal of Traumatic Stress and follow their author guidelines.

Chapter Three is an empirical study exploring survivors' of childhood trauma changing experience of shame and guilt through the therapeutic process. The results are written up in the form of a journal article for submission to the Journal of Sexual Abuse, and follow their author guidelines.

Chapter Four provides a detailed outline of the qualitative methodology employed in the empirical study.

The systematic review and journal article follow the American Psychological Association referencing style, in line with the Journal's requirements. The thesis portfolio follows referencing guidelines issued by the University of Edinburgh’s Doctorate in Clinical Psychology Research Handbook.
Thesis Abstract

Aims: The experience of abuse in childhood can lead to psychological distress later in life. In particular the impact of trauma on the development of the self can render survivors more vulnerable to chronic feelings of shame and guilt. The aims of this research portfolio are twofold. First, a systematic review examines the impact of therapeutic interventions on depression outcomes for survivors of Childhood Sexual Abuse. Second, a research study explores experiences of shame and guilt for this population. More specifically, the study examines those factors in the therapeutic process which survivors find helpful in their changing relationship with these emotions.

Method: To address the first aim a systematic review of the literature was carried out. The methodology employed strict inclusion criteria and ten Randomised Control Studies were identified and included in the review. A prospective longitudinal qualitative study was conducted to explore the experiences of shame and guilt for survivors of childhood abuse. Participants (n=10) were interviewed at two different time intervals whilst accessing psychological therapy. Data was analysed using the Framework Method.

Results: Findings from the systematic review show existing studies are mostly of poor to medium methodological quality; but that therapeutic interventions do improve depression outcomes for survivors of Childhood Sexual Abuse. Results from the empirical study suggest feelings of shame more so than guilt are core emotions in the experience of psychological distress for survivors.

Conclusion: Evidence-based therapeutic interventions for the range of complexities experienced by survivors of CSA are still to be established and more strong methodological trials are required. Shame is a core emotion in psychological distress for survivors and requires to be assessed and addressed routinely in therapeutic interventions.
Outcomes of psychotherapy on measures of depression for survivors of Childhood Sexual Abuse: A Systematic Review

Key words: systematic literature review, depression, emotions, childhood sexual abuse
Abstract

Depression is a frequent co-morbid disorder with Post-Traumatic Stress Disorder for survivors of Childhood Sexual Abuse. A systematic review was undertaken on the available literature to examine the impact of psychotherapy outcomes on measures of depression for this population. Ten randomised controlled trials were included and their findings synthesised. Results suggest psychotherapies have a small to large effect size for depression outcomes, however most studies were assessed as being of poor to medium design quality. The findings are discussed in relation to the methodological strengths and weaknesses and recommendations for future research are considered.
The psychological sequelae for a Type 1 trauma, a singular traumatic event, differ from those following Type 2 trauma (Terr, 1991). Exposure to domestic violence and physical, sexual or emotional abuse in childhood are classified as Type 2 trauma and the range of difficulties survivors may experience can be multiple and complex in nature. A meta-analysis of the international literature found that approximately 20% of women and 8% of men experience sexual abuse as children (Pereda, Guilera & Gomez-Benito, 2009). Not all individuals with a Type 2 trauma history develop mental health difficulties but the literature demonstrates traumatic experiences in childhood are associated with poor mental health outcomes in adult life (Putnam, 2003; Maniglio, 2009). By reason of the relational and developmental context in which Child Sexual Abuse (CSA) occurs, it is conceptualised that survivors may have disruptive relationships with both the self and others, experience difficulties with affect regulation ability, and often develop maladaptive coping strategies (Herman, 1992; Van der Kolk, 1997). It is imperative to understand these complex presentations in order to provide the most efficient service to address the health care needs of this population.

There is a high prevalence of Post Traumatic Stress Disorder (PTSD) for individuals exposed to childhood abuse. Symptoms include persistent re-experiencing of the trauma by flashbacks, hallucinations or nightmares, avoidance of stimuli associated with the trauma, hyper-vigilance and a numbing of emotional responses. This may be the reason many studies investigating treatment outcomes for CSA view reducing PTSD as a particularly desirable outcome. However, it is long recognised that difficulties experienced by survivors of CSA are not fully explained by the diagnostic criteria for PTSD. CSA has been identified as a non-specific risk factor for psychopathology: such as dissociative disorders (Read, van Os, Morrison & Ross, 2005); internalised disorders such as depression and anxiety (Chaffin, Silovsky & Vaughn, 2005; Johnson, 2004); maladaptive coping strategies, such as substance misuse (Herrenkohl, Hong, Klika,
Herrenkohl & Russo, 2013; Lown, Nayak, Korcha & Greenfield, 2010), and self-harm (Weierich & Nock, 2008) among others. The evidence in these studies suggests these disorders do not occur in isolation but instead are experienced as co-morbid conditions. Cloitre, Koenen, Cohen and Han (2002) cautioned “the psychological sequelae of child abuse include symptoms beyond the PTSD diagnosis, leading to complex treatment considerations” (p.1067).

A history of CSA has been associated with the onset of major depression in adulthood (Gibb, Helminski & Zimmerman, 2007; Kendler, Kuhn & Prescott, 2004; Tiecher, Samson, Polcari & Andersen, 2009). A meta-analysis examining treatment outcomes in depression for survivors of maltreatment in childhood reported that individuals were twice as likely to develop recurrent depression and were more likely to show poor treatment outcomes for psychotherapy, pharmacological treatment and combined treatment (Nanni, Uher & Danese, 2012). It should be noted that childhood maltreatment was not limited to sexual abuse but included physical abuse, neglect and family violence. In their review Whiffen and MacIntosh (2005) nominated a number of mediators between CSA and depression. These included high levels of shame and self-blame associated with psychological maladjustment, a lack of a robust support system as a protective factor against depression and a restricted range of coping behaviours leading to maladaptive strategies being over-utilised.

A clinical trial in the child and adolescent population reported that abuse-focused psychotherapies decreased co-occurring depression symptoms, in addition to having a primary effect in reducing PTSD symptoms (Aderka, Foa, Applebaum, Shafran & Gilboa- Schechtman, 2011). Liverant, Suvak, Pineles and Resick (2012) examined the association between changes in PTSD and depression symptoms during the course of Cognitive Processing Therapy (CPT) for adult participants who had experienced various Type 1 and Type 2 traumas. In the parent study 78% of
the sample reported CSA, but only 38% nominated CSA as the index event for therapy focus (Resick et al., 2008). The lagged mediation analysis reported that change in PTSD symptoms and depression symptoms occurred concurrently and that there was no evidence to support the temporal precedence of changes in one of these variables over the other.

A number of systematic reviews which focused on a range of difficulties provided evaluations of psychological interventions for survivors of CSA. These were from various theoretical perspectives and included both individual and group formats. Each reported that abuse-focused psychotherapy treatments are effective in symptom reduction and increased functioning (Cahill, Llewelyn & Pearson, 1991; Callahan, Price & Hilsenroth, 2004; de Jong & Gorey, 1996; Kessler, White & Nelson, 2003; Martsolf & Draucker, 2005; Peleikis & Dahl, 2005; Price, Hilsenroth, Petretic-Jackson & Bonge, 2001). In addition all highlighted the methodological limitations of the studies reviewed and called for a more rigorous evaluation using strong methodological design. Furthermore Cahill et al. recommended that the most effective form of treatment for working with survivors of CSA needed to be uncovered and its characteristic features identified.

Taylor and Harvey's (2010) meta-analysis of the effects of psychotherapy with adults sexually abused in childhood included nineteen independent sample studies and twenty-six repeated measures studies. It focused on six domains of outcome which included PTSD/trauma symptoms, internalising symptoms, externalising symptoms, interpersonal functioning, self-concept/self esteem and global symptoms or functioning. The study concluded that overall psychotherapy for the treatment of psychological affects of CSA was beneficial but that different therapy characteristics moderate the effectiveness of intervention depending on the outcome domain of interest. There were a wide range of treatment goals across the studies but the amelioration of PTSD symptoms was often a primary focus of treatment. Furthermore the study did not separate internalising
symptom domain into depression and anxiety but reported that the single clear moderator was
cognitive-behavioural therapies in producing the greatest effect size in this domain.

This systematic review aims to evaluate the effectiveness of psychotherapy on depression outcomes
for adult survivors of CSA. The review will employ strict inclusion criteria to ensure that only
studies of the highest methodological quality are identified for review.

**Method**

**Inclusion criteria:**

The following eligibility criteria were used to identify studies and was based on recommendations
from the Cochrane Handbook for Systematic Reviews of Interventions (Higgins & Green, 2011):

**Types of study:** (i) Randomised controlled trials (RCT) of psychotherapy for survivors of childhood
sexual abuse. (ii) Studies where the control participants did not receive active treatment, thus
excluding studies where control participants received treatment as usual or medication. (iii) The
intervention examined was the only difference between groups, thus studies which included
concurrent therapy were excluded. (iv) Reported in the English language.

**Types of participant:** (i) Participants aged 18 years or above. (ii) The majority of the sample, i.e.
more that fifty per cent had experienced CSA.

**Types of intervention:** This study used Weisz, Weiss, Alicke and Klotz (1987) definition of therapy,
“any intervention designed to alleviate psychological distress, reduce maladaptive behaviour or
enhance adaptive behaviour through counselling, structured or unstructured interaction, a training
program, or a predetermined treatment plan” (p.543). A range of interventions were included by
reason of a lack of clear evidence on what protocols most effectively treat depression for survivors.

**Types of outcome measure:** (i) Validated continuous measures of depression symptom severity. (ii) Collected at both pre and post intervention, and follow-up where applicable. (iii) Data sufficient for estimating effect sizes.

**Search strategy:**

The following search strategies were used to generate the sample of studies: (i) Computerized electronic searches of medical and social scientific databases (PsycINFO, EMBASE, MEDLINE, PILOTS, ASSIA) for articles published before 2013, using the search terms: ['sex* abuse' OR 'child abuse'] AND ['treatment' OR 'therapy' OR 'intervention'] AND ['outcome'] AND [depression] with a search limit of adulthood. (ii) The reference lists of the articles identified for inclusion in the review were checked. Also studies which cited the articles identified were appraised. (iii) The following journals were hand-searched from 2008 to 2013: Journal of Aggression, Maltreatment and Trauma; Journal of Consulting and Clinical Psychology; Journal of Rational-Emotive & Cognitive-Behaviour Therapy; Journal of Trauma and Dissociation; Journal of Traumatic Stress; Psychological Trauma, Research, Practice and Policy; Psychotherapy Research; Social Work Research.

**Study selection & Data collection:**

Using the eligibility criteria outlined above, abstracts were initially reviewed in order to determine suitability for inclusion in a full-text review. At the second stage of screening full texts were reviewed and a total of ten papers were selected for methodological review and appraisal. A flowchart of the selection process appears at Appendix A. Information about study characteristics, participant characteristics, intervention and outcome data were extracted.
Quality appraisal:

A quality assessment tool was developed to evaluate the strength of the methodological rigour for the studies. This was based on the Scottish Intercollegiate Guidance Network methodology checklist for Randomised Control Trials and information was collated using the SIGN 50 check-list and study design algorithm (SIGN 2008). There were ten quality criteria across five dimensions which included (i) research question and objectives (ii) chance of bias (iii) statistical issues (iv) outcome measures and (v) quality of the intervention. Each quality criterion was classified as 'well-covered' (1 point), 'adequately addressed' (0.5 points) and 'poorly addressed', 'not addressed' and 'not reported' (0 points). The scores were summed to produce an overall quality rating score out of ten.

These were categorised in order to provide an overall descriptive quality rating of each study. Studies that scored 7 or more were given a 'good' grade indicating few flaws and a low risk of bias, studies that scored between 5 and 7 were given a grade of 'fair' indicating some flaws and a moderate risk of bias, those studies with scores less than 5 were given a grade 'weak' indicating significant flaws and a high risk of bias in their methodology. In an attempt to reduce bias in ratings five studies were co-rated by an independent researcher. An agreement of 88% was found. All articles with differences greater than one mark were reviewed and amended through discussion. Although the rating scale does not provide an exact comparative measure across studies, it does offer a guide to their relative methodological strength.

Effect size:

In addition the effect size for the therapeutic intervention was calculated for each of the studies. Cohen's d was used to calculate the magnitude and direction of effect and represents the standardised mean difference (Cohen, 1988). An effect size for the active treatment group compared to the control condition at post-treatment is reported. Where applicable an effect size is calculated for the active treatment group between post-treatment and the longest available follow-up point.
The benchmark for interpretation of effect size consists of 0.2 equates to a small effect, 0.5 equates to a medium effect and 0.8 equates to a large effect (Volker, 2006).

Results

Study selection:
A total of 916 potentially relevant studies were screened for inclusion and their title and abstract screened. 740 of these were excluded at stage one as they were either purely theoretical, included a child population, or psychotherapy for CSA was not the focus of intervention. Once duplicates of the remaining articles were removed, the full texts of 129 articles were retrieved and assessed for eligibility. At this stage 119 articles were excluded for a range of reasons, including the study was not a randomised control trial or did not have a control group, it was not an independent dataset, the majority of the participants had not experienced CSA, a depression measure was not used, the effect size was not computable, the study was not written in the English language and participants accessed concurrent therapy that was not assessed.

Characteristics of included studies:
Ten RCT studies met requirements for inclusion in the review. All of the studies were conducted in the United States from 1989 to 2008. Participants' characteristics for the included studies involved a total of N = 585 participants, with sample sizes ranging from 12 to 166. All of the sample participants were female and the average age ranged from 31 to 40 years. With regards to format, five studies employed a group format, four studies evaluated individual treatment. One study employed a combined format. An overview of the studies and their findings is presented for each RCT, see Table 1 for sample characteristics and Table 2 for summary of studies included.
Various goals of therapy were identified in the included studies. The majority of the studies set out to treat the psychological effects or trauma symptoms of CSA, such as depression, emotion regulation, interpersonal problems, self esteem, anxiety, anger, dissociation, psychological health (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Bradley & Follingstad, 2003; Cole, Sarlund-Heinrich & Brown, 2007; Edmond, Rubin & Wambach, 1999; Freedman & Enright, 1996). Chard (2005) and Cloitre, Koenen, Cohen & Han (2002) studies focused on the amelioration of both PTSD and psychological effects of CSA. Three of the studies explicitly intended to treat PTSD following CSA (Classen et al., 2011; Krupnick et al., 2008; McDonagh et al., 2005).
Table 1: Sample Characteristics

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample</th>
<th>Age onset</th>
<th>Ethnicity</th>
<th>Education mean</th>
<th>Martial description</th>
<th>N - ITT N - completed</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexander et al. (1989)</td>
<td>Women</td>
<td>6</td>
<td>76% Caucasian 24% African American</td>
<td>13.7 years</td>
<td>39% single 36% married 20% divorced</td>
<td>65 57</td>
<td>America</td>
</tr>
<tr>
<td>Bradley &amp; Follingstad (2003)</td>
<td>Women Mean age 37 Incarcerated</td>
<td>DNR</td>
<td>38% Caucasian 62% African American</td>
<td>DNR</td>
<td>DNR</td>
<td>49 31</td>
<td>America</td>
</tr>
<tr>
<td>Chard (2005)</td>
<td>Women</td>
<td>6.4</td>
<td>81.4% Caucasian 14% African American 4.5% Other</td>
<td>13.83 years</td>
<td>DNR</td>
<td>71 55</td>
<td>America</td>
</tr>
<tr>
<td>Classen et al. (2011)</td>
<td>Women</td>
<td>6.65</td>
<td>63% Caucasian 7.9% African American 29.1% Other</td>
<td>DNR</td>
<td>36% single 32% married 26% divorced</td>
<td>166 141</td>
<td>America</td>
</tr>
<tr>
<td>Cloitre et al. (2002)</td>
<td>Women</td>
<td>DNR</td>
<td>46% Caucasian 20% African American 34% Other</td>
<td>DNR</td>
<td>42% single 34% married 24% divorced</td>
<td>58 46</td>
<td>America</td>
</tr>
<tr>
<td>Cole et al. (2007)</td>
<td>Women</td>
<td>DNR</td>
<td>33% Caucasian 11% African American 66% Other</td>
<td>12.5 years</td>
<td>56% single 11% married 33% divorced</td>
<td>13 9</td>
<td>America</td>
</tr>
<tr>
<td>Study</td>
<td>Sample</td>
<td>Age onset</td>
<td>Ethnicity</td>
<td>Education mean</td>
<td>Martial description</td>
<td>N - ITT</td>
<td>N - completed</td>
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</tr>
<tr>
<td>Edmond et al. (1999)</td>
<td>Women</td>
<td>6.5</td>
<td>85% Caucasian</td>
<td>15 years</td>
<td>24% single</td>
<td>59</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Mean age 35</td>
<td></td>
<td></td>
<td></td>
<td>53% married</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>23% divorced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freedman &amp; Enright (1996)</td>
<td>Women</td>
<td>6.3</td>
<td>100% Caucasian</td>
<td>15 years</td>
<td>42% single</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mean age 36</td>
<td></td>
<td></td>
<td></td>
<td>25% married</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>33% divorced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Krupnick et al. (2008)</td>
<td>Women</td>
<td>DNR</td>
<td>6.2% Caucasian</td>
<td>12 years</td>
<td>42% single</td>
<td>48</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Mean age 32</td>
<td></td>
<td>75% African American</td>
<td></td>
<td>35% married</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>18.8% Other</td>
<td></td>
<td>23% divorced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>McDonagh et al. (2005)</td>
<td>Women</td>
<td>6.6</td>
<td>93.6% Caucasian</td>
<td>DNR</td>
<td>55% married</td>
<td>74</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Mean age 40</td>
<td></td>
<td>1.6% African American</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4.6% Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DNR: Did Not Report
Table 2: Summary of Studies Included

<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment &amp; Length of Intervention</th>
<th>Treatment Goals</th>
<th>Control Condition</th>
<th>Follow Up Period</th>
<th>Measure</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexander et al. (1989)</td>
<td>Interpersonal Transaction Group (IT) &amp; Interpersonal Process Group (IP) 10 weekly sessions</td>
<td>Treat CSA</td>
<td>Wait-list</td>
<td>6 months</td>
<td>BDI (Beck et al., 1961)</td>
<td>Both groups improved depression over wait-list, gains maintained at follow up</td>
</tr>
<tr>
<td>Bradley &amp; Follingstad (2003)</td>
<td>Two stage intervention: Combined DBT skills &amp; written assignments 18 sessions</td>
<td>Reduce mood and trauma symptoms</td>
<td>Control group</td>
<td>NA</td>
<td>BDI II (Beck et al, 1996)</td>
<td>Significant decrease in depression symptomatology</td>
</tr>
<tr>
<td>Chard (2005)</td>
<td>CPT for Sexual Abuse 26 sessions: 17 group &amp; 9 individual 17 weeks</td>
<td>Treat PTSD related to CSA</td>
<td>Wait-list</td>
<td>3 &amp; 12 months</td>
<td>BDI II (Beck et al, 1996)</td>
<td>Significant change in treatment condition that was maintained at follow up</td>
</tr>
<tr>
<td>Classen et al. (2011)</td>
<td>Trauma-Focused Group Psychotherapy (TFGT) &amp; Present-Focused Group Psychotherapy (PFGT) 24 sessions</td>
<td>Treat PTSD, reduce HIV risk</td>
<td>Wait-list</td>
<td>6 months</td>
<td>TSI (Briere et al. 1995)</td>
<td>A trend for improving depression, reported an advantage for treatment on depression</td>
</tr>
<tr>
<td>Study</td>
<td>Treatment &amp; Length of Intervention</td>
<td>Treatment Goals</td>
<td>Control Condition</td>
<td>Follow Up Period</td>
<td>Measure</td>
<td>Outcome</td>
</tr>
<tr>
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</tr>
<tr>
<td>Cloitre et al. (2002)</td>
<td>Two phased CBT: skills training (STAIR) &amp; prolonged exposure 16 sessions 12 weeks</td>
<td>Treat PTSD, emotion regulation &amp; relationship difficulties</td>
<td>Wait-list</td>
<td>3 &amp; 9 months</td>
<td>BDI (Beck et al., 1961)</td>
<td>Significant change at post-treatment for depression, gains maintained at follow up</td>
</tr>
<tr>
<td>Cole et al. (2007)</td>
<td>Trauma-Focused Group 16 sessions</td>
<td>Treat CSA</td>
<td>Wait-list</td>
<td>NA</td>
<td>TSI (Briere et al.1995)</td>
<td>No significant change for depression symptomatology</td>
</tr>
<tr>
<td>Edmond et al. (1999)</td>
<td>EMDR &amp; Routine Individual Treatment 6 sessions</td>
<td>Reduce trauma symptoms</td>
<td>Wait-list</td>
<td>3 months</td>
<td>BDI (Beck et al., 1961)</td>
<td>Both groups significant improvement at post-treatment</td>
</tr>
<tr>
<td>Freedman &amp; Enright (1996)</td>
<td>Long-term Forgiveness Therapy 17 sessions</td>
<td>Improve psychological health</td>
<td>Wait-list</td>
<td>12 months</td>
<td>BDI (Beck et al., 1961)</td>
<td>Significant impact in reducing depression scores</td>
</tr>
<tr>
<td>Krupnick et al. (2008)</td>
<td>IPT 16 weeks</td>
<td>Treat PTSD related to CSA and co-morbid depression</td>
<td>Wait-list</td>
<td>4 months</td>
<td>HRSD (Hamilton, 1960)</td>
<td>Significant impact on depression scores at post-treatment. Follow-up data collected for both conditions</td>
</tr>
<tr>
<td>McDonagh et al. (2005)</td>
<td>CBT &amp; Present-Centred Therapy (PCT) 14 sessions</td>
<td>Treat PTSD related to CSA</td>
<td>Wait-list</td>
<td>3 &amp; 6 months</td>
<td>BDI (Beck et al., 1988)</td>
<td>CBT was comparable to PCT for depression symptomatology</td>
</tr>
</tbody>
</table>

DBT: Dialectical Behavioural Therapy; CPT: Cognitive Processing Therapy; CBT: Cognitive Behavioural Therapy; EMDR: Eye Movement Desensitisation and Reprocessing; IPT: Interpersonal Psychotherapy
Methodological quality appraisal:

Of the studies included in the review, the scores of the summed criteria ranged from 2.5 to 7 suggesting a range of weak to good methodological quality. A number of factors was responsible for these varied scores, in particular most studies achieved a low score because of poor or absent reporting of a criterion rather than study design or failure to meet a criterion. A table displaying the scores for each dimension is set out in Appendix B.

Research question and Objectives:

The majority of the studies achieved high scores in the dimension of research question and objectives. Theory should guide treatment interventions and clear aims and objectives are important when ascertaining if a study achieved their goals. Most addressed an appropriate and clearly focused question drawn from a theoretical model or previous research and provided rationale for the intervention. An adequate rating was given when the aims and hypothesis of the study were not clearly stated, these included Alexander, Neimeyer, Follette, Moore & Harter, 1989; Chard, 2005; Cole, Sarlund-Heinrich & Brown, 2007; Freedman & Enright, 1996.

Chance of Bias

Chance of bias being introduced into the studies design was assessed by (i) randomisation (ii) concealment (iii) attrition rates and (iv) the intervention which was assessed was the only therapy the treatment arm accessed.

The reporting of randomisation of participants to groups varied from poorly addressed to well covered. Classen et al. (2011) and Cole, Sarlund-Heinrich & Brown (2007) studies reported appropriate methods of random selection. Bradley & Follingstad (2003), Freedman & Enright (1996) and McDonagh et al. (2005) reported randomisation was used, but did not specify how this
was achieved. The remainder either used methods such as allocation based on date of birth, which is not pure in the randomisation method because it does not prevent potentially confounding subject characteristics from being systematically assigned to one treatment arm (Schulz & Grimes, 2002). The poor reporting of concealment methods used made it difficult to assess whether the chosen method was susceptible to bias and eight of the studies did not report on concealment. For those that did report an appropriate method of concealment was used and researchers collecting data were blind to the assigned conditions of the participants (Chard, 2005; Classen et al. 2011).

Rates of attrition can impact on treatment findings, especially if there is differential attrition between group arms. When there is a differential attrition rate it is difficult to determine if this is due to the nature of the intervention or other factors such as the personality characteristics of the participants in the group. In order to have confidence in the results of an intervention it is recommended that at least 80% of participants should complete treatment (Desmond, Maddux, Johnson & Confer, 1995). In the studies reviewed, attrition rate for the active treatment group ranged from no drop out during treatment (Edmond, Rubin & Wambach, 1999) to 54% (Bradley & Follingstad, 2003). Three of the studies had an attrition rate of less that 20% (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Chard, 2005; Edmond et al. 1999). All of these studies ran analysis to ascertain differences between those who completed and those who dropped out of treatment. The remainder of the studies did not report the percentage of individuals who dropped out before the study was completed in each treatment arm or otherwise statistically account for drop out rate in their findings.

Only two studies (Classen et al., 2011; Edmond, Rubin & Wambach, 1999) reported on participants accessing non-treatment therapy during the follow-up period which could influence findings. It is important in research trials that the intervention which is assessed is the only difference between the
treatment group and the control group. If participants undergo other types of therapy it is impossible to determine if this, the intervention or both are responsible for the outcome scores.

**Statistical Issues:**
Statistical issues were assessed by (i) baseline similarities (ii) Intention To Treat (ITT) and (iii) power calculations. The studies varied in their management of these. Overall, McDonagh et al., (2005) study achieved the highest score in this domain which indicates that it performed the best in terms of methodology rigour. The studies conducted by Alexander, Neimeyer, Follette, Moore & Harter (1989), Cole, Sarlund-Heinrich & Brown (2007) and Freedman & Enright (1996) failed to meet any of the criteria for statistical issues.

Only three studies provided clear details of psychological distress being similar among groups at baseline (Chard, 2005; Edmond, Rubin & Wambach, 1999, and McDonagh et al., 2005). The remainder of the studies either did not report it or when they did, they did not support it with statistical analysis. Apart from the study by Bradley & Follingstad (2003) all of the studies used wait-list controls. Participants who served as the wait-list group accessed treatment once post-treatment data from the initial trial was collected with the exception of Krupnick et al. (2008) and Classen et al. (2011); wait-list participants in these studies received treatment after the follow-up period (4 months and 6 months consecutively). For the majority of studies it was difficult to determine the accurate number of participants who were initially recruited and who comprised the control groups. Only Alexander, Neimeyer, Follette, Moore and Harter (1989) and Edmond et al. explicitly stated that outcome data for each participant were limited to data obtained during the wait-list period.

The majority of studies did not use ITT principles to incorporate results from participants who did
not complete the intervention in their analysis. The four studies that did use ITT in their analysis included Classen et al. (2011), Chard (2005), Krupnick et al. (2008), and McDonagh et al. (2005) and all included clear and appropriate details of this process. None of the studies reported a power calculation, the most likely reason being that the small sample sizes made the studies underpowered. The number of participants in the treatment groups ranged from 4 to 56. Adequate power is important for the detection of differences in effect sizes.

Outcome Measures:
All of the studies used standardised self-report questionnaires for the purpose of monitoring symptoms and measuring intervention outcomes for depression. Beck Depression Inventory (BDI) was most frequently utilised. Other psychometric measures included the Trauma Symptom Inventory (TSI), and the Hamilton Rating Scales for Depression (HRSD). All of these measures have established reliability and validity for assessing depression for survivors of interpersonal trauma.

Depression was a primary outcome for the majority of the studies (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Bradley & Follingstad, 2003; Chard, 2005; Cloitre, Koenen, Cohen & Han, 2002; Cole, Sarlund-Heinrich & Brown, 2007; Edmond, Rubin & Wambach, 1999; Freedman & Enright,1996). For the remainder of the studies the primary aim was to treat PTSD following CSA and the effect on depression was a secondary outcome. By reason of this review's aim to examine depression outcomes for survivor's of CSA, studies with secondary outcomes were included. However, it is not clear if depression scores improved as a result of alleviating PTSD symptoms or if the interventions directly improved depression.
Quality of the Intervention:

The quality of the intervention was well covered and most met the criterion of fidelity adequately. All provided sufficient information of the intervention design which appeared to be delivered as planned. All of the studies followed a treatment manual. The use of standardized treatment protocols is important as it provides accurate results of the effectiveness of the treatment and allows for replication. Measuring fidelity in delivering the treatment protocol was varied and ranged from formal supervision (Krupnick et al., 2008), reviewing recordings of sessions (Alexander et al., 1989; Chard, 2005; Classen et al., 2011; Cloitre et al., 2002; Edmond et al., 1999 Freedman & Enright, 1996; McDonagh et al., 2005) to evaluating therapists notes (Cole et al., 2007). Bradley & Follingstad (2003) did not provide details to assess fidelity.

External Validity:

Although not formally assessed in the methodological quality check-list, information was gathered on external validity of the included studies. Recruitment of participants for the majority of studies was through self-referral, by means of advertisements and flyers (Alexander et al., 1989; Chard, 2005; Classen et al., 2011; Cloitre et al., 2002; Edmond et al., 1999). The participants for two studies were incarcerated (Bradley & Follingstad, 2003; Cole et al., 2007). Krupnick et al. (2008) recruited non-treatment seeking women through family planning and gynaecology clinics. The remaining two studies (Freedman & Enright, 1996; McDonagh et al., 2005) were unclear in their recruitment procedure. All reported that the psychological distress of the participants was similar to those found in clinical samples.

Clear inclusion and exclusion criteria across study designs are recommended for strong outcome research to allow for findings to be generalised. The inclusion criteria used in the studies varied widely. The most common inclusion criteria included a PTSD diagnosis (Chard, 2005; Cloitre et al.,
2002, Krupnick et al., 2008); one explicit memory of CSA (Chard, 2005; Classen et al., 2011; Cloitre et al., 2002) with the perpetrator being 5 years older (Classen et al., 2011; Cloitre et al., 2002; McDonagh et al., 2005). Exclusion criteria were much more consistent across studies. The majority of studies excluded participant with a substance misuse problem (Alexander et al., 1989; Chard, 2005; Cloitre et al., 2002; Freedman & Enright, 1996; Krupnick et al., 2008; McDonagh et al., 2005), suicidal intent (Alexander et al., 1989; Chard, 2005; Classen et al., 2011; Cloitre et al., 2002; Edmond et al., 1999; McDonagh et al., 2005) or a serious psychopathology (Alexander et al., 1989; Classen et al., 2011; Cloitre et al., 2002; Edmond et al., 1999: Freedman & Enright, 1996; Krupnick et al., 2008; McDonagh et al., 2005).

All studies included a follow-up period in their evaluation, with the exception of Bradley and Follingstad, (2003) and Cole et al. (2007). The follow-up period ranged from three months to a year and three studies included two points of data collection post-intervention (Chard, 2005; Cloitre, Koenen, Cohen & Han, 2002; and McDonagh et al., 2005). Follow-up data is important to demonstrate if treatment gains are maintained. The effect size for post-treatment scores and scores from the longest available follow-up time point for the active treatment condition were calculated.

**The effectiveness of interventions for depression:**

At post-treatment, for studies with depression as a primary outcome, the effect size between active treatment and control conditions ranged from $d = 0.12$ to $d = 1.42$ (small to large effect size). The largest effect size of $d=1.42$ was reported by Chard (2005). For studies with depression as a secondary outcome, the effect size ranged from $d = 0.23$ to $d = 1.28$ (small to large effect size).

At the follow-up time period the effect size for studies with depression as a primary outcome ranged from $d = 0.02$ to $d = 0.99$, again indicating a small to large effect size for improvements in
depression symptoms. Edmond, Rubin & Wambach (1999) reported the largest effect size of 
d = 0.99 for EMDR. Of the studies that found a medium effect size, Chard (2005) reported d = 0.5 
at 12 month follow up. The effect size for studies with depression as a secondary outcome, ranged 
from d = 0.05 to d = 0.56.

For the studies where depression was a primary outcome, the average effect size for group 
interventions at post-treatment was d = 0.54, for individual psychotherapy with a trauma focused 
intervention, the average effect size was d = 0.81. The strongest study in relation to methodological 
vigour and the largest effect size employed both group and individual format (Chard, 2005).

These effect sizes should be interpreted with caution by reason of the heterogeneous nature of the 
studies included. The risk of bias within studies design as ascertained by the quality assessment 
means that effect sizes calculated are most likely an overestimation.
<table>
<thead>
<tr>
<th>Study</th>
<th>Quality rating</th>
<th>Primary or Secondary Outcome</th>
<th>Effect Size at Post-Treatment</th>
<th>Effect Size at Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexander et al. (1989)</td>
<td>4 (weak)</td>
<td>Primary</td>
<td>IT: d=0.6</td>
<td>IT: d=0.07</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>IP: d=0.12</td>
<td>IP: d=0.02</td>
</tr>
<tr>
<td>Bradley &amp; Follingstad (2003)</td>
<td>3 (weak)</td>
<td>Primary</td>
<td>d=0.51</td>
<td></td>
</tr>
<tr>
<td>Chard (2005)</td>
<td>7 (good)</td>
<td>Primary</td>
<td>d=1.42</td>
<td>d=0.5</td>
</tr>
<tr>
<td>Classen et al. (2011)</td>
<td>6.5 (fair)</td>
<td>Secondary</td>
<td>TFGT: d=1.28</td>
<td>DNR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PFGT: d=0.23</td>
<td></td>
</tr>
<tr>
<td>Cloitre et al. (2002)</td>
<td>5 (fair)</td>
<td>Primary</td>
<td>d=1.24</td>
<td>DNR</td>
</tr>
<tr>
<td>Cole et al. (2007)</td>
<td>2.5 (weak)</td>
<td>Primary</td>
<td>d=0.94</td>
<td></td>
</tr>
<tr>
<td>Edmond et al. (1999)</td>
<td>4 (weak)</td>
<td>Primary</td>
<td>EMDR: d=0.78</td>
<td>EMDR: d=0.99</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Routine: d=0.49</td>
<td>Routine: d=0.1</td>
</tr>
<tr>
<td>Freedman &amp; Enright (1996)</td>
<td>3 (weak)</td>
<td>Primary</td>
<td>d=1.2</td>
<td>d=0.26</td>
</tr>
<tr>
<td>Krupnick et al. (2008)</td>
<td>5.5 (fair)</td>
<td>Secondary</td>
<td>d=0.97</td>
<td>d=0.56</td>
</tr>
<tr>
<td>McDonagh et al. (2005)</td>
<td>7 (good)</td>
<td>Secondary</td>
<td>CBT: d=0.51</td>
<td>CBT: d=0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PCT: d=0.79</td>
<td>PCT: d=0.17</td>
</tr>
</tbody>
</table>

Discussion:

This review systematically evaluated the efficacy of psychotherapy on depression for survivors of CSA, based upon evidence from RCTs. Methodologically, the quality of the studies reviewed varied greatly. However in all studies, participants in the treatment group performed better than their control counterparts. This indicates that psychotherapies focused on alleviating distress resulting from the experience of CSA have positive gains for improving depression scores, even when depression is not the focus of the intervention. Good methodological quality was noted in two studies (Chard, 2005; McDonagh et al., 2005). Three studies achieved a fair methodological quality (Classen et al., 2011; Cloitre, Koenen, Cohen & Han, 2002; Krupnick et al., 2008). For the remainder, a weak methodological quality was noted (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Bradley & Follingstad, 2003; Cole, Sarlund-Heinrich & Brown, 2007; Edmond, Rubin & Wambach, 1999; Freedman & Enright, 1996).

Regardless of theoretical orientation, each of the studies reported favourable outcomes for depression symptoms. The two studies with the largest effect sizes were Chard et al. (2005) and Cloitre, Koenen, Cohen & Han (2002). Both followed Herman’s framework protocol for working with individuals with a complex trauma history. This includes working on safety and stabilisation in the present before moving onto remembrance and mourning of the past. The experience of CSA can negatively impact on an individuals capacity to develop emotion regulation skills and Herman (1992) emphasised the need to directly address these deficits. In addition to emotional distress, a history of CSA is also associated with interpersonal difficulties as it can create difficulties in trusting others as a source of support (Whiffen & MacIntosh, 2005). High levels of shame and blame can be present. These factors can make survivors isolated and further increases the risk of the development of depression (Herman, 2008). In both these studies, a skills training component focused on developing affect regulation abilities and improving interpersonal relationships, were
derived from cognitive-behaviour and dialectical behaviour therapy. Trauma narratives were
targeted through prolonged exposure and schemas, which developed in response to early abusive
experiences, were elicited and challenged. The focus of these studies was on relieving
psychological distress by targeting both PTSD and depression as primary outcomes. The findings of
this review support the theory that skills training and interpersonal difficulties need to be addressed
in treatment protocols.

McDonagh et al. (2005) study also used a prolonged exposure protocol in their CBT treatment arm,
but did not include the additional focus on skills training and interpersonal difficulties. The PCT
group in this study addressed interpersonal difficulties and the focus was on developing problem-
solving skills. Depression was a secondary outcome and the authors reported a large effect size for
depression in the PCT group and medium effect size for the CBT group. Two studies found to have
a fair methodological design and reported a large effect size for depression outcomes were Classen
et al. (2011) and Krupnick et al. (2008). The aims of both were to relieve PTSD symptoms as the
primary outcome. Classen et al. (2011) study compared trauma-focused group psychotherapy with
present-focused psychotherapy and a wait-list control. The trauma-focused group did not follow a
strict PE protocol but involved the activation of trauma memories and the exploration between
abusive histories and current affect-regulation and interpersonal difficulties. Krupnick et al. (2008)
study used a group format and focused on the link between PTSD and interpersonal difficulties, and
addressed ways of changing these relational patterns, such as social isolation associated with
avoidant/numbing symptoms and the re-enacting of past trauma associated with intrusive or hyper-
arousal symptoms. Although depression was not the primary focus of these studies’ interventions
the effect sizes for depression were in the ‘large’ category. Both studies reported a 'large' effect size
for PTSD. It is unclear if the relational focus of the intervention or the alleviation of PTSD
symptoms was responsible for the positive impact on depression scores. These results support
Liverant, Suvak, Pineles and Resick (2012) findings which suggest changes in PTSD and depression symptoms occurred concurrently.

Both group formats and individual interventions produced improved results for the experience of depression. Group treatment has been shown to have beneficial effects for survivors of complex trauma (de Jong & Gorey, 1996; Foy et al., 2000). In addition to being cost effective, group treatment provides members with an opportunity to normalise their experiences and focus on social dynamics. On the whole individual interventions within this review reported larger effect size, which may indicate that in this format individuals can access and process traumatic material which may be more problematic to address in a group setting. However the largest overall effect size observed occurred when both individual and group format was utilised (Chard, 2005), allowing the participants to access all benefits of group and individual formats.

These findings should be interpreted with caution due to a number of limitations in the studies’ methodologies. First, the small sample sizes and the exclusion of ITT analysis can inflate the effect sizes found. Hollis and Campbell (1999) recommended “intention to treat gives a pragmatic estimate of the benefit of a change in treatment policy rather than of a potential benefit in patients who received treatment exactly as planned” (p.673). If ITT is not calculated the clinical effectiveness of an intervention is prone to be overestimated. For the majority of the studies, the data available to calculate effect sizes were for those who completed the intervention as distinct from those who had dropped out, thus the effect size calculated for these studies were over inflated. Furthermore adequate power was not assessed and for the majority of the studies participant numbers were very small. The percentage of participants who dropped out in the studies reflects the number in other studies in the literature. However, the drop-out rates in clinical practice is estimated to be much higher, Zayfert et al. (2005) reported a 28% completion rate for CBT for PTSD in “real
world” clinical practice. In addition half of the studies excluded participants with substance misuse problems and psychopathology. Substance misuse and psychopathology are co-morbid difficulties significant in this population. This draws into question whether the participants are representative of a 'truly' clinical population. Further, although not specified in the inclusion criteria for the review, all the studies included were composed of women participants, thus sex differences are not addressed.

This review has a number of strengths. First, a transparent process of the quality assessment related to the nature of the research question was developed. Second, a high level of inter-reliability of the methodological quality of the studies was established by two independent raters which reduced the potential for subjective bias. Both of these factors strengthen the design of this systematic review.

The a priori decision to only include RCTs limited the number of studies that could be included in the review. This decision was made by reason of RCTs being considered the gold standard for clinical trials and previous reviews have recommended their evaluation. However this inclusion criterion limited the number of studies included in the review, which also satisfied the other inclusion criteria, resulting in only ten studies being included. Future reviews might benefit from considering other research designs and focus on specific theoretical models to allow for more meaningful comparisons to be made. Due to resource constraints, this review was limited in that only studies which were published in the English language and in peer-review journals were included. Future reviews might benefit from contacting authors in the field about unpublished research so as to reduce publication bias.

Individuals with a history of Type 2 trauma are significantly more likely to access mental health services and social services in comparison to their control group counterparts. These difficulties
creates a burden on the healthcare system. The high economic cost, in addition to ethical considerations, makes finding an effective and acceptable intervention for these individuals vital.

The findings of this review suggest treatment protocols which include traumatic processing in addition to attending to current affect regulation difficulties and interpersonal problems have the highest impact in reducing depression for this population. Of the three studies that used a PE protocol (Chard, 2005; Cloitre, Koenen, Cohen & Hans, 2002; McDonagh et al. 2005), all had modified it to include more sessions than the original protocol of ten. McDonagh et al. (2005) study, which most closely resembled the protocol developed by Foa and colleagues (2000), reported a high drop-out rate of 41.4%. Its primary components were Prolonged Exposure (PE), in vivo exposure and cognitive restructuring. The authors reported this intervention as highly effective in achieving remission of PTSD symptoms for completers but those that dropped out endorsed greater severity of non-PTSD symptoms such as depression and anxiety. Chard (2005) and Cloitre et al. (2002), which included components on skills training and interpersonal relationships in addition to PE, had lower drop-out rates (18% and 29% respectively). Both reported that the intervention worked equally well for PTSD and depression and highlighted the additional components as tolerable and effective. Future interventions should be designed with these considerations in mind. The findings also suggest interventions delivered in groups may produce large effects in reducing depression outcomes for women. Psychotherapy delivered in groups has the potential to not only reduce the healthcare costs but to do so in a cost-effective manner (Callahan, Price & Hilsenroth, 2004).

While the current review found that psychotherapy, from various theoretical models, had a positive impact on depression, more methodologically rigorous studies are needed to draw firm conclusions. Despite practical difficulties, such as recruitment and retaining participants, continuing to plague research designs in this population, certain measures can be easily included in future research, for example uniform inclusion and exclusion criteria to allow comparisons, and the inclusion of ITT
data in order to generate more conclusive findings. One new area, deserving of further exploration, is the use of IPT for the psychological difficulties encountered by CSA survivors. IPT was originally developed to alleviate symptoms of depression (Weissman, Markowitz & Klerman, 2000). However, Krupnick et al. (2008) results suggest that group-based IPT is beneficial in reducing PTSD symptoms and improve interpersonal functioning.

In summary this systematic review found that psychotherapy is effective for alleviating depression for survivors of abuse and these effects are largely maintained or improved at follow-up. The strongest evidence supports interventions that address a combination of skills deficits, cognitive restructuring of traumatic schemas and interpersonal functioning, for a reduction in both PTSD and depression symptoms. While the levels of depression were lowered by all interventions, the limitations of the included studies meant that firm conclusions could not be drawn. As Kessler et al. (2003) noted “as researchers in this area continue to identify the essential elements of effective treatment for CSA, the ability to detect subtle differences between treatment approaches will become important.” (p.1057). Here there is an echo of the recommendations of Cahill et al. (1991) twelve years earlier. It would appear that we are still in the process of ascertaining which treatment produces the most effective benefits for a CSA population with complex presentations. The findings from this review support Herman's Phased Intervention Model when addressing trauma symptoms for survivor's of CSA.
References


“I don't want to be this broken little girl anymore”

Tasks Involved in Shifting Shame and Guilt for Female Survivors of Childhood Trauma Accessing Therapy

*Key words:* emotions, shame, guilt, female childhood sexual abuse, qualitative research
Abstract

Shame and guilt are prevailing emotional experiences associated with psychological difficulty. This study explores the changing experience of shame and guilt for survivors of childhood trauma through the therapeutic process. It employs a prospective longitudinal qualitative panel design. Participants' accounts are explored using the Framework Approach. Two superordinate themes emerge: constructing a healthier sense of self and the process of change and self-discovery. Results suggest shame and guilt are important emotional experiences for survivors of childhood abuse and should routinely be assessed and addressed in therapy.
A strong correlation between experiencing abuse in the formative years of childhood and psychological difficulties in adulthood is documented in the literature. Yanos, Czaja, & Widom, (2010) reported that individuals with a history of childhood abuse were significantly more likely to access mental health and social services. The experience of Childhood Sexual Abuse (CSA) can negatively impact on an individual’s emotion regulation ability, impede the development of effective coping strategies and create difficulties in interpersonal relationships and identity formation (Herman, 1992). Increasingly the clinical presentation of adult survivors is understood and formulated in relation to the impact of abuse on the child’s development (Briere & Scott, 2006, ). In the UK 21% of girls and 11% of boys experience CSA (May-Chahal & Cawson, 2005). It is a chronic epidemic that can have a prolonged negative impact on the individual's quality of life and create a burden on the mental health system. Thus it is imperative that interventions designed to treat the psychological difficulties resulting from childhood abuse are built on sound empirical research.

It is increasingly recognised that shame and guilt are important emotional underpinnings of the psychological difficulties experienced by survivors of abuse (Beck et al., 2011; Hathaway, Boals & Banks, 2010; Negrao II, Bonanno, Noll, Putman & Trickett, 2005; Robinaugh & McNally, 2010). Indeed it has been argued that the interplay of primary emotions, namely happiness, fear, disgust, anger and sadness are the building blocks of emotional disorders (Power & Dalgleish, 2008). Shame and guilt belong to the disgust category and in moderation these self-conscious, moral emotions have an adaptive function and play a key role in the promotion of pro-social behaviour (Gilbert, 1997). Yet chronic states of these emotions can trap an individual in a destructive and vicious cycle. Shame is generally viewed as the more pervasive painful affect. Tangney, Wagner, Fletcher and Gramzow (1992), however, noted “both involve negative affect but the focus of the negative affect differs leading to distinct phenomenological experiences” (p.669).
It has been proposed that shame stems from global negative evaluations of the self, while guilt focuses on evaluations of specific behaviours (Lewis, 1971). Each is multifaceted in nature and involves a complex interaction of cognition, affect and behaviour. Not only are there different schools and theoretical approaches to understanding these emotions, but they can also be distinguished by their components and mechanisms. Tangney & Dearing (2002) conceptualised the key differences as, firstly, the focus and impact on the sense of self, global impairment in shame versus unimpaired self in guilt; secondly, on the emotional experience, such as feelings of worthlessness and powerlessness in shame versus remorse and regret in guilt, and thirdly, the consequential behaviours elicited such as a desire to escape and evade for shame versus an impulse to confess and repair for guilt. In a qualitative study investigating the experience of moving on from CSA, one of the key processes identified in recovery was a change in the survivors’ experience of shame and guilt which highlighted the need to deal effectively with these emotions (Chouliara, Karatzias & Gullone, 2013).

Theoretical accounts in the literature have postulated why exposure to chronic and repetitive abuse in childhood can lead to enduring negative consequences for the survivor. Finkelhor and Browne (1985) developed the Traumagenic Dynamics Model which proposed that the child's mental and emotional orientation to the world is disturbed by the event of sexual abuse. The four dynamics of the model are (i) traumatic sexualisation: the child's sexuality is altered and shaped by the abuse (ii) betrayal: the trust felt towards the perpetrator and those who failed to protect the victim is destroyed (iii) powerlessness: the child is helpless and unable to alter the situation (iv) stigmatization: the child develops a sense of being bad, guilty and responsible for the abuse. These are reinforced by the perpetrator's behaviour either by shaming and blaming or giving special attention and rewards to the victim.
Attachment refers to the biologically driven bond with a caregiver, two primary functions of which are to learn about the nature of relationships and develop affect regulation abilities. A central tenet is the internal working model. This mental construction, developed in the context of early relationships, forms the basis of personality. Relationship bound children learn of their own self-worth, develop expectations from others and the relationship between the two. Empirical research demonstrates that children with histories of chronic and repetitive abuse are more likely to develop insecure attachment styles (Schore & Schore, 2008). Drawing on attachment theory, Talbot (1996) proposed three major reasons why shame is a core emotional experience for survivors of CSA. First, for the construction of a healthy sense of self the development of self-control and power are crucial; abusive experiences remove a child's sense of power, forcing a helpless state and the doubting of capacity for control. Second, to maintain attachment, a child must deny or distort affective experience and the negative affect is directed inwards. While this has a short-term adaptive function it renders the child's experience of the self and others as incomplete and unintegrated. Third, in the absence of a nurturing environment, the child internalises a message of not being worthy of protection and of being instead an object to be used, thus forming an internal working model where basic needs of love and care are inherently shameful and others are a source of danger.

Cognitive theory is concerned with the progressive reorganisation of mental, faculties that is based on biological maturation and environmental experience, in which an individual thought processes develop. Two pathways to explain the development of shame-based and guilt-based PTSD were outlined by Lee, Scragg and Turner (2001). Both highlighted the role of early maladaptive schemas in understanding the meaning of traumatic events. In the first, shame and guilt were considered to arise because the traumatic event confirms, or is congruent with, underlying schemas. When this schema is activated it becomes the dominant mode of thinking and biases information received from the external world, thus reinforcing belief in self-inadequacy or defectiveness.
Avoidance of thoughts and behaviours associated with the traumatic event is employed as a coping strategy which in turn obstructs the individual’s emotional processing. The second route occurs when the meaning of the traumatic event is incongruent with an individual's schemas, leading to a sense of humiliation and the individual engaging in ruminative thoughts on their experiences, which in turn evokes feelings of shame and guilt. In addressing the two pathways to shame and guilt the authors highlight the importance of assessing meaning in the context of pre-existing schemas as a prerequisite to successful treatment.

Empirical research supports the hypotheses that survivors of CSA experience chronic levels of disgust based emotions and in particular shame. Andrews (1995) reported that bodily shame was an important mediator in the occurrence of depression for women with a CSA history. Holmes, Grey, and Young (2005) investigated emotions contained in ‘hotspots’ of trauma memory. The authors reported that in addition to fear, emotions of anger, sadness and shame were present at the peak of emotional distress. A longitudinal study which investigated abuse-related shame found individuals who reported persistent high shame-states maintained clinically significant levels of intrusive trauma symptoms six years after disclosure (Feiring & Taska, 2005). The authors concluded that persistent shame explained the failure to process abusive memories which in turn led to symptom maintenance of PTSD. A similar finding was reported in a study exploring emotions in victims of violent crimes who had a history of CSA (Andrews, Brewin, Rose & Kirk, 2000). At a six month follow up, shame was the only predictor of PTSD symptoms. Talbot, Talbot, and Tu (2004) reported that shame-proneness was associated with dissociation for women with a CSA history. Dutra, Callahan, Forman, Mendelsohn and Herman (2008) found that shame schemas and dissociation were significantly associated with PTSD symptoms in trauma survivors. Rüsch et al. (2007) reported women with Borderline Personality Disorder (BPD) experienced higher levels of shame and guilt which were associated with a poorer quality of life, self esteem and greater anger.
In a qualitative study exploring the role of attributions in the process of overcoming shame Van Vliet (2009) outlined three key elements: the identification of external causes, the shrinking of negative global self judgments and the increasing of a sense of self agency in the possibility of change, reporting a shift in global and stable attributions leading to the resolution of issues of shame. Where internal attributions were not present, the experience of shame was linked to events evoking humiliation, which does not necessarily involve self blame. Tangney and Dearing's (2002) conceptualisation of shame relies heavily on internal, global and stable attributions about the self, while Gilbert (1997) postulates that shame can occur in the absence of internal evaluations. The phenomena under investigation were shameful experiences in adulthood. It is important to note that shame states arising from experiences in adulthood differ from those developed in childhood. Herman (1992) explained: “repeated trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood forms and deforms the personality” (p.96). Van Vliet (2009) recommended longitudinal case studies to follow individual's recovery over time to further understand the attributions related to recovery.

To date there has been only one qualitative study in the literature focused on survivors of CSA experiences of these emotions, namely Dorahy and Clearwater (2012). This study explored the experiences of shame and guilt for adult males who were sexually abused as children. Cross-sectional analysis from a focus group revealed four themes: self-as-shame; pervasiveness and power of doubt and denial; uncontrollability, and dissociation. The study recommended further research focused on shame and guilt using an individual interview methodology. Furthermore the results highlighted how the secretive nature of shame facilitated denial among healthcare professionals about the realities and dynamics of abuse. Shame and guilt can be difficult to address directly in therapy because of transference and counter-transference issues. As Gilbert (1997) opined “in
therapy itself shame can exert a major impact on both patient and therapist, as each dance around
the other in concealed efforts to avoid 'being shamed' and having inadequacies exposed” (p.114).
However, Lee Scragg and Turner (2001) cautioned if not addressed shame and guilt can impact
effective help-seeking behaviours; be responsible for treatment drop out, and may serve to
aggravate trauma symptoms particularly within exposure-based interventions.

Although it has been demonstrated that shame and guilt have a mediating relationship between
childhood trauma and emotional distress and should be assessed to inform therapeutic interventions,
the actual role these emotions play in the recovery process has not yet been vigorously investigated.
Most studies focus on retrospective accounts. What is less clear is the emotional journey undertaken
by these individuals, psychological processes are involved in their resolution. The aim of this
research is to explore through the therapeutic process the changing experience of shame and guilt in
female survivors of CSA.

Method
Design
To address the research aims this study employed a prospective longitudinal qualitative panel
design. A prospective longitudinal design was deemed most appropriate because it allowed the
dynamics of change and the experience of these emotions to be captured at different time points.

Data Collection
Participants were identified and approached by their health care professionals with a view to taking
part in the research and when interested were given a Participant Information Sheet (see Appendix
C). Adult survivors of childhood trauma in receipt of therapy related to their abuse history was the
only inclusion criterion and those identified by their healthcare professional as having high suicidal
intent were excluded. Written consent was sought at both waves of data collection. Favourable ethical approval was obtained from local ethics and governance committees (see Appendix D).

Ten women agreed to participate in the research and were interviewed at the first round. Two were lost to follow-up, thus eight women were interviewed at a second time point. The period between the two waves of data collection ranged from three months to seven months, with an average of a five month interval.

The participants’ ages ranged from 26 to 58 years with a mean age of 40.3 years. All participants were of white British ethnicity. Four of the participants were living with their partners, five were living alone and one was living with her adult children. Seven participants had never married and the remaining three were divorced. Two of the participants identified with homosexual and eight with heterosexual orientation. Four of the participants had attained University qualifications, while the remaining six had reached secondary school level education. All the participants had previously worked. At the first round of interviews two had recently returned to full time employment after a period of sick leave, two were involved with voluntary work and the remaining six were unemployed. At the second round of interviews a further two participants had returned to work, one in a voluntary and the other in a paid capacity.

On average the participants had been in therapy for four months prior to the first interview. Information was also gathered from therapists about the therapeutic modality. The main model reported was Cognitive-Behavioural Therapy, however, most described using an eclectic mix of therapeutic models.
Data Analysis

Framework Method is a qualitative analysis approach developed by Ritchie and Lewis (2003) which explores themes, narratives and relationships in a dynamic and fluid manner. This approach was chosen over other qualitative approaches, such as Grounded Theory (Strauss & Corbin, 1990) or Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009), because it lends itself to analysing longitudinal qualitative data in a systematic and transparent manner and facilitates evaluations of change while remaining linked to raw data in the thematic matrices (Lewis, 2007). The stages within the Framework Method include: (i) data management and becoming familiar with the transcripts through reading and re-reading; (ii) identifying initial themes and categories so as to devise a conceptual framework; (iii) indexing and assigning data to the categories in the conceptual framework; (iv) thematic charting, summarising and distilling initial themes and categories, and developing abstract concepts so as to allow a 'whole picture' to emerge, and (v) generating descriptive and explanatory accounts of interpretations. The NVivo computer software programme was used to help organise the data.

All the interviews were transcribed verbatim and a reflective journal was kept by the principal investigator. The temporal structure of the data was retained in its organisation within the thematic charts. Analysis of the data employed cross-sectional analysis at each time point and analysis of individual case narratives over the duration of the study.

Results

The results of this analysis are divided into two sections. The first section is concerned with the research's first aim; how do survivors of childhood trauma experience the emotions of shame and guilt. The second part addresses the research question, what processes impact or change the experience of these emotions and how does therapy support this.
Section one: The development of a 'shameful self' as a consequence of childhood abuse

Several themes emerged from the interviews suggesting that shame had manifested due to the impact of childhood abuse on the development of the self and was a core emotion experienced in daily lives. Ultimately it was the way participants' attempted to manage shameful emotion which precipitated a crisis leading to a gateway to therapeutic services.

A prominent theme of a 'shameful self' reflected the participants' perception of self. At the initial round of interviews participants discussed feeling ‘defective’ and ‘damaged’. This negative internal view gave rise to descriptions such as 'stupid', 'broken', 'bad' and 'un-loveable', which originated in early relationships and reinforced low self-esteem:

*I would just say I am a big lump of rubbish... this ugly twisted mess just a mess that no one would want* (Participant 10: T1)

Strong sentiments of inward directed hate were revealed and words such as 'black' and 'dirty' were used in describing how the participants felt about themselves. Most reported an uncomfortable relationship with their bodies as it served as a reminder of their past:

*you feel dirty but you can never clean like inside you and all your bones just feel wrong... I would almost like to take off all of my own skin and burn it, that's the kind of disgust you feel, I just feel really uncomfortable in myself* (Participant 5: T1)

Engaging in self-harming behaviours functioned to inflict harm perceived to be deserved by the self. The idea of deserved pain and innate 'badness' hindered participants in developing a compassionate view of the self. One participant explained:

*I find it hard, this self soothing thing cause I don't know how to do it and it is hard to self soothe yourself, if you hate yourself how do you start* (Participant 7: T1)

Some survivors talked about not having a sense of ownership over how others treat them, and likened themselves to a 'puppet on a string' or 'a piece of meat'. In adulthood they reported
avoiding close connections with others. Reasons given included people being 'repulsed' if they knew their history, viewing themselves as a 'burden' on others and a sense of being 'false' or of 'pretending'. Abusive experiences had negatively affected self-worth with several describing themselves as 'outsiders' or 'the black sheep' in their family of origin. Avoidance of close connections ultimately led to feelings of isolation:

*I have never been wanted or loved or felt I don't know just taken care of, I just feel I am here for people to just do what they want with me (Participant 1: T1)*

There was an implicit link between 'being bad' and 'being responsible' for the abuse. All the participants had assumed varying levels of self-blame. Some spoke of being directly responsible, a belief was compounded by multiple perpetrators and/or abusive experiences in adulthood. Several referred to having a 'marker', which rendered them vulnerable to further abuse and reinforced feelings of shame:

*em the only way I make sense of it is that I just think it is my fault and for it to happen again in adulthood I must be doing something to encourage them... things that I had to do and things that were done to me it is just disgusting and I feel really embarrassed about it and feel wrong because I am to blame and the shame just goes along with that fact (Participant 1: T1)*

More commonly, survivors differentiated the power imbalance between the perpetrator and the child. However participants assumed blame in their perceived role in the continuation of abuse, either by not stopping it, or making an earlier disclosure to others.

All described chaotic and abusive home environments. With the exception of one participant whose mother died when she was young, all participants' described a turbulent relationship with their mothers and most acknowledged feelings of anger directed at the non-abusing parent:

*besides the abuse he [father] was my only pal growing up... I have a lot of hatred and anger towards her [mother] (Participant 9: T1)*

Confusion and uncertainty was a dominant feature in survivors’ narratives and consequently there
was a fragile internal locus of control:

> my brain keeps thinking these awful things are happening, I can't separate I can't understand, I am an adult now hmm those things don't happen any more, I don't want to be this broken little girl any more (Participant 5: T1)

The majority had repressed memories of their abusive experiences and several spoke about 'locking away' their childhood. Feelings of separation to the younger self were observed in the use of the third person pronoun. In distressing situations survivors talked about reverting back to and acting in a childlike manner. This reinforced self directed anger and their perceived inability to take control and behave in an 'adult' manner:

> I think that's part of the confusion I totally dislike this other person the young one... there is obviously still situations where just now I keep coming back to this little scared person and I wish I was I don't know somebody different em that is kind of hard actually because sometimes I just kind of blame the 7 year old really I suppose that all gets burdened onto the young one (Participant 2: T2)

Participants spoke of not having any respite from the past and from abusive memories. Phrases such as 'constant cloud' and 'death sentence' were used in illustration. Death was a considered antidote, and gaining 'peace' was exclusively offered as the reason for previous suicide attempts.

Cumulative negative cognitions, affects, behaviours and interpersonal difficulties contributed to survivors' feelings of powerlessness. All attributed having a 'break-down' as the primary reason for accessing therapy. Each had extensive previous contact with mental health services but were struggling, to cope by themselves prior to 'break-down'.

> I kinda had eh a break-down I had reached crisis point, I was getting really bad flashbacks and intrusions from my past and I had no control over them and it was like a film in your head that wouldn’t go off (Participant 5: T1)

> it took you know 30 years of blocking it out but it doesn't take that much for it to come back and that is quite scary as well you know because you think it is gone and it is not really (Participant 9: T2)
Section two: Pathways to developing a compassionate sense of self

A superordinate theme of a changing self-concept was the pathway in altering the impact of shame on the participants’ life. This included subordinate themes of increasing sense of agency, assertiveness and developing compassion. Therapy provided a safe space to explore and challenge the legacy of the past and helped participants to gain insight and make sense of confusion.

A marked change in how participants described themselves between the first and second interview was observed, which reflected a growing sense of self-worth and agency. A shift in a global and stable sense of 'being bad' to a tentative internal understanding and accepting relationship with the self was observed:

*I used to think that the core essence of me was essentially bad and that I didn't deserve to live but since the group I am clinging to the fact that there might be some good in me but it is wobbly at the moment* (Participant 7: T2)

At the second stage of interviews a movement in a sense of responsibility for the abuse was observed for most participants. The resolution of blame and of change in its underlying components of shame and guilt was a gradual process. There was a pattern of shifting from global shame and specific guilt towards absolution from blame:

*I know generally the abuse wasn't my fault, generally like on the whole but you know there are aspects of it that I can't forgive myself for and I am really finding that tough* (Participant 1: T2)

A turning point for participants was taking ownership and assuming responsibility for breaking maladaptive behavioural patterns. An important relationship was found between feeling more empowered and establishing a stronger internal locus of control. Some spoke of tapping into inner resources and learning to trust gut instincts on what was right for them.

There was also a marked difference in how participants reported interacting with others over the
course of the two interviews. At the first interview the majority spoke about not trusting others and keeping a distance as a means of protecting themselves from further hurt, and also as a means of avoiding further exposure and shame. By the second round of interviews participants were connecting differently with others, sharing their inner feelings. This shift was associated with more confidence in being assertive, and in establishing and maintaining boundaries:

*I have given up pretending I think it is a positive change that I have said to people explained about my anxiety and that I have depression and sometimes I can't face things I think it is good that I have been more honest, it feels quite empowering though the first time I did it I was scared because I thought I would be rejected* (Participant 10: T2)

Therapy played a key role in this transformation. Analysis revealed that participants had an inherent sense of being abnormal and fundamentally different to others which influenced their self-image of being shameful. Being able to place their experiences of abuse into a larger social context helped to decrease feelings of isolation. Many described normalisation of their difficulties and distress by therapists as helpful:

*It has impacted on everything, everything me whole life, me parenting, em me sense of who I am and my relationship with females and males I don't think there is any part that it hasn't impacted on, and I think when I realised that in therapy that is when I felt worse but at least it makes sense why me life has been so weird* (Participant 7: T2)

Increasing sense of agency was connected with making sense of emotions, cognitions and behaviours. The role of therapy in facilitating the development of insights into the link between emotions, cognitions and behaviours was articulated by the majority of participants:

*it was really helpful [therapy], linking awareness to what type of emotions were going through my head and a lot of that behaviour was about really wanting to damage myself... but not being able to self-harm, so finding another way of going out and making myself feel bad* (Participant 4: T1)

Most participants spoke about how making sense of and reappraising confusing messages received in childhood helped in relinquishing feelings of self-blame.

*I hate what he did to my mind, I feel that everything he told me had a slant on it so now I can't believe anything that he told me and I have to rethink a lot of things* (Participant 10: T1)
Participants spoke of the importance of providing a safe space to explore their abusive memories and how this helped them to get in touch with painful affects and gently challenge their sense of responsibility:

[therapist] has been really helpful and supportive...we're talking about the past and going over and over it until it loses its kind of grip on you (Participant 3: T2)

The majority of participants identified as helpful learning how past repetitive behavioural patterns perpetuated current difficulties. Developing an awareness of these patterns supported survivors in breaking repetitive practices and finding different ways of relating to the self and others:

in the past I realised that I either see people as rescuers all good or abusers all bad and then after the session I thought why do I think that and I thought it was because I am still a victim and how I always see myself as a victim but I don't want that any more (Participant 3: T2)

In addition gaining an understanding of why they behaved in a particular manner facilitated letting go of feelings of shame and guilt. A sense of resiliency and growth along with the beginnings of positive self-worth were reported by most participants:

I have made mistakes but I look back and think I was so alone I was so isolated how the hell was one person supposed to deal with all this and I do feel compassion for myself (Participant 7: T2)

All of the participants described the road to healing as a long and difficult journey. Survivors' reflected on a sense of sadness and on tasks that had to be negotiated, such as their role within the family. The majority of participants spoke of a 'wasted life' and made harsh judgements on how they have lived their lives as adults. This introspection was linked to processing loss, representing a difficult and critically important step in the therapeutic process:

all of this keeps coming up you know I am just going to have to learn you know understand it and probably never really know why it happened you... that is one of the hardest things to understand and accept (Participant 2: T2)

Connecting with painful emotions was a powerful factor in change and most acknowledged the importance of safety in the therapeutic relationship as important in this process.
what really helped me was that she [therapist] wasn't shocked because I think if she had been shocked that would have made me feel even more ashamed and guilty but the fact that she was very matter of fact about it that helped me so much and I was able to tell her things that I was so ashamed of (Participant 10: T2)

Several participants referred to their history 'bubbling under the surface' and most found verbalising and sharing their experiences difficult but helpful in diminishing its negative hold on their lives:

its been tough but a relief as well to talk to somebody because it just eats away inside (Participant 1: T2)

I think the guilt is what made me tell [therapist] the guilt was coming to the surface too much and feeling I was this terrible person and I had this hidden relationship and it is so awful... I was being consumed by guilt and then as soon as it came out to the light the guilt has started to go a bit (Participant 10: T2)

Participants' reported therapists reflecting change and instilling hope as valuable:

we were talking about the same sort of thing [progress] and she said you know I can see you have moved on and you are on that path and I don't I am still here treading water .....she says would you have been able to do that 6/7 months ago and I go probably not so when people put those points of view across I kind of trust and have belief and it does kind of help a little bit to see OK I have progressed (Participant 2: T2)

Figure 1 provides a proposed model of the conceptualisation of shame for survivor's of childhood abuse. Drawing from the results, it provides an explanatory account of how shame develops, the impact of this emotion in daily life and the mechanisms involved in its resolution.
Figure 1: A conceptual model for letting go of shame
This model conceptualises shame as a core experience for adult survivors of childhood abuse. The impact of abuse on the development of the self generates disturbances in identity [1] and in relationships [2]. In the absence of a secure attachment children develop internal working models of being inherently defective and unworthy and view others as dangerous and harmful. This in turn can prevent the abused child from confiding in others or seeking support and is further compounded by a chaotic home environment and a poor relationship with the non-abusing parent. Victims are alone in trying to make sense of their experiences and internalise a shameful sense of self and an overwhelming sense of blame for their experiences which generates confusion and further isolation [3].

The subsequent sequence to confusion and isolation is concealment. Cognitive maturation incapacitates the child to resolve resulting inner trauma on their own. As adults they become caught in cycles of behaviour which are motivated by perceived deserved harm, fear of others, anticipated rejection, failure to manage painful affect and a sense of powerlessness. Engulfed in the world of their abusers and in the pain of their abuse, there is no space for them to discover who they are outside of the abusive experience. Their identity, experience of relationships, maladaptive coping strategies, isolation and confusion [4] all contribute to the development and maintenance of a shameful sense of self.

At some point survivors are no longer able to cope with their experiences and there is a resulting 'breakdown' [5]. Help is mobilised and a referral to therapy is sought. Successful therapeutic intervention with survivors of childhood sexual abuse requires the unmasking of the shamed self and an eradication of any associated guilt. The path to recovery is through the instillation of a compassionate sense of self and an increased ability to reflect on their past and present difficulties [8]. Several experiences facilitate the survivor in moving on and shredding their shameful self. During this process survivors evaluate and reappraise cognitions, behaviours and
emotions which contributed to their break-down. The therapist offers a safe environment and relationship and initially holds the reflective space, providing a different view-point which can help individuals challenge long-standing beliefs. Normalisations, incorporating external factors, making links and gaining insight are central to letting go of the shame and guilt that have dominated their life [6]. An understanding and accepting relationship with the self is fostered, in which the individual is able to review their history compassionately. It is only then that the individual can begin to connect differently with others and work through painful affect which results in an increased sense of agency [7].

This model is supported by the literature. It is well established that CSA affects a child's developing sense of self. Indeed it has been postulated that at the core of sexual abuse is an annihilation of the self and as a result a 'contaminated identity' is formed (Herman, 1992). All the women in this study had a contemptible sense of self, in which pain and punishment were perceived as the rightful consequences of their early experiences. This is in keeping with Talbot's (1996) conceptualisation of shame being a core emotional experience for survivors of abuse. In order to maintain attachment as young children, these women internalised the negative affect and a powerless persona. They developed internal working models of being inherently shameful and as others being a source of danger and hurt. The more an individual can attribute blame to an external source the less likely they are to feel shame (Lewis, 1995). However due to the developmental stage and attachment needs, young children are more susceptible to the internalisation of blame. Self blame then becomes the precursor of shame.

Pearlman and Courtios (2005) identified difficulties in the sense of self, in relating to others, utilising avoidant coping strategies and revictimisation as key problems for individuals with histories of childhood abuse. A theme of confusion and isolation was prominent in the narratives. Each woman had developed maladaptive coping strategies and behavioural patterns to try and
manage their difficulties but which ultimately reinforced feelings of shame. These experiences are identical to those found by Kaufman's (1996) and in respect of which he coined the term 'shame spirals'; and concluded “when an individual is enmeshed in shame, the focus turns inward and the experience becomes totally internal, frequently with visual imagery present, Shame feelings and their accompanying thoughts flow in a circle, endlessly triggering each other. The event that activated shame is typically relived over and over internally through imagery, causing the sense of shame to deepen and absorb other neutral experiences that happened before as well as those that may come later, until finally the self is engulfed” (p.90).

The confusion expressed by the women participants in this study highlighted how enmeshed and engulfed survivors were with their abusive experiences and the pain associated with that experience. In the literature the attribution pathways to recovery from shame include identifying external causes and influences, the shrinking of global self-judgement and believing in the possibility of change. These women were not able to generate these coping mechanisms within themselves, the abusive experiences had deprived them of the opportunity to develop reflective skills to and appraise situations accurately. Their shameful perceptions were internal, global and stable in nature, consistent with Tangney and Dearing's (2002) conceptualisation. This confusion and isolation appears central to women's difficulties in understanding, articulating and moving on from shame.

An eventual 'breakdown' triggered the mobilisation of therapy. Consistent with the work of Herman (1992), all the women spoke about the impact of, and moving away from, a 'contaminated identity'. This was characterised by the replacement of a defective and blameful self with a more positive, integrated and compassionate self. Within the context of the therapeutic relationship these women were able to dismantle the self that had formed in response to abusive experiences. A progression of moving along the disgust based emotions continuum from global
shame to behaviour specific guilt was observed in the narratives. Tangney and Dearing (2002) suggested that shifting from shame-proneness to guilt-proneness is more adaptive as guilt is associated with less psychological distress.

Instilling hope and providing a space for reflection and growth was nominated by the women as the most powerful factors facilitating the construction of a new empowered self. The literature supports the hypotheses of the importance of a strong therapeutic alliance as an imperative driver in change and treatment outcomes (Martin, Garske & Davis, 2000; Lambert & Barley, 2001). Sexual abuse experienced by children is of intentional interpersonal design and for this reason healing requires positive relationships and connections (Herman, 1992). Therefore a supportive therapeutic alliance can address and repair trauma associated with interpersonal disturbances. This alliance plays a significant role in successful therapeutic outcomes for individuals whose trauma occurred in an interpersonal context (Cloitre, Chase Stovall-McClough & Chemtob, 2004). Providing a secure base within the therapeutic relationship allowed the women participants to explore painful affects and modify negative impacts through connection with others, which facilitated empowerment.

**Discussion**

The aim of this study was to explore the changing experience of shame and guilt among survivors of CSA through the therapeutic process. The results showed that shame, more than guilt, was a core emotion experienced by survivors of abuse and was a consequence of the impact of abuse on the development of the self. Healing involved strengthening a reflective capacity to analyse the role of shame, explore the impact of their histories on current functioning, thus creating new pathways of relating to the self and to others. What was particularly striking, but perhaps unsurprising was when asked directly about their experience of disgust based emotions; survivors
struggled to articulate experiences of shame and much more readily identified experiences of guilt. This highlighted how fused the women were with their shameful self and is consistent with the 'secretive' nature of shame (Livingston, 2006). However chronic shame experiences manifested in participants’ accounts of self, cognitions, affect, behaviours and interpersonal relationships and in the reflective journal.

The first section of the results explored how survivors of childhood abuse experience shame and guilt. These results revealed that participants had internalised a defective, blaming and powerless sense of self. This is in keeping with Fonagy, Target, Gergely, Allen and Bateman (2003) description of shame as “an intense and destructive sense of self-disgust verging on self hatred” (p.445). The narratives also contained trauma inducing factors specific to CSA including traumatic sexualisation, betrayal, powerlessness and stigmatisation (Finkelhor & Browne, 1985). These experiences led to powerful negative affects and contributed to maladaptive coping strategies such as self-harm and substance abuse. In addition abusive experiences adversely impacted on interpersonal relationships, and the majority of the participants had experienced abusive relationships in adulthood. Alarmingly, all the participants had previously made serious suicidal attempts and each had a long history of contact with mental health services. A 'break-down’ was the common precipitant for help being mobilised.

The second section of the results revealed a changing relationship with the self and the mechanisms of therapy which underpinned this process. The construction of a healthier sense of self captured a positive movement from defective personae to more balanced, compassionate, less blaming and more empowered individuals. The process of change and self-discovery explored the mechanisms driving the altered relationship with the self. Barringer (1992) conceptualised a 'spiral' of healing from the impact of CSA as “a repeated traversing of the issues, layer by layer, piece by piece, sorting and resorting, until the toxicity of the abusive experience
has been released” (p.15). These parameters are pertinent to healing the adverse psychological affects associated with shame and guilt. Participants identified developing insight, connecting with emotions and reappraising the legacy of the abuse as important factors in facilitating change in their emotional responses to shame and guilt inducing experiences.

At the heart of traumatic experience is the process of break-down and disorganisation of the self-structure. A consistent finding in the literature suggests that psychological distress occurs when the experience overwhelms an individual’s capacity to cope. Recovery is a concept not only based on symptom remission but also survivors’ personal experience and process over time to reach a meaningful sense of life post-abuse. Two theoretical models of healing from CSA have been proposed by Chouliara, Karatzias and Gullone (2012) and Draucker, Martsolf, Roller, Knapik, Ross and Stidham (2011) respectively. Both models highlight the importance of disclosure and critical life events in the recovery process and the dynamic process of moving on.

Chouliara, Karatzias and Gullone (2012) model emphasises the emotional aspects of shame and guilt and the key role these emotions play in recovery. They postulated that survivors engage in a number of ways to try to cope with the impact of CSA which they characterised as the 'Affected Self'. The moving on process begins with a disclosure which can reduce feelings of hopelessness and helplessness. Alternatively, depending on their experience, feelings of shame and guilt can intensify. The 'Recovering Self' is characterised by increased levels of confidence and assertiveness, acceptance of the whole self and embracing vulnerability. Factors which enhance recovery include strengthening inner resources, developing a more positive self-image and engaging in meaningful relationships and activities. The authors proposed that shame and guilt can prevent individuals from achieving the ‘Recovering Self’. Draucker, Martsolf, Roller, Knapik, Ross and Stidham (2011) conceptualised recovery as achieving psychosocial reintegration into the community. The study identified the first two stages as 'grappling with the
meaning of CSA' and 'figuring out the meaning of CSA' and both involve an increased understanding of the conditions that contributed to the abuse, its impact on current distress and an exploration of blame. The next stage involves 'tackling the effects of CSA' which include mobilising psychological or psychiatric support, making changes in interpersonal relationships and seeking out new occupational or educational opportunities. The final stage they call 'laying claim to one's life' and reflects a stronger internal locus of control.

The findings of this study have similarities with these models but the results indicate that shame is at the core of psychological distress for survivors of childhood trauma and the therapeutic process plays an important role in ameliorating its painful and damaging affects. Unless experiences of these emotions are successfully altered individuals can remain in a vicious shaming cycle. This has a number of clinical implications. A key finding to emerge is the benefit of therapy in offering a safe space to explore beliefs and cognitions which developed in the context of abusive experiences. Tangney and Dearing (2002) postulated that “simply verbalizing the events and associated experiences often serve to ameliorate the feeling of shame. As clients translate into words pre-verbal, global shame reaction, they bring to bear a more logically differentiated thought process” (p.175). Difficulties with trust and being vulnerable with others may hinder this process and priority should be given to establishing a safe base within therapy to foster a positive therapeutic relationship. To achieve a positive result therapists require to be aware of the covert nature of these emotions and of their potential impact on the therapeutic relationship. It is recommended that shame and guilt should be routinely assessed and addressed in therapy in a sensitive manner. At a wider level, survivors of CSA may benefit from media campaigns that normalise their distressing experiences in response to abuse which may reduce feelings of confusion and isolation.

Some limitations should be noted. Data collection took place in Scotland, thus generalising the
findings more widely could encounter difficulties. This is an inherent limitation of qualitative research methodology where the focus is more on producing rich descriptions of the phenomena under investigation rather than large representational sample sizes. Furthermore, the constraints posed by a limited time period and resources may have conceptual limitations. Although ongoing change was captured, the period of time between the sets of interviews was relatively short. It is likely that a time interval of longer duration between the interviews would have led to further refinement of the themes and may have yielded a fuller picture. In addition, selection bias may have been an issue due to the self-selection of a cohort of the sample. No information was gathered on the number of individuals who declined to take part and they may have differed markedly in their experiences of shame and guilt from those who participated. Alternatively persons who declined participation may be still in the isolation and confusion stage of the model. Either way there is no way of knowing. Finally although procedures for ensuring rigour and validity were employed, ultimately the data analysis and interpretation was filtered through the researcher. This process may have been further compounded by the longitudinal aspect. Collating feedback from the participants on the findings of the study would have helped to strengthen the analysis.

Despite these limitations, this study has a number of strengths. First a prospective longitudinal qualitative design was employed. This methodology captured participants' experiences in a different way to those studies using a retrospective design. Retrospective research relies on individuals recalling past experiences and it is suggested that had this methodology been used the complex detail of participants' narratives may have been compromised because of the nature of shame and guilt. Although the analysis of longitudinal data can be more challenging, the temporal structure of the data within the Framework Method allowed for individual change to be monitored and explored. Second, Chouliara et al. (2011) identified a distinctive lack of research with survivors of abuse focused on survivors’ experience. This research aimed to fill that gap by
providing a comprehensive description of survivors’ perspectives of their experiences in both their emotional and therapeutic journeys.

Lewis (1995) proposed females are more likely to internalise and blame themselves for failure and there are gender differences in the experience of shame, by reason of the socialisation process of children. This study did not find themes similar to Dorahy and Clearwater such as dissociation and the pervasiveness and power of doubt and denial. It would be useful if future studies were to explore the model across the genders as this study focused only on women's experiences of shame and guilt.

In conclusion this study provides a detailed description of the experience of disgust based emotions for female survivors of childhood trauma. The participants underwent a changing relationship with the self in consequence of accessing therapy. At the core of these women's difficulties lay chronic feelings of shame.
References


Extended Methodology

4.1 Qualitative Research Design

The main aims of this study were to explore how survivors of Childhood Sexual Abuse experienced emotions of shame and guilt and what processes in therapy facilitated individuals to process and overcome these emotions. A qualitative research design was chosen to address this question in preference to a quantitative research design. The rationale for using this approach was threefold. First qualitative research is a particularly useful methodology when there is little empirical research and understanding in the field. Second qualitative analysis lends itself to detailed examination of complex issues and finally the method of data collection allows for the exploration of deeply rooted experiences that are sensitive in nature and may prove distressing or emotive to participants (Ritchie & Lewis, 2003).

The Framework Analysis method was originally developed for social policy research in the 1980's (Ritchie & Spencer, 1994). Since then it has become increasingly commonplace in applied health research (Smith & Firth, 2011). The method sits broadly within the family of thematic analysis or qualitative content analysis and seeks to develop explanatory conclusions clustered around themes. This is a flexible tool that can be adapted for use with many qualitative approaches that aim to develop themes rather than being aligned to specific epistemological, philosophical or theoretical approaches. Similar to other qualitative approaches, there was ongoing interplay between data collection, analysis and theory development. However the feature of matrix outputs is unique and defining about this approach. This includes cases (rows), category (columns) and 'cells' of summarised data that provides a structure for the systematic reduction and analysis of data by case and code. It affords the ability to compare across cases as well as within individual cases.
Other qualitative approaches were considered, namely Grounded Theory (Strauss & Corbin, 1990) and Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009). The Grounded Theory approach adheres to a strict protocol to generate a theoretical account of a particular phenomenon. The two central components are theoretical sampling, being a strategy to recruit specific individuals in developing theoretical categories combined with the constant comparative method which involves making systematic comparisons across cases to refine themes. The main reason that this approach was discounted was because theoretical sampling was not achievable for this study. For ethical reasons, discussed below, the researcher was reliant on other individuals to recruit participants and as such a purposive sampling method was used. IPA is based on three principles of hermeneutics, phenomenology and idiography. It aims to offer insights into how individuals make sense of a particular experiences. The main reason this approach was discounted was because the aim of the study was to generate a general understanding of shame and guilt for survivors rather than in-depth idiographic accounts.

The Framework Analysis method was employed to analyse the qualitative data over these other approaches because it addressed the aims of the study and generated themes in a systematic manner to provide an overview of issues prominent for survivors of childhood trauma and develop a tentative theory in understanding their changing experience of shame and guilt. This method provided a structured way of managing the large data sets while adhering to the principles of reliability and validity. As the study aims were about the process of change of shame and guilt for the same individuals over a specific time a longitudinal design was deemed most appropriate because of its allowance for participants' experiences of these emotions to be captured at different time points. Farrall (2006) defined longitudinal qualitative research as “returning to interviewees to measure and explore changes which occur over time and the processes associated with these changes” (p.2).
4.2 Researcher Position & Context

There are a number of ontological and epistemological stances within the qualitative field. The ontological stance adopted by the researcher most closely resembles 'subtle realism' (Hammersley, 1992). Subtle realism recognises that the social world does exist independently of individual subjective understanding but that it is only accessible through the human mind and socially constructed meanings. Thus it is understood through individuals' interpretations which then are further interpreted by the researcher. With regard to the epistemological position the researcher embraced aspects of interpretivism, aiming for rich descriptions of participants' accounts while acknowledging the impact she had on process. The inductive – deductive debate is of interest in this context. Themes were generated from the data by use of open coding. However, as a specialist trainee in the area of CSA it was important to consider how previous knowledge and theories influenced the findings. Indeed the researcher's interest in the area of emotions and in particularly shame and guilt grew because of her clinical interactions with individuals who have had experiences of sexual abuse in their childhoods. This research was carried out in the author's final year on the Doctorate of Clinical Psychology.

4.3 Ethical Considerations

Procedures were adopted to help safeguard the participants. Inclusion criteria were confined to individuals over the age of 18 who were accessing psychological therapy for the effects of childhood abuse. Those deemed at high risk of suicide were excluded. A participant information sheet was designed to provide potential participants with clear and comprehensive information regarding all aspects of the study including informed consent, the right to withdraw from the study and confidentiality (see Appendix C).

Safeguarding the confidentiality and anonymity of participants was of paramount importance. Steps
taken to protect the identity of participants included developing a database of personal information stored on a password protected NHS network drive. The principal researcher transcribed all interviews and each participant was given a number referring to their position in the first interview sequence, this number was used in the reporting of the findings. Identifying features contained in the interviews were either removed or changed during the transcription. For example [therapist] was used instead of including the therapist’s name in the transcript.

It was acknowledged that the topic under investigation was emotive in nature and potentially could prove upsetting and distressing for the participants. To help manage this potential difficulty participants were informed at the start of the interview that they could stop and take a break at any stage during the interview. The primary researcher had clinical experience working with this population and monitored participants’ welfare throughout the process. An opportunity to debrief after the interview was available and information about support services in the local community was given to each participant. In addition, by virtue of the inclusion criteria, participants were in active treatment and they were encouraged to discuss any issues raised within their existing professional network. However it was recognised this might prove problematic as part of the interview focused on their therapy experiences. To help overcome this difficulty the contact details of an independent person were provided so that participants could discuss any difficulties with the research process or any issues it raised for them.

Prior to the study being carried out the researcher reflected on potential ethical considerations and distress she might experience. It was decided at the outset that disclosures pertaining to risk which were made during the interview would be discussed in clinical supervision and an appropriate course of action, according to NHS policy, would be taken. Participants were informed of this at the start of the interview. Regular clinical supervision was provided. This is a mechanism used by
health care professionals to process distressing experiences and protect against vicarious trauma. In addition the use of a reflective journal, discussed below, proved essential in helping the researcher reflect on, understand and manage the impact of the research.

4.4 Recruitment

As noted above purposive sampling was considered an appropriate sampling method as it involves selective recruitment of individuals known to have experienced the phenomenon under investigation (Ritchie, Lewis & Elam, 2003). It was decided to keep the inclusion criteria broad so as to try to generate a sample which reflected the complex presentations in clinical settings. Adult survivors of childhood trauma in receipt of therapy related to their abuse history was the only inclusion criterion and those identified by their healthcare professional as having suicidal intent were excluded.

The researcher contacted the primary and secondary mental health care teams in the local vicinity and discussed with them the projects aims. She also presented information about the project at a Continued Professional Development event for psychologists. Some health care professionals (HCP) voiced apprehension about approaching individuals at the start of the therapeutic journey as they were concerned that such an approach may negatively impact on the therapeutic relationship. To address these concerns it was agreed that participants could be recruited at any stage in their treatment, not just at the start of therapy.

Potential participants were identified and approached by their HCP. This was decided upon for ethical reasons, notwithstanding that it potentially induced bias in the sample selection. In addition, by virtue of shame and guilt being secretive in nature individuals with high levels of these emotions may have not opted to participate. This risk could potentially skews the findings.
Recruitment was carried out between September 2012 and February 2013. The contact details of individuals who expressed an interest in taking part were given to the researcher. She then contacted the individuals to arrange a suitable date and time to meet.

4.5 Participant Demographics

Ten individuals agreed to take part in the initial round of interviews. Two were lost to follow-up, thus eight were interviewed at a second time point. Of the two who did not complete the second round of interviews both had dropped out of therapy. Please see Table 1 for participant characteristics.

All participants were women with an age range from 26 to 58 years, mean age of 40.3 years. All were of white British ethnicity. Four of the participants were living with their partners, five were living alone and one was living with her adult children. Seven participants had never married and the remaining three were divorced. Two of the participants identified with homosexual and eight with heterosexual orientation. Four of the participants had attained University qualifications, while the remaining six had reached secondary school level. All the participants had previously worked. At the first round of interviews two had recently returned to full time employment after a period of sick leave, two were involved with voluntary work and the remaining six were unemployed. At the second round of interviews a further two participants had returned to work, one in a voluntary and the other in a paid capacity.

On average the participants had been in therapy for four months prior to the first interview.

Information was gathered from therapists about their therapeutic modality. While the main model reported was Cognitive-Behavioural Therapy, most described using an eclectic mix of therapeutic models.
<table>
<thead>
<tr>
<th>Participant</th>
<th>Age Group</th>
<th>Mental Health Professional(s) Involved</th>
<th>Perpetrator (Male)</th>
<th>Adulthood</th>
<th>Psychiatric Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>25-30</td>
<td>Psychologist &amp; 10 week Complex Trauma psycho-educational group</td>
<td>Outside the family: multiple</td>
<td>SA DA</td>
<td>ED OCD</td>
</tr>
<tr>
<td>2</td>
<td>40-45</td>
<td>Counsellor, Occupational Therapist &amp; 10 week Complex Trauma psycho-educational group</td>
<td>Outside the family</td>
<td>DA</td>
<td>ED</td>
</tr>
<tr>
<td>3</td>
<td>30-35</td>
<td>Psychologist</td>
<td>Outside the family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>25-30</td>
<td>Psychologist</td>
<td>Outside the family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>25-30</td>
<td>Psychologist</td>
<td>Outside the family: multiple</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>45-50</td>
<td>Community Psychiatric Nurse; &amp; 18 week Complex Trauma group</td>
<td>Family member</td>
<td>DA</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>55-60</td>
<td>Psychologist &amp; 18 week Complex Trauma group</td>
<td>Family members: multiple</td>
<td>SA DA</td>
<td>BPD OCD</td>
</tr>
<tr>
<td>8</td>
<td>45-50</td>
<td>Psychologist &amp; 18 Complex Trauma Group</td>
<td>Family member</td>
<td>DA</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>45-50</td>
<td>Psychologist</td>
<td>Family member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>50-55</td>
<td>Community Psychiatric Nurse; &amp; 10 week Complex Trauma</td>
<td>Outside the family</td>
<td></td>
<td>BPD ED</td>
</tr>
</tbody>
</table>

SA: Sexual Assault; DA: Domestic Abuse; ED: Eating Disorder; OCD: Obsessional Compulsive Disorder; BPD: Borderline Personality Disorder
4.6 Data Collection

Data were collected through the use of semi-structured interviews. Participants were interviewed on two separate occasions and written consent was obtained at the start of each interview. The period between the two waves of data collection ranged from three months to seven months, with an average of a five month interval. All interviews were held in an NHS Outpatients Department.

Initially an interview schedule of the key topics and issues to be covered was developed as opposed to specific questions (Legard, Keegan & Ward, 2003). This structure was flexible in nature to encouraging participants to express their views in their own manner and allow for the researcher's understanding to evolve rather that starting from an assumptive position.

At time point one the interview was opened with the question “Can you tell me about what difficulties brought you to seek help?” and the themes covered included childhood experiences, emotions and the impact of the past on the present. According to the principles of qualitative interviewing (Legard, Keegan & Ward, 2003) responses were followed up with relevant prompts and probes such as “can you tell me more about what that was like for you?” so as to penetrate the 'surface' level response and obtain a deeper, more fuller understanding.

After the first two interviews were transcribed and preliminarily coded it became clear that this method was not tapping in sufficiently into experiences of shame and guilt. It was agreed that specific questions about these two emotions would be introduced in the interview at a point when the researcher judged it to be appropriate. These questions were the same for shame and guilt and consisted of (1) do you experience feelings of shame? (2) how do you experience it (3) how often would you say you experience it (4) are there any particular triggers (5) how do you cope with this feeling (6) do you speak to others about it (7) how do you think it relates to your earlier
experiences?

Although these first two interviews could have been used as pilot interviews a decision was made to retain the data for the research study. The reason was two-fold. First the participants did provide information regarding feelings of shame and guilt, and second, ethically it would have been unjust to limit their inclusion to pilot interviews as they had agreed to participate in the second round of interviews which did not require a pilot as there was just one question. In hindsight it might have been more appropriate to have conducted pilot interviews prior to the interview stage so as to ensure the process tapped into the constructs being explored.

At the second time point the interview opened with the question “how have things been since we last met?” Participants were encouraged to reflect on if and how things had changed; what these changes were and the processes that underpinned the change. Again prompts were used to gain fuller descriptions.

4.7 Data Analysis

The analysis required multiple readings and interrogation of the data which asked questions about change and its absence. It employed approaches used in cross-sectional studies, such as exploring diversity, negative or atypical cases, constant comparative method and exploring patterns, in addition to conceptual and thematic linkages. Cross-sectional, within case analysis and between case analysis were employed. This multi-layered nature for analysis of qualitative longitudinal research makes it more complex (Lewis, 2007). The Framework Analysis method provided a structured way of organising and making sense of the data.
At each time point a cross-sectional analysis of the cohort was completed and main themes identified. Data from eight participants, who completed both waves, were paired together and changes analysed. This matrix structure limited the impact of attrition rates on the findings as material is extracted and summarised schematically which allows for analysis for both wave and case. The series of stages for the procedure of analysis are discussed below:

4.7.1 Data management and familiarisation

The first stage in qualitative data analysis is transcribing the interviews. Interviews were transcribed verbatim and this labour-intensive task was completed by the primary researcher. This was in keeping with Yardley's (2008) principle of commitment and rigour as it facilitates the researcher in becoming immersed in the data. Familiarisation was achieved by reading and re-reading the transcripts and the reflective notes.

4.7.2 Indexing

During the initial stages of analysis, notes of the main ideas and topics were collected by the researcher. Once it was felt that the data were adequately represented by the identified categories, each was written on a 'post it' note. This allowed the categories to be explored in different organisations until they were collated into a workable structure which provided the foundation of the indexing framework. It was important that the framework remained flexible and an 'other' category was included to log anomalies which could be later revised. A copy of the initial indexing framework is included in Appendix E. The next stage involved applying this to the whole data set. Each line of the transcripts was considered in accordance with the indexing framework and when a theme or concept was mentioned it was 'indexed'. This was an evolving process and during this stage the indexing framework was revised, with some categories merging and others being removed, so as to best fit the data. Several revisions to the framework were required before the
elimination of additional codes

The same process was repeated at time two and new categories identified were integrated into the initial indexing framework.

4.7.3 Charting and mapping
Thematic charts or matrices were created to enable a view of the whole data set using spreadsheets. A chart for each main theme was developed to include key words, quotations and summarised content for each participant within each thematic sub-topic. Within the matrix index category was represented by a column and each participant was represented by a separate row. This process was completed twice at the two different waves of data collection.

4.7.4 Interpretation
The final stage of framework analysis was to develop a way of summarising and interpreting data in terms of identified patterns, concepts and explanations. The reflective journal included impressions and early interpretations of the data to assist interpretation. These matrices within the framework method allowed for cross-sectional analysis at each time point as well as whole case summaries and thematic analysis of key issues across cases at different time points.

4.7.5 Computer Software
The analysis of the qualitative data was aided by using the computer programme NVivo 9. This helped to organise and track the analysis process. Once transcribed the interviews were imported into the programme. Codes (nodes) were assigned to text according to the indexing framework.
<table>
<thead>
<tr>
<th>Participant</th>
<th>Relationship self</th>
<th>Relationship others (general)</th>
<th>Other Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1 29 y.o</td>
<td>hates self / body “everything is a reminder” p5 doesn't think any good qualities 'bad' Feels responsible for the abuse – paedophile ring “the only way I can make sense of it is to blame me” p3 “a horrible person evil just like them” p11 “look stupid, vulnerable an easy target” p3 'unlovable' / never felt loved “I feel I am just here for people to do what they want with me” p3 self harming</td>
<td>Poor relationship with M M. uncaring “shut up &amp; stop crying do you want everyone to know your secret” p8 “we don't speak about anything important” p8 Neglect “that is why they shut me away so that they could have their little life and get drunk” p10 SD “didn't like me he made that obvious... I was just a hassle to have around” p10</td>
<td>No supports when younger “there wasn't anybody to protect me I didn't know what that was I didn't get hugs or so being hurt was normal” p8 Isolated Only child making sense feels like a burden</td>
</tr>
<tr>
<td>P2 43 y.o</td>
<td>An outsider p2 poor self care / hates body p6 “I just feel like this puppet on a string” p10 “I am weak” p16 difficulties with assertiveness – aggression p16 “to describe myself as a person is v hard... I am not a nice person” p22 “I don't feel an adult either” p23 “I am not good enough / “feel like just like a piece of meat sometimes” p24 'bad' / 'feel like damaged goods' p24</td>
<td>“I destroy good relationships because of my insecurities” p.5 pushes people away Feels like pretending to be OK p5 “I am burdening yous.. I am going to let you get on with your life and I am not going to be a part of it anymore” p6 compares self neg to friends p20* “I never felt part of anything as a kid you know if you are in a rel at least somebody wants to be with you” p21 cross with self for not being stronger feels let down by parents didn't see a change in her</td>
<td>Violent household both parents alcoholics crying was a sign of weakness in family Raised her younger sister – responsibility “that is kind of weird I am 43 and I don't know who I am” p24</td>
</tr>
</tbody>
</table>
Table 3: Example of a Thematic Chart Pairing Time One & Time Two for Sense of Self

<table>
<thead>
<tr>
<th>No</th>
<th>Time One</th>
<th>Time Two</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>hates self / body</td>
<td>“I knew that if I didn't do it they would really kind of hurt me and it was really horrific as well what they did if we ever said no to them” p3</td>
<td></td>
</tr>
<tr>
<td>29y</td>
<td>“everything is a reminder” p5</td>
<td>“it was just at the beginning that he did that he soon turned a lot more sinister and he already had me trapped ..he didn't care if I enjoyed it it was more about like he enjoyed hurting me and then when the others came as well they did the same” p7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>doesn't think any good qualities 'bad'</td>
<td></td>
<td>Shift in shame observed, moved from a global sense of being bad and shameful to feelings of guilt re: specific situations</td>
</tr>
<tr>
<td></td>
<td>Feels responsible for the abuse – paedophile ring</td>
<td></td>
<td>More emotional at second interview – lots of affect</td>
</tr>
<tr>
<td></td>
<td>“the only way I can make sense of it is to blame me” p3</td>
<td></td>
<td>Change in how the situation is appraised, more distant / reflective about factors and context of abuse</td>
</tr>
<tr>
<td></td>
<td>“a horrible person evil just like them” p11</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“look stupid, vulnerable an easy target” p3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>'unlovable' / never felt loved “I feel I am just here for people to do what they want with me” p3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>self harming</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Space to do other things which she enjoys (see Theme 1B personal details)</td>
</tr>
</tbody>
</table>
4.8 Reflective Journal

In qualitative research it is proposed that the primary investigative tool is the 'person' of the researcher (Mays & Pope, 1996). Throughout the research a reflective journal was kept with the aim of making explicit the researcher's subjective reactions and 'internal processes' so as to increase transparency in relation to the analysis procedure. Field notes were written up after each interview which included content of the interview and reflections about the process and interaction between the researcher and the participant. Particular attention was given to non-verbal information and the tone of the interview. Throughout the analysis of the data, memos were written to integrate and track new insights. These memos increased the level of abstraction and guided theorising about the data (Mays & Pope, 2000). Experts of three memos are given below:

Memo: If the perpetrator is not to blame then who is?

I have just completed another interview and again struck by how forcefully these ladies feel a sense of blame for what has happened to them. Participant 7 struggled to see herself outside of the abusive experience, it consumes her in every sense and interferes with everything in her daily life. Again she acknowledged logically children are not responsible and are powerless to stop situations however she can't shift 'that feeling in me bones'. What is it that stops this logical step of blaming the perpetrator appropriately, is it shame? Is it that she can't distance herself to reflect? Like in previous interviews it is like they are still in the egocentric stage of development. She strikes me as a very caring and compassionate lady but at this point is not able to generate compassion for her own circumstances. Like all of the women so far she is there for others when they need her, has been a source of support. What is blocking this process for her and stopping her from seeing that she is not to blame. Is it 'badness', is it hate? What happens when you can't blame the perpetrator for the crimes they have committed?
Memo: Researcher's avoidance

I have just realised that it has been two weeks since participant 5's interview and I have yet to transcribe it. Am I experiencing a form of avoidance! Looking back over the notes I wrote I felt an overwhelming sense of sadness and hopelessness after the interview was conducted. Out of all the interviews conducted so far she was the most articulate about her experiences of shame and described beautifully how it affected her. Need to discuss this with supervisor.

Memo: Researcher v Clinician

The role of researcher v clinician came into play again. I was delighted to hear that participant 1 has shifted from a core sense of blame, there has been a change and she said that she did realise that the abuse was not her fault however elements of guilt have swept in. I found I had to bite my tongue and not jump in. There was a window of opportunity to examine this further and if she was a patient I know exactly what I would do. However I am not, I am a researcher and my role was to elicit as much information about her experience as possible. A number of times now I have questioned if this is ethically right, is there a chance that I am inadvertently reinforcing feelings of blame and shame by keeping my 'researcher hat' on? It is a tricky balance.

4.9 Validity and Quality

In order to maintain reliability and validity within the qualitative analysis process, the researcher adhered to the four flexible and open-ended principles proposed by Yardley (2000). These included (i) sensitivity to context; (ii) commitment and rigour (iii) transparency and coherence and (iv) impact and importance.

Sensitivity to context can be demonstrated through an awareness of the social-cultural setting, recognition of the power imbalance between researcher and participants and how the researcher's own perceptions and actions can impact on the data. For the present study two specific contextual f
Commitment infers extensive engagement with relevant background literature and for the need of the researcher to develop competencies and skills within the qualitative approach. For the present study the researcher strove to achieve commitment by carrying out a comprehensive review of the literature, transcribing all the interviews and consulting with various professionals in the field.

Rigour refers to methodological thoroughness, in terms of how appropriate sampling and data collection techniques are evaluated, and how credible the reader deems the data analysis. The broad inclusion criteria for the present study facilitated the inclusion of multiple psychological presentations related to childhood abuse. The sample was therefore relatively homogeneous. Although it was not possible to gain a full second opinion on applying the codes to data, three researchers were consulted through the process. Discussions were carried out on the emerging themes in the data, potential refinements, the development of matrices, cases which provided contradictory accounts and interpretation. The researcher routinely checked themes against the individual transcripts to ensure they were data-driven.
Transparency refers to the extent to which the researcher discloses and clearly documents all steps undertaken in the analytic process. The researcher aimed to carry out the analysis in a clear and transparent manner by using summary tables, illustrative quotes from the participants and extracts from the reflective journal.

Coherence refers to whether findings are presented in a way that is consistent with the research questions and methodological approach. Efforts to increase coherence included discussions in supervision about the themes emerging from the data.

The final principle refers to whether research finding will be of interest to readers and more importantly contribute and inform clinical practice. It is anticipated that the results of the present study may offer new insight to professionals working with individuals with mental health difficulties as a consequence of childhood abuse.

In conclusion this study provided an insight into the impact of abuse on the development of the self for survivors of childhood abuse. Early traumatic experiences had given rise to the construction of a shameful and damaged sense of self. An understanding of the importance and role that shame plays in the lives of survivors and the essential mechanisms for inducing change can help professionals tailor interventions to best meet the needs of the individual. Through providing such interventions it is hoped that survivors can develop an exit pathway from mental health difficulties and improve their quality of life.
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Yanos, P.T., Czaja, S.J. & Widom, C.S. (2010). A Prospective Examination of Service Use by


Appendix A: Flow chart of selection procedure for Systematic Review

![Flow chart](image)

* Batten et al. (2002); Brotto et al. (2012); Clarke & Llewelyn (1994); Cloitre et al. (2010); Devilly (2001); Dodds (1996); Dorrepaal et al. (2012); Dorrepaal et al. (2010); Fallot et al. (2011); Freyd et al. (2005); Ghee et al. (2009); Hall et al. (1995); Hein et al. (2004); House (2006); Jespen et al. (2009); Jung & Steil (2012); Kaiser et al. (2010); Kearns et al. (2010); Kellett (2005); Kimbrough (2010); Korn & Leeds (2002); Kraftcheck et al. (2007); Krakow et al. (2001); Kreidler (2012); Kreidler (2005); Kriedler et al. (1999); Lau & Kristensen (2007); Langmuir et al. (2012); Longstreth et al. (1998); Lubin et al. (1998); Lundqvist & Ojehagen (2001); MacIntosh & Johnson (2008); Marcello et al. (2009); Marks et al. (1998); Masten et al. (2007); Morrison & Treliving (2002); Najavits et al. (2005); Najavits et al. (1998); Paivio et al. (2010);
Paivio & Greenberg (1995); Perry & Bond (2012); Pole & Bloomberg-Fretter (2006); Poleshuck at al. (2009); Poon (2009); Price et al. (2005); Price (2004); Resick et al. (2008); Roberts & Lie (1989); Ryan et al. (2005); Sachsse et al. (2006); Scheck at al. (1998); Searcy & Lipps (2012); Sharpe et al. (2001); Sikkema et al. (2004); Smith (2004); Smith (1995); Stalker & Fry (1999); Steil et al. (2011); Talbot et al. (2011); Talbot et al. (2005); Talbot et al. (1999); Taylor & Thordarson (2002); Trute et al. (2001); Turner et al. (1996); Van Velsor & Cox (2001); Vitriol et al. (2009); Wade & Meyer (2009); Wright et al. (2003); Zaidi (1994); Zayfert et al. (2005); Zeper (1997); Zobel et al. (2011).

b Lundqvist et al. (2006); Morgan & Cummings (1999); Paivio et al. (2001); Richter et al. (1997); Saxe & Johnson (1999); Westbury & Tutty (1999).

c Foa et al. (2005); Foa et al. (1999); Leirvag et al. (2010); Monson et al. (2012); Payne et al. (2007); Resick et al. (2002); Rothbaum (1997); Tarquino et al. (2012).


* Anderson et al. (2010); Ginzburg et al. (2009); Meade et al. (2010); Owens et al. (2001); Sikkema et al. (2007); Wyatt et al. (2004).

† Classen et al. (2005); Rieckart & Moller (2000).• Bergeron & Hebert (2006); Lampe et al. (2008).• Zlotnick et al. (1997).
## Appendix B: Quality Ratings of Studies in Systematic Review

WC: Well Covered; AA: Adequately Addressed; PA: Poorly Addressed; NR: Not Reported

<table>
<thead>
<tr>
<th>Study</th>
<th>Research Question</th>
<th>Random</th>
<th>Conceal-ment</th>
<th>Groups similar at the start</th>
<th>Difference is treatment</th>
<th>Outcome measure</th>
<th>Drop Out</th>
<th>ITT</th>
<th>Power</th>
<th>Fidelity</th>
<th>Quality rating</th>
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<tbody>
<tr>
<td>Alexander et al (1989)</td>
<td>AA</td>
<td>AA</td>
<td>NR</td>
<td>NR</td>
<td>PA</td>
<td>WC</td>
<td>WC</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>Bradley &amp; Follingstad (2003)</td>
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<td>PA</td>
<td>NR</td>
<td>AA</td>
<td>AA</td>
<td>WC</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
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<td>Chard (2005)</td>
<td>AA</td>
<td>AA</td>
<td>WC</td>
<td>WC</td>
<td>AA</td>
<td>WC</td>
<td>WC</td>
<td>AA</td>
<td>NR</td>
<td>WC</td>
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<td>Classen et al (2011)</td>
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<td>WC</td>
<td>AA</td>
<td>PA</td>
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<td>NR</td>
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<td>NR</td>
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<td>Cole (2007)</td>
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<td>WC</td>
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<td>7</td>
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</table>
Appendix C: Participant Information Sheet

Survivors of Childhood Adverse Experiences & Emotions

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Contact us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
It is very common for people who have had adverse childhood experiences to feel high levels of shame and guilt. These are painful emotions that we can find difficult to talk about however an important part of the recovery journey is to address these feelings. This study will explore the feelings of shame and guilt and seek to understand how people’s ability to cope and deal with these emotions changes over the course of therapy. Understanding what is and isn’t helpful may be able to help us improve future therapeutic interventions.

Why have I been asked to take part?
You have been invited to take part in this research project because you have experienced adversity in your childhood and therefore you may be able to provide us with information which helps us better understand the emotional experiences for adult survivors.

Do I have to take part?
No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. Deciding not to take part or withdrawing from the study will not affect the healthcare that you receive.
What will happen if I take part?
If you agree to take part you will be interviewed twice, once near the start of therapy/intervention and another at a later date (about 3 months later). Interviews will be carried out at a location that is convenient for you, as far as possible. This may involve attending your local health centre or at the Outpatient Department at the Royal Edinburgh Hospital.

The researcher will contact you to arrange a time and date that is convenient. Interviews will last a maximum of 60 minutes. Only the researcher and you will be present at the interview so nobody else will have access or hear what you say. Interviews will be audio-taped and transcribed and all information will be anonymised. The audio-tapes will be kept in a locked filing cabinet and will be destroyed once the interview has been transcribed.

All information that is collected about you during the course of the research will be kept strictly confidential. Your name and any other personal details will be removed from the final report so that you cannot be identified from it. Furthermore your care providers (eg: psychologist, GP or CPN etc) will not be aware of what you discuss during the interviews.

What are the possible advantages involved in taking part?
There are not expected to be any direct advantages to you personally from taking part in the study. However it is hoped that, by finding out more about people’s experiences of coping with painful emotions will help us to offer an improved service in the future.

What are the possible disadvantages and risks involved in taking part?
It is possible that talking about your adverse childhood experiences might cause you some distress. You will be able to bring someone with you to the interview if you choose, as long as this person does not contribute to the interview. If you do become distressed during the interview, you will be given the option to pause or stop the interview. You may withdraw at any stage. You will have the opportunity to talk about your experiences to the researcher who has experience working with survivors of childhood trauma.

Who is organizing and funding the research?
This is a Doctorate of Clinical Psychology student project organized by the University of Edinburgh and NHS Lothian.
Who has reviewed this study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable ethical opinion obtained from the South East Scotland REC. NHS management approval has also been obtained.

Further information and contact details
For further information about the topic of this study, or details of the study itself, please contact the researcher – Deirdre Buckley (Trainee Clinical Psychologist) Psychology Department, MacKinnon House, Royal Edinburgh Hospital Tel: 0131 5376904.

If you would like to discuss this study with someone independent of the study team please contact Professor Thanos Karatzias at 01315376904 (please leave a message with the secretary and he will contact you as soon as possible).

If there is a problem
If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. I can be contacted at the Department of Psychology on 0131 5376904. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure.

Thank you for taking the time reading this information sheet.
Appendix D: Letters of Ethical Approval

Lothian NHS Board

South East Scotland Research Ethics Committee 02
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Telephone 0131 536 9000
Fax 0131 465 5789
www.nhslothian.scot.nhs.uk

Date 02 July 2012
Your Ref
Our Ref
Enquiries to: Joyce Clearie
Extension: 35674
Direct Line: 0131 465 5674
Email: Joyce.Clearie@nhslothian.scot.nhs.uk

02 July 2012
Ms Deirdre Buckley
Trainee Clinical Psychologist
NHS Lothian
Psychology Department
MacKinnon House
Royal Edinburgh Hospital, Edinburgh
EH10 5HF

Dear Ms Buckley

Study title: A longitudinal qualitative exploration on the role of shame and guilt in the recovery journey for adult survivors of childhood abuse.

REC reference: 12/SS/0092

Thank you for your letter of 29 June 2012, responding to the Committee’s request for further information on the above research and submitting revised documentation. The further information was considered in correspondence by the chair on behalf of the REC.

Confirmation of ethical opinion
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.
Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at [http://www.rdforum.nhs.uk](http://www.rdforum.nhs.uk).

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
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<tr>
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<td>29 June 2012</td>
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<td>CI Buckley</td>
<td>01 June 2012</td>
</tr>
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<td>Investigator CV</td>
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<td>Participant Consent Form: PCF</td>
<td>3</td>
<td>29 June 2012</td>
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<td>Participant Information Sheet: PIS</td>
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<td>01 June 2012</td>
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<td>Protocol</td>
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<td>22 April 2012</td>
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<tr>
<td>REC application</td>
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<td>01 June 2012</td>
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<td>Response to Request for Further Information</td>
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</table>

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements.

The attached document "After ethical review – guidance for researchers" gives detailed guidance.
on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

**Feedback**

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

| 12/SS/0092 | Please quote this number on all correspondence |

With the Committee’s best wishes for the success of this project

Yours sincerely

Mr Thomas Russell
Chair

Email: joyce.clearie@nhslothian.scot.nhs.uk

Enclosures: After ethical review – guidance for researchers [SL-AR2]

*Copy to:* Ms Marianne Laird
Ms Karen Maitland, NHS Lothian
University Hospitals Division
Queen’s Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

CPP/SS/approval

09 July 2012
Ms Deirdre Buckley
Psychology Department
MacKinnon House
Royal Edinburgh Hospital
Edinburgh
EH10 5HF

Research & Development
Room E1.12
Tel: 0131 242 3330
Fax: 0131 242 3343
Email: R&DOffice@luht.scot.nhs.uk
Director: Professor David E Newby

Dear Ms Buckley

<table>
<thead>
<tr>
<th>Lothian R&amp;D Project No: 2012/P/PSY/21</th>
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<tr>
<td>REC No: 12/SS/0092</td>
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<td>CTA No: N/A</td>
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<td>Consent Form: Version 3 dated 29 June 2012</td>
</tr>
<tr>
<td>Protocol: Version 3 dated 22 April 2012</td>
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</tbody>
</table>

I am pleased to inform you that this study has been approved for NHS Lothian and you may proceed with your research, subject to the conditions below. This letter provides Site Specific approval for NHS Lothian.

Please note that the NHS Lothian R&D Office must be informed if there are any changes to the study such as amendments to the protocol, recruitment, funding, personnel or resource input required of NHS Lothian. This includes any changes made subsequent to management approval and prior to favourable opinion from the REC.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please inform this office when recruitment has closed and when the study has been completed.

I wish you every success with your study.

Yours sincerely

Dr Christine P Phillips
Deputy R&D Director

Cc Paul Dearie, QA Manager
Appendix E: Initial Indexing Framework

Index One: personal details
1.1 relationship status
1.2 employment
1.3 living arrangements
1.4 psychiatric diagnosis
1.5 other issues

Index Two: life history
2.1 sexual abuse in childhood
2.2 physical abuse in childhood
2.3 emotional abuse in childhood
2.4 neglect in childhood
2.5 relationships with family in childhood
2.6 sources of support in childhood
2.7 housing situation in childhood
2.8 abusive relationships in adulthood
2.9 other issues

Index Three: health care
3.1 experiences of seeking help from professionals
3.2 good/ things that were helpful
3.3 bad/ things that weren't helpful
3.4 making links / sense of life story
3.5 other issues

Index Four: relationships
4.1 relationship with self
4.2 intimate relationships
4.3 relationship with friends
4.4 relationship with mother
4.5 relationship with perpetrator
4.6 relationship with partner
4.7 other issues

Index Five: psychological experiences
5.1 flashbacks
5.2 coping strategies drugs & alcohol
5.3 blocking it out
5.4 fantasy world
5.5 loss / grief
5.6 breakdown / crisis
5.7 suicide or self-harming / overdoses
5.8 disclosures
5.9 fears for the future
5.10 other issues
Index Six: tasks
6.1 negotiate reminders / media
6.2 others opinions
6.3 becoming vulnerable with others
6.4 doing things differently
6.5 ground hog day / breaking free
6.6 connecting
6.7 other issues

Index Seven: other issues
7.1 medication
7.2 power
7.3 abandonment
7.4 rejection
7.5 other issues
Appendix F: Journal of Traumatic Stress

Author Guidelines

1. The Journal of Traumatic Stress accepts submission of manuscripts online at:

http://mc.manuscriptcentral.com/jots

Information about how to create an account or submit a manuscript may be found online in the "Get Help Now" menu. Personal assistance also is available by calling 434-817-2040, x167.

2. Three paper formats are accepted. All word counts should include references, tables, and figures. Regular articles (no longer than 6,000 words) are theoretical articles, full research studies, and reviews. Purely descriptive articles are rarely accepted. In special circumstances, the editors will consider longer manuscripts (up to 7,500 words) that describe complex studies. Authors are requested to seek special consideration prior to submitting manuscripts longer than 6,000 words. Brief reports (2,500 words) are for pilot studies or uncontrolled trials of an intervention, case studies that cover a new area, preliminary data on a new problem or population, condensed findings from a study that does not merit a full article, or methodologically oriented papers that replicate findings in new populations or report preliminary data on new instruments. Commentaries (1,000 words or less) cover responses to previously published articles or, occasionally, essays on a professional or scientific topic of general interest. Response commentaries, submitted no later than 8 weeks after the original article is published (12 weeks if outside the U.S.), must be content-directed and use tactful language. The original author is given the opportunity to respond to accepted commentaries.

3. The Journal follows the style recommendations of the 2010 Publication Manual of the American Psychological Association (APA; 6th). Manuscripts should use non-sexist language. Files must be formatted using letter or A4 page size, 1 inch (2.54 cm) margins on all sides, Times New Roman 12 point font, and double-spacing for text, tables, figures, and references.

4. The title page should include the title of the article, the running head (maximum 50 characters) in uppercase flush left, author(s) byline and institutional affiliation, and author note (see pp. 23-25 of the APA manual).

5. An abstract no longer than 200 words follows the title page on a separate page.

6. Format the reference list using APA style: (a) begin on a new page following the text, (b) double-space, (c) use hanging indent format, (d) italicize the journal name or book title, and (e) list alphabetically by last name of first author. If a reference has a Digital Object Identifier (DOI), it must be included as the last element of the reference.

Journal Article

7. Tables and figures should be formatted in APA style. Count each full-page table or figure as 200 words and each half-page table or figure as 100 words. Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table and figure should begin on a separate page. Only black and white tables and figures will be accepted (no color). Figures (photographs, drawings, and charts) should be numbered (with Arabic numerals) and referred to by number in the text. Place figures captions at the bottom of the figure itself, not on a separate page. Include a separate legend to explain symbols if needed. Figures should be in Word, TIFF, or EPS format.

8. Footnotes should be avoided. When their use is absolutely necessary, footnotes should be formatted in APA style and placed on a separate page after the reference list and before any tables.

9. The Journal uses a policy of unmasked review. Author identities are known to reviewers; reviewer identities are not known to authors. During the submission process, authors may request that specific individuals not be selected as reviewers; the names of preferred reviewers also may be provided. Authors may request blind review by contacting jots@ucsf.edu prior to submission in order to provide justification and obtain further instructions.

10. Statement of ethical standards: All work submitted to the Journal of Traumatic Stress must conform to applicable governmental regulations and discipline-appropriate ethical standards. Responsibility for meeting these requirements rests with all authors. Human and animal research studies typically require approval by an institutional research committee that has been established to protect the welfare of human or animal subjects. Data collection as part of clinical services or for program evaluation purposes generally does not require approval by an institutional research committee. However, analysis and presentation of such data outside the program setting may qualify as research (i.e., an effort to produce generalizable knowledge) and require approval by an institutional committee. Those who submit manuscripts to the Journal of Traumatic Stress based on data from these sources are encouraged to consult with a representative of the applicable institutional committee to determine if approval is needed. Presentations that report on a particular person (e.g., a clinical case) also usually require written permission from that person to allow public disclosure for educational purposes, and involve alteration or withholding of information that might directly or indirectly reveal identity and breach confidentiality.

11. Reports of randomized clinical trials should include a flow diagram and a completed CONSORT checklist (available at http://consort-statement.org/resources/downloads). The checklist should be designated as a "Supplementary file not for review" during the online submission process. As of 2007, the Journal of Traumatic Stress now follows CONSORT Guidelines for the reporting of randomized clinical trials. Please visit http://consort-statement.org for information about the consort standards and to download necessary forms.

Submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere. A statement transferring copyright from the
authors (or their employers, if they hold the copyright) to the International Society for Traumatic Stress Studies will be required before the manuscript can be accepted for publication. Click on the Copyright Transfer Agreement link above for the form. Such a written transfer of copyright, which previously was assumed to be implicit in the act of submitting a manuscript, is necessary under the U.S. Copyright Law in order for the publisher to carry through the dissemination of research results and reviews as widely and effectively as possible.

13. Pre-Submission English-Language Editing: Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. Japanese authors can find a list of local English improvement services at http://www.wiley.co.jp/journals/editcontribute.html. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

14. The author(s) are required to adhere to the "Ethical Principles of Psychologists and Code of Conduct" of the American Psychological Association (visit apastyle.org) or equivalent guidelines in the study's country of origin. If the author(s) were unable to comply, an explanation is requested.

15. The journal makes no page charges. Author Services – Online production tracking is now available for your article through Wiley-Blackwell’s Author Services. Author Services enables authors to track their article - once it has been accepted - through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated emails at key stages of production. The author will receive an email with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete email address is provided when submitting the manuscript. Visit http://authorservices.wiley.com/ for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission, and more. Corresponding authors: In lieu of a complimentary copy free access to the final PDF offprint of your article will be available via Author Services only. Please therefore sign up for Author Services if you would like to access your article PDF offprint and enjoy the many other benefits the service offers. Should you wish to purchase reprints of your article, please click on the link and follow the instructions provided: https://caesar.sheridan.com/reprints/redir.php?pub=10089&acro=JTS

Appendix G: Journal of Child Sexual Abuse

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

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.

The Journal of Child Sexual Abuse receives all manuscript submissions electronically via their ScholarOne Manuscripts website located at: http://mc.manuscriptcentral.com/WCSA . ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, as well as facilitating the review process and internal communication between authors, editors and reviewers via a web-based platform. For ScholarOne Manuscripts technical support, you may contact them by e-mail or phone support via http://scholarone.com/services/support/ . If you have any other requests please contact the journal at journals@alliant.edu

The Journal of Aggression, Maltreatment, and Trauma, the Journal of Child and Adolescent Trauma, and the Journal of Child Sexual Abuse are 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.

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. As an author you are required to secure permission if you want to reproduce any figure, table or extract text from any other source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source). All accepted manuscripts, artwork, and photographs become the property of the publisher. In addition, please submit a separate document clearly outlining if: (a) if the author has any financial conflicts of interest, (b) if you have approval from your Institutional Review Board for a study involving animal or human patients, (c) if there are any informed consent notifications to state. Please see: http://journalauthors.tandf.co.uk/preparation/copyright.asp#link3 for more details. Please note that The Journal of Child Sexual Abuse uses CrossCheck™ software to screen papers for unoriginal material. By submitting your paper to The Journal of Child Sexual Abuse you are agreeing to any necessary originality checks your paper may have to undergo during the peer review and production processes.

Manuscript Format: All manuscripts submitted to the Journal of Child Sexual Abuse must 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. The title page should also include author address and contact information for correspondence, affiliation, and eight keywords or phrases for abstracting. Each article should be summarized in an abstract of not more than 120 words. Avoid abbreviations, diagrams, and reference to the text in the abstract. Please consult our guidance on keywords here.

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